STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965923	**06/08/2018**
NAME OF PROVIDER OR SUPPLIER **GRACIOUS AGE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1401 MAGNOLIA AVENUE** **SANFORD, FL 32771**	

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

0000 - Initial Comments

Complaint Investigation #2018000616 was conducted on , , and . Gracious Age, License #10274, had deficiencies at the time of the investigation.

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

Based on record review and interview, the facility failed to ensure a resident (#9) had a face-to-face medical examination by a health care provider after a significant change.

Findings:

On at 9:15 a.m., the wellness coordinator said resident #9 received hospice services.

Resident #9's record revealed she was admitted to the facility on . An admission health assessment form 1823 was completed on .

Resident #9 was admitted to hospice on . Resident #9's record did not contain a new health assessment form 1823 to indicate she had a face-to-face medical examination by a health care provider when she was admitted to hospice, which was a significant change.

On at 11:25 a.m., the administrator said a new health assessment form 1823 was not completed, as required.

Class III

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

Based on record reviews and interviews, the facility failed to provide adequate supervision and interventions when a resident (#4) experienced multiple .

Findings:

Resident #4's record revealed he was admitted to the facility on . An admission health assessment form 1823, dated on , indicated the resident had a diagnoses of ( ) with residual deficiency, had general , was a risk, and had poor vision. The form indicated that he was independant with ambulation and transferring.

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Review of incident reports, facility observation notes, and health care provider notes revealed the following:

On , an established care visit was completed by a health care provider. The note indicated resident #4 had a history of a with , and . Home health care would be ordered for his gait and .

On at 10:30 p.m., the resident walked back to his , was observed swaying a little, lost his balance, then backwards in the hallway. He said he was not hurt, got himself up, and walked back to his . The facility staff would closely monitor him, and he would use proper footwear.

On at 12:35 p.m., the resident tripped over his feet while walking. He had no injuries. He was instructed to use proper footwear, and staff were instructed to monitor him closely.

On , an order for physical and lab work was received.

On at 10:46 a.m., the administrator said the resident never received the prescribed because he had no insurance coverage. In addition, the administrator said he never made any attempts to find alternate placement for the resident and never issued a 45-day notice of discharge.

On at 11 a.m., the resident tripped and in the hallway. He sustained a laceration above his left eye. First aid was applied and he was sent to the hospital. The staff would continue to monitor him. Physical and Occupation services were denied because the resident did not have insurance.

On at 4:30 a.m., the resident said that he tried to take a shower when he and hit his head. The floor was wet. He was sent to the hospital. The facility instructed the hospital to send him to a skilled nursing facility but the hospital indicated there were no injuries, he would not be admitted to the hospital, and he would be discharged back to the facility. The incident report indicated broken furniture or equipment was involved. On at 10:51 a.m., the administrator said the shower curtain down with him.

On , the resident was seen by a health care provider following a that resulted in a visit to the emergency . The note indicated that he was legally and ambulated around the facility by touch. He tripped, , and sustained a laceration above his left eye.

On at 1 p.m., the resident was found on the floor in the hallway. He complained of pain to his

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right shoulder. The area was poorly lit. He was sent to the hospital. The facility staff would monitor him closely and he would have his eyes checked. Resident #4's record did not contain documented evidence to indicate his eyes were checked. Physical and occupation , , services were not able to be provided because the resident did not have insurance.

On at 10:52 a.m., the administrator said the resident did have his eyes checked by a doctor but he was unable to provide any documentation to indicate an exam was completed. He said the documentation on the report that indicated the area was poorly lit was inaccurate and the hallway would have been brightly lit.

On , the resident returned to the facility with a diagnoses of and .

On , the resident was seen by a health care provider for right shoulder pain that was controlled with pain medications. He had a and sustained right and a right . He was unable to return to the Orthopedic physician due to a lack of insurance and he was noncompliant with the ordered sling.

A health assessment form 1823, dated on , indicated resident #4 required supervision with ambulation and transferring.

On at 1 p.m., the resident was found on the floor in the elevator. There were no apparent injuries. He was instructed to wait for the staff to escort him to and from the dining , and he was non-compliant.

On at 12 p.m., he lost his balance when he went to sit down in a dining . There were no apparent injuries. The staff was instructed to monitor him closely and he was instructed to use his hands to feel the chair before he sat down. On , the resident was sent to the hospital after his for an evaluation. He complained of pain in his right elbow, and was present. On , the resident returned to the facility.

On , the resident was seen by a health care provider due to having a . Physical and occupational , , were ordered for an increase in , gait training, and strengthening.

On at 8 a.m., the resident tried to get to his walker, lost his balance, and tripped in the hallway. He and another resident to the floor. There were no apparent injuries. The staff would closely monitor him and implement precautions due to his poor vision. There was no documentation to indicate what specific precautions were implemented.

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On at 3 p.m. the resident was found on the floor. There were no apparent injuries. The staff would provide close monitoring, conduct frequent checks on him, and would leave his door open or keep him in the front.

On , the resident was seen by a health care provider for a monthly follow-up for , and an increasing number of . Physical was ordered on , and staff reported that physical had not seen the resident. Physical was reordered, prevention was to be continued, and the resident was to use a walker.

On , an order from the health care provider indicated physical and occupation evaluations were to be completed for an unsteady gait and , lab work due to , and the resident was to be monitored for changes for 24 hours. A handwritten note on the bottom of the order indicated the resident's case manager said he had no insurance, so he was unable to receive .

On at 11:15 a.m., the resident was found on the patio and sent to the hospital. The facility instructed the hospital to admit him and transfer him to a rehabilitation facility. The hospital indicated he would be returned to the facility, and he did not need rehabilitation. The facility staff would closely monitor him, a review of his medications would be completed, and he was instructed to request assistance to access the patio. Resident #4's record did not contain documentation to indicate a review of his medications was conducted.

On at 10:57 a.m., the administrator said a doctor would have conducted a medication review but would not have documented it.

On , the resident was sent to the emergency a and . He remained in the hospital at the time of the complaint investigationon .

Resident #4 was admitted to the facility on with documentation that he was at risk for . Between and , he experienced 10 , and on one of those occasions, he sustained to his right ribs and right . Due to his lack of insurance coverage, he was unable to receive physical and occupational therapies. The facility's records contained documentation that indicated only staff monitoring and resident reminders occurred following his multiple .

Class II