STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965424	02/02/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Horizon Bay Vibrant Ret Living 445	217 Boston Avenue Altamonte Springs, FL 32701	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= G
St - A - Z821 - 59a-35.110, Fac - Reporting Requirements; Electronic Submission S-S= C

Specific Tag Findings:
0000-Initial Comments
Complaint Investigation #2014010420 was conducted on through . Horizon Bay Vibrant Retirement Living 445 had deficiencies found at the time of the visit.

0010-Admissions - Continued Residency 58A-5.0181(4) FAC
Based on record review and interview, the administrator failed to monitor 1 of 15 sampled residents (#4) for continued appropriateness of placement in the facility. This resulted in the resident falling numerous times, the resident had uncontrolled behavioral issues, and a subsequent resulted in the resident breaking her neck. The resident later

Findings:

Record review for resident #4 revealed a Resident Health Assessment 1823 form that was dated with diagnoses including and and . The 1823 noted that the resident should be on precautions. The resident also received hospice services.

Review of the electronic facility notes revealed the following:
Resident had behavior problems that continued to escalate from through . She had 7 four with injuries.

Behavior:
at 10:54 PM - "Resident agitated today. Left her alone until she was calm and went to bed"
at 8:27 PM - "Found taking ensure from the refrigerator. Irritable when redirected."
at 10:36 PM (7 AM-11 PM note) - "Son brought a walker per Vitas (hospice) request-they will schedule 3 sessions of Physical for (Resident #4) to learn how to use it. Gait unsteady feels more comfortable when has a 1 person assist".
at 2:57 PM - Vitas in to see resident to teach walker use. Resident disinterested-rude to instructor-refused use walker. Further sessions discontinued due to futility.
at 1:17 PM - Irritable, rude with childish behavior, demanding & needy.
at 2:43 PM - Resident extremely Irritable & rude-hitting male resident unprovoked. Very difficult to redirect.

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at 2:51 PM - observed hitting female resident-behavior unprovoked.
at 2:57 PM - Continued to be irritable and rude with staff & peers.
at 2:30 PM - Continued to be irritable & rude to staff and peers.
at 2:45 PM - Seen by Dr. from Vitas. Resident irritable-cursing & spitting at staff. Posturing threatening gestures. Difficult to redirect.
at 2:01 PM - Resident is irritable, rude with childish behavior. Spitting in staff's face-putting her fist in their face& threatening to punch them. Irritating peers with her behavior. PCP notified of behaviors via fax.
at 2:42 PM - Resident very rude to staff and other residents. Very loud, combative when tried to check her sugar and . Took her meds after several attempts but refused to be touched for .
at 2:42 PM - Resident sitting in hallway this am screaming. On approach became verbally & physically threatening-using much profanity-spitting at staff. Appetite poor. Difficult to redirect. Upsets peers with her outburst.
at 11:16 AM - Appetite poor. Continues to be verbally & disruptive. Striking at male resident-action unprovoked. Difficult to redirect will yell using much profanity with verbal threats. PCP (primary care physician) notified - waiting response.
at 11:19 AM - Continues to be irritable & difficult to redirect. New order for psych eval received. Dr. notified.
at 3:16 PM - Irritable & rude to staff & peers. Mimics redirection in a very nasty & childish tone of voice. Refused noon & meal.
at 2:47 PM - Behavior cont. to be loud, argumentative childlike, demanding & rude. Attention seeking. Rude to peers. Makes childish gestures to staff, mimics staff as would a spoiled child. Difficult to redirect-becomes louder & more irritating.
- Inappropriate behavior continues. Throwing books at staff yelling and cursing and could be heard down the hall. Seen by Dr.
at 10:25 PM - Resident slightly agitated this PM, but did not curse, calmed down and was compliant.
at 10:08 PM - In apartment screaming denied needing anything or wanting help - hostile to staff when assistance offered.
at 10:59 PM - Resident in foul mood this PM, shouting and cursing. Calmed down when in her Apt. Currently resting quietly
at 2:35 PM-Hit a staff with a walker-unprovoked. Cont. to be hostile, demanding, childlike & rude.
at 3:01 PM - Resident irritable & hostile. Yelling out to staff & Peers-taunting & ridiculing-using much profanity with threats to do bodily harm. Is loud, demanding, disruptive. Combative during care. Very difficult to redirect-tends to irritate resident resulting in an increased in inappropriate behavior. Had eaten in living herself so as not to upset others.

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at 3:03 PM - Was using foul language today when not allowed back into her it was being cleaned.

at 2:42 PM - Resident frequently Yelling & profane language-could be heard outside Clare Bridge doors cursing, making vulgar gestures to staff. Rude & hostile to peers. Redirection results in escalated behavior.

at 9:21 PM - "Resident was very rude and disrespectful to staff and peers this shift yelling profanity and spitting. Resident also tried to hit another resident at dinner this evening. I had to intervene. Resident's behavior only seems to escalate when you try to redirect."

at 2:31 PM (Per 11-7 staff) - resident verbally attempted to kick staff-during rounds.

at 2:41 PM - resident was observed after lunch to be agitated, using foul language and spitting towards fellow peers. Resident redirected to another area where agitation deescalated.

at 3 PM - resident irritated with female peer who was enjoying music-began yelling at her-kicking & hitting her with a book. Had to be removed. Continued to yell obscenities with gestures-difficult to redirect. Eventually settled down.

at 2:42 PM - "Resident got into a verbal conflict with another resident that was almost physical as both residents had forks in their hands making stabbing gestures. Residents separated and redirected to their respective tables. However, this resident continues to swear and make obscene gestures even after being redirected."

There was a l assessment conducted on and it was recommended that the resident start 2 milligrams (mg.) in the AM to address agitation, mood instability and physical aggression, after oncologist cleared her. The medication was written on the Medication Observation Record (MOR) for and read on "Hold till PCP approves" for the medication. The medication was discontinued on The resident did not take any of the medication.

During an Interview with the Health and Wellness Director on at approximately 3 PM, she stated the medication was discontinued because the resident's son contacted the health care provider because he did not want her to take the medication.

The following were documented in the Facility notes:

1. at 2:48 PM - "Resident observed lying on floor in hallway. She felt and PCP on the premises-evaluated resident. No apparent injury."

2. - "Resident found on by nurse. Stated she slipped off her bed onto floor. No apparent injury."

3. Per 11-7 staff - "Resident observed on floor of apartment. Large hematoma L (left)

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965424	02/02/2015
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SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

occipital area with small - 3 small & 1 mod. size L elbow. 911 notified. Sent to...Hospital via...county fire department. Family, Vitas notified. Returned from hospital at 7 AM."8/29 AM-Remains on Crisis care due to - Hospice crisis care was discontinued.

4. at 10:14 AM - "When I arrived on the unit this morning, I was told by care staff that (resident #4) I earlier. I assessed this resident first thing. She was resting quietly in bed and was easily aroused with verbal stimuli. She has a nickel sized on her left outer lower extremity. She does not remember falling. I was told Vitas was called on the 11-7 shift but when I called them, they knew nothing about this event. Registered Nurse (RN) will be out to assess."

5. - "Resident observed sitting on floor outside of doorway of 7:50 AM. Alert to self. Noted to right cm/2 cm. site cleansed with soap and water and clean dry dressing applied."

6. at 8:51 PM - "Nurse observed large 10 CM (centimeter) to upper right back of resident. Resident states she but could not remember how."

7. at 4:12 PM - "Called to hallway staff stating that a resident had , observed laying on the floor face down, resident responsive and asking for help. Observed resident from her nose with a large goose egg above her right eye. I instructed activities associate...to call 911 while I took care of the resident, applying pressure to her nose."

at 2:42 PM - "Per son, resident is in the Has of the CV 1 and CV 2; on a due to fluid in lungs. Dr. unsure if she had a event. Prognosis is poor. He will keep up informed. As of late this shift, son informs us they will be taking (resident #4) off the

The resident was on hospice care. There was no evidence that the hospice agency was notified to discuss the resident's continued extreme behavior issue and the need to have a plan to keep the resident safe and ensure the facility's ability to meet her needs other than getting physical

Staff statements received from the administrator's investigation concerning resident #4's with injury on

LPN (licensed practical nurse) H was no longer employed at the facility. She worked as the nurse on the Clare Bridge wing the day of the Earlier in the day, the resident argued with a male resident and they tried to each other with forks. She had a good lunch and was conversing with staff and other residents as usual. At around 2:45-2:50 PM, she got up off of

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

the couch in the common area and she said she was going to her apartment. She had been ambulating independently. At 2:55 PM, she heard a care assistant holler, "Someone has ... " When she went down the hallway, she found resident #4 lying face down on the floor. She approached the resident and called her name. At first there was no response. She touched the resident's shoulder and she responded that it was hurting. The resident's nose was ... and there was a pool of ... She turned the resident's head so that she could breath. She observed a raised area above her left eye and her glasses were bent. She left the care associate with the resident while she called 911 and attempted to contact the resident's son. She returned and placed a pillow under the resident's head to make her comfortable. Vital signs were B/P ... R-22, Pulse 99, and ... Saturation 98%. ... arrived and the attendants placed a neck collar on the resident. At the time of the ... the resident wore white sneakers with Velcro straps. There were no other residents in the area. There were no objects in the hallway.

Staff I Care Associate's statement indicated that at 1:50 PM, she assisted the resident to her apartment and helped her to the ... She then walked her back to the common area and she sat on the couch. Resident was walking with a steady gait. She heard the resident say "I want to go back to my ... " She heard (staff K) tell her "Okay, you can go to your ... " She did not see the resident ambulating. She heard a thump and scream. She looked down the hallway and hollered somebody has ... She said another care giver arrived at the same time as she did. The resident was moving her arms and legs and complaining of pain. There was ... from her nose and she had a bump on her head. She stayed with the resident while the nurse called 911 and attempted to call her son. The resident wore white Velcro tennis shoes. She had seen (resident #4) on occasion bend over to tighten her Velcro straps on her tennis shoes. There were no objects in the hallways.

Staff J Care Associate's statement indicated she was sitting at the table doing her charting when she heard (staff I) holler out that somebody had ... She stayed in the common area with the rest of the residents. She stated the resident was her normal self earlier. She had been agitated and asking to go to her ...

Staff K, the Activities Director's statement indicated she was doing activities that day. The resident had participated in activities. She was continuously asking to go to her apartment but then when she got there, she did not want to stay there. In the afternoon, she was sitting on the couch. She asked to go to her apartment and was told that it was okay to go. She did not see or hear anything until staff I hollered that someone ... She ran to the resident and staff I and staff H were already there. The resident was on her stomach, groaning. She said she was hurt. She asked staff H if she wanted her to call 911 and she stated "Yes". She called

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911. She returned and stayed with her until (emergency medical services) arrived. The resident had a large bump over her left eye and was from her nose. She had on white Velcro tennis shoes.

Medical Examiner's Report:

I. Complications of with:

A. C 2 (dens) following unwitnessed (DENS= The odontoid process is another name for dens. This is a part of C2 (axis) which is joined with C1 (atlas). These two parts are connected by three different joints, namely: (1) joint, (2) central atlantoaxial joint; and (3) lateral atlantoaxial joint. In terms of support for dens, there are ligaments, the dentate and the that enable the dens to have translational and rotational stability. In fact, the dens can grow closer to C1 when it is being held by the ligament. Basically, dens are made up of the remnants of the body that are usually left out and have now gathered together. 2015 Bone

B. Complications of flash following before intervention
C. Clinical deterioration
II. Clinical history of with resultant lack of history of details of
III.Ostec
inical History of
V. Clinical history of
VI.Clinical history chronic with platelet count of 49000 at the time of event

Conclusion: The of (resident #4) was due to complications of a with C 2 and contributing factors of and

The Hospital Clinical Record noted:

- The CT demonstrated a large right frontal scalp facial hematoma,
CT of the neck: Moderate spinal displaced C 2
Facial
- Patient had developed acute failure and required
and She had developed flash after of just 1 pack of platelets. She had developed requiring Patient was very unstable on 100% and and not a for management. Patient had persistent hypoxemia and The patient continued to deteriorate and

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

Discharge diagnosis: Elderly female with
1. Mechanical
2. CS displaced Spine
3. Acute failure, dependent
4. Persistent
5. Adult distress with
6. requiring vasopressers.

During an interview with the Health and Wellness director on at approximately 10 AM, she stated when residents are admitted into the facility, a assessment is conducted and a review of the 1823 is done to determine if the residents are a risk. She further stated if they are a risk, they will have the doctor order physical and occupational OT). She stated if a current resident began to have she would get laboratory and tests to check for and contact the doctor to go over the resident's medications. The residents would be placed on the risk log. The staff would be alerted those residents at risk for Some residents would be assigned an escort if the facility has determined one was needed. The staff would also check on the residents every two hours.

Review of resident #4's care plan revealed the following:

Escort & Mobility - Provide staff attention and/or verbal prompts to and from the dining and/or community activities as needed. Memory is one of the reasons for the escort assistance. Risk 2 hour checks

Behavior Management - Resident demonstrates disruptive or behaviors requiring additional attention. Approach resident with gentle voice and expression to tell the resident that he/she is safe and cared for. Encourage repetitive manual activities (e.g., tearing coupons out of a newspaper). Use validation, respond to emotions behind behavior (e.g., looking for mother may mean need for comfort, security, and sense of belonging). Note that all repetitive behaviors are not necessarily harmful or disruptive. Redirect resident to their most familiar and comfortable area of the community if disruptive to others. Use the Positive Physical Approach (e.g., go slow make eye contact, get down low). Used preferred name, calm and gentle voice and yes/no questions. Respect and acknowledge the resident's reality and avoid attempts to argue or reason. Involve resident in community activities and Life skills. Avoid statements and/or interactions that may embarrass or shame the resident (e.g., reacting with , scolding or parental tone). Be alert to triggers that cause the resident stress and reduce as much as possible (e.g., pain, boredom, physical or emotional needs, loud noises, crowded spaces, other residents care staff approach). Provide support to families

regarding the common nature of these behaviors in residents with or memory loss. Refer to resident's social history information.

Management Investigation Documentation:

What actions/plans can be made from this new knowledge to reduce resident risk? Frequent monitoring. Keep pathways clean and well lit.

What actions/plans can be made from this new knowledge to reduce resident risk? Increased monitoring, redirect.

Review of the other care plans the facility used for the resident revealed that they were all the same wording. There was no individualized care plan for resident #4 provided in order to keep the resident safe.

During an interview with the Health and Wellness Director on at approximately 3:30 PM, she stated after resident #4 on , the management investigation form did note the facility was to do frequent monitoring and keep pathways clean. She was informed at the time that there was no documentation in the facility notes that there was anything in the resident's pathway when she had the and there was no documentation that the area was not lit. The Health and Wellness Director confirmed that plan was generated form the computer and that there was no evidence that there was anything in the pathway of the resident when her occurred.

During an interview with the administrator on at approximately 4:45 PM, she confirmed that the resident had numerous that resulted injuries. She stated that she was not aware that the resident had any behavioral issues until the day of the resident's last Resident #4 resided in the Memory Care unit. She ambulated without assistance and sustained numerous with injuries. The resident received hospice services. The hospice agency attempted to provide the resident with but she resisted The resident was and on occasions it was noted she refused to be tested or take her medications.

Resident #4 had behavioral issues and was combative to staff and other residents in the memory care unit. There was no documentation found that the facility had proactive measures in place to minimize and behavioral issues other than conducting a assessment on The health care provider made a recommendation on starting the resident on a medication. One month later, the medication was received and then discontinued because the son did not want her to take it.

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The resident's care plan noted she would be escorted to and from activities and dining. The day of the resident's , she wanted to go to her . . . . . Staff allowed her to go alone and she . . . There was no assessment done by the administrator to determine it the resident remained appropriate for the facility. The staff were not able to meet the resident's needs because she was ambulatory and could not be restrained from walking. Resident #4 had behavioral issues that the staff was not able to control. There were no proactive measures in place to keep the resident and other residents safe while she was in the memory care unit, causing the resident to , and break her neck. The resident later in the hospital.

Class II

Z821-Reporting Requirements; Electronic Submission 59A-35.110, FAC

Based on record review, adverse incident reports and interview, the facility failed to submit an adverse incident report when 1 of 15 sampled residents . . . . . a staff member, and Law Enforcement was called (#14).

Findings:

During an interview with the facility staff who worked in the memory care unit on . . . . . at approximately 11:30 AM, it was revealed that resident #14 . . . . . a staff and bit another staff. The police arrived to investigate and both staff had to receive medical care.

Review of the medical record revealed the following for resident #14:
. . . AM - Late entry: "Notified by staff of resident having aggressive and belligerent behaviors. Resident had come out of his studio with paddle board, stating 'Why are you in my house.' Resident then hit associate with paddle board, when associate . . . resident then continued to hit associate on the hip while she was on the floor. A second associate in attempting to remove paddle board from resident was bitten on index finger by resident. Resident sent by ambulance to hospital due to increased . . . and agitation. For evaluation for . . . . .

During an interview with the administrator on at approximately 3 PM regarding the above incident, she was asked to provide an Adverse Incident report because the police came to investigate. The administrator stated at the time an adverse incident report was not

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completed. She explained that she was not aware that a police investigation was an Adverse Incident report because a police investigation was not one of the reportable events that were on the form provided to the facility by the corporate office.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2015

Horizon Bay Vibrant Ret Living 445
217 Boston Avenue
Altamonte Springs, FL 32701
Attn: Beverly Skaggs, Administrator

Dear Skaggs:

This letter reports the findings of a complaint investigation (CCR #2014010420) conducted on through by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **five business days** of receipt of this faxed report.

The investigation resulted in findings of non-compliance in the following areas:

1. A0010 - Admissions - Continued Residency - Class II
The Assisted Living facility failed to monitor 1 of 15 sampled residents (#4) for continued appropriateness of placement in the facility. This resulted in the resident falling numerous times, the resident had uncontrolled behavioral issues, and a subsequent resulted in the resident breaking her neck. The resident later

The Facility must comply with the following:

1) Your facility must assess residents on a continuous basis to ensure that residents continue to be appropriately placed in your Assisted Living Facility. Residents need to be re-assessed when behaviors are a concern and residents are continuing to You must have disciplinary team meetings to ensure all parties involved in the care of the resident are aware of the changes in the resident's condition. This must be completed **by** .

2) Your facility must involve all disciplines to create a plan a care for the resident that addresses the current state of the resident's condition. Make sure that the resident's family is involved. If the resident is on Hospice; Hospice should be called immediately and informed on the resident's current behaviors/condition. The interdisciplinary care plan should be updated to reflect the residents current concerns and condition. The care plan should reflect new interventions and approaches based on the resident current concern. This must be completed **by 3/13/15.**

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.com

3) Your facility must retrain staff to be aware of changes in residents condition and report these changes immediately to the appropriate staff. Residents should be trained on resident behaviors, ... and the chain of command when reporting injuries of a resident. This must be completed **by** _____.

4) Your facility need to create a mechanism for discussing residents that have concerns weekly so that all members of your administrative team are aware and can give input on what steps need to be taken to provide adequate care and services to your residents. This must be completed **by** _____

Documentation demonstrating that all of the above tasks were completed must be available for agency review upon request.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact ..... Lorraine Henry, Orlando Area Office (407) 420-2534.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be

D7JR

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RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2015

Administrator
Horizon Bay Vibrant Ret Living 445
217 Boston Avenue
Altamonte Springs, FL 32701

RE: CCR #2014010420

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 2015, through 2015, by representative(s) 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 surveyor(s). Should you have any questions please call Lorraine Henry at

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure
XG90

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