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
	AL11965462	A. BUILDING: _____ B. WING _____	02/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORCHASE OF TAMARAC	6855 NW 70TH AVENUE TAMARAC, FL 33321

(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 An unannounced licensure Complaint survey (#2022001219) was conducted on [redacted] at Harborchase of Tamarac. The facility had a deficiency at the time of the survey.	A 000		
A 025	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 [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 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 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 resident diets in accordance with Rule	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 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 interview, record review and observations, the facility failed to provide the supervision required to prevent the elopement of two (2) of two (2) Residents reviewed (Residents 1 and 2). The Findings Include: On a Complaint Survey was conducted at the Facility. During the Survey a request was made to the Administrator for the facility's elopement policy.	A 025		

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A 025	Continued From page 2 A review of the facility's undated HRA, Resident Standard Manual, Standard 4.06 Memory Care Elopement and Drills provided by the Administrator documents the following: When a resident residing in the Memory Care gets outside of the secured environment unaccompanied by an associate or responsible party it is considered an elopement. Further review of the document revealed information on Elopement interventions, Precautions to reduce the risk of elopements, Preventing an elopement, Resident checks, and Elopement drills. However, it does not provide instructions on searching for/locating a missing resident. Review of Resident #1's facility file revealed a Resident Agreement dated which documents procedures for facility Elopement. Review of Resident #2 facility file revealed also revealed a Resident Agreement dated . Review of both Agreements document procedures for locating a missing Resident. The Agreements states that when there is concern that a resident is unaccounted for or has eloped, the following actions are promptly initiated by the associate: -All residents are promptly accounted for. -Resident Sign In/Out logs are checked. -Searches of the interior, exterior and perimeter of the Community are performed. -Determine when the Resident was last seen. -The area surrounding the Community is searched. -The following are notified: Resident's responsible party, physician and police. -If the Resident is found, inform all prior notified parties, agencies and organizations.	A 025		

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A 025	Continued From page 3 1) A review of the Facility's Adverse Incident Report for Resident #1 dated at 06:20:02 PM documented that on 0/6/22 At approximately 1115, (Local Law Enforcement) officer arrived to the community and asked us if we had a (Resident #1) as a resident. (Administrator) went to the officers car and identified resident as (Resident #1). Per officer the resident was seen at the store less than 1 from HarborChase. Resident identified herself but was unable to indicate where she lives. (Administrator), Executive Director got the resident from the officers car and escorted her into the nurses station where she was assessed by Nurse #2 and found to be unharmed and in good spirits. A count was completed and all residents were accounted for. Investigation is in progress. The Resident's son, Jesse was informed. As was the Doctor. A review of the facility's Incident Report (CHRA Resident/Visitor Incident/Occurrence) dated for Resident #1 documented at approximately 11:15 AM the resident was brought to the community by a local law enforcement officer who reported Resident #1 was seen at the convenience store across from the community. Resident was taken to the Wellness station where the Nurse did an assessment and voiced no complaints. A review of Resident #1's AHCA Form 1823 (1823) dated documents here Diagnosis as High in the past and /. It also documented Resident #1 is an elopement risk and has difficulty walking sometimes. It also documents that she requires assistance with Bathing, Eating and Self Care.	A 025		

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A 025	Continued From page 4 In an interview with the Director of Memory Care on at 9:51 AM she stated the Resident # , have walked (unnoticed) across the street the day of the incident on and got some stuff. "They gave her a bag with some stuff in it." She stated they were called by the police, and facility staff and police brought her . She stated it was the store at the corner and that the police did not do a report or anything. She stated Resident #1 is more passive, walking around playing the piano. In an interview with the Administrator on at 9:57 AM she stated she was in the front of the facility on and the police came and brought her . The officer asked if Resident #1 was theirs, Resident #1 popped out of the car and walked in. She stated Resident #1 left trough the employee exit. She stated Resident #1 isn't really exit seeking, and would sit on the patio, the piano. In an interview with the Administrator and Director of Memory Care on at 10:03 AM the Administrator stated the lock company came and provided a consultation, but there was no work order. She stated they looked at the door Resident #1 was said to have exited it was okay. She further stated Resident #1 went out the door behind an employee, so there was no alarm to be heard. She further stated she ran the camera that caught the Incident, but it was a blur, so it's not known who the employee was Resident #1 tailgated behind. In an interview on at 1:36 PM the Maintenance Director stated he was not at the facility , the day Resident #1 eloped. He stated all the doors, including the Employee door where Resident was said to have exited	A 025		

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A 025	Continued From page 5 through. He stated the door company representative checked all the doors including that one, and nothing was wrong. He further stated they do not keep maintenance logs of their door checks, so no documentation was available. In an interview with Nurse #2 on [redacted] at 3:48 she stated she was at work the day of the incident on [redacted] but was not sure what time it was when the Resident eloped, but that she was seen by staff at breakfast. She stated she got a call at the Nurses station to come to the front because Resident #1 had been brought to the facility by the (local County Law Enforcement) officer, who asked if they had a Resident named (Resident #1). She stated they informed the officer that they did and took Resident #1 to the Nurses station where she did a full body assessment. She stated Resident#1 was fine and had no or anything. She further stated she did not recall Resident#1 having any identification when she was returned to the facility. On [redacted] this Surveyor walked the route Resident #1 was said to have taken to the Convenience store located across the street from the facility. After existing the employee's exit door, Resident #1 would have turned right and walked down the pavement about 20-25 and onto the asphalt driveway with the Convenience store visible ahead. Resident #1 would have then walked across the driveway and parking lot between 125-150 yards and approached the 2-lane street that runs North and South between the facility and the Convenience Store. She would have then walked across the street and onto the parking lot of the Convenience store where she is said to have been gone. The travel from the door which Resident #1 is to have exited, to the	A 025		

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A 025	Continued From page 6 convenience store was one minute, 12 seconds. 2) A review of the Facility's Adverse Incident Report for Resident #2 dated documents that at approximately 1815 hours, Community concierge (name) received a call from (Resident #2) son who informed her that his mother is not in the Community and then went on to inform her that he received a call notifying him that his mother was at the (local store). Concierge stated she called Nurse #1 and informed him of the call. Nurse #1 immediately left the Community to locate resident. Per Nurse #1, resident was found in the parking lot behind the Community less than a [redacted] away. The caller to the family was with the Resident, Nurse #1 identified himself as the Nurse for the Community and accompanied the Resident to the Community. Resident was assessed by Nurse #1 upon her return and was found to be unharmed. A [redacted] count was done and all Residents were accounted for. An investigation is in progress. Family and MD notified. A review of the facility's Incident Report (CHRA Resident/Visitor Incident/Occurrence) Report for Resident #2 dated [redacted] documented the facility received a call from Resident #2's son stating she was not in the community, that she was at the (store). Stated she was located in the parking lot of the Plaza behind the community. Resident was brought to community by the (Nurse#1). An assessment was done, and Resident was fond to be unharmed and in good spirits. A review of Resident #2 AHCA Form 1823 (1823) dated documents her diagnosis as PMH: [redacted], T2DM, [redacted], Hx [redacted]. It also documents	A 025		

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A 025	Continued From page 7 Resident #2 is an elopement risk, has gait instability and requires assistance in Ambulation, Bathing, [illegible], Self Care, Toileting and Transferring. In an interview with the Administrator on [illegible] at 10:06 AM she stated Resident #2 exited through the courtyard gate during her elopement on [illegible]. She stated it was dark when the Resident eloped. She further stated that when the gate is opened it will sound an alarm, but it is an audible alarm that is heard from the device on the gate and that no one reported hearing the alarm when she exited. In an interview with the Administrator and Director of Memory Care on [illegible] at 10:12 AM they both stated Resident #2 walked to the Plaza just South of the facility. In an interview with the Maintenance Director on [illegible] at 1:31 PM he stated that he was at home and got a phone call and he came [illegible] to the facility. He stated there is a lock at the gate, and a latch on the outside of the gate that locks the gate. He stated you have to have a key and push the lock in to unlatch the gate. He stated he is not sure how/who opened it, but when he got [illegible] to the facility it was locked. He also stated it's not possible to get out without a key, unless someone left it unlocked. If left unlocked, you would only have to push the lock. The Maintenance Director further stated in the interview that he had the lock company inspect the doors/gate and they didn't find anything wrong with it. He stated they let the lawn crew in and out, but they were not here that day. He stated they were at the facility a day or two before, and maybe it didn't latch all the way.	A 025		

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A 025	Continued From page 8 In an interview with the Staff A on at 2:06 PM she stated she was not sure of the time Resident #2 eloped, but it was at night. She stated she received a call from Resident #2 son who stated his mom was not at the facility. She stated she asked him why he would say that as no one had exited the building. She stated he said informed her that he received a call from someone that she was at (the store). She stated she placed him on hold and went to inform the nurses and Nurse #1 went out to check for her. She stated Nurse #1 headed toward the parking lot next door and he found her in the Plaza parking lot with several people who found her and was with her. In an interview with Staff B on at 2:35 PM she stated she was at the facility the day of the elopement. She stated: "Everybody drops what they were doing, and they run." She stated everybody was looking for her, including her. She stated they (Nurse #1) found her at the parking lot and brought her . She stated she saw the Resident when she came to the facility, and she was okay and there were no injuries. She further stated She doesn't know how Resident #2 got out, and that they did not hear an alarm. In an interview with Resident #2's son on at 2:51 PM, he stated Resident #2 is fine, she knows she did it (eloped), she's very proud she did it, and points where she did it. He stated Resident #1 would leave their house when she was living with him. He stated Resident #2 is high functioning in the moment but can't remember eating breakfast. Then there are times when she is just in the moment. In an interview with Nurse #1 on at	A 025		

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A 025	Continued From page 9 9:36 AM he stated he got a call from the receptionist who called him in the and informed him that she spoke to Resident #2's son and who said his mom left the building and we set out to look for her. He stated some staff went East and he went West as most of the time they (Memory , . . .) . . . west, so he went West. He stated he ran into her in the adjoining parking with a group of men who run into her and realized she needed help. He stated Resident #2 was trying to tell them she was looking for her son, and that she was able to give them her son's name and they googled him and the that's how the son was able to call the facility. He further stated Resident #2 was seen at dinner which ends at 6:30 PM, and that the elopement was in the evening about 6:30 PM - 7:00 PM and sunset was already. He stated he did the assessment, and she was perfect. He also stated Resident #2 did not have any identification. He further stated Resident #2 took the girls out . . . and showed them the gate she walked through. He stated it is the gate he observed workmen was doing work and exited it to get to the dumpster. He further stated the door doesn't have an alarm. On . . . . . at 10:28 AM this Surveyor toured the Courtyard and observed the gate that Resident #2 is alleged to have exited the community. The Courtyard is secured with a 6- . . -tall white vinyl fence that encloses the Courtyard. Observation of the two doors leading to the Courtyard revealed that they are both secured by Mag-locks that are controlled by keypad. Observation revealed the gate is secured with a lock that must be opened with a key. Observation further revealed that once outside the gate, there is a 35-40 greenbelt (grass) with a lake just beyond it.	A 025		

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A 025	Continued From page 10 This Surveyor retraced the alleged path she took and observed that she would have exited the Courtyard gate and immediately in front is a lake approximately 35 away. She would have then turned right and walked down the grass for approximately 75 yards, crossed the driveway (approximately 40), walked for approximately 60 along the sidewalk separating the plaza's service road from the facility's service road, and to the section of the Plaza where she was said to have been located. The retracing of the alleged route took this Surveyor 2 minutes from the courtyard gate to the section of the Plaza she said to have been found. The plaza is visible from the South side of the facility, just beyond the wall that separates the facility and the plaza. Observation by this Surveyor also revealed that cameras are mounted on the wall near the roof on the North side of the building and the wall near the roof on the South side of the building. This allows video of the entire Courtyard from two angles, which is monitored via monitors located in the Nurses Station and the front desk. A request was made to the Administrator for the video. She stated it was not clearly visible and was not provided during the Survey. On at 1:46 PM the Maintenance Director and this Surveyor walked to the gate at the Courtyard. He demonstrated how the gate has to be opened (with a key, turned to the left, push in and open). He also demonstrated the outside lock with the latch that keeps the door from opening without the key. The Maintenance Director restated that the gate had to have been not securely locked, which allowed Resident #1 to exit the community.	A 025		

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A 025	Continued From page 11 On ... . at 3:02 PM this Surveyor met with the Administrator and Memory Director of Memory Care to conduct the Exit Interview. They were informed the findings of the Survey (elopement). They acknowledged the findings. Class III	A 025		