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 _____	09/15/2026

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 compalint survey for complaint numbers 2025019117, 2026003878, 2026005200 and 2026006748 was conducted at Harborchase of Palm Coast on 9/15/26. The facility had deficiencies identified at the time of survey.	A 000		
A 054	59A-36.008(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 allergies the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 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 restraints, 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	A 054		

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A 054	Continued From page 1 medication. This Statute or Rule is not met as evidenced by: Based on observation, record review,and interview the facility failed to ensure medication records were accurate and contained required information for two of eight sampled residents (Residents #6 and #8). The findings include: Review of the Resident Health Assessment for Assisted living Facilities (Form 1823) revealed Resident #8 had diagnosis of degenerative disc disease and osteoarthritis, and was under hospice services. The 1823 did not indicate the level of assistance Resident #8 needed with medications. Photographic evidence obtained. Review of Resident #8's September 2026 medication record revealed an order for Tramadol 50 mg (milligrams), take one tablet by mouth three times a day for pain, written 9/7/26. Initials were filled in from 9/8/26-9/15/26 indicating they were using this entry box to document the Tramadol use. Further review of the documentation revealed that the medication was given but not documented on 9/12/26, 9/14/26, and 9/15/26. Photographic evidence obtained. There medication record also contained an order for Tramadol 50mg as needed twice a day, written 9/5/26 and again on 9/14/26. Neither had an end date indicating the order was discontinued so both were active orders at the time of the survey. The as needed medication was marked as being given on 9/6/26 and 9/7/26. The as needed medication didn ' t have parameters written for unlicensed staff to follow, including when it could be taken in conjunction with the	A 054		

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A 054	Continued From page 2 scheduled dose. Photographic evidence obtained. An observation of the medication cart was conducted at 10:45 am on 9/15/2026. The card containing the Tramadol revealed the order was the as needed order, to be taken twice a day as needed for pain. The card had 25 tablets remaining; 5 slots had been opened. Photographic evidence obtained. Employee A, Medication Technician, was interviewed during the observation. She explained that staff were supposed to do a count the medication before each shift, and after medication was given. A controlled drug receipt/record/disposition form, documented each time the Tramadol was given, revealed the same order, for one Tramadol by mouth twice a day as needed. 30 tablets were delivered 9/6/26. Staff signed that they gave Resident #8 a Tramadol on 9/13/26 at 10 pm, 9/14/26 at 6 am, 2 pm, and 10 pm, for a total of 4 doses, and 26 pills should have been on hand. Photographic evidence obtained. Employee A could not explain why the Tramadol container had 25 pills, but the controlled drug record showed only 4 of the 30 were given. Review of the Resident Health Assessment for Assisted living Facilities (Form 1823) revealed that Resident #6 was under hospice services and required assistance with self administration of medication. Photographic evidence obtained. Review of the physician orders for Resident #6	A 054		

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A 054	Continued From page 3 revealed orders for Acetaminophen 500 mg, give 2 tablets twice a day for pain, and for one multivitamin tablet daily. Review of the September 2026 medication record revealed that these medications were marked as unavailable for 9 days between 9/1/26- 9/15/26. Photographic evidence obtained. In an interview on 9/15/26 at 4:45 pm the Director of Memory Care (DMC) and the Director of Resident Services (DRS) stated that the most of the residents received medication refills on a cycle. If medication is missing, the nurse, physician, and family should be notified. The DRS stated that she ran daily reports daily to check resident medications and conducted and necessary followed up. She stated that medications should be documented as soon as they are given. The DRS was asked if she had reviewed the medication record for Resident #6. She said she had and she was aware that Resident #6 was missing medications. There was an issue with the hospice billing. The DRS stated she had informed with Resident #6's daughter, but was unable to provide any documentation supporting that communication. She also confirmed that she had not notified the physician. Regarding Resident #8's Tramadol, the DMC stated that the overnight staff gave the Tramadol but forgot to sign off on the controlled drug sheet. When asked about the facility's process for narcotic reconciliation, the DMC stated that the oncoming and offgoing staff should count the medication and the beginning of each shift, and if there was a discrepancy, she should be notified. She confirmed that the process was not followed at the beginning of the shift on 9/15/26.	A 054		

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A 054	Continued From page 4 Review of the facility policy titled Medication Management, last revised on 4/25/26, revealed that the type of assistance with medication management will be determined by reviewing most recent physician evaluation or Health Assessment form (1823). The community will make every reasonable effort to ensure that prescriptions for residents who received assistance with self administration of medication or or medication administration were filled in a timely manner. The policy also mandated that as needed medications needed to, "define the circumstances under which it would be appropriate for the resident to request the medication." Steps in assisting with self-administration of medication included the following on page 3 and 4 of the policy: verifying "current orders match medication that is properly labeled", "recording the consumption of medication immediately after observing resident swallow medication", and "assisting with as needed medications if orders specify parameters." Photographic evidence obtained. Class III	A 054		