STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968140	08/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZON HEALTHCARE INC	3114 PHILIPS HWY JACKSONVILLE, FL 32207

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

0000 Initial Comments

A biennial licensure survey with Extended Congregate Care and Limited Mental Health was conducted on . New Horizon Healthcare had deficiencies found at the time of the visit.

0081 Training - Staff In-Service

Based on Record Review and Interview, the facility failed to provide 1 out of 4 employees (Employee D) with required trainings.

The findings include:

A review of Employee D's record was conducted on . There was no Incident reporting Training in Employee D's file.

An interview was conducted with Employee A, who is the owner at 1:35 pm on . Employee A, stated that he thought Staff D did not have to complete incident reporting training because she was a nurse.

Class III

0086 Training - ADRD

Based on record reviews and interviews, the facility failed to provide 1 (Employee D) out of 4 employees with required trainings.

The findings include:

A review of Employee D record was conducted on . There was no (I, II) training in Employee D record.

An interview was conducted with Employee A, the owner at 1:50 pm on . Employee A stated that the Employee D was scheduled for the Training in the past, but could not attend because she had an emergency.

Class III

0152 Physical Plant - Safe Living Environ/Other

AGENCY FOR HEALTH CARE ADMINISTRATION

PRINTED: 09/08/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968140	08/14/2015
NAME OF PROVIDER OR SUPPLIER **NEW HORIZON HEALTHCARE INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **3114 PHILIPS HWY** **JACKSONVILLE, FL 32207**	

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

Based on record review, resident and staff interviews and interview with the administrator, the facility failed to provide a safe living environment for 6 of 6 residents residing in the main building. (Residents #4, #5, #7, #8, #9, #10)

The findings include:

On during record review of the staffing schedule dated 2015, the 10th-16th. Review of the night shift staffing revealed Employee A was scheduled to work 11:00 pm to 7:00 am on 11-16, 2015. Employee C was scheduled to work 11:00 pm-6:00 am on 10 and 12, 2015. (Photographic Evidence)

On during record review of the staffing schedule dated 2015, the 3rd-9th. Review of the night shift staffing revealed Employee A was scheduled to work 11:00 pm to 7:00 am on 6-9, 2015. Employee C was scheduled to work 11:00 pm-6:00 am on 3 and 5, 2015. (Photographic Evidence)

On during record review of the staffing schedule dated , and , 2015. A review of the night shift staff revealed Employee A was scheduled to work 11:00 pm to 7:00 am on 28 and 31, and 1 and 2, 2015. Employee C was scheduled to work 11:00 pm-6:00 am on , 29, and 30, 2015. (Photographic Evidence)

On during record review of the bed-checks form dated / and . Employee A signed the bed-checks every hour from 11:00 pm to 7:00 am for every resident at the facility as completed. (Photographic evidence)

An interview on was conducted with Employee B, Certified Nursing Assistant at 11:33 am. She stated there is one staff person on the night shift to relieve her. She said she occasionally works the night shift if they need her. She said every two hours they go out and check on the residents who live in the outer . She stated they keep the main building door locked at all times. She stated she takes her badge with her, it is like a key that opens the door. She stated the building door automatically locks and the residents can't get out. She stated the back door to the main building is always locked.

AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968140	**08/14/2015**
NAME OF PROVIDER OR SUPPLIER **NEW HORIZON HEALTHCARE INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **3114 PHILIPS HWY JACKSONVILLE, FL 32207**	

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

On an interview with Resident #1 at 1:50 pm. She said staff come every 2 hours at night to check on her. She said there is only 1 who comes at night.

On at 1:55 pm an interview with Resident #3 stated he is occasionally awake at night when night staff check on him. He said 1 person comes to check on him. He said it is usually 1 person who works the night shift.

On at 2:55 pm an interview with Employee A revealed she was a full time employee on the night shift. She said she goes into resident every hour with a flashlight to check on them. She said the main building stays locked, magnetically. She stated she used a badge and a button to open the door. She stated there is also switch, it's like a light switch, when you flip the switch it unlocks the door. She stated there are three residents who try to get out, so they have to keep the door locked at all times. She stated that sometimes they are up at night. She also stated that most residents have a cell phones, but most would not know how to use it.

An interview was conducted with Resident #2 at 3:16 pm on . Resident #2 stated that the staff members who work the night shift, come from the main building and check on him every two hours at night.

On at 3:35 pm an interview with the administrator. He said the night shift makes rounds every hour. There is only one person who works on the night shift. He said the back door is supposed to be open for ten minutes or so when they are out checking on the other residents. He said the front gates are locked during the night. He confirmed there was only one staff employee scheduled to work the night shift.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[redacted], 2015

Administrator
New Horizon Healthcare, Inc.
3114 Philips Highway
Jacksonville, FL 32207

Dear Administrator:

This letter reports the findings of a state biennial licensure with Extended Congregate Care and Limited Mental Health survey that was conducted on [redacted], 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than [redacted] 4, 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 [redacted]-4201.

Sincerely,

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

MB/JM/sm
Enclosure
XG90

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