STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965844	**02/20/2018**
NAME OF PROVIDER OR SUPPLIER **FRESH HORIZON'S ASSISTED LIVING FACILITY**	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 licensure complaint survey, CCR# 2017015452, was conducted on at Fresh Horizon's ALF, License # 10323. The allegations were substantiated. The facility had deficiencies at the time of the investigation.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on interview and record review it was determined the facility failed to ensure each resident has received a face-to-face medical examination completed by a health care provider (a licensed physician; a licensed physician's assistant; or a licensed nurse practitioner) and that the owner or administrator of the facility shall use the information contained in the health assessment to assist in the determination of the appropriateness of the resident's admission and/or continued stay at the facility for 1 of 3 sampled residents (Resident #1).

The findings include:

During interview and review of Resident #1's health assessment conducted with the Administrator, on beginning at approximately 11:45 AM, she was asked why she accepted a health assessment (1823 form) that had been completed and signed by a RN (Registered Nurse) for Resident #1 on . She stated she was not aware that a RN could not complete a health assessment (1823 form).

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on interview it was determined the facility failed to have a written grievance procedure for receiving and responding to resident complaints and that the facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint (in accordance with Section 429.28, F.S.).

In addition, based on interview and record review it was determined the facility failed to ensure its house rules and procedures (that must be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C.) must at a minimum address the facility's policies regarding resident elopement and reporting resident , neglect, and , .

The findings include:

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1) During entrance conference conducted with the Administrator, on [redacted] beginning at approximately 10:15 AM, she was asked for copies of the facility's grievance procedure and documentation of grievances filed within the past 6 months. The Administrator stated the facility does not have any written grievance procedure and that she was not aware the facility was required to have one. She stated if a resident has a complaint that it is just addressed and that the facility does not maintain any documentation of resident grievances.

2) During entrance conference conducted with the Administrator, on beginning at approximately 10:15 AM she was asked for copies of the facility's resident elopement policy and procedure and for the facility's policy and procedure related to reporting resident , neglect, and [redacted]. The Administrator stated the facility does not have these policies and procedures and that she was not aware the facility was required to have them. The Administrator was asked if there had been any allegations of [redacted], neglect, or [redacted] in the past 6 months. She stated there was a resident to resident incident in 2017. She was asked for all documentation related to this incident. A typed document, not signed by any staff member that was dated [redacted], reflected Resident #2 Resident #3 with his cane and injured his (Resident #3's) head. This injury was noted to have required stitches. Law Enforcement was notified and this document noted that Law Enforcement documented the incident. This document reflected the hotline was called and informed of the resident to resident [redacted] incident.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on interview and record review it was determined the facility failed to maintain an up-to-date admission and discharge log (with all of the required components documented).

The findings include:

During entrance conference conducted with the Administrator, on [redacted] beginning at approximately 10:15 AM, she was asked for the facility's admission and discharge log. She provided it for review. She acknowledged she had not maintained this document in an up-to-date manner and that she was going to take it home with her, this week.

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0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on interview and record review it was determined the facility failed to file the preliminary adverse incident report within 1 business day after the incident pursuant to Rule 59A-35.110, F.A.C. and a full adverse incident report within 15 days of the incident pursuant to Rule 59A-35.110, F.A.C. It was also determined the facility failed to maintain adverse incident reports, specifically related to any condition that requires transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident or an even that was reported to law enforcement or its personnel for investigation for 2 of 3 sampled residents (Resident #2 and Resident #3).

The findings include:

During entrance conference conducted with the Administrator, on beginning at approximately 10:15 AM, she was asked to provide all adverse incidents, for the past 6 months, for review. She stated there had not been any. She was asked if there had been any resident to resident incidents. She confirmed there was one in 2017. She was asked for all documentation related to this incident. A typed document, not signed by any staff member that was dated , reflected Resident #2 Resident #3 with his cane and injured his (Resident #3's) head. This injury was noted to have required stitches. Law Enforcement was notified and this document noted that Law Enforcement documented the incident. This document reflected the hotline was called and informed of the resident to resident incident. The Administrator acknowledged that Resident #3 had to go to the hospital to receive stitches in his head. She was asked if she filed a preliminary or full adverse incident report related to this incident. She confirmed that she did not.

Class III

L240 - LMH - Licensing - 429.075

Based on interview and record review it was determined this facility currently serves one mental health resident without first obtaining a limited mental health license for 1 of 4 sampled residents (Resident #1).

The findings include:

During entrance conference conducted with the Administrator, on beginning at approximately 10:15 AM, she was asked if the facility had any LMH (Limited Mental Health) residents. She confirmed that the facility has a LMH (Limited Mental Health) resident (Resident #1) and that her primary diagnosis

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is , , . The Administrator stated this resident has been living at this facility since approximately 2005. The admission and discharge log noted Resident #1 was admitted in 2005. The Administrator stated she thought an ALF (Assisted Living Facility) could have one (1) LMH resident without a LMH license. She was informed that was not the current regulatory requirement and that a LMH license needs to be obtained if any ALF is going to serve any LMH residents.

Class III

Z813 - Results of Screening & Notification In File - 59A-35.090(3)(c), FAC

Based on interview and record review it was determined the facility failed to maintain the signed Attestation referenced in subsection 59A-35.090(2), F.A.C. in each employee's personnel file that is maintained by the provider for 4 of 4 sampled staff (Staff A, Staff B, Staff C, and Staff D).

The findings include:

During interview and personnel record review conducted with the Administrator, on beginning at approximately 1:30 PM, she was provided the opportunity to locate the signed Attestation form in the following employee's files and was unable to locate this required documentation:

a) Staff A: date of hire noted as
b) Staff B: date of hire noted as
c) Staff C: date of hire noted as
d) Staff D: date of hire noted as

Unclassified

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on interview and record review it was determined the facility failed to ensure each staff member subject to level 2 screening must register with the clearinghouse (initial and any changes in status must be reported within 10 business days) for 1 of 4 sampled staff (Staff B).

The findings include:

During interview and review of the facility's clearinghouse roster conducted with the Administrator, on beginning at approximately 1:30 PM, she acknowledged Staff B (date of hire noted as) was not listed on the facility's clearinghouse roster. The Administrator could not provide an

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explanation as to why.

Unclassified

Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c) FS

Based on interview and record review it was determined the facility failed to ensure if there was a break in service that exceeded 90 days from a position that requires a level 2 screening for 1 of 4 sampled staff (Staff B).

The findings include:

During interview and personnel record review conducted with the Administrator, on [redacted] beginning at approximately 1:30 PM, Staff B' (date of hire noted as [redacted]) file was reviewed. Her most recent eligible level 2 background screening was dated [redacted]. Review of Staff B's employment application did not note dates of employment for her last employer. The Administrator acknowledged the facility did not check employment reference for that employer in order to verify if there had been a break in service that exceeded 90 days.

Unclassified