AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942812	**12/23/2016**
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 relicensure survey was conducted from / through at Horizon Bay Vibrant Retirement Living 449, an assisted living facility (license #8261) in Sarasota, Florida. The survey was completed in conjunction with a second follow up to a complaint survey.

The following is description of the deficiencies.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, interview and record review, the facility failed to provide supervision to prevent two residents (Resident #25 and #26) of thirty residents surveyed from multiple placing both residents at serious risk of harm.

The findings included:

1. Review of Resident #26's "Resident Log" shows:
On , Resident #26 in the doorway of the dining complained of right hip pain. On / the resident was diagnosed with a of the right femur neck. He returned from the hospital ten days later.

On , Resident #26 in his stated he hit his shoulder and was sent to the hospital. He returned with a diagnosis of a possible hairline .

On Resident #26 going into his apartment. The resident log reads,"Slipped out of slipper." He was sent to the hospital with the left side of his skull .

On at 9:00 a.m., Resident #26 was observed lying in bed. A large scab was observed over the left side of his head.

Review of Resident #26's "Personal Service Plan" dated , under Escort and Mobility reads, "Provide physical assistance to and from the dining /or community activities as needed."
On at 9:50 a.m., licensed practical nurse, Staff H said resident assistant ( ), Staff Q found Resident #26 laying on floor at his apartment entrance yelling "help." Staff H said after the medication technician, Staff Q had arrived Resident #26 informed her he had slipped out of his slippers. When Staff H verified the resident still had those slippers. Staff H replied, "Well we didn't take away his slippers."
On at 9:55 a.m., Staff Q said it was 7:00 p.m., when she had observed Resident #26 on the floor at the door of his apartment. Staff Q said Resident #26 had been coming from the dining

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unaccompanied. Staff Q said he was supposed to have someone walking with him. Staff Q said the resident had slipped when he went from the carpet to the vinyl flooring of his room because he was wearing slippers. Staff Q verified the resident was still wearing the same slippers he had in. Staff Q said no supervisor had ever questioned her about how Resident #26 had .

On at 10:00 a.m., the Wellness Coordinator, Staff W said resident care assistants received information regarding the expected care of residents from the "Care Profile." Review of Resident #26's Care Profile reads, "Provide physical assistance to and from the dining /or community activities as needed." There were no other prevention interventions listed on the Care Profile. Staff W verified Resident #26's had not yet been investigated. Staff W said she could not say much about the prevention program at the facility. Staff W said she had only been at the facility for one month and had just received access to the computer system two weeks ago.

2. Review of the "Resident Log" shows:

On , Resident #25 attempting to change a bulb in a lamp. There was no documentation of any interventions to prevent further .

On , Resident #25 was found on the floor in his apartment by a Medication Technician. There was no documentation of any interventions to prevent further .

On / , Resident #25 was found on the floor of his apartment calling for help. He was unable to provide any information on the cause of the . The resident was sent to the hospital. He returned from the hospital on / .

On / , Resident #25 was found in his apartment on the ground sitting. He said he had slipped out of his chair when he was trying to get up. There was no documentation of any interventions to prevent further .

On , Resident #25 was found on the floor in his . The resident told staff he had try to put on his pants. He complained of pain to his left pinky finger and he was sent to the hospital.

On / , Resident #25 while being weighed by a staff member. There was no documentation of any interventions to prevent further .

Review of the "Personal Service Plan" dated , shows Resident #25 was able to put on and take

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off his clothing, shoes, and socks with staff attention and verbal prompts as needed.

Review of the "Care Profile" under Escort and Mobility reads, "Resident uses a walker as a mobile aid." There was no documentation on the Care Profile of prevention interventions.

On at 9:07 a.m., , Staff X said she had recently found out that she could write things in the communication book. Staff X said Resident #25 a lot. Staff X said no one had spoke with her about checking on Resident #25 frequently or things to do to prevent the resident from falling.

On at 11:00 a.m., the Occupational (OT) said Resident #25 needs to have staff assist him with all activities of daily living and needs to be escorted to and from dining to prevent him from falling. The OT said the Care Profile needed to be updated.

On at 11:26 a.m., the Administrator verified the system to monitor and intervene to prevent was broken. The Administrator said, "There are polices in place but they have by the wayside."

Class II

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on observation, interview, and, record review, the facility failed to assess 82 residents for risk of elopement and failed to identify 8 residents (Resident #1, #8, #25, #26, #27, #28, #29, and #30) of 30 residents surveyed to be at risk for elopement and failed to implement procedures to prevent residents from eloping from the facility placing residents at serious risk of harm resulting in 5 residents (Resident #1, #8, #25, #29, and #30) eloping six times from the facility during a 9 month period. The Facility failed to ensure residents who had eloped from the facility had identification of the person and the address and phone number of the facility on their person when they eloped.

The findings included:

The facility is located in a city area. There are major roads to the front and sides of the building. There is a canal located in the back of the facility that is accessible by walking.

Review of the "Elopement Risk Policy" dated / reads, "Resident who are at risk for elopement should be identified ...Any resident at a non- and Care community who has a diagnosis of shall also be considered at risk for elopement."
The "Guidelines for Elopement Risk Interventions" was a paper showing what intervention to prevent

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elopement was needed for the action being displayed by the resident at risk for elopement. The form instructs if the action of the resident is to walk through the door/exit, the appropriate staff action would be to place a staff member one to one with the resident at risk for at least 48 hours or until proper placement.

1. Review of Resident #25's Agency for Health Care Administration AHCA Form 1823 completed on / , showed the resident had a diagnosis of and was an elopement risk.

Review of Resident #25's "Resident Log" shows on , "Staff reported Resident out in the parking lot at 4:30 am escorted back to his ."

On at 12:32 p.m., licensed practical nurse (LPN), Staff H confirmed she had documented in the resident log that Resident #25 was found in the parking lot at 4:30 a.m. on . She said staff had reported the incident to her. Staff H confirmed she had not taken any other action than to make a note in the log. She had not reported the incident to her supervisor nor took any other actions to prevent further elopements by the resident.

Review of a physician's order for Resident #25 showed on / the resident was to evaluated by a , nurse for increased and hallucinations.

The resident log dated at 5:15 p.m. read, "Resident is wandering on the main floor stated he was 'looking for my students, I am supposed to teach a class.'"

On , the nurse's faxed note to the resident's primary physician, documented, "Resident has increased and hallucinations; and is wandering. Requesting evaluation for appropriateness of placing the resident in unit for increased supervision such as memory care."

On , the physician wrote "Ok" and faxed it back on the same order form.

On/ / , a fax to Resident #25's primary physician read, "Resident continues to present with , hallucinations, and paranoia; and has been found wandering. We are requesting updated 1823 which includes diagnosis so resident may be moved to memory care." The physician wrote, "Completed" on the same form, on the same date.

On / at 1:00 p.m., the resident's log read, "Initial discussion with resident's son re: transfer to memory care services. Resident's behaviors discussed. He has M.D. [medical doctor] appointment on Thursday and son will discuss further with MD." This note was the first documented contact with the

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resident's family regarding the resident's risk for elopement.

On 12/14/16, the Resident Log read, "Resident experiencing episodes of increased this morning. Received AM medication per MD order. Resident sitting in main lobby stating 'he had an appointment that he needs to go to.'" Fifteen minutes later the resident was reported to be off the facility site. It was tat that time the resident was placed in the memory care unit.

On / at 3:30 p.m., several residents were observed sitting on couches in the front lobby unsupervised near an automatically opening door. No staff member was observed at the front desk in the lobby nor observed within the vicinity of the front desk at that time.

2. Record review revealed Resident #1 was admitted to the facility with minimal , , but forgetful. Resident progress notes reveal on , Resident #1 was found next to a local restaurant by a home health nurse. The resident was returned to the facility and was transported by Emergency Medical Services ( ) to the hospital. The corrective action of the facility was to place the resident in memory care. The family arranged for 1 to 1 private care until the resident could be moved to memory care.

3. Record review revealed Resident #8 was admitted on / with a diagnosis of , with occasional agitated features. The Resident Log noted on Resident #8 left the facility and staff as notified by a family member that the resident had not returned at 10:30 a.m.. 911 was called and the resident was found out in the community by the police. The resident was returned by 12:15 p.m. The resident said he had gotten while walking and was unable to find his way back to the facility. The corrective action of the facility did not include identifying residents at risk for elopement at the facility.

4. Record review revealed Resident was admitted on . On , Resident #30 was found in the parking lot by staff. The resident "appeared to be " and was returned to the facility. A review of the Agency for Health Care Administration AHCA Form 1823 dated / , revealed Resident #30 is alert with periods of .

5. Record review revealed Resident #29 was admitted on . The Agency for Health Care Administration AHCA Form 1823, dated revealed the resident is alert with periods of .

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On 9/17/16 at 4:30 p.m., a local restaurant notified the facility that Resident #29 was not at the facility. The facility was not sure what time Resident #29 had left the building. The corrective action of the facility was, "Resident was assessed, family agreed to move to memory care." A progress note dated, at 9:45 p.m. documented the Health and Wellness Director was notified by phone the resident was found wandering outside a local restaurant. The resident was and disoriented when staff went to get him. He was returned to the facility and staff were to take extra care to watch him.

6. On at 9:10 a.m., resident assistant ( ), Staff Q said she was not aware of any facility listing of residents who were elopement risks. She said Resident #28 had started seeing things that were not there about a week ago. The resident is mobile and uses a walker. , Staff Q said Resident #28 was at risk for eloping. , Staff Q was not aware of any intervention implemented to prevent the resident from eloping.

On / at 12:18 p.m., the Wellness Coordinator said she was not aware that Resident #28 was a risk to elope.

On at 5:42 p.m., Resident #28 was unable to be interviewed and observed to be to time and place.

7. On / at 9:10 a.m., medication technician, Staff Q said Resident #27 gets at night and comes down the elevator and has to be redirected several times to return to her the night. Staff Q said Resident #27 is throughout the day and is mobile.

Review of Resident #27's resident log dated / documented, "Staff notified by HH [Home Health] nurse that resident is experiencing episodes of increased and hallucination."

On / at 12:18 p.m., The Wellness Coordinator said she was not aware that Resident #27 was a risk to elope.

On at 5:32 p.m., Resident #27 was unable to be interviewed and observed to be to time and place.

8. On at 12:18 p.m., the Wellness Coordinator, Staff W said she did not know of any residents in the building that were an elopement risk. A few minutes later she said she thought Resident #26 could

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be a risk to elope. Staff W said she has gotten calls at night from staff that the resident is and restless. Staff W said she was not too concerned because the front doors lock at night so residents cannot get out of the facility. Staff W said she was not aware of any system in place to identify residents at risk for elopement. Staff W said according to the policy any resident with a diagnosis of would be a risk for elopement.

Review of Resident #26's Resident Log dated / / at 4:15 p.m. read, "Resident noted walking in the hallway outside of his from the waist down; he was unable to explain his situation only stating that he needed 'help.'"

On at 1:09 p.m., the Maintenance Director stated the front door locks at 7:00 p.m. at night to prevent anyone from coming into the building, not to prevent residents from leaving the building. The Maintenance Director demonstrated the doors locking system. The door was locked in the same way the door would lock at 7:00 p.m. at night. A silver button was observed on the side of the door. The button being pushed caused the front doors to swing open. It was observed, that once outside the doors, the doors would not reopen to enter the facility without intervention from the inside.

On / at 2:45 p.m., the Administrator and the Wellness Coordinator produced a large white notebook with several residents' pictures in it. The book had some residents information listed and some residents had no information listed. The Administrator said he and Wellness Coordinator had not been aware the book was in the facility. He said the concierge had been keeping the book at the front desk. He said there was not another book in the facility for staff.
The Administrator produced a box of plastic bracelets. He said he was not sure when the facility had obtained the bracelets, but he thought it was it was in when another resident had eloped from the building. He said the former Wellness Coordinator had failed to initiate the bracelet system for residents at risk for elopement. The Administrator verified that none of the residents at risk for elopement had identification bracelets on. The Administrator said there were policies in place to identify residents at risk for elopement but the policies were not being followed. The Administrator said the system was broken.

Class II

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2017

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

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by representative(s) 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 , 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(s). 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

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