

**AGENCY FOR HEALTH CARE  
ADMINISTRATION**

PRINTED: 06/02/2017  
FORM APPROVED

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| STATEMENT OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>AL11963806</b>                      | (X3) DATE SURVEY COMPLETED<br><br><b>05/24/2017</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ORMOND IN THE PINES</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>101 CLYDE MORRIS BLVD<br/>ORMOND BEACH, FL 32174</b> |                                                     |
| SUMMARY STATEMENT OF DEFICIENCIES<br>(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                  |                                                     |
| <p><b>0000 - Initial Comments</b></p> <p>A complaint investigation, CCR #2017002308, was conducted on _____ at Ormond in the Pines (License #AL5535). Ormond in the Pines had deficiencies found at the time of the survey.</p> <p><b>0030 - Resident Care - Rights &amp; Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS</b></p> <p>Based on interview and record review, the facility failed to honor 1 of 3 sampled resident's rights (Resident #2) by failing to reimburse a resident a prorated amount based on the day he vacated his apartment to seek a higher level of care.</p> <p>The findings include:</p> <p>An interview with the Director of Nursing (DON) on _____ at 2:43 PM, revealed Resident #2 was discharged to a nursing home due to a need for a higher level of care. The DON stated the resident's son and the son's daughter were removing the residents belongings all week and on _____ that had taken everything out.</p> <p>Record review of the business office file for Resident #2 on _____ at 3:30 PM, and with the assistance the interim Executive Director (ED) the most recent contract for Resident #2 was found to have an addendum dated _____. In an interview with the ED at the time of the review, she stated the addendum modified the earlier contract that the resident or his son had signed. She confirmed that under Section II of the refund policy it stated, that "in the event the contract is terminated because of _____ or for medical or mental health reasons, you, your estate or responsible party shall be entitled a prorated refund." She also confirmed that under Section II refund policy appendix C "the termination date shall be the date the unit is vacated by the resident and cleared of all belongings." She confirmed there was no mention of returning a key as the date the prorated refund would go into effect. She stated that since the resident vacated the _____ the 20th starting the _____ through _____, he would be due a refund. She also confirmed Resident #2 was charged until the keys were returned on _____.</p> <p>Class III</p> |                                                                                                  |                                                     |