| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11910708 | 06/08/2018 |
| NAME OF PROVIDER OR SUPPLIER<br>**HORIZON ALF** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**1490 NW 21ST STREET**<br>**FORT LAUDERDALE, FL 33311** | |

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

**0000 - Initial Comments**

An unannounced licensure complaint survey, CCR #2018007359 was conducted on thru and at Horizon ALF, License # 8595. The facility had deficiencies at the time of the visit.

**0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC**

Based on record review and interviews, it was determined that the facility failed to ensure that a resident's health assessment (AHCA form 1823) was accurate and reflective of a resident's diagnosis and care needs; to ensure that appropriate care and services would be provided to the resident, for 1 out of 3 sampled residents (Resident #1). As evident of the facility failure to ensure that Resident #1's mental health diagnoisis was documented on the assessment to properly alert staff on how to manage the resident's non-compliance and aggressive behavior.

The findings included:

Review of Resident #1's record revealed a Health Assessment completed on . The assessment dated documented the resident's diagnoses as dependent type II; ; chronic ; and recurrent . The and behavioral status documented as /re-direct able with treatment can be irritable. The assessment also documented nursing/treatment/ services requirements as outpatient services for therapies, psychiatrist (we will refer) visits and primary care physician visits. Special precautions noted as gets verbally at times. Additional comments noted as the following; resident is Type II dependent and needs help with monitoring and administration by a 3rd party Home Health Nurse. Further review of the resident's file revealed a physician note dated documenting that the resident suffers from , history of non-compliance and . However, neither of these diagnosis and/medical conditions are noted on the resident's health assessment.

Further record review of observation notes completed by the facility staff revealed Resident #1 exhibited non-compliant behavior and aggressive behavior from the day of admission to the date of (day resident was ). The staff on the above dates were unable to redirect the resident behavior and/or address the LMH behavior due the facility Administrator not properly assessing and ensuring the resident's current diagnosis and needs were documented on the AHCA 1823 form. The Resident was even physically restrained on by staff and a resident, at this time, pepper sprayed as a result of his agressive behavior. Record review revealed at no time during the resident's stay did the facility exhibit any redirection techniques to counter-act the resident's behavior.

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SUMMARY STATEMENT OF DEFICIENCIES
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Review of Resident #1's MORs for , 2018 revealed the resident was non-compliant in taking his medications on numerous days. There was no evidence to indicate notification to his physician and family regarding his refusal.

The facility is a licensed LMH facility and trained to deal with residents that suffer from identified LMH diagnosis. This includes techniques to redirect unpleasant behavior, aggressive behavior and/or non-compliance behavior. Resident #1 was identifed as suffering from , , exact date of onset per physician could not be identified. However, the diagnosis was identified prior to the resident's admission to the facility.

During an interview with the Administrator on , he confirmed the resident has a psychiatrist and that he had been in communication with the MD regarding recent behavioral issues. However, record review failed to indicate any evidence of physician communication.

During an interview with the Administrator on , aforementioned was discussed. The Administrator confirmed the findings and stated no further documentation was available for review.

Class II

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

Based on observation, interview and record review, it was determined that the facility failed to ensure that all residents reside in a safe environment free from and neglect; and treated with dignity and respect. As evidence of the facility failure to prevent staff (including the Administrator) from using pepper spray as a chemical and physically restraining a resident as a method of redirecting aggressive behavior (Resident #1).

The findings include:

Record review of observation notes completed by the facility staff revealed Resident #1 exhibited non-compliant behavior (including refusal to take physician order medications) and aggressive behavior from the day of admission to the date of (day resident was , discharged). The facility based on review of Resident #1's observation notes, had numerous opportunities to intervene and contact the resident's physician to redirect aggressive behavior and to prevent the use of physical and chemical on Resident #1. The facility failure to intervene early in the residency of Resident #1 contributed to the increase aggression of the resident.

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Further review of observation notes and interview with the Administrator revealed the following incident occurred on . Resident#1 demanded his cigarettes to the Administrator and rushed into the office. Staff A grabbed and pulled the residents shirt, resulted in the resident on the ground outside the office. Staff A and another resident (Resident #2) held Resident#1 down on the floor. The Administrator went back into his office, retrieved the pepper spray bottle from top desk drawer and sprayed into Resident #1' eyes. Police 911 activated after resident was pepper sprayed. Police came and since Resident #1 was subdued, the police left. Administrator escorted the resident to wash eyes out with water. The facility provided no additional medical attention and no notification to the doctor. According to the Administrator, the family was notified by a voice message left by him. However, during an interview with Resident #1's representative, it was noted they did not receive notification and learned about incident while visiting with Resident on .

During interview with Administrator on at 11:00AM, he stated he felt the need to protect himself because he felt threatened. Upon examining the pepper spray bottle used, provided by the Administrator. It was determined the Pepper spray bottle label read "Law Enforcement Use". Further interview with the Administrator revealed he was unaware of the strength of this chemical and its side effects, prior to use. The Administrator stated that it was his facility policy to use the pepper spray on the residents. The policy was requested from the Administrator; however, it was never provided. The Administrator was also questioned regarding the dates and names of the residents in which he or staff last used the spray; he failed to provide the information.

Review of Resident #1's record revealed a Health Assessment completed on . The assessment dated documented the resident's diagnoses as dependent type II; ; chronic ; and recurrent . The and behavioral status documented as /re-direct able with treatment can be irritable. The assessment also documented nursing/treatment/ services requirements as outpatient services for therapies, psychiatrist (we will refer) visits and primary care physician visits. Special precautions noted as gets verbally at times. Additional comments noted as the following; resident is Type II dependent and needs help with monitoring and administration by a 3rd party Home Health Nurse. Further review of the resident's file revealed physician notes dated documenting that the resident suffers from , , history of non-compliance and . However, neither of these diagnosis and/medical conditions are noted on the resident's health assessment.

The facility is a licensed LMH facility and trained to deal with residents that suffer from identified LMH diagnosis. This includes techniques to redirect unpleasant behavior, aggressive behavior and/or non-compliance behavior. Resident #1 was identified as suffering from , ; exact date of

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onset per physician could not be identified. However, the diagnosis was identified prior to the resident's admission to the facility.

Review of facility records with the Administrator revealed the facility did not have a policy and procedure regarding resident rights, , neglect and , . The Administrator, at this time, was questioned on how and when he makes the determination of when to use the pepper spray on a resident. He constantly, repeated, "I had to protect myself" and never provided an explanation.

Review of LMH (Limited Mental Health) protocol manual used for training for staff provided to the surveyor for review by the Administrator revealed the following.

1. Develop a Crisis Plan
   a. Have an agreement and written procedure for responding to a crisis
   b. train your staff on how to follow the plan
2. Act Early - warning signs
   a. Do not ignore the situation and hope it will go away
   b. Simply giving some of your time, a good listening ear may prevent a crisis
   c. Not paying attention and failing to repsond early may lead residents at your facility to believe that attention only comes when they are in a crisis
   d. Be familiar with responsibilities and limitations related to assistance from law enforcement
3. Be aware of situations that can lead to a crisis
   a. stops taking medications
   b. increases in hallucinations
   c. saying things that don't make sense
   d. mood or attitude changs suddently or frequently
4. Responding to a Crisis
   a. Remain calm
   b. Give the person plenty of space
   c. Tell the person what you are going to do before you do it
   d. Take a hopeful stance that the situation can be dealt with successfully. Try to establish trust and rapport with the individual .

During an interview with the Administrator on , he confirmed the resident had a psychiatrist and that he had been in communication with the MD regarding recent behavioral issues. However, record review failed to indicate any evidence of physician communication.

During an interview with the Administrator on and , aforementioned was discussed. The Administrator confirmed the findings and stated no further documentation was available for review.

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Class II

**0054 - Medication - Records - 58A-5.0185(5) FAC**

Based on interview and record review, the facility failed to ensure that the MOR (Medication Observation Records) were complete and accurate, for 1 out of 3 MORs reviewed. As evidence of discrepancies identified on the MORs for , 2018 for Resident #1.

The findings included:
A) Resident #1 was prescribed the following medications daily.

1) - 500 mg - take one tab by mouth 2x daily
2) -5mg tab - take one tab 2x daily by mouth
3) -1000mg tab take one tab by mouth 2x daily
4) -1mg tab - take one tab by mouth at bedtime
5) - 20 mg tab - take one tab by mouth at bedtime
6) -40 mg tab - take one tab by mouth at bedtime
7) Sulfa -325 mg - take one tab 2x daily by mouth
8) - 100mg tab - take one tab 2x daily by mouth
9) - 20 mg tab - take one tab by mouth at bedtime
10) unit injections in morning

B) During a review of Resident #1's MOR for , 2018, numerous discrepancies were identified regarding medications refused and medications not available. The following concerns were noted.

1) Staff initials on dates (various) as resident received his medication and on the back of the MOR (reverse side under nurse's medication notes) states refused .
2) Staff initials on dates (various) as resident received his medication and on the back of the MOR (reverse side under nurse's medication notes) states not available.
3) The exact dates of refusal of medications could not be clearly identified due to lack of documentation on the MORs (reverse side under nurse's medication notes).
4) The exact medications refused could not be clearly identified due to discrepancies on the front and back of the MOR.
5) The exact medications not available could not be clearly identified due to discrepancies on the front and back of the MOR. For example, for it states (under the medication /dosage section) the

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following ; meds some 7AM/6PM/9PM "THEY WERE NOT AVAILABLE (under the reason section) , NOT GIVEN (under the results section). During an interview with the Administrator on , it was revealed the facility had no documentation to reflect Resident #1's medications were order timely and reasonable efforts were made to obtain the medications.

(photographic evidence obtained)

During an interview with the Administrator on at 10:00AM, he confirmed findings and no further information provided.

Class III

**0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC**

Based on record review and interview, it was determined that the facility failed to ensure all physician order medications for residents are ordered and refilled in a timely manner, for 1 out of 3 sampled residents (Resident #1).

The findings included:
A) Resident #1 was prescribed the following medications daily.

1) - 500 mg - take one tab by mouth 2x daily
2) -5mg tab - take one tab 2x daily by mouth
3) -1000mg tab take one tab by mouth 2x daily
4) -1mg tab - take one tab by mouth at bedtime
5) - 20 mg tab - take one tab by mouth at bedtime
6) -40 mg tab - take one tab by mouth at bedtime
7) Sulfa -325 mg - take one tab 2x daily by mouth
8) - 100mg tab - take one tab 2x daily by mouth
9) - 20 mg tab - take one tab by mouth at bedtime
10) unit injections in morning

However, review of Resident #1's MORs for 2018 revealed on numerous dates all of the residents medications were not available for assistance. Review of the MORs (reverse side of the MOR) revealed numerous documentation of medications not available. The exact date and medications not available could not be determined due to numerous documention discrepancies on the MOR. For example, for

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it states (under the medication /dosage section) the following ; meds some 7AM/6PM/9PM "THEY WERE NOT AVAILABLE (under the reason section) , NOT GIVEN (under the results section). During an interview with the Administrator on , it was revealed the facility had no documentation to reflect Resident #1's medications were order timely and reasonable efforts were made to obtain the medications.

Class III

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

Based on record review and interview, it was determined that the facility failed to report an adverse incident to the Agency for Healthcare Administration regarding an event that involved a resident that was reported to law enforcement for investigation, for 1 out of 3 sampled residents' records reviewed (Resident # 1).

The findings included:

During an interview with Administrator on at 9:42 AM, revealed that an incident occurred on with Resident # 1 which involved aggressive behavior resulting in the Administrator using pepper spray to restrain the resident, the police were called out. The Administrator stated that Resident # 1 was on due to aggressive behavior. The Administrator stated that both incidents were not reported to The Agency of Health Care Administration and that the required adverse reports (1 day and 15 day) were not completed. The Administrator stated that Resident # 1 is no longer at the facility.

Class III

Refer to A 0030 for additional findings