

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11963919</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARBORCHASE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2960 TAMPA ROAD<br/>PALM HARBOR, FL 34684</b>                                |                          |                               |
| (X4) ID<br>PREFIX<br>TAG                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                               |
| A 000                                                  | Initial Comments<br><br>Assisted Living Facility<br><br>A biennial state licensure survey with extended<br>congregate care (ECC) was conducted on<br>.....<br><br>The Harborchase, assisted living facility, had a<br>deficiency found at the time of the visit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | A 000                                                                          |                                                                                                                          |                          |                               |
| A 083                                                  | 58A-5.0191(4) FAC Training - First Aid and<br><br>(4) FIRST AID AND<br>..... A staff member who<br>has completed courses in First Aid and ..... and<br>holds a currently valid card documenting<br>completion of such courses must be in the facility<br>at all times.<br>(a) Documentation of attendance at First Aid or<br>..... course offered by an accredited college,<br>university or vocational school; a licensed<br>hospital; the American Red Cross, American<br>..... Association, or National Safety Council; or<br>a provider approved by the Department of Health,<br>shall satisfy this requirement.<br>(b) A nurse shall be considered as having met the<br>training requirement for First Aid. An emergency<br>medical technician or paramedic currently<br>certified under Part III of Chapter 401, F.S., shall<br>be considered as having met the training<br>requirements for both First Aid and .....<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, five of five<br>staff sampled (A-E) did not hold<br>current certification in First Aid and/or .....<br><br>Findings include: | A 083                                                                          |                                                                                                                          |                          |                               |

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

8890

E8X011

If continuation sheet 1 of 2

Agency for Health Care Administration

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>HARBORCHASE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2960 TAMPA ROAD<br/>PALM HARBOR, FL 34684</b>                                |  |                               |
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| A 083                                                  | <p>Continued From page 1</p> <p>A review of personnel files during the survey revealed that the First Aid certificates for Staff A and B, hired _____ and _____ respectively, had expired _____ and _____ respectively. In addition, Staff A had no _____ documentation, while the _____ had expired _____ and _____ respectively, for Staff B and C (hired _____). Finally, neither Staff D nor E, hired _____ and _____ respectively, had any documentation verifying the completion of First Aid and _____ Interview with facility staff/administration confirmed that these documents were missing from the records.</p> <p>Class III</p> | A 083                                                                          |                                                                                                                          |  |                               |



RICK SCOTT  
GOVERNOR

*Better Health Care for all Floridians*

ELIZABETH DUDEK  
SECRETARY

2013

Administrator  
Harborchase  
2960 Tampa Road  
Palm Harbor, FL 34684

Dear Administrator:

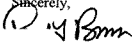
Re: **CCR# 2013004608** & Abbreviated biennial

This letter reports the findings of a complaint survey and an abbreviated biennial state licensure survey that was conducted on , 2013, by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that was identified on the day of the visit relative to the abbreviated biennial state licensure survey. Section 408.811(4), Florida Statutes, requires that you correct this deficiency within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiency identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,  
  
for Patricia Reid Cauffman  
Field Office Manager

PRC/kpr

Enclosures: State Forms 3020

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<http://ahca.myflorida.com>



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