

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965462	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/13/2026
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF TAMARAC		STREET ADDRESS, CITY, STATE, ZIP CODE 6855 NW 70TH AVENUE TAMARAC, FL 33321			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 000	Initial Comments An unannounced Complaint investigation (#2025010180), was conducted at Harborchase of Tamarac on _____ Deficiencies were identified at the time of survey.	A 000			
A 010	429.26() FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician	A 010			

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965462	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/13/2026
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF TAMARAC			STREET ADDRESS, CITY, STATE, ZIP CODE 6855 NW 70TH AVENUE TAMARAC, FL 33321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 010	Continued From page 1 who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965462	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/13/2026
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF TAMARAC			STREET ADDRESS, CITY, STATE, ZIP CODE 6855 NW 70TH AVENUE TAMARAC, FL 33321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 010	Continued From page 2 (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a _____ may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner. 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965462	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/13/2026
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF TAMARAC			STREET ADDRESS, CITY, STATE, ZIP CODE 6855 NW 70TH AVENUE TAMARAC, FL 33321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 010	Continued From page 3 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A _____, ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C.	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965462	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/13/2026
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF TAMARAC			STREET ADDRESS, CITY, STATE, ZIP CODE 6855 NW 70TH AVENUE TAMARAC, FL 33321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 010	Continued From page 4 This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, it was determined that, the facility failed to ensure a resident was reassessed after the resident exhibited a significant behavior change that directly threaten the safety of self and others, for 1 out of 2 sampled residents; and the findings documented on a new health assessment form (AHCA form 1823). The facility failed to discharge a resident that no longer met the criteria for continued residency. Cross reference A 0025 for additional findings. The findings include: During the survey on _____ a tour of the facility was conducted by this surveyor. During the tour on _____ at 9:00 AM, this surveyor made observation of six residents including Resident #2, having breakfast in the dining room located in 300 hall area. During an interview conducted on _____ at approximately 8:45 AM with the Director of Memory Care (B), she stated Resident #1 is no longer a resident of the facility; but that Resident # 2 continues to reside at the facility. During an interview conducted on _____ at approximately 9:05 AM with the Director of the Memory Care Unit (MCU), she was asked to provide Resident #2's facility record. A review of Resident #2's record provided revealed she was admitted to the facility on _____. A review of Resident #2's Resident Health Assessment, AHCA Form 1823 (1823) dated and signed on _____ by a licensed health provider, documented that Resident #2 was	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965462	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/13/2026
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF TAMARAC			STREET ADDRESS, CITY, STATE, ZIP CODE 6855 NW 70TH AVENUE TAMARAC, FL 33321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 010	Continued From page 5 physically unstable and exhibited swings related to her behavioral status. Further review of her 1823 documented her diagnosis included During an attempted interview with Resident #2 on _____ at 9: 15 AM, the Resident stared and smiled but provided no response to this surveyor's questions. During an interview conducted on _____ at 10: 14 AM with Staff C (Facility's License Practical Nurse), she stated that Resident #2 could become aggressive if someone approached her or attempted to stop her from doing something she wanted to do. She also confirmed that the resident had assaulted Residen #1 causing injury. During an interview conducted on _____ at 11:15 AM with Staff A (Executive Director), she stated that she did not know why Resident #2s health assessment (1823) was not updated due a significant change of condition as required. She further stated that she did not know to discharge the resident after the incident occurred. During an interview conducted on _____ at 11:38 AM with Staff F (Director of Nursing), she stated that to her knowledge the resident was assessed after the incident. She stated that she was not employed at the facility when the incident took place. She also stated that she was told by the facility's Advanced Practice Registered Nurse, APRN (Staff J) that the resident was Backer Acted (BA), and sent to the hospital. She further, she stated that she did not know why the resident did not have a new 1823 updated upon her return from the hospital or after she was reassessed by Staff J, as she was told it was completed. No	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965462	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/13/2026
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF TAMARAC			STREET ADDRESS, CITY, STATE, ZIP CODE 6855 NW 70TH AVENUE TAMARAC, FL 33321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 010	Continued From page 6 updated 1823 for Resident #2 was provided during the survey. During the Exit Conference conducted on at 3:00 PM with the Executive Director and the Director of Memory Care, they were informed of the findings, and they both acknowledged the findings. Class III	A 010			
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 _____. 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	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965462	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/13/2026
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF TAMARAC			STREET ADDRESS, CITY, STATE, ZIP CODE 6855 NW 70TH AVENUE TAMARAC, FL 33321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 025	Continued From page 7 accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 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, interviews and observation, it was determined that, the facility failed to provide adequate supervision and implement appropriate safety measures to ensure the safety of residents; for 1 of 2 sampled residents (Resident # 2). It was determined the facility also failed to provide adequate supervision to all residents residing in the facility after Resident #2 exhibited aggressive violent behaviors	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965462	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/13/2026
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF TAMARAC			STREET ADDRESS, CITY, STATE, ZIP CODE 6855 NW 70TH AVENUE TAMARAC, FL 33321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 025	Continued From page 8 with injuries to others. The findings include: A review of the facility's supervision policies and procedures, dated /20212 and revised on , provided by the facility documented the following: An Assisted Living Facility will list the services the facility is prepared to provide or arrange in order to meet resident needs. Such services may not exceed the scope of the facility's license capability. Personal services means direct physical assistance with or supervision of the activities of the daily living, the self-administration of medication, or other similar services that the agency may define by rule. Care and services offered by the community may include: 1). Daily observation of resident activities while on premises 2). Overall general awareness of resident's health, safety and physical and emotional well-being 3). Overall general awareness of resident's whereabouts 4). Notifying appropriate party, including health care providers and third-party providers, when resident experiences a significant change of condition 5). Maintaining a written record that will be updated as needed with any significant changes, consisting of documentation of acute conditions or illnesses that resulted in medical attention, altering type or method of medication administration, or other changes that resulted in the provision of additional services. A review of the facility's resident's rights policies and procedures, provided by the facility without	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965462	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/13/2026
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF TAMARAC			STREET ADDRESS, CITY, STATE, ZIP CODE 6855 NW 70TH AVENUE TAMARAC, FL 33321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 025	Continued From page 9 an issued or revised date, documented the following: 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. A review of the facility's investigation report dated _____ revealed of following: " Nurse was called to common area where resident (Resident #1) seen _____ from _____ to forehead. Staff responded that she was hurt in the forehead by another resident with a knife. 911 called. Resident transported to [name of Hospital] for evaluation." A review of the facility's staffing schedule revealed that on _____, the date of the incident, there were five direct care staff members working the 6:00 AM to 2:00 PM shift. However, the surveyor was only able to interview three out of the five direct care staff (Staff G, H, and I). A review of Resident #1's health assessment dated and signed on _____ by a licensed health provider, documented that Resident #1 used a rollator for mobility, suffered from _____, and had _____. A review of Resident #2's health assessment dated and signed on _____ by a licensed health provider, documented that Resident #2's diagnosis as _____. Resident #2 also noted as physically unstable and exhibited _____	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965462	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/13/2026
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF TAMARAC			STREET ADDRESS, CITY, STATE, ZIP CODE 6855 NW 70TH AVENUE TAMARAC, FL 33321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 025	Continued From page 10 swings related to her behavioral status. Record review of Resident #1's medical records revealed a documented incident on that the resident sustained an injury on her forehead after being struck by Resident #2 with a butter knife in the common area where residents congregate to socialize. On this surveyor requested from the Executive Director (Staff A), a copy of the hospital discharge documentation related to the incident for review. The documentation was not provided during the survey. On this surveyor requested from the Executive Director with documentation report from the Local Law Enforcement Agency and a report the State Agency charged with investigating the of the elderly. No reports were provided to the surveyor for review. During an interview with the Director of Memory Care, Staff B on at approximately 8:45 AM she stated that Resident #1 is no longer a resident of the facility, and that Resident #2 continues to reside at the facility. In addition, she provided the surveyor with the facility investigation report for review. During an attempted interview on at 9:15 AM with Resident #2, the resident stared and smiled but provided no response to the surveyor's questions. Resident #2 was seen throughout the survey from 9 am to 4pm on and roaming freely throughout the facility with no additional supervision to ensure resident didn't possess any dangerous items to cause harm to self or others.	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965462	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/13/2026
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF TAMARAC			STREET ADDRESS, CITY, STATE, ZIP CODE 6855 NW 70TH AVENUE TAMARAC, FL 33321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 025	Continued From page 11 During an interview conducted on _____ at 10:14 AM with the facility's License Practical Nurse, (Staff C), she stated that Resident #2 could become aggressive if someone approached her or attempted to stop her from doing something she wanted to do. During an interview conducted on _____ at 2:59 PM with Staff D, (Medication Technician), she stated that her _____ was turned at the time of the incident involving Resident #1 and #2). She stated that she heard a loud scream and when she turned around, she saw _____ on Resident #1's forehead. Staff D stated that she attempted to remove the butter knife from Resident 2's _____, but the resident was combative during her attempt to intervene. During an interview conducted on _____ at 3:20 PM with Staff E (Life Enrichment Coordinator), she stated that she did not see what had occurred because she was redirecting residents to the common area after breakfast. She stated she heard Resident #2 yelling for help. When she went to assist, she observed _____ on Resident #1's forehead. During an interview conducted on _____ at 3:30 PM with the Executive Director, she stated that she was aware of the aggression but was not the Executive Director at the time of the incident and could not provide any firsthand information During an interview conducted on _____ at 4:10 PM with Resident #1's representative, she stated that during her own investigation with Resident #1, Resident #1 reported that she was sitting in the common area when another resident approached her and struck her on the forehead with a knife. The representative stated that she	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965462	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/13/2026
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF TAMARAC			STREET ADDRESS, CITY, STATE, ZIP CODE 6855 NW 70TH AVENUE TAMARAC, FL 33321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 025	Continued From page 12 did not know whether the object was a butter knife or a steak knife but confirmed that it was a knife. She further stated that she decided to remove Resident #1 from the facility because Resident #2 was still residing there and she felt that Resident #1 remained in danger. During a tour of the facility on _____ at 9:00 AM, this surveyor observed residents, including Resident #2, having breakfast in the dining room. This surveyor also observed Resident #2 refuse to give her plate to staff after breakfast had concluded, stating she had not finished eating. Observation of Resident 2's plate revealed that there was still food remaining on the plate (Photo obtained). On _____ at 9:45 AM, this surveyor observed activity staff redirecting residents to the common area after they finished eating breakfast. However, this surveyor did not observe staff verifying whether residents had taken any objects out of the dining room. Resident #2 was later observed at 9:50 AM in a location named 100 Sitting Area with three other residents and one staff member. It was not known to the surveyor if Resident #2 possessed a utensil she could have taken during the breakfast meal. During an interview conducted on _____ at 2: 28 PM with Staff B (Director of the Memory Care), she stated that this incident had never happened before. She stated that she has been employed for 20 years and it was the first time a resident used a table knife against another resident. She further stated that the facility no longer provides table knives to any residents. During the Exit Conference with the Executive	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965462	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/13/2026
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF TAMARAC		STREET ADDRESS, CITY, STATE, ZIP CODE 6855 NW 70TH AVENUE TAMARAC, FL 33321			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 025	Continued From page 13 Director and Memory Care Director on at 3:00 PM, they were informed of the findings of the survey, which they acknowledged. Class III	A 025			