STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965225	12/18/2017
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

Complaint Investigation #2017011401 was conducted on . Golden Pond Communities, License #9626,
had a deficiency at the time of the visit.

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

Based on record review, facility adverse incident report and interview, the facility failed to provide adequate supervision and general awareness of whereabouts for 1 of 4 sampled residents (#1), who was and eloped from the secured memory care unit.

Findings:

Record review for resident #1 revealed a resident health assessment form 1823 dated that noted he had advanced and was an elopement risk. Resident #1 resided in the secured memory care unit. The facility had three other buildings that were not secured.

A nurse's progress note on at 2 PM reflected that the resident was observed on outdoor back trail beside the facility; staff were unaware how resident got out of the building; the resident had increased , the majority of the morning, stating someone was trying to kill him and run him over with a car; and anti- , medication was given and the resident was redirected by staff. On at 3 PM, the resident was pacing back and forth, trying to get out of the building, and was redirected by staff several times.

The facility adverse incident report noted the date of the incident to be for resident #1 and noted the following: "Resident Elopement if the elopement places the resident at risk for harm or injury" was checked on the form. A certified nursing assistant (CNA) found resident #1 in the courtyard and did indicated the resdient did not act like he wanted to come for lunch, but he did and was left with the nurse for medications before lunch. After the CNA was not able to locate the resident after lunch, she started looking for him in the building. She alerted staff that she was not able to find him, so staff started the elopement procedures to find the resident, and alert the Assisted Living staff in the other three buildings as well. The nurse was notified by the receptionist that the resident got out of the building and went to the West Orange Trail but a jogger called police who returned him to the community before he could get far. The trail was woods and was located on the side of the memory care unit. The nurse assessed the resident upon return to the facility and did not find any apparent injuries. The resident kept saying someone was trying to kill him. Staff indicated that family did not want the resident to go to the hospital.

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Staff statements are as follows:
On , a licensed practical nurse documented "The resident had increased , stating someone is trying to kill him. The resident was observed in the hedges out back. Administered anti- medications at 12:40 PM and sat resident down to relax. Around 1:30 PM, a phone call was received stating that resident was found out back trail right beside the facility. Resident was picked up from trail. Assessed for any injury and there was on right , no other apparent injuries noted."

A caregiver documented on that "She was doing rounds at 1:30 when she noticed [resident #1] was missing, upon looking for him the nurse told her police found [resident #1] by the trail."

A caregiver documented on (error) read, "I saw [resident #1] sitting in the TV at the table. I was on break at the time he left the building.]

A caregiver documented, "On (error) I saw [resident #1] this morning at 8 AM and at 12:30 PM for lunch."

A caregiver documented on that she was looking for resident #1 around lunch time, and found him hiding in the bushes. She said, "I took him to change his clothes, he ate lunch" and she took him to the nurse to give him his medications and left him with the nurse...."

There was no further documentation found that the facility staff would be monitoring the resident closely due to his exit seeking behavior after being found hiding in the bushes outside of the secured unit.

Based on the statements obtained from the staff, the resident was able to leave the secured memory unit, and was not seen for at least 30 minutes before staff realized he was missing. The resident was at risk for harm once he left the facility. He had advanced , was found on a trail that was located in a wooded area by a jogger who called the police.

On at 1:15 PM, the administrator said the resident was in the secured memory care unit and should not have been able to exit. She said the resident possibly walked out of building when a family member left and the staff did not notice because they were busy with the other residents during lunch time.

Class II