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
	AL11965346	A. BUILDING: _____ B. WING _____	06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORCHASE OF JACKSONVILLE	3455 SAN PABLO ROAD JACKSONVILLE, FL 32224

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A 000	Initial Comments A complaint investigation (complaint numbers 2023009689, 2021007730, and 2021013690) was conducted at Harborchase of Jacksonville on [redacted]. Deficient practice was identified at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of [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 record review and interview, the facility failed to ensure the personal supervision needs were met for two of four residents sampled (Resident #1 and Resident #2). The findings include: During an interview with a family member of Resident #1 during pre-survey preparation on , concerns were expressed that Resident #1 and Resident #2 were engaged in activities. The theory given was that because of the resident's , cognition she may have thought Resident #2 was her spouse.	A 025		

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A 025	Continued From page 2 Both Resident #1 and her spouse had resided at the facility for approximately five years. Record review for Resident #1 showed an 1823 Health Assessment dated [redacted] indicating a diagnosis of [redacted]. She was listed as independent with all Activities of Daily Living (ADLs). A Personal Service Plan dated [redacted] showed she needed regular prompting due to [redacted] and disorientation and could be disruptive and/or agitated. Record review for Resident #2 showed an 1823 dated [redacted]. Included in the medical history was [redacted] and [redacted]. He was listed as having mild [redacted] and needed Memory Care. He was independent with all ADLs except bathing and grooming. Photographic evidence obtained. The resident records found the most recent entry in Resident #2's record dated [redacted] authored by the Director of Resident Care (DRC.) It stated Resident #2's family visited and had concerns Resident #2 wanted to kill himself. They were concerned because there were picture frames with glass in the room with him. The note indicated staff were told to watch the resident and make frequent checks on him. Psych would be in on [redacted] to see the resident. Review of the note from the clinician who visited Resident #2 on [redacted] revealed the purpose of the visit was a two-week follow-up visit. The clinician documented Resident #2's diagnosis of [redacted] with behavioral disturbances and [redacted]. There was nothing documented in the note to indicate a clinical follow-up to the statements he made on [redacted] about self-harm or to follow up to the events between	A 025		

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A 025	Continued From page 3 he and Resident #1. Under the section titled "Screenings/Interventions/Assessments," nothing was recorded. There were no records dated between and /202023 indicating a clinician had been consulted about the statement made to his daughter in law. Photographic evidence obtained. Employee D, Care Partner, was interviewed on at 8:57am. Topics she mentioned getting training in recently involved food service, control, and resident care. She did not indicate recent training or guidance received in resident supervision needs. Employee C, Care Partner, was interviewed on at 9:08am. She stated she had training when she began employment several years ago but could not mention any recent education she'd been provided. She did not recall training she received in incident reporting. When asked about resident behaviors, Employee C stated the first day she worked with Resident #2, he asked her to have with him. He then said he was joking, but she took it seriously enough to report it. She said she told the Memory Care Director (MCD) and DRC. She did not mention anything about needing to supervise Resident #2 closely because of the risk of self-harm. She continued to explain that Resident #1, "Loves men and flirts with all the guys here, even co-workers." She explained this involved talking to them, wheeling them around, holding their , and rubbing them. Resident #1 did "not know what she was doing" and had acted this way in front of her spouse when he visited. It is not a topic she has received guidance on from	A 025		

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A 025	Continued From page 4 management, but she stated she knew that when Resident #2 made the comment to her, she should keep an . , . out because of Resident #1's behaviors. Employee E, Medication Assistant, was interviewed on . . . . . at 9:28am. When asked if there were any resident behaviors on the memory care unit (MCU) she mentioned Resident #1. She said Resident #1 flirts with "all the men. Any man walking by, she goes and grooms them." When asked if Resident #1's behavior had ever escalated beyond the grooming, she was unaware, but had heard from Resident #1's daughter that her mom was found in Resident #2's room. When asked if she reported that to anyone, she said she hadn't. She has not been given any guidance from management since that happened and has not been told to enhance any resident's supervision. Employee E described Resident #2 as "flirtatious, even with staff." She admitted she didn't know much about him because he was new, and they hadn't been given any special direction on how to work with him. She was not aware of Resident #2 having memory issues and explained he can do many ADLs independently. Resident #2 was interviewed on at 10:00am. He explained he had been here, "about a week." He said he is adjusting and mentioned he likes an evening snack after dinner because meals are so early. He mentioned making friends with Resident #1 but that staff think, "I'll drag her off and have relations." He mentioned his desire for "companionship at dinner or to go to an event."	A 025		

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A 025	Continued From page 5 Resident #2 said he did not know why direct care staff take Resident #1 away when they're seen together. He acknowledged holding with her but denied ever having been in another resident's room. He mentions his observations that she was not and staff may think it would, "progress to a point where it shouldn't." At 10:48am on , the MCD was interviewed. She explained her duties included, among other things, oversight of the care of the residents and some in-servicing. When asked what topics she'd given training in recently, she mentioned elopement and washing. When discussing resident behaviors, she stated Resident #2 had recently moved in and they were told by the family prior to move-in that he, "loves women, so he's a flirt." When asked if there had been any issues since he moved in, she explained he was caught with Resident #1 naked and kissing last Friday, . She confirmed his move-in date was , a week earlier. The MCD claimed she informed direct care staff of what the family said about Resident #2 loving women. She acknowledged she didn't give them formal instruction on how to supervise him. She was asked if he had been assessed as someone who couldn't make his own decisions, and said, "yes." She said after the incident with Resident #1 she spoke to him and told him to stay away from her. The MCD denied ever being told by Employee C that Resident #1 approached her for	A 025		

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A 025	Continued From page 6 She explained that after Resident #1 and Resident #2 were seen kissing on the 2pm to 10pm shift, Employee B called her and she gave directions to Employee B to keep them separated and supervise them. She told Employee B to give the upcoming 10pm to 6am shift these directions. The MCD explained that the 10pm to 6am shift experienced a second incident between Residents #1 and #2 where they were again observed alone, but it wasn't reported to her, it was reported to the Director of Resident Care (DRC). She did not know the exact time. When asked how a second occurrence could have happened if staff were supposed to be supervising them, she did not have a response. When she was called by the DRC on , she learned Resident #1 was found nude with Resident #2. She stated it was during this call that she made the DRC aware of the issue on the 2pm-10pm shift where they were seen kissing. She stated she spoke to the morning shift staff, which included Employees C, D, and E, about keeping Resident #1 and #2 separated. She said she did not tell them why because, "they already knew" and explained Resident #1 had been flirting and rubbing the men since she started working there in . When asked if the facility had a policy on how to respond to these incidents, she stated, "if there is, I'm not familiar with it." Regarding whether Residents #1 or #2 need increased supervision, she stated she hadn't looked into it, maybe other managers have" and she has not been asked to provide input on their needs to anyone else in management. She had no documentation to share regarding any investigation and deferred to the DRC.	A 025		

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A 025	Continued From page 7 Review of the Position Description for the MCD revealed she held "responsibility of the safety and well-being of all MC residents." The MCD was to "respond to resident, family, and associate concerns in an appropriate, timely and courteous manner and communicate outcomes to the ED." Photographic evidence obtained. The DRC was interviewed on at 11:32am. She explained the investigative process was collaborative between she and the MCD and ED. The DRC is investigating the event on the 10pm-6am shift because it was brought to her attention when she came on shift on . . . . . She had not yet received a statement from one of the witnesses and needed it to close her investigation. Up to that point she had not identified any areas of improvement or identified issues. The events on the 10pm to 6am shift were explained as such: Employee H said she received in report to lay , on Resident #1 and Resident #2 because their families wanted to keep them separated because they were "too friendly." They were seen around 11pm in Resident #2's room where she was nude on the bed. Staff went to go get help and upon return to the room, the door was shut and locked. They had to get the key to unlock it and when they did, she was still nude and he was standing next to the bed in a towel. The DRC did not have any details about the events on the 2pm to 10pm shift. To her knowledge the event on the 10pm to 6am shift was . . . . . She said when she got a statement from Employee A about the second incident, he did not mention it happening before.	A 025		

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A 025	Continued From page 8 She explained she had not yet given staff reeducation or guidance on how to supervise these residents, but she said she has spoken to Employees C and D about keeping the residents apart. She was unsure if the facility had a policy she needed to follow because she had only ever investigated . . . up to this point. A clinician was already visiting the following Monday, ... She asked that clinician to see Resident #1 and #2 at that time but she said she did not document that conversation. Employee F, Care Partner, was interviewed on . . . . . at 2:56pm. He could not list any residents he was supposed to provide increased supervision to, other than those determined to be . . risks. When asked if there were residents he needed to keep apart from each other, he mentioned Residents #1 and #2. The MCD gave him this guidance yesterday (. .) but did not say why. He said he assumed it was because Resident #1 was "touchy" and she "probably did something." He expressed knowledge that they were found together in a room but did not say it came from management. Employee A, Care Partner, was interviewed on . . . . . at 3:28pm. He explained Resident #1 was "very touchy" with men. She will rub your arm and . . . Last weekend was the first time he witnessed her doing anything more than just touching. He explained the shift was running smoothly. Resident #1 was up late watching TV around 9:30 or 9:40pm on . . . . . Resident #2 approached him for an evening snack. He left	A 025		

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A 025	Continued From page 9	A 025		

the unit to go to the kitchen and was gone a few minutes. Upon return, they were not in the common area and were discovered in Resident #1's bed. Her dress was up and her brief was off. Their . . . were touching their faces. He told them to stop and got Employee B to help separate them. Employee H received he report of what happened when her shift started at 10pm.

Employee A confirmed he had not been told prior to this incident to watch them more closely or keep them apart.

When asked about the note in Resident #2's chart, the DRC explained at 3:19pm on that Resident #2's insurance wasn't fully set up yet so he didn't have an established mobile practitioner. When residents make these statements, she goes in and talks to them to see if they have a plan in place or if it was just a thought. She said he said these statements on the day shift on and after discussing it with him decided he just didn't want to be at the facility anymore. She told staff to make frequent checks on him. She did not advise how often or for how long and was unable to say how often they checked on him. At the time of the interview on , she was unaware of what the psych assessment indicated.

The Position Description for the DRC detailed the following essential functions: Monitors nursing care for compliance with federal, state, and local regulations and company performance standards. Observes residents health status, takes action to address concerns within scope of practice and reports all significant changes, reactions to medications and treatment or significant incidents to nurse and/attending physician immediately. Photographic evidence obtained.

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A 025	Continued From page 10 The Executive Director (ED) was interviewed on [illegible] at 4:20pm. She had been newly hired several weeks earlier and was still acclimating to the company's policies and procedures, and was not involved with Resident #2's recent admission. She was made aware of the event the previous weekend and the DRC was charged with investigating. She explained there isn't necessarily an actual report but she's been made aware of the details of what happened between Resident #1 and Resident #2. Her understanding was that the DRC and MCD provided staff guidance on what level of supervision these residents needed. The ED gave directions today to do checks every 30 minutes to an hour. Her expectation was that staff immediately report their concerns to management. Review of the facility's policy titles [illegible], Neglect, and [illegible], dated [illegible] and revised [illegible] showed, "instances or allegations of [illegible] or [illegible] should be treated seriously and must be reported to the ED or the supervisor on duty for investigation and appropriate follow-up." Photographic evidence obtained. Class II	A 025		