STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965225	02/05/2016
NAME OF PROVIDER OR SUPPLIER **GOLDEN POND COMMUNITIES**	STREET ADDRESS, CITY, STATE, ZIP CODE **400 LAKEVIEW ROAD** **WINTER GARDEN, FL 34787**	

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

0000 Initial Comments

Complaint Investigation #2015009103 was conducted on / , / and / , / , / , and . Golden Pond Communities had deficiencies found at the time of the visit.

0010 Admissions - Continued Residency

Based on interview and record review, the facility failed to determine appropriateness of admission of an individual for 1 of 4 sampled residents (#2), and failed to determine the continued appropriateness of residency assessed to have aggressive behaviors to his spouse and caregivers for 1 of 4 sampled residents (#2).

Findings:

Resident #2's health assessment (1823) dated / revealed the resident was but awake, and had a history of aggressive behavior and violent outburst. The physician documented, "Be aware of patient's history of violence to spouse and caregivers. Act accordingly." The statement on the 1823 read, "In your professional opinion, can this individual's needs be met in an assisted living facility, which is not a medical, nursing or facility?" The physician answered "NO" to this question but Resident #2 was admitted to the facility on / .

Nurse's note dated at 9 AM documented staff advised the nurse that while assisting the resident with activities of daily living (ADLs), the resident slapped a staff member in the face.

Nurse's note dated at 9 AM read, "Staff advised this nurse that when assisting resident (#2) with ADLs, resident slapped staff member in the face. Resident was asked why he did that. Resident replied that it was an accident and didn't mean to. DON (director of nursing) notified. Will continue to monitor."

Nurse's note on at 10:15 PM read, "Resident (#2) was in his he shares with another resident when staff observed resident (#2) on his right arm. Resident's (#1) was lying on the floor on his back....with on floor. Resident states 'he was swinging at me.' Allegedly (there) was an altercation between the two but no witnesses. Resident (#2) denies any pain or discomfort, no other injuries noted at this time. Resident (#2) ambulated to the sitting area, were cleansed with cleaner and aid applied. Resident (#2) seemed a little but calmed down shortly. DON, ED (executive director) notified and will call spouse in AM...."

Nurse's note on / at 4 PM read, "Staff CNA (certified nursing assistant) told this nurse that resident (#2) is combative. Resident is refusing to be changed and is swinging at staff. He did manage

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to hit the CNA that is on duty at this time. Will notify family and DON."

The resident continued to have aggressive behavior as documented in the nurse's progress notes as follows:

Nurse's note on at 7 PM read, "Staff was in D.R. (dining) and resident (#2) was walking by CNA when resident (#2) punched CNA in the stomach then resident went in to kitchen and locked the door. Resident would not willingly open door key was obtained to open door. Resident still would not come out of kitchen called male staff to help get resident out of kitchen with success. DON and family notified."

Nurse's note on , no time listed, read, "spoke to resident's physician after receiving fax about resident may not be appropriate for facility, due to combative behavior. PCP (primary care physician) requested faxed original behavior. PCP requested and it was faxed with original 1823 to his office-fax sent. Call placed to POA (Power of Attorney) to inform. Left message. Will F/U (follow up) in morning."

Nurse's note on at 4:50 PM read, "This nurse called POA (power of attorney) in regards to husband's combative behavior. POA states that she was unaware of the behavior and that he did not have any combative behavior at previous facility."

Nurse's note on at 1 PM read, "Talked to primary doctor he was not aware that the resident resides on a secured unit. The resident's physician is okay with this, he just wanted us to know resident's history and to act accordingly."

Nurse's note on at 2:30 PM read, "Staff assisting resident with ADLs (activities of daily living) when resident kicked staff member in the knee and said "I'm gonna kill you all if you don't stop." Resident refused to have undergarment changed which is soaking wet. DON notified.

Nurse's note on at 3 PM read, given for agitation, resident took with difficulty.

Nurse's note on at 1 PM read, "Resident attempting to hit staff with fist while assisting with ADLs had to have three staff to assist changing briefs, will continue to monitor."

Nurse's note on at 7:15 AM read, "Resident swing his fist at staff while sitting in dining ....then got up from table and walked toward the front door another resident was sitting by the door. Resident touched his walker and other resident and other resident said 'No, that's mine', then this resident swung and punched other resident in the mouth. Other resident got up and started punching resident. This nurse attempting to separate the two and finally did but resident ended up with a bloody

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nose. Sat resident down with paper towel pinching the nose to try and stop the . Resident complaint of pain to cheek and nose. 911 was called to send to Hospital in Apopka. H.C.C and family notified."

Nurse's note on at 12 PM read, "Resident was returned to the facility via car accompanied by spouse and daughter resident is alert and verbal. The resident has a diagnosis of nasal ; will continue to monitor."

Record review revealed resident #2 had a consult on / and labs were ordered.

Nurse's note on / at 2 PM received new order from consultant to start 250 mg. EF at its faxed to pharmacy.

Nurse's note on / at 2 PM read, "This nurse talked with the daughter in regards to recent incident. After talking with corporate quality assurance nurse, the decision was made to accept resident if family can provide a sitter to be with the resident around the clock. If family cannot find a sitter, then a family member will need to stay with resident. Family verbalizes understanding."

It is unclear from the resdient's record if a family member or a sitter was present to monitor the resident around the clock.

Nurse's note on read, "Resident was being assisted with and resident got aggressive with caretaker with his hands up. She blocked him from hitting her. Administered 1 mg. (milligram). 911 called for ."

Nurse's notes dated at 1 PM read, "Resident sent to ER via private vehicle; family refusal 911 service, wife and daughter drove resident to the Hospital's Emergency to . Resident slapped sitter and attempted to throw a radio at the sitter. Staff intervened preventing resident from throwing radio."

Review of the Medication Observation Record for revealed the resident was prescribed 1 mg. by mouth every 6 hours as needed for . The resident received on / / / / / / and /

The nurses throughout the resident's stay from / to would write "continue to monitor" but never explained what type of monitoring was being conducted.

The resident's family was given a 45-day notice of discharge on

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On / at approximately 2:30 PM, the administrator stated she was unaware of resident #2's aggressive behavior and injury to another resident on because she was not employed with the facility during that time period.

On / at approximately 3:30 PM, the director of marketing acknowledged that she prepared admission into the facility for resident #2, acting as interim administrator, and thought resident #2 was appropriate to accept in the facility, and appropriate to remain in the facility, even after several aggressive documented behaviors.

On at 4:30 PM, the physician who completed the 1823 revealed that he only had seen the resident twice. The first visit was as a new patient on . The next time he saw the resident was on / when he completed the 1823 form prior to admission to the facility. The physician stated he did not know how the resident ended up at the facility. He said the facility called him and assured him that the resident had been in the hospital, was medicated, and there were no concerns with the resident. The physician said he had only seen the resident one other time and that the resident's wife told him of the resident's violent behavior. He explained that the facility contacted him on / via a faxed communication form to request a evaluation. The response on the form stated "OK psych eval (consultation) (patient) not appropriate for ALF in my opinion." I read the statement to the physician and asked if he wrote this and he stated I am sure that I did. When asked if the resident was prescribed any anti- medication, he stated that he received a call requesting anti- medication but by the time he gave an order for the anti- medication, the resident had been and sent to a receiving facility.

The facility retained a resident who was assessed prior to admission with violet outbursts and aggressive behavior toward his spouse and caregivers. There were seven incidents of aggressive behavior to staff and injury to two residents:

- / - hit resident #1 who sustained injury
- / - hit staff
- / - hit staff
- / - hit staff member
- / - attempting to hit staff.
- - hit resident who sustained injury and hit staff
- - hit sitter

At no time did the facility institute any interventions or document how monitoring will be conducted. The facility maintained the resident after the physician wrote that the resident was not appropriate for an assisted living facility.

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The facility left all the residents and staff at risk by continuing let resident #2 remain in the facility for more than thirty days.

Class II

0025 Resident Care - Supervision

Based on record review and interview, the facility did not provide the appropriate care and services, including supervision, to 1 of 4 sampled residents who displayed aggressive behavior to staff and had a history of documented aggressive behavior with violent outbursts toward caregivers and spouse (#2).

Findings:

Resident #2's Health Assessment (1823) form, dated , revealed diagnoses including , , and emotional/behavior problems. The physician documented " but alert, history of aggressive behavior with violent outburst....be aware of the patient's history of violence to his wife and caregivers and to act accordingly." The statement on the 1823 read, "In your professional opinion, can this individual's needs be met in an assisted living facility, which is not a medical, nursing or facility?" The physician answered "NO" to this question but Resident #2 was admitted to the facility on / .

Nurse's progress note, dated / at 9 AM, read, "Staff advised this nurse that when assisting resident (#2) with ADLs (activities of daily living) resident slapped staff member in the face. Resident was asked why he did that. Resident replied that it was an accident and didn't mean to. DON (director of nursing) notified. Will continue to monitor."

Nurse's note on at 10 PM read, "Staff observed resident (#1) lying on his on his back by the bookcase with on the bookshelf and the floor. Resident (#1) is alert and verbal there is a bump to the back of head along with . Resident (#1) couldn't really say what happened. 911 was called. DON, ED and family called. Resident's (#2) was also in the two to right arm and stated 'he was swinging at me.' There were no witness to confirm the statement. It seems there may have been some kind of altercation between the two."

Nurse's note on at 10:15 PM read, "Resident (#2) was in his he shares with another resident when staff observed resident (#2) on his right arm. Resident's (#1) was lying on the floor on his back....with on floor. Resident states 'he was swinging at me'. Allegedly (there) was an altercation between the two but no witnesses. Resident (#2) denies any pain or

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discomfort, no other injuries noted at this time. Resident (#2) ambulated to the sitting area, were cleansed with ' cleaner and aid applied. Resident (#2) seemed a little but calmed down shortly. DON, ED (executive director) notified and will call spouse in AM...."

Nurse's progress notes on / at 11 AM read, "Spoke with RN (registered nurse)...at.... Hospital ED (Emergency Department) regarding condition of resident (#1). Per (RN) resident (#1) has been extubated and hospice has been consulted. Resident (#1) found to have a possible d/t (due to) ' ' and a ' ' d/t . Resident (#1) also has an acute of C2 (')...undetermined...." The nurse indicated that Resident #1 was to be transferred to the hospital for possible surgical interventions but the wife opted not to, and chose hospice services instead to be rendered at the facility.

Nurse's note on at 3 AM read, "Resident (#1) was pronounced at 10:56 PM on ."

Hospital medical record, received on for Resident #1, indicated an admission date of with diagnoses including acute failure, right side , large , head injury, , accident in neck with midline shift to left side, possible , large hematoma to back of head...."

The resident continued to have aggressive behaviors as documented in the nurse's progress notes as follows:

Nurse's note on at 4 PM read, "Staff CNA (certified nursing assistant)) told this nurse that resident (#2) is combative. Resident is refusing to be changed and is swinging at staff. He did manage to hit the CNA that is on duty at this time. Will notify family and DON."

Nurse's note on / / at 7 PM read, "Staff was in D.R. (dining) and resident (#2) was walking by CNA when resident (#2) punched CNA in the stomach then resident went in to kitchen and locked the door. Resident would not willingly open door key was obtained to open door. Resident still would not come out of kitchen called male staff to help get resident out of kitchen with success. DON and family notified."

On / at approximately 2:30 PM, the administrator stated that she was unaware of this incident because she was not employed with the facility at all during that time period.

On / / at approximately 3 PM, the DON stated that he was not working on the day of this incident and had not been promoted to DON yet.

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On / / at approximately 3:30 PM, the DON who was employed with the facility at the time of the incident but not in his current position, stated that there was no investigation conducted or statements taken from staff working that shift.

On / at approximately 3:45 PM, the marketing director who was the acting Executive Director at the time of the incident on / , stated that there was no investigation conducted or statements taken from the staff who worked that shift.

Direct care staff present at the time of the incident on were not currently employed at the facility at the time of the survey on / .

Class II

0165 Risk Mgmt & QA: Adverse Incident Report

Based on interview and record review, the facility failed to conduct a thorough internal investigation of an incident which resulted in hospitalization and eventual , and failed to file an adverse incident report for 1 of 4 sampled residents transferred to the hospital due to injuries sustained from another resident (#1).

Findings:

Resident #2's Health Assessment (1823) form, dated / / , revealed diagnoses including , and emotional/behavior problems. The physician documented " but alert, history of aggressive behavior with violent outburst....be aware of the patient's history of violence to his wife and caregivers and to act accordingly." The physician answered "NO" to the question: "In your professional opinion, can this individual's needs be met in an assisted living facility, which is not a medical, nursing or facility?" However, Resident #2 was admitted to the facility on / .

Nurse's progress note, dated at 9 AM, read, "Staff advised this nurse that when assisting resident (#2) with ADLs (activities of daily living) resident slapped staff member in the face...."

Nurse's note on / at 10 PM read, "Staff observed resident (#1) lying on his on his back by the bookcase with on the bookshelf and the floor. Resident (#1) is alert and verbal there is a bump to the back of head along with . Resident (#1) couldn't really say what happened. 911 was called....Resident's (#2) was also in the two to right arm and stated 'he was swinging at me.' There were no witnesses to confirm the statement...."

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Nurse's note on at 10:15 PM read, "Resident (#2) was in his he shares with another resident when staff observed resident (#2) on his right arm. Resident's (#1) was lying on the floor on his back....with on floor. Resident (#1) states 'he (resident #2) was swinging at me'...."

Nurse's note on at 11 AM, indicated Resident #1 was sent to the hospital and had diagnoses including acute failure, right side , large a , head injury, accident in neck with midline shift to left side, possible , and a large hematoma to back of head. The resident's spouse refused surgical intervention. Resident #1 was then placed on hospice care, sent back to the facility and expired at 10:56 PM on .

On / at 2 PM, the director of nursing (DON) was asked to provide the adverse incident report for review but could not provide it.

On / at approximately 2:30 PM, the administrator stated that she was unaware of this incident because she was not employed with the facility during that time period.

On / at approximately 3 PM, the DON stated that he was not working on the day of this incident on and had not been promoted to DON at that time.

Class III

0167 Resident Contracts

Based on record review and interview, the facility failed to honor the refund policy set according to the resident's agreement contract for 1 of 4 sampled residents (#1).

Findings:

Resident #1's contract and the facility's refund consolidation report for 2015, 2015, 2015, and 2015 were reviewed. There was no documentation that the facility provided a refund to resident #1's beneficiary. Resident #1 expired on , 2015.

On / / at approximately 2:45 PM, the Business Office Manager said she was unaware of the refund policy process as she was just employed with the facility for 2 days.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Golden Pond Communities
400 Lakeview Road
Winter Garden, FL 34787
Attention: Melissa Duhamel

Dear . Duhamel:

This letter reports the findings of a complaint 2015009103 investigation, conducted on , , / / , , and , by representatives of the Agency for Health Care Administration (Agency). Attached 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) **by** .

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

1) A - 0010 - Admissions - Continued Residency Class II
The facility failed to determine appropriateness of admission of an individual and failed to determine the continued appropriateness of residency assessed to have aggressive behaviors to his spouse and caregivers.

2) A- 0025 - Fac - Resident Care - Class II

Directed Corrective Actions:

1. The ultimate responsibility for appropriateness of residents in the facility lies with the administrator. The Resident Health Assessment should be reviewed by the administrator and other appropriate staff to ensure the facility can meet the needs of all residents admitted to the facility. All staff should be trained to know who is appropriate to be a resident in an Assisted Living facility. The facility need to establish a policy on who will be responsible for reviewing health assessments and indicating the appropriateness of residents for admission. The policy should also indicate the steps the facility will take when there are incidents, including resident/staff or resident/resident assault to determine if the facility can continue to safely meet the needs of the resident. This must be conducted by .

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.com

2. An in-service must be conducted to address resident that have a history of violent outburst. The resident should not be admitted to the facility unless there is a plan in place and the resident is being monitored for a period of time to ensure his or her appropriateness for the facility. Staff should be educated on the resident's behavior and given training on how to handle the resident's behavior. There must be a sign in sheet and course content available for review upon request of the agency. This in-service and training must be conducted by

3. An in-service must be conducted to educate all direct care staff on dealing with residents with combative behaviors, documentation of this behavior and to when to report the behavior. This training must include appropriate interventions for protecting all residents, including one-on-one supervision when necessary. Staff must be trained on the facility's policy and definition of monitoring in these situations. all residents in the facility are the responsibility of the administrator and should be kept safe. This must be conducted 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 . Lorraine Henry, ALF Supervisor, Orlando Office, at (407) 420-2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

D7JR

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
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RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Golden Pond Communities
400 Lakeview Road
Winter Garden, FL 34787

RE: CCR #2015009103

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on / / , / / / and , by representative(s) 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 surveyor(s). Should you have any questions please call Lorraine Henry at -2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

XG90

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