STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965356	06/12/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
HARBORCHASE OF TALLAHASSEE	100 JOHN KNOX ROAD TALLAHASSEE, FL 32303	

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

0000 - Initial Comments

An unannounced complaint survey (CCR#2015002786, CCR#2015005126 and CCR#2015003903) in conjunction with the Biennial survey was conducted at Harborchase Assisted Living Facility. At the time of survey there were deficiencies identified found.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review and staff interview, the facility failed to maintain a written record of any illnesses that resulted in medical attention for 1 of 19 sampled residents, #12.

The findings.

Review of physician order fax sheets revealed that resident #12 [redacted] twice on [redacted]. There was no time on either form. After the second [redacted], the resident complained of [redacted] hip and back pain and was taken to the emergency [redacted].

The hospital records were reviewed. Resident #12 was admitted to the hospital on [redacted]. The hospital documented that resident #12 had a hematoma to her forehead [redacted] with [redacted], and [redacted] to the left shoulder, left knee and back. Resident #12 was complaining of pain to her head, hip and [redacted] area. Resident #12 was discharged back to the facility on [redacted].

The 'Resident Progress Notes' were reviewed. There were only 2 entries in 2015. There were no progress notes regarding the [redacted] of [redacted] nor of the subsequent hospitalization.

An interview was conducted with the Director of Resident Care (DRC) on [redacted] at approximately 2:00pm. The DRC confirmed that nurses should be documenting accidents such as [redacted] in the nurse's notes.

The policy for documentation was requested and reviewed. The provided policy was entitled: Standard R1.09: Change in Resident's Condition, undated. The policy stated, "Any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services will be documented in the resident record."

Class III

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

Based on resident interviews, record review of the Residency Agreement and review of the Status Solutions Report (call system response time), the facility failed to ensure the rights of 3 of 19 residents in regard to staff answering the call system (pendants) in a timely manner (#4 and #6, #11).

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The findings:

On at approximately 2:01pm an interview was conducted with resident #4 who reported that staff does not respond right away with the call buzzers. Resident #4 stated that sometimes staff will respond right away and then not at all. Resident #4 stated overall, the biggest problem at the facility staff does not respond to the buzzers in a timely manner.

On at approximately 2:39pm an interview was conducted with resident #6 who reported that staff does respond in a timely manner with call buzzer.

A record review was conducted of the Residency Agreement, Article 1. Staff Response Time which indicated, to the resident and responsible party understand that a non-emergency request, for example a request to be assisted with changing into your nightgown, assisted with a shower or bath, assisted to the etc., may take 15 minutes or more to be responded to.

A record review was conducted of resident #4 status solutions report and on at 12:55pm elapsed time for responding by staff was 30 minutes and 3 seconds. On at 12:25pm elapsed time 30 minutes and 4 seconds. On at 11:55am elapsed response time 30 minutes and 1 second. On at 11:25am elapsed response time 30 minutes 3 seconds. On at 9:34am elapsed time response 24 minutes and 30 seconds. On at 9:04am elapsed response time 30 minutes and 5 seconds. On at 1:19pm elapsed response time 30 minutes 5 seconds. On at 9:19am elapsed response time 30 minutes and seconds. On at 4:02pm elapsed response time 20 minutes and 47 seconds.

A record review was conducted of Resident #11 Status Solutions report on ; resident was near when the pendant was pressed at 3:52:27pm alarm cleared at 4:19pm (27 minutes and 3 seconds). On On it took 21 minutes and 27 seconds before staff responded to the alarm. On it took 30 minutes and 4 seconds to respond to the pendant.

On at approximately 11:00am an interview was conducted with the Maintenance Director who verified the findings for the above status solution reports.

On at approximately 2:00pm an interview was conducted with the Administrator who verified the above findings and stated that staff should respond to the call lights in 15 minutes to ensure safety.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and staff interview, the facility failed to ensure the risk management and quality assurance program assessed resident care practices. The facility failed to investigate a medication transcription error, failed to

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SUMMARY STATEMENT OF DEFICIENCIES
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complete an incident report and failed to evaluate their process for ensuring medication accuracy for 1 of 19 sampled residents, #12.

The findings:

A record review of medication orders was conducted for resident #12. There was a hospital discharge form dated with medication orders which stated to continue a list of 9 medications. There was no resident name on the form from the hospital. The form was faxed to the facilities contracted pharmacy. At the top of the form was the question, "Who is the patient?" and a response which stated that per nurse Z, the patient was resident #12. The only other resident identifying information on the form was an identification number provided by the discharging hospital.

On at approximately 11:30am, an interview was conducted with the Risk Manager at the discharging hospital. The Risk Manager was given the patient identification number on the medication order sheet and was able to identify the resident as a different resident (#20), who also resided at the facility. A subsequent review of hospital records confirmed that these discharge orders were for resident #20 and had been incorrectly labeled with resident #12's name.

On at approximately 12:17pm, an interview was conducted with the pharmacy, staff Y, about the error. Staff Y confirmed that the pharmacy received an order for medications on without any resident identifying information. The pharmacy called the facility and spoke with nurse Z who verbally told them that the resident was #12.

An interview was conducted with nurse Z on at approximately 4:25pm. Nurse Z was shown the discharge medication list and confirmed it was the medication list that she had identified to the pharmacy as belonging to resident #12. Nurse Z did not feel she made an error in identifying resident #12 as the recipient of the orders, but did stated that the resident's daughter said that these were not her medications. Nurse Z stated the medication process is that the nurses fax the order to the pharmacy and write it on the MOR (medication observation record). As for a double check system to ensure accuracy, each nurse checks her own order before sending. If she gets tied up will ask someone else to double check.

A review of the Medication Observation records revealed that the medications ordered on the above hospital discharge form were transcribed to the MOR, and were administered for the first 8-9 days in , 2015.

A further record review revealed evidence that the facility discovered the medication error and corrected it. On a Physician Visit Form was completed for resident #12. The purpose of the visit was listed as "to reconcile medication list". Under current findings, the form stated, "patient has been administered medications not prescribed to her." The document discontinued 7 of the medications.

An interview was conducted with the Executive Director on at approximately 3:00pm. She confirmed that an

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incident report was not completed for the medication error, nor had she been informed of the error. The Executive Director stated that the medication orders were not implemented until , and were only in effect for 9 days before they were corrected. There were no adverse incidents associated with this error. The director stated that an incident report would be initiated today.

Interviews were conducted with additional nursing staff regarding their process to ensure medication order accuracy. On at approximately 2:23pm, Nurse X stated "You go back and double check it yourself or ask the drc (Director of Residential Care)". On at approximately 12:20pm, Nurse V stated that the nurse who took the order will check to see if the medication comes in and is on the MOR.

On at approximately 1:00pm, and interview was conducted with the DRC. The DRC stated that the current medication process for receipt and transcription of orders will be reviewed.

The facility policy on the completion of incident reports was requested and reviewed. The facility provided a policy entitled: Standard R1.01: Incident / Exception report and Quality Indicator report, undated. It is the policy of the company to have an incident reporting system that applies to incidents, events unusual occurrences and situation involving injury and the potential for injury. For purposes of this policy and procedure, an incident is defined as any situation event, accident or occurrence that is outside the course of normal operations.

The following incidents arise to the level of "significant events" and, in addition to the immediate verbal reporting as stated above, a copy of the incident report must be promptly faxed to the Legal Services "medication error with injury or potential adverse effect."

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2015

Administrator
Harborchase Of Tallahassee
100 John Knox Road
Tallahassee, FL 32303

RE: CCR #2015002786, 2015005126, 2015003903

Dear Administrator:

This letter reports the findings of a state licensure biennial survey, a complaint survey and an Extended Congregate Care monitoring survey that was conducted on 2015 - 2015 by representatives 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 days of the date of this letter unless the Agency has approved another timeframe. **Please forward documentation of correction to the Field Office.** Staff from this office will conduct a review after 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 surveyors. Should you have any questions please call me at (850) 412-4540.

Sincerely,

for Donah Heiberg, M.S.W.
Field Office Manager

DH/kb
Enclosure
XG90

Tallahassee Field Office
2727 Mahan Drive, Mail Stop #46
Tallahassee, FL 32308
Phone:850-412-4540; Fax:(850) 922-9162
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida