STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942812	**06/09/2016**
NAME OF PROVIDER OR SUPPLIER **HORIZON BAY VIBRANT RET LIVING 449**	STREET ADDRESS, CITY, STATE, ZIP CODE **730 SOUTH OSPREY AVENUE SARASOTA, FL 34236**	

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

0000 Initial Comments

An unannounced complaint survey for CCR #2016003702 was conducted / at Horizon Bay Vibrant Retirement Living, an Assisted Living Facility (license #8261) in Sarasota, Florida.

The complaint contained 5 allegations, of which 5 allegations were substantiated with deficiencies.

The following is description of the deficiencies.

0030 Resident Care - Rights & Facility Procedures

Based on observation and interview, the facility failed to allow visiting at any time between the hours of 9:00 a.m. and 9:00 p.m. at a minimum.

The findings included:

In an interview with Resident 1's daughter on at 1:00 p.m. she said it doesn't matter, day or night, it is very frustrating trying to get in or out to visit on the memory care unit. You have to wait a long time for someone to let you in and you have to search for someone to let you out.

In an interview with Resident 2's daughter on at 1:45 p.m. she said there is apparently not enough staff and has had to wait to get in the building, she rings and rings the bell and on one occasion she never did get in. She said it happens more and more often and seems to be almost always before 2:30 p.m. because the aides are very busy.

In an interview with Staff J on at 3:45 p.m. she said she can hear the doorbell and answers it as quickly as she can, but sometimes there are only 2 aides in memory care and if they are busy assisting a patient they can't get to the door right away and the visitors have to wait.

During an observation of length of time to answer front door, surveyor rang the bell to the memory care front door at 11:45 a.m. on . Facility staff responded to open front door at 11:54 a.m.

In an interview with Executive Director on / at 4:45 p.m. he explained he is new to the facility last week and realized they need to work on staffing issues.

Class III

0079 Staffing Standards - Levels

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Based on observation, interview, and record review, the facility failed to provide enough qualified staff to provide resident supervision and to arrange for resident services in accordance with the residents' scheduled service needs and resident care standards.

The findings included:

During a tour of Resident #1's the toilet had bio-growth in the bowl and on the shower chair had brown residue/stain. The has brown staining and other debris. Dirty clothes in the shower and on the floor in the . Towels on grab bars. Clothes in the closet were haphazardly placed and were dirty. The mattress has a large stain which was covered by an incontinence , , and a sheet covering the mattress. (Photographic evidence obtained).

During an interview with the family of Resident #1, she said that she has a problem getting into the memory care unit at all hours of the day and that even today she had to wait a long while before the door was opened. She said Resident #1 eloped from the main building one morning and was found by an employee of a home health company that was coming into the building and recognized her. Resident #1 was in a wheelchair by the restaurant down the street. Nobody working at the facility noticed she was gone until this person brought her back and no one had an explanation. Resident #1 was then placed into the memory care unit. She said that the resident's never cleaned properly. It is supposed to be cleaned once a week but often she comes in and has to clean the removing fecal matter from her equipment. She often ends up taking soiled clothing home to wash them because they have been left and causes a bad odor in the . She confirmed that Resident #1 has not been in the facility in over a week and the not been cleaned.

During an interview on / at 10:32 a.m., with Maintenance Director/Housekeeping supervisor (MD), he stated, "I do not have enough housekeeping staff to adequately meet the needs of the residents." He said the interim Executive Director (ED) has brought him in from another community to help. Staffing is 2 housekeepers in the main building and one in the memory care. The housekeepers have to clean each apartment once a week in the main building. In the Memory care building, they mop the floors; wipe down , and vacuum. The care associates do the cleaning on evenings and laundry on night shift. He stated, "I am allowed 6.5 hours [for housekeeping staff] twice per week in memory care. I feel I could use a housekeeper on each floor." During an additional tour of Resident #1's the MD, he confirmed that the not cleaned and said that it should have been cleaned on / .

During an interview on at 2:30 p.m. Staff H said she feels the facility is lacking staff. She feels that resident care and housekeeping is being affected by the lack of staffing on some days. She said that the memory care unit did not have a housekeeper for a while. The housekeeper is supposed to do general cleaning of the which includes cleaning the toilets, showers, and wiping down the floors

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and other areas. She feels this is not done and said some residents need their floors cleaned daily because of incontinence. The current housekeepers are not properly cleaning the . Staff H confirmed that one day a staff member did not show up for work and some residents in the memory care unit did not receive their morning medications. She had to pass the meds for the residents she was assigned to that day in the main unit and then go over to the memory care side to pass medications. She was only able to pass the medication to residents on one floor but it was too late to pass them to the other floor. She confirmed documentation found on incident reports dated / for 15 residents. No staff trained to pass medications arrived until 3:00 p.m. Staff H feels that to properly care on the memory care side would consist of staffing a nurse, 2 aides and activities person for each floor.

During an interview on / at 3:20 a.m. Staff I said the staffing issues have been going on for more than a year. She feels they need more nurses and medication technicians/resident assistants. She knows of things happening due to lack of supervision such as resident and missed medications. She also feels they need more housekeeping. The resident and the staff are not getting cleaned. She said the pay is too low for the workload and causes a high turnover.

During an interview on at 3:32 p.m. Staff J said she is one of the new employees. She works the 3-11 shift and says she has only seen a housekeeper a couple times and is not sure of their schedule. She said she does not feel the are being cleaned properly and she has reported toilets left un-cleaned.

During an interview on at 3:40 p.m. Staff K said, "Staffing is not good. Fecal matter is left on the floor and on the walls, some beds are changed some are not." She said, "There is supposed to be 2 resident care aides on each floor. There is only 1 resident care aide [responsible for] cleaning , doing laundry and caring for residents. There is no housekeeper on this side (memory care). Sometimes there is no one to pass meds; sometimes the residents do not get their meds."

Review of Medication Observation Records (MOR) for Residents #1, #5, and #7 for the month of showed that morning medications were not administered on the 21st as shown in the incident reports. Further review noted that on that morning medications were also not administered on the 5th, 10th, 11th, 12th and the evening medications were not administered on the 2nd, 8th, 13th, 14th,17th, 18th, 19th, 20th, 28th, 29th and 30th. Residents #1, #5 and #7 MORs all reflect the same days of missed medications above. Record review of the staffing schedule provided by the facility showed that on the days listed above, there was not a qualified staff scheduled on the unit to pass medications to the residents.

During an interview on at 4:00 p.m. Staff L said that she didn't know why the medication documentation for the days listed were left empty and said even if something is not given they are

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supposed to document on them. She confirmed that there was no documentation as to why the medications were missed.

During an interview on / at 4:00 p.m. the interim Health and Wellness Director, said they hired a lot of staff and the then lost several staff again. She said she thinks the workload is overwhelming at times for the staff and overwhelming at times for the staff to work with new people and train them. She said they looked into the issue with the [missed] medications and they are making sure there is enough staff available. She has passed medication herself on occasions. She said she was not aware of the issues of visitors not gaining access to the memory care unit.

Class III

0081 Training - Staff In-Service

Based on record review and staff interview, the facility failed to provide all required training certificates for 2 (Staff C and F) of 3 staff personnel files reviewed.

The findings included:

1. On , a review of 3 staff personnel files revealed there was no Elopement Response Training Certificate, no Emergency Preparedness Certificate, no Resident Rights Training Certificate, and no Incident Report Training Certificate in Staff C's personnel file. Staff C's date of hire was / /.

2. On / , a review of 3 staff personnel files revealed there was no Elopement Response Training Certificate in Staff F's personnel file. Staff F's date of hire was .

3. In an interview on at 3:05 p.m. the Business Office Director said, "That's all I have."

Class III

0086 Training - ADRD

Based on record review and staff interview, the facility failed to provide all required training certificates for 1 (Staff E) of 3 staff personnel files reviewed.

The findings included:

1. On / , a review of 3 staff personnel files revealed there was no Training Level 1

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Certificate [illegible] Training Level 2 Certificate in Staff E's personnel file. Staff E's date of hire was [illegible].

2. In an interview on [illegible] at 3:05 p.m. the Business Office Director said, "That's all I have."

Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observation and interview, the facility failed to provide a safe, clean living environment for 1 (Resident #1) of 5 sampled [illegible].

The findings included:

On [illegible] at 12:25 p.m., during an interview with the daughter-in-law of Resident #1, she said her mother-in -law (Resident #1) had [illegible] a week ago and was sent to the hospital on [illegible]. She said she was here to get her mother-in-law some clothes.

On [illegible] at 12:30 p.m. (accompanied by family member of Resident #1) during a tour of resident #1's [illegible], the following observations were made: (Photo evidence attached).

Clothes were not folded properly or hung up properly in the closet.

There were dirty, soiled clothes in a basket in the chair in the living [illegible].

There were dirty, soiled clothes in the shower.

The toilet was dirty and there was toilet paper and garbage on the floor beside commode.

There was a dirty wash cloth on the grab bar beside the toilet.

The shower chair had brown residue/stain on it.

A cord and debris were noted under the bed.

The bed was not made, blankets were strewn upon the bed. When the blankets were removed, a large quilted [illegible] was noted. When this was removed, a soiled pink soaker [illegible] was observed. When that was removed, a very large, brownish/reddish stain was noted on the mattress. The family member

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stated "That was not there 2 weeks ago."

On at 1:05 p.m. during a tour of Resident #1's the interim Director of Health and Wellness, she confirmed the presence of the above findings.

During interview she said when the resident went to the hospital someone should have inspected and secured the . She also said she had no idea why the in this condition but she would have "It cleaned up."

On at 1:30 p.m. after a tour of Resident #1's the housekeeping supervisor, he confirmed the presence of the above findings.

During an interview he said housekeeping is responsible for mopping the floors, wiping down the and vacuuming. The remainder, such as laundry, making the bed, hanging up clothes, is the responsibility of the care associates. He revealed is cleaned by housekeeping once a week on a regularly scheduled basis. He then confirmed was scheduled to have been cleaned on Sunday and that had not occurred.

Class III

0165 Risk Mgmt & QA: Adverse Incident Report

Based on record review and staff interview, the facility failed to provide within 1 business day after the occurrence of an adverse incident, a preliminary report to The Agency; and failed to provide within 15 days after the occurrence, a full report to The Agency.

The findings included:

1. In a progress note dated , at 3:02 p.m., Resident #1 was reported to have been found in the parking lot at 7:00 a.m. by a home healthcare nurse. The progress note stated that the family and the doctor were notified.

2. The Incident Log dated / stated Resident #1 was sent to emergency evaluation and subsequently was placed in another facility's Memory Care Community.

3. In an interview with the Business Office Director at 3:10 p.m., when she was asked if the incident was reported to The State Agency, she stated, "That's all we have."

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Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Horizon Bay Vibrant Ret Living 449
730 South Osprey Avenue
Sarasota, FL 34236

RE: CCR #2016003702

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 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 , 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 surveyors. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form

XG90

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