Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910786	A. BUILDING: _____ B. WING _____	09/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER SHORES, INC.	125 56TH AVENUE, SOUTH SAINT PETERSBURG, FL 33705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation (complaint 2021008873) was conducted at Westminster Shores, Inc. on . Deficiencies were identified at the time of the survey.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide supervision to prevent elopements for 3 of 3 residents whose records were reviewed (Residents #1, #2, and #3). Findings included: An observation of the facility's assisted living, one-story villas, was conducted at 12:20pm on . The villas, in which assisted living residents lived, consisted of 19 separate one-story apartments that opened to the outside of the buildings. The facility was set in a residential neighborhood and was part of an	A 025		

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A 025	Continued From page 2 overall campus that was not enclosed by fencing or any other barrier. The dining hall for the assisted living villas was located in a separate building near the villas. Sidewalks connected the villas to each other and the dining hall. Resident #1 was observed with other residents at a dining room table eating lunch. A review of the facility's adverse incident reports, on , revealed that on , Resident #1 eloped from the facility. The report stated that at 3:03pm, a care staff member was coming to work and saw the Resident #1 walking down the street away from facility. Shortly afterward, an employee of the facility saw the resident walking by herself and asked her to join him in his vehicle, she got in and he took her to the facility. The adverse incident had a corrective action plan that included the provision of a private duty aide for Resident #1, deeming Resident #1 with the status of "elopement risk" and that Resident #1 would be checked on frequently throughout each shift. A review of Resident #1's record on revealed an AHCA form 1823 (1823) dated , more than 2 months after the elopement incident reported to the agency. The 1823 assessment revealed that Resident #1 was not considered to be at risk for elopement. Elopement risk assessment tools reviewed in Resident 1's record revealed that on , she scored a 9 and on she scored an 11. The elopement risk assessment tool said that residents should be considered an elopement risk if total score is 9 points or higher. There was no information in Resident #1's record indicating there was ever a private duty aide and there was no documentation of any frequent checking on the resident, nor any care plan element that addressed supervision or the risk of elopement.	A 025		

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A 025	Continued From page 3 On , a review of the facility's adverse incident reports revealed that on , Resident #2 eloped from the facility and Resident #3 eloped from the facility on . Both Resident #2 and Resident #3 resided in the facility's assisted living villas, the same area as where Resident #1 resided. A review of the facility's elopement policy and procedures on revealed that after an elopement, there would be documentation in the eloper's medical record that would include findings from nursing and social service assessments, care plan discussions and consultation notes as applicable. On , a review of the facility's elopement drills revealed that the last elopement drill conducted in the facility was on . The other information in the elopement drill records were for in-service trainings after actual elopements that happened on (Resident #1) and on (Resident #3). An interview was conducted with the facility Administrator and Assisted Living Coordinator at 3:10pm on . They both stated that after Resident #1's elopement, her family paid for a private duty sitter to stay with her at night but that they no longer felt it was necessary, so they ceased paying the expense for the sitter. The facility did not provide sitter service. When told about Resident #1's 1823 assessment that said she was not an elopement risk, and the elopement risk assessments found in the Resident #1's record indicating that she was at risk for elopement, along with the fact that she eloped on , and the absence of any care planning that addressed the risk for elopement	A 025		

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A 025	Continued From page 4 (as the facility's policy and procedure following elopements directed), they were both expressed surprise and stated they could not explain the discrepancies and oversights. Photographic evidence obtained. Class III	A 025		