Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969234	A. BUILDING: _____ B. WING _____	06/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORCHASE OF PALM BEACH GARDENS	3000 CENTRAL GARDENS CIR PALM BEACH GARDENS, FL 33418

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A 000	Initial Comments A relicensure survey with Extended Congregate Care (ECC) was conducted at Harborchase Of Palm Beach Gardens on and . The Provider had deficiencies identified at the time of the survey. Note: The ECC portion of the survey was conducted on a separate date. Please refer to the report for the findings.	A 000		
A 010 SS=D	429.26(1&9) FS; 58A-5.0181(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination shall be based upon an assessment of the strengths, needs, and preferences of the resident, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (9) A , ill resident who no longer meets the criteria for continued residency may remain in	A 010		

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A 010	Continued From page 1 the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident are being met. 58A-5.0181 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a [illegible]-to-[illegible] medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 58A-5.0131, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days. (b) A resident requiring care of a [illegible] may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care	A 010		

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A 010	Continued From page 2 provider, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C. This Statute or Rule is not met as evidenced by:	A 010		

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A 010	Continued From page 3 Based on record review and interviews, the facility failed to monitor the continued appropriateness of residency in this assisted living facility (ALF) for 1 out of 2 sampled residents (Resident #12). The findings included: On at 10:30 AM, the Director of Resident Care (DRC) stated during interview that Resident #12 had a , , "but she is on hospice". Documentation showing the date of onset and current stage of the was requested from the DRC at this time. During review of the hospice notes, the DRC stated that the date of onset of the was , and that the current stage was unknown. Review of the resident's record revealed the resident had an , on her right heel with care documented as follows: 1) Quarter size right heel (Physician Visit Form) 2) "left" heel-difficult to heal and "right" heel (physician's order) 3) , "right" heel (prescription for " ") 4) Medical examination (AHCA Form 1823), signed by a health care provider, notes "no" , The hospice Integrated Plan of Care, with hospice start of care on , indicated the following for care of the , : 1) care 2 to 3 times a week for healing	A 010		

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A 010	Continued From page 4 A plan of care for staff at the ALF to follow related to the resident's , with interventions to prevent further , could not be identified in this plan of care. During interview with the DRC at 10:30 AM on , she stated that the staff ensure the resident keeps pressure off of her heel while in bed. A resident who is admitted to hospice may remain in an ALF with a , that is improving within 30 days. A resident with a , or 4 , does not meet the criteria for continued residency in an ALF. Resident #12 had a , of an unknown on . There was insufficient documentation to show the was monitored for improvement within 30 days. There was no documentation to show the resident was identified as inappropriate for continued residency in an ALF when the , worsened to " " on or about . Additionally, the resident had a medical examination (AHCA Form 1823) completed on for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care provider after a significant change. A significant change is defined in rule 58A-5.0131, F.A.C. and includes the onset of a , and admission to hospice. Resident #12 did not have a new assessment completed on or about when the , was identified. A new assessment could not be located either for the resident's admission to hospice on . The last assessment in the resident's file was dated .	A 010		

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A 010	Continued From page 5 These findings were discussed with the DRC on [redacted] at 10:30 AM. She acknowledged that the resident had not been identified as inappropriate for ALF residency. There was insufficient documentation showing the coordination and provision of care and services by ALF staff in conjunction with hospice in the plan of care. New medical examinations were not completed and in the resident's file for the significant changes. The facility provided no additional documentation at this time. Class III	A 010		
A 054 SS=D	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known [redacted] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number;	A 054		

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A 054	Continued From page 6 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [illegible], the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure staff maintained an accurate daily medication observation record (MOR) for each resident who received assistance with self-administration of medications by immediately updating each time the medication was offered or administered, including reason(s) for any missed dosages and/or refusals for 5 of 7 residents whose MORs were reviewed (Residents #4, #5, #11, #13 and #14). The findings included: A. Review of MOR revealed the following concerns: 1) Resident #4 had missing staff initials for the provision of the following medications/supplements: a) Ensure, 1 bottle twice daily, at 5 PM on [illegible], and [illegible]; b) [illegible], 50 mg, twice daily, at 5 PM on [illegible]; c) Cranberry Supplement, 100 mg, once daily, at 9 AM on [illegible], and [illegible]; d) [illegible], 25 mcg, once daily, at 6 AM on [illegible] and [illegible].	A 054		

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A 054	Continued From page 7 2) Resident #13 had missing staff initials for the provision of the following medications: a) Mirilax Powder 17 GM (hold for loose stools) once daily, at 9 AM on . 3) Resident #14 had missing staff initials for the provision of the following medications: a) Voltaren 1% Gel 4 GM , , every 8 hours, at 6 AM on . B. Review of MOR revealed the following concerns: 1) Resident #11 had missing staff initials for the provision of the following medications: a) , 0.5 mg, once daily at 4 PM on ; b) , 25 mg, twice daily, at 9 PM on ; c) , 10 mg at bedtime, at 9 PM on ; d) Immodium A-D 2 mg, 1 tab every day as needed. Note documented on of MOR that resident received Immodium on at 4 PM, but staff did not initial dose given on the MOR for . 2) Resident #5 had missing staff initials for the provision of the following medications: a) 15 mg, once daily, at 9 AM on . On at 1:15 PM, the Regional Director of Health and Wellness, Business Office Manager, and Administrator were informed of the missing initials on the MORs for the residents listed above. Class III	A 054		

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A 055	Continued From page 8	A 055		
A 055 SS=D	58A-5.0185(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in rule 58A-5.0181, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other	A 055		

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A 055	Continued From page 9 locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days	A 055		

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A 055	Continued From page 10 of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to centrally store a medication as per facility's rules and regulations for 1 out of 1 sampled residents (Resident # 2). The findings included: During a tour on at 9:53 AM a resident interview was conducted with Resident # 2. The surveyor observed a physician ordered ˘ suppressant medication sitting on top of the resident's kitchen counter. The medication's label stated Major Robafen . . . . ˘ Suppressant order date and the expiration date . . . . . take 1 tsp by . . . . every 6 hours needed for ˘ . The surveyor inquired of Resident # 2 as to why a physician ordered medication was sitting on top of her kitchen counter out in the open. Resident # 2 stated that the medication is 24 hours and it was ordered by her physician and they allow her to keep it in her room because she uses it so frequently. An interview was conducted with the Director of Resident Care on . . . . . at 12:14 PM in her office to discuss the physician order ˘ suppressant medication in resident #2's room. The Director of Resident Care and the surveyor	A 055		

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A 055	Continued From page 11 reviewed the Medication Observation Record (MOR) for - and it was revealed that the Robafen was listed. The Director of Resident Care contacted the pharmacy and was told that the original suppressant was called in on and it was good for 11 refills. The last prescription was sent to the facility by the pharmacy on . The Director of Resident Care stated that the night nurse ordered the medication. The Director of Resident Care stated that when the medications arrive to the facility they are taken to the nurses station and someone would have to obtain the medication from the nurse. She stated that she doesn't understand why the medication was in the resident's room. She stated that maybe there was a request from the caretaker to order the medication. The Director of Resident Care and the Surveyor reviewed the resident's medical chart together and there was no documentation in the Case Management/Care Coordination/Communication notes that a caretaker requested the medication. On at 9:23 AM the surveyor reviewed Resident # 2's Health Assessment (1823) dated and page 3 noted the resident "Needs Assistance with Self-Administration of Medications". On at 9:54 AM the surveyor met with the Business Office Manager, obtained the Admissions Package, and the facility's rules/regulations. The Admissions package and Resident Agreement for Informed Consent to Assistant with Medication by unlicensed personnel states that medications are put in storage. Also the facility's medication storage policy states assistance with medications are to be centrally stored. During an interview conducted on at	A 055		

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A 055	Continued From page 12 1:30 PM with the Regional Director of Health and Wellness, Business Office Manager, and Administrator the findings were acknowledged and no additional information was provided. Class III	A 055		
A 078 SS=D	58A-5.019(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . . . . . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative . . . . . examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual . . . . . examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . . . . . . 2. If any staff member has, or is suspected of having, a communicable . . . . , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable	A 078		

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A 078	Continued From page 13 . . . . . . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 58A-5.0191, F.A.C. (d) An assisted living facility _ to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff . . . . . by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the Facility failed to ensure: 1) Newly hired staff provided a written statement from a health care provider documenting that the individual does not have any signs or symptoms	A 078		

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	AL11969234	A. BUILDING: _____ B. WING _____	06/12/2019

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A 078	Continued From page 14 of communicable . . . . . for 1 of 3 sampled staff (Staff C); and 2) Evidence of a negative . examination was documented and provided to the Facility on an annual basis for 1 of 3 sampled staff (Staff C). The findings included: 1) A review of the employment record for Staff C, a direct care staff member whose date of hire was . . . . , produced no written statement from a health care provider verifying freedom from signs or symptoms of any communicable . 2) A review of the employment record for Staff C did not produce any documentation of a current, annual negative examination for the year 2018. On . . . . . at approximately 10:00 AM, a request was made to the Business Office Manager for documentation from a health care provider dated within 30 days from date of hire verifying Staff C was free from signs and symptoms of any communicable , and documentation of a current annual . exam for 2018. On at 1:10 PM, during the exit interview conducted with the Regional Director of Health and Wellness, Business Office Manager, and Administrator, no further documentation was provided. The RDHW, BOM, and Administrator acknowledged the missing health statement and annual exam for 2018. Class III	A 078		

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A 090	Continued From page 15	A 090		
A 090 SS=D	58A-5.0191(11) FAC Training - . . . (11) . . . TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding . (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding . . within 30 days after employment. (c) Training shall consist of the information included in rule 58A-5.0186, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure 3 out of 3 sampled staff had received the required one hour training in the facility's policy and procedures regarding ( ) within 30 days of employment (Staff A, B, and C). The findings included: On the personnel files for the following staff members were reviewed: 1) Staff A is a direct care staff member (7:00 AM - 3:00 PM) whose hire date is . Staff A's employment record did not contain the required one hour training in the facility's policy and	A 090		

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A 090	Continued From page 16 procedures regarding . . . 2) Staff B is a direct care staff member (3:00 PM - 11 :00 PM) whose hire date is . Staff B's employment record did not contain the required one hour training in the facility's policy and procedures regarding . . . 3) Staff C is a direct care staff member (11:00 PM - 7:00 AM) whose hire date is . Staff C's employment record did not contain the required one hour training in the facility's policy and procedures regarding . . . On . . . at approximately 10:00 AM, a request for additional documentation showing completion of the . Training was made to the Regional Director of Health and Wellness (RDHW) and the Business Office Manager (BOM). On at 1:10 PM, during the exit interview conducted with the RDHW, BOM, and Administrator, no further information showing completion of the . . Training was provided. The RDHW, BOM, and Administrator acknowledged the missing training documentation for Staff A, B, and C at this time. Class III	A 090		
A 092 SS=D	58A-5.020(1) FAC Food Service - General Responsibilities (1) GENERAL RESPONSIBILITIES. When food service is provided by the facility, the administrator, or an individual designated in writing by the administrator, must be responsible for total food services and the day-to-day	A 092		

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A 092	Continued From page 17 supervision of food services staff. In addition, the following requirements apply: (a) If the designee is an individual who has not completed an approved assisted living facility core training course, such individual must complete the food and nutrition services module of the core training course before assuming responsibility for the facility's food service. The designee is not subject to the 1 hour in-service training in safe food handling practices. (b) If the designee is a certified food manager, certified dietary manager, registered or licensed dietitian, dietetic registered technician, or health department sanitarian, the designee is exempt from the requirement to complete the food and nutrition services module of the core training course before assuming responsibility for the facility's food service as required in paragraph (1)(a) of this rule. (c) An administrator or designee must perform his or her duties in a safe and sanitary manner. (d) An administrator or designee must provide regular meals that meet the nutritional needs of residents, and therapeutic diets as ordered by the resident's health care provider for residents who require special diets. (e) An administrator or designee must comply with the food service continuing education requirements specified in Rule 58A-5.0191, F.A.C. This Statute or Rule is not met as evidenced by: Based on employee record review and staff interview, the facility failed to ensure the individual designated to be responsible for total food services and the day-to-day supervision of food services (Food Designee), and who had not completed an approved assisted living facility core training course, had completed the 2 hour Food and Nutrition services module of the core	A 092		

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A 092	Continued From page 18 training course before assuming responsibility for the facility's food service; and the facility failed to ensure the Food Designee complied with the 2 hour annual Food Service continuing education requirements specified in Rule 58A-5.0191 F.A.C. The findings included: On , a review of the employee record for the facility's appointed Food Designee (Director of Hospitality), hired , failed to produce any documentation showing completion of the required 2 hour Food and Nutrition Training provided by an approved trainer prior to assuming responsibility for the facility food service. In addition, it was noted that the Food Designee had not completed any annual 2 hour Food and Nutrition Training course since the date of hire. On , the Business Office Manager produced Nutrition and Food Safety Training certificates completed through Relias Training, but the trainings were not a 2 hour Food and Nutrition course specific for Assisted Living Facilities, nor was the Trainer who signed off on the training certificate an approved trainer (i.e. Certified Dietary Manager, Registered or Licensed Dietitian, Dietetic Registered Technician, or a Health Department Sanitarian). On at 1:10 PM, during the exit interview conducted with the Regional Director of Health and Wellness, Business Office Manager, and Administrator, no further information showing completion of an approved Food and Nutrition Training was provided. The RDHW, BOM, and Administrator acknowledged the missing training documentation for the Food Designee	A 092		

Agency for Health Care Administration

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A 092	Continued From page 19 Class III	A 092		