

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>AL11965157</b>	(X3) DATE SURVEY COMPLETED  <b>10/18/2016</b>
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NAME OF PROVIDER OR SUPPLIER <b>HARBORCHASE OF CORAL SPRINGS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2975 NW 99TH AVENUE CORAL SPRINGS, FL 33065</b>
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SUMMARY STATEMENT OF DEFICIENCIES  
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

**0000 Initial Comments**

An unannounced licensure survey with Extended Congregate Care services was conducted on \_\_\_\_\_ through \_\_\_\_\_ at Harbor Chase of Coral Springs (license #9503). The facility had a deficiency identified at the time of the visit.

**0054 Medication - Records**

Based on interview and record review, the facility failed to maintain accurate Medication Observation Records (MORs) for each resident in which the facility's staff provided assistance with self-administered medications, for 4 out of 81 sampled residents (Resident # 17, # 18, # 19 and # 20) MORs. As evidence of the facility failure to sign the MORs immediately after assisting residents with his/her medication(s).

The findings include:

On \_\_\_\_\_ at 11:20 AM, a review of the facility's MORs revealed Resident #17 -#20 were prescribed 9 AM medication. However, further review of the MORs found no documentation was noted on the MORs for assistance provided on \_\_\_\_\_ at 9 AM to Resident # 17, # 18, # 19 and # 20 (photographic evidence obtained). On \_\_\_\_\_, interviews with all residents, (Resident #17-#20) in the facility revealed they had received their medications on time.

During an interview with Staff X and the Administrator at 11:35 AM; Staff X was asked why she did not sign the MORs at the time assistance was provided to each resident. Staff X stated she was going to sign the MORs but became distracted when other residents required attention and she forgot to sign the MORs.

In an interview with the Administrator on \_\_\_\_\_ at 11:40 AM, she acknowledged the findings and stated no further information was available for review.

Class III



RICK SCOTT  
GOVERNOR

JUSTIN M. SENIOR  
INTERIM SECRETARY

September 1, 2016

Administrator  
Harborchase Of Coral Springs  
2975 NW 99th Avenue  
Coral Springs, FL 33065

**RE: Relicensure survey with Extended Congregate Care**

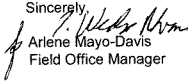
Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on September 1, 2016 by representatives of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than September 1, 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtm> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representatives. Should you have any questions please call this office at (561) 381-5840.

Sincerely,  
  
Arlene Mayo-Davis  
Field Office Manager

AMD/dso  
Enclosure: State form 5000-3547  
XG90

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