STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967020	07/28/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Harmony Care Home Inc	534 Se Thanksgiving Ave Port Saint Lucie, FL 34984	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced Limited Nursing Services (LNS) survey was conducted on at the Harmony Care Home Inc. The facility had a deficiency found at the time of the visit.

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observation and interviews, the facility failed to ensure residents' medications were stored in a locked cabinet or all times.

The findings include:

An observation of the medication storage was conducted on at 11:35 AM. The Administrator was asked to show the surveyor where residents' medications were stored. She escorted the surveyor into an office was directly opposite two occupied resident Observations of the an unlocked cabinet with numerous residents' medications inside. They cabinet had a lock in place, but it had not been locked. When asked if the cabinet is locked, the Administrator stated that residents are not allowed into the office so the cabinet is kept open. When asked to locate the key to the cabinet, the Administrator unsuccessfully attempted to locate a key. She confirmed that the key was not in the building and might be with another staff member who was off duty. The Owner arrived at the facility at approximately 1:32 PM, and confirmed that medications should be locked at all times.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Harmony Care Home Inc
534 SE Thanksgiving Ave
Port Saint Lucie, FL 34984

RE: Limited Nursing Services Survey

Dear Administrator:

This letter reports the findings of a monitoring survey that was conducted on , 2014 by a representative 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. Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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.shtml 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure

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