

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER THE HARMONY HOUSE OF OCALA		STREET ADDRESS, CITY, STATE, ZIP CODE 5762 S.W. 60TH AVENUE OCALA, FL 34474			
(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 re-licensure survey with Emergency Power Plan monitoring was conducted at The Harmony House of Ocala on through Deficiencies were identified at the time of the survey.	A 000			
A 078	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable	A 078			

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER THE HARMONY HOUSE OF OCALA			STREET ADDRESS, CITY, STATE, ZIP CODE 5762 S.W. 60TH AVENUE OCALA, FL 34474		
(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 078	Continued From page 1 (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that 2 of 3 staff sampled (Staff B and Staff C) submitted a written statement from a health care provider documenting that the individual does not have any signs or symptoms	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER THE HARMONY HOUSE OF OCALA			STREET ADDRESS, CITY, STATE, ZIP CODE 5762 S.W. 60TH AVENUE OCALA, FL 34474		
(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 078	Continued From page 2 of communicable within 30 days after beginning employment, and failed to ensure that 2 of 3 sampled employees (Staff A and Staff B) submitted evidence of a negative examination on an annual basis. Findings include: Review of employee records conducted on revealed that Staff A, Medication Technician, was hired on . Staff A's record did not have the documentation of a completed negative () examination. Review of employee records conducted on revealed Staff B, Resident Care Aide was hired on . Staff B's record revealed that there was no written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . Staff B's record also did not have any documentation of a completed negative () examination. Review of employee records conducted on revealed Staff C, Resident Care Aide was hired on . Staff C's record revealed that there was no written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . During an interview on at 10:28 AM, the Administrator stated, "No test and/or have been completed yet on these employees. No forms for Free of Communicable have been completed at this time." Class III	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER THE HARMONY HOUSE OF OCALA		STREET ADDRESS, CITY, STATE, ZIP CODE 5762 S.W. 60TH AVENUE OCALA, FL 34474			
(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 152	Continued From page 3	A 152			
A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable ↳ to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not	A 152			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER THE HARMONY HOUSE OF OCALA			STREET ADDRESS, CITY, STATE, ZIP CODE 5762 S.W. 60TH AVENUE OCALA, FL 34474		
(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 152	Continued From page 4 be This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe, clean living environment for all residents who use the hallways and living room area and for 4 residents (Residents #10, 13, 14, and 15) out of 15 residents sampled for room observations. Findings include: During an observation of the facility on _____ at 10:00 AM, several residents were sitting in the activity room waiting for staff. A stale odor of _____ and _____ movement was present in the activity room, the end of the 300 Hall, in the front Television Viewing/Lobby Area, and on the 100 Hall. At 10:30 AM, Resident #10's bathroom sink was observed to be cracked and a sticky substance with black flecks observed on the floor of the bedroom from the bed to the bathroom. At 10:35 AM, Resident #15's bathroom was found to have an empty bleach bottle which still had a lingering odor of bleach on the bathroom counter. At 10:42 AM, Resident #13's room was observed to have napkins soiled with brown substance on the floor under the desk and next to the bedside table, a brown substance smeared on the bathroom floor, and an adult brief in the corner of the bathroom soiled with brown substance. At 10:46 AM, Resident #14's electric controlled bed was not plugged in and the electrical outlet cover was on the cord lying on the floor beneath the bed. There was a black substance on the bottom front edge of the toilet in his bathroom and the bathroom baseboard was peeling in several areas. During an observation on _____ at 11:35 AM	A 152			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER THE HARMONY HOUSE OF OCALA			STREET ADDRESS, CITY, STATE, ZIP CODE 5762 S.W. 60TH AVENUE OCALA, FL 34474		
(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 152	Continued From page 5 conducted with the Administrator, all of the resident rooms remained in the same condition and the lingering odor was present in the 300 Hall and the 100 Hall. During an interview conducted on at 11:39 AM, the Administrator confirmed bleach was not to be used in the bedrooms at all and the container should not have been left on the bathroom counter, the electrical outlet cover should be attached to the wall and the bed plugged in, the floors in Resident #10's room needed to be cleaned and refinished and the sink needed replacing. She further reported that the soiled brief and items in Resident #13's room needed to be removed and disposed of and that all resident rooms and common areas should be odor free. Review of facility policy titled, "Maintenance plan," dated read, "Repair of building, furnishings and grounds... plumbing- check plumbing regularly. make necessary repairs immediately.... electrical: check wiring and equipment regularly and repair as needed." Review of facility policy titled, "Housekeeping Checklist," dated read, "The following times that must be done daily:... 5. make sure room has no odor. 6. report any maintenance problem..The following that are to be done in addition to daily scheduled housekeeping: 2. clean and sanitize... floors... make sure floor is clean, odor and stain free..." Class III	A 152			