Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969452	A. BUILDING: _____ B. WING _____	05/04/2021

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 complaint investigation 2021006382 was conducted at Harborchase of Dr. Phillips on . The facility had a deficiency at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall 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 must notify the resident ' s representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for 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	A 025		

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A 025	Continued From page 1 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 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: Based on observations, record reviews and interviews, the facility failed to provide adequate supervision to 1 of 7 sampled residents who eloped from the facility's secured memory care unit (#2). Findings: Review of a facility adverse incident report (AIR) revealed documentation that indicated on . . . . at 1:37 p.m. resident #2 was observed in the facility's lobby with a sheriff's deputy. The deputy saw the resident on a road located approximately two-tenths of a mile from the facility. The resident appeared and was escorted	A 025		

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A 025	Continued From page 2 . . . to the facility. The resident was last seen at the facility at 12:45 p.m. At 1:01 p.m. on , staff B said that on . . . . . she last saw resident #2 at 12:20 p.m. in the dining room. At 1:04 p.m. on , nurse G said that on . . . . . at approximately 1 p.m. a sheriff's deputy returned the resident to the facility. A count of all the residents was conducted. The resident was assessed for injuries and his vital signs were checked. The nurse said he did not know how the resident got out of the unit. He believed the resident followed a visitor out of the unit because the visitors were given the code to the door. Staff G last saw the resident on that day in the dining room at 12:35 p.m. At 1:14 p.m. on the resident was seen walking outside in the courtyard. A private caregiver was walking closely behind him. At 1:19 p.m. on , the memory care manager said that on . . . . . she was in a meeting when the concierge informed her that the resident was brought . . . to the facility by a deputy. After the resident's return, all the egress doors in memory care were tested to see if the alarms were working, and they were. She said it was unknown how the resident eloped but said that at the time, visitors were able to sign-out a key card at the front desk which allowed them to enter and exit the unit and perhaps the resident went out when a visitor opened the door. At 1:27 p.m. on . . . . . , staff C said she first saw the resident on between :15 a.m. when she gave him medications. She said the last time she saw the resident was at 12:30 p.m.	A 025		

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A 025	Continued From page 3 in the dining room. She never heard a door alarm. At 1:36 p.m. on . . . . . the memory care manager was seen testing all four of the unit's egress doors and all emitted a loud audible alarm when opened. At 1:56 p.m. on , the activities director said she last saw the resident on . . . . . at approximately 12 p.m. in the dining room. The activities director stated she never heard a door alarm. At 1:59 p.m. on , staff H said she last saw the resident on . . . . . at 12:30 p.m. in the dining room and she never heard a door alarm. At 3:21 p.m. on , the director of nursing (DON) said that on . . . . . at 1:37 p.m. the resident, who appeared . . . . . The resident was found by a deputy on a road located approximately two-tenths of a mile away from the facility. The Sheriff's deputy called the resident's son, who told the deputy where the resident lived. The facility arranged for a private sitter was assigned to the resident following the elopement. At 3:49 p.m. on , the facility's manager said that at the time of the resident's elopement, visitors to memory care were able to exchange their identification for a key card to be able to enter and exit the memory care on their own. Upon their departure, they would turn in the key card and receive their identification . She said this was stopped on . . . . . , following the resident's elopement. Review of resident #2's record revealed an admission date of . . . . . Review of his 1823 health assessment form that was dated	A 025		

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A 025	Continued From page 4 revealed he had a diagnosis of . . . . with behavioral disturbances. The resident was identified as an elopement risk. Continued review of the resident's record revealed a hospital history and physical that was dated . . . . . that indicated he was there after escaping a memory care unit. He was running down the street when he tripped and . . He was seen by police, who then transported him to the ER. He tried to leave the hospital twice and was stopped by security. Resident #2 lived in the facility's secured memory care unit when he eloped. He had a diagnosis of , was identified as an elopement risk on his 1823 and documentation from a hospital visit that occurred prior to his admission to the facility indicated that he eloped from another memory care unit. The facility's inadequate supervision and subsequent resident elopement directly threatened the physical and emotional health, safety, and security of the resident. Class II	A 025		