

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965356	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/03/2022
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF TALLAHASSEE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 JOHN KNOX ROAD TALLAHASSEE, FL 32303		
(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 000	Initial Comments A biennial re-licensure and complaint investigation (complaints number 2022000042, 2022001934, and 2022002280) was conducted at Harborchase of Tallahassee on Deficiencies were identified at the time of survey.	A 000		
A 081 SS=E	429.52(1 & 7) FS; 59A-36.011() FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously	A 081		

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: AL11965356	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/03/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HARBORCHASE OF TALLAHASSEE

**100 JOHN KNOX ROAD
TALLAHASSEE, FL 32303**

(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 081	Continued From page 1 completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in _____ control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its _____ control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to _____ borne _____, may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965356	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/03/2022
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF TALLAHASSEE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 JOHN KNOX ROAD TALLAHASSEE, FL 32303		
(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 081	Continued From page 2 chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident neglect, and The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965356	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/03/2022
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF TALLAHASSEE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 JOHN KNOX ROAD TALLAHASSEE, FL 32303		
(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 081	Continued From page 3 This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that 1 of 3 employees received a minimum of 1 hour in-service training within 30 days of hire on reporting adverse incidents (Staff B), and elopement training (Staff C) and failed to ensure that 1 of 3 employees received 1 hour of preservice orientation before interacting with residents (Staff C). The findings include: A review of the employee files revealed that there was no documentation to verify that Staff B, a Recreation Aide, hired, received training on incident reporting. It was also found that Staff C, a Dietary Aide, hired, did not have documentation to verify receiving a preservice orientation or elopement response training. On at approximately 3:30 PM, an interview was conducted with the Executive Director, who verified the documentation was not available and should have been present in the records. Class III	A 081		
A 082 SS=E	59A-36.011(4) FAC Training - / (4) (/). Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on	A 082		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965356	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/03/2022
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF TALLAHASSEE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 JOHN KNOX ROAD TALLAHASSEE, FL 32303		
(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 082	Continued From page 4 and _____, including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that employees received education related to _____ (_____) within 30 days of employment for 2 of 3 employees reviewed (Staff B and C). The findings include: A review was conducted of the employee files which revealed for Employee B, a recreation aide, hired _____, and Employee C, a dietary aide, hired _____, did not have documentation of a one-time training on _____ and _____. On _____ at approximately 3:30 PM, an interview was conducted with the Executive Director, _____ during which she stated she could not find documentation that staff member B or C had received one-time training on _____. She agreed that these trainings should have been completed. Class III	A 082		
A 086 SS=F	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,	A 086		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965356	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/03/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HARBORCHASE OF TALLAHASSEE

**100 JOHN KNOX ROAD
TALLAHASSEE, FL 32303**

(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 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. (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	A 086		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965356	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/03/2022
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF TALLAHASSEE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 JOHN KNOX ROAD TALLAHASSEE, FL 32303		
(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 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 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	A 086		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965356	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/03/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HARBORCHASE OF TALLAHASSEE

**100 JOHN KNOX ROAD
TALLAHASSEE, FL 32303**

(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 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: Based on record review and interviews, the agency failed to ensure that employees completed _____ and Related _____ (ADRD) training for 2 of 3 employees reviewed, (Staff A, B, and C). The findings include: A review of the employee files revealed that the facility had documentation confirming the completion of either a Level I or Level II ADRD training for the following staff:	A 086		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965356	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/03/2022
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF TALLAHASSEE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 JOHN KNOX ROAD TALLAHASSEE, FL 32303		
(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 8 Staff B, an Activities Aide, date of hire of /220 Staff C, a Dietary Aide, date of hire of On at approximately 3:30 PM, an interview was conducted with the Executive Director, during which she stated that these trainings should have been completed and were missing from the files. Class III	A 086			
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order.	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965356	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/03/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HARBORCHASE OF TALLAHASSEE

**100 JOHN KNOX ROAD
TALLAHASSEE, FL 32303**

(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 162	Continued From page 9 (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , CF-ES 1006, (),	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965356	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/03/2022
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF TALLAHASSEE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 JOHN KNOX ROAD TALLAHASSEE, FL 32303		
(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 162	Continued From page 10 2005, which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the _____ of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's _____, DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement. 2. The resident demographic data required in this paragraph. 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965356	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/03/2022
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF TALLAHASSEE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 JOHN KNOX ROAD TALLAHASSEE, FL 32303		
(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 162	Continued From page 11 retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on resident record review and staff interview, the facility failed to ensure that resident records were maintained to include documentation of the _____ of a power of attorney (POA) for 1 of 2 resident record reviewed. (Resident #6) The findings include: A review of resident #6's record revealed the documentation of the _____ of a POA was missing. On _____ at approximately 1:00 PM, an interview was conducted with the Executive Director, who agreed resident #6's record should contain documentation of the _____ of a POA due to the facility contract being signed by resident #6's POA. Class III	A 162			
CZ816	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation	CZ816			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965356	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/03/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HARBORCHASE OF TALLAHASSEE

**100 JOHN KNOX ROAD
TALLAHASSEE, FL 32303**

(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
CZ816	Continued From page 12 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's _____ to the Federal Bureau of Investigation for a national criminal history record check unless the person's _____ are enrolled in the Federal Bureau of Investigation's national retained print notification program. If the _____ of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit _____ electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the _____ to the Federal Bureau of Investigation for a national criminal history record check. The _____ shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person _____. The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or	CZ816		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965356	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/03/2022
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF TALLAHASSEE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 JOHN KNOX ROAD TALLAHASSEE, FL 32303		
(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	
CZ816	Continued From page 13 professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers: (2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if _____ for any of the disqualifying offenses while employed by the employer. 59A-35.090 Background Screening. (2) Processing Screening Requests, Required Documents and Fees. (d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, _____, herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Service	CZ816			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965356	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/03/2022
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF TALLAHASSEE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 JOHN KNOX ROAD TALLAHASSEE, FL 32303		
(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
CZ816	Continued From page 14 s/Background_Screening/Regulations_Forms.sht ml. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if _____ for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to _____ to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the _____ report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S. This Statute or Rule is not met as evidenced by: Based on interview and record reviews, the facility failed to ensure that employees had a signed Attestation of compliance within their employee files for 1 of 3 employees reviewed (Employee B).	CZ816		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965356	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/03/2022
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF TALLAHASSEE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 JOHN KNOX ROAD TALLAHASSEE, FL 32303		
(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
CZ816	Continued From page 15 The findings include: A review was conducted of the employee personnel files which revealed that Employee B, an Activities Aide, hired on _____, did not have a signed attestation of compliance in the employee file. On _____ at approximately 3:30 PM, an interview was conducted with the Executive Director, who stated that the form could not be found and agreed it should have been signed upon Employee #2's hire. Unclassified	CZ816		
CZ830 SS=D	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are	CZ830		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965356	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/03/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HARBORCHASE OF TALLAHASSEE

**100 JOHN KNOX ROAD
TALLAHASSEE, FL 32303**

(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
CZ830	Continued From page 16 required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan	CZ830		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965356	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/03/2022
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF TALLAHASSEE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 JOHN KNOX ROAD TALLAHASSEE, FL 32303		
(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
CZ830	Continued From page 17 for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to review their Comprehensive Emergency Management Plan (CEMP) and submit it to the local reviewing agency annually. The findings include: A review of the facility's latest CEMP approval letter, issued by the local reviewing agency, was dated . On at approximately 2:00 PM, the Leon County Emergency Management Coordinator was called via telephone to inquire about an updated CEMP. He stated that a plan had been submitted by the facility but they were	CZ830			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965356	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/03/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HARBORCHASE OF TALLAHASSEE

**100 JOHN KNOX ROAD
TALLAHASSEE, FL 32303**

(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
CZ830	Continued From page 18 waiting on some additional approvals for the fire safety part of their plan On _____ at approximately 3:00 PM, an interview was conducted with the Executive Director, who confirmed that the facility did not have a current annual review of the CEMP. She stated that it " _____ through the cracks" in 2020 under the previous administrator but she had submitted for an update with the county as soon as she had started in the month of _____. She did confirm that the approval letter had not been received as of the date of the survey. Class III	CZ830		