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
	AL11965157	A. BUILDING: _____ B. WING _____	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORCHASE OF CORAL SPRINGS	2975 NW 99TH AVENUE CORAL SPRINGS, FL 33065

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A 000	Initial Comments An unannounced Complaint survey (#2025012092) was conducted on at Harborchase of Coral Springs. Deficiencies were identified at the time of survey.	A 000		
A 028	59A-36.007(4) FAC Resident Care - Activities of Daily Living (4) ACTIVITIES OF DAILY LIVING. Facilities must offer supervision of or assistance with activities of daily living as needed by each resident. Residents should be encouraged to be as independent as possible in performing activities of daily living. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to offer supervision of or assistance with activities of daily living as needed by 2 out 2 sampled residents (Resident #1 and Resident #2). The findings included: 1) A review of documentation provided by the Administrator at the time of survey revealed a letter written by a representative of Resident #1 to the facility. The letter stated the following: 'On through she visited her mother and spent approximately 8 hours each day. She witnessed a lack of care and concern, when the emergency cord was pulled, no one came. The event happened 3 times. Documented dates are , , and she had to go physically get help after waiting 20 mins plus each occurrence. Her mother is almost , .'	A 028		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 028	Continued From page 1 During an interview conducted with the Director of Nursing on at 10:29AM, she was asked her protocol for ensuring the staff completes their assignments with respect to ADL care. The Director of Nursing stated she makes rounds on the hours that she's here to ensure the work is done. There is no list or end of shift report done to confirm completion. When asked about the facility's response time protocol, she stated the staff can be busy and the wait time can be up to 30-40 mins for the call bell to answered. She further stated the is nothing in writing for the wait time but she stated an acceptable wait time is no longer than 45 mins. During an interview conducted with the Administrator on at 11:30 AM, the Administrator stated she and the Director of Nursing were responsible for the receipt and resolution of grievances. When asked about the facility's investigation into the concerns mentioned in the letter, she stated that the allegations in letter written by Resident #1's representative were unfounded. She further stated that the resident never experienced a wait that was considered long, and the facility staff has been performing activities of daily living (ADLs) for the resident. During a tour of the facility on at 12:00 PM, Resident #1 was observed lying in her bed with raised half bed rails. Resident #1's were dirty with brown debris under the nails, and her hair was unbrushed and unkempt. The resident was very thin and frail. When asked if she could provide care for herself, Resident #1 stated she can't get out her bed on her own. She further stated that when she calls for help, the facility staff does not come. Resident #1 then stated she had not been changed for the day and	A 028		

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A 028	Continued From page 2	A 028		

she needed changing. At 12:03 PM, the Agency intervened and pulled the resident's call light to get assistance for the resident. While pulling the call light for the resident, it was observed that the light was in the far-right corner behind the resident's bed and out of the resident's reach. The Agency intervened and placed the brown string attached to the resident's bed for easier access.

On at 12:14 PM, while waiting for the response with Resident #1, a foul fecal odor was noted. Resident #1 told the Agency she had soiled her adult brief. Resident #1 began to cry as she continued to soil herself. When attempting to leave to get assistance, Resident #1 begged the Agency to stay because the presence was comforting. At 12:17 PM the fecal smell became stronger as the resident continued to soil herself. At this time, the Agency intervened by contacting a team member on site to facilitate a response from the facility's care staff.

On at 12:22 PM, Staff D (CNA) arrived to assist the resident. At this time Staff D was notified that the resident had not been changed for the day, in addition to the current soiling event that occurred. Staff D asked the Agency and Resident #1 if hospice services had arrived for the day. Resident #1 stated no, she was alone all day. When asked about the protocol when hospice does not arrive, Staff D stated she expected hospice to change the resident, so did not think she had to.

A review of Resident #1's file revealed an admission date of . Further review revealed a Resident Health Assessment (AHCA Form 1823) dated . Resident #1 had diagnoses of of , Rim of

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A 028	Continued From page 3 R-Pubis, , , , in R- , , , and Difficulty walking. Resident #1 had , , , , and hospice as a , , /treatment service. The resident required assistance with ambulation, bathing, , grooming, toileting, and transferring. Further review of the resident's file revealed an Initial Integrated Care Plan between a hospice provider and the facility dated . Further review of the plan revealed orders, goals and intervention that stated the following: Orders: Facility-Home Health Aide to assist with ADL's and personal care needs. Goals: Facility- Patient's personal care needs will be met. Intervention: Hospice Staff coordinated with Facility. The Integrated Care Plan was signed by the Director of Nursing on . During an interview conducted with the Administrator at 3:56 PM, she was notified that Resident #1 was left unchanged for the day and was sitting in her own fecal matter for over 15 minutes. She was further notified that the Agency had to intervene twice to get assistance for the resident and the resident was crying for help. The Administrator stated that the wait time was only 20 minutes and was not long per the facility's protocol. At this time, the Administrator was notified she was not providing supervision of or assistance with activities of daily living for Resident #1's per the Resident Health	A 028		

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A 028	Continued From page 4 Assessment and Integrated Care Plan with hospice to assist with the resident's ADL need. Subsequently, the Administrator acknowledged the findings. 2) During a tour of the facility on at 1;24 PM, Resident #2 was observed seated in a recliner chair and his representative was present in the room. When asking Resident #2's representative about care and services, the representative stated that the facility was not performing ADLs for Resident #2. The representative further stated that she visited Resident #2 daily for 8 hours a day since the resident has been living here. At this time, the representative mentioned an incident that occurred on during which Resident #2 slid down his recliner chair on to the floor in her presence. The representative stated she pulled the call bell and waited almost an hour for help. On at 1:31PM, the representative mentioned another incident that occurred approximately one month prior, during which Resident #2 was observed to have foul odor without being soiled. When the representative spoke with the care staff involved, she stated their response was they did not have any wipes so they only changed his brief. The representative stated that she immediately informed the Administrator and Director of Nursing about this incident and nothing was done. On at 1:40PM, the representative mentioned another incident that occurred while she was away from the facility on to . The representative stated upon her return to the facility on at 9:15AM,	A 028		

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A 028	Continued From page 5 Resident #2 had a foul odor. Upon changing the resident, she discovered the resident was soaked and had been sitting in a -filled adult brief to the point it was disintegrating from the overflow (Photographic evidence obtained). The representative further stated when she addressed the concern with Staff E (CNA) she ignored her and began retaliating against Resident #2 by not giving him his medications timely and not performing his ADL care appropriately. The representative stated when these concerns were brought to the Administrator, nothing was done. A review of Resident #2's file revealed an admission dated . Further review revealed a Resident Health Assessment (AHCA Form 1823) dated . Resident #2 had diagnoses of , , , , Gait D/O, at Night, and . The resident was wheelchair bound and required a hospital bed. Resident #2 had hospice as a , /treatment service. The resident required assistance with bathing, , toileting, and transferring. A review of the facility's documentation for call light response for Resident #2's room, titled "Location Event Report", revealed the following for: Occurred: , 2:05PM Responded: , 2:58PM Response Time: 52 minutes During an interview conducted with the Administrator at 4:00 PM, she was notified that the facility was not providing supervision of or assistance with activities of daily living for Resident #1 per the Resident Health Assessment. Subsequently, the Administrator acknowledged	A 028		

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A 028	Continued From page 6 the findings. Class III	A 028		
A 030	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of	A 030		

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A 030	Continued From page 7 its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside.	A 030		

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A 030	Continued From page 8 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both	A 030		

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A 030	Continued From page 9 are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a	A 030		

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A 030	Continued From page 10 facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman	A 030		

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A 030	Continued From page 11 Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on interview and record review, it was determined, the facility failed to implement and follow an effective grievance procedure that demonstrated a system for receipt and resolution of all grievances of residents and/or their representatives. This was evidenced by the facility's failure to maintain documentation of grievances and resolutions. The findings included: A review of the facility's grievance policy and	A 030		

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A 030	Continued From page 12 procedure titled, " STANDARD: INVESTIGATING A COMPLAINT/GRIEVANCE " [Effective date , Revised date] revealed the following: Policy: Our community investigates all grievances and complaints filed with the community. It is the policy of this community to encourage each resident to exercise their right to voice or present a grievance, concern or suggestion , all areas of living. Grievance, concerns or suggestions shall be acknowledged and addressed to the satisfaction of the resident. Procedure: 1. In this community, the Executive Director or designee has the assigned responsibility of investigating grievances and complaints. 2. Residents may voice their concerns or suggestions to a staff member at any time. Residents may also present a formal grievance or concern and make suggestions via the Grievance Form and/or at the monthly Resident Council Meeting. Family members, on behalf of residents, may present a grievance or concern as per above. 3. Upon the receipt of a grievance and complaint report, the above designated manager will begin an investigation into the allegations. The department director of an involved employee will be notified of the nature of the complaint and that an investigation is underway. The investigation and report will include, as each may apply: a. The date and time of the alleged incident; b. The circumstances surrounding the alleged incident; c. The location of the alleged incident; d. The names of any witnesses and their account of the alleged incident;	A 030		

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A 030	Continued From page 13 e. The resident's account of the alleged incident; f. The employee's account of the alleged incident; g. Accounts of any other individuals involved (i.e., employee's supervisor, etc.); and h. Recommendations for corrective action. 4. The "Resident Grievance/Complaint Investigation Report Form" must be filed with the administrator/ED as soon as possible. 5. The resident, or person acting in behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended upon completion of the investigation. 6. Should a grievance or concern be presented that is difficult for the designated department to rectify to the resident's satisfaction, it will then be brought to the attention of the NHA/Executive Director and Home Office support team (RDO, RDHW, NDHW), if needed. 7. A Grievance Log will be maintained in a binder by the Executive Director/NHA. Annually a new Grievance Log will be implemented for the year. 8. Copies of all reports must be signed and will be made available to the resident or person acting in behalf of the resident. A review of documentation provided by the Administrator at the time of survey revealed a letter written by a representative of Resident #1 to the facility. The letter stated the following: 'On . . through she visited her mother and spent approximately 8 hours each day. She witnessed a lack of care and concern, when the emergency cord was pulled, no one	A 030		

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A 030	Continued From page 14 came. The event happened 3 times. Documented dates are , , and she had to go physically get help after waiting 20 mins plus each occurrence. Her mother is almost , .' During an interview conducted with the Director of Nursing on at 10:30AM regarding grievances, she stated the residents complain often, but not about the care directly. She further stated that the residents are demanding and they want care services immediately, but the staff were busy. During an interview conducted with the Administrator on at 11:30 AM, she stated she and the Director of Nursing were responsible for the receipt and resolution of grievances. When asked about the facility's investigation into the concerns mentioned in the letter, she stated that the allegations in letter written by Resident #1's representative were unfounded. She further stated that the resident never experienced a wait that was considered long, and the facility staff has been performing activities of daily living (ADLs) for the resident. During an interview conducted with a representative of Resident #2 at 1:24PM-1:40PM, the Agency was notified of three separate instances of ADL care unperformed for Resident#2 within the last 3 months. The representative stated on each occasion, she notified both the Administrator and the Director of Nursing about her concerns with the care and services Resident #2 was receiving. Nothing had been done. A review of the facility's grievance intake documentation revealed the facility maintained a	A 030		

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A 030	Continued From page 15 grievance log. Further review revealed the log contained grievances from 2020 to 2025. Review of the 2025 grievances revealed there was no documentation or investigation of the ADL concerns that were mentioned by the representatives of Resident #1 and Resident #2, nor were there any resolutions. During an interview conducted with the Administrator and the Director of Nursing on at 4:07PM, they were notified that the facility failed to follow their grievance protocol due to the lack of grievance and resolution documentation. Additionally, they were informed that fully honoring resident rights and grievances required both intake and resolution of the grievance to be documented. The Administrator acknowledged the findings. Class III	A 030		
A 031	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being	A 031		

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A 031	Continued From page 16 provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the , resident's needs. (c) The administrator or designee must ensure that: 1. Care coordination includes documented communications about the resident's condition and response to treatment or services ordered by the physician which may impact the resident's appropriateness for continued residency in the facility; 2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and 3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition. 4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the timeframes in subparagraphs 59A-36.007(6)(c)2. and 3.	A 031		

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A 031	Continued From page 17 (d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on interview, observation, and record review it was determined that the facility failed to coordinate with a third-party provider to deliver care and services that met the residents' needs and ensured eligibility for continued residency. This was evidenced by the facility's failure to implement the facility's policy for the documentation, coordination, and supervision of third-party services for 1 out 2 sampled hospice residents (Resident #1). The findings included: A review of the facility's third-party policy titled, "Standard: Third Party Services and Documentation form-FL specific" [Issued] revealed the following: Policy: 1. All TPP must sign in and out of log prior to and at conclusion of resident visit 2. All third party will complete "Third party documentation form" at time of service to give Health and Wellness designee. For purposes of this form third party includes: - , , (, ,ST,SN)	A 031		

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A 031	Continued From page 18 -Hospice -Psych Services - During a tour of the facility on at 12:00 PM, Resident #1 was observed lying in her bed with raised half bed rails. Resident #1's were dirty with brown debris under the nails, and her hair was unbrushed and unkempt. The resident was very thin and frail. When asked if she could provide care for herself, Resident #1 stated she can't get out her bed on her own. She further stated that when she calls for help, the facility staff does not come. Resident #1 then stated she had not been changed for the day and she needed changing. At 12:03 PM, the Agency intervened and pulled the resident's call light to get assistance for the resident. While pulling the call light for the resident, it was observed that the light was in the far-right corner behind the resident's bed and out of the resident's reach. The Agency intervened and placed the brown string attached to the resident's bed for easier access. On at 12:14 PM, while waiting for the response with Resident #1, a foul fecal odor was noted. Resident #1 told the Agency she had soiled her adult brief. Resident #1 began to cry as she continued to soil herself. When attempting to leave to get assistance, Resident #1 begged the Agency to stay because the presence was comforting. At 12:17 PM the fecal smell became stronger as the resident continued to soil herself. At this time, the Agency intervened by contacting a team member on site to facilitate a response from the facility's care staff. On at 12:22 PM, Staff D (CNA) arrived to assist the resident. At this time Staff D	A 031		

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A 031	Continued From page 19	A 031		

was notified that the resident had not been changed for the day, in addition to the current soiling event that occurred. Staff D asked the Agency and Resident #1 if hospice services had arrived for the day. Resident #1 stated no, she was alone all day. When asked about the protocol when hospice does not arrive, Staff D stated she expected hospice to change the resident, so did not think she had to.

A review of Resident #1's file revealed an admission date of . Further review revealed a Resident Health Assessment (AHCA Form 1823) dated . Resident #1 had diagnoses of of , Rim of R-Pubis, , , , in R- , , , and Difficulty walking. Resident #1 had , , , , , and hospice as a , /treatment service. The resident required assistance with ambulation, bathing, , grooming, toileting, and transferring. Further review of the resident's file revealed an Initial Integrated Care Plan between a hospice provider and the facility dated . Further review of the plan revealed orders, goals and intervention that stated the following:

Orders:
Facility-Home Health Aide to assist with ADL's and personal care needs.

Goals:
Facility- Patient's personal care needs will be met.

Intervention:
Hospice Staff coordinated with Facility.

The Integrated Care Plan was signed by the

Agency for Health Care Administration

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A 031	Continued From page 20 Director of Nursing on . Further review revealed there was no documentation of hospice, , , , , , , and , , notes nor was the "Third Party Documentation" form on file to identify care and services provided by the third-party providers. During an interview conducted with the Administrator at 4:10 PM, she was notified that the facility was not coordinating care and services with hospice for Resident #1 effectively per the facility policy. She was further notified that she was not following the Integrated Care Plan provided by Hospice, which allows Resident #1 to maintain continued residency. The Administrator acknowledged the findings. Class III	A 031		