STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965462	10/20/2016
NAME OF PROVIDER OR SUPPLIER **HARBORCHASE OF TAMARAC**	STREET ADDRESS, CITY, STATE, ZIP CODE **6855 NW 70TH AVENUE** **TAMARAC, FL 33321**	

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

0000 Initial Comments

An unannounced licensure complaint survey, CCR# 2016011145 , was conducted on 10/19/2016 through 10/21/2016 at Harbor Chase of Tamarac. The facility had a deficiency identified at the time of the investigation.

This licensure complaint was conducted in conjunction with the Relicensure survey on the same date. Please see separate report for findings.

0025 Resident Care - Supervision

Based on record reviews and interviews, the assisted living facility's (ALF) failed to provide care and services as appropriate and to provide implementation of interventions to meet a resident ' s needs (Resident # 6) during a significant decline in condition requiring immediate intervention, for 1 of 3 residents' records reviewed. Specifically, Resident #6 experienced a ultimately resulting in a hematoma above the left eye and the facility's staff failure to transfer a resident upon injury to the hosptial.

The findings included:

On through , 2016 a record review revealed Resident # 6 was admitted to Harbor Chase of Tamarac, a memory care facility, on and discharged from the facility on / . Resident # 6's AHCA Form 1823 Health Assessment dated / states Resident # 6 has the following diagnoses: and . Resident # 6's AHCA 1823 assessment also indicates that Resident # 6 is independent with ambulation, transferring, dressing, and required daily general oversight for whereabouts, well being, and reminders for general tasks. Resident # 6's AHCA health assessment indicates "memory ". Further record review revealed on Resident # 6 was seen by her physician and was diagnosed with severe pain to her back, unsteady gait, poor balance, an (copies obtained).

On a record review of the facility's incident reports revealed that on at 9:30 AM Resident # 6 had an unwitnessed and was found face down on the by a certified nurse assistant (care manager). Resident # 6 was assessed by Staff E, a licensed practical nurse (LPN). Staff E called 911 immediately, notified Resident # 6's power of attorney (POA) and physician and sent Resident # 6 to the hospital. Staff E completed an incident report which revealed that Resident # 6 had a complaint of pain all over after her .

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Record review revealed on 5/8/2016 Resident # 6 returned to the ALF with her POA. Resident # 6 was instructed by the ALF to call for assistance whenever needed. Resident # 6's hospital records dated states Resident # 6 was diagnosed with a ( ) as a result of this Resident # 6 suffered a minor head injury (copy obtained). Resident # 6's hospital discharge instructions states Resident # 6 should return immediately if there is a loss of balance, trouble with movement, or worsening of condition in any way. A record review of Resident # 6's nurses notes revealed Resident # 6 was monitored every 2 hours by the facility's care managers.

The facility's Incident Reports dated / at 9:15 PM, revealed documentation by Staff D, a LPN, as follows: " Resident # 6 had an unwitnessed in her was found by a Staff F, a care manager. Staff F immediately informed Staff D. At 9:20 PM, Resident # 6's vitals were taken and Resident # 6 was found with a large hematoma on her forehead over her left eye. Staff D stated on the incident report that Resident # 6 refused to go the hospital. Staff D notified Resident # 6's POA of her on / at 9:35 PM and called the physician at 10 PM. The incident report states that the nurse on duty, Staff D, applied an ice pack to Resident # 6's forehead and Resident # 6's POA transferred Resident # 6 to the hospital at 10:30 PM.

On at 11:55 AM, an interview with the ALF's Director of Memory Care and the Administrator revealed that on Resident # 6 had an unwitnessed and 911 should have been called even if the resident refused to go to the hospital. During the interview the Memory Care Director, stated if there is an incident resulting in an injury the nurse must assess the resident and call 911. The Director of Memory Care and the Director of Nursing (DON) stated if a resident has an incident or a significant change in health status the information is updated on the facility's 24 hour report and in the residents chart. The DON further stated the nurse on duty must review the 24 hour report in the beginning of their shift.

On at 12:15 PM, the AHCA surveyor contacted Resident # 6's POA. The interview revealed the following. The facility staff followed the proper procedure after Resident # 6 on and Staff E notified me immediately of what happened and stated Resident # 6 was sent to the hospital. The POA further stated, on , the facility nurse on duty (Staff D) did not follow the proper procedure. The POA stated Staff D found a egg shaped hematoma on Resident # 6's forehead over her left eye and did not call 911. The POA stated that Staff D informed her that Resident # 6 was asked if she wanted to go to the hospital, had on her forehead and he just put an ice pack on it and stated Resident # 6 is okay. The POA stated that Resident # 6 has and she had informed staff that if any injury or occurs with Resident # 6 they should send her to the hospital immediately because Resident # 6 is disoriented and has . The POA stated when she arrived to the facility on / after the incident, Staff D argued with her about calling 911 and stated Resident # 6 was assessed and is okay with the ice pack. The POA stated that Staff D stated to her that she could take Resident # 6 to the

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hospital if she wanted to. The POA stated Resident # 6 never refused to go to the hospital, was disoriented and was unaware that she had and developed a hematoma on her head from the . On at 2 PM, a telephone interview with Staff F revealed on during the 2 PM through 10 PM work shift at approximately after 9 PM, she found Resident # 6 sitting on the floor. Staff F stated that Resident # 6 stated she while trying to get back to bed. Staff F stated she noticed a on Resident # 6's forehead. Staff F stated she called Staff D, the nurse on duty, to assess Resident # 6. Staff F stated Staff D assessed Resident # 6 and made some telephone calls. Staff F stated she worked until 10 PM and does not recall if 911 was called for Resident # 6.

On a telephone interview with Staff D revealed that on / Resident # 6 had an unwitnessed . Staff D stated he assessed Resident # 6 and saw a hematoma over her left eye and applied an ice pack. Staff D stated he does not recall reviewing Resident # 6's file that states Resident # 6 had a recent and was sent to the hospital prior to . Staff D stated he does not recall reviewing the 24 hour shift report. Staff D stated he is aware that the ALF is a memory care facility and that Resident # 6 has a memory , but further stated Resident # 6 stated she did not want to go to the hospital. Staff D stated he waited for Resident # 6's POA to arrive to the facility. Staff D stated he told Resident # 6's POA that she can take Resident # 6 to the hospital if she wanted to. During the interview, Staff D admitted that he should have used better judgement and should have call 911 to have Resident # 6 sent to the hospital instead of waiting on Resident # 6's POA.
A record review of the hospital emergency dated on / at 11:19 PM states Resident # 6 was in the emergency family. The hospital report states Resident # 6 has a history of advanced . Further review of the report states Resident # 6 was taking and and limited information was obtained from the ALF that the resident tripped and . The hospital report states Resident # 6 had a large hematoma over her left eye.
Facility record review revealed that Harbor Chase of Tamarac maintains a policy and procedure entitled " Standard." The policy states : We cannot eliminate all , but we can reduce the risk of falling and help to minimize injuries when a happens by adopting a culture of safety. The policy guidelines states the following: 1. After a , review the situation and determine if emergency services are needed. Observe the resident for signs of injury and check the following: a)vital signs, b) , c) evidence of injury, d) body parts obviously out of proper position, e) broken/ skin, f) , g) pain, h) inability to move, i) / open wounds. 2. Provide immediate first aide and calm the resident. 3) Immobilize the resident if injury noted. 4. Notify physician and if needed emergency services. 5. Notify the residents family and/or legal representative. 6. Document the in the resident's record. 7. Communicate any resident care changes.

On , a record review of the facility's employee files revealed both Staff D, Staff E, and Staff F had current training in Level I and Level II, Resident Rights, Incident Reporting, and Emergency Preparedness. Staff D used neither of the skilled training for Resident # 6, instead awaiting

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the arrival of Resident # 6's POA.

On 10/20/2016, at 3 PM, the Administrator, Director of Nursing, and the Director of Memory Care acknowledged the findings.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Harborchase Of Tamarac
6855 NW 70th Avenue
Tamarac, FL 33321

RE: CCR #2016011145

Dear Administrator:

This letter reports the findings of a state complaint survey that was conducted on , 2016 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 attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 representatives. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure
XG90

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com

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