STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910117	**12/26/2017**
NAME OF PROVIDER OR SUPPLIER **HARMONY RETIREMENT LIVING, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1411 EL PASO AVENUE** **ORLANDO, FL 32806**	

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

0000 - Initial Comments

The biennial relicensure survey with Limited Mental Health (LMH) was conducted on , 2017. Harmony Retirement Living Inc., license #7361, had deficiencies at the time of the survey.

0004 - Licensure - Requirements - 58A-5.016 FAC

Based on observations, record review, and interview, the facility failed to obtain prior approval from the Agency Central Office prior to increasing the facility capacity.

Findings:

Review of the facility's posted license revealed the facility was licensed for a capacity of 12.

On at 10 am, the administrator said the resident census was 12.

Observations made on at 11:25 am revealed there were 13 residents in the facility.

On at 11:30 am, the administrator confirmed the facility's licensed capacity was 12 and the facility had a resident census of 13.

Class III

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record reviews and interview, the facility failed to ensure a face-to-face medical examination was completed by a health care provider and documented on a health assessment form 1823 within 60 days prior to admission or within 30 days following admission for 1 of 3 sampled residents (#7.)

Findings:

Record review for resident #7 revealed she was admitted to the facility on .

The health assessment form 1823 for resident #7 was signed and dated by a health care provider on . The assessment was greater than 60 days prior to her admission to the facility.

The record did not contain any additional health assessment forms.

On at 3:38 pm, the administrator confirmed the findings.

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Class III

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record reviews and interview, the facility failed to ensure an interdisciplinary care plan was completed for a resident (#7) who received Hospice services and failed to ensure resident (#7) had a face-to-face medical examination by a health care provider after a significant change.

Findings:

Record review for resident #7 revealed she was admitted to the facility on . . . and she was admitted to Hospice services on .

The record did not contain an interdisciplinary care plan between the facility and Hospice, as required.

In addition, the record did not contain a health assessment form 1823 to indicate a health care provider completed a face-to-face medical examination when she was admitted to Hospice, which was a significant change.

On at 4 pm, the administrator confirmed the findings.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observations, record reviews, and interviews, the facility failed to ensure health care provider orders were followed for 3 of 3 sampled residents (#1, #4, and #7).

Findings:

1. Record review for resident #1 revealed a health assessment form 1823 signed and dated by a health care provider on . The form indicated resident #1 had diagnoses of of the and a history of . . . . . .

Hospital discharge instructions, dated on , indicated resident #1 was to take . . . . . 1 milligram (mg) by mouth daily and 100 mg by mouth daily.

On at 2:25 pm, the administrator said resident #1 was sent to the hospital on and

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returned to the facility on .

Review of the 2017 Medication Observation Record (MOR) for resident #1 revealed the and were not on the MOR and there was no indication she was being given the medications.

On at 4:20 pm, the administrator confirmed the findings and said resident #1 was not given the medications because she did not return from the hospital with prescriptions for the medications. She did not contact a health care provider to obtain a prescription.

2. Observations made during a medication pass for resident #4 on at 12:17 pm revealed staff C, a caregiver, gave resident #4 two 400 mg tablets of .

The prescription label for the indicated resident #4 was to take two 400 mg tablets (800 mg) by mouth three times a day as needed.

Review of the 2017 MOR for resident #4 revealed the was scheduled to be given three times a day at 8 am, 12 pm, and 8 pm.

An order written by a health care provider and dated on indicated resident #4 was to be given 800 mg by mouth three times a day as needed for pain.

On at 12:30 pm, the administrator confirmed the health care provider's order was to give resident #4 the as needed, confirmed the medication was being given scheduled each day, and said it was because resident #4 wanted it scheduled three times a day.

The record for resident #4 did not contain documented evidence to indicate the facility contacted a health care provider regarding the resident's request to change the medication from as needed to schedule.

3. Record review for resident #7 revealed an order from a health care provider, dated on , for 650 mg by mouth every 6 hours as needed for back pain.

Review of the 2017 MOR for resident #7 revealed an undated entry for 325 mg tablets, take two tablets (650 mg) by mouth three times a day for back pain and it was scheduled at 8 am, 12 pm, and 5 pm. The medication was signed as given beginning on .

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On at 3:59 pm, the administrator confirmed the order for the was as needed. She said the medication was given scheduled because the staff gave it based on the instructions located on the prescription label and the pharmacy made an error when they created the label.

4. The record for resident #7 contained an order from a health care provider, dated on , for 400 mg by mouth every 6 hours as needed for pain.

Review of the 2017 MOR for resident #7 revealed an undated entry for 400 mg; take one tablet by mouth every 6 hours for pain. The medication was scheduled at 8 am, 2 pm, and 8 pm and was signed as given at 8 am and 2 pm on .

On at 4 pm, the administrator confirmed the order was to give the medication as needed and the order was not followed.

5. Review of a health assessment form 1823 for resident #7 that was dated on and signed by a health care provider indicated that resident #7 had a diagnoses of , ( ) and was to use a Furo- Inhaler 200-5 micrograms (mcg) two puffs twice daily.

Review of the 2017 MOR for resident #7 revealed there was no entry for the inhaler to indicate she received the medication.

On at 4:33 pm, the administrator confirmed resident #7 did not receive the medication because her insurance would not pay for it. She said a health care provider was not notified when the facility determined the insurance would not pay for the medication.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observations and interviews, the facility failed to post a copy of the Resident Bill of Rights in full view in a freely accessible resident area.

Findings:

During an interview with resident #1 on at 9:42 am, she said she did not believe she had been informed of her rights as a resident.

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Observations made on at 9:50 am revealed there was not a copy of the resident bill of rights posted in the facility, as required.

On at 12:39 pm, the administrator confirmed the findings.

Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on record reviews and interview, the facility failed to have a photo identification within 10 days of admission for a resident (#1) who was identified as an elopement risk.

Findings:

Record review for resident #1 revealed she was admitted to the facility on . Her admission health assessment form that was dated on and signed by a health care provider indicated she was at risk for elopement.

The record did not contain a photo identification for resident #1, as required.

On at 3:28 pm, the administrator confirmed there was not a photo identification for resident #1 because the health assessment form was wrong and that resident #1 was not an elopement risk. She did not contact a health care provider to clarify or correct the information.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observations, review of the facility's menus, and interviews, the facility failed to follow their menus and failed to have substitutions based on the preferences of the residents.

Findings:

1. During an interview with resident #1 on at 9:42 am, she said she had been asking for Orange Juice because the facility ran out of it.

On at 3:04 pm, the administrator said the facility ran out of Orange Juice two days ago. She said there were no other juices to substitute for the orange juice and the facility only had tea.

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2. Observations made during the lunch meal on at 12:25 pm revealed the residents were served spaghetti with meatballs, bread, salad, and peaches.

Review of the facility's posted menu revealed it was labeled as week 4. However, review of the menu dates that were documented on a separate piece of paper revealed that for the week of through , week 2 menu was to be used.

On at 3:15 pm, the administrator confirmed the findings regarding the menus.

Class III

0167 - Resident Contracts - 58A-5.025 FAC

Based on record reviews and interview, the facility failed to ensure a resident contract contained all the required information for 2 of 2 resident contracts (#1 and #7).

Findings:

Review of the contract for resident #1 revealed it was dated on . The contract did not contain any resident rights, as required.

Review of the contract for resident #7 revealed it was dated on . The contract did not contain any resident rights, a provision stating whether the facility was affiliated with any religious organization, and the facility's policies and procedures related to a properly executed (,) as required.

The record for resident #7 contained a form that outlined the facility's policies regarding . However, the signature line was blank.

On at 4 pm, the administrator confirmed the findings.

Class

L243 - LMH - Training - 429.075(1) FS; 58A-5.0191(8) FAC

Based on review of the facility's license, personnel record reviews, and interview, the facility failed to ensure 1 of 3 staff (A) who had direct contact with mental health residents received a minimum of 6 hours of training that was provided or approved by the Department of Children and Families (DCF) within 6 months of employment and failed to ensure 1 of 2 staff (C) received a minimum of 3 hours of

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continuing education in LMH biennially.

Findings:

Review of the facility's posted license revealed the facility held a Limited Mental Health (LMH) license.

Personnel record review for staff A, a caregiver, revealed a hire date of . The record contained no documented evidence to indicate staff A received the required minimum of 6 hours of training in LMH.

Personnel record review for staff C, a caregiver, revealed a hire date of . . . . . A certificate of training, dated on , indicated staff C received the required minimum 6 hours of training in LMH. However, the record did not contain documented evidence to indicate staff C received a minimum of 3 hours of continuing education in LMH biennially since , as required.

On at 4:54 pm, the administrator confirmed the findings.

Class III