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 _____	07/09/2021

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 #2021007628 was conducted at Harborchase of Dr. Phillips on and . The facility had deficiencies at the time of the survey.	A 000		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the	A 010		

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A 010	Continued From page 1 resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . . . . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident ' s representative or designee or the resident ' s family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial	A 010		

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A 010	Continued From page 2 examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 59A-36.002, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days. (b) A resident requiring care of a , may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care provider, the resident must be discharged from the facility. (c) A ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions	A 010		

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A 010	Continued From page 3 are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility retained 1 of 11 sampled residents (#2) who exceeded the continued residency criteria in an Assisted Living Facility	A 010		

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A 010	Continued From page 4 (ALF). Findings: Observations made at 10:17 a.m. on revealed resident #2 was laying in her bed. Caregivers A, B & C were all providing care to the resident. Throughout the process, the resident yelled and swung both her arms at the caregivers. Due to the resident's resistance to care, the caregivers had to provide her with total assistance with care, grooming and . All three caregivers said the resident consistently required total assistance with care due to her resistance. At 10:26 a.m. on the same caregivers were seen assisting the resident to a sitting position on the side of her bed. While caregivers A & B supported the resident's , caregiver C placed the resident's wheelchair parallel to the bed. Then caregivers A & C each placed one of their arms under each of the resident's underarm then, while grabbing the of the resident's pants, they both lifted the resident from the bed and placed her in the chair. The resident's were touching the ground during the transfer however, she did not use them to bear and pivot into the chair. The resident's need for total assistance with transferring exceeded the continued residency criteria for an ALF. At 9:49 a.m. on a home health , assistant said she assisted the resident with transferring from her bed to the wheelchair in the afternoon of . She said the resident was able to use the arms of the chair to stand up but required 74% for the task and 100% with pivoting to the chair. She said the	A 010		

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A 010	Continued From page 5 resident was pleasant and did not fight at the time. At 10:40 a.m. on caregivers C & J were seen assisting the resident to a sitting position on the side of her bed. They each placed one of their arms under each of the residents under arms then lifted her up from the bed, at which time the resident became resistive and bent her . . . . The caregivers then placed the resident in her chair. They then wheeled her into her bathroom and began assisting her with grooming, at which time the resident kept her . . . clinched and made no efforts to participate. Review of the resident's record revealed she was admitted to the facility on . Her most recent 1823 health assessment form that was dated . . . . indicated that she required only assistance at that time with her ADLs and transferring. A health care provider's note that was dated indicated that staff reported the resident was very combative during ADL assistance, she liked to herself in her room and when staff went in to get her out of bed she kicked and hit and was hard to redirect. A facility note that was dated 11/15/20 at 8:30 a.m. indicated she was combative during ADLs, and she dropped herself to the floor. She was half dressed, screaming, calling the staff pigs, and tried to bite them. A facility note that was dated 11/22/20 indicated that she was able to stand and pivot to her wheelchair at that time. A facility note that was dated at 6:45 p.m.	A 010		

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A 010	Continued From page 6 revealed she yelled and attempted to grab and strike staff during evening care. She had both verbal and physical outbursts, was resistant to being undressed and had difficulty standing up to transfer from the wheelchair to her bed. Class III	A 010		
A 030 SS=D	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The	A 030		

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A 030	Continued From page 7	A 030		

telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and universal precautions; and,
8. The requirements for coordinating the delivery of services to residents by third party providers.
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where

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A 030	Continued From page 8 residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical . . . . . by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue	A 030		

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A 030	Continued From page 9 the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , , the guardian shall be	A 030		

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A 030	Continued From page 10 given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local	A 030		

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A 030	Continued From page 11 long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder [illegible] Hotline operated by the Department of Children and Families, and [illegible], Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated [illegible] or [illegible] under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to safeguard sixty-four residents' well-being by failing to follow its visitation policy regarding the use of masks by visitors for 2 of 2 sampled residents (#3	A 030		

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A 030	Continued From page 12 & #6). Findings: At 9 a.m. on the front desk concierge was seen not wearing a mask. When asked whether the facility still required people visiting the facility to wear a mask, she said if the visitor was for Covid then they were not required to wear one. At 10:06 a.m. on resident #3's family member was seen entering the resident's room and she did not wear a mask. At 10:23 a.m. on resident #6's family member was seen in the common area of the memory care unit, and he did not wear a mask. A request was made of the administrator to provide the facility's visitation policy. When she did so she said the facility had entered phase of the policy, which indicated that visitors were allowed and shall mask if not . At 9:30 a.m. on the administrator said visitors were asked whether they were , and their answer was not tracked in writing because the concierge was able to remember who said they were or were not . At 11:05 a.m. on the concierge confirmed she was present when both residents #3's & #6's family visited but she did not ask them what their status was because she'd never been told she had to. Class III	A 030		

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AE205	Continued From page 13	AE205		
AE205 SS=D	59A-36.021(5); 429.07 (3)(b). ECC - Health Assessment 59A-36.021 (5) HEALTH ASSESSMENT. Before receiving extended congregate care services, all persons. including residents transferring within the same facility to that portion of the facility licensed to provide extended congregate care services, must be examined by a health care provider pursuant to rule 59A-36.006, F.A.C. A health assessment conducted no more than 60 days before receiving extended congregate care services meets this requirement. Once receiving services, a new health assessment must be obtained at least annually. 429.07 (3)(b), FS 6. Before the admission of an individual to a facility licensed to provide extended congregate care services, the individual must undergo a medical examination as provided in s. 429.26(4) and the facility must develop a preliminary service plan for the individual. 7. If a facility can no longer provide or arrange for services in accordance with the resident's service plan and needs and the facility's policy, the facility must make arrangements for relocating the person in accordance with s. 429.28(1)(k). This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure a resident who required total assistance with ADLs in a facility licensed to provide Extended Congregate Care (ECC) services had a new 1823 completed for 1 of 11 sampled residents (#2.) Findings:	AE205		

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 _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORCHASE OF DR PHILLIPS	7233 DELLA DRIVE ORLANDO, FL 32819

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AE205	Continued From page 14 Review of the facility's license revealed it held an ECC license. Observations made at 10:17 a.m. on revealed resident #2 was laying in her bed. Caregivers A, B & C were all providing care to the resident. Throughout the process, the resident yelled and swung both her arms at the caregivers. Due to the resident's resistance to care, the caregivers had to provide her with total assistance with care, grooming and . All three caregivers said the resident consistently required total assistance with care due to her resistance. At 10:40 a.m. on caregivers C & J were seen assisting the resident to a sitting position on the side of her bed. They each placed one of their arms under each of the residents under arms then lifted her up from the bed, at which time the resident became resistive and bent her . The caregivers then placed the resident in her chair. They then wheeled her into her bathroom and began assisting her with grooming, at which time the resident kept her clinched and made no efforts to participate. Review of the resident's record revealed she was admitted to the facility on . Her most recent 1823 health assessment form that was dated indicated that she required only assistance at that time with her ADLs and transferring. A health care provider's note that was dated indicated that staff reported the resident was very combative during ADL assistance, she liked to herself in her room and when staff went in to get her out of bed she kicked and hit	AE205		

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AE205	Continued From page 15 and was hard to redirect. A facility note that was dated 11/15/20 at 8:30 a.m. indicated she was combative during ADLs, and she dropped herself to the floor. She was half dressed, screaming, calling the staff pigs, and tried to bite them. A facility note that was dated [redacted] at 6:45 p.m. revealed she yelled and attempted to grab and strike staff during evening care. She had both verbal and physical outbursts, was resistant to being undressed and had difficulty standing up to transfer from the wheelchair to her bed. Therefore, the resident should have had a new 1823 health assessment completed when she began requiring total assistance with ADLs. At 11 a.m. on [redacted] the director of nursing said she did not have an answer as to why a new 1823 was not completed. Class III	AE205		
AE206 SS=D	59A-36.021(6) FAC ECC - Service Plans (6) SERVICE PLANS. (a) Before receiving services, the extended congregate care administrator or manager must develop a preliminary service plan that includes an assessment of whether the resident meets the facility's residency criteria, an appraisal of the resident's unique physical, [redacted] and social needs and preferences, and an evaluation of the facility's ability to meet the resident's needs. (b) Within 14 days of receiving services, the extended congregate care administrator or	AE206		

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AE206	Continued From page 16	AE206		

manager must coordinate the development of a written service plan that takes into account the resident's health assessment obtained pursuant to subsection (6); the resident's unique physical, [illegible] and social needs and preferences; and how the facility will meet the resident's needs including the following if required:
1. Health monitoring,
2. Assistance with personal care services,
3. Nursing services,
4. Supervision,
5. Special diets,
6. Ancillary services,
7. The provision of other services such as transportation and supportive services; and,
8. The manner of service provision, and identification of service providers, including family and friends, in keeping with resident preferences.
(c) Pursuant to the definitions of "shared responsibility" and "managed risk" as provided in section 429.02, F.S., the service plan must be developed and agreed upon by the resident or the resident's representative or designee, surrogate, guardian, or attorney-in-fact, and must reflect the responsibility and right of the resident to consider options and assume risks when making choices pertaining to the resident's service needs and preferences.
(d) The service plan must be reviewed and updated quarterly to reflect any changes in the manner of service provision, accommodate any changes in the resident's physical or mental status, or pursuant to recommendations for modifications in the resident's care as documented in the nursing assessment.

This Statute or Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to, within 14 days of 1 of 11 sampled residents receiving an ECC

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AE206	Continued From page 17 service, coordinate the development of a written service plan that takes into account the resident's health assessment; the resident's unique physical, , , and social needs and preferences; and how the facility will meet the resident's needs (#2). Findings: Review of the facility's license revealed it held an ECC license. Observations made at 10:17 a.m. on revealed resident #2 was laying in her bed. Caregivers A, B & C were all providing care to the resident. Throughout the process, the resident yelled and swung both her arms at the caregivers. Due to the resident's resistance to care, the caregivers had to provide her with total assistance with care, grooming and . All three caregivers said the resident consistently required total assistance with care due to her resistance. At 10:40 a.m. on caregivers C & J were seen assisting the resident to a sitting position on the side of her bed. They each placed one of their arms under each of the residents under arms then lifted her up from the bed, at which time the resident became resistive and bent her . The caregivers then placed the resident in her chair. They then wheeled her into her bathroom and began assisting her with grooming, at which time the resident kept her clinched and made no efforts to participate. Review of the resident's record revealed she was admitted to the facility on . Her most recent 1823 health assessment form that was dated indicated that she required only	AE206		

Agency for Health Care Administration

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AE206	Continued From page 18 assistance at that time with her ADLs and transferring. A health care provider's note that was dated . . . . . indicated that staff reported the resident was very combative during ADL assistance, she liked to . . . . . herself in her room and when staff went in to get her out of bed she kicked and hit and was hard to redirect. A facility note that was dated 11/15/20 at 8:30 a.m. indicated she was combative during ADLs, and she dropped herself to the floor. She was half dressed, screaming, calling the staff pigs, and tried to bite them. A facility note that was dated . . . . . at 6:45 p.m. revealed she yelled and attempted to grab and strike staff during evening care. She had both verbal and physical outbursts, was resistant to being undressed and had difficulty standing up to transfer from the wheelchair to her bed. Therefore, a service plan should have been developed. At 11 a.m. on . . . . . the director of nursing said she did not have an answer as to why a service plan was not developed. Class III	AE206		