STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965157	12/12/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Harborchase Of Coral Springs	2975 Nw 99th Ave Coral Springs, FL 33065	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D

Specific Tag Findings:

0000-Initial Comments
Unannounced complaint inspection survey (CCR #2013009209 and CCR #2013010349) were conducted on and at Harbor Chase at Coral Springs Assisted Living Facility. The facility had deficiencies found at the time of the visit.

Deficient practice identified at:

CCR #2013010349 at A0030

CCR # 2013009209 at A0010

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on interview and record review, the facility failed to provide supervision appropriate to meet the needs of 1 out of 3 sampled residents (Resident #1), which resulted in the resident found wandering outside from the facility.

The findings include:

Resident #1 was admitted to the facility on with medical diagnosis including and history of
The admission health assessment form 1823 dated reveals the resident uses a rolling walker for ambulation. Her behavior was documented as fair, requiring assistance with bathing, dressing and self- care. Further review of the health assessment revealed she required supervision with phone calls and assistance with personal and financial affairs.

Review of facility "Elopement Risk Assessment" form dated reveals a score of 15. The form documents 12 or more requires interventions. Areas assessed included: mobility as ambulatory, stability as requires assist with finding own history of elopement attempts as new resident disoriented to new surroundings, and diagnosis including and Review of the facility" Elopement Risk Assessment policy" dated provided by the Patient Care Manager states that each

resident will be assessed on admission, readmission and on quarterly basis for elopement/wandering potential. The policy documents each resident will be assessed in the seven identified clinical areas noted on the form. A resident shall be considered at risk for elopement if the score is 12 or more on the assessment form. The policy states that elopement risk prevention guidelines include for a score of 12-15, a special door alarm be installed on the apartment door and when a resident is another area of the community will be monitored by staff observation.

Review of the admission physician note dated revealed the following: The resident was oriented to self only, forgetful and . The resident had a history of and and The resident is prescribed ointment to prevent due to incontinence. The resident is also placed on precautions.

Review of the physician note dated after the resident wandered from the facility, reveals the plan for a Urinalysis (UA) and Culture and Sensitivity to rule out . The resident is noted to be but forgetful on exam. Results of UA dated reveal Gram Negative Bacilli, Organisms .

Review of the Nurses Notes from admission reveals the resident as alert and oriented to name with . The resident was documented on as refusing to eat or drink and refusing to take her medications. The physician is notified of her refusal. The note documents staff required giving much encouragement and coaxing to get the resident to eat and drink fluids and take her medications. On the Nurse Note documents the resident is reported by a visitor, to be naked standing in the hallway. The resident is assisted back to her the Care Manager and Aide. The note documents the resident to be re-evaluate as to appropriate placement. "

Review of the Nurses Notes on reveals at dinner time, 5:30 PM. The care manager cannot locate the resident. The note documents the staff searched the common areas of the facility, also the outside building perimeter. The Executive Director is notified. The Patient Care Director drives thru the neighborhood and observes the resident in an adjacent parking lot with her walker. The resident is returned to the facility and is described as having increased and the resident was asking for "her mother and father." The resident is assessed and physician and family notified. New orders were written for UA and C&S as well as psych consult was ordered; no injuries are noted. The family arranges for 1:1 observation and monitoring of the resident. On the resident refuses her medications even after several attempts by the nursing staff. On the resident is transferred to a Memory Care facility by her daughter.

On at 9 AM, an interview was conducted with the Front Desk Concierge. She provided for

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review the" sign- in and out log" at front desk which revealed two sections, one for family/ visitors to sign in and out and the another section for resident to sign out when the resident goes out of the building. She stated that she works the day shift and recalls the resident would ambulate with a walker. She stated the resident was and was not allowed to go walk outside unsupervised. She stated that she would allow the resident to go sit outside on the front bench, near the door. She stated that she could see the resident from her desk. She stated that if she observed the resident getting up, she would go out and redirect the resident back inside. She stated that the resident should not be allowed to go outside by herself unsupervised. Record review of the log revealed no "sign in and out log sheets" from 2013 available for review by the surveyor. Further review of the current log reveals completed sign in and out sheets for family/visitors and for residents out on leave for all other months.

An interview was conducted with 3-11 PM shift LPN on at 3:45 PM. She stated that "she monitored the resident very closely due to her and the resident was ". She stated that resident had history of refusing her medications and could be resistive to care. She stated that the resident was ambulatory with use of a walker and would walk around the entire facility. She stated that she would attempt to keep the resident near the Nurses Station on the " Main Street" to better monitor the resident. She stated that the resident was not able to go outside without supervision. She stated that she recalled an incident when the resident was observed totally naked in the hallway and had to be redirected back to her staff.

On at approximately 2:30 PM during an interview with the resident ' s daughter, she stated that her mother was admitted to the facility due to the decline in mental status and memory. She stated that her mother was never able to go outside alone due to the . She stated that she had been at the facility earlier in the day on the day of the incident to visit with her mother. She stated that the facility telephoned her around dinner time on the to inquire if the resident was with her. When she stated that the resident was not with her, the facility informed her "they cannot find the resident "and "they did not know when the resident had left the facility." She stated that she would have signed the resident out on the "sign out" log if she had taken the resident out of the facility.

Review of the Police Department Incident reported dated reveals the police were alerted at 5:20 PM by an employee at 9750 NW 33rd Street, Coral Springs (½ mile from facility) that an elderly woman was found in the parking lot. When the officer arrived, he found the resident in good health and spirits per the report. The officer noted the residents name on the walker. The Patient Care Director drove up in her car and informed the officer that the resident had a habit of leaving the facility and going on long walks. She informed the officer that the staff thought the resident was with her daughter. The report documents the officer followed the Patient Care Director and resident back to the facility. He contacted the resident ' s daughter who informed the officer that she tells the facility when she takes

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the resident out. She also informed him that the resident has a habit of leaving the facility and taking long walks.

On ... at approximately 2:00 PM during an interview with the Patient Care Director, she stated that the resident had a history of ... and ... She stated the resident was independent for ambulation and eating but required assistance with bathing, dressing and self- care. She confirmed that the resident required daily observation for her wellbeing and whereabouts. She stated that the resident had no history of elopement and that the resident was easily redirected when she would wander thru the facility. She stated that the resident would walk outside with her daughter. When questioned by the surveyor about the admission elopement risk assessment for the resident, the Director stated that the resident had an identification bracelet on and staff would regularly conduct 2 hour checks. She stated that the facility was not a Memory Care unit and the residents had the right to come and go at will. She recalled that on ... she was still in the building at 5:15 PM when staff alerted her that the resident was unaccounted for. She stated that the facility protocol was to canvas the entire building searching for the resident. She stated that when the resident was not located, she immediately phoned the resident ' s daughter to inquire if the resident was with her. She stated that the daughter stated that she had not seen the resident since the afternoon. The Director stated that she drove around the facility property searching for the resident. She stated she found the resident walking in the adjacent medical center parking lot. A police officer was speaking with the resident. The Director stated that she directed the resident into the car and brought her back to the facility; the resident appeared to have no injury. The physician and family were notified that the resident had been located. She stated that the facility completed the required reports to AHCA about the elopement incident.

On ... at approximately 11:30 AM, during an interview with the Executive Director, he stated that he was familiar with the resident and the incident. He stated that the resident was not an elopement risk and did not elope but was unaccounted for resident. He stated that because the facility was not designated as a secure Memory Care Community, the resident incident was "unaccounted for" not an elopement. He stated that the residents have the right to come and go at will. He provided a written policy titled "Missing Persons" stating that it was the current policy.

Review of the facility ' s policy entitled " Missing Person " reveals the missing resident definition: an Assisted Living resident has the right to come and go at will and when there is cause for concern regarding the whereabouts of a resident he or she is considered to be "unaccounted for." This is not elopement. He stated that the facility no longer assesses the resident on admission using the Elopement tool. When questioned by the surveyor, if the results of the assessment tool conducted for the resident were inaccurate, he stated that the tool was no longer utilized. He stated that the facility had not implemented any specific interventions for the resident, other than staff monitoring because the resident

had made no previous attempts to wander from the facility. He stated that the resident was allowed to take walks outside but had been accompanied by her family. He acknowledged that the resident had exhibited behaviors for which the staff was monitoring her. He stated that he discussed the discharge with the family and had recommended a Memory Care Facility after the incident when the resident was "unaccounted for."

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS

Based on interviews and record reviews, it was determined that the facility failed to ensure that residents are treated with consideration, respect and with due recognition of personal dignity and to ensure grievances presented by residents are addressed in a timely manner . As evidence of the facility's failure to address the behavior of Resident#1 in a timely manner.

The findings include:

Resident #2 was admitted on after sustaining a head injury after a at home. Further medical diagnosis included Recurrent with surgical history for Head Injury and unsteady Gait. The Resident Assessment form (AHCA form 1823) on admission documents the resident needed minimal to with his ADL care. He was documented as alert and oriented and able to make his needs known to staff. He required daily oversight for wellbeing and whereabouts, also required reminders for important tasks. The resident is documented on the facility "Resident Assessment" dated as having occasional and some difficulty recalling details. He had no history of wandering but had episodes of refusal with care and expressed feelings of . The resident was able to ambulate independently but with unsteady gait.

Review of the Nurses Notes dated reveals the resident exhibiting inappropriate behavior and gestures, also verbalizing obscenities which resulted in the other residents becoming offended. The family and physician are informed of the behaviors. Review of Physician ordered dated reveals a request for a consult to evaluate the resident. Review of the Nurses Notes on documents the resident was hit in the face twice by another resident. He has no apparent injury but is unable to describe circumstances. The physician and family are again notified.

Review of the Nurses note on reveals the resident was observed throwing objects at other

residents in the dining . . . . The resident was redirected by the staff and seen by his private psychiatrist.

Review of the Nurses Note on reveals the resident "grabbed a staff member ' s bottom." The resident was once again redirected by staff and the family and physician were notified. There was no internal documentation of the incident/event or investigation for this incident located within the file.

Review of Physician Orders dated , reveals request for in-house psych consult at the request of the family. An initial evaluation described the resident as "wanted to leave facility and has not made very many friends." The past history reveals the resident has made inappropriate behavior, has poor impulse control, shown physical aggression with male peers and verbalizes obscenities. The evaluation documents the resident has . . . with agitation but no . . . . . thoughts. The evaluation reveals the resident as alert and oriented, to person and place and has poor judgment and . The resident is documented to be prescribed . 10 mg in the AM and . . . . . patch 9.5 mg every day. The impression documents the resident has difficulty adjusting to the ALF and communal living. He has poor impulse control, intrusive behavior and . preoccupation. The resident was prescribed . 125 mg 2 x a day with a goal to improve mood and maintain calm behavior.

Review of the monthly visit evaluation for , reveals the resident as having a positive response to the . Review of the Nurses notes dated . . . reveals the resident was observed with a change in behavior, with inappropriate touching of staff. The psych ARNP was notified and the . dose was increased to 125 mg 3 x a day for poor impulse control. The resident was seen by the psych ARNP on . . and the evaluation documents the resident is awakened frequently to go to the . . . . . night. He expresses that "he does not talk to all the sick people in the ALF."

On . the resident expresses his desire to die, he refuses to eat breakfast or lunch. The family and psychiatrist are notified. The resident is transferred to the hospital for evaluation per psych orders. The resident returns to the facility . . . and assessed to be oriented to person and place with . . . . . The resident is documented as being calm with no behaviors noted. He continues to ambulate throughout the facility independently.

Review of the note written by the Administrator on . . . reveals the resident had an inappropriate gesture to another resident. The resident is interviewed and he denies incident. The Administrator notifies the family to discuss the current behavior and treatment plan with possible 45 day notice to be given due to the behavioral changes in the resident. The Administrator recommends the resident be

transferred to a sister community with an unit.

The resident is seen by the psych ARNP on and the note reveals the resident does not recall his recent hospitalization and comments that his memory is not great. The medications are adjusted, is decreased to 2 x day, the is discontinued and 25 mg at bedtime and 5 mg at PM are added. The resident is documented as stable mood and calm behavior.

Review of the nurse note dated reveals the resident's family is planning to transfer him to another facility. On the resident is involved in unwitnessed physical contact with another resident. Review of the Nurses Note reveals the resident was touching arts and craft items completed by other residents, removing lettering which caused distress for Resident #1. She told him to leave it alone and grab the item out of his hand, and she punched him in the chest. The resident was not injured and walked away. The family and physician were notified of incident. The family contracted with a private aide to sit with the resident after the incident. The resident is discharged from the facility on by his family to a memory care unit.

On at approximately 9:00 AM during an interview with Resident #1, she stated she had complained to the administration about Resident #2's behavior numerous times. She stated that she was so distraught about his and inappropriate gestures that she felt sick. She stated that she had witnessed Resident #2 making obscene gestures to other female residents and stating "He wanted to milk their ." She stated that Resident #2 had touched 2 staff members on the and she reported him to the Patient Care Director and the Executive Administrator. She stated she witnessed Resident #2 put both hands on the evening Activity aide's bottom. She stated that Resident #2 would become defensive when other residents would attempt to correct him about his inappropriate behavior and he would give them the "Heil Hitler" sign with his hand. She stated that Resident #2 was Jewish and she could not understand his choice of gesturing to his fellow residents. She stated that she had several verbal altercations with Resident #2 about his behaviors. The final altercation was when she observed Resident #2 in the activity her crafts. She stated that he was tearing the craft apart, which angered her. She stated that she approached him and yelled at him to stop. She stated that he continued and she grabbed the craft piece and punched him in the chest. She stated that she felt badly about her actions but that was the last straw with Resident #2. She stated that she was very distressed because she felt the Administration had done nothing to protect the residents and staff from Resident #2's inappropriate gestures and behaviors for months.

On at approximately 11:30 AM during an interview with Resident # 6, an alert and oriented resident, she stated that she was aware of Resident #2's inappropriate behaviors. She stated that she was disgusted and had notified the Administrator of the actions.

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On ... at approximately 1:15 PM during an interview with Resident #4, an alert and oriented resident, she stated that she had witnessed a fight between Resident #2 and another male resident. She stated that he had made an inappropriate gesture towards the resident. She stated that she had not seen any ... gestures.

On ... at approximately 10:30 AM during an interview with Resident #5, she stated she recalled Resident #2 and his inappropriate manners towards other residents. She stated "he did not belong at this facility." She stated he had not made any ... gestures toward her but she had screamed at him when he approached other residents.

On ... at approximately 1:00 PM during an interview with the Life Enrichment Director she stated she knew Resident #2 very well. She stated the residents did not like him due to his inappropriate verbal obscenities and gestures. She stated the residents would report to her about his verbal ... harassment regarding their ... She stated Resident #2 had slapped the evening activity aide and another volunteer aide, name unknown, on the ... She stated she had reported both behaviors at the daily administrative morning meeting. She stated Resident #2 had tickled a visitor and wanted to the visitor. She was unable to describe any interventions that were implemented to prevent further inappropriate behavior. She stated the residents were very uncomfortable around Resident #2 and had been happy to see him transferred.

On ... at approximately 1:30 PM during an interview with the afternoon Activity Aide, she stated Resident #2 had "swatted her on the bottom" on numerous occasions. She stated the activity volunteer had warned her about Resident #2's actions. She stated Resident #2 had patted the volunteer aide ' s bottom when she was carrying a full tray of hot coffee and the aide had screamed at Resident #2 for his dangerous inappropriate actions. She stated when Resident #2 hit her on the bottom on ... she confronted him immediately. She stated he told her "What's the big deal?" and he was told to apologize by the residents and a fellow staff manager who had observed the incident. She stated she did not feel he was a threat and he was harmless. She stated she was aware he would make obscene statements to other female residents and she had informed her manager. When questioned if the Executive Director had spoken to her about the ... incident, she stated he had not and felt it was strange he did not want to hear her side of the story.

On ... at approximately 2:00 PM during an interview with the Maintenance Director, he stated he had witnessed Resident #2 grabbing the Activity Aide on her bottom on ... He stated he immediately told Resident #2 that his behavior was not appropriate and asked him to apologize for his action. He stated Resident #2 told him "He did not do anything." He stated Resident #2 did not talk

much and kept to himself; the other residents did not like him because he offended them with his gestures and verbal comments and Hitler sign. He stated he had informed the Administrator on the morning after the incident. He stated he was unaware of any interventions to prevent further incidents except that a 45 day notice had been discussed with the resident ' s family and Resident #2 was transferred to another facility by his family.

On at approximately 9:30 AM, during an interview with the Director of Sales, she stated she was aware of numerous concerns about Resident #2's behaviors. She stated he got along with most residents but had problems with a few residents. She stated she never saw any behaviors or concerns. She stated she had heard from some residents that Resident #2 would offend them when he would use the Hitler hand sign if they disagreed with him. She stated his behaviors lead to his discharge by his family.

On at approximately 11:00 AM during interview with the Patient Care Manager, she stated she never witnessed any behaviors by Resident #2. She stated she only had heard about the and inappropriate behaviors from staff and other residents. She stated the resident was being seen by the ARNP monthly and that his medications had been adjusted after each incident. She stated she felt Resident #2 was harmless to the other residents and his behaviors were a result of his

On at approximately 12:00 PM during an interview with Executive Director, he confirmed Resident #2 had several incidents with inappropriate behaviors and gestures toward residents and staff. He stated that the facility had notified the resident ' s family and physician after each incident. He stated he felt the other residents would pick on Resident #2 and they did not like him. He stated when he would question Resident #2 about his inappropriate verbal behavior or gestures, the resident could not recall his actions or he would state "it was not a big deal". He confirmed Resident #2 had inappropriately touched two staff members on their He stated an investigation was conducted for both but could not provide any documentation about the incident. He stated the facility would notify the family and physician but could not describe any other interventions to prevent further incidents from occurring. He stated that he had spoken directly with the staff member involved with the incident and stated she told him she understood Resident #2's actions were a result of his He stated he did not realize the resident ' s behavior could be harassment. He stated he had spoken directly with the resident ' s family about a transfer after an incident on after the resident had again made inappropriate gestures to another resident. When questioned if he was aware of the verbal obscenities toward female residents, he stated he was not aware of these behaviors.

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Review of the medical record including the facility incident reports with the Executive Director and Patient Care Manager revealed that Resident #2 had recurrent episodes of inappropriate behavior toward other residents and staff which had continued for months. They acknowledged other residents may have been uncomfortable with Resident #2's actions but they stated they had notified the family and physician. The facility was unable to provide evidence or documentation of other interventions to protect or shelter the other residents from his behaviors could be provided for review.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Harborchase Of Coral Springs
2975 NW 99th Ave
Coral Springs, FL 33065

RE: CCR #2013009209 & CCR #2013010349

Dear Administrator:

This letter reports the findings of complaint surveys that were conducted on , 2013 and _ . . . . . 12, 2013 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within **thirty (30) days** of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after , **2014** to verify that the necessary corrections are in place to correct the deficiencies 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

I Wedges - Phoenix, Supervisor

for Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone (561) 381-5840; Fax (561) 496-5924