RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Harborchase Of Villages Crossing
13517 NE 86th Court
Lady Lake, FL 32159

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 2015 by a representative of this office.

Enclosed 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 days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after , **2015** 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 surveyor. Should you have any questions please call this office at (386) 462-6201.

Sincerely,

for

Kristie J. Mennella
Field Office Manager

KJM/amw
Enclosure

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968586	03/25/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
HARBORCHASE OF VILLAGES CROSSING	13517 NE 86TH CT LADY LAKE, FL 32159	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannouced Extended Congregate Care monitoring visit was conducted at Harborchase of Villages Crossing on . Deficient practice was identified at the time of the survey.

0052 - Medication - Assistance with Self-Admin - 58A-5.0185(3) FAC

Based on observation, interview and record review, the facility failed to properly assist 1 of 1 resident observed with the self administration of medication by not following the physician ' s order (Resident #1)

The findings include:
On at 12:07 a.m. Staff A was observed assisting Resident #1 with the self-administration of medication. Staff A dispensed one 2 mg capsule of a capsule into a small cup and handed the cup to Resident #1. Staff A observed the resident take the medication. She then documented the MOR and returned the medication container to the medication cart.
A review of Resident #1 ' s medication label revealed each capsule was 2 mg. further review of the label revealed the instruction were to, " take 2 capsules 3 times a day before meals (photographic evidence obtained).
A review Resident #1 ' s medication observation record (MOR) revealed the instruction for taking was documented as, " Take 2 caps (4 mg) by mouth before breakfast 2 caps before lunch and 2 caps after dinner. "
A review of the physician ' s order for Resident #1 the instruction were to take two 2 mg capsules before breakfast, two 2 mg capsules before breakfast and two 2 mg capsules after dinner.
On at approximately 12:35 p.m. Resident #1 ' s MOR and the physician ' s order for were reviewed with the Director of Resident Care and Services. She confirmed Staff A should have dispensed two pills (for a total of 4 mg) to Resident #1.
On at 12:37 p.m. Staff A was interviewed. Staff A confirmed she did not dispense the correct number of pills to Resident #1.
Class III

E204 - ECC - Admissions & Continued Residency - 429.26(10) FS; 58A-5.030(5) FAC

Based on record review and interview, the facility failed to have an interdisciplinary care plan which specified the service being offered by hospice and the services provided by the facility for 1 of 1 hospice residents reviewed (Resident #1).
The finding include:
A review of Resident #1 ' s record revealed she was admitted to hospice on . Further review revealed a care plan developed by hospice, which specified only the services that will be provided by hospice. The plan states a hospice nurse would visit Resident #1 one to two times per week and a hospice aide would visit Resident #1 2-3 times per week.
at approximately 1:00 p.m. The Resident Care and Services Director stated she will contact hospice to develop a new interdisciplinary plan of care.

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	AL11968586	**03/25/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
HARBORCHASE OF VILLAGES CROSSING	**13517 NE 86TH CT LADY LAKE, FL 32159**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

E204 Continued From page 1

Class III

E206 - ECC - Service Plans - 58A-5.030(7) FAC

Based on observation an interview, the facility failed to review and update an Extended Congregate Care (ECC) service plan on a quarterly basis for 1 of 2 residents reviewed (Resident #1).
The findings include:
A review of Resident #1 ' s record revealed she was admitted to ECC program on to receive as needed. Her preliminary service plan was completed on Further review of the record revealed there was no documentation the service plan had been reviewed or updated since the preliminary service plan was completed.
On at 12:25 p.m. an interview was conducted with the Director of Resident Care and Services/ECC supervisor. She stated she is past due on the quarterly update for Resident #1.
Class III