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
	AL11969452	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORCHASE OF DR PHILLIPS	7233 DELLA DRIVE ORLANDO, FL 32819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{CZ821} SS=C	59A-35.110 FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under chapter 408, part II, F.S., or authorizing statutes for the provider type as specified in section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections; and, (f) Approval of revisions to emergency management plans. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and availiable at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On	{CZ821}		

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{CZ821}	Continued From page 1 Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 2. Assisted living facilities: a. Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 days after the occurrence of the incident as required in section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and availiable at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. b. Liability claim reports required pursuant to section 429.23(5), F.S., and rule 58A-5.0242, F.A.C. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and availiable at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted	{CZ821}		

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{CZ821}	Continued From page 2 electronically to the Agency within 15 calendar days after the occurrence of the incident as required in section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and availiable at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: DEFICIENCY REMAINED UNCORRECTED Based on record review and interview, the facility failed to submit electronic adverse reports when a resident eloped three times from the secure memory care unit (#5), when an event was reported to law enforcement for investigation (#6), and when a resident eloped from the memory care unit and was potentially at risk for harm (#8). Findings:	{CZ821}		

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{CZ821}	Continued From page 3 1. Resident #5, previously cited for 3 separate elopement incidents in , and , , was discharged from the facility on after being given a 45-day notice of discharge. There was no adverse report available for review. 2. Resident #6, previously cited after being accused of touching another resident inappropriately on , was discharged from the facility on . Law enforcement was involved in investigating the allegation. There was no adverse report available for review. 3. Review of the record for resident #8 found she was admitted to the assisted living facility on and transferred to memory care on . Her most recent health assessment was dated . She was noted to have diagnoses which included mild-moderate , a balance , , , a , and recurring . She was noted to be at risk for . She was not documented to be an elopement risk. A progress note dated at 3:13PM documented "possible elopement" and described an event where resident #8 was found walking on the sidewalk outside, off facility property, by a staff member coming to work at 3:00PM. The note documented the resident was seen last around 1PM when staff took her to the facility hairdresser after lunch. She was returned to community by the staff member who recognized her on the street. MD and family notified. There were no signs of injury. Notes indicated no further attempts to leave facility. (photographic evidence obtained) The facility had a secure memory care unit- a designated area were residents who were (/) lived.	{CZ821}		

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{CZ821}	Continued From page 4 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. 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. On at 1:30PM, a regional manager stated the former administrator had left the facility in mid- , and she was unable to locate copies of the adverse reports. She did not have access to the agency portal at the time of the visit. She said she was not aware of the 3rd elopement and could not say if adverse reports had been submitted for any of the incidents. Unclassified	{CZ821}		
{A 000}	Initial Comments A revisit to complaint investigation #2019002173 was conducted at Harborchase of Dr Phillips Assisted Living on . Deficiencies were identified at the time of the visit.	{A 000}		
{A 025} SS=G	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification	{A 025}		

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{A 025}	Continued From page 5 must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 58A-5.0182 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by:	{A 025}		

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{A 025}	Continued From page 6 DEFICIENCY REMAINS UNCORRECTED Based on observation, interview and record review, the facility failed to ensure 1 of 3 sampled residents at risk of elopement was provided appropriate supervision to prevent her from leaving the facility unescorted (#8). Findings: Review of the record for resident #8 found she was admitted to the assisted living facility on [redacted] and transferred to the secured memory care unit on [redacted]. Her most recent health assessment was dated [redacted]. She was noted to have diagnoses which included mild-moderate [redacted], a balance [redacted], [redacted], a [redacted], and recurring [redacted]. She was noted to be at risk for [redacted]. She was not documented to be an elopement risk. A progress note dated [redacted] at 3:13PM documented "possible elopement" and described an event where resident #8 was found walking on the sidewalk outside, off facility property, by a staff member coming to work at 3:00PM. The note documented the resident was seen last around 1PM when staff took her to the facility hairdresser after lunch. She was returned to community by the staff member who recognized her on the street. MD and family notified. There were no signs of injury. Notes indicated no further attempts to leave facility. (photographic evidence obtained) Observation during the tour revealed a secure memory care unit- a designated area were residents who were [redacted] ([redacted]) lived. The memory care unit doors were secured (locked) and needed the	{A 025}		

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{A 025}	Continued From page 7 assistance of staff to enter and exit or an electronic card to unlock the doors. 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. At 11:00 AM on a caregiver in the memory care unit stated resident #8 goes out to the main dining room in the assisted living for her meals each day. She stated there is always a caregiver in the dining room when resident #8 is dining. At 1:20 PM on , the resident care director #8 did not sign out, did not leave the building with an escort and that resident #8 is a memory care unit resident. On . . . the resident continues to have lunch and dinner outside of the memory care unit in the Main Dining room. On . . . . at 1:30PM, a regional manager stated she was not aware of the elopement for resident #8. Class II	{A 025}		
{A 032} SS=D	58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(i) Resident Care - Elopement Standards 58A-5.0182 (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or	{A 032}		

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{A 032}	Continued From page 8	{A 032}		

a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 58A-5.0181(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days.

1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 58A-5.0191(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times.

2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative.

(b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for:

1. An immediate search of the facility and premises,

2. The identification of staff responsible for implementing each part of the elopement

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{A 032}	Continued From page 9 response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to sections 429.41(1)(a)3. and 429.41(1)(l), F.S. 429.41(1)(a)3 & 3(l),FS 3. Resident elopement requirements.-Facilities are required to conduct a minimum of two resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills which shall include a review of procedures to address resident elopement. Facilities must document the implementation of the drills and ensure that the drills are conducted in a manner consistent with the facility's resident elopement policies and procedures. (l) The establishment of specific policies and procedures on resident elopement. Facilities shall conduct a minimum of two resident elopement drills each year. All administrators and direct care staff shall participate in the drills. Facilities shall document the drills. This Statute or Rule is not met as evidenced by: Based on resident record review and interview, the facility failed to follow the facility elopement policy and did not accompany a memory care resident at all times when they were outside the secure unit and allowed the resident to elope (#8).	{A 032}		

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{A 032}	Continued From page 10 Findings: Tour of the secure memory care unit on found all of the residents were wearing ID . . . . on their , even if they had not been determined to be at risk for elopement. On . . . . at 11:20AM, a caregiver in the memory care unit stated resident #8 had moved to the unit about 1 month prior from the assisted living side. She said resident #8 required more care. She also stated the resident went out of the secure unit each day for her meals in the main dining room, but that a caregiver was always present in the dining room when resident #8 was present. Review of the record for resident #8 found she was admitted to the assisted living facility on and transferred to memory care on . . . . . Her most recent health assessment was dated . She was noted to have diagnoses which included mild-moderate . . . . , a balance . . . . , , , a , ... , and recurring . . . . . She was noted to be at risk for . She was not documented to be an elopement risk. A progress note dated at 3:13PM documented "possible elopement" and described an event where resident #8 was found walking on the sidewalk outside, off facility property, by a staff member coming to work at 3:00PM. The note documented the resident was seen last around 1PM when staff took her to the facility hairdresser after lunch. She was returned to community by the staff member who recognized her on the street. MD and family were notified. There were no signs of injury. Notes indicated no further attempts to leave facility.	{A 032}		

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{A 032}	Continued From page 11 (photographic evidence obtained) Review of 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. At 1:20 PM on [redacted], the resident care director stated another caregiver had told her resident #8 was going out to walk to the store and knew where she was going. She confirmed resident #8 did not sign out, did not leave the building with an escort, and that resident #8 is a memory care unit resident. On [redacted] at 1:30PM, a regional manager stated she was not aware of the elopement for resident #8. Class III	{A 032}		
A 162 SS=D	58A-5.024(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name; 2. [redacted]; 3. Race; 4. Date of birth; 5. Place of birth, if known; 6. Social security number; 7. Medicaid and/or Medicare number, or name of other health insurance [redacted]; 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and	A 162		

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A 162	Continued From page 12 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in Rule 58A-5.0181, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider ' s order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 58A-5.020, F.A.C., if applicable. (e) The resident care record described in paragraph 58A-5.0182(1)(e), F.A.C. (f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 58A-5.0181, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 58A-5.0185, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 58A-5.025, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written	A 162		

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A 162	Continued From page 13 statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an [illegible] recipient, a copy of the Department of Children and Families form Alternate Care Certification for [illegible] ([illegible]), CF-ES 1006, [illegible], which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the [illegible] of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 58A-5.0181, F.A.C. (o) The resident's [illegible], DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement;	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969452	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORCHASE OF DR PHILLIPS	7233 DELLA DRIVE ORLANDO, FL 32819

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A 162	Continued From page 14 2. The resident demographic data required in this paragraph; 3. The health assessment described in Rule 58A-5.0181, F.A.C.; 4. The resident's contract described in Rule 58A-5.025, F.A.C.; and 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on resident record review and interview the facility failed to obtain a complete and accurate Interdisciplinary Care Plan for hospice services for 1 of 4 sampled residents (#9). Findings: Review of the record for resident #9 revealed she was admitted to the facility on and resided in the secured memory care unit. Her admission health assessment (1823) was dated and documented "hospice care." There was also documentation from the hospice provider noted resident #9 entered hospice care on . The Interdisciplinary Care Plan in the record was	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 162	Continued From page 15 dated . . . . and signed by a hospice representative, a facility representative and a family member. The form was blank for all sections denoting who was responsible for what services for the resident. On . . . . at 1:00PM, the resident care director confirmed the finding. Class III	A 162		