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
	AL11911229	A. BUILDING: _____ B. WING _____	R 10/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER WINTER PARK	1111 S. LAKEMONT AVENUE WINTER PARK, FL 32792

(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 revisit to Complaint Investigation 2021007762 was conducted at Westminster Winter Park on . The facility had a deficiency 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 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}		

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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: DEFICIENCY REMAINED UNCORRECTED Based on record reviews and interviews, the facility failed to follow health care provider's orders for 3 of 4 sampled residents (#2, #16, #18). Findings: 1. Review of resident #2's record revealed an admission date of . An 1823 that was dated indicated the resident's diagnoses included , type 2, , and .	{A 025}		

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{A 025}	Continued From page 2 Review of the resident's Medication Observation Record (MOR) revealed the following entries: inject 8 units (u) (SQ) daily at 8 a.m. with breakfast. Hold if (BG) < 100 and call MD. The dose was not signed as given on and neither the MOR nor the resident's record contained documentation to indicate why. inject 4 u SQ daily at 5 p.m. with dinner. Hold if BG < 100 and call MD. The result of the BG was 83 on . The MOR nor the resident's record contained documentation that indicated an MD was called, as ordered. 2. Review of resident #16's record revealed an admission date of . An undated 1823 indicated the resident's diagnoses included type 2. A hospital discharge summary that was dated contained a health care provider's order for inject 15 u SQ once a day. However, review of the resident's MOR revealed it was not signed as given on . In addition, the MOR contained an entry to check the resident's BG before meals but there was not a result documented on at 4:30 p.m. Neither the resident's MOR nor record contained documentation that indicated why the was not signed and the BG was not checked. On at 11:15 a.m. the ALF coordinator confirmed the findings, said an agency nurse worked on those dates for both residents and she	{A 025}		

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{A 025}	Continued From page 3 was unable to provide additional documentation. On at 11:45 a.m. a review of the stored BG results in resident #16's BG machine was conducted along with nurse A. No result was in the memory on at 4:30 p.m. although there was for dates and times before and after that. 3. Review of resident #18's record revealed an admission date of . An 1823 that was dated indicated the resident's diagnoses included and 's . The resident's record contained a health care provider's order that was dated for BG check daily. However, review of the resident's MOR revealed no results were documented on and . Neither the MOR nor the resident's record contained documentation to indicate why. On at 12:25 p.m. the ALF coordinator confirmed the findings, said an agency nurse worked on those dates and was unable to provide additional documentation. A review of the stored BG results in the resident's BG machine was conducted along with the coordinator. No results could be found for and . Class III	{A 025}		