STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968140	**12/12/2016**
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)

0000 Initial Comments

A complaint investigation (CCR#2016011034) was conducted at New Horizon's Health Care (License #12082) on 12/12/2016. New Horizon's Healthcare had deficiencies at the time of the investigation.

0165 Risk Mgmt & QA: Adverse Incident Report

Based on staff interview and record review, the facility failed to submit a adverse incident report to the Agency for Healthcare Administration as required for 1 of 3 sampled residents. (Resident #1)

The findings include:

During an interview with Resident #1 on at 1:15 PM he was found to be at risk for elopement due to a lack of orientation to person, place and time or location. Progress notes signed by the Registered Nurse state he eloped from the ALF (assisted living facility) at 6:30 AM on and was found at 2:30 PM that day by the police department several miles from the ALF and disoriented. The notes state the police transported the resident to the emergency he was monitored for approximately 20 hours before being returned to the ALF on via medical transportation with no injuries. During an interview with the Administrator on he agreed this incident qualifies of an adverse incident as defined by the ALF regulations. He said a mistake was made by not submitting an adverse incident report to the Agency for Healthcare Administration for this elopement.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

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

RE: CCR #2016011034

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on , 2016 by representative 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 20, 2017.** 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 surveyor. Should you have any questions please call this office at -4201.

Sincerely,

Jana Meyering

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

JS/JM/sm
Enclosure
XG90

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