AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965400	09/15/2016
NAME OF PROVIDER OR SUPPLIER **HORIZON BAY VIBRANT RETIREMENT LIVING 444**	STREET ADDRESS, CITY, STATE, ZIP CODE **3141 NORTH MCMULLEN BOOTH ROAD CLEARWATER, FL 33761**	

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

0000 Initial Comments

Assisted Living Facility

Three complaint investigations (CCR# 2016007314, CCR# 2016007673, and CCR# 2016008136) were conducted at Horizon Bay Vibrant Ret #444 on . Horizon Bay Vibrant Ret #444 had a deficiency at the time of the investigation.

(License number # 9748)

0086 Training - ADRD

Based on record review and interview, the facility failed to ensure that direct care staff received in-service training regarding and Related (ADRD) within 3 months (ADRD Level I) and/or within 9 months of employment (ADRD Level II) for 2 (Staff A and Staff B) of 3 employee records reviewed.

Findings included:

An employee record review for Staff A showed a hire date of / and revealed that there were no training certificates for ADRD Level I or ADRD Level II. A review of Staff B's employee record showed a hire date of and revealed that there was no training certificate for ADRD Level I.

The facility was observed to maintain a secured area with a keypad entry/exit and staffing schedules indicated that both Staff A and Staff B provided direct care to residents.

During an interview on at 4:41 PM, Business Office Manager acknowledged that Staff A and Staff B did not have the required ADRD training and stated that this was due to a lack of ADRD trainers and conflicting work schedules.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Horizon Bay Vibrant Retirement Living 444
3141 North McMullen Booth Road
Clearwater, FL 33761

RE: CCR# 2016007314, 2016007673, & 2016008136

Dear Administrator:

This letter reports the findings of three complaint surveys that were conducted on , 2016, by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency 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 the identified deficiency. 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 deficiency 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.

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Thank you for the assistance provided to the surveyor(s). Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

FOR Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State Form 5000-3547

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