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
	AL11964626	A. BUILDING: _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORCHASE OF NAPLES	7801 AIRPORT PULLING ROAD N.E. NAPLES, FL 34109

(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 An unannounced complaint survey for #2019013426 & #2019013745 was conducted on through at Harborchase of Naples, an assisted living facility in Naples, Florida. Complaint #2019013426 was unsubstantiated. Complaint #2019013745 was substantiated at A025 and A168. The following is description of the deficiencies.	A 000		
A 025	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 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,	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 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: Based on resident and staff interview and record review, the facility failed to provide appropriate supervision for two (Resident #13 and #15) out of three residents reviewed. Furthermore, the facility failed to notify the resident's family of change in condition for 1 (Resident #13) of 3 residents reviewed. The findings included: 1. During an interview with Resident #13's daughter on at 9:46 a.m., she said her mother had a ... that resulted in a . . . . . She said they did not let her know her mother had a . She said she came to visit her mother on Sunday in the afternoon. She said her	A 025		

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A 025	Continued From page 2 mother was complaining she was in , . Her mother told her she had a . Resident #13's daughter said, "If it wasn't for me coming, they wouldn't have known my mom had a . No one even called me." Record review for Resident #13 found an incident report dated . Per the report the resident had an unwitnessed on at 10:00 a.m. The resident was found in the bathroom on the floor sitting against the wall. The resident stated, "I did not . I tried to pick up something off the ground and lost my balance. I pressed my against the wall and slid down." The facility's nurse assessed the resident. Resident #13 denied having , . Per a note on record, the resident's daughter was notified on , four days after the . The note stated that when the facility staff notified the resident's daughter, she said, "why wasn't I notified earlier?" Per additional note on at 2:00 p.m., Resident #13 came down to the wellness center with her daughter. Resident #13 complained she had a and her was hurting. At that point the daughter requested the resident to be sent out to the emergency room (ER) for evaluation. The Director of Resident Care (DRC) said on at 7:40 a.m., she did not know why the staff in the facility did not notify the resident's daughter after she had a on . She said when a resident has a , nursing staff need to assess the resident, notify the resident's next of kin and physician. She said they were supposed to monitor the resident for the next 72 hours every shift. They do not have a policy in place, but that is the standard of practice for all nurses.	A 025		

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A 025	Continued From page 3 Record review for Resident #13 found no documentation of post protocol. Record review for Resident #13 found she had a compressed of the , and had surgery. Resident #13 was admitted to skilled nursing on for rehabilitation. Practical Nurse Staff G said on at 8:00 a.m., she remembered the resident's daughter told her Resident #13 was in , . She said the resident went to the hospital. She said the resident broke her . She said Resident #13 had surgery and did not return to the facility. She said the standard of practice is, if a resident has a to follow up on the resident and check on them every shift for the next 72 hours. On at 9:27 a.m., the DRC provided a sample 72 hour charting log. The corporate nurse walked into the conference room and said, "What is that? No we don't use that." She tore the page in to pieces. Further record review for Resident #13 found the following: A dated . At 10:00 a.m., Resident #13 was observed on her at bedside. She stated she slid off the bed while she was trying to put on underwear. She had an of the right and right . The daughter was notified at 10:15 p.m. No post assessments or other interventions were in place. A on . Resident #13 was found on the floor next to her walker. Resident #13 was assisted to bed. No notification of family was on record. No further interventions were found on record.	A 025		

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A 025	Continued From page 4 On . . . . . Resident #13 was observed sitting on the floor in front of the recliner in her room. The resident's daughter and physician were notified. No new interventions. On Resident #13 had a at 7:00 p.m. Resident #13 was found on the floor in her bathroom by the sink. Daughter was notified at 7:15 p.m. She had a small . . . . of the right as a result of the . No new interventions. On Resident #13 had a at 7:30 a.m. Resident #13 was found on the floor close to the elevator on the second floor. She said her let go and . . The daughter was notified. There was no post protocol or observations or new interventions in place. On . . . . Resident #13 had a . . Resident #13 in the commode and hit her . No interventions in place after the . . On . . . . Resident #13 slid off the toilet and in the bathroom. Resident #13 was able to get up by her self. Resident #13 reported the . to staff on and they notified the physician and family. On at 8:30 a.m., Resident #13 was observed sitting on the floor alert and oriented. She said she in the bathroom as she was trying to reach her walker. Notified family and physician. Post . assessment for 72 hours was not in the record. On Resident #13 had a at 10:00 a.m., Resident #13 was found on the floor by her bed. No 72 hours post protocol or interventions were in place.	A 025		

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A 025	Continued From page 5 Resident #13 had a . dated . . . . Per report, Resident #13 was observed sitting in front of the recliner on the floor. The resident said she while she was trying to go to her closet. Assessment in place. Daughter was notified. No post documentation on record. No new interventions after the . . On ... (does not mention year), the resident had a at 9:45 a.m. Per narrative, resident was observed sitting on the floor by the shower. She said she while getting up out the shower by herself. Notified Resident #13's physician and daughter. No post assessment. No new interventions. Resident #13 had a at 6:45 a.m. The resident was found on the floor by her bed. The resident said she . while she was trying her new pajamas. The daughter was notified. No post . assessment or new measurements in place. Record review revealed that Resident #13 had a total of 14 . . while in the facility. During an interview on . at 10:00 a.m., the corporate nurse said are discussed on a daily basis and staff assess and re-assess residents. They put interventions in place, but they do not necessarily document those interventions for the residents. She said there was nothing in writing on record indicating they put any interventions in place. She was asked if there were any interventions or re-assessments for Resident #13. She said she will look on the record. She could not find any interventions. Practical Nurse Staff G on . at 11:11 a.m. said she has been working in the facility for 12	A 025		

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A 025	Continued From page 6 years. She said the resident had multiple . . . She said as far as she knows they did not put any interventions in place for her. She said some time ago, Resident #13 and broke her , and ended up in the skilled nursing next door. She returned and as far as she knows there was no change in the way they treated her. They did not do anything different. She said Resident #13 . . . . . her . . . right before she was discharged. Record review for Resident #13 found she had a right . . . . . on . . . . . . The resident was admitted to skilled nursing for rehabilitation. No new intervention in place after the first . On at 7:13 a.m., the director of resident care (DRC) said residents were to be assessed upon admission, quarterly and when a significant change takes place. The level of care and monthly fees are adjusted based on outcome of the assessment. Record review for Resident #13 found she was receiving Level III care. The DRC said they have a policy that speaks to that and provided a copy. Staff C (LPN) said on at 2:02 p.m., he did not notify Resident #13's daughter after the that took place on . Staff C said it was a misunderstanding on his end. He said he usually fills out the incident report and calls the family right away. He said when he found the resident on the floor she told him she did not . He said he believed her and that was why he did not feel out the form right away. He said a few days after when she was complained of , . , he realized that was a mistake then he filled out the form and called her daughter. Staff C was asked by the surveyor, what did he mean by saying that even	A 025		

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A 025	Continued From page 7 though the resident was found on the floor he though that was not a ? Staff C said, "you know when they just slid off the chair or bed." Staff C said he was aware Resident #13 had multiple . Staff C acknowledged no further interventions were in place after Resident #13's multiple . He said, "I check them times each shift. I told upper management, they knew about it. No we did not do anything different." The facility's personal service plan policy and procedure that was issued on and was reviewed on . Protocol: A personal service plan (PSP) is developed per the following schedule: Initially- pre-residency. Community specific may be updated 30 days after move in and then quarterly. Change in condition. The executive director or director of resident care is responsible for completing the initial personal service plan. Post incident report if change service required. The PSP is updated by collecting information from: Resident Family Care associates Record review for Resident #13 found a contract dated . Per contract on record resident was identified as needing level of care III assistance. An additional $1500.00 monthly fee applied to resident's monthly rent. Per level III care assistance policy and procedure issued , revised , reviewed , Resident #13 was to be provided one person transfer assistance. Actual assistance was unable to be verified since all 14 the resident had during the course of her stay were	A 025		

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A 025	Continued From page 8 marked as unwitnessed. No documentation was found on record indicating Resident #13 was provided with verbal reminders that she needed to call when she needed help to transfer. In addition, there was no documentation on record indicating the facility met with the family in order to discuss the resident's multiple or potential interventions. 2. Resident #15 was admitted on . On at 6:00 p.m. Resident #15 was found on the floor on her button with her against the recliner. She said she had tried to stand up, got , and on the floor. The daughter and physician were notified. The physician examined the resident the same day . She complained of , at her right . An , was ordered. No negative outcome. At 8:00 p.m. the resident was found on the floor again. She refused to be assisted. She said she wanted to stay on the floor until tomorrow so her daughter and her attorney can see that no one cares. The resident continued refusing to be assisted they finally convinced her to go to bed at 8:20 p.m. No negative outcome. On the resident was found on the floor in her bathroom. The resident was very upset. No negative outcome. The daughter was notified. The physician (MD) was notified. On at 8:30 p.m., the resident was observed on the floor in front of the bathroom door alert and responsive and unable to state how she . No apparent injuries. The daughter and MD were notified. On at 6:40 a.m., the resident was found on the floor in her bathroom unable to state how she . The resident obtained a tear at the right	A 025		

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A 025	Continued From page 9 side of her [illegible] and right [illegible], The daughter was notified. The resident was transferred via emergency medical service ([illegible]) to the hospital for treatment. On [illegible] the resident was observed laying on the floor by her recliner at 11:45 a.m. Post [illegible] protocol with no issues. On [illegible] at 11:45 a.m., the resident was found on her on the floor by her recliner, No issues. The family and MD were notified. Post protocol ok. On [illegible] at 3:10 p.m., the resident was found on the floor. She said she [illegible] as she was trying to get out of her bed. Post [illegible] protocol followed ok no issues. MD and resident's daughter were notified. On [illegible] the resident was found on the floor at 12:00 p.m. She said she went backwards and ended up on the floor. The daughter was notified. The resident's physician was notified and post protocol was followed. On [illegible] at 8:00 a.m., the resident was found on the floor laying [illegible] up. On [illegible] at 9:00 a.m., the resident's physician ordered an [illegible], for [illegible] reviews. On [illegible] the family hired a private caregiver. On [illegible] at 8:30 p.m., the resident [illegible] on the floor with private caregiver present. The resident was agitated at time. Post [illegible] protocol no issues. On [illegible] at 7:00 p.m., the resident [illegible] and was observed sitting on the floor. The family was notified.	A 025		

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A 025	Continued From page 10 The DRC said on . . . . at 8:30 a.m., the resident's daughter had given the facility a 30 day notice. The day before the resident was supposed to be discharged she had a resulting in . . . . . Resident #15 was complaining of , on her , . She was sent out for evaluation. She broke her right , . She never returned to the facility. There was an incident report in place dated . . . . . indicating Resident #15 off her bedside on at 2:40 a.m. The facility notified the resident's daughter at 2:43 a.m., and the resident was sent out for evaluation. Resident #15 never returned to the facility. Resident #15 obtained a right , as a result of the . . No interventions were found on record after the resident's multiple . The DRC said on at 10:06 a.m., no further interventions or medication reviews took place even though the resident almost daily. The DRC said, "no we did not do anything different." The administrator said on at 10:21 a.m., "I inherited a major problem. I don't know what to say. I have know idea why nothing was done. They should have reassessed the residents." On . . . at 10:34 a.m., Staff C said he had been working for the facility for about a year and a half ago. He said Resident #15 had . . . . and forgot that she needed help. She tried to get up and and . . We told management about it. I will check on her times every shift that's about it. No we had no other interventions." Per contract on record Resident #15 was identified as needing level of care III assistance. An additional $1500.00 monthly fee was applied to resident's	A 025		

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A 025	Continued From page 11 monthly rent. Per level III care assistance policy and procedure issues , revised , reviewed . Resident #15 was to be provided one person transfer assistance. Actual assistance was unable to be verified since all . Resident #15 had during the course of her stay were marked as unwitnessed. No documentation was found on record indicating Resident #15 was provided with verbal reminders that she needed to call when she needed help to transfer. In addition, there was no documentation on record indicating the facility met with the family in order to discuss the resident's multiple or potential interventions. Class II	A 025		
A 168	429.24(3)(a) FS; 429.27(7), FS Resident Refund Policy 429.24(3)(a) The contract shall include a refund policy to be implemented at the time of a resident's transfer, discharge, or . The refund policy shall provide that the resident or responsible party is entitled to a prorated refund based on the daily rate for any unused portion of payment beyond the termination date after all charges, including the cost of damages to the residential unit resulting from circumstances other than normal use, have been paid to the licensee. For the purpose of this paragraph, the termination date shall be the date the unit is vacated by the resident and cleared of all personal belongings. If the amount of belongings does not preclude	A 168		

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A 168	Continued From page 12	A 168		

renting the unit, the facility may clear the unit and charge the resident or his or her estate for moving and storing the items at a rate equal to the actual cost to the facility, not to exceed 20 percent of the regular rate for the unit, provided that 14 days' advance written notification is given. If the resident's possessions are not claimed within 45 days after notification, the facility may dispose of them. The contract shall also specify any other conditions under which claims will be made against the refund due the resident. Except in the case of or a discharge due to medical reasons, the refunds shall be computed in accordance with the notice of relocation requirements specified in the contract. However, a resident may not be required to provide the licensee with more than 30 days' notice of termination. If after a contract is terminated, the facility intends to make a claim against a refund due the resident, the facility shall notify the resident or responsible party in writing of the claim and shall provide said party with a reasonable time period of no less than 14 calendar days to respond. The facility shall provide a refund to the resident or responsible party within 45 days after the transfer, discharge, or of the resident. The agency shall impose a fine upon a facility that fails to comply with the refund provisions of the paragraph, which fine shall be equal to three times the amount due to the resident. One-half of the fine shall be remitted to the resident or his or her estate, and the other half to the Health Care Trust Fund to be used for the purpose specified in s. 429.18.

429.27, FS Property and personal affairs of residents. -
(7) In the event of the of a resident, a licensee shall return all refunds, funds, and

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(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 168	Continued From page 13 property held in trust to the resident's personal representative, if one has been appointed at the time the facility disburses such funds, and, if not, to the resident's spouse or adult next of kin named in a beneficiary designation form provided by the facility to the resident. If the resident has no spouse or adult next of kin or such person cannot be located, funds due the resident shall be placed in an interest-bearing account, and all property held in trust by the facility shall be safeguarded until such time as the funds and property are disbursed pursuant to the Florida Probate Code. Such funds shall be kept separate from the funds and property of the facility and other residents of the facility. If the funds of the resident are not disbursed pursuant to the Florida Probate Code within 2 years after the resident's , the funds shall be deposited in the Health Care Trust Fund administered by the agency. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a refund within 45 days as it is required for 1(Resident #13) out of 3 residents reviewed. The findings included: During a telephone interview at 9:46 a.m., Resident #13's daughter (durable power of attorney) said she did not get a full refund after her mother was discharged from the facility. She	A 168		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964626	A. BUILDING: _____ B. WING _____	09/18/2019

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A 168	Continued From page 14 said she provided a 30 day notice on . On her mother had a . Her mother ended up in the hospital due to obtained secondary to the . She went for rehabilitation to the nursing home next to the facility. Resident #13's daughter felt the issue has not yet been resolved even though it has been close to 85 days. She said they offered them a partial refund of about $2208.00, but they feel they need about $3100.00. She said when her mother was at the hospital having surgery, they charged them for medication management and level of care charges even though she was not there. She said in 2016 or 2017 when she was out of the building for another surgery, they charged them only for basic rent not medication management and level of care while she was out. Record review for Resident #13 found a contract dated . Per the contract on record, Resident #13 was identified as needing level of care III assistance. An additional $1500.00 monthly fee applied to the resident's monthly rent. Record review for Resident #13 found Resident #13's daughter provided the facility a written 30 day notice of discharge on . Resident #13 had a on . Resident #13 was sent to the hospital on . Resident #13 had a surgery due to of the lower . She was transferred to a skilled nursing facility on for rehabilitation. The resident move out day was . Financial record review for Resident #13 found the resident's daughter was entitled to a refund of $1589.48. The money was not refunded to the resident's daughter. The facility applied it as a credit towards residents nursing home bill.	A 168		

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A 168	Continued From page 15 During an interview on at 12:10 p.m., the business office manager (BOM) confirmed Resident #13 was entitled to a refund. Instead of giving the refund they transferred the money to the skilled nursing facility located next to the assisted living facility. The BOM said Resident #13 had Humana as a primary insurance and had a co-payment for skilled nursing services. The BOM said she did not think it was a big issue since both the assisted living facility and the skilled nursing are the same corporation. The BOM said she did not realize the importance of providing the refund to the resident. She said, "eventually when the whole issue with Humana was resolved they ended up getting a refund. I don't see what the issue is. No it was not done within 45 days. No, I didn't know that had to be done within 45 days. I had a meeting with the family couple weeks ago. I understand they should not have to pay for medication management or level of care since resident was not here. It is not my decision to make. I had to bring it to corporate. They will have to make the decision. I sent them a check for $2289.49 few days ago. Here look." Record review for Resident #13 found a refund of $2289.48 as of . . . . . the BOM e-mailed the executive director with a breakdown of additional refund for level of care $394.74 and medication management $85.53. During an interview on at 10:34 a.m., the executive director (ED) said she was recently made aware of the issues. She acknowledged there was an issue. She said taking the resident's refund and placing it as credit towards the nursing home bill was not an appropriate course of action. She said she had to re- educate staff to make	A 168		

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A 168	Continued From page 16 them understand that the assisted living facility is a separate entity with a different license number and they had no right to take the resident's refund and place it as a credit to the nursing home bill. She said she had arranged a meeting with the family on at 11:00 a.m. In a follow up interview on at 1:10 p.m., the ED said the family did not come to the facility even though they had an , , with her. She said she had made arrangements and an additional $540.00 refund will be issued to resident's daughter. Class III	A 168		