STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965225	**08/07/2018**
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

A Complaint investigation #2018006858 was conducted on . . . . . & . . . . . . Golden Pond Communities, license #9626, had deficiencies related to this investigation at the time of the visit.

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

Based on record review and interview, the facility failed to obtain a new AHCA form 1823 Health Assessment for 3 of 13 sampled residents (#3, #5, and #7) for continued residency after a significant change by a healthcare provider as required.

Findings:

1. Resident #5's record review revealed admission into facility on and a significant change occurred resulting admission to Hospice care . . . There was no evidence of a new AHCA form 1823 Health Assessment that was completed by the healthcare provider.

On at 3 PM, an interview with the Assistant Health and Wellness Director who confirmed the findings.

2. Observation of resident #3 revealed he uses a power chair to move around the facility. He is able to maneuver the chair in and out of his to get to meals and activities without assistance.

On at 11:50 AM, he stated he gets assistance with his shower and dressing (mostly for pants, socks, shoes), but he can do a lot for himself. The resident explained he had a . . . . and paralyzed on his right side. He further stated that he uses the powered wheelchair to get around the facility independently. He stated he could typically get in and out of the chair with the assistance of one staff member.

Review of the record for resident #3 revealed a health assessment (1823) dated . The form indicated total assistance was required for ambulation and transferring.

3. Observation of resident #7 revealed she uses a wheelchair for ambulation.

On . . . at 10:40 AM, resident #7 stated she was able to propel herself using her feet, although she was slow and preferred to have one of the aides help her get to the dining activities. She stated she gets assistance with her medications and with showering. She stated she can dress herself on top,

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but needs help with her pants and shoes because she does not have good balance any more.

Review of the record for resident #7 revealed a health assessment (1823) dated . The form indicated total assistance was required for all activities of daily living.

On at 3:00 PM, the Health & Wellness Director confirmed the findings.

Class III

0052 - Medication - Assistance with Self-Admin - 429.256(3-4); 58A-5.0185 (3)

Based on observations, record reviews and interview, the facility failed to ensure the unlicensed staff (A) who assisted a resident (#13) with self-administered medications followed the correct procedure.

Findings:

Observations made during a medication pass for resident #13 on at 9:18 a.m. revealed unlicensed caregiver A unlocked the medication cart, removed medication bottles from the cart, compared the prescription labels to the Medication Observation Record (MOR,) locked the cart then she took the bottles and MOR to the resident in her . She told the resident the name of each medication then she poured each one into a medicine cup. The resident poured the pills into her own hand then she took them with water and without assistance. The caregiver observed the resident take the medication then she returned to the cart and signed the MOR.

Caregiver A did not read the medication labels aloud in the presence of the resident, as required.

On at 9:30 a.m., caregiver A confirmed the findings.

Resident #13's record contained an 1823 health assessment form, dated , that indicated she required assistance with self-administered medications.

Class III

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

Based on observation, record review and interview, the facility failed to ensure all medications were refilled in a timely manner for 4 of 13 sampled residents who required assistance with self-administration of medications (#3, #7, #8 and #11).

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Findings:

1. Resident #3's record revealed a facility admission date of . The current 1823-health assessment form, dated , indicated his diagnoses included a left hip replacement, , , unsteady gait, mild , and risk. He required assistance with self-administered medications.

Review of the MORs for resident #3 for , & , 2018 revealed 3 medications were marked "unable to assist" on 37 occasions. In , 2018, 1 medication documented as "unable to assist"12 times between and . 75mg, take 1 tablet three times daily was documented and "unable to assist" for all doses from through . There was no documentation to indicate why the medication was not given. Review of the MOR for , 2018 found documentation of "unable to assist" for continued for all doses from to . There was no documentation as to why this medication was not given for 19 days. Further review of the MOR for , 2018 found , 2.5mg, take 1 tablet daily was documented as "unable to assist" on 5/1, 5/2 and 5/3 and 20mg, take 1 tablet daily at bedtime was documented as "unable to assist" every day from 5/1 through . There was no documentation to indicate why the medication was not given.

2. Resident #7's record revealed a facility admission date of . The most recent 1823 health assessment form, dated , indicated diagnoses included , , , , and , . She required assistance with self-administered medications.
Review of the MORs for resident #7 for , & , 2018 revealed 2 medications were marked "unable to assist" on 27 occasions. Review of the MOR for resident #7 for the month of , 2018 revealed 1 medication documented as "unable to assist" 9 times between and . (, 0.25mg) take twice daily, was documented as not given for all doses on 5/1, 5/2, 5/3, 5/4 and . There was no documentation to indicate why the medication was not given. Review of the MOR for , 2018 revealed was also documented as "unable to assist/not given for all doses on , , and . Again, there was no documentation in indicate why the medication was not given.

3. Resident #8's record revealed a facility admission date of . The current 1823 health assessment form, dated , indicated diagnoses, which included Parkinson's , and mild , . She required assistance with self-administered medications.

On at 11:30 AM, resident #8 stated she recently did not have her , medication available. The staff said it was not on the cart. She said it took about 2-3 days to get the refills, and this

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was not the first time this happened.

Review of the , 2018 MOR for resident #8 revealed , / , 25 mg, take 2 tablets at bedtime was documented as "unable to assist on 10 days from through . There was no documentation to indicate why the medication was not given.

Review of the MOR for resident #8 for the month of , 2018 revealed medications documented as "unable to assist" 25 different times between - . Medications affected were 1) 75 mg, take one tablet twice daily, documented as "unable to assist" 13 times, "not given" on and "waiting on pharmacy" on ; 2) , 10mg tablets, take 1 tablet three times daily, documented as "unable to assist" 12 times, "not given" on and , and "waiting on pharmacy" on twice. There was no documentation to indicate why the medication was not given.

On at 11:30 AM, the Health & Wellness Director looked at the MORs and stated she was not sure what "unable to assist" meant.

On at 12:15 PM, staff B, caregiver, stated they used to write "unable to assist" when the medication was out of stock. She stated they were recently told to stop by the new Health & Wellness Director. They are to write the reason the medication was not given, such as waiting for pharmacy and include when the pharmacy was contacted.

On at 2:30 PM, the administrator confirmed the findings.

4. On at 11:05 a.m. resident #11 said the facility stored and ordered his medications. On , he ran out of one of his nighttime medications. He was supposed to receive three pills but only received two. He took pain medications and the facility did run out of them in the past. He did not experience an increase in his pain level due to not having the medications.

Resident #11's record revealed a facility admission date of . A most recent 1823-health assessment form, dated , indicated his diagnoses included a left hip replacement, , , unsteady gait, mild , and risk. He required assistance with self-administered medications.

His 2018 Medication Observation Record (MOR) listed 50 milligram (mg) tablet, take 2 tablets by mouth daily for pain. From through the initials to indicate the medication was given were circled and the documentation on the back of the MOR indicated the medication was not available and not given.

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His record did not contain documentation to indicate the facility made any efforts to obtain a refill before he ran out of the .

Resident #11's 2018 MOR listed / 7.5mg-325mg tablet, take 1 tablet by mouth every 12 hours for pain. Documentation on the back of the MOR indicated the medication was unavailable from through .

On at 11:05 a.m. caregiver A confirmed the findings and said the facility was waiting on a prescription for the from the doctor.

His record contained a prescription; dated , for / 7.5mg-325mg tablet, take 1 tablet by mouth every 12 hours.

His record contained a nurse's note, dated , that indicated a prescription for the was faxed to Express Scripts. The staff spoke with the pharmacy and it may take up to two weeks for the medication to be refilled. The staff left a message for his family to ask if the prescription could be filled at a local pharmacy. His record did not contain documentation to indicate the facility made any efforts prior to to obtain a refill for his .

On at 11:20 a.m., the health and wellness director confirmed the findings and said she was unable to provide any additional details.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on personnel record review and interview the facility failed to obtain an annual statement from the health care provider for 3 of 7-sampled Staff (A, B and G) documenting freedom from ( ).

Findings:

1. Personnel Record review for Staff A (caregiver, hired), revealed the last documentation to confirm she was free from was dated . There was no documentation from a healthcare provider indicating she was free from in 2017 or 2018.

2. Personnel Record review for Staff B (caregiver, hired), revealed the last documentation to

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confirm she was free from was dated . There was no current documentation from a healthcare provider indicating she was free from in 2018.

3. Personnel Record review for Staff G (caregiver, hired), revealed the last documentation to confirm she was free from was not read or signed by a licensed healthcare provider

On at 12:10 PM, the business office manager confirmed that the documentation was not available.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observations, menu review and interview, the facility failed to display or provide the current weekly menu to residents.

Findings:

Observations during a tour of the facility on the morning of found menus posted in each building were all of different weeks, none of them current. Building 402 had the menu for the week of - posted. Building 404 had the menu for the week of - posted. Building 406 had the menu for the week of - posted.

The facility chose to post a weekly menu, but did not post the correct one. Residents had no way to know what the menu for the week would be.

On at 1:30 PM, the administrator stated the menus were posted in each building. When shown the posted menus, she confirmed the findings.

Class III

N278 - LNS - Records - 58A-5.031(3) FAC

Based on record reviews and interview, the facility failed to obtain an order from a health care provider prior to providing a Limited Nursing Service (LNS) to 1 of 13 sampled residents (#12.)

Findings:

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Review of the facility's license revealed it held a standard license with a LNS specialty license.

On at 9:30 a.m., the assistant director of nursing identified resident #12 as receiving LNS for care.

Resident #12's record revealed a facility admission date of . A facility progress note, dated , indicated she called for assistance using her pendant. She said she lost her balance while trying to go to the , became , and . She complained of left arm pain and she was sent to the hospital.

On , she returned to the facility with a diagnosis of a left wrist .

A facility note, dated , indicated a nurse performed care.

Resident #12's record did not contain an order from a health care provider for the care, as required.

On at 11:30 a.m. the assistant director of nursing provided a fax that was addressed to a doctor, dated , to admit the resident to LNS for care however, the fax was not signed by a health care provider and did not contain documentation to indicate a nurse obtained a telephone order.

Class III