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
	AL11942716	A. BUILDING: _____ B. WING _____	R 05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTCHESTER OF WINTER PARK	558 N. SEMORAN BLVD. 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 the change of ownership survey was conducted at Westchester of Winter Park on . The facility had uncorrected deficiencies at the time of the visit.	{A 000}		
A 052 SS=D	429.256(.); 59A-36.008(3) Medication - Assistance with Self-Admin 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.	A 052		

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A 052	Continued From page 1 (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 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.	A 052		

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A 052	Continued From page 2 (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 SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be [illegible] 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	A 052		

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A 052	Continued From page 3 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 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 record reviews and interviews the facility failed to provide care and services appropriate to meet the needs of 1 of 6 sampled residents who needs assistance with self-administration by failing to notify the residents' health care provider of any concerns or suspected non-compliance of significant changes that may resulted in medical attention. (#18)	A 052		

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A 052	Continued From page 4 Findings: On at 9:34am the Administrator stated Resident #18 was out of the facility due to his behavior and was by the police. She stated he started acting , so we called 911 to alleviate him. An incident reported dated indicated an incident that requires transfer of the resident from the facility to a unit providing more acute care and reported to law enforcement for investigation. The Resident was being aggressive towards staff and other residents. Review of Medication Observation Record (MOR) found that resident has been refusing to take his , for 3 doses in the week prior. A record review revealed a facility's admission on . A 1823 health assessment indicated known to and a medical history of , prostatic hyperplasia ( ), , ( ), major , post- stress ( ), , and needs assistance with self-administration. On review of , Medication Observation Records revealed Invega Sustenna Suspension Prefill Syringe 156 MG/ML inject 1 vial , one time a day every 28 days for was not administered on . On review of , Medication Observation Records revealed , Oral Tablet (,) give 150 mg by at bedtime for , was not	A 052		

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A 052	Continued From page 5 administered on .... On ... . review of ..... Medication Observation Records revealed Invega Sustenna ..... Suspension Prefill Syringe 156 MG/ML inject 1 vial , one time a day every 28 days for ... ... was not administered on . On review of Medication Observation Records revealed .... , Oral Tablet (,) give 150 mg by .... at bedtime for ... ..., ... was not administered on , , , , and . On review of , Medication Observation Records revealed Invega Sustenna Suspension Prefill Syringe 156 MG/ML inject 1 vial ... . , one time a day every 28 days for ..... was not administered on ... .. On ..... review of ..... , ... Medication Observation Records revealed .... , Oral Tablet (..... , ...) give 150 mg by at bedtime for , was not administered on ... . On ..... review of ..... , ... Medication Observation Records revealed .... , Oral Tablet (..... , ...) give 150 mg by ... at bedtime for , with a start date of ..... at 2000. On ..., , , , , , , and did not indicate if the medication was administered. A facility note on ..... at 10:15 read, "resident sent out emergency medical services ( ) due to ..... . Resident's sister stated he had been talking strange and	A 052		

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A 052	Continued From page 6 making threatening calls to family." A facility note on [redacted] at 20:24 read, "resident out of facility." A facility note on [redacted] at 10:30 read, "resident sent out [redacted] due to [redacted]." A facility note on [redacted] at 09:43 read, "Invega Sustenna [redacted] Suspension Prefilled Syringe 156 MG/ML inject 1 vial [redacted], one time a day every 28 day(s) for [redacted] awaiting." A facility note on [redacted] at 21:42 read, "[redacted] Oral Tablet give 150 mg by [redacted] at bedtime for [redacted] supervised self-administration awaiting pharmacy." A facility note on [redacted] at 21:05 read, "resident not available." A facility note on [redacted] at 21:03 read, "resident wasn't available." A facility note on [redacted] at 19:57 read, "[redacted] Oral Tablet give 150 mg by [redacted] at bedtime for [redacted] supervised self-administration unavailable." A facility note on [redacted] at 22:42 read, "[redacted] Oral Tablet give 150 mg by [redacted] at bedtime for [redacted] supervised self-administration available from the pharmacy." A facility note on [redacted] at 09:43 read, "Invega Sustenna [redacted] Suspension Prefilled Syringe 156 MG/ML inject 1 vial [redacted], one time a day every 28 day(s)	A 052		

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A 052	Continued From page 7 for . . . . . waiting for nurse practitioner." A facility note on at 08:24 read, "Invega Sustenna . . . . . Suspension Prefilled Syringe 156 MG/ML inject 1 vial . . . . . , one time a day every 28 day(s) for waiting for pharmacy." A facility note on at 13:12 read, "this order is outside of the recommended dose or frequency. Invega Sustenna Suspension Prefilled Syringe 156 MG/ML inject 1 vial , one time a day every 28 day(s) for . . . . . ." On at 2:19pm unlicensed care staff A stated, "I use to give him meds but not anymore. A few days prior, I saw him downstairs and for me I thought he was ok. I heard he was aggressive with the other residents, but I did not witness it. He started walking around the place telling other residents he could help them if they paid him $50 to get car insurance. I didn't understand because he always stayed in his room. So, I thought he was getting better by coming out of his room making friends." On . . . . . at 2:38pm unlicensed care staff F stated, "yes, I did give Resident #16 his meds in the morning. He always takes his meds for me. You have to know how he is with his schedule. Sometimes if he refuses, we just document it. No, I didn't tell the nurse because we put it in his chart. When I started working here, he was not social but then he became interactive just before the incident, maybe one week before." A review of Resident #16's Progress Notes did not reveal his doctor or guardian was notified of	A 052		

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A 052	Continued From page 8 the missed medications or refusals to take his medications for , . There was no documented evidence that the resident was out of the facility on and . Further review of Resident #16's records revealed the facility obtained a new 1823 health assessment dated indicating a medical history of post- stress ( ) and needs assistance with self-administration. A review of the facility's Medication Administration Policy states, "usual reactions or a significant change in the resident's health or behavior will be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider will be documented in the resident's clinical record." On at 5:04pm the Administrator stated, "I was not aware that he was refusing his medications and prior to that I was not aware of his behavioral changes. I heard Staff G on the phone with Resident #16's doctor the day of the incident. I'm not sure why she didn't document it." On at 2:00pm Resident #16's Guardian stated, "No, the facility didn't tell me he wasn't talking his meds. I'm always at the facility taking him to the VA doctors for his , , . I told Staff G about his medications and that he cannot miss any doses." (photographic evidence obtained) Class III	A 052		

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{A 056}	Continued From page 9	{A 056}		
{A 056} SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must	{A 056}		

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{A 056}	Continued From page 10 be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and,	{A 056}		

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{A 056}	Continued From page 11 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure medications were refilled in a timely manner to ensure doses were not missed for 2 of 6 sampled residents who required assistance with self-administration of medications (#16, #18). Findings: A record review of Resident #18 revealed a facility's admission on [redacted]. A [redacted] 1823 health assessment indicated known [redacted] to [redacted] and a medical history of [redacted] prostatic hyperplasia ([redacted]), [redacted] ([redacted]), major [redacted], post-[redacted] stress ([redacted]), [redacted], and needs assistance with self-administration. A facility note on [redacted] at 09:43 read, "Invega Sustenna [redacted] Suspension Prefilled Syringe 156 MG/ML inject 1 vial [redacted], one time a day every 28 day(s) for [redacted] awaiting." A facility note on [redacted] at 19:49 read, [redacted] External [redacted] 0.1% apply to [redacted], two times a day for atopic supervised self-administration needs to be ordered."	{A 056}		

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{A 056}	Continued From page 12 A facility note on at 16:45 read, "50mcg Spray 1spray in both nostrils two times a day for supervised self-administration awaiting pharmacy." A facility note on at 22:28 read, "unavailable." A facility note on at 21:43 read, "50mcg Spray 1spray in both nostrils two times a day for supervised self-administration awaiting pharmacy." A facility note on at 21:42 read, " Oral Tablet give 150 mg by at bedtime for supervised self-administration awaiting pharmacy." A facility note on at 20:30 read, " External 0.1% apply to two times a day for atopic supervised self-administration self admin." A facility note on at 22:52 read, "unavailable." A facility note on at 19:57 read, " Oral Tablet give 150 mg by at bedtime for supervised self-administration unavailable." A facility note on at 22:42 read, " Oral Tablet give 150 mg by at bedtime for supervised self-administration available from the pharmacy." A facility note on at 09:43 read, "Invega Sustenna Suspension Prefilled Syringe 156 MG/ML inject 1 vial	{A 056}		

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{A 056}	Continued From page 13 , one time a day every 28 day(s) for waiting for nurse practitioner." A facility note on at 09:27 read, " Oral Tablet 20mg give 1 tablet by one time a day related to - without supervised self-administration awaiting pharmacy." A facility note on at 13:29 read, "VA pharmacy outreached for refill of all treatment. Rep stated expected delivery in days." A facility note on at 08:24 read, "Invega Sustenna Suspension Prefilled Syringe 156 MG/ML inject 1 vial , one time a day every 28 day(s) for waiting for pharmacy." A review of the facility's Medication Labeling and Orders states, "the facility will make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner." Based on review of Resident #18's facility note there was only one documentation the facility attempted to obtain refills timely. 2. A record review of Resident #16 reveals a facility's admission date on . A 1823 health assessment form indicated a medical history of , of fourth , history of , a fib,	{A 056}		

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	AL11942716	A. BUILDING: _____ B. WING _____	R 05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTCHESTER OF WINTER PARK	558 N. SEMORAN BLVD. 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 056}	Continued From page 14 forgetful and needs assistance with self-administration. On a review of an incident report dated indicated an event that is reported to law enforcement for investigation of 30 capsules of , 30mg prescribed to resident #16 that were unable to be located. On at 11:00am Resident #16 stated, "yes, my medication , was missing, but I believe that was when I was on the Skilled Nursing side. Resident stated, oh it happened here. I didn't know about that." On a review of Resident #16's , Medication Observation Record revealed on , cap 30mg give 1 capsule orally at bedtime for at 2100 was not administered. On at 2:19pm unlicensed care staff A stated, "Resident #16's medication delivery most of the time is in the mornings around 4am and sometimes it can come in the evenings. The pharmacy sends 2 receipts, one for the pharmacy and one for the facility. You sign and give a copy to the pharmacy and they take a picture. Our copies are kept in a binder. We compare the list of medications before signing. If it's listed but not include you make them aware and notate on the form. When a resident is missing meds. I just call the pharmacy to reorder or call the doctor to have a new script sent to the pharmacy." On at 2:38pm unlicensed care staff F stated, "I'm part time and I don't give medications. The medications usually come between 3am - 4am and the overnight staff would typically be the ones to receive it."	{A 056}		

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{A 056}	Continued From page 15 O at 3:00pm unlicensed care staff C stated, "I stated it was the medication I threw away. I didn't check the bag and they had 911 to come in to investigate. I explained to the police and Administrator what happened. The pharmacy delivery brought 2 receipts and I signed one. I was on the floor when he came with the meds. He took it and put it on the desk. I never opened the bag. I didn't look in the bag and I didn't follow protocol. When I opened the bag, I never saw the medication, and someone said I may have thrown it in the trash. So, maybe that's what happened." On at 3:13pm Staff G who was the nurse at the time of the event was contacted to verify the incident and that she reordered the medication. No return call was received. On at 4:40pm the Administrator stated, "The overnight staff stated they would have the pharmacy to leave the meds at the desk and would just sign. Yes, I have a receipt to show that unlicensed care staff C did sign for the medications on . Staff G reordered and Resident #16 only missed one day on . We've educated the staff that they're supposed to check the medications before signing." (photographic evidence obtained) Class III	{A 056}		

Agency for Health Care Administration

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{A 000}	Initial Comments AMENDED 6/14/24 DELETED A0052 AND A0056. A revisit to the change of ownership survey was conducted at Westchester of Winter Park on 05/21/2024. The deficiencies were corrected at the time of the visit.	{A 000}		

AHCA Form 3020-0001

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