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
	AL11942718	A. BUILDING: _____ B. WING _____	03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTCHESTER OF SUNRISE (THE)	9701 WEST OAKLAND PARK BLVD SUNRISE, FL 33351

(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 An unannounced Relicensure, Complaint (#2020017051, #2021012646, #2022013166, #2021006899, #2020002846, #2021006988, #2021009364, #2022002441, #2022003748, #2022007284, #2022008697, #2022010323, #2022003841 and #2022003876) and Generator Monitoring survey was conducted from . . . . . through . . . . . at The Westchester of Sunrise. The facility had deficiencies identified related to the Relicensure and Complaints (#2021006899, #2022002441, #2021009364 and #2022010323) at the time of the survey.	A 000		
A 028	59A-36.007(4) FAC Resident Care - Activities of Daily Living (4) ACTIVITIES OF DAILY LIVING. Facilities must offer supervision of or assistance with activities of daily living as needed by each resident. Residents should be encouraged to be as independent as possible in performing activities of daily living. This Statute or Rule is not met as evidenced by: Based on interview, record review and observation, the facility failed to provide the care and services to meet the needs for Activities of Daily Living (ADL) care for 3 of 10 sampled residents, Resident #4, Resident #8, and Resident #10. The findings included: In an interview conducted with Resident #4 on . . . . . at 11:16 AM, she stated she has to do everything for herself as she does not get any assistance with her ADLs from staff. She stated her friend helps her to get around. Observation	A 028		

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A 028	Continued From page 1 was made of Resident #5 assisting Resident #4 out of her room and downstairs to the dining room. Resident #5 stated during the interview, that she assists Resident #4 with her ADLs. In an interview conducted with Resident #8 on [redacted] at 11:44 AM, he stated he needs help with showers and cleaning his room, but he has to do it all by myself. He stated he does not get any assistance from staff and has to do everything himself. A review of Resident #8's Resident Health Assessment (AHCA Form 1823) dated [redacted], documented the resident is an [redacted] of the right [redacted] (as observed by this Surveyor), requires [redacted] care, is wheelchair bound with limited mobility, is a [redacted] risk, and requires assistance with ambulation, bathing, [redacted], grooming, toileting, and transfers. Resident #8 did a demonstration of the difficulty he experiences in trying to negotiate the to the bathroom and shower. During observation of the resident trying to get into the bathroom, he was observed to be almost falling out of his wheelchair, thus demonstrating that he is at risk of falling without receiving assistance. In an interview conducted with Resident #10 on [redacted] at 12:04 PM, she stated she is dependent upon her walker and requires assistance with her ADLs (bathing and toileting), which she does not get, so her friend, Resident #9, comes across the hall to assist her. She further stated she is unable to attend activities and has to listen to them from her front door because there is no staff to take her downstairs. During the interview this Surveyor observed Resident #10 with her walker, being assisted [redacted] to her room by Resident #9 after visiting with her.	A 028		

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A 028	Continued From page 2 On . . . . . at 11:13 AM, during the exit conference conducted with the Administrator, Activity Coordinator, Regional Consultant and Director of Nursing, they were informed of these observations and findings. Class III	A 028		
A 032	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times.	A 032		

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A 032	Continued From page 3 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to implement adequate Elopement Prevention Policies and Procedures to ensure that its 2 residents identified as at risk for elopement, Resident #26 and Resident #28, had identification on their person.	A 032		

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A 032	Continued From page 4 The findings included: Review of the facility's records indicated that its Elopement Policy and Procedures did not have details relating to the responsibilities of its staff to ensure that at risk residents must have some kind of identification that included their name, the facility's name, address and telephone number, on their person as a precaution in the event of an elopement. In an interview conducted with the Director of Nursing (DON) on at 9:25 AM, she stated that the facility assessed and identified a total of 2 current residents for being at risk for elopement. She stated that these elopement risk residents, Residents #26 and Resident #28, were required to have a bracelet on their . . . for identification and precautionary purposes due to their . . . condition. In an observation conducted on . . . . . at 9:35 AM, Resident #26 was observed ambulating independently from the dining room towards the front lobby of the facility, and it was noted that he was not wearing a bracelet. In an interview conducted with the DON at this time, she stated that she also noticed that the resident was wearing his identification bracelet or had any other form of identification on his person. In an observation conducted on . . . . . at 9:45 AM, Resident #28 was observed resting on his bed while wearing a bracelet issued from the hospital where he was previously at. Review of the bracelet worn by the resident indicated that his name was printed on the bracelet with other hospital related information on it and without any facility related information on it. (Photographic	A 032		

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A 032	Continued From page 5 evidence was obtained). In an interview conducted with Resident #28 on at 9:50 AM, he stated that he had been wearing this hospital issued bracelet since he visited the hospital a few weeks ago and that he was not aware that he needed to wear a facility-issued identification bracelet while being in the facility due to his elopement risk. He stated that he liked to go watch sports at the local bar once in a while. He stated that just over a month ago, he departed the facility on his own to go watch a football game at a nearby bar and that he did not have a facility-issued bracelet or any identification on his person when he left the facility. He stated that the facility did not know where he was at during this time, and his family had to call him on his cell phone to ascertain his whereabouts. In an interview conducted with the Administrator on at 10:55 AM, he stated he was not aware that the facility needed to ensure daily monitoring of at risk for elopement residents to ensure they had some kind of identification that included their name, the facility's name, address and telephone number, on their person as a precaution in the event of an elopement. Class III	A 032		
A 079	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and	A 079		

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A 079	Continued From page 6	A 079		

Respite Care Residents Staff Hours/Week
0-5 168
[illegible] 212
16-25 253
26-35 294
36-45 335
46-55 375
56-65 416
66-75 457
76-85 498
86-95 539

For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week.
2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours.
3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.
4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night.
5. A staff member who has completed courses in First Aid and [illegible]
( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times.
a. Documentation of attendance at First Aid or

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A 079	Continued From page 7 courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with	A 079		

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A 079	Continued From page 8 the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs.	A 079		

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A 079	Continued From page 9 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on interview, record review and observation, the facility failed to provide sufficient staffing to meet the care and service needs required for 9 of 10 sampled residents interviewed and/or observed, Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #8, Resident #9 and Resident # 10. The findings included: In an interview conducted with Resident #1 on [redacted] at 10:41 AM, he sated there are not enough staff, and that he gets services eventually. During the interview Resident #1 was observed to be in a wheelchair, for which he stated he is dependent on to get around. An observation conducted revealed Resident #1 is unable to perform cleaning of his apartment by himself.	A 079		

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A 079	Continued From page 10 In an interview conducted with Resident #2 on [redacted] at 10:51 AM, she stated she has been at the facility for over 6 years and it is like living in a Nursing home. She stated it has gone down, there are not enough staff and the one's that are here are stressed out. In an interview conducted with Resident #3 on [redacted] at 10:58 AM, he stated the one employee Home Health Aide (HHA) Staff C is good, but the facility could use more staff. He stated he does things himself because they are short staffed. In an interview conducted with Resident #4 on [redacted] at 11:16 AM, she stated she has to do almost everything herself. She stated more staff would fix all of the concerns she has. In an interview conducted with Resident #5 on [redacted] at 11:19 AM, she stated there are not enough staff. She stated HHA Staff C is the only one for both floors for cleaning. She stated her friend, Resident #4, who is dependent on a walker for ambulation, has to do everything herself as there is not enough staff to assist. During the interview, an observation was conducted of Resident #5 assisting Resident #4 out of her room to go downstairs to the dining room. In an interview conducted with Resident #6 on [redacted] at 11:21 AM, she stated she has to assist Resident #5 as there is only 1 staff here today to help for both floors. She stated they need more staff to attend to the needs, and that she has to do everything herself. In an interview conducted with Resident# 8 on	A 079		

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A 079	Continued From page 11 . . . . . at 11:44 AM, he stated they have one person to work, so you cannot get good service. They come get garbage and they get out of your room. He stated you are not supposed to ask someone to fix your bed or clean your room. He stated that if you don not ask, bed sheets will stay on your bed for one month. He further stated in the interview, they could help him with showers and cleaning his room, but he has to do it all by myself. In an interview conducted with Resident #9 on . . . . . at 11:56 AM, she stated she would like help to make it better and cleaner. Resident #9 stated she has been a resident for 7 years and it has gone down. She further stated they do not have enough staff, and there is only 1 employee on the whole floor. She stated she does everything herself because there is nobody available to do it. In an interview conducted with Resident #10 on . . . . . at 12:04 PM, she stated they do not clean her bathroom, and that it has not been cleaned in over 2 months. She stated that if they have activities, she does not participate because there is no one to take her downstairs. She stated her neighbor, Resident#9, has to go down and beg someone to come get her. She stated they just do not have enough staff, and there is only one staff person running around on both floors trying to clean and do things. In an interview conducted with the HHA Staff C on . . . . . 10:37 AM, she stated that it was she alone working both floors, and that it is like this a lot of the time. She stated sometimes there are 2 people, but a lot of the time it is just her. On , observations were made by this	A 079		

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A 079	Continued From page 12 surveyor of HHA Staff C working on both the 1st and 2nd floors throughout the day. No other staff member was observed assisting residents with their Activities of Daily Living (ADLs). On at 10:17 AM, HHA Staff C was observed on the 2nd floor going in and out of resident rooms providing care. No other staff was observed providing care other than 2 Medication Technicians (MT) who was observed passing medications only. On at 2:38 PM, HHA Staff C was observed outside the front door assisting residents who were outside talking. No other staff was observed throughout the day providing care other than two MTs who were passing medications only. In an interview conducted with the Administrator on at 11:21 AM regarding their Extended Congregate Care (ECC) status, he stated they would not staff for ECC, confirming it is lean staffing around here, so we want to make sure we can take care of the one's (residents) we have. A review of the facility's Staff Schedule provided revealed that when fully staffed, the facility staffing reflects the following staff for each shift: 7:00 AM to 3:00 PM - 2 MT and 2 Care Staff 3:00 PM to 1100 PM - 2 MT and 2 Care Staff 11:00 PM to 7:00 AM - 1 MT and 2 Care Staff Further review of the facility's calendar for revealed shifts where a Care Staff may work a shift alone as reflected on and , where there was only 1 employee, Certified Nursing Assistant Staff A to care for 102	A 079		

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WESTCHESTER OF SUNRISE (THE)	9701 WEST OAKLAND PARK BLVD SUNRISE, FL 33351

(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 079	Continued From page 13 Residents, thus putting residents of the facility at risk of not receiving or receiving timely care and services required to meet their needs. On [redacted] at 11:13 AM, during the exit conference conducted with the Administrator, Activity Coordinator, Regional Consultant and Director of Nursing, they were informed of the findings. Class III	A 079		
A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable [redacted] to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, [redacted] or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor	A 152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 152	Continued From page 14 lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . . . . . . This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe, clean and decent living environment to its residents, by not ensuring that its resident rooms, bathrooms and common areas were properly maintained and free from hazards. The findings included: In an observation conducted on . . . . at 1:00 PM in resident # , the floor had dried black-colored glue between its wooden planks. In an observation conducted at this time, it was noted that the throw rug placed on top of this floor had several black stains and smears on it. In an interview conducted with Resident #27 at this time, he stated that when the wood floors were installed, the glue used to apply the wood planks overflowed out of the joints between the planks and it had dried in place. He stated this dried-glue caused staining from walking on the wooden floor onto other surfaces and it was difficult walk on because it was tacky. (Photographic evidence was obtained).	A 152		

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A 152	Continued From page 15 In an observation conducted on at 1:10 PM, there were several bunched up soiled linens strewn on the ground of the 2nd floor stairwell landing in the west wing of the facility. In an observation conducted on at 9:30 AM, the soiled linens continued to be observed strewn on the ground of the 2nd floor stairwell landing. In an observation conducted on at 9:35 AM, resident # had no door attached to the doorway's hinges. (Photographic evidence was obtained). During an interview conducted with Resident #7 on at 11:35 AM, the carpet in his room was observed to be severely soiled and the bathroom was unclean. (Photographic evidence obtained). During an interview conducted with Resident #8 on at 11:44 AM, an observation was made of the resident's bathroom which was dirty and unkept looking. Resident #8 is an of the right and is dependent on his wheelchair for ambulating, and unable to perform cleaning tasks himself. During an interview conducted with Resident #10 on at 12:04 PM, she stated they do not clean her bathroom, and that it has not been cleaned in over 2 months. Observation by this surveyor revealed the bathroom was not clean or sanitary looking. Resident #10 was observed to be dependent on a walker for ambulation and unable to perform cleaning tasks herself. In an interview conducted with the Administrator on at 11:40 AM, he stated that he was	A 152		

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A 152	Continued From page 16 aware of the soiled linens which were placed inside the 2nd floor stairwell and the missing front door in resident # . He stated that the linens were used to clean up some repairs done on the 2nd floor last week and were placed in the stairwell after getting soiled. He stated that # 's door came off its hinges and the facility was in the process of replacing this door. He stated that he was aware of the dried-on glue on the wooden floors throughout the facility. Class III	A 152		