STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965844	05/06/2016
NAME OF PROVIDER OR SUPPLIER **FRESH HORIZON'S ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **4836 35TH AVENUE** **VERO BEACH, FL 32967**	

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

0000 Initial Comments

An unannounced relicensure survey was conducted at Fresh Horizon's ALF(license #10323). The facility had deficiencies identified during the survey.

0056 Medication - Labeling and Orders

Based on observation, interview and record review, the facility failed to obtain a health care provider's (HCP) written medication order, for 1 of 3 sampled Residents (3) by altering a medication's dose without first obtaining the required order.

The findings included:

A review of the facility's medication system conducted on revealed the following concern.
Review of Resident 3's records revealed the following:
a. Her AHCA 1823 Form (medical examination) dated documented she required assistance with self-administration.
b. A written HCP order dated . The Administrator stated this was a typographical error, she had received it some time before. The order called for (a high medication) 10 milligrams (MG) daily.
c. Her 2016 medication observation record contained the same order information, and was initialed by staff indicating she received the medication daily.

Observation of the prescription label on the actual medication container disclosed 5 MG, half of the currently ordered dose. In an interview conducted at 1:32 PM, the Administrator confirmed Resident #3 was receiving only 5 MG. She contacted the pharmacy and was told they have orders for both doses and are pending clarification from the HCP. The Administrator acknowledged staff are required to have written HCP orders before changing medication instructions.

Class III

0084 Training - Assis Self-Admin Meds & Med Mgmt

Based on record review and interviews, the facility failed to ensure unlicensed staff who assistance residents with self-administration received the required training, for 2 of 3 sampled Employees (Staff A and B).

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

The findings included:

Employee file review conducted 05/06/16 revealed 2 staff that provide medication assistance to residents had not received the required trainings.

1. Employee A, a Caregiver and Medications Technician (MT), was hired on /. Review of his Assisting with Self Administration of Medications training certificates revealed he received the required training on and on . Further review revealed no documentation showing he had received the required 2 hours of training from a licensed registered nurse or a licensed pharmacist in 2015.

2. Employee B, a Caregiver and MT, was hired on . Review of her Assisting with Self Administration of Medications training certificates revealed she received the required training on / and on . Further review revealed no documentation showing she had received the required 2 hours of training from a licensed registered nurse or a licensed pharmacist in 2015.

In an interview conducted at 9:28 AM, the Administrator stated she knew they all took it and would get copies from the pharmacy. At survey's end at 3:25 PM, the Administrator was not able to produce the 2015 training certificates for Employees A and B. The Administrator confirmed both staff assisted residents with medications in 2015.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Fresh Horizon's Alf
4836 35th Avenue
Vero Beach, FL 32967

Dear Administrator:

This letter reports the findings of a State Relicensure Survey that was conducted on , 2016 by a representative from 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 , 2016.** 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 representative. Should you have any questions please call this office at (561) 381- 5840.

Sincerely,

for Arlene Mayo-Davis
Field Office Manager

AMD/jw
Enclosure

XG90

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida