STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969452	**03/20/2019**
NAME OF PROVIDER OR SUPPLIER **HARBORCHASE OF DR PHILLIPS**	STREET ADDRESS, CITY, STATE, ZIP CODE **7233 DELLA DRIVE** **ORLANDO, FL 32819**	

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

0000 - Initial Comments

Complaint Investigations #2019002173 and #2019002653 were conducted from /19. Harborchase of Dr. Phillips had deficiencies found at the time of the visit for Complaint Investigation #2019002173. There were no deficiencies related to Complaint Investigation #2019002653.

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on observation, records review and interviews, the facility admitted 1 of 4 residents who exceeded assisted living facility admission criteria, and needed total assistance with activities of daily living (#1).

Findings:

During the facility entrance on at 9:30 AM resident #1 was identified as receiving hospice care. At 10:30 AM, resident #1 sat in a wheel chair and was wheeled by a caregiver to the dining room. Her were elevated and had a blanket over her . She was . She was fed by staff.

Record review for resident #1's revealed she was admitted on . The health assessment report, dated , listed diagnoses of , and . She was non ambulatory, had physical limitations, was , required left care, and received hospice services for a prognosis. Page 2 of the health assessment was not available.

The healthcare provider's order, dated , reflected to "Replace with bigger , - 18 French to attempt to reduce leakage. care , to review current , to left heel." She was admitted to hospice care on , prior to admission to the facility.

A facility note, dated , indicated the resident was wheel chair bound, was of and , and her left heel was black in color.

In an interview with the administrator on at 3 PM, who said she thought the resident was appropriate for admission since she was admitted with hospice.

Class III

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

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Based on observation, interview and record review, the facility failed to ensure 1 of 6 residents at risk of elopement was provided appropriate supervision to prevent him for leaving the memory care unit 3 times unescorted (#5).

Findings:

Observations at on at 10 AM of the facility's secure memory care unit (MCU) noted no code was needed to enter. A pass card was needed to exit. There was a green button to use for emergency exit, and would ring if pressed. At 10:30 AM, resident #5 sat in dining room with a private sitter. At 10:35 AM, the resident was looking for his wife. At 11 AM, he was taken to activities by the MCU director. He said he wanted to go to his room, headed one way, turned , and headed another way. He stood by a door other than his room and said, "I'm locked out". The activity staff was alerted that the resident needed help. She assisted him to his room.

On at 10:00 AM, the private sitter said the resident had sundowners and was , . He wanted to go to Jamaica. She sat with him from Monday to Friday from 8 AM to 4 PM. Another sitter came from 4 PM-11 PM, and another 11 PM-8 AM. The sitter said the resident eloped from the facility 3 times before she became his sitter. She worked for a companion agency. She said he used to live with his wife at the facility but she moved out. She came to visit today, just for a few minutes. He then started looking for her, and then wanted to go to Jamaica. She said the facility was not properly secured, and the resident learned how to press the green button to go out. She said he had a pendant and a bracelet but doesn't want to use it. She said she put the bracelet in a brief case he carried in case he left the facility again.

Observations on at 1:45 PM noted a bracelet inside a computer case inside a bible case. The private sitter was unsure of the purpose of it, maybe it rang if he went by the door. There was also a pendant in the closet.

On at 2 PM, the memory care director checked the resident's wallet for identification. The resident's wallet was in his pants pocket. After looking at the resident's wallet the memory care director said the license was not valid. In addition it did not have the facility address on it.

Resident #5's record revealed he was admitted on . The health assessment report, dated , listed diagnosis of , . He was disoriented to place, time and situation. Per the assessment report, he was at risk for elopement, and needed supervision for whereabouts/ precautions, was disoriented during evenings, could be aggressive at times, was agitated at home. He was independent with ambulation and transferring.

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Facility notes reflected the following on:

Resident called 911, said caregiver stole his keys
- walked through facility, exit-seeking continued, not easily redirected, stayed up through night
continue exit-seeking
up through night, exit-seeking, verbally aggressive
exit-seeking, , not effective
exit-seeking, not easily redirected
- exit-seeking x 10, not easily redirected
7- 11 - with sitter on 15 minute checks, hallways most of shift, wanted to leave with his bag

Nurse's notes reflected the following on:

9 AM - at YMCA Alarm rang at 9 AM by , discovered resident not in MCU area
10:20 AM - Found on Della Drive, , and medicated , no effect noted.
Investigation report indicated the resident left through a secure exit that can only be accessed with a code or a pass card, as the alarm did not sound, and did not .
- exit-seeking
10 PM - was in room packing. Told wife to leave him alone or he would kill her.
- began exit seeking at 4 PM, , had no effect. At 4:30 PM, nurse received call, the resident was outside MCU, walked into Citrus room (bristo in lobby of facility), redirected. Looking for wife and daughter Continued exit-seeking, difficult to redirect.
A 45 day notice of discharge was given on .

Record review revealed he was placed on 1 to 1 supervision on , after the third elopement.

In an interview on at 2 PM, the administrator said after an investigation, it was discovered the first time he left through the front door of the unit by the MCU director's office. The other times maybe the doors did not latch properly. Maintenance and Pal Care (company that installed locks), checked numerous times and there was nothing wrong with the system or locks. The second time, the MCU director found the resident outside on Della Drive (the same street where the facility was located, the resident was on the sidewalk). When she found him, she was able to redirect him. The third time, the camera caught images of him leaving through a side exit by . In order to exit, you have to pass the card or press the green emergency button, which make the alarm sound very loud, which

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alerted the staff. His wife never intended to move in with him, it was for a transition period. She went and came as she pleased. Every time she would leave the resident became and wanted to go find her.

Class II

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(I)

Based on observation, interview and record review, the facility failed to ensure photo identification of an at risk resident on file (#4), and failed to ensure at risk residents had identification on their person that included their name, and the facility's name, address, and telephone number (#4 & 5).

Findings:

1. On at 11 AM, the private sitter for resident #5 said there a new resident (#4) wanted to go to the bank. She said resident #5 "got out 3 times" because the facility was not properly secured, and he learned how to press the green button to go out. He had a necklace (pendant) and a bracelet but did not want to use it; she put the bracelet in a brief case that he carried, in case he got out again. The pendant was in the closet.

Observations on at 1:45 PM noted a bracelet inside a computer case inside a bible case, and a pendant in the closet. The private sitter was unsure of the purpose of the guard, maybe it rang if he went by the door. She said the resident always had a wallet in his pant pocket.

2. Resident #4's record revealed she was admitted on . Her health assessment, dated , listed diagnoses 's , high , , , and precautions was listed. She needed assistance with medication, was independent with ambulation, transferring, toileting, and eating, needed supervision with , and assistance with bathing and grooming. The healthcare provider indicated she was a risk for elopement.

Observation on at 1:30 PM noted resident #4 did not have identification on her person. The memory care unit (MCU) director stated there was no current picture of the resident, and she did not have any identification. The resident walked independently around the unit. The resident said her supervisor let her go home; she was done working. The MCU director tried to redirect the resident, she insisted she had to go, eventually she saw some visitors and engaged in conversation with them. This was an attempt to demonstrate the resident was , thought she was at work and was ready to leave the facility.

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3. Resident #5 was admitted on . . . . . The health assessment report, dated . . . . . , listed diagnoses of and , ... He was disoriented to place, time and situation. Per the assessment report, he was at risk for elopement, and needed supervisor for whereabouts/ precautions, was disoriented during evenings/sun downing/ could be aggressive at times, and was agitated at home. He was independent with ambulation and transferring. The facility notes documented that on , he was exit-seeking at 4 PM. At 4:30 PM, the nurse received a call that the resident was outside MCU, walked into the Citrus room, a bristo in the facility lobby. A note dated . . . . . at 10:20 AM, reflected that he was found outside the facility on Della Drive, the same street where the facility is located. He was found on the sidewalk. On . . . . . at 9 AM, he was at the YMCA (the distance from the facility to the YMCA is 0.2 miles).

Interview with the MCU director who said the driver's license was not valid, nor did it had the facility address.

On . . . . . at 2 PM, the MCU director said she had not taken a picture of resident #4. She thought she had 10 days to get one, and resident #5 refused to wear the bracelet or pendant.

In an interview with the administrator on who said she thought resident #1 was appropriate for admission since she was admitted with Hospice.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on record review and interview, the facility failed to ensure that facility records included an up to date admission and discharge log.

Findings:

On . . . . at 9:45 AM, the Resident Care Director said the facility census was 32 residents.

Review of the admission and discharge log revealed the log listed 27 admissions and one discharge, resident #2. Resident #3 was not listed as a discharge, although he moved out. The facility census on . . . . was 32. Therefore, all residents were not listed on the log.

On . . . . . at 1 PM, the administrator confirmed the findings.

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On [redacted] at 2 PM, the Resident Care Director confirmed the findings.

Class III

Z821 - Reporting Requirements; Electronic Submission - 59A-35.110 FAC

Based on record review and interview, the facility failed to submit electronic adverse reports when resident #5 eloped three times from the secure memory care unit and when an event was reported to law enforcement for investigation (# 6).

Findings:

1. The administrator said on [redacted] at 11:00 AM that resident #6 accused resident #3 of touching her inappropriately on [redacted]. Law enforcement was called to investigate. Resident #3 moved out right away, as the daughter was in disbelief about the accusation toward her father. Law enforcement responded to the facility, but the resident #3 had moved out. She did not file an adverse report because the resident was no longer there.

2. The facility had a secure memory care unit a designated area were residents who were [redacted] lived. The memory care unit doors were secured (locked) and needed the assistance of staff to enter and exit or an electronic card to unlock the doors.

Resident #5 eloped from the secure memory care unit three times. On [redacted] at 9 AM, he was found 0.2 miles from the facility. On [redacted] at 10:20 AM, he was outside the facility walking down the street. On [redacted] at 4:30 PM, the nurse received a call that the resident was outside the memory care unit, walked into the Citrus room, the bristo in facility's lobby. The facility's elopement policy and procedures indicated any time a resident from the memory care unit went outside the secure environment without an associate or responsible party, it was considered an elopement.

In an interview with the administrator on [redacted] at 11 AM, who said she was unable to submit the adverse reports electronically, because she did not have access to the system, so she faxed them to the Agency for Health Care Administration.

Unclassified