STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965225	11/27/2018
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

Complaint Investigation #2018014475 was conducted on . Golden Pond Communities Assisted Living Facility, 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 resident record review and interview, the facility did not provide care, supervision and services appropriate to meet the needs to ensure the safety through proactive measures to minimize the potential for and injuries which resulted in medical attention for 1 of 5 sampled residents who was a risk (#3).

Findings:

Resident #3's record revealed she had a resident health assessment form 1823 that was dated with diagnosis that included 's precautions, and required assistance with all of her activities of daily living. She also received hospice services and resided in the secured memory care (MC) unit.

Record review revealed the facility notes for and the 72 hour follow-up on resident that documented as follows:
at 8:30 AM - "observed on floor by CNA (certified nursing assistant) unwitnessed observed laying on floor by a resident's room on her right side. She could not explain what happened. She had a on her right side of her . Sent to ER (emergency room)."
at 2 PM - "returned with stitches on right side of -forehead area."
The 72 hour follow-up on resident document noted the steps taken to correct: "Monitor resident closely."

at11:30 AM - "staff contacted nurse on duty to advise that resident was lying on the floor in 408 building after hearing a scream. Resident was assisted up to then discovered a to the between ring and pinky that appears to need stitches, no other injuries. Non-emergency transported to hospital.
at 7:30 PM - "resident returned with daughter, 5 stitches to right between small and #3 ."
The 72 hour follow-up on resident document noted the steps taken to correct was left blank

at 7 PM - "nurse observed resident laying supine with seeping from what may appear to

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be the of her . 911 was called. Resident was alert and breathing."
- "resident arrived to facility via ambulance at 1:30 AM with stitches on her left side her ."
The 72 hour follow up on resident document noted the steps taken to correct was left blank.

at 6:30 (AM-PM not noted) - "resident observed on the floor to her right side when appear to be on her right side . 911 called arrived to facility and transported her via ambulance to hospital."
- "resident returned from hospital with family member , done resident have bone , hematoma of , due to . Bandage on her right side of her ."
The 72 hour follow-up on resident document noted the steps taken to correct was left blank.

PM shift - "resident was showered by hospice nurse then brought to dining room area and sat in chair; nurse returned to resident's bathroom to straighten, resident got up from chair and stumbled over her and to floor, observed resident with pool of under her , called 911."
at11:15 PM - "resident arrived to facility via ambulance. , to of . Dissolvable placed at hospital. noted to ."

at 10:30 AM - "staff was in the dining room passing the medication, staff heard someone said 'Oh no'." Staff turned to the voice, observed resident was on the floor with wheelchair still on her , some noted on the of her . Staff [put] pressure on injury site and cover with gauze. Resident's daughter was in the dining room at the time. She spoke that resident saw her walking into the front door and she tried to get up from her wheelchair by pushing her wheelchair backward and leaning her wheelchair backwards. Wheelchair tipped over and resident hit her on the floor, resident was transported to hospital."
shift - "resident returned to facility via daughter at 1:06 PM, resident provided new wheelchair to fit her needs."
The resident was discharged from the facility on .

There was no documentation found in the record to confirm any proactive measures to minimize the that resulted in injuries other than monitoring the resident closely. The resident received hospice services. There was no documentation that the facility had contacted the hospice agency to discuss the resident's and interventions that could have been put in place to keep the resident safe and minimize the .

On at 11:30 AM, the director of nursing confirmed resident #3 did have many and was a risk. She confirmed the resident had 's and had a shuffled walk. She said

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resident #3 was in the secured memory care unit where staff could keep a closer watch on her, and said they would keep the resident's in that unit in the central area to watch them. She said when a resident has , she tries to determine the problem or cause. For resident #3, she thought it may have been her shoes at one time, so they changed her shoes, and they would have meetings to discuss her . She said hospice offered to get a chair alarm but she told them the facility could not have chair alarms. She said after the resdient's last , she suggested to the administrator that the facility was no longer appropriate for the resdient and the resident was discharged.

Class II