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 _____	02/17/2022

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 Complaint Investigations #2021017281 and #2022001442 were on [redacted] and [redacted]. Harborchase of Dr. Phillips with Extended Congregate Care (ECC) had a deficiency at the time of the visit.	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 [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. 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 [redacted] 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 Resident Care Standards. 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	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 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 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, and failed to provide care and services appropriate to meet the needs to ensure safety through proactive measures to minimize the potential for and injuries for 1 of 10 sampled residents who experienced repeated (#1), failed to follow a health care practioner's medication order for 2 of 10 sampled residents (#1 & #4), failed to ensure care that was performed by a nurse was documented in the record for 1 of 10 sampled residents (#5), and failed to maintain appropriate documentation for 1 of 10 sampled resident after a (#10).	A 025		

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A 025	Continued From page 2 Findings: 1. Resident #1's record revealed a facility admission date of [redacted]. Documentation in the record indicated the resident's diagnoses included [redacted] Type 2, [redacted], and [redacted] with behavioral disturbances. On [redacted], a health care practitioner (HCP) ordered a [redacted] referral due to [redacted] with [redacted] and "Sundowning". "The term 'sundowning' refers to a state of [redacted] occurring in the late afternoon and spanning into the night. Sundowning can cause a variety of behaviors, such as [redacted], aggression or ignoring directions. Sundowning can also lead to pacing or [redacted]." (obtained mayoclinic.org). On [redacted], an initial [redacted] evaluation was conducted. On [redacted], a [redacted] evaluation was conducted. On [redacted] at 5:58 a.m., the resident was sitting on the edge of his bed. He reached for his walker, which was not locked, and it rolled away from him. He slipped to the floor. He was instructed to lock his wheels before standing. On [redacted] at 6:15 p.m., the resident slapped a staff member in the [redacted]. He was instructed to not hit people because he's upset.	A 025		

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A 025	Continued From page 3 On . . . . . at 12:27 p.m., the resident was walking in his room. Staff heard his door slam. When he was checked on, he was observed on the floor behind his door. He said he hit his . Emergency Medical Services was called and he was taken to the hospital. He returned to the facility at 5:45 p.m. On . . . . . at 10:30 a.m., the resident was observed lying on the floor on his right side. He said he . off the chair. His walker was seen at his bedside. He was instructed to use his walker at all times. On . . . . . at 2:40 p.m., a staff member prompted the resident that it was time for his . . . . . He sat up in bed then stood to grab his walker. He took a step then lost his balance. On at 4 p.m., the resident slapped a staff member twice. The HCP ordered a . . follow up. On , the HCP ordered physical and occupational therapies. On at 7 p.m., the resident was observed sitting on his on his room floor. He was instructed to always use an assistive device when ambulating. On at 5:30 p.m., the resident was observed lying on his . . . in another resident's room. He was trying to walk to the bathroom and lost his balance. The follow up intervention was to perform safety checks. On at 2:35 p.m., the resident was observed laying on his left side on the floor. He said he hit his and he sustained a	A 025		

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A 025	Continued From page 4 on his left . . . . 911 was called and he was taken to the hospital. On at 8:40 a.m., the resident was observed sitting on the floor in the hallway. His walker was in front of him. On at 5:30 a.m., the resident was observed on the floor in the living room and by the kitchen wearing only socks. He was instructed to refrain from wearing those while walking. On . . . . . at 12:30 p.m., the resident was heard yelling for help. Upon staff entering his room, he was observed sitting on the floor. He said he lost his balance while trying to remove another resident's walker from his room. The follow up intervention was to keep the apartment door closed. On . . . . . at 6 a.m., the resident was heard yelling for help and another resident entered the room to check if he was okay. This resident grabbed the other resident's right arm and also scratched the resident's . . . . On . . . . . at 7:30 a.m., the resident was observed on the floor in a sitting position. A walker was in front of him. On . . . . at 7:40 p.m., the resident was observed in a position on the hallway floor with his walker in front of him. On . . . . . , a , , ... evaluation was conducted. On at 2 a.m., during safety rounds, the resident was observed on the floor at the end of his bed between the bed and dresser. Clothes	A 025		

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A 025	Continued From page 5	A 025		

were on hangers and on his bed. He sustained a on his right . He was instructed to press his call pendant for assistance and safety checks were increased.

On at 7:20 a.m., the resident hit a staff member on the left cheek while that person was assisting him with his pants and then again in the hallway. He also ran his walker into the of the same staff's . He was given breakfast and medications. The follow up intervention was to give him a snack a little earlier than breakfast and change the time of his meds.

On at 1:35 p.m., staff entered his room and observed the resident sitting on his on the floor near the door with shoes to the left of his . He said he was trying to get his shoes on and felt himself falling so he sat on the floor. He wore non-skid socks. The note indicated he was known to walk around with his shoes untied. The follow up intervention was to put his shoes on and to instruct the staff to make sure his shoes were tied.

On , a , evaluation was conducted.

On at 10:10 p.m., the resident was observed sitting upright on the floor. The follow-up intervention was non-skid socks.

On at 5 a.m., the resident was observed on the floor.

On at 10:38 p.m., the resident was yelling for help. He was observed sitting on the floor next to his walker.

On at 3:50 p.m., the resident was

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A 025	Continued From page 6 screaming for help. Another resident told him to stop yelling. He proceeded to push a table over in the common area and it landed on another resident's / On at 6:40 a.m., the resident was sitting on the seat of his walker near the dining room. A caregiver had their turned away from the resident and when they turned around, the resident was observed laying on his on the floor. The follow-up intervention was to remind the resident that his walker was not a chair. On at 1 p.m., the staff heard the sound of a crash. Upon entering the resident's room, he was observed on the floor in the living room area with his walker behind him and a broken plate. He said he felt himself become , and just went down with the plate. On , , and , a , evaluation was conducted. On at 7:27 a.m., the resident called for help. He was observed sitting on his on the floor with a 4-wheel walker in front of him. His shoes were off and located to his right. They had no laces in them. The follow-up intervention was to place laces in the shoes. On at 1:45 p.m., the resident had a physical altercation with another resident. The other resident into this resident's room. This resident was punched on the left side of his and . On at 4 p.m., was seen in his brief. He was sent to the hospital. A hospital computerized , , (CT) scan,	A 025		

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A 025	Continued From page 7 dated . . . . . , indicated the resident had an acute or subacute , at T12, as well as severe central canal . . . . at T12. On . . . . . at 3:45 p.m., the resident returned from the hospital with an order for a brace. On , a , evaluation was conducted. On . . . . at 5:45 a.m., this resident and another resident were hitting each other. On at 3:30 p.m., the resident was observed on the floor in a doorway with on the of his . Follow-up intervention was to offer more fluids and to ensure he wore non-skid socks and shoes. On at 10:15 p.m., the resident's right was . . . . , and a staff member said the resident was bitten by another resident. On at 7:45 p.m., the resident was pushed by another resident and was observed on the floor. On at 9:20 a.m., the resident was observed on the floor in the dining room. He said he lost his balance while walking. On at 3:30 p.m., the resident was observed on the floor in his room. His walker was next to him. On at 5 p.m., the resident was agitated and tried to throw things at people. On at 2:20 p.m., the resident was observed laying on the floor. He sustained a	A 025		

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A 025	Continued From page 8 on his right and his right . He was sent to the hospital. On he returned from the hospital. On , a , evaluation was conducted. On at 8:10 p.m., the resident was observed on the floor by his wheelchair. He said he stood up to reach for the fire alarm on the wall, he lost his balance, and hit the top of his against the wall. 911 was called and he was sent to the hospital. On , he returned from the hospital. On at 12 p.m., the resident was observed on the floor in his room. He was laying on his left side with his shoes on and his walker was six away and next to his bed. On at 5:15 p.m., he threw his dinner plate onto the floor. On at 6 p.m., the resident was observed on the floor in the dining room after he was observed being agitated with other residents. He was seen kicking another resident and trying to grab another resident's walker. He complained of right and said he was not sure whether he hit his . 911 was called and he was taken to the hospital. The follow-up intervention was to encourage him to eat in his room when he was very and agitated. On at 2:25 a.m., he returned from the hospital. On at 3:31 p.m., he was observed lying	A 025		

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A 025	Continued From page 9 on his left side on the floor. On ... ... at 1:50 p.m., the resident slapped another resident across the . On , the resident attempted to throw a drinking glass. On ... ... at 2:45 p.m., the resident was observed on the floor. His walker was not nearby. He was aggressive towards both staff and other residents. was administered to him. On at 4:52 a.m., the resident was observed walking with a walker and was observed falling onto his . He hit his left and the left side of the ... of his .... He was taken to the hospital. On , he returned from the hospital under hospice services. He wore a ... brace. On .... , the resident , ... On .. .. at 11:44 a.m., the memory care supervisor said to decrease the risk of resident #1 falling, she checked on him every two hours and also instructed the staff to do the same. When she saw resident #1 walking around, she observed for unsafe actions and intervene. When resident #1 threw things, she intervened and removed the items from within the resident's reach and also moved other residents away from the area. On at 12:52 p.m., staff B said resident #1 walked and his ... were from walking. When asked whether she implemented any interventions to decrease resident #1's risk for , staff B shook her no.	A 025		

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A 025	Continued From page 10 On at 12:56 p.m., staff I said she always checked on resident #1 to see if he was safe in his wheelchair or bed. When the resident yelled out for help, staff checked on him. On at 12:59 p.m., staff P said resident #1 always had his walker and said most of the time, the resident was in the bed because he enjoyed sleeping. Staff P said she ensured the resident's walker was with him and she always checked on him. On at 1:01 p.m., staff Q said she helped decrease resident #1's risk for by getting the resident involved with activities. When the resident called out for help, she asked him how she could help him. Resident #1 was inadequately supervised by the facility when he experienced thirty-two between and , some of which resulted in injuries and hospitalizations. In addition, facility documentation did not indicate sufficient interventions were implemented by the facility following each to minimize the potential for further . Also, the facility did not have any documentation to show what actions were taken when the resident became physical with other residents and staff. 2. Review of resident #1's 1823, dated , revealed the medication list attached included , and Review of resident #1's medication observation records (MORs) revealed	A 025		

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A 025	Continued From page 11 they did not contain any of those medications. The resident's record neither contained additional MORs nor documentation elsewhere to indicate the resident was given the medications. On at 9:50 a.m., the administrator said there were no additional MORs for resident #1. On at 1:15 p.m., nurse F said she too looked for additional MORs, but she could not locate any. 3. Review of resident #4's record revealed a facility admission date of . An 1823, dated , indicated the resident's diagnoses included , , , , hematoma, left displaced . She required assistance with self-administration of medications. The record contained a HCP's order, dated , for 0.05% solution, instill one drop in both twice daily. On at 10:31 a.m., resident #4 said the facility ran out of her and she was unable to provide a time frame of when she last received them. Review of resident #4's MOR revealed they were given during that month, but review of both and MORs revealed neither one contained documentation that indicated the drops were given in either month. The resident's record did not contain an order after to discontinue . On at 3:15 p.m., nurse F confirmed the findings and was unable to provide additional	A 025		

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A 025	Continued From page 12 documentation. 4. Resident #5's record revealed a facility admission date of . An 1823, dated , indicated the resident's diagnoses included left supracondylar , closed of T1, and closed of L2 and L5. On at 10:48 a.m., a gauze wrap was seen around resident #5's left upper arm. The resident said she hit her arm on a toilet paper holder on , which caused a . She said a facility nurse applied a when it first occurred. Review of a facility report revealed resident #5 had a reported and sustained a on her left arm on at 9:05 a.m. The report indicated the was cleaned and dressed by the director of memory care, who was a nurse. The report did not contain documentation by that nurse to describe the and the details of the care that she provided. On at 11:05 a.m., the memory care director said she treated resident #5's left arm by cleansing it with normal , approximated the edges of the then applied steri-strips, applied a non-adhering , then wrapped the arm with kerlix gauze. She then reported the injury to nurse F. When the memory care direct was asked why she did not document the details that she described, she said because nurse F was the nurse on duty. 5. Resident #10's record revealed an admission date of . On at 10 AM, nurse AA identified that resident #10 , the left , and was currently in rehabilitation	A 025		

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A 025	Continued From page 13 A physician verbal order, dated , found that nurse D gave , 325 milligram tablet to resident #10 because of , . Another order found in the file that the nursing home rehabilitation documented on providing , , ( ) for the broken left . There was no documentation of how and where the occurred. The facility had no documented evidence the . Photographic evidence was obtained. On at 2 PM, the Vice President Health Wellness and nurse D both confirmed the findings. Class II	A 025		