STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965225	**07/25/2017**
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

The Change of Ownership Survey including Limited Nursing Services was conducted on and . In addition, revisits to a 6 month licensure survey and complaint investigations #2016000369, #2015009103, #2015007905, #20150013342 were conducted on the same dates. Golden Pond Communities Assisted Living Facility, License #9626, had deficiencies at the time of the visit.

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

Based on record review and interview the facility failed to obtain a resident health assessment form (1823) that was completed by health care provider licensed under Chapter 458, 459 or 464, F.S. for 1 of 9 sampled residents (#11).

Findings:

Record review for Resident #11 revealed she was admitted to the facility on . Further record review revealed the resident heath assessment form 1823 dated (admissions) was completed by a health care provider from Puerto Rico.

There was no heath assessment in her record completed by a health care provider licensed under Chapter 458, 459 or 464, F.S.

On at 2 PM, the Director of Nursing confirmed the findings.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on observations, record reviews, and interviews the facility failed to ensure centrally stored medications were properly labeled for 1 of 1 sampled resident (#4).

Findings:

Observations made during a medication pass for resident #4 on at 12:50 pm revealed the unlicensed caregiver removed a medication bottle from the medication cart and appeared to compare the prescription label to the Medication Observation Record (MOR). The caregiver took the bottle of medication to resident #4, read the label, and then placed a pill into a medicine cup. The caregiver handed the medication to resident #4, who took the medication with water and without assistance.

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The prescription label on the medication bottle indicated the bottle contained milligrams (mg) and the instructions were to take one tablet by mouth every 4 hours for pain.

Review of the 2017 MOR for resident #4 revealed only one entry for mg and the directions were to take one tablet by mouth four times a day and it was scheduled to be given at 8 am, 12 pm, 4 pm, and 8 pm.

The medication bottle did not contain an alert label that directed staff to examine the revised directions for use in the MOR, as required.

Record review for resident #4 revealed a health assessment form 1823 that was dated on . She had diagnoses of and chronic pain and she required assistance with self-administration of her medications.

An order from a health care provider that was dated on indicated that resident #4 was to take mg, one tablet by mouth four times a day.

On at 12:47 pm, the director of nursing confirmed the prescription label did not match the MOR for resident #4 and she confirmed an alert label was not placed on the bottle.

Class III

0086 - Training - ADRD - 58A-5.0191(9) FAC

Based on personnel record review and interview the facility maintained a secure area and provided special care for persons with 's and related (ADRD); failed to ensure that 3 of 5 sampled staff (B, C and D) who had regular contact with persons with 's and Related (ADRD) participated in 4 hours of continuing education annually, that was not previously received.

Findings:

1. Personnel record review for Staff B a caregiver hired revealed she had received the Level 1 and Level 2 on . Further record review revealed there was no documentation to confirm she had received continuing education annually, that was not previously received. There were other training's certificates for 2017 for the other Level 2 trainings

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2. Personnel record review for staff D, a resident caregiver, revealed a hire date of . The record contained a certificate of completion that was dated on for 4 hours of level 1 and 4 hours of level 2 trainings. The record did not contain evidence to indicate staff D received 4 hours of continuing education on an annual basis, as required.

3. Review of the personnel record for Staff C, hired on , revealed she had not obtained an annual update in and Related . She had certificates for Level 1 and Level 2 dated . She also had a second certificate for Level 2 dated . There was no certificate for an Update in-service.

In an interview with the administrator and nursing director on at 3:00 PM, they stated it was their policy to repeat Level 2 as an update.

Class III

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

Based on record review and interview the facility failed to ensure direct care staff received training and were knowledgeable in regards to ( ) for 1 of 5 sampled staff (C).

Findings:

In an interview with Staff C, a caregiver and med tech, on at 2:55 PM, she was unable to answer the question about . She said she did not remember what those letters stood for. When shown the letters on a piece of paper, she said she still could not recall what they meant.

Review of the personnel record for Staff C revealed she had a certificate for training dated .

In an interview with the administrator on at 2:45 PM, she said she would make sure additional training was provided to Staff C.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and interview the facility failed to obtain a weight record initiated on admission for 1 of 9 sampled residents (3).

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Findings:

In an interview with resident #3 on . . . . . at 1:15 PM who stated the aides help her with showers and anything else she needed.

Resident record review for resident #3 revealed a health assessment report 1823 dated that did not indicate the resident's weight. Continued review revealed a weight taken on . . . .

In an interview with the director of nursing no . . . at 11 AM who said she needed to research for additional documentation.

No additional documentation was provided.

Class III