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
	AL11922281	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENS OF WESTBROOKE	6701 DAIRY ROAD ZEPHYRHILLS, FL 33542

(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 (#2024002491 and #2024000455) was conducted at Gardens of Westbrooke on . Deficiencies were identified at the time of the visit.	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 and interview the facility failed to provide care and services appropriate to the needs of residents by ensuring adequate staffing for supervision of the memory care unit for all eleven residents. Additionally, the facility failed to respond timely to call pendant requests for staff assistance for seven (Resident #1, Resident #2, Resident #4, Resident #6, Resident #8, Resident #9, and Resident #10) of eight sampled residents. Findings Included: In an interview with Staff B conducted on at 10:15am she said there were "ten	A 025		

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A 025	Continued From page 2 or eleven residents" on the unit and asked surveyor if they would mind watching the eight residents painting in the common area while she assisted another resident with care in their room. The surveyor suggested Staff B contact another staff member. In an observation on the Memory Care Unit conducted on at 10:15am Staff B was the only staff on the unit and eight residents were at a table in the common area and one asked surveyor for assistance. Staff B went down the hall with gloves and into a resident room to provide care. No other staff was present. In an interview with the Administrator conducted on at 10:20am she said there should never just be one staff member in the memory care unit, and she would address it. In an interview with Staff A conducted on at 10:42am they said it was hard to meet the needs of the residents when there were only two on duty. Additionally, they said that staffing had been cut on C and D halls and at times the Medication Technicians could not pass medications because there were not enough staff to do ADL (activities of daily living) care. Staff A stated there were a lot of times that staff on the evening shift would not answer call lights for Resident #2, Resident #3, Resident #4 and Resident #5 because the evening staff felt they were annoying. In an observation of Resident #6 conducted on at 10:58am the call pendant was pushed by resident at request by surveyor. In an interview with Resident #6 conducted on at 10:58am they said that there was	A 025		

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A 025	Continued From page 3 never enough staff to answer the call lights, and that Staff C never had the call light pager with her, but they were supposed to carry them to know who needed assistance. In an interview with the Receptionist conducted on . . . . . at 11:08am she said that the call lights pushed would show on the staff pagers and that every aide should have one. She said the monitor at her desk showed the call pendants pressed by residents. She said that Resident #8's call light might be broken and that it was showing pressed for 219 minutes and the same for Resident #9 at 57 minutes. Additionally, she was not sure if anyone had let the Administrator know that sometimes the call lights did not clear and that two were broken. Furthermore, she said she would be the one to notify the aides of call lights pending if the duration went longer than expected. She did not confirm that she had notified any staff of the pending call lights activated. In an observation of the reception desk pendant call system monitor conducted on . . . . . at 11:19am the screen showed Resident #8's call pendant activated duration of 219 minutes and 19 seconds, Resident #9's call pendant activation duration of 57 minutes and 50 seconds, Resident #10's call pendant activation duration of 12 minutes and 32 seconds, and Resident #6's call pendant activation duration of 8 minutes and 50 seconds. In an observation conducted on at 11:36am Resident #6's call pendant activated at 10:58am was answered by staff. In an interview with Resident #2 conducted on	A 025		

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A 025	Continued From page 4 . . . . . at 12:17pm they said most of the call lights did not work, and that there were times when no staff came, or they had to go and look for them, especially in the afternoons and at night. Resident #2 stated the facility needed more staff and that recently there was one aid for the entire facility. In an interview with Resident #4 conducted on at 12:25pm they said it took a long time for staff to answer the call pendants. Additionally, they said they called for help after a . . . movement a few days before and no staff ever came. In an interview with Resident #1 conducted on . . . . . at 1:20pm they said they had several . . . and one within the last month where they had pressed the call button and laid on the floor a long time before any staff came. In an attempted record review of the facility's call light policy conducted on . . . . . the requested policy was never provided. In an interview with the Administrator conducted on . . . . . at 11:40am she said call pendants should be answered within 5 minutes of activation and that the Receptionist was supposed to inform the staff if she saw call lights going off on the desk monitor. At 2:00pm she said she would be looking into staffing levels. Photographic Evidence Obtained. Class III	A 025		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin	A 052		

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A 052	Continued From page 5 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into	A 052		

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A 052	Continued From page 6 the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , converting, or ˘ medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a , of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH	A 052		

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A 052	Continued From page 7 SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving	A 052		

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A 052	Continued From page 8 the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure proper assistance with self-administration of medications which included ensuring standards of control for one (Residents #13) of one sampled resident that required assistance with self-administration of medication. Findings Included: In an observation conducted on at 10:25am Staff A (unlicensed Medication Technician) was observed walking from the medication cart behind the nursing desk to Resident #13's room with a cup of five pills and a	A 052		

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A 052	Continued From page 9 cup of water. She poured the pills into Resident #13's . She did not tell the resident the medication name or dosage. A pill dropped on the floor and Staff A said she could not see so she went to get a flashlight. She used the flashlight to search on the floor and found a pill and gave it to the resident who swallowed it. In an interview with the Administrator conducted on at 1:55pm she said she expected the medication technicians to pull the medications in front of the residents, tell them the medication name and dosage and not give residents medications that on the floor. Class III	A 052		