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 _____	02/07/2025

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 licensure Complaint survey, complaint numbers 2024008250 and 2025001081 and Generator Monitoring survey, were conducted on through at Haborchase of Tamarac. The facility had deficiencies identified 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 supervision as appropriate for each resident, including the following:	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 (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, it was determined that the facility failed to provide appropriate supervision to residents that suffered from , and resided in the memory care unit. The facility's failure to provide supervision to these residents resulted in an altercation for 2 out of 2 sampled residents (Resident #1 and #2) and an elopement of 1 out of 1 sampled residents (Resident #3) Based on review of the facility's dining service policy or established protocol, interviews with staff	A 025		

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A 025	Continued From page 2	A 025		

who have knowledge of the facility's dining service supervision policy, and based on the facility's elopement policy, history of elopement at the facility, as well as the facility's failure to maintain the main exit door alarm in good working order, it is determined that the facility failed to prevent resident to resident of 1 of 2 sampled residents (Resident #1), and failed to provide adequate supervision of 2 of 3 sampled residents (Resident #2 & Resident #3) to prevent adverse incident and elopement of 1 of 1 sampled resident (Resident #3).

The findings included:

I. Review of an undated facility's policy or established protocol related to Memory Care (MC) Hospitality Service and Supervision, outlined the following:
" MC dining requires that there are associates present during meals.
" DMC or Director of Memory Care will appoint an associate for each meal who will champion the overall dining/meal service process.
" Invite, escort, and assist residents in seating, transfer residents ...where appropriate, etc.
" Ensure that residents do not leave the dining area with any utensils after dining.

Interviews conducted with Care Partners and Staff from to revealed there was an established protocol in place to preventing Residents from leaving the dining room area with utensils, protective clothing, or anything else that did not belong to the residents. Record review of the investigation documents revealed that on , right after breakfast, Resident #2 stabbed Resident #1 with a metal butter knife, after leaving the dining area. The incident

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A 025	Continued From page 3 occurred in the lobby adjacent to the dining room. Resident #1's health assessment record (AHCA form 1823) dated documented that Resident #1 was a adult due to organic damage. Resident #1 was diagnosed with which affected her state and short-term memory. The AHCA form 1823 also documented that Resident #1's needs could be met at the facility. Review of the AHCA form 1823 dated documented that Resident #2's was diagnosed with , , , . Resident #2 experienced swings and had unsteady gait. The health assessment also documented that Resident #2's needs could be met at the facility. An interview conducted with Staff B, a licensed practical nurse (LPN), on at 1:57 PM, revealed that Resident #2 was a quiet person but unpredictable at times. Staff B said that she was called to the scene after Resident #2 had stabbed Resident #1 on the forehead. Staff B said that Resident #2 could be aggressive and had exhibited aggression towards staff. Staff B said that Resident #2 could be "boisterous", especially when she did not want to be bothered. Staff B also affirmed that "All staff knew how to monitor the residents when they are going into the dining room and coming out of the dining room, to make sure they do not come out with utensils". Staff B continued and said that every member of the staff knew that information even before the incident between Resident #1 and Resident #2 had occurred. Staff B also stated, at times, the residents would come out with plates, cups, knife; so, they have to tell them, "let me wash it for you, in order to not allow the residents to leave the	A 025		

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A 025	Continued From page 4 dining room with those items". On at 2:30 PM, Staff C, a Life Enrichment Staff, said she was informed, like all the other staff, to make sure residents do not come out of the dining room with "stuff in their ". Staff C reported that the Care Partners and the Life Enrichment personnel are responsible for taking the residents in and out of the dining room or to activities. As soon as the residents finish to dine, they usually take them (Residents) right away to activities. Staff C added it was she and another life enrichment Staff who were taking residents in and out of the dining room. On at 3:03 PM, Staff D, a Life Enrichment Staff, said she has been working at the facility for many years. Her role in the dining room is to help the residents in and out, serve coffee and assist with feeding. Staff D said, most of the residents are independent and eat by themselves. Staff D said that they are supposed to monitor the residents while they are eating in the dining room, when they are leaving the dining room, and when they are going in. However, Staff C continued and stated that sometimes, "we do not see when they are going out". Because "we may be busy feeding somebody and assisting someone with coffee". Staff C said that Resident #2 is a "fighter"; "when they try to remove her clothing protector, she wants to fight and hit you". If you tell her she cannot sit there to eat, she would hit you. Staff D also said that Resident #2 hit the Caregivers all the time, but not the residents. Staff D concluded that Resident #2 had picked up utensils from the dining room before and they (staff) know that she does that. An interview with Staff E, a Care Partner, on	A 025		

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A 025	Continued From page 5	A 025		

at 3:31 PM revealed she worked at the facility for nearly five years. Staff E said, she assists residents in the dining room, and out of the dining room. Staff E also confirmed that the residents frequently remove utensils, such as spoons, clothing protectors, etc., out of the dining room. Staff E said they are told to always make sure that residents do not take things out of the dining room when they are coming out of the dining room. She said she has to make sure the residents do not have any items in their that they should not leave out with, when they are going out of the dining room. If residents do not want to give them up, she plays with the residents until they do.

In an interview with the Memory Care Director (MCD) on at 3:50 PM, it was noted that all Staff are aware of the facility's protocol to make sure that residents do not leave the dining room area with utensils. The MCD said: There is a known unwritten policy that staff need to make sure when residents are going out of the dining room to remove any cutlery, they may have taken from the dining room. The MCD said there usually are three representatives in the dining room (two life enrichment representatives and one dietary staff). The MCD also affirmed that no such incident had ever occurred in the facility during the nineteen years she has been working at the facility. Nevertheless, the MCD did not deny the fact that residents do remove those items from the dining room from time to time, and that their unwritten policy was to prevent unfortunate incident such as the one that occurred between Resident #1 and Resident#2.

On at 4:41 PM, Staff F, a Medical Technician (Med/Tech) reported that she was in the hallway near Residents #1 and Resident #2

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A 025	Continued From page 6	A 025		

when she heard Resident #1 screaming. Staff F said her was turned away from them, but as soon as she heard the screaming, she turned around and saw on Resident #1's . She said that she also saw Resident #2 holding a knife in her . Staff F said when she tried to take the knife away from Resident #2, she did not want to let it go. Staff F said that Resident #2 also had another bag in her that had a fork and a spoon which she refused to let go of. Resident #2 kicked her Staff F added; it was a struggle, but Staff F said she managed to get the items away from Resident #2.

II)
Review of the facility's investigation documents revealed that on , Resident # 3 had eloped from the facility. Review of the facility's investigative report concluded that Resident #3 left the facility through the main entrance door. Yet, no one could determine how it happened.

Review of the facility's elopement history revealed at least two previous elopements occurred at the facility. One in 2022 and another more recently occurred in , , . Both elopements resulted from faulty exit door alarms.

On at 11:07 AM, Staff H, a Care Partner, reported that every staff member is required to check all their assigned residents, and initiate a count at the beginning of every shift and return their tracking or count-sheet to the nursing station. Staff H said that she heard someone had eloped, but it was not during her shift. Staff H also said that Resident #3 used to throughout the facility.

Staff (I), a Care partner said on at 4:04 PM, she has been working at this facility for 15

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A 025	Continued From page 7 years. On the day that Resident #3 eloped from the facility, there were three Care Partners on duty during the night. Staff (I) said that Resident #3 was on her assignment. Staff (I) said when residents are new to the facility, they a lot and say, "they want to go home". Staff (I) said, during the night shift someone always sits at the nursing station located near the main entrance door of the facility to monitor residents who and to also pay attention to the alarm. Staff (I) said there is a camera monitor at the nursing station for staff to monitor the hallways and to make sure they can identify Residents' location when the residents activate their call lights. Staff (I) said, once the call lights are activated an audible sound is heard and an electronic indicator lets them know which room or bathroom the call comes from. Furthermore, Staff (I) said she was not at the station on . She said Resident #3 was assigned to her and she did her rounds every two hours. Staff (I) said she checked and saw Resident #3 at about 5:00 AM or 5:15 AM. Staff (I) said she clocked out and left the facility at 6:00 AM. Before she left, she gave a basic report to the incoming staff. Staff (I) reported that their responsibility at the beginning of the shift was to make sure the report they receive from the outgoing staff coincides with the report they receive about their assigned residents, by making rounds and checking on every resident. Staff (I) said before she left, she changed Resident #3. She said that "Resident #3 a lot at night, looking for her parents". Whoever is at the nursing station monitors Resident #3 at night in the hallway. When they see Resident #3 , near the exit doors, they radio it to the other staff and said, "Resident #3 is up, keep an ". Staff (I) said the alarm did not go off when Resident #3 left the facility.	A 025		

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A 025	Continued From page 8 On at 9:45 AM, the Maintenance Director said that when Resident #3 eloped from the facility, he was not at the facility. However, when he arrived in the facility, staff were complaining about the front door magnet not working properly. The Maintenance Director said when he checked the front door, he entered the door alarm code, he checked the door magnets everything was working fine. On at 10:00 A. M., an interview with an employee of another facility (Staff J) located across the street where Resident #3 was found, revealed that Resident #3 was found on that property at about 7:00 AM, on , by Staff J's coworker who arrived at work at about 7:00 AM. Staff J reported that Resident # 3 was seen on the lawn of the parking lot. Staff J said she arrived at work at 8:00 AM, they called the police and Staff J recalled that Resident #3 was taken to the facility at about 10:00 AM. On at 10:52 AM, the Memory Care Director (MCD) explained that the staff assigned to provide care to Resident #3 (Staff L) the morning of failed to perform her rounding after she reported for work that day, and after receiving report from the night shift Care Partner, Staff (I). The MCD said Staff (I) had reported that she saw Resident #3 at 5:00 AM. Staff (I) shift ended at 6:00 A.M. The MC Director said because Staff L who replaced Staff (I) the day shift staff, failed to check her resident, they were not able to determine the exact time Resident #3 had left the facility. The MCD said she found out that Resident #3 was missing because she had asked Staff L to go do something for her at about 9:00 AM. It was then that Staff L reported to her that she did not see	A 025		

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A 025	Continued From page 9 Resident #3 in the room. They immediately activated their elopement response protocol and started searching for Resident #3 throughout the entire facility. While their search was ongoing, at about 10:00 A. M., they received a call from the police informing them that Resident #3 was found across the street. The Executive Director (ED) said on at 9:17 AM, they could not determine how Resident #3 had left the facility. All the exit doors were alarmed and had double locks prior to Resident #3's elopement incident. In addition, no one reported hearing the door alarms. She said there is always a staff member at the nursing station. If someone forcefully left through the front door, they would have heard the alarm. The ED said, although they could not understand how the event happened, as a precautionary measure, they had requested that a technician reassessed the doors' alarm system functionality, they conducted extensive training with the staff, and took disciplinary action against Staff L who failed on her responsibility to ensure Resident #3 was accounted for, at the beginning of her shift. Class II	A 025		
A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good	A 152		

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A 152	Continued From page 10 working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation and interviews, it was determined that a safe and sanitary environment was maintained in 3 of 3 sections of the facility (Section 100, Section 200 & Section 300). The findings included: On from 10:00 AM to 10:30 AM, an environmental tour of the facility was undertaken	A 152		

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A 152	Continued From page 11 alongside the Memory Care Director. Multiple safety concerns were identified photographed and noted. In Section 100, the following were observed: a) The laundry rooms containing hazardous materials were observed unlocked in sections 100, 200 and 300. b) Two electrical rooms in section 200 and 300 were observed unlocked c) An uncovered garbage bin containing biohazard material (soiled diapers) was observed in section 300, d) Two mechanical rooms, and two storage rooms were observed unlocked. e) A large storage room in section 300 was unlocked and exposed feces were observed on the floor. During the tour on at 10:15 AM, the MC Director expressed disbelief of what was observed and requested that those doors be secured immediately. However, on at 10 AM, during a follow-up tour, two mechanical doors were still not secured, and one storage room containing various objects was left unlocked or was partially secured with a chair. The findings were discussed with the Executive Director on at 12:20 PM during the exit meeting. No additional information was provided. Class III	A 152		