STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964591	02/25/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Horizon Bay Vibrant Retirement Living 447	500 Grand Plaza Drive Orange City, FL 32763	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0079 - 58a-5.019(3) Fac - Staffing Standards - Levels S-S= D
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0165 - 429.23(1-4 & 6-10) Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced biennial licensure survey was conducted at Horizon Bay Vibrant Retirement Living on 25, 2015. Deficiencies were identified.

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation, and staff interview the facility failed to ensure personal privacy for 1 out of 2 sampled Residents (Residetn # 12), and failed to display the AHCA poster in full view in a common area. This had the potential to effect all 74 residents.

The findings include:

1. During medication pass observation on _____ Employee A was observed leaving Resident #12's _____ the Medication Observation Record (MOR)computer screen open with Resident #12's photograph and medication information exposed. The nurse continued to push the medication cart down the hall into the elevator and up to the second floor. The nurse was observed coming off the elevator and continued to push the medication cart down the hall of the second floor to the medication _____ closing the MOR computer screen.

During an interview on _____ at 2:30pm with Employee A, she confirmed that the MOR computer screens are to be closed when leaving the Medication Cart unattended or when transporting the Medication Cart throughout the facility.

2. A tour was conducted of the facility on _____ at 9:40 AM, and revealed that the AHCA poster was not displayed in the facility.

An interview was conducted on _____ at 2:20 PM with the facility Executive Director and she confirmed the AHCA poster was not posted.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on observation, record review, and staff interview the facility failed to proerly label prescription drugs for 1 out 4 sampled Residents. (Resident #12)

The findings include:

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During medication observation Employee A was observed with a bottle of syrum eye drops for Resident #12.

Record review of Resident #12's Medication Observation Record (MOR) revealed an order for syrup eye drops instill one drop in each eye 4 times a day.

Record review for Resident #12 revealed a physician order for syrum eye drops instill one drop to both eyes 4 times daily.

Record review of Resident #12's prescribed syrum eye drop bottle box revealed a label that was wrapped around the eye drop box that read eye drops instill one drop in each eye twice daily.

During an interview on at 12:00pm with Employee B, she stated that there was not a physician order label on the syrum eye drop box. She also confirmed that the eye drops were in the correct box but had the wrong label wrapped around the box. She reported the label was for eye drops to instill one drop to both eyes twice daily.

Class III

0079-Staffing Standards - Levels 58A-5.019(3) FAC
Based on a review of employee records, and interview with staff, the facility failed to have a staff member on duty with current First Aid on for the 11:00 pm -7:00 am shift, which had the potential to affect all the residents for the current census of 74.

The Findings Include:

A personnel file review was conducted for the Employees scheduled on the 11:00 pm -7:00 am (overnight) shift. The review revealed none of the scheduled employees for the overnight shift had current First Aid training.

An interview was conducted with the Business Office Manager on at 2:10 pm. She confirmed there was no staff on the 11:00 pm -7:00 am shift with current First Aid training.

Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC
Based on employee record review and staff interview, the facility failed to provide required trainings on safe food handling practices, and emergency preparedness and evacuations to 1 of 3 sampled employees (Employee F), and on reporting major incidents and resident rights to 1 of 3 sampled employees (Employee G) within 30 days of hire. In addition, the facility failed to provide the required three hour training in activities of daily living (ADLs) and behavioral needs to 1 of 3 sampled employees (Employee F).

The findings include:

A personnel file review conducted for Employee F revealed she was hired on as a resident care aid. The file contained no documentation Employee F had received the required training in safe food handling practices, emergency preparedness and evacuations, or reporting major incidents within 30 days of hire. In addition,

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Employee F had not received the required three hour training in ADLs and resident's behavioral needs.

A personnel file review conducted for Employee G found she was hired on _____ as a Licensed Practical Nurse. There was no documentation Employee G received the required training in resident rights within 30 days of hire.

An interview was conducted with the Business Office Manager on _____ at 12:55 pm. She reviewed the records and confirmed the missing trainings.

Class III

0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on observation, and staff and resident interviews, the facility failed to post a planned weekly menu. This had the potential to impact 74 out of 74 residents.

The findings include:

An observation of the facility posted information was conducted on _____ at 11:45 am. At no location in the facility was the weekly planned menu posted. On the wall of the dining , only the current day's menu was posted.

An interview was conducted with the food service manager on _____ at 12:39 pm, who confirmed the weekly menus were not posted at the time of the observation. The food service manager stated the menus had been removed for remodelling, and never replaced.

An interview was conducted with Resident #21 on _____ at 12:00 pm. She confirmed there was no weekly menu posted in the facility, stating she only knew what was being served in the dining that same day.

Class III

0165-Risk Mgmt & QA; Adverse Incident Report 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC
Based on a review of facility records, and interview with staff, the facility failed to provide, within 15 days of an occurrence of an adverse incident, a full report to the agency for 2 of 11 sampled residents who had adverse incidents in the facility (Residents # 13, #19), and failed to file the reports in a timely manner for 5 of 11 sampled residents (Residents # 14, #15, #17, #19, #20).

The findings include:

A facility record conducted for Resident #13 found that on , she eloped on foot to walk to a neighboring drug store. The investigation reported Resident #13 forgot to sign out, and returned to the facility without injures. The 1-day adverse incident report was filed on , however no 15-day report was filed.

A review of the adverse incident report for Resident #14 dated _____ found he was discovered on his floor next to his bed. Resident #14 was face up, and had received a laceration above right eye. He was sent to the emergency department for evaluation and treatment. The 1-day report was filed , however, the 15-day

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report was not filed until , 20 days later.

On , Resident #15 was found outside, face down on the pavement. Resident #15 told staff that she . . . l off of the curb. She was evacuated to the hospital emergency department. The 1-day adverse incident report was filed on . . . . . The 15-day report was not filed until ; 21 days later.

An adverse incident report filed for Resident #17 on . . . . . revealed the resident eloped from the facility on . . . . . to a restaurant across the street. Resident #17 had last been seen in the facility at 5:30 pm on this same evening. She was returned to the facility by a local business employee at 6:00 pm. The 1-day report was filed on . and the 15-day report was filed on ; 18 days later.

On , Resident #18 left the facility on her motorized scooter without signing herself out. The police notified the facility that the resident had been located, and she was retrieved from the community, and returned to the facility. The 1-day adverse incident report was filed on . There was no 15-day report filed.

On , Resident #19 eloped from the facility. A neighboring community phoned the facility to report Resident #19 was in the area with her walker, and did not know where she resided, nor did she know her own name. The resident was returned to the community by the Executive Director (ED) and another employee. A day-1 adverse incident report was filed on ; 2 business days later. There was no 15-day report filed.

A report dated . . . . . for Resident #20 revealed she departed the facility on . . . . . without signing herself out. She was noted to have left on foot with another resident, who also failed to sign out. A visitor alerted staff that Resident #20 had been observed leaving the area. Facility staff located the resident(s), and the family member hired a private duty aide for Resident #20's safety until she could be relocated to a more secure location. The 1-day adverse incident report was filed on . . . The 15-day report was not filed until , 22 days later.

A report dated for Resident #15 revealed she departed the facility on . . . with Resident #20 without signing herself out. A visitor alerted staff that Resident #15 had been observed leaving the area with another resident. Facility staff located the resident(s) and returned her to the facility. The 1-day adverse incident report was filed on , however, the 15-day report was not filed until , 22 days later.

An interview was conducted with the ED on . . . . . at 3:25 pm. She reviewed the adverse incident reports and checked the Agency for Health Care Administration (AHCA) Internet reporting site. She confirmed the late submissions of the reports for Residents #14, #15, #17, #19, #20, and the missing 15-day reports for Residents #13 and #19. The ED stated she thought she had 15 business days to file the 15-day report.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2015

Administrator
Horizon Bay Vibrant Retirement Living 447
500 Grand Plaza Drive
Orange City, FL 32763

Dear Administrator:

This letter reports the findings of a state biennial licensure survey that was conducted on , 2015 by representatives of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyors. Should you have any questions please call this office at .

Sincerely,

Jana Meyering, QIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

LL/JM/sm
Enclosure

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