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 _____	01/10/2024

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

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A 000	Initial Comments An unannounced Relicensure with Extended Congregate Care (ECC), Complaint (2022018844, 2024000056) and Generator Monitoring Survey was conducted on - at Harborchase Of Tamarac. The facility had deficiencies identified related to the Relicensure and Complaint (2022018844, 2024000056) 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 , , , 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	A 025		

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A 025	Continued From page 1 supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of 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 provide appropriate care and services to meet the needs of a resident, for 1 out of 4 sampled resident files reviewed (Resident #2) . As evidence of the facility failure to provide personal assistance and transfer to Resident #2 who was assessed to require a two-person transfer. The findings include:	A 025		

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A 025	Continued From page 2 Review of Resident#2 Health Assessment completed by the Medical Doctor (MD) dated . . . . . documents that the resident has a medical history of , , , , , , right . . . . . , right . . . . . , ... , Physical limitations; bedbound/wheelchair as tolerated, nursing treatment requirements; hospice care, assist with Activities of Daily Living (ADL). Further review of the Health Assessment revealed page 2 of 3 section 1 indicates with a checkmark that Resident #2 needs Total care (staff completes the action for the resident) ambulation and transferring. Review of the facility's incident report dated . . . . . revealed that between the hours of 6:30 PM and 7:00 PM Caregiver (Staff H), went to Resident #2 to provide PM care and assist her into bed. Caregiver Staff H stated that she asked for assistance from another caregiver (no longer with the facility). However, the Caregiver was unable to assist at the time and would be there as soon as she can. Caregiver Staff H stated she attempted to transfer resident #2 by herself from her wheelchair and to the floor. Caregiver Staff H stated another caregiver (no longer with the facility) came in and assisted her in transferring Resident #2 from the floor and into bed. Further review of the facility's report revealed that on . . . . . an , was ordered for resident #2 right , and , showed a . . . . . Resident #2 was transferred to the Coral Springs Hospital hospice unit on . . . . . and remained there for , management and orthopedic consultation. On at 2:30 PM, in an interview with the Administrator, she stated she was not at the facility at the time of the incident. The	A 025		

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A 025	Continued From page 3 Administrator stated the incident happened in 2023 and she does not remember the details. The administrator stated that she does remember that the resident was admitted to Hospital related to the . . . The Administrator stated she had a meeting with Staff B Licensed Practical Nurse (LPN) manager to make sure caregivers would follow protocol when assisting a resident who needs assistance with a two-person transfer. She acknowledged that the incident could have been prevented by the caregiver. On . . . . . at 1:46 PM, in an interview with Staff B Licensed Practical Nurse (LPN) manager, she stated she was not at the facility when the incident happened. She stated she remembers having a meeting with caregiver Staff H but does not remember the details. She stated training was scheduled with all caregivers on the importance of following the plan of care when performing care for all residents. On . . . . . at 3:51 PM, This surveyor attempted an interview with caregiver Staff H, due to a language barrier (native language Creole) she was not able to understand the questions. At this time Staff B, LPN manager was asked to join the interview and she acknowledged caregiver was not able to understand the surveyor's questions. Staff B, LPN manager acknowledges the incident could have been prevented. She stated caregiver Staff H, failed to follow the facility plan of care when performing care for residents. On . . . . . at 4:58 PM, an exit conference was conducted with the Administrator and LPN manager. They both acknowledged the findings. No further documentation was provided at this time.	A 025		

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A 025	Continued From page 4 Class III	A 025		
A 032	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being	A 032		

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A 032	Continued From page 5 assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record review, interviews and observation, the facility failed to prevent an elopement from a secured Memory Care facility, for 2 of 4 sampled residents (Residents #1 and #3). It was also determined that the facility failed to implement a system to prevent reoccurrence of elopements. As evidence of the facility failure to make repairs to the exit door alarm system and increase supervision to the residents that reside in the Memory Care Unit.	A 032		

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A 032	Continued From page 6 The findings include: A review of the facility's informational website www.harborchase.com/haborchase-tamarac-memory-care/ was conducted on . . . . . which advertises under Memory Care. The description of the Memory Care states, Attention to detail, secure community, our memory care neighborhood in Tamarac, Florida, is a warm and welcoming community that includes unique touches that cater to memory care residents. The Cove in Tamarac is secure, safe, and tranquil, and designed to be familiar and welcoming to residents. Care partners are available 24/7 to ensure the health and safety of all residents. Review of Resident#3's AHCA form 1823 (Resident Health Assessment form) dated . . . . . documented her diagnosis as . . . . Resident #3's AHCA form 1823 also documented she is on hospice care and requires assistance with her Activities of Daily Living (ADL), and requires general oversight of her wellbeing and whereabouts. A review of the Adverse Incident Report dated . . . . . submitted by the facility revealed Resident #3 eloped at approximately 8:30 AM on . . . . . And further documented that Resident #3 was last observed shortly after breakfast at 8:00 AM on . . . . . Resident #3 left the building through the west hallway door and walked across the parking lot to [place of business] not associated with the facility. While associates were assisting other residents with dietary duties, care, and medication management. An observation by this surveyor (who was accompanied by the Administrator) of the 200	A 032		

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A 032	Continued From page 7 Section revealed two sets of doors on the west side of the building. The set of doors inside the unit was observed to be open, and the external doors leading to the outside were shut. An observation was made by this surveyor of the external door that Resident #3 is said to have exited. The doors were unlooked and still posed a danger to all residents in the MCU. This surveyor pushed the emergency break bar on the door, it opened immediately, and the alarm sounded. As the alarm was sounding, this surveyor walked between 20 -25 . . . down the hall in the 200 Section to determine if the alarm could be heard, and it could be. Further observation revealed that there was no staff responding to the alarm, or physically observed in the 200 section. Observation made by this surveyor of the nurse's station located near the main dining room revealed there are monitors inside the station that receive visual feeds from the cameras located in the section, and outside of the facility. This allows staff to monitor residents and circumvent elopements visually and audibly. However, still no staff responed. Additional review of facility documents revealed that another resident (Resident #1) eloped on . . . . . at 4:38 PM from the community (the facility). The facility received a call from an individual at a nearby apartment . . , . . which is adjacent to the community informing the community that Resident #1 was with her. The individual also informed that she called the Broward Sheriff's Office for assistance at that time. An investigation into the resident's elopement revealed Resident#1 is suspected to have eloped from the rear patio, a secured fence of the community, through the same exit doors as Resident #3.	A 032		

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A 032	Continued From page 8 On between 3:00 PM and 3:45 PM, a family interview was conducted by this surveyor. The family member stated resident #3 had eloped three times approximately around , , and . The family member was advised to hire a Private Duty Aide (PDA) and advised to look for a secure community for the safety of the resident. The Family member stated that having a Private Duty Aide would be financially impossible, but she's diligently looking for a place to move resident#3 as she was advised by the administrator. Review of Resident#1's AHCA form 1823 (Resident Health Assessment form) dated documents that the resident has a medical history of , , agitated , , , special precaution of elopement risk, nursing treatment requirements assistance with Activities of Daily Living (ADL). On between 9:00 AM and 10:30 AM a facility tour was conducted by Staff I, Caregiver Supervisor/Activity Director. She stated residents are allowed to be in the courtyard unsupervised because it is their home. She also stated there are cameras in the common areas, and all care staff members carry a two-way radio for effective communication when present in different parts of the building (Sections 100s, 200s, and 300s) An observation by this surveyor during the tour on revealed approximately 5 residents without supervision in the 100s section courtyard (southside of the facility). No staff observed in the area attending to the residents or monitoring the unsecured exit doors. On an observation by this surveyor of	A 032		

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A 032	Continued From page 9 the 100 Section, south courtyard a fenced area between 6' and 7' high revealed there is a large body of water (photo evidence obtained) on the south side of the facility where Resident #1 was found at apartment . . . On . . . . . between 1:30 PM and 2:30 PM in an interview with the administrator, she stated Resident #1 did not go to the hospital, he was assessed by Licensed Practical Nurse (LPN) Staff G upon return after the incident and assessed the next day by LPN community manager Staff B. This surveyor requested a police report from the administrator, and she stated there was no report given by the police. No additional documentation was provided at the time of the survey. On . . . . . at 4:58 PM, an exit conference was conducted with the Administrator, LPN Manager Staff B, and Caregiver Supervisor / Activity Coordinator Staff I, and they acknowledged the findings. Both staff acknowledged that they have had problems with the doors being secured. Further interview revealed the facility had no system in place to prevent the reoccurrence of elopements for resident residing in the MCU. No further documentation was provided at this time. Class II	A 032		
A 078	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms	A 078		

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A 078	Continued From page 10 of communicable . . . . . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative . . . . . examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual . . . . . examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . . . . . . 2. If any staff member has, or is suspected of having, a communicable . . . . . , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training	A 078		

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A 078	Continued From page 11 requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility , to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff . . . . by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure that within 30 days of employment staff submit a written statement from a health care provider documenting the individual is free from signs/symptoms of communicable . . . . . and evidence of freedom from ( ) documented annually thereafter for 3 (Staff A, E and F) of 4 employee records reviewed. The findings include: A review of Staff A's employee file revealed a hire date of . . . . . as a Administrator. Staff A's file contained no evidence of documentation of a statement from a health care provider that indicated Staff A was free from signs or symptoms of communicable . . . . . including . .	A 078		

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A 078	Continued From page 12 On review of Staff E's employee file revealed a hire date of as a Certified Nursing Assistant. Staff E's file contained no evidence of documentation of a statement from a health care provider that indicated Staff C was free from signs or symptoms of communicable including . On a review of Staff F's employee file revealed a hire date of as a Certified Nursing Assistant. Staff F's file contained evidence of documentation of , completed Expired on and electronically signed by the healthcare provider which indicated no radiographic evidence for active . There was no further evidence of freedom form communicable including annually thereafter. On at 10:30 a.m., during an interview, the Administrator confirmed there was no evidence of documentation of a communicable statement signed by a healthcare provider indicating Staff A, and E were free from signs and symptoms of communicable , She also confirmed there was no evidence of freedom from annually for Staff F. Class III	A 078		
A 082	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	A 082		

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A 082	Continued From page 13 complete a one-time education course on 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 one (2) of three (4) staff records reviewed had evidence of / training in their file/or available for review (Staff E and F). The findings include: During a Re-licensure Survey at the facility on , a review of employee facility files was conducted. During review of Staff E (Certified Nursing Assistant) with a hire date of , it was revealed the file did not contain the required documentation. During a Re-licensure Survey at the facility on a review of employee facility files was conducted. During review of Staff F (Certified Nursing Assistant) with a hire date of , it was revealed the file did not contain the required documentation. In an interview with the Administrator on at 2:09 PM she was informed of the missing document and given an opportunity to review the file. She stated she was sure she had received the training and would provide it. No documentation was provided during the Survey. On the Survey team met with the Administrator to conduct the Exit Conference.	A 082		

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 _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 082	Continued From page 14 She was informed of the findings of the Survey, to which she stated she understood. Class III	A 082		
AE210	59A-36.011(8) FAC ECC - Training (8) EXTENDED CONGREGATE CARE (ECC) TRAINING. (a) The administrator and ECC supervisor, if different from the administrator, must complete core training and 4 hours of initial training in extended congregate care prior to the facility receiving its ECC license or within 3 months of beginning employment in a currently licensed ECC facility as an administrator or ECC supervisor. Successful completion of the assisted living facility core training shall be a prerequisite for this training. ECC supervisors who attended the assisted living facility core training prior to [illegible], shall not be required to take the assisted living facility core training competency test. (b) The administrator and the ECC supervisor, if different from the administrator, must complete a minimum of 4 hours of continuing education every two years in topics relating to the physical, [illegible], or social needs of frail elderly and [illegible] persons, or persons with [illegible]'s [illegible] or related [illegible]. (c) All direct care staff providing care to residents in an ECC program must complete at least 2 hours of in-service training, provided by the facility administrator or ECC supervisor, within 6 months of beginning employment in the facility. The training must address ECC concepts and requirements, including statutory and rule requirements, and the delivery of personal care and supportive services in an ECC facility.	AE210		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AE210	Continued From page 15 This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure the Extended Congregrate Care Manager/Director of Wellness completed the ECC training every 2 years. The findings include: Upon entrance to the facility on at 9:40 AM, Staff B introduced herself to the survey team as the facility's designated ECC Manager/Director of Wellness. During review of Staff B's personnel file revealed she was hired on . Further review of Staff B's file revealed there was no documentation of completion of the ECC training every 2 years. During a further interview, conducted on ..... at 12:30 PM, Staff B confirmed she started (hired) on ....., as the ECC Manager/Director of Wellness. On at 2:30 PM, an interview with the Administrator confirmed Staff B is the ECC Manager/Director of Wellness. The Administrator acknowledged the findings. Class III	AE210		