

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 11/04/2020
---	--	--	--

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
A1300 SS=D	Dem Emerg Order 2009 Visitation 1. Every facility must continue to prohibit the entry of any individual to the facility except in the following circumstances listed below within this Section. All facilities must require any individual who is entering the facility and who will have physical contact with any resident to wear PPE pursuant to the most recent CDC guidelines. Persons without physical contact with any resident must wear a mask. A. Family members, friends, and individuals visiting residents in end-of-life situations only; B. Hospice or _____ care workers caring for residents in end-of-life situations; C. Any individuals or providers giving necessary health care to a resident, provided that such individuals or providers (1) comply with the most recent Centers for _____ Control and Prevention (CDC) requirements for PPE, (2) are screened for signs and symptoms of COVID-19 prior to entry, and (3) comply with the most recent control requirements of the CDC and the facility; D. Facility staff; E. Facility residents; F. Attorneys of Record for a resident in an Adult Mental Health and Treatment Facility or forensic facility for court related matters if virtual or telephonic means are unavailable; G. Public Guardians as set forth in chapter 744, Florida Statutes, Professional Guardians as defined by subsection 744.102(17), Florida Statutes and their professional staff pursuant to subsection 744.361(14), Florida Statutes; H. Representatives of the federal or state government seeking entry as part of his or her official duties, including, but not limited to, Long-Term Care Ombudsman program, representatives of the Department of Children and Families, the Department of Health, the	A1300		

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 11/04/2020
---	--	--	--

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
A1300	Continued From page 1 Department of Elderly Affairs, the Agency for Health Care Administration, the Agency for Persons with _____, a protection and advocacy organization under 42 U.S.C. §15041, the Office of the Attorney General, any law enforcement officer, and any emergency medical personnel; i. Essential caregivers and compassionate care visitors who meet the following definitions and satisfy the following criteria: i. Essential caregivers are those who have been given consent by the resident or his or her representative to provide services and/or assistance with activities of daily living to help maintain or improve the quality of care or quality of life for a facility resident. Essential caregivers include persons who provided services before the pandemic and those who request to provide services. 1. Care or services provided by essential caregivers must be identified in the plan of care or service plan and may include bathing, _____, eating, and/or emotional support. ii. Compassionate care visitors provide emotional support to help a resident deal with a difficult transition or loss, upsetting event, or end-of-life. Compassionate care visitors may be allowed entry into facilities on a limited basis for these specific purposes. iii. Each resident or his or her representative may designate up to two (2) essential caregivers and up to two (2) compassionate care visitors. Other than in end-of-life situations, a resident may be visited by one (1) such visitor at a time; however, an intermediate care facility or Agency for Persons with _____ licensed foster-care or group home facility may allow up to two (2) such visitors at a time. . Regarding essential caregivers and	A1300		

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 11/04/2020
---	--	--	--

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
A1300	Continued From page 2 compassionate care visitors, the facility shall: 1. Establish policies and procedures for designation and utilizations of essential caregivers and compassionate care visitors. 2. Set a limit on the total number of visitors allowed in the facility based on the ability of staff to safely screen and monitor visitation. 3. Develop an agreeable schedule in concert with the resident and visitor, including evening and weekends, to accommodate work or childcare barriers. 4. Provide prevention and control training, including training on proper use of personal protective equipment (PPE), hygiene, and social distancing. 5. Designate key staff to support prevention and control training. 6. Screen general visitors to prevent possible introduction of COVID-19; 7. Maintain a visitor log for signing in and out. 8. Prohibit visits, except for compassionate care visits, if the resident is _____ or if the resident is positive for or shows symptoms of COVID-19. 9. Monitor visitor adherence to appropriate use of _____ masks, PPE, and social distancing. 10. After attempts to mitigate concerns, restrict or revoke visitation if the essential caregiver or compassionate care visitor fails to follow prevention and control requirements or other COVID-19-related rules of the facility. v. Essential caregivers and compassionate care visitors shall: 1. Wear a surgical mask and other PPE as appropriate. PPE for essential caregivers and compassionate care visitors must be consistent	A1300		

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 11/04/2020
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
A1300	Continued From page 3 with the most recent CDC guidance for health care workers. 2. Participate in facility-provided training on prevention and control, use of PPE, use of masks, sanitation, and social distancing, and sign acknowledgement of completion of training and adherence to the facility's prevention and control policies. 3. Comply with facility-provided COVID-19 testing, if offered; 4. Provide care or visit in the resident's room or in facility designated areas within the building. 5. Maintain social distance of at least six feet with staff and other residents and limit movement in the facility. vi. The facility may require essential caregivers and compassionate care visitors to submit to facility-provided COVID-19 testing so long as use of testing is based on the most recent CDC and U.S. Food and Drug Administration (FDA) guidance. J. General visitors, i.e. individuals other than essential caregivers or compassionate care visitors, under the criteria detailed below. i. To accept general visitors, the facility must meet the following criteria: 1. Other than in a dedicated wing or unit that accepts COVID-19 cases from the community, the facility must have no new facility-onset of resident COVID-19 cases in the previous fourteen (14) days; 2. The facility must have fourteen (14) days with no new facility-onset of staff COVID-19 cases where a positive staff person was in the facility in the ten (10) days prior to the positive test; 3. Sufficient staff to support management of visitors;	A1300			

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 11/04/2020
---	--	--	--

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
A1300	Continued From page 4 4. Adequate PPE for staff, at a minimum; 5. Adequate cleaning and supplies; and 6. Adequate capacity at referral hospitals for the facility. ii. General visitors must: 1. Be eighteen (18) years of age or older; 2. Wear a mask and perform proper hygiene; 3. Sign a consent form noting understanding of the facility's visitation and prevention and control policies; 4. Comply with facility-provided COVID-19 testing, if offered; 5. Visit in a resident's room or other facility-designated area; and 6. Maintain social distance of at least six feet with staff and residents, and limit movement in the facility. iii. Before allowing general visitors, the facility shall: 1. Prohibit visitation if the resident receiving general visitors is positive for COVID-19 and not recovered (as defined by most recent CDC guidance), or for COVID-19; 2. Screen general visitors to prevent possible introduction of COVID-19; 3. Establish limits on the total number of visitors allowed in the facility based on the ability of staff to safely screen and monitor visitation, including limits on the length of visits, days, hours and number of visits per week; 4. Schedule visitors by _____ only; 5. Maintain a visitor log for signing in and out;	A1300		

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 11/04/2020
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
A1300	Continued From page 5 6. Immediately cease general visitation if a resident-other than in a dedicated wing or unit that accepts COVID-19 cases from the community-tests positive for COVID-19, or is exhibiting symptoms indicating that he or she is presumptively positive for COVID-19, or a staff person who was in the facility in the ten (10) days prior tests positive for COVID-19; 7. Monitor visitor adherence to appropriate use of masks, PPE, and social distancing; 8. Notify and inform residents and their representatives of any changes in the facility's visitation policy; 9. Clean and visiting areas between visitors and maintain handwashing or sanitation stations; and 10. Designate staff to support-prevention and control education of visitors on use of PPE, use of masks, sanitation, and social distancing. . Facilities allowing general visitation shall enable general visitation as described in either or both paragraphs 1 and 2 below: 1. Provide outdoor visitation spaces that are protected from weather elements, such as porches, courtyards, patios, or other covered areas that are protected from heat and sun, with cooling devices if needed. 2. Create indoor visitation spaces for residents in a room that is not accessible by other residents, or in the resident's private room if the resident is bedbound and for health reasons cannot leave his or her room. v. Each resident or his or her representative may designate up to five (5) general visitors. A resident may be visited by no more than two (2) general visitors at a time. vi. Each facility may require general visitors	A1300			

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 11/04/2020
---	--	--	--

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
A1300	Continued From page 6 to submit to facility provided COVID-19 testing so long as use of testing is based on the most recent CDC and FDA guidance. K. Barbers and beauty salons may resume services to residents with the following precautions: i. Services are permissible only if: 1. Other than in a dedicated wing or unit that accepts COVID-19 cases, the facility has had no new facility onset of resident COVID-19 cases in the previous fourteen (14) days; and 2. Fourteen (14) days have passed with no new staff COVID-19 cases where a positive staff person was in the facility in the ten (10) days prior to the positive test. ii. Barbers and salon staff must wear surgical masks, gloves, practice good hygiene, and follow the same requirements as essential caregivers; iii. Waiting customers must follow social distancing guidelines; iv. Residents receiving services must wear masks; v. Services are only provided to facility residents, not outside clients or guests; vi. Services may not be provided to a resident who tests positive for COVID-19 or is exhibiting symptoms indicating that he or she is presumptively positive for COVID-19; and vii. Service and salon areas must be properly cleaned and disinfected, and equipment must be sanitized between residents. 2. Individuals seeking entry to the facility, under the above section 1, will not be allowed to enter if they meet any of the screening criteria listed below: A. Any person with COVID-19 who does not meet the most recent criteria from the	A1300		

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 11/04/2020
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
A1300	Continued From page 7 CDC to end B. Any person showing, presenting signs or symptoms of, or disclosing the presence of a _____, including _____, chills, _____, repeated shaking with chills, new loss of taste or smell, or any other COVID-19 symptoms identified by the CDC. C. Any person who has been in contact with any person(s) known to be _____ with COVID-19, who does not meet the most recent criteria from the CDC to end isolation. 3. Residents leaving the facility temporarily for medical _____ or other activities, and residents receiving visits from health care providers, must wear a _____ mask, if tolerated by the resident's condition. All residents must be screened upon return to the facility. _____ protection should also be encouraged. _____ should be scheduled through the facility or group home to ensure proper screening and adherence to _____ control measures. 4. All visitors must immediately inform the facility if they develop a _____ or symptoms consistent with COVID-19, or test positive for COVID-19 within fourteen (14) days of a visit to the facility. 5. Documentation showing compliance with the following requirements must be kept for all visitation within a facility: A. Individuals entering a facility must be screened. To achieve this purpose, a facility may use a standardized questionnaire or other form of documentation. B. The facility is required to maintain documentation of all non-resident individuals entering the facility. The documentation must	A1300			

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 11/04/2020
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
A1300	Continued From page 8 contain: i. Name of the individual entering the facility; ii. Date and time of entry; and iii. The screening mechanism used by the facility to conclude that the individual did not meet any of the enumerated screening criteria. This documentation must include the screening employee's printed name and signature. This Statute or Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to safe guard 69 resident's well-being by failing to follow Florida Governor's emergency orders DEM Order 20-011, dated _____, delineating that general visitors must be screened to prevent possible introduction of COVID-19 and must sign an acknowledgement form noting receipt and understanding of the facility's visitation and _____ prevention and control policies. Findings: At 10 a.m. on _____, the facility's visitor sign-in log was reviewed with the front desk concierge, who identified a name as a family member who visited resident #9 on _____. A request was made of the concierge to provide the visitor's Covid-19 screening however, the form she provided contained the name and signature of the visitor, but the screening questions were not answered. (photographic evidence obtained.) At 10:23 a.m. on _____, the administrator confirmed the questions were not answered. Additionally, at 10:35 a.m. on _____, the administrator said resident #9's visitor did not sign an acknowledgement form noting receipt	A1300			

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 11/04/2020
---	--	--	--

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
A1300	Continued From page 9 and understanding of the facility's visitation and prevention and control policies. Class III	A1300		
(A 000)	Initial Comments A second revisit to Complaint Investigation 2020010367 was conducted at Harborchase of Dr. Phillips on Deficiencies were identified at the time of the visit.	(A 000)		
A 163 SS=D	429.49 FS Records - Resident, Penalties for Alteration (1) Any person who fraudulently alters, defaces, or falsifies any medical or other record of an assisted living facility, or causes or procures any such offense to be committed, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. (2) A conviction under subsection (1) is also grounds for restriction, suspension, or termination of license privileges. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility, in an attempt to deceive the Agency, provided a falsified Covid-19 screening for a visitor of 1 of 1 sampled resident (#9.) Findings: At 10 a.m. on , the facility's visitor sign-in log was reviewed with the front desk concierge, who identified a family member who visited resident #9 on A request was made of the concierge to provide the visitor's Covid-19	A 163		

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 11/04/2020
---	--	--	--

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 163	Continued From page 10 screening however, the form she provided contained the name and signature of the visitor, but the screening questions were not answered. (photographic evidence obtained.) At 10:19 a.m. on _____, the administrator took the blank screening form then returned with a completed one however, a comparison of the two revealed they were exactly the same. When asked why, he said the second form was located at the front desk. (photographic evidence obtained.) At 10:21 a.m. the concierge said there had not been a second form and said she provided the surveyor with the only form she had. The administrator was present during the interview and a request was made of him to provide the first blank form. At 10:23 a.m. on _____, the administrator said "full disclosure. It was blank when you gave it to me and based on my memory, I filled it in." He repeatedly apologized and said he just wanted the facility to be in compliance. A request was again made for him to return the first blank form then he said he could not because he cut the bottom of it off, as it had initially been on a long page, in order to make a copy of it after he filled it in. Class III	A 163		