STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968706	04/20/2017
NAME OF PROVIDER OR SUPPLIER **ENCORE AT AVALON PARK**	STREET ADDRESS, CITY, STATE, ZIP CODE **13798 CYGNUS DR** **ORLANDO, FL 32828**	

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

0000 - Initial Comments

An Extended Congregate Care (ECC) monitoring visit was conducted on , , 2017. Encore at Avalon Park, license #12618, had deficiencies at the time of the visit.

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

Based on record review and interview the facility failed to contact a health care provider and failed to maintain a written record when 1 of 1 sampled residents (#1) was sent to the hospital.

Findings:

During an entrance conference on at 3:30 pm, the nursing director identified resident #1 as being in the hospital for behavioral issues. She said the police were called to the facility when resident #1 was sent to the hospital.

A request was made to review the facility's 1-day and 15-day adverse reports related to the event that was reported to law enforcement. On at 5:45 pm, the facility administrator said the adverse reports were not completed and were not submitted to the agency, as required.

Record review for resident #1 revealed a progress note that was dated at 7:24 am and was authored by staff A that reflected staff A was called to the second floor by staff C because resident #1 pulled the hair and struck the face of staff C.

During an interview with staff A on at 5:55 pm, she said that on three police officers responded to the facility and attempted to take resident #1 with them. She said resident #1 became argumentative and refused to go with the police. She said facility staff placed resident #1 in a wheelchair but she planted her feet on the floor and would not allow anyone to push her in the wheelchair. She said a police officer then wheeled resident #1 backwards in the wheelchair and they left the unit. The record of resident #1 did not contain documentation of those details. She said she did not notify a health care provider of the event and she was unaware of whether any other staff member had.

During an interview with staff B on at 6:09 pm, she confirmed the details of the event that were provided by staff A and said she was the one who called 911 on . She said she followed the police off the unit and she unlocked the front door of the facility to allow the police to exit with resident #1. The record of resident #1 did not contain documentation of those details. She said she did not notify a health care provider of the event and she was unaware of whether any other staff member had.

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SUMMARY STATEMENT OF DEFICIENCIES
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During an interview with staff C on at 6:11 pm, she confirmed the details of the event that were provided by staff A and staff B. She said she did not notify a health care provider and she was unaware of whether any other staff member had.

On at 6:15 pm, the administrator confirmed the record of resident #1 did not contain all of the details from the event that occurred on and confirmed there was no evidence a health care provider was notified when resident #1 was sent to the hospital.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on personnel record reviews and interview the facility failed to have evidence that 1 of 4 sampled staff (D) received the required in-service training on the facility's policies and procedures regarding ( ) within 30 days of hire.

Findings:

Personnel record review for staff D, a registered nurse, revealed a hire date of .

There was no evidence to indicate staff D received in-service training on the facility's policies and procedures regarding , as required.

On at 5:30 pm, the facility's business office manager confirmed the finding.

Class III

E207 - ECC - Services - 58A-5.030(8) FAC

Based on observations, record reviews, and interviews, the facility failed to complete nursing progress notes for 1 of 2 residents (#2) who received an Extended Congregate Care (ECC) service.

Findings:

During an entrance conference on at 3:30 pm, the nursing director said resident #2 received ECC services for and a .

Observations made on at 4:15 pm revealed resident #2 was wearing .

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During an interview with resident #2 on at 4:15 pm, she said the facility staff assisted her with her and .

Review of the ECC records for resident #2 revealed there were no nursing progress notes documented on , , and , as required.

On at 5:38 pm, the nursing director confirmed the findings.

Class III

Z821 - Reporting Requirements; Electronic Submission - 59A-35.110 FAC

Based on interviews and record review, the facility failed to maintain an adverse incident report and failed to provide a preliminary adverse incident report to the agency within 1 business day and a full report to the agency within 15 days of an event that was reported to law enforcement for 1 of 1 sampled residents (#1.)

Findings:

During an entrance conference on at 3:30 pm, the nursing director identified resident #1 as being in the hospital for behavioral issues. She said the police were called to the facility when resident #1 was sent to the hospital.

A request was made to review the facility's 1-day and 15-day adverse reports related to the event that was reported to law enforcement. On at 5:45 pm, the facility administrator said the adverse reports were not completed and were not submitted to the agency, as required.

Record review for resident #1 revealed a progress note that was dated at 7:24 am and was authored by staff A that reflected staff A was called to the second floor by staff C because resident #1 pulled the hair and struck the face of staff C.

During an interview with staff A on at 5:55 pm, she said that on three police officers responded to the facility and attempted to take resident #1 with them. She said resident #1 became argumentative and refused to go with the police. She said facility staff placed resident #1 in a wheelchair but she planted her feet on the floor and would not allow anyone to push her in the wheelchair. She said a police officer then wheeled resident #1 backwards in the wheelchair and they left the unit. The record of resident #1 did not contain documentation of those details. She said she did not notify a health care provider of the event and she was unaware of whether any other staff member had.

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SUMMARY STATEMENT OF DEFICIENCIES
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During an interview with staff B on at 6:09 pm, she confirmed the details of the event that were provided by staff A and said she was the one who called 911 on . She said she followed the police off the unit and she unlocked the front door of the facility to allow the police to exit with resident #1. The record of resident #1 did not contain documentation of those details. She said she did not notify a health care provider of the event and she was unaware of whether any other staff member had.

During an interview with staff C on at 6:11 pm, she confirmed the details of the event that were provided by staff A and staff B. She said she did not notify a health care provider and she was unaware of whether any other staff member had.

On at 6:15 pm, the administrator confirmed the record of resident #1 did not contain all of the details from the event that occurred on and confirmed there was no evidence a health care provider was notified when resident #1 was sent to the hospital.

Class III