STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910708	**08/21/2018**
NAME OF PROVIDER OR SUPPLIER **HORIZON ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **1490 NW 21ST STREET** **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#2017014114 & 2017013272, was conducted on - at Horizon ALF, License #8595. The facility had a deficiency at the time of the investigation

This survey was conducted in conjunction with the revisit to licensure complaint survey, CCR#2018007359. See separate report for findings.

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(6) FAC

Based on records review and interviews, the facility failed to ensure that eight of ten employees (Employees A, B, C, D, E, F, G, & H) completed the updated Assistance with the self-administration and medication management training every year.

The findings included:

a) On at 12:45 PM, a review of the Employees' Records Revealed that Employee A with a date of hire (DOH) of completed her initial 4 hours of medication training on and had completed 2 hours update on .
b) Employee B, an Aide, DOH completed 4 hours initial medication training on and 2 hours update on .
c) Employee C, an Aide hired on / 2016 completed 4 hours initial medication training on 4 hrs.) and no update.
d) Employee D an Aide DOH completed 4 hours initial medication training on updated 2 hrs. on .
e) Employee E and Aide DOH completed 4 hours initial medication training on and 2 hrs. of update on .
f) Employee F and Aide DOH completed 4 hours initial medication training on and no update.
g) Employee G an Aide DOH completed 4 hours initial medication training on no update.

During an interview with the Executive Director, on at 12:45 PM, he indicated that all employees but one assist with self-administration of medication. He therefore acknowledged the findings and plans to have the issue resolved.

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

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

Class III