

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969452	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/13/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HARBORCHASE OF DR PHILLIPS

**7233 DELLA DRIVE
ORLANDO, FL 32819**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments A revisit to Complaint Investigation 2020010367 and a revisit to a generator and control monitoring was conducted at Harborchase of Dr. Phillips on 8/13/2020 and 8/14/2020. Uncorrected deficiencies were identified at the time of the revisit.	{A 000}		
{A 025} SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of _____ or _____ or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such _____ or _____. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the	{A 025}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969452	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 08/13/2020
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF DR PHILLIPS			STREET ADDRESS, CITY, STATE, ZIP CODE 7233 DELLA DRIVE ORLANDO, FL 32819		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{A 025}	Continued From page 1 resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: DEFICIENCY REMAINED UNCORRECTED Based on observations, record reviews and interviews, the facility failed to follow a health care provider's care orders for 1 of 3 sampled residents (#8). Findings: At 9:30 a.m. on _____, the director of nursing (DON) identified resident #8 and said he had a _____ on his _____ and his right _____ and a _____ on his left heel. Resident #8's current 1823 health assessment form, dated _____, indicated that his diagnoses included _____ and _____. A health care provider's order, dated _____, instructed to admit the resident to extended congregate care (ECC) for _____ management.	{A 025}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969452	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/13/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HARBORCHASE OF DR PHILLIPS

**7233 DELLA DRIVE
ORLANDO, FL 32819**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 025}	Continued From page 2 The resident's ECC service plan, dated _____, indicated that _____ care would be provided by the facility twice weekly on Thursday and Saturday. A health care provider's visit note, dated _____, indicated that he had an acute _____ on his left heel, an acute _____ on his left _____, an acute _____ on his right upper _____, an acute sheering on his _____, an acute sheering on his _____, an acute _____ on his left _____ heel and an acute _____ on his right _____. The _____ care orders on the note indicated the following: _____, wet to dry, _____ covering, and a kexfix wrap was to be applied daily to the left heel _____. Skin prep was to be applied daily to the left _____. Triple _____ and a dry _____ was to be applied three times a week to the right upper _____. _____ cream was to be applied daily to the _____ sheering. Dakin's solution, _____, a wet to dry _____ and a foam cover was to be applied three times a week to the _____ sheering, the left _____ heel _____ and the right _____. A health care provider's visit note, dated _____, indicated the _____ care orders would remain _____.	{A 025}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969452	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/13/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HARBORCHASE OF DR PHILLIPS

**7233 DELLA DRIVE
ORLANDO, FL 32819**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 025}	Continued From page 3 the same. However, review of the resident's record and Medication Observation Record (MOR) revealed there was no documentation to indicate the facility provided the ordered care to the left , the right upper , the sheering and the left heel . The resident's record did not contain an order to discontinue the treatments. In addition, documentation on the MOR indicated the facility did not treat the sheering with Dakin's solution, , and wet to dry but rather, the was treated with normal and Silvasorb gel and the right , was cleansed with normal and not Dakin's solution, as prescribed. At 3 p.m. on , the DON confirmed the findings and said that she did not know the resident had on his right upper and his and she thought he had only one left heel . An opportunity was given for her to provide additional documentation, but she was unable to do so. At 11:40 a.m. on observations made of the resident's skin revealed that his skin was intact on his left , his and his right upper . The on his measured approximately 4 cm x 3 cm and the bed was pink in color. The on his right measured approximately 5 cm x 5 cm x 4 cm and the bed contained yellow . His left heel had one that measured approximately 1 cm x 1 cm and the bed was pink in color. Class III	{A 025}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969452	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/13/2020
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF DR PHILLIPS		STREET ADDRESS, CITY, STATE, ZIP CODE 7233 DELLA DRIVE ORLANDO, FL 32819	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
{A 086} SS=D	59A-36.011(10) FAC Training - ADRD (10) AND RELATED ("ADRD") TRAINING REQUIREMENTS. Facilities which advertise that they provide special care for persons with ADRD, or who maintain secured areas as described in Chapter 4, Section 464.4.6 of the Florida Building Code, as adopted in rule 61G20-1.001, F.A.C., Florida Building Code Adopted, must ensure that facility staff receive the following training. (a) Facility staff who interact on a daily basis with residents with ADRD but do not provide direct care to such residents and staff who provide direct care to residents with ADRD, shall obtain 4 hours of initial training within 3 months of employment. Completion of the core training program between _____ and _____ shall satisfy this requirement. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. Initial training, entitled "_____ and Related _____ Level I Training," must address the following subject areas: 1. Understanding _____'s _____ and related _____; 2. Characteristics of _____; 3. Communicating with residents with _____'s _____; 4. Family issues; 5. Resident environment; and, 6. Ethical issues. (b) Staff who have successfully completed both the initial one hour and continuing three hours of ADRD training pursuant to sections 400.1755, 429.917 and 400.6045(1), F.S., shall be considered to have met the initial assisted living facility _____ and Related _____ Level I Training.	{A 086}	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969452	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/13/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HARBORCHASE OF DR PHILLIPS

**7233 DELLA DRIVE
ORLANDO, FL 32819**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 086}	Continued From page 5 (c) Facility staff who provide direct care to residents with ADRD must obtain an additional 4 hours of training, entitled " _____ and Related _____ Level II Training," within 9 months of employment. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. _____ and Related _____ Level II Training must address the following subject areas as they apply to these _____: 1. Behavior management, 2. Assistance with ADLs, 3. Activities for residents, 4. Stress management for the care giver; and, 5. Medical information. (d) A detailed description of the subject areas that must be included in an ADRD curriculum which meets the requirements of paragraphs (a) and (b) of this subsection, can be found in the document "Training Guidelines for the Special Care of Persons with _____'s and Related _____," dated _____, incorporated by reference, available from the Department of Elder Affairs, 4040 Esplanade Way, Tallahassee, Florida 32399-7000. (e) Direct care staff shall participate in 4 hours of continuing education annually as required under section 429.178, F.S. Continuing education received under this paragraph may be used to meet 3 of the 12 hours of continuing education required by section 429.52, F.S., and subsection (1) of this rule, or 3 of the 6 hours of continuing education for extended congregate care required by subsection (7) of this rule. (f) Facility staff who have only incidental contact with residents with ADRD must receive general written information provided by the facility on interacting with such residents, as required under	{A 086}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969452	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/13/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HARBORCHASE OF DR PHILLIPS

**7233 DELLA DRIVE
ORLANDO, FL 32819**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 086}	Continued From page 6 section 429.178, F.S., within three (3) months of employment. "Incidental contact" means all staff who neither provide direct care nor are in regular contact with such residents. (g) Persons who seek to provide ADRD training in accordance with this subsection must provide the department or its designee with documentation that they hold a Bachelor's degree from an accredited college or university or hold a license as a registered nurse, and: 1. Have 1 year teaching experience as an educator of caregivers for persons with _____ or related _____, or 2. Three years of practical experience in a program providing care to persons with _____ or related _____, or 3. Completed a specialized training program in the subject matter of this program and have a minimum of two years of practical experience in a program providing care to persons with _____ or related _____. (h) With reference to requirements in paragraph (g), a Master's degree from an accredited college or university in a subject related to the content of this training program can substitute for the teaching experience. Years of teaching experience related to the subject matter of this training program may substitute on a year-by-year basis for the required Bachelor's degree referenced in paragraph (g). This Statute or Rule is not met as evidenced by: DEFICIENCY REMAINED UNCORRECTED Based on observation, personnel record reviews and interview, the facility failed to ensure 1 of 3 sampled staff (I) obtained 4 hours of _____'s _____ and Related _____ (ADRD) level I training within 3 months of employment and 4 hours of ADRD level II training within 9 months of	{A 086}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969452	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/13/2020
---	--	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HARBORCHASE OF DR PHILLIPS

**7233 DELLA DRIVE
ORLANDO, FL 32819**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 086}	Continued From page 7 employment. Findings: At 9:40 a.m. on observations made revealed the facility had a secured memory care unit. Caregiver I's personnel record revealed a hire date of The record did not contain documented evidence to indicate she obtained 4 hours of ADRD level 1 training within 3 months of employment and 4 hours of ADRD level II training within 9 months of employment. At 2:45 p.m. on the administrator confirmed the findings and was unable to provide additional documentation. Class III	{A 086}		