STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965169	**03/18/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
HORIZON BAY VIBRANT RET LIVING 448	**9825 S. U.S. HIGHWAY 1 PORT SAINT LUCIE, FL 34953**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced Relicensure survey was conducted on , 2015 through 18, 2015 at Horizon Bay Vibrant Retirement Living 448. The facility had deficiencies found at the time of the visit.

0052 - Medication - Assistance with Self-Admin - 58A-5.0185(3) FAC

Based on observation, interview, and record review, it was determined the facility failed to ensure that the required standards of practice for providing assistance with the self administration of medications was followed by unlicensed staff members, for 10 of 10 sampled residents; specifically related to the timeliness of medications and not informing the residents of the medications they are receiving (Residents #3, 4, 8, 9, 11, 12, 13, 14, 15, 16).

The findings include:

1) During medication observation conducted with Staff F (unlicensed staff member), on beginning at approximately 9:33 AM, Resident #11 was provided the following medications:
a) 3.125mg scheduled for 9:00 AM
b) Clopidgrel 75mg scheduled for 9:00 AM
Staff F failed to inform Resident #11 of what medications she was receiving. Staff F just handed Resident #11 a souffle cup with her medications.

2) During medication observation conducted with Staff F (unlicensed staff member), on beginning at approximately 9:40 AM, Resident #3 was provided the following medications:
a) 10mg scheduled for 9:00 AM
b) CoQ10 100mg scheduled for 9:00 AM
c) 0.025mg scheduled for 9:00 AM
d) 500mg scheduled for 8:00 AM
e) 20mg scheduled for 9:00 AM
f) Royal Jelly 1000mg; Propolis 600mg; Bee Pollen 1500mg scheduled for 9:00 AM
g) D3 2000iu scheduled for 9:00 AM
h) 3mg scheduled for 9:00 AM
i) Tears 2 drops both eyes daily scheduled for 8:00 AM

Staff F failed to inform Resident #3 of what medications she was receiving. Staff F just handed Resident #3 a souffle cup with her medications. Staff F also assisted with the administration of the eye drops. Staff F was asked why the two medication scheduled for 8:00 AM were provided at 9:40 AM. She replied, "You will have to ask my supervisor". She would not provide an answer to this question.

3) During medication observation conducted with Staff F (unlicensed staff member), on beginning at approximately 9:57 AM, Resident #4 was provided the following medications:
a) 1000mg take 2 tablets scheduled for 10:00 AM

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b) [redacted] for Men scheduled for 10:00 AM
c) Onfi 10mg three times a day scheduled for 10:00 AM
d) [redacted] 100mg take 2 tablets in the AM scheduled for 10:00 AM
Staff F failed to inform Resident #4 of what medication he was receiving. Staff F just handed Resident #4 a souffle cup with his medications.

4) During medication observation conducted with Staff F (unlicensed staff member), on [redacted] beginning at approximately 10:02 AM, Resident #12 was provided the following medications:
a) [redacted] C 500mg scheduled for 9:00 AM
b) [redacted] with C scheduled for 9:00 AM
c) Clopidrogel 75mg scheduled for 9:00 AM
d) [redacted] D3 2 capsules scheduled for 9:00 AM
e) [redacted] 30mg 4 times daily scheduled for 9:00 AM
f) [redacted] 20mg scheduled for 9:00 AM
g) [redacted] 300mg scheduled for 9:00 AM
h) [redacted] 250mg scheduled for 9:00 AM
i) [redacted] ER 50mg scheduled for 9:00 AM
j) [redacted] scheduled for 9:00 AM
k) PreserVision scheduled for 9:00 AM
l) [redacted] 40mg scheduled for 9:00 AM
m) [redacted] Diskus [redacted] every 12 hours(Inhale contents and rinsed mouth with water) scheduled for 9:00 AM

Staff F failed to inform Resident #12 of what medications she was receiving. Staff F just handed Resident #12 a souffle cup with her medications. She also handed the inhaler to this resident and stated here is your inhaler. These medication were not provided in a timely manner.

5) During medication observation conducted with Staff F (unlicensed staff member), on [redacted] beginning at approximately 10:20 AM, Resident #13 was provided the following medications:
a) [redacted] 30mg scheduled for 9:00 AM
b) [redacted] Val[redacted] scheduled for 9:00 AM
c) [redacted] 10mg scheduled for 9:00 AM
d) [redacted] 500mg scheduled for 9:00 AM
e) [redacted] 500mg scheduled for 9:00 AM
f) [redacted] 500mg scheduled for 9:00 AM
g) [redacted] 20mg scheduled for 8:00 AM

Staff F failed to inform Resident #13 of what medications she was receiving. Staff F just handed Resident #13 the souffle cup with her medications. These medication were not provided in a timely manner, especially the [redacted] 20mg that was scheduled for 8:00 AM.

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SUMMARY STATEMENT OF DEFICIENCIES
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6) During medication observation conducted with Staff F (unlicensed staff member), on beginning at approximately 10:35 AM, Resident #14 was provided the following medications:
a) Diskus scheduled for 9:00 AM
b) 10mg (1/2 tab in pack) scheduled for 8:00 AM
c) 40mg scheduled for 8:00 AM
d) Pyridostigm 60mg scheduled for 9:00 AM
e) Sertaline 50mg scheduled for 9:00 AM
f) drops 2 drops in both eyes three times daily scheduled for 9:00 AM

Staff F failed to inform Resident #14 of what medications she was receiving. Staff F just handed Resident #14 a souffle cup with her medications. She also handed the inhaler to this resident and stated here is your inhaler. These medication were not provided in a timely manner, especially the 10mg and the 40mg.

7) During medication observation conducted with Staff F (unlicensed staff member), on beginning at approximately 10:45 AM, Resident #15 was provided the following medications:
a) 0.25mg scheduled for 9:00 AM
b) 50mg scheduled for 9:00 AM
c) Levothyroxin 50mcg scheduled for 8:00 AM

Staff F failed to inform Resident #15 of what medications she was receiving. Staff F just handed Resident #15 the souffle cup with her medications. These medication were not provided in a timely manner, especially the that was scheduled for 8:00 AM.

8) During medication observation conducted with Staff G (unlicensed staff member), on beginning at approximately 9:08 AM, Resident #16 was provided the following medication:
a) diskus inhale 1 puff by mouth 2 times per day in AM and evening approximately 12 hours apart scheduled for 9:00 AM

Staff G failed to inform Resident #16 of what medication he was receiving. Staff G just handed Resident #16 his inhaler.

9) During medication observation conducted with Staff G (unlicensed staff member), on beginning at approximately 9:15 AM, Resident #3 was provided the following medication:
a) 10mg scheduled for 9:00 AM
b) CoQ10 100mg scheduled for 9:00 AM
c) 0.025mg scheduled for 9:00 AM
d) 500mg scheduled for 8:00 AM
e) 20mg scheduled for 9:00 AM
f) Royal Jelly 1000mg; Propolis600mg; Bee Pollen 1500mg scheduled for 9:00 AM

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g) D3 2000iu scheduled for 9:00 AM
h) 3mg scheduled for 9:00 AM
i) Tears 2 drops both eyes daily scheduled for 8:00 AM

Staff G failed to inform Resident #3 of what medications she was receiving. Staff G just handed Resident #3 a souffle cup with her medications. Staff G also assisted with the administration of the eye drops.

During interview with the Assisted Living Medication Nurse/Supervisor, conducted on beginning at approximately 10:45 AM, she was asked why the 8:00 AM and 9:00 AM medications are bring provided late. She stated there is only one Med Tech for Assisted Living and that sometimes she (the nurse) helps out, but not today. She stated sometimes it is confusing when she does help out as to who has received medications.

During subsequent interview and policy review with the Health and Wellness Director, conducted on beginning at approximately 11:05 AM, the policy and procedure entitled "Medication & Treatment - General Guidelines for Medication Administration/Assistance" was reviewed. This policy indicates that medications are to be provided in "the correct window of time, that is, 1 hour before or 1 hour after the stated time". The Health and Wellness Director stated that this is the facility's expectation and that she did not realize medications were still being provided at this time.

During observation and interview of Resident #1, conducted on beginning at approximately 11:15 AM, Staff F knocked and entered the order to provide this resident with her medications. This resident was asked when she usually receives her medications. She replied that it depended on if she and her spouse went to the nursing office (wellness center) or not. She stated she gets her medicine earlier if she goes to the wellness center and later if she forgets to go and they have to bring them to her.

During interview with the Health and Wellness Director and the Medication Nurse Supervisor, on beginning at approximately 9:25 AM, the Health and Wellness Director stated that medications are almost completed as the Med Tech (unlicensed staff member), the Medication Nurse Supervisor, and she (the Health and Wellness Director) all provided medications to the residents this morning. She stated this seemed to work out well. She was reminded that the facility currently has 70 Assisted Living residents and that this is too much for one unlicensed staff member to assist with providing medications and expect for them to be completed in a timely manner.

10) During medication observation conducted with Staff A (LPN), on beginning at approximately 9:35 AM, Resident #8 was provided the following medications:
a) Sustain scheduled for 8:00 AM
b) 1200mg scheduled for 8:00 AM
These medication were not provided in a timely manner.

11) During medication observation conducted with Staff A (LPN), on beginning at approximately 9:50

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AM, Resident #9 was provided the following medications:
a) [illegible] 40mg scheduled for 8:00 AM
b) [illegible] 20meq scheduled for 8:00 AM
c) [illegible] 25mg scheduled for 8:00 AM
d) [illegible] 50mg scheduled for 8:00 AM
These medication were not provided in a timely manner.

During interview with the Administrator and the Health and Wellness Director at 2:30 PM on [illegible] they acknowledged the above findings related to untimely assistance with self-administration and administration of medications as well as unlicensed staff not verbalizing medications to residents while assisting.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and an interview, the facility failed to ensure that 2 out of 3 sampled staff (Staff A, B and C) had freedom from [illegible] documented by a health care provider on an annual basis. Under 58A-5.0131, F.A.C., " Health Care Provider " means a physician or physician ' s assistant licensed under Chapter 458 or 459, F.S., or advanced registered nurse practitioner licensed under Chapter 464, F.S.

The findings include:

The files for Staff A and C were reviewed for freedom from [illegible] documented by a health care provider on an annual basis. There was no documentation of this dated within the previous year for these staff members.

a) Staff A (hired [illegible])-last documented freedom from [illegible] was dated [illegible]
b) Staff C (hired [illegible] documentation of freedom from [illegible] TB results test dated [illegible] was present but signed by an unknown staff member (not a health care provider)

The Administrator and the Health and Wellness Director were interviewed at approximately 2:30 PM on [illegible] and confirmed that the documentation was not present and available for review. No additional documentation by a health care provider was presented at this time.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on record review and an interview, the facility failed to ensure that 1 out of 3 sampled staff (Staff B) who provides direct care to residents had received the required in-service training within 30 days of employment.

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The findings include:

Review of the personnel file for Staff B (Staff B was hired on , who provides direct care to residents revealed there was no documentation of in-service training dated within 30 days of employment that covers the subjects.

1. Reporting of incidents and facility emergency procedures including chain of command and staff roles relating to emergency evacuation (1 hour).

2. The facility 's resident elopement response policies and procedures.

The Administrator and the Health and Wellness Director were interviewed at approximately 2:30 PM on and confirmed that the documentation was not present and available for review. No additional documentation of the required training was presented at this time.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on record review and an interview, the facility failed to ensure that 1 out of 3 sampled staff (Staff B) who provides direct care to residents had received at least one hour of training in the facility's policies regarding RO's within 30 days of hire.

The findings include:

Review of the personnel file for Staff B who provides direct care to residents revealed there was no documentation of at least one hour of training in the facility's policies regarding RO's within 30 days of hire. Staff B was hired on

The Administrator and the Health and Wellness Director were interviewed at approximately 2:30 PM on and confirmed that the documentation was not present and available for review. No additional documentation of the required training was presented at this time.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation, interviews and record review, the facility failed to ensure 1 out of 2 sampled residents (Resident #8) was served a therapeutic diet as ordered.

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The findings include:

On [redacted] at 12:00 PM, Resident #8 was observed in the dining [redacted] corned beef for lunch, served by staff in the secured unit. The unit nurse was interviewed at this time and stated the resident's representative wanted the resident to eat what she requested regardless of her diet order.

Review of the resident's records revealed the most recent diet order dated [redacted] indicating the resident was to receive a "vegetarian diet with fish and eggs". The order was signed by the unit nurse and a health care provider.

During interview with the resident's representative on [redacted] at 3:30 PM, she confirmed that the resident's diet is vegetarian with no pork or beef allowed. She stated she did not sign a waiver for the resident's refusal of the ordered therapeutic diet.

During interview with the Administrator and the Health and Wellness Director at 2:30 PM on [redacted] they acknowledged the above findings. No additional documentation of the resident's refusal to adhere to the diet order was presented at this time.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Horizon Bay Vibrant Ret Living 448
9825 S. U.S. Highway 1
Port Saint Lucie, FL 34953

RE: Relicensure Survey

Dear Administrator:

This letter reports the findings of a state Relicensure survey that was conducted on 2015 through , 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 representatives. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure

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