STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105538	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbour Health Center	23013 Westchester Blvd Port Charlotte, FL 33980

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, review of facility's policy and procedure, and staff interviews, the facility failed to ensure the medical record for 1 (Resident #1) of 3 residents reviewed was complete by failing to safeguard medical record information against destruction.The findings included:Review of the facility's policy and procedure titled, admission Assessment and Follow Up: Role of the Nurse revealed the steps in the procedure included, .Reconcile the list of medications from the medication history, admitting orders, the previous Medication Administration Record (if available), and the discharge summary from the previous institution, according to established procedures. 12) Contact the Attending Physician to communicate and review the findings of the initial assessment and any other pertinent information and obtain admission orders. Documentation: The following information should be recorded in the resident's medical record: 5) Orders obtained from the physician; 6) the signature and title of the person recording the data.Review of the facility's Policy titled, Retention of Medical Records revised 2006 revealed, Medical records shall be retained by the facility in accordance with current applicable laws. Policy Interpretation and Implementation: 1) Medical records of discharged residents will be retained for a period of 5 years. 2) Inactive medical records, those that extend beyond the above requirements, will be destroyed. 3) Persons delegated by the administrator shall witness the destroying of the medical records. 4) A record of the medical records destroyed shall be maintained and shall include at least the following: a) Date and time destroyed; b) medical record number; c) how records were destroyed; d) where medical records were destroyed e) signature of personnel destroying records; and f) others as appropriate or necessary.Review of the Medical Records Coordinator job description revealed the medical records secretary is responsible for the proper recording, filing and upkeep of the Health Center medical records.Review of the medical record for Resident #1 revealed an admission date of 7/4/25 from an acute care hospital. Diagnoses included hip fracture, post hip surgery, hypothyroidism (abnormally low activity of the thyroid gland), hypertension (high blood pressure) and arthritis.The medical record lacked documentation of signed admission physician's orders. There was no documentation the discharge summary and list of medications from the acute care hospital were reviewed and communicated to the attending physician.On 12/30/25 at 12:32 p.m., in an interview Unit Manager Registered Nurse (RN) Staff A said hospital discharge orders are sent with the resident from the hospital. She said the Unit Managers are responsible for entering new admission orders into the electronic medical record. She said the physician is notified to verify the orders. She said the nurse who calls the physician should write a progress note including date, time the physician was contacted and any new orders. Unit Manager RN Staff A said a second nurse checks the medications and initials the hospital discharge orders. She said the completed admission orders are placed in the physician's binder for signature. She said once the admission orders are signed, it goes to medical records for filing.On 12/30/25 at 12:50 p.m., in an interview the Medical Records Coordinator Staff B said the admissions orders for Resident #1 had been shredded. She said sometime around July an Interim Director of Nursing (DON) told her there would be no paper charts going forward and told her to shred the residents' records. Staff B said she shredded residents' records from July 2025 through October 2025 until the Administrator told her not to shred residents' records. She said there was no record of the medical records that were destroyed.On 12/30/25 at 2:30 p.m., in an interview the Director of Nursing (DON) said that she could not find any documentation or evidence that the nurse called the physician to verify Resident #1's admission orders. She said no progress note was written and Medical Record Coordinator Staff B shredded Resident #1's original hospital discharge orders. The DON said it was not the facility's current practice to shred residents' medical records. She said a prior interim DON had asked Staff B to shred the documents.On 12/30/25 at 4:30 p.m., in an interview, the Administrator said he was not aware until today that medical records were being shredded. Staff B told him she was following orders. He said, Shredding medical records is not our practice. The Administrator said they have to look at proper destruction procedures and the whole medical record retention process.