STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968474	07/17/2018
NAME OF PROVIDER OR SUPPLIER **OAKMONTE VILLAGE OF LAKE MARY-CORDOVA**	STREET ADDRESS, CITY, STATE, ZIP CODE **1001 ROYAL GARDENS CIR** **LAKE MARY, FL 32746**	

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

0000 - Initial Comments

A Complaint Investigation #2018005009 was conducted on and . Oakmonte Village of Lake Mary-Cordova license #12350 had deficiencies at the time of the visit.

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

Based on observations, record review and interview, the administrator failed to monitor the continued appropriateness of placement for 2 of 5 sampled residents (#2 and #4) and retained the residents who required total care with all activities of Daily living, (ADL's) and could not transfer and ambulate which exceeded the continued residency criteria.

Findings:

On through interviews with facility staff/caregivers, it was revealed that resident's #2 and #4 required total care with their ADL's. They did not assist at all with toileting bathing, dressing, toileting, transferring and ambulation. The staff stated they had to lift the residents when transferring because they could not transfer. All exceeded the continued residency for an Assisted Living Facility.

1. Observations on at 12 PM revealed 2 caregivers (A and B) instructed resident #2 to stand. When the caregivers tried to assist the resident to a standing position, resident #2 lifted her left foot, placed it behind her right foot, and began to shake. The staff had to move quickly to grab the resident prevent her from falling forward. The caregivers had to lift the resident because she would not assist with the transfer from the wheelchair to the bed. The caregivers both stated they had to provide the resident incontinence care in the resident's bed because she could not stand to hold onto the grab bars for them to remove her clothing for her to be seated on the commode.

2. Observations on at 11:45 Am revealed resident #4 had a large white bandage wrapped around her head. The caregivers present (A and B) said the resident had a trying to get up. She had declined since returning from the hospital after the . The two caregivers present said they were about to remove resident #4 from her bed to the wheelchair. One staff was observed lifting the resident's bottom so the other staff could pull up the resident's pants. The resident did not assist at all. The two caregivers then sat the resident up in the bed and tried to place her in a standing position, when transferring the resident the caregivers lifted her from her bed to the wheelchair because she would not move her feet to assist with the transfer.

On at 2:15 PM, the director of nursing stated resident #4 had a on and had a decline.

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He was not aware that she could not transfer. He did not feel resident #2 was total care with ADL's and transferring.
The administrator said at the time she was not aware that resident #2 and #4 required total care. She believed that that both residents could assist with ADL's and transfers, she did not feel the staff was aware what total care meant. She said the staff would be trained on what total care was and assisting with transfers.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on fire report and interviews, the facility failed to maintain a door lock in good working condition in which to provide a safe living environment, a staff remained locked in 1 of 5 sampled resident's (#3) for hours during the night shift due to the broken door lock/mechanism.

Findings:

An interview was conducted with a former staff on at 4:15 PM who said on between 5:20 AM and 8:50 AM; the door to resident #3's would not open because the lock had broken. She said she could not get out of the window because there were screws in them and the windows would not go up enough for her to climb out. She said there was another staff present and she tried to call her, however her ringer was turned off on the telephone. She said the resident was becoming agitated and aggressive because he could not leave the . She said the fire department arrived and told her they also could not get her out because of the windows had screws in them. She said the fire department staff arrived and could not get her out. She said they contacted the maintenance staff who did not want the fire department staff to break the door down. Therefore, she would have to wait until the maintenance staff arrived to get them out. She said she did not get out of the around 8:50 AM.

On at 11 AM, caregiver C said he did recall a staff who was no longer employed at the facility being locked in the resident #3 when he arrived to work at 6 AM. He said the maintenance staff arrived between 7-8 AM and the staff and resident were let out of the .

On at 11:15 AM, the executive director of the memory care unit said he was not aware of a staff being locked in the resident #3. He said the staff did not make him aware of this. After being informed, the administrator said he spoke with a staff who told him that she did hear about the incident. The staff did not report the incident to executive director so that he could have investigated to ensure

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there were no other locks in the unit that required repair.
Review of a fire department report revealed it noted on :
Dispatch 6:54 AM-Arrived 6:58 AM-Clear 7:41 AM.
Engine 36 (E 36) responded to a public assist (locked inside) dispatch. E 36 made several attempts to unlock and or open door and windows without success. Windows completely locked from the inside with screws. Facility's maintenance on their way to disassemble door mechanism as this is the second instance of staff or resident being locked inside due to the door latch mechanism .
Staff member and resident locked inside at no time in any distress. E 36 advised facility general manager to contact emergency locksmith.

Class III