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
	AL11969274	A. BUILDING: _____ B. WING _____	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORCHASE OF PALM COAST	2125 PALM HARBOR PKWY PALM COAST, FL 32137

(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
A 000	Initial Comments A complaint investigation (complaint number 2026008808) was conducted at Harborchase Of Palm Coast on June 2, 2026 though June 3, 2026. Deficiencies were identified at the time of the survey.	A 000		
A 165	429.23(1-4 & 6-10) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. Death; 2. Brain or spinal damage; 3. Permanent disfigurement; 4. Fracture or dislocation of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or	A 165		

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A 165	Continued From page 1 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) Abuse, neglect, or exploitation must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to	A 165		

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A 165	Continued From page 2 disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to submit an adverse incident report to the agency following a resident elopement of 1 of 1 resident reviewed, Resident #1. The facility also failed to ensure their policies and procedures for adverse incidents, applicable to all residents of the facility, was consistent with the regulatory reporting requirements for assisted living facilities. The findings include: Observation of the facility on 6/2/2026 at 9:00 AM found one large building with a central main entrance. After leaving the main entrance, there is a parking lot which then leads to a driveway. The facility sits in the bend of a curved two-lane road with a speed limit of 40mph and sidewalks on either side.	A 165		

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A 165	Continued From page 3 On 6/2/2026 at 10:00 AM, an interview with conducted with Employee A, Lead Concierge. She explained the facility has a sign out sheet that residents or families use. The entrance doors are open from 8:00 AM to 8:00 PM for residents of the assisted living to be able to leave without restriction. They monitor the sign out book to see if someone didn't come back after leaving. At 10:25 AM on 6/2/2026, the Activity Assistant was interviewed. She explained residents were supposed to sign out when they left. During an interview with the Administrator on 6/2/2026 at 11:45 AM, she stated the facility had not had any adverse incidents. She then discussed an accident involving Resident #1, but explained that since she was alert and oriented, they did not do an adverse incident report. Record review for Resident #1 revealed she left the facility on 4/27/2026 some time after 8:00 PM. She did not sign out of the facility; she left the facility property and was struck by a car while standing in the road. Further review of found a note dated 4/27/2026 at 10:00 PM which stated: "Resident #1 went on walk. While crossing the street, a car not paying attention hit the resident. Staff reacted immediately and called 911. Resident had an obvious broken leg." The report also showed the resident was taken to the nearest trauma center. Employee C, Caregiver, was interviewed on 6/2/2026 at 4:00 PM. She stated she gave Resident #1 her medications on the evening of 4/27/2026 and Resident #1 made no indication she intended to leave. She stated residents have to sign out to leave.	A 165		

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A 165	Continued From page 4 Page one of the facility's elopement policy defined elopement as "an occurrence in which a resident leaves the (community) without following policy and procedure" and referenced the Florida Administrative Code. Record review of the resident handbook found that on a page titled Resident Agreement Quick Overview, under "Out of the Building" the following was included: "We require that all residents sign out of the building at the Concierge desk. If you expect to be gone for an extended period of time for either medical or personal reasons, please leave information about where we may be able to reach you in case of emergency." Review of the logs for residents signing in and out for no listing for Resident #1 on 4/27/2026. During further interview with the Administrator on 6/3/2026 at 10:00 AM, she stated the investigation into the incident with Resident #1 included getting the statement of everyone involved. These showed Resident #1 was given her medication an hour before she left, which is something she was allowed do. The Administrator was then asked if she did an analysis into the situation. She stated when she did her investigation, there was not anything that risk management needed to be involved with. She stated Resident #1 decided to go for a walk, which she usually did. It was not out of the ordinary. The Administrator was asked if Resident #1 normally walked in the evening, and she replied Resident #1 could go in and out as she pleased, so it was not reported to her when she went out, and there was never a question about her coming and going. She was asked if she was	A 165		

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A 165	Continued From page 5 aware Resident #1 would cross the street. She stated she was aware the resident would walk down the street and go across the street. She stated she was only aware of her doing it twice, during the day. She stated they did tell Resident #1 that it was not a good idea and that it wasn't safe. The Administrator explained she used the company's "HR tool" which followed state regulations to determine if they should file an adverse incident. She explained she didn't file one because there was nothing that they could have done to prevent her from going out. She stated Resident #1 was never an elopement risk because she just took walks. She explained the road outside and the park across the street was close enough for them to see. She stated this wasn't an elopement because Resident #1 was alert and oriented. The Administrator was notified Resident #1 did not sign out of the building on 4/27/2026. She stated that residents do not sign out if they are going for a walk. The Administrator confirmed the street in front of the facility was not facility property. She explained because Resident #1 was not an elopement risk, and she assessed the couldn't have prevented the accident on 4/27/2026, it wasn't an elopement that needed to be reported. When asked to explain what would be considered leaving the premises, she stated what they have is in the employee handbook and in the contract. When asked about how the facility would prevent this from happening again, she stated they did an inservice for residents on safety and the risks of going outside on their own by themselves. They were also going to update their pre-move in packet, and they developed a managed risk form for residents and families to sign starting that day,	A 165		

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A 165	Continued From page 6 6/3/26. She said she also reached out to the city council to get a flashing crosswalk or additional lighting for better visibility. Record review of the tool referenced by the Administrator regarding Resident #1's accident on 4/27/26 showed a multi-step form titled Adverse Incident Questionnaire. Step one contained eight questions, but only two were answered: whether the event resulted in death, and whether the resident was transferred to a unit providing more acute care, which were both circled "yes." The other questions were not answered, including whether the event was an elopement that placed the resident at risk of harm or injury. Step two of the form asked the reviewer to answer whether this was an event that community personnel could have exercised control, to which "no" was circled. Instructions on the form stated that if step two's answer was "No" and step one's answers were all "No" this was not an adverse incident. If Step two was "Yes" and one or more questions in step one were "yes," one should continue to step three. (There was no explanation on how to proceed if you received a yes/no combination, as in the case of Resident #1.) Step three stated, "Did you answer yes to any question in Step One and Step Two? If YES, Please complete an adverse incident report within one business day of the incident. If No, the incident is not adverse and does not require reporting." A second part of the form asked questions regarding abuse, neglect, and exploitation. The summary section at the end of the questionnaire had a hand written comment which read, "Resident was alert and orientated. Resident	A 165		

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A 165	Continued From page 7 often went on walks." Record reviews found no other policy about leaving the building in the resident handbook or resident contract. The facility's Adverse Incidents and Reporting policy revised 2/19/24 defined adverse incidents as an event over which personnel could exercise control, rather than as a result of the resident's condition, and resulted in the conditions listed in the regulation. The policy was a different than the regulatory language, because it also included "resident elopement, if the elopement places the resident at risk of harm or injury" as reportable if the facility could have exercised control. The elopement was not it's own reportable category, outside of an event the facility could control, as it was in the regulations. When the differences between the facility policy and the regulation were reviewed with the Administrator on 6/3/2026 at 12:30 PM, she confirmed the findings. Photographic evidence obtained. Class III	A 165		