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
	AL11910547	A. BUILDING: _____ B. WING _____	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER OAKS	4449 MEANDERING WAY TALLAHASSEE, FL 32308

(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 #2023011649 and #2023012253) was conducted at Westminster Oaks on . The provider had deficiencies at the time of the investigation.	A 000		
A 011 SS=D	59A-36.006(5) FAC Admissions - Discharge (5) DISCHARGE. If the resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident's needs, as determined by the facility administrator or health care practitioner, the resident must be discharged in accordance with Section 429.28, F.S. This Statute or Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide an appropriate 45 day notice of discharge to Resident #2, and refused to allow the resident to return to the facility upon discharge from Acute Care. The findings include: On .. ... at 11:40 am, an interview was conducted with the Business Office Manager and the Assisted Living Administrator. This interview revealed that Resident #2 was discharged on ... to the hospital. They stated the resident was provided with a 45 Day Notice of Discharge on .. due to behavior issues. However, when Resident #2 was sent out to the hospital on .. ..., he was not allowed to return. A review of the Leon County Emergency Medical Services Physician Certification Statement for Ambulance Services dated ... revealed the call originated from Westminster Oaks. Resident #2 was transported to Capital Regional Medical Center.	A 011		

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A 011	Continued From page 1 A record review of a letter dated addressed to Resident #2's son read, "This letter is to advise you, as discussed, it is determined that your father's needs will best be met by a facility with a higher level of care. This letter will serve as notice to relocate to a new residence immediately upon discharge from Capital Regional Hospital. As a reminder, it is the policy of Westminster Oaks to conform to Florida Statutes and Codes: 429.28 and 58A-5.0182. You are being requested to move him immediately for the following reasons: He has engaged in behavior or actions that have repeatedly and substantially interfered with the rights or wellbeing of other residents. He has a medical condition that is , , , unstable, or unpredictable and treatment cannot be developed and implemented at the facility. Upon discharge from Westminster Oaks, any refund due will be processed. Please feel free to contact our business office manager for questions about this process." This letter was signed by the Assisted Living Facility Administrator. There was no evidence the notice provided information to the son that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and did not include the statewide toll-free telephone number of the program, per Section 429.28, F.S. On at 3:21 pm, a follow up interview was conducted with Assisted Living Administrator. At this time, it was verified the letter addressed to the son was being considered as the facility's official 45 day notice of discharge. Class III	A 011		

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A 025	Continued From page 2	A 025		
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 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.	A 025		

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A 025	Continued From page 3 (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 record review and interviews, the facility failed to appropriately supervise residents and maintain awareness of the resident's whereabouts, resulting in a resident being entrapped inside their bathroom. (Resident #1) The findings include: A review of the facility's investigation of an incident reported to the Agency for Healthcare Administration was conducted. The report revealed that, on at approximately 7:40 AM, Resident #1, a memory care resident, was found by Staff B, a housekeeper, inside her room's bathroom. There were 3 sweaters tied and connected between the bathroom and the closet door knobs which prevented Resident #1 from leaving the bathroom. The facility interviewed Staff A, a Certified Nurse Assistant (CNA) that worked the overnight shift on the night of the	A 025		

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A 025	Continued From page 4 incident. Staff A's statement indicated she observed Resident #1 in bed at approximately 4:00 AM. Staff A left the unit at approximately 7:00 AM and reportedly she did not see Resident #1 again. The facility's tracker system revealed Resident #1 was in the bathroom at 4:15 AM but did not come out of the bathroom until 7:50 AM. A review of the cameras in the common area verified that none of the staff visually observed Resident #1 between 4:00 AM and 7:40 AM. It could not be determined by the camera footage if anyone else entered Resident #1's room during this period. On [redacted] at 3:21 PM, an interview was conducted with the Administrator. She stated Staff A did not provide adequate supervision to Resident #1. The administrator stated that, since the incident, the facility has implemented new policies and protocols that include visually locate and documentation of the resident's whereabouts every 2 hours. Class III	A 025		