STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968474	04/01/2019
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)

Z821 - Reporting Requirements; Electronic Submission - 59A-35.110 FAC

Based on record reviews and interviews, the facility failed to electronically submit to the agency, a preliminary report within 1 business day and a full report within 15 days of an event that was reported to law enforcement for 2 of 2 sampled residents (#5 and #14).

Findings:

1. On [redacted] at 11 AM, the administrator was asked to provide copies of adverse incident reports for 2018 and 2019. The administrator said there were no adverse reports.

A complaint of alleged [redacted] involving resident #5 was received on [redacted].

Observations made of resident #5 on [redacted] at 10 a.m. revealed both of his arms were [redacted] from his elbows down to his [redacted], he had [redacted] on both of his arms, and a [redacted] was on his left ring [redacted].

At 10:52 a.m. resident #5 was questioned about the cause of the injuries and his response was "I was living in a bed and when I didn't do something, one of the guys, I had that thing in my [redacted], and that did it for me." Regarding his arms, he said "that is another thing."

At 11:08 a.m. his wife said the [redacted] and broken [redacted] were injuries that occurred at the facility and no one could tell her how the injuries occurred. When she left after visiting him on [redacted] he had only a [redacted] on the top of his left [redacted]. On [redacted] at 1 p.m. she received a call from the facility notifying her that his left [redacted] was [redacted]. An [redacted] revealed a [redacted] to his left ring [redacted] without [redacted]. The memory care nursing director told her he did not know how the [redacted] occurred and said the resident was [redacted] with staff during care that morning. She reported his injuries to law enforcement on [redacted]. On [redacted] she spoke with the memory care director who had no additional information but suggested possible scenarios that included he slammed his [redacted] in a door, another resident broke his [redacted], or possibly a spontaneous [redacted].

Review of a Seminole county sheriff's office report revealed that an investigation was conducted on [redacted].

A request was made to review the preliminary adverse report submitted by the facility when law enforcement conducted an investigation.

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On at 1 p.m. the memory care nursing director said the facility did not complete and submit a preliminary adverse report, as required.

2. Review of facility notes revealed they noted the following:

On 9:53 AM-received report from staff indicating the staff went into this resident's room to give her meds and when staff opened the door, staff observed this resident on the floor with her pants down. This resident tripped over pants causing the . This resident received a to the right forehead with . This resident was sent to the hospital via 911 to be evaluated and treated post . Doctor (name mentioned) made aware as well as family. This incident happened approximately at 7:20 AM. Called the hospital and they indicated that this resident had an abnormal . Awaiting report and or this resident's return.
On the resident ,

On 11 AM and interview was conducted with a representative Seminole County Sheriff Office who said her agency did conduct a police investigation regarding the .

On at 10 AM, the administrator confirm there was no adverse report completed regarding the police investigation.

Unclassified

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0000 - Initial Comments

A Complaint Investigation #2018017949 and Complaint investigation #2019004297 were conducted on , and . Oakmonte Village Of Lake Mary-Cordova license #12350 had deficeincies related to complaint investigation 2018017949.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on observations, record reviews, and interviews, the facility failed to follow its policy and procedures on resident , neglect, and , and failed to conduct an investigation into injuries of an unknown origin for 1 of 16 sampled residents (#5.)

Findings:

A complaint of alleged involving resident #5 was received on .

Observations made of resident #5 on at 10 a.m. revealed both of his arms were from his elbows down to his , he had on both of his arms, and a , was on his left ring .

At 10:52 a.m. resident #5 was questioned about the cause of the injuries and his response was "I was living in a bed and when I didn't do something, one of the guys, I had that thing in my , and that did it for me." Regarding his arms, he said "that is another thing."

At 11:08 a.m. his wife said the and broken were injuries that occurred at the facility and no one could tell her how the injuries occurred. When she left after visiting him on he had only a on the top of his left . On at 1 p.m. she received a call from the facility notifying her that his left was . An revealed a to his left ring without . The memory care nursing director told her he did not know how the occurred and said the resident was , with staff during care that morning. She reported his injuries to law enforcement on . On she spoke with the memory care director who had no additional information, but suggested possible scenarios that included he slammed his in a door, another resident broke his , or possibly a spontaneous .

Review of a Seminole county sheriff's office report revealed that an investigation was conducted on .

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At 12 p.m. an interview was conducted with the administrator, memory care director, and memory care nursing director.

The memory care nursing director said that on he phoned the resident's wife to notify her that the resident was being combative. On staff called him and reported that the resident had on his arms and they did not know how they occurred. He asked the health care provider to see the resident and home health was ordered to treat the . On at approximately 1 p.m. caregiver C brought the resident to him and pointed out that the resident's left was .

The memory care director said that the resident's wife reported that a man caused the resident's injuries and the only male caregiver was caregiver C, who was working the day of the survey and was also on the schedule to work on , , , , and . The director said caregiver C was never removed from the schedule pending an investigation because he was responsible for passing medications on it was believed that he did not provide direct care to the resident on that day.

The administrator said she did not believe caregiver C did anything to the resident because he worked at the facility for three years and he was a very good employee.

A request was made to review any written documentation of an investigation conducted by the facility. The memory care nursing director could only provide incident reports which did not contain documentation of an investigation. The incident report, dated , indicated that "this resident had to his left and right arm. This resident was also noted with x 3 to his right arm. Origin of unknown. Noted to arms as well. An of this resident's left due to some around the 4th and fifth was obtained."

At 12:17 p.m. the memory care director said the Department of Children and Families (DCF) came to the facility on and reported that the resident's wife brought up caregiver C's name as the male person involved. The director said the caregiver was not removed from the schedule pending an investigation, the facility did not obtain written statements from other staff, and only verbal conversations were held.

The administrator provided what she identified as the facility's policy and procedures on reporting resident , neglect, and . The policy indicated that an investigation into alleged would be conducted and would include signed and dated written statements, timesheets reflecting assigned staff to the residents, witness statements, ALF major incident report reflecting injuries, physical observation, resident records review, personnel file review, and any other relevant information. In addition, the procedures included a case study in which the caregiver was to be suspended pending the outcome of the investigation.

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Resident #5's record revealed a facility admission date of . His diagnoses included , , and sleep , , , and Advancing . He required supervision with his Activities of Daily Living.

On at 9:54 a.m. the resident's health care provider said the resident takes , and , both of which caused his skin to be fragile and to easily, however she acknowledged the development of his injuries, seemingly overnight, and she could not provide an explanation.

The facility failed to follow its policy when it did not conduct an investigation, as outlined in the policy, into resident #5's injuries of unknown origin.

The facility obtained written statements however, it was during the survey.

Photographic evidence obtained.

Class III

0081 - Training - Staff In-Service - 58A-5.0191( ) FAC

Based on personnel record reviews and interview, the facility failed to ensure that 2 of 5 sampled staff (C and E) received the required in-service training prior to interacting with residents.

Findings:

1. Caregiver C was hired on . His personnel record contained a certificate that included trainings on control, reporting major and adverse incidents and facility emergency procedures, resident rights and , neglect, and , , resident behavior and ADL needs, safe food handling practices, and elopement however, the instructor's signature was that of caregiver C.

On at 2:30 p.m. the administrator confirmed the findings.

2. Caregiver E was hired on . Her personnel record contained a 2-hour preservice orientation certificate, dated however, the signature of the trainer was that of the memory care director.

Another certificate, dated , was only signed by the administrator and not the employee.

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The record did not contain a statement, signed by both the administrator and the employee, indicating that the employee completed the preservice orientation, as required.

The record did not contain documented evidence to indicate caregiver E completed core training to exempt her from the requirement.

On at 2:35 p.m. the administrator confirmed the findings.

Photographic evidence obtained.

Class III

0082 - Training - / - 58A-5.0191(4) FAC

Based on personnel record reviews and interview, the facility failed to ensure 1 of 5 sampled staff (C) completed a one-time education course on ( ) and , ( ) within 30 days of employment.

Findings:

Caregiver C was hired on . His personnel record contained a certificate that included training on / however, the instructor's signature was that of caregiver C.

On at 2:30 p.m. the administrator confirmed the findings.

Photographic evidence obtained.

Class III

0083 - Training - First Aid and - 58A-5.0191(5) FAC

Based on personnel record review and interview, the facility failed to have evidence that a staff member who held a currently valid card that documented the completion courses in First Aid and was in the facility at all times.

Findings:

Review of the staff schedule for revealed staff H and I worked together on from 10 PM-6

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AM.
The administrator was asked to provide evidence that the staff had a currently valid card for first aid.
On at 3 PM, the administrator said the staff had the first aid training and she could not provide the documentation. She said she could not provide documentation that any staff that worked the same shift had a currently valid card for first aid.
On at 9:15 a.m. the director of nursing said the facility staffed licensed nurses Monday through Friday from 9 a.m. to 5:30 p.m.

Review of the staffing schedule for Siena memory care unit revealed that on caregivers E, J, L, and M were scheduled to work from 2 p.m. to 10:30 p.m. and caregiver K was scheduled to work from 9:30 a.m. to 6 p.m. There were no other employees listed on the schedule to work during these times.

On at 3:10 p.m. a request was made to review the valid first aid and cards for a staff member who was present in the facility during those times. The memory care director said he could not provide the requested information.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on personnel record reviews and interview, the facility failed to ensure 1 of 4 direct care staff (C) received at least one hour of training in the facility's policy and procedures regarding ( ) that included information in Rule 58A-5.0186, F.A.C.

Findings:

Caregiver C was hired on . His personnel record contained a certificate that included training on however, the instructor's signature was that of caregiver C.

On at 2:30 p.m. the administrator confirmed the findings.

Photographic evidence obtained.

Class III