RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Harmony House At Ocala
5762 S.W. 60th Avenue
Ocala, FL 34474

Dear Administrator:

This letter reports the findings of a complaint (CCR#2016003761) inspection survey conducted on - , by representatives of the Agency for Health Care Administration (Agency). Enclosed is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) as directed below:

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0025 - 429.26(7) Fs; 58a-5.0182(1) Fac - Resident Care - Supervision S-S=Class II

The facility failed to provide supervision to prevent one resident from eloping out of the secure assisted living facility; the facility failed to notify the physician and the public guardian after the resident eloped out of the secure assisted living facility and after the resident exhibited signs of a change in condition; and, the facility failed to document in the record significant changes for the resident after the resident eloped out of the secured assisted living facility and after the resident was observed by facility staff to be exhibiting signs of and .

St - A - 0030 - 58a-5.0182(6) Fac; 429.28(1-2) Fs - Resident Care - Rights & Facility Procedures S-S=Class II

The facility failed to ensure that one resident was living in a safe environment, free from negelct, due to the facility's failure to ensure the resident did not elope from the secure assisted living facility. The facility failed to obtain medical care for the resident after numerous facility staff observed a change in condition, as the resident was exhibiting and symptoms.

St - A - 0032 - 58a-5.0182(8) Fac - Resident Care - Elopement Standards S-S=Class II

The facility failed to follow their Elopement Policy and Procedure by not notifying the physician and responsible party after the resident eloped out of the secure assisted living facility.

St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S=Class III

The facility failed to ensure that one staff person, Licensed Practical Nurse (LPN)/Resident

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Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

Care Director, had completed the required Elopement Response In-Service Training.

St - A - 0165 - 429.23(1-4 & 6-10) Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S=Class II

The facility failed to complete an AHCA Adverse Incident Report, failed to notify the Department of Children and Families (DCF), and failed to conduct an internal investigation after the resident eloped out of the secured assisted living facility. The resident was found in the facility parking lot on a and rainy morning.

Directed Corrective Actions:

1. The Assisted Living Facility is required to establish an Elopement Policy and Procedure to include: measures to prevent residents from elopement; procedures to ensure that the proper and required entities, to include law enforcement, Department of Children and Families (DCF), the resident's physician, and the resident's responsible party, are notified once it is determined that a resident has eloped from the facility; procedures to be followed to direct the search of the facility's internal and external premisis in a coordinated effort to locate the resident; procedures to be followed once the eloping resident is located, to include a medical assessment, an assessment to determine future risk of elopement; and, an assessment of system failures that led to the resident elopement, and subsequent corrective measures to prevent recurrence of elopement. The Administrator, the Resident Care Manager, and the Resident Care Director must be actively involved in the quality assurance assessment. Documentation of the above must be maintained and available for review by the Agency upon request. **This must be completed by** .

2. The Assisted Living Facility is required to train all facility staff on the policy above. Documentation of the training, including sign-in sheets and any materials, must be maintained and available for review by the Agency upon request. **This must be completed by** .

3. The Assisted Living Facility is required to establish a Resident Change In Condition Policy and Procedure to include: a definition of what consitutues a change in condition; who is to be notified of the change in condition, to include internal facility staff and the residents' physician and responsible party; and, steps to follow in documenting significant changes in residents to include documenting the significant changes in the residents' facility records. The policy and procedure must include steps to be taken by the facility Resident Care Manager and Resident Care Director to ensure that residents exhibiting a significant change in condition receive the needed medical assessment and care. Documentation of the above must be maintained and available for review by the Agency upon request. **This must be completed by** .

4. The Assisted Living Facility is required to train all facility staff on the policy above. Documentation of the training, including sign-in sheets and any materials, must be maintained and available for review by the Agency upon request. **This must be completed by** .

5. The Assisted Living Facility is required to re-train all facility staff on resident rights and

recognizing and report , neglect, and of adults. This training must be provided by a representative of the Department of Elder Affairs or the Department of Children and Families or an approved provider by one of those agencies. Documentation of the above must be maintained and available for review by the Agency upon request. **You must initiate contact and schedule this training within 10 days of receipt of this letter.**

6. The Assisted Living Facility is required to re-train all facility staff on incident reporting, to include what constitutes an adverse incident; who is the designated contact in the facility to report adverse incidents to; and, the Administrator, Resident Care Manager, and Resident Care Director will implement procedures in writing to determine when, and by whom, AHCA Adverse Incident Reports will be completed. Documentation of the above must be maintained and available for review by the Agency upon request. **This must be completed by .**

7. The Assisted Living Facility is required to assess all residents for their current risk of elopement. This elopement risk assessment must be documented in the residents' facility records. Any residents who are assessed as at risk for elopement must have a safety plan developed and implemented to prevent elopement. Furthermore, the facility management, to include the Maintenance Director, must assess the facility's secure entrances and exits, to include the kitchen, to ensure that all entrances and exits are secure, lessening the risk of resident elopement. This assessment must also include evaluating the wooden fences on the far side of the facility courtyard, to ensure that residents are not at risk of eloping through in the wooden fences or through the gates. Documentation of the above must be maintained and available for review by the Agency upon request. **This must be completed by .**

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact Charles Bory, Alachua-Area 3 Office Supervisor, at 386-462-6201.

Sincerely,

Charles Bory for

Kriste J. Mennella
Field Office Manager

KJM/CB
Enclosures

Received by Date

D7JR

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Alachua Field Office
14101 N W Hwy 441, Suite 800
Alachua, FL 32615-5669
Phone (386) 462-6201; Fax (386) 418-5300

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911084	04/12/2016
NAME OF PROVIDER OR SUPPLIER **HARMONY HOUSE AT OCALA**	STREET ADDRESS, CITY, STATE, ZIP CODE **5762 S.W. 60TH AVENUE** **OCALA, FL 34474**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

An unannounced complaint investigation for CCR#2016003761 was conducted on and at The Harmony House at Ocala. The Harmony House at Ocala had deficiencies at the time of the investigation.

0025 Resident Care - Supervision

Based on observation, interview, and record review, the facility failed to provide adequate supervision to 1 of 46 residents (Resident #1) to prevent elopement from the secure facility; the facility failed to notify the physician and the public guardian for 1 of 46 residents (Resident #1) after the resident eloped out of the secured assisted living facility and after the resident exhibited signs of a change in condition; and, the facility failed to document in the record significant changes for 1 of 46 residents (Resident #1) after the resident eloped and after the resident was observed by facility staff to be exhibiting signs of and

Findings:

1.) A tour of the facility on at 9:36 AM showed that the facility was locked and secured. There was an additional locked unit within the secured building. There were two doors, with key locks, that lead into the kitchen which was located within the additional locked unit. The kitchen also contained a large window with a counter used to put meal plates on for the staff to serve to the residents at meal times. There was a metal shutter, with a padlock, that slid up and down at the kitchen serving window. During the tour, all doors were checked and all were found to be locked. All of the doors, except for the two doors leading into the kitchen, were observed to have keypad locks. The exit door in the kitchen, to the outside of the building, was observed to have a knob device for locking and unlocking.

On at 9:40 AM, during the tour of the facility, an interview was conducted with the Licensed Practical Nurse (LPN)/Resident Care Director. She stated, to her knowledge, Resident #1 had not wandered from the building.

On a review of Resident #1's facility record revealed a Resident Health Assessment (AHCA Form 1823), dated , that showed diagnoses of (ETOH) and . Resident #1 was documented as an elopement risk. Page three of the Resident Health Assessment showed daily observation of well-being and whereabouts checked. There was no documentation in the facility record regarding the resident wandering out of the facility on .

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On at 11:52 AM, a follow-up interview was conducted with LPN/Resident Care Director. She stated they do not have proof of documentation of well-being or whereabouts checks for Resident #1 daily, but stated there is a meal roster.

An interview was conducted on at 12:48 PM with Certified Nursing Assistant (CNA)/Resident Care Manager. She stated she received a telephone call from Staff F, who worked the overnight shift on . She stated Staff F told her they were getting off duty when Staff D saw Resident #1 outside in the front parking lot. She stated she did ask Staff F when was the last time that they saw Resident #1 and she was told that they last saw him around 6:15 AM when Resident #1 asked for a cigarette. She stated they found Resident #1 outside at around 7:00 AM. She stated she told LPN/Resident Care Director on Thursday night that Resident #1 had gotten out of the facility and had a slight . She stated LPN/Resident Care Director told her that this was the first time she had heard about this.

An interview was conducted on at 1:30 PM with Staff A. She stated on she was just coming to work and it was kind of dark. She stated after she clocked in, Staff D said Resident #1 had gotten out of the facility. She stated she did see Resident #1 after he was brought back into the facility. Resident #1 had a snotty nose and looked sort of wet. She stated this was at 7:00 AM on Tuesday.

An interview was conducted on at 1:50 PM with Staff B. He stated when he came to work last week, on , Staff D from the overnight shift told him she found Resident #1 out by her car. He stated he called the CNA/Resident Care Manager, and then the Administrator. He stated the Administrator told him to keep an eye on Resident #1. He stated he spoke to Resident #1, who told him he was out of the facility for about two hours. He stated Resident #1 told him that he got out through the kitchen. He stated Resident #1's pants were wet and dirty and Resident #1 was short of breath. It was rainy and outside that morning.

An interview was conducted on at 3:39 PM with the Administrator. He stated Resident #1 left the building when it was raining. Staff D was leaving from the overnight shift and saw him outside. He stated Staff D and Staff B brought Resident #1 back inside.

An interview was conducted on at 7:01 AM with Staff D. She stated on Thursday morning, , she worked the midnight shift and clocked out at 6:54 AM. She stated when she walked out the door, Resident #1 was coming from the highway. She stated she asked Resident #1 what he was doing outside. She stated Resident #1 was wet and his nostrils were full of .

An interview was conducted on at 7:16 AM with Staff E. She stated on Thursday, , she came on duty at 11 PM. She stated throughout the night, Resident #1 was asking for cigarettes quite often. She did not give him cigarettes after 11:30 PM. She stated Resident #1 would go back and

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forth from his ask for cigarettes. The last time she saw him was around 5:00 AM when he asked for a cigarette again. She then stated she saw him again sometime around 6:00 AM when he asked Staff F for a cigarette. After that, she stated she remembered seeing the kitchen window was open. She stated another resident, Resident #2, was rolling the kitchen window shutter up and down. She stated they got Resident #2 away from the window and then pushed the shutter down. She stated about 15 minutes after that Staff D came and said Resident #1 got out. She stated Resident #1 seemed wet and out of breath. She stated they told Staff B that Resident #1 had gotten out. Staff B then contacted the CNA/Resident Care Manager. She stated she asked Resident #1 how he got out and he said he got out through the kitchen. She stated all doors are locked and have key codes. She stated the kitchen doors are usually locked, but the shutter to the kitchen window was open that night.

An interview was conducted on at 7:32 AM with Staff F. She stated she Resident #1 early in the morning before he eloped. She stated he asked her for a cigarette by the back porch in the lounge area. She told him it wasn't time for a cigarette, he went and sat on the back porch. She stated she dropped linen off, then about 6:25-6:30 AM, he again asked for a cigarette. She stated the next thing she knew it was about 7:00 AM, Staff D was bringing him back inside. She stated Resident #1 was soaking wet, breathing heavy, white snot was coming out of his nose. She stated she is not 100% sure how he got out of the building. She stated she and Staff E saw Resident #2 on that shift, lifting the shutter to the kitchen window, she didn't think anything of it. She stated the doors at night are locked; that was the first morning she has ever seen the kitchen window unlocked. She stated she is constantly checking the residents. She stated that morning she thought she saw him go back to his .

An interview was conducted on at 9:58 AM with the LPN/Resident Care Director. She stated she was not notified when Resident #1 wandered out of the building. When asked about other staff saying she was notified of this, she stated they are telling non-truths. She stated yesterday is first time she heard about it, from the Administrator. She stated the doors all are electronically and magnetically locked; the door leading out of the kitchen is not key-code locked.

An interview was conducted on at 8:46 AM with the Dietary Manager. She stated she worked 7:00 AM to 6:00 PM on Wednesday, . She stated after the dinner meal, she was cleaning. She stated she made sure everything was locked, she makes sure the little lock on the kitchen window is closed and locked. She stated the kitchen has 3 doors, inside doors are always locked, and need a key to unlock them. She stated she, the other cooks, and the had keys. She stated the outside kitchen door will open from the inside when you pull up on the handle. She stated it has to be this way due to fire regulations. She was here the morning of at 6:40 AM. When asked how did she enter the kitchen on the morning of , she stated she a used key to go through kitchen side door. When asked, she stated the kitchen window shutter was closed, but she can't say for sure it was locked. She then stated she forgot to close and lock the padlock on the shutter on the kitchen window on night of

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. She stated the padlock was just hanging in there, unlocked.

2.) A review of Resident #1's facility record showed a note entered on at 11:40 AM which documented in part: staff asked writer to come to resident's unable to rouse resident for meal. Resident noted laying on his bed on his back, resident failed to respond to his name, resident was shaken, unable to palpate pulse, was initiated, 911 was called. Prior note entered was dated /. It read seen by Nurse Practitioner, orders received to obtain level and . No notes entered between / and , no notes entered regarding him having symptoms.

A review of the facility's Elopement Policy and Procedure, which is entitled Missing Resident Checklist, showed the following: Assign staff to search community interior, scan perimeter, if resident is not observed, call family responsible party, continue search, call executive director, resident services director. Expand search, once found, assess immediately, including elopement risk assessment, if evidence of injury or pain complaints, send to emergency . Place resident on short-term monitoring, ideally 1:1 supervision. Refer resident to a physician for evaluation to rule out cause. Ensure safety and direct supervision (via family, paid companion, increased staffing) until the resident has been evaluated by MD or /behavioral health center and re-assessed by staff for continued residency at the community. Invite responsible party in immediately and draft shared risk agreement (SRA). Communicate safety interventions with team. Update short-term monitoring, service plan and resident record. The policy and procedure defines Elopement as, "A resident leaves the residence without staff knowledge or supervision. The resident lacks safety awareness."

An interview was conducted on at 12:48 PM with Certified Nursing Assistant (CNA)/Resident Care Manager. She stated she received a telephone call from Staff F, who worked the overnight shift on . She stated Staff F told her they were getting off duty when Staff D saw Resident #1 outside in the front parking lot. She stated she told Staff F that she needed to call the Administrator and the LPN/Resident Care Director. She stated she was later told by Staff A that Resident #1 was completely soaking wet, coughing, and he looked like he was outside for a while. She stated she did ask Staff F when was the last time that they saw Resident #1 and she was told that they last saw him around 6:15 AM when Resident #1 asked for a cigarette. She stated they found Resident #1 outside at around 7:00 AM. She stated that she cared for Resident #1 on and . She stated Resident #1 sounded like he had a and was . She stated LPN/Resident Care Director knew that Resident #1 was . She stated she does not know if Resident #1 was seen by a doctor. She stated the Nurse Practitioner was at the facility last Tuesday or Wednesday before Resident #1 got out on Thursday morning. When asked, she stated if she notices a change in condition of a resident, she is

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supposed to let the nurse know. She stated the nurse is then supposed to contact the doctor and family. She stated she told LPN/Resident Care Director on Thursday night that Resident #1 had gotten out and had a slight [illegible]. She stated LPN/Resident Care Director told her that this was the first time she had heard about this. When asked, she stated she did not document that Resident #1 had a [illegible]. She further stated that there are hallway rosters where they document resident conditions, but the rosters are not saved. She stated the staff on duty do not always fill the hallway rosters out.

An interview was conducted on [illegible] at 1:50 PM with Staff B. He stated he noticed Resident #1 was sleeping a lot, a change from his regular status. He stated he did go to LPN/Resident Care Director and reported this. He stated Resident #1 appeared to be limping. He stated he notified LPN/Resident Care Director the same day, [illegible], Resident #1 wandered out of the facility. He stated they have hall rosters on each shift with residents' names. He stated they write if the residents slept, if they ate, if they acted normal or not. He stated they put the rosters in a plastic box in the break [illegible], then LPN/Resident Care Director or the Administrator picks them up.

An interview was conducted on [illegible] at 2:11 PM with the Nurse Practitioner. He stated he has been caring for Resident #1 for the past 6 months. He stated Resident #1 has heavy [illegible] and is a heavy smoker. He stated he was not contacted by the facility about Resident #1 being ill or wandering out of the facility.

An interview was conducted on [illegible] at 7:47 AM with Staff G. She stated she cared for Resident #1 the night before he [illegible]. She stated she noticed mainly his [illegible], he could barely talk, he had a [illegible] and runny nose. She stated he had a bad [illegible] for about week. She stated they all knew about his [illegible]. She wrote on a report he had been up all night and just laid down. She stated she puts the report in a paper holder in the break [illegible]. She stated she thinks the nurse, LPN/Resident Care Director, looks at the reports.

An interview was conducted on [illegible] at 8:40 AM with Resident #1's public guardian. She stated she visited Resident #1 once a month. When asked, she stated she was not aware that Resident #1 eloped out of the building and was found in the parking lot on [illegible]. She stated she was notified when Resident #1 [illegible], but not contacted prior to this. When asked, she stated she was not notified that he had a change in condition with a [illegible] and [illegible].

An interview was conducted on [illegible] at 9:10 AM with LPN/Resident Care Director. When asked for the hallway Resident Care Aid sheets for Resident #1 from [illegible] through [illegible], she stated the shift reports are destroyed once they are reviewed. When asked why the shift reports are destroyed, she stated they are destroyed because they are not legal records.

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An interview was conducted on at 9:17 AM with the Administrator. He stated they do not have a policy and procedure for resident observation sheets. He stated the Resident Care Aid observation sheets are destroyed, as the company does not require that they have them. When asked, he stated he did not document the facility's internal investigation regarding Resident #1 eloping from the facility. He stated he believes they notified Resident #1's public guardian, but then stated they did not notify the public guardian. He stated he believes LPN/Resident Care Director notified Resident #1's nurse practitioner. When asked, he stated Staff B told him that Resident #1 was wet, as it was raining out. He stated he was not told how Resident #1 was medically. He stated he saw Resident #1 every day after he wandered out of the building, until he . He stated he observed nothing unusual, he wanted his cigarettes, he was friendly.

An interview was conducted on at 9:58 AM with the LPN/Resident Care Director. She stated she was not notified when Resident #1 wandered out of the building. When asked about other staff saying she was notified of this, she stated they are telling non-truths. She stated yesterday is first time she heard about it from the Administrator. She stated she did see Resident #1 on ; he had a little bit of a runny nose. She stated staff told her Resident #1 was exhibiting ' ' symptoms. She stated she monitored Resident #1 the next couple of days. She stated the symptoms seemed to dissipate so she didn't ' do anything about it; she did not contact anyone; she did not contact the nurse practitioner. She stated each shift is responsible for filling out the hallway sheets, it is a tickler for the next hallway shift. She stated she or the Administrator reviews the hallway sheets to see if they need to contact a doctor for one of the residents. She stated the hallway sheets for Resident #1 documented that he requested cigarettes, and there were comments about ' ' symptoms. She stated Resident #1 was not getting medicine because they did not have a doctor's order, because she didn't ' feel it was absolutely necessary.

review of Change in Resident Condition Policy and Procedure dated I/ , reviewed 2014, stated in part: The Charge Nurse will recognize and appropriately intervene in the event of a change in resident condition. The Physician/Family/Responsible party will be notified as soon as the nurse has identified the change in condition and the resident is stable. Procedure: 5. The Resident/Physician/Family/Responsible Party will be notified when there has been: a. An accident or incident involving the resident; d. A significant change in the resident's physical/emotional/mental condition. 7. The clinical nurse will record in the resident's clinical chart information relative to changes in the resident's medical/mental condition or status.

3.) On at 11:52 AM, a follow-up interview was conducted with LPN/Resident Care Director. She stated they do not have proof of documentation of well-being or whereabouts checks for Resident

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#1 daily, but stated there is a meal roster.

An interview was conducted on at 12:48 PM with Certified Nursing Assistant (CNA)/Resident Care Manager. When asked, she stated if she notices a change in condition of a resident, she is supposed to let the nurse know. She stated the nurse is then supposed to contact doctor and family. She stated she told LPN/Resident Care Director on Thursday night that Resident #1 had gotten out and had a slight . ' '. She stated LPN/Resident Care Director told her that this was the first time she had heard about this. When asked, she stated she did not document that Resident #1 had a . ' '. She further stated that there are hallway rosters where they document resident conditions, but the rosters are not saved. She stated the staff on duty do not always fill the hallway rosters out.

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Class II

0030 Resident Care - Rights & Facility Procedures

Based on observation, interview, and record review, the facility failed to ensure that 1 of 46 residents (Resident #1) was living in a safe environment, free from neglect, due to the facility's failure to ensure the resident did not elope from the secured assisted living facility; and, due to the facility's failure to obtain medical care for the resident after numerous facility staff observed a change in his condition, as he was exhibiting symptoms and .

Findings:

1.) A tour of the facility on at 9:36 AM showed that the facility was locked and secured. There was an additional locked unit within the secured building. There were two doors, with key locks, that lead into the kitchen which was located within the additional locked unit. The kitchen also contained a large window with a counter used to put meal plates on for the staff to serve to the residents at meal times. There was a metal shutter, with a padlock, that slid up and down at the kitchen serving window. During the tour, all doors were checked and all were found to be locked. All of the doors, except for the

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two doors leading into the kitchen, were observed to have keypad locks. The exit door in the kitchen, to the outside of the building, was observed to have a knob device for locking and unlocking.

On at 9:40 AM, during the tour of the facility, an interview was conducted with the Licensed Practical Nurse (LPN)/Resident Care Director. She stated, to her knowledge, Resident #1 had not wandered from the building.

On a review of Resident #1's facility record revealed a Resident Health Assessment (AHCA Form 1823), dated , that showed diagnoses of (ETOH) and . Resident #1 was documented as an elopement risk. Page three of the Resident Health Assessment showed daily observation of well-being and whereabouts checked. There was no documentation in the facility record regarding the resident wandering out of the facility on .

On at 11:52 AM, a follow-up interview was conducted with LPN/Resident Care Director. She stated they do not have proof of documentation of well-being or whereabouts checks for Resident #1 daily, but stated there is a meal roster.

An interview was conducted on at 12:48 PM with Certified Nursing Assistant (CNA)/Resident Care Manager. She stated she received a telephone call from Staff F, who worked the overnight shift on . She stated Staff F told her they were getting off duty when Staff D saw Resident #1 outside in the front parking lot. She stated she did ask Staff F when was the last time that they saw Resident #1 and she was told that they last saw him around 6:15 AM when Resident #1 asked for a cigarette. She stated they found Resident #1 outside at around 7:00 AM. She stated she told LPN/Resident Care Director on Thursday night that Resident #1 had gotten out of the facility and had a slight . She stated LPN/Resident Care Director told her that this was the first time she had heard about this.

An interview was conducted on at 1:30 PM with Staff A. She stated on she was just coming to work and it was kind of dark. She stated after she clocked in, Staff D said Resident #1 had gotten out of the facility. She stated she did see Resident #1 after he was brought back into the facility. Resident #1 had a snotty nose and looked sort of wet. She stated this was at 7:00 AM on Tuesday.

An interview was conducted on at 1:50 PM with Staff B. He stated when he came to work last week, on , Staff D from the overnight shift told him she found Resident #1 out by her car. He stated he called the CNA/Resident Care Manager, and then the Administrator. He stated the Administrator told him to keep an eye on Resident #1. He stated he spoke to Resident #1, who told him he was out of the facility for about two hours. He stated Resident #1 told him that he got out through the kitchen. He stated Resident #1's pants were wet and dirty and Resident #1 was short of breath. It was

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(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

rainy and outside that morning.

An interview was conducted on at 3:39 PM with the Administrator. He stated Resident #1 left the building when it was raining. Staff D was leaving from the overnight shift and saw him outside. He stated Staff D and Staff B brought Resident #1 back inside.

An interview was conducted on at 7:01 AM with Staff D. She stated on Thursday morning, , she worked the midnight shift and clocked out at 6:54 AM. She stated when she walked out the door, Resident #1 was coming from the highway. She stated she asked Resident #1 what he was doing outside. She stated Resident #1 was wet and his nostrils were full of .

An interview was conducted on at 7:16 AM with Staff E. She stated on Thursday, , she came on duty at 11 PM. She stated throughout the night, Resident #1 was asking for cigarettes quite often. She did not give him cigarettes after 11:30 PM. She stated Resident #1 would go back and forth from his ask for cigarettes. The last time she saw him was around 5:00 AM when he asked for a cigarette again. She then stated she saw him again sometime around 6:00 AM when he asked Staff F for a cigarette. After that, she stated she remembered seeing the kitchen window was open. She stated another resident, Resident #2, was rolling the kitchen window shutter up and down. She stated they got Resident #2 away from the window and then pushed the shutter down. She stated about 15 minutes after that Staff D came and said Resident #1 got out. She stated Resident #1 seemed wet and out of breath. She stated they told Staff B that Resident #1 had gotten out. Staff B then contacted the CNA/Resident Care Manager. She stated she asked Resident #1 how he got out and he said he got out through the kitchen. She stated all doors are locked and have key codes. She stated the kitchen doors are usually locked, but the shutter to the kitchen window was open that night.

An interview was conducted on at 7:32 AM with Staff F. She stated she Resident #1 early in the morning before he eloped. She stated he asked her for a cigarette by the back porch in the lounge area. She told him it wasn't time for a cigarette, he went and sat on the back porch. She stated she dropped linen off, then about 6:25-6:30 AM, he again asked for a cigarette. She stated the next thing she knew it was about 7:00 AM, Staff D was bringing him back inside. She stated Resident #1 was soaking wet, breathing heavy, white snot was coming out of his nose. She stated she is not 100% sure how he got out of the building. She stated she and Staff E saw Resident #2 on that shift, lifting the shutter to the kitchen window, she didn't think anything of it. She stated the doors at night are locked; that was the first morning she has ever seen the kitchen window unlocked. She stated she is constantly checking the residents. She stated that morning she thought she saw him go back to his .

An interview was conducted on at 9:58 AM with the LPN/Resident Care Director. She stated she was not notified when Resident #1 wandered out of the building. When asked about other staff

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saying she was notified of this, she stated they are telling non-truths. She stated yesterday is first time she heard about it, from the Administrator. She stated the doors all are electronically and magnetically locked; the door leading out of the kitchen is not key-code locked.

An interview was conducted on at 8:46 AM with the Dietary Manager. She stated she worked 7:00 AM to 6:00 PM on Wednesday, . She stated after the dinner meal, she was cleaning. She stated she made sure everything was locked, she makes sure the little lock on the kitchen window is closed and locked. She stated the kitchen has 3 doors, inside doors are always locked, and need a key to unlock them. She stated she, the other cooks, and the had keys. She stated the outside kitchen door will open from the inside when you pull up on the handle. She stated it has to be this way due to fire regulations. She was here the morning of at 6:40 AM. When asked how did she enter the kitchen on the morning of , she stated she a used key to go through kitchen side door. When asked, she stated the kitchen window shutter was closed, but she can't say for sure it was locked. She then stated she forgot to close and lock the padlock on the shutter on the kitchen window on night of . She stated the padlock was just hanging in there, unlocked.

2.) A review of Resident #1's facility record showed a note entered on at 11:40 AM which documented in part: staff asked writer to come to resident's unable to rouse resident for meal. Resident noted laying on his bed on his back, resident failed to respond to his name, resident was shaken, unable to palpate pulse, was initiated, 911 was called. Prior note entered was dated /. It read seen by Nurse Practitioner, orders received to obtain level and . No notes entered between / and , no notes entered regarding him having symptoms.

A / review of the facility's Elopement Policy and Procedure, which is entitled Missing Resident Checklist, showed the following: Assign staff to search community interior, scan perimeter, if resident is not observed, call family responsible party, continue search, call executive director, resident services director. Expand search, once found, assess immediately, including elopement risk assessment, if evidence of injury or pain complaints, send to emergency . Place resident on short-term monitoring, ideally 1:1 supervision. Refer resident to a physician for evaluation to rule out cause. Ensure safety and direct supervision (via family, paid companion, increased staffing) until the resident has been evaluated by MD or /behavioral health center and re-assessed by staff for continued residency at the community. Invite responsible party in immediately and draft shared risk agreement (SRA). Communicate safety interventions with team. Update short-term monitoring, service plan and resident record. The policy and procedure defines Elopement as, "A resident leaves the residence without staff knowledge or supervision. The resident lacks safety awareness."

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An interview was conducted on at 12:48 PM with Certified Nursing Assistant (CNA)/Resident Care Manager. She stated she received a telephone call from Staff F, who worked the overnight shift on . She stated Staff F told her they were getting off duty when Staff D saw Resident #1 outside in the front parking lot. She stated she told Staff F that she needed to call the Administrator and the LPN/Resident Care Director. She stated she was later told by Staff A that Resident #1 was completely soaking wet, coughing, and he looked like he was outside for a while. She stated she did ask Staff F when was the last time that they saw Resident #1 and she was told that they last saw him around 6:15 AM when Resident #1 asked for a cigarette. She stated they found Resident #1 outside at around 7:00 AM. She stated that she cared for Resident #1 on and . She stated Resident #1 sounded like he had a and was . She stated LPN/Resident Care Director knew that Resident #1 was . She stated she does not know if Resident #1 was seen by a doctor. She stated the Nurse Practitioner was at the facility last Tuesday or Wednesday before Resident #1 got out on Thursday morning. When asked, she stated if she notices a change in condition of a resident, she is supposed to let the nurse know. She stated the nurse is then supposed to contact the doctor and family. She stated she told LPN/Resident Care Director on Thursday night that Resident #1 had gotten out and had a slight . She stated LPN/Resident Care Director told her that this was the first time she had heard about this. When asked, she stated she did not document that Resident #1 had a . She further stated that there are hallway rosters where they document resident conditions, but the rosters are not saved. She stated the staff on duty do not always fill the hallway rosters out.

An interview was conducted on at 1:50 PM with Staff B. He stated he noticed Resident #1 was sleeping a lot, a change from his regular status. He stated he did go to LPN/Resident Care Director and reported this. He stated Resident #1 appeared to be limping. He stated he notified LPN/Resident Care Director the same day, , Resident #1 wandered out of the facility. He stated they have hall rosters on each shift with residents' names. He stated they write if the residents slept, if they ate, if they acted normal or not. He stated they put the rosters in a plastic box in the break , then LPN/Resident Care Director or the Administrator picks them up.

An interview was conducted on at 2:11 PM with the Nurse Practitioner. He stated he has been caring for Resident #1 for the past 6 months. He stated Resident #1 has heavy and is a heavy smoker. He stated he was not contacted by the facility about Resident #1 being ill or wandering out of the facility.

An interview was conducted on at 7:47 AM with Staff G. She stated she cared for Resident #1 the night before he . She stated she noticed mainly his , he could barely talk, he had a and runny nose. She stated he had a bad for about week. She stated they all knew

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about his [illegible]. She wrote on a report he had been up all night and just laid down. She stated she puts the report in a paper holder in the break [illegible]. She stated she thinks the nurse, LPN/Resident Care Director, looks at the reports.

An interview was conducted on [illegible] at 8:40 AM with Resident #1's public guardian. She stated she visited Resident #1 once a month. When asked, she stated she was not aware that Resident #1 eloped out of the building and was found in the parking lot on [illegible]. She stated she was notified when Resident #1 [illegible], but not contacted prior to this. When asked, she stated she was not notified that he had a change in condition with a [illegible] and [illegible].

An interview was conducted on [illegible] at 9:10 AM with LPN/Resident Care Director. When asked for the hallway Resident Care Aid sheets for Resident #1 from [illegible] through [illegible], she stated the shift reports are destroyed once they are reviewed. When asked why the shift reports are destroyed, she stated they are destroyed because they are not legal records.

An interview was conducted on [illegible] at 9:17 AM with the Administrator. He stated they do not have a policy and procedure for resident observation sheets. He stated the Resident Care Aid observation sheets are destroyed, as the company does not require that they have them. When asked, he stated he did not document the facility's internal investigation regarding Resident #1 eloping from the facility. He stated he believes they notified Resident #1's public guardian, but then stated they did not notify the public guardian. He stated he believes LPN/Resident Care Director notified Resident #1's nurse practitioner. When asked, he stated Staff B told him that Resident #1 was wet, as it was raining out. He stated he was not told how Resident #1 was medically. He stated he saw Resident #1 every day after he wandered out of the building, until he [illegible]. He stated he observed nothing unusual, he wanted his cigarettes, he was friendly.

An interview was conducted on [illegible] at 9:58 AM with the LPN/Resident Care Director. She stated she was not notified when Resident #1 wandered out of the building. When asked about other staff saying she was notified of this, she stated they are telling non-truths. She stated yesterday is first time she heard about it from the Administrator. She stated she did see Resident #1 on [illegible]; he had a little bit of a runny nose. She stated staff told her Resident #1 was exhibiting [illegible] symptoms. She stated she monitored Resident #1 the next couple of days. She stated the [illegible] symptoms seemed to dissipate so she didn't do anything about it; she did not contact anyone; she did not contact the nurse practitioner. She stated each shift is responsible for filling out the hallway sheets, it is a tickler for the next hallway shift. She stated she or the Administrator reviews the hallway sheets to see if they need to contact a doctor for one of the residents. She stated the hallway sheets for Resident #1 documented that he requested cigarettes, and there were comments about [illegible] symptoms. She stated Resident #1 was not getting [illegible] medicine because they did not have a doctor's order, because she didn't feel it

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was absolutely necessary.

review of Change in Resident Condition Policy and Procedure dated / , reviewed 2014, stated in part: The Charge Nurse will recognize and appropriately intervene in the event of a change in resident condition. The Physician/Family/Responsible party will be notified as soon as the nurse has identified the change in condition and the resident is stable. Procedure: 5. The Resident/Physician/Family/Responsible Party will be notified when there has been: a. An accident or incident involving the resident; d. A significant change in the resident's physical/emotional/mental condition. 7. The clinical nurse will record in the resident's clinical chart information relative to changes in the resident's medical/mental condition or status.

Class II

0032 Resident Care - Elopement Standards

Based on observation, interview, and record review, the facility failed to follow their Elopement Policy and Procedure by not notify the physician and responsible party after 1 of 46 residents (Resident #1) eloped out of the secured assisted living facility.

Findings:

An interview was conducted on at 9:01 AM with the Administrator. The Administrator stated there was a resident who went out a door, but this was seen by a staff member who brought the resident back into the facility. He stated this is the last elopement that he recalls, which occurred prior to 2015. When asked, the Administrator identified the resident who went out the door as Resident #1. He stated he is notified immediately of a resident elopement.

A tour of the facility on at 9:36 AM showed that the facility was locked and secured. There was an additional locked unit within the secured building. There were two doors, with key locks, that lead into the kitchen which was located within the additional locked unit. The kitchen also contained a large window with a counter used to put meal plates on for the staff to serve to the residents at meal times. There was a metal shutter, with a padlock, that slid up and down at the kitchen serving window. During the tour, all doors were checked and all were found to be locked. All of the doors, except for the two doors leading into the kitchen, were observed to have keypad locks. The exit door in the kitchen, to the outside of the building, was observed to have a knob device for locking and unlocking.

On at 9:40 AM, during the tour of the facility, an interview was conducted with the Licensed Practical Nurse (LPN)/Resident Care Director. She stated, to her knowledge, Resident #1 has not

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wandered from the building.

A review of Resident #1's facility record showed a note entered on at 11:40 AM which documented in part: staff asked writer to come to resident's unable to rouse resident for meal. Resident noted laying on his bed on his back, resident failed to respond to his name, resident was shaken, unable to palpate pulse, was initiated, 911 was called. Prior note entered was dated /. It read seen by Nurse Practitioner, orders received to obtain level and . No notes entered between / and , no notes entered regarding him having symptoms.

An interview was conducted on at 12:48 PM with Certified Nursing Assistant (CNA)/Resident Care Manager. She stated she received a telephone call from Staff F, who worked the overnight shift on . She stated Staff F told her they were getting off duty when Staff D saw Resident #1 outside in the front parking lot. She stated she told Staff F that she needed to call the Administrator and the LPN/Resident Care Director. She stated she was later told by Staff A that Resident #1 was completely soaking wet, coughing, and he looked like he was outside for a while. She stated she did ask Staff F when was the last time that they saw Resident #1 and she was told that they last saw him around 6:15 AM when Resident #1 asked for a cigarette. She stated they found Resident #1 outside at around 7:00 AM. She stated that she cared for Resident #1 on and . She stated Resident #1 sounded like he had a and was . She stated LPN/Resident Care Director knew that Resident #1 was . She stated she does not know if Resident #1 was seen by a doctor. She stated the Nurse Practitioner was at the facility last Tuesday or Wednesday before Resident #1 got out on Thursday morning. When asked, she stated if she notices a change in condition of a resident, she is supposed to let the nurse know. She stated the nurse is then supposed to contact the doctor and family. She stated she told LPN/Resident Care Director on Thursday night that Resident #1 had gotten out and had a slight . She stated LPN/Resident Care Director told her that this was the first time she had heard about this. When asked, she stated she did not document that Resident #1 had a . She further stated that there are hallway rosters where they document resident conditions, but the rosters are not saved. She stated the staff on duty do not always fill the hallway rosters out.

An interview was conducted on at 1:50 PM with Staff B. He stated he noticed Resident #1 was sleeping a lot, a change from his regular status. He stated he did go to LPN/Resident Care Director and reported this. He stated Resident #1 appeared to be limping. He stated he notified LPN/Resident Care Director the same day, , Resident #1 wandered out of the facility. He stated they have hall rosters on each shift with residents' names. He stated they write if the residents slept, if they ate, if they acted normal or not. He stated they put the rosters in a plastic box in the break , then LPN/Resident Care Director or the Administrator picks them up.

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An interview was conducted on at 2:11 PM with the Nurse Practitioner. He stated he has been caring for Resident #1 for the past 6 months. He stated Resident #1 has heavy and is a heavy smoker. He stated he was not contacted by the facility about Resident #1 being ill or wandering out of the facility.

An interview was conducted on at 7:47 AM with Staff G. She stated she cared for Resident #1 the night before he . She stated she noticed mainly his , he could barely talk, he had a and runny nose. She stated he had a bad for about week. She stated they all knew about his . She wrote on a report he had been up all night and just laid down. She stated she puts the report in a paper holder in the break . She stated she thinks the nurse, LPN/Resident Care Director, looks at the reports.

An interview was conducted on at 8:40 AM with Resident #1's public guardian. She stated she visited Resident #1 once a month. When asked, she stated she was not aware that Resident #1 eloped out of the building and was found in the parking lot on . She stated she was notified when Resident #1 , but not contacted prior to this. When asked, she stated she was not notified that he had a change in condition with a and .

An interview was conducted on at 9:17 AM with the Administrator. He stated they do not have a policy and procedure for resident observation sheets. He stated the Resident Care Aid observation sheets are destroyed, as the company does not require that they have them. When asked, he stated he did not document the facility's internal investigation regarding Resident #1 eloping from the facility. He stated he believes they notified Resident #1's public guardian, but then stated they did not notify the public guardian. He stated he believes LPN/Resident Care Director notified Resident #1's nurse practitioner. When asked, he stated Staff B told him that Resident #1 was wet, as it was raining out. He stated he was not told how Resident #1 was medically. He stated he saw Resident #1 every day after he wandered out of the building, until he . He stated he observed nothing unusual, he wanted his cigarettes, he was friendly.

An interview was conducted on at 9:58 AM with the LPN/Resident Care Director. She stated she was not notified when Resident #1 wandered out of the building. When asked about other staff saying she was notified of this, she stated they are telling non-truths. She stated yesterday is first time she heard about it from the Administrator. She stated she did see Resident #1 on ; he had a little bit of a runny nose. She stated staff told her Resident #1 was exhibiting symptoms. She stated she monitored Resident #1 the next couple of days. She stated the symptoms seemed to dissipate so she didn't do anything about it; she did not contact anyone; she did not contact the nurse practitioner. She stated each shift is responsible for filling out the hallway sheets, it is a tickler for the

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next hallway shift. She stated she or the Administrator reviews the hallway sheets to see if they need to contact a doctor for one of the residents. She stated the hallway sheets for Resident #1 documented that he requested cigarettes, and there were comments about symptoms. She stated Resident #1 was not getting medicine because they did not have a doctor's order, because she didn't feel it was absolutely necessary.

A review of the facility's Elopement Policy and Procedure, which is entitled Missing Resident Checklist, showed the following: Assign staff to search community interior, scan perimeter, if resident is not observed, call family responsible party, continue search, call executive director, resident services director. Expand search, once found, assess immediately, including elopement risk assessment, if evidence of injury or pain complaints, send to emergency . Place resident on short-term monitoring, ideally 1:1 supervision. Refer resident to a physician for evaluation to rule out cause. Ensure safety and direct supervision (via family, paid companion, increased staffing) until the resident has been evaluated by MD or /behavioral health center and re-assessed by staff for continued residency at the community. Invite responsible party in immediately and draft shared risk agreement (SRA). Communicate safety interventions with team. Update short-term monitoring, service plan and resident record. The policy and procedure defines Elopement as, "A resident leaves the residence without staff knowledge or supervision. The resident lacks safety awareness."

Class II

0081 Training - Staff In-Service

Based on observation, interview, and record review, the facility failed to ensure that 1 of 29 staff (Licensed Practical Nurse/Resident Care Director) had completed the required Elopement Response In-Service Training.

Findings:

Review of the employee record for License Practical Nurse (LPN)/Resident Care Director showed no documentation of a certificate for completion of the required Elopement Response Training.

An interview was conducted on at 9:58 AM with LPN/Resident Care Director. When asked about no documentation of a certificate for Elopement Response Training for her, she stated they are waiting for Vanguard to provide the training certificate.

Observations were conducted during the survey on and of the LPN/Resident Care

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Director working and on the premises of the facility.

Class III

0165 Risk Mgmt & QA: Adverse Incident Report

Based on observation, interview, and record review, the facility failed to complete an AHCA Adverse Incident Report, failed to notify the Department of Children and Families (DCF), and failed to conduct an internal investigation, after 1 of 46 residents (Resident #1) eloped from the secured assisted living facility, being found in the facility parking lot during a and rainy morning.

Findings:

An interview was conducted on at 9:01 AM with the Administrator. The Administrator stated there was a resident who went out a door, but this was seen by a staff member who brought the resident back into the facility. He stated this is the last elopement that he recalls, which occurred prior to 2015. When asked, the Administrator identified the resident who went out the door as Resident #1. He stated he is notified immediately of a resident elopement.

A tour of the facility on at 9:36 AM showed that the facility was locked and secured. There was an additional locked unit within the secured building. There were two doors, with key locks, that lead into the kitchen which was located within the additional locked unit. The kitchen also contained a large window with a counter used to put meal plates on for the staff to serve to the residents at meal times. There was a metal shutter, with a padlock, that slid up and down at the kitchen serving window. During the tour, all doors were checked and all were found to be locked. All of the doors, except for the two doors leading into the kitchen, were observed to have keypad locks. The exit door in the kitchen, to the outside of the building, was observed to have a knob device for locking and unlocking.

On at 9:40 AM, during the tour of the facility, an interview was conducted with the Licensed Practical Nurse (LPN)/Resident Care Director. She stated, to her knowledge, Resident #1 had not wandered from the building.

On a review of Resident #1's facility record revealed a Resident Health Assessment (AHCA Form 1823), dated / , that showed diagnoses of (ETOH) and . Resident #1 was documented as an elopement risk. Page three of the Resident Health Assessment showed daily observation of well-being and whereabouts checked. There was no documentation in the facility record regarding the resident wandering out of the facility on .

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On at 11:52 AM, a follow-up interview was conducted with LPN/Resident Care Director. She stated they do not have proof of documentation of well-being or whereabouts checks for Resident #1 daily, but stated there is a meal roster.

An interview was conducted on at 12:48 PM with Certified Nursing Assistant (CNA)/Resident Care Manager. She stated she received a telephone call from Staff F, who worked the overnight shift on . She stated Staff F told her they were getting off duty when Staff D saw Resident #1 outside in the front parking lot. She stated she did ask Staff F when was the last time that they saw Resident #1 and she was told that they last saw him around 6:15 AM when Resident #1 asked for a cigarette. She stated they found Resident #1 outside at around 7:00 AM. She stated she told LPN/Resident Care Director on Thursday night that Resident #1 had gotten out of the facility and had a slight . She stated LPN/Resident Care Director told her that this was the first time she had heard about this.

An interview was conducted on at 1:30 PM with Staff A. She stated on she was just coming to work and it was kind of dark. She stated after she clocked in, Staff D said Resident #1 had gotten out of the facility. She stated she did see Resident #1 after he was brought back into the facility. Resident #1 had a snotty nose and looked sort of wet. She stated this was at 7:00 AM on Tuesday.

An interview was conducted on at 1:50 PM with Staff B. He stated when he came to work last week, on , Staff D from the overnight shift told him she found Resident #1 out by her car. He stated he called the CNA/Resident Care Manager, and then the Administrator. He stated the Administrator told him to keep an eye on Resident #1. He stated he spoke to Resident #1, who told him he was out of the facility for about two hours. He stated Resident #1 told him that he got out through the kitchen. He stated Resident #1's pants were wet and dirty and Resident #1 was short of breath. It was rainy and outside that morning.

An interview was conducted on at 3:39 PM with the Administrator. He stated Resident #1 left the building when it was raining. Staff D was leaving from the overnight shift and saw him outside. He stated Staff D and Staff B brought Resident #1 back inside. He stated Staff B called him and told him. He stated Resident #1 did not leave the premises, so did not consider it an elopement. He stated Resident #1 has always been an elopement risk, but if you keep him in a routine, give him his cigarettes, he ' s fine. He stated they believe he got out by following an employee out, slipped out behind her. He stated he discussed Resident #1 leaving the building in the morning at the risk meeting. He stated the Dietary Manager and the Maintenance Director were at the meeting. When asked, he stated he doesn't ' ' have the minutes of the risk meeting in writing. He stated they do a head count to make sure all of the residents are in the building. He stated he can ' t say how Resident #1 got out.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911084	**04/12/2016**
NAME OF PROVIDER OR SUPPLIER **HARMONY HOUSE AT OCALA**	STREET ADDRESS, CITY, STATE, ZIP CODE **5762 S.W. 60TH AVENUE OCALA, FL 34474**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

An interview was conducted on at 7:01 AM with Staff D. She stated on Thursday morning, , she worked the midnight shift and clocked out at 6:54 AM. She stated when she walked out the door, Resident #1 was coming from the highway. She stated she asked Resident #1 what he was doing outside. She stated Resident #1 was wet and his nostrils were full of .

An interview was conducted on at 7:16 AM with Staff E. She stated on Thursday, , she came on duty at 11 PM. She stated throughout the night, Resident #1 was asking for cigarettes quite often. She did not give him cigarettes after 11:30 PM. She stated Resident #1 would go back and forth from his ask for cigarettes. The last time she saw him was around 5:00 AM when he asked for a cigarette again. She then stated she saw him again sometime around 6:00 AM when he asked Staff F for a cigarette. After that, she stated she remembered seeing the kitchen window was open. She stated another resident, Resident #2, was rolling the kitchen window shutter up and down. She stated they got Resident #2 away from the window and then pushed the shutter down. She stated about 15 minutes after that Staff D came and said Resident #1 got out. She stated Resident #1 seemed wet and out of breath. She stated they told Staff B that Resident #1 had gotten out. Staff B then contacted the CNA/Resident Care Manager. She stated she asked Resident #1 how he got out and he said he got out through the kitchen. She stated all doors are locked and have key codes. She stated the kitchen doors are usually locked, but the shutter to the kitchen window was open that night.

An interview was conducted on at 7:32 AM with Staff F. She stated she Resident #1 early in the morning before he eloped. She stated he asked her for a cigarette by the back porch in the lounge area. She told him it wasn't time for a cigarette, he went and sat on the back porch. She stated she dropped linen off, then about 6:25-6:30 AM, he again asked for a cigarette. She stated the next thing she knew it was about 7:00 AM, Staff D was bringing him back inside. She stated Resident #1 was soaking wet, breathing heavy, white snot was coming out of his nose. She stated she is not 100% sure how he got out of the building. She stated she and Staff E saw Resident #2 on that shift, lifting the shutter to the kitchen window, she didn't think anything of it. She stated the doors at night are locked; that was the first morning she has ever seen the kitchen window unlocked. She stated she is constantly checking the residents. She stated that morning she thought she saw him go back to his .

An interview was conducted on at 8:46 AM with the Dietary Manager. She stated she worked 7:00 AM to 6:00 PM on Wednesday, . She stated after the dinner meal, she was cleaning. She stated she made sure everything was locked, she makes sure the little lock on the kitchen window is closed and locked. She stated the kitchen has 3 doors, inside doors are always locked, and need a key to unlock them. She stated she, the other cooks, and the had keys. She stated the outside kitchen door will open from the inside when you pull up on the handle. She stated it has to be this way due to fire regulations. She was here the morning of at 6:40 AM. When asked how did she enter the kitchen on the morning of , she stated she a used key to go through kitchen side door. When

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	AL11911084	04/12/2016
NAME OF PROVIDER OR SUPPLIER HARMONY HOUSE AT OCALA	STREET ADDRESS, CITY, STATE, ZIP CODE 5762 S.W. 60TH AVENUE OCALA, FL 34474	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

asked, she stated the kitchen window shutter was closed, but she can't say for sure it was locked. She then stated she forgot to close and lock the padlock on the shutter on the kitchen window on night of . She stated the padlock was just hanging in there, unlocked.

On , review of the facility ' s Incident Report Log showed no documentation of an Incident Report regarding Resident #1 wandering outside of the building.

An interview was conducted on at 9:17 AM with the Administrator. When asked, he stated he did not document the facility ' s internal investigation regarding Resident #1 eloping from the facility. He stated he did not speak to Staff D, who found Resident #1 outside in the parking lot. He stated he got details of the incident from Staff B. He stated he does not believe it was possible for Resident #1 to get out through the kitchen, so he felt Resident #1 might have followed someone out the front door. He stated he did not complete an AHCA incident report, he did not notify law enforcement, he did not notify DCF. He stated he believes they notified Resident #1 ' s public guardian, but then stated they did not notify the public guardian. He stated he believes LPN/Resident Care Director notified Resident #1 ' s nurse practitioner. When asked, he stated Staff B told him that Resident #1 was wet, as it was raining out. He stated he was not told how Resident #1 was medically.

An interview was conducted on at 9:58 AM with the LPN/Resident Care Director. She stated she was not notified when Resident #1 wandered out of the building. When asked about other staff saying she was notified of this, she stated they are telling non-truths. She stated yesterday is first time she heard about it, from the Administrator. She stated the doors all are electronically and magnetically locked; the door leading out of the kitchen is not key-code locked.

Class II