

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11942716	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/19/2024
NAME OF PROVIDER OR SUPPLIER WESTCHESTER OF WINTER PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 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 complaint #2024013877 was conducted on _____ at Westchester of Winter Park. Deficiencies were identified at the time of the survey.	{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}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

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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 _____ 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 observation, record reviews, and interviews Unlicensed caregiver E failed to follow proper medication - assistance with self-administration of an improper med pass for 1 of 2 sampled residents. (#5). Findings:	{A 052}			

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{A 052}	Continued From page 4 On at 11:20am, observations of Resident #5's med pass administered by unlicensed care giver E revealed the following. Resident #5 approached the med cart in the hallway on the first floor asking the unlicensed caregiver if she needed to see her numbers. The unlicensed caregiver stated yes and agreed with the resident the number stated 192 on the monitor. After following proper hygiene, the unlicensed caregiver removed a pink container from the med cart which had the listed. Resident #5 stated, "I get 2 units and after reviewing the , the unlicensed staff agree. Unlicensed caregiver E removed the Flasp Flex Touch Solution Pen Injector from the pink container, retrieved the container which held the needles and proceeded to put the needle on the pen. After the needle was placed, the unlicensed caregiver attempted to the pen to the resident realizing that it was not dialed. The unlicensed caregiver proceeded to dial the pen to 2 units, afterwards handing it to the resident. The resident was not given an wipe to clean the injection site before or after administering the medication. Resident #5 lifted her blouse and injected the medication with no assistance from the staff. Resident #5 returned the pen to the care staff, asked if there was any , and lowered her blouse. The unlicensed staff removed the needle and properly disposed, returning the pen into the pink container. A record review of Resident #5 revealed a facility's admission on . A 1823 Health Assessment Form indicated needs assistance with self-administration. A review of Resident #5's Medication Observation Record for stated Flasp Flex Touch Solution Pen Injector 100 unit/ml	{A 052}			

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{A 052}	Continued From page 5 Inject as per _____ : if 151-200 = 2 units. The unlicensed caregiver was asked to explain the process for passing meds or preparing for an med pass On _____ at 11:24am the unlicensed caregiver stated, I sanitize my _____ and put on my PPE. I check the resident _____ or in this case Resident #5 checked her sugar. She let me know the numbers and she showed them to me. I prepare the pen by putting the needle on, put how many units, then give her the needle. She administers her own injection and then I take the pen and dispose of the needle. I then take off my gloves, sanitize again and update the Medication Observation Record (MORs). The unlicensed caregiver stated, "I didn't know I couldn't dial the pen. No, I'm not a nurse. I always do it for the residents. Yes, I just completed my 2hr training and nothing was said that we couldn't do it. On _____ at 11:36am the Director of Nursing (DON) stated, oh, I didn't know. I thought they could. I told them they could. I'm at fault. We just had the pharmacy to come in and retrain everyone. They didn't say anything about it. Resident #5 is not able to dial the pen. I know she can't. On _____ at 12:38am Resident #5 stated they always dial my pen because I can't see the little bit of stuff. The numbers are so small, even with my glasses. No, I'm not able to dial it myself. Sometimes they give me the _____ wipes and sometimes they don't. She didn't give it to me today. Sometimes I have to remind them. On _____ at 2:10pm the Administrator and	{A 052}		

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{A 052}	Continued From page 6 DON confirmed the findings. (photographic evidence obtained) Class III	{A 052}		
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	A 056		

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A 056	Continued From page 7 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 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	A 056			

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A 056	Continued From page 8 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, 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 observation, record reviews, and interviews, the facility failed to follow the physician orders for 1 of 2 sampled residents as required (#4). Findings: On at 11:12am observation of Resident #4's med pass revealed the following. Unlicensed caregiver E followed proper hygiene, knocked, entered the resident's room, acknowledged resident by name informing him of his medications. The resident stated I already had my meds. The caregiver stated its time for the afternoon medications. Unlicensed caregiver E reviewed the MORs for Resident #4's medications and removed the medications from the cart. She retrieved a medicine cup and the 2 bubble packs to prepare in the presence of the resident as he sat in the doorway of his room. The resident proceeded to take his meds as the staff handed him the cup of water. The medications were returned to the medication cart, and observation did not reveal the MORs were	A 056			

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A 056	Continued From page 9 updated. The unlicensed caregiver stated that I have to go into this screen and enter my password to update. Observation of the MORs revealed Cap 100 mg give 2 capsules orally three times day at 1300 (1pm) and Oral tablet 12.5mg give 1 tablet by three times a day at 1300 (1pm). A record review of Resident #4 revealed a facility's admission on A 1823 Health Assessment Form indicated needs assistance with self-administration. Unlicensed caregiver E was asked why did she give Resident #4 his meds at 11:00am? On at 11:15am the unlicensed caregiver stated, it's my first time dealing with state, I'm sorry. I guess I'm nervous. On at 11:36am the DON stated, oh, I probably didn't realize his MORs were not fixed. I have to go in and update everyone's MORs because I have most of them on the same schedule. No, I have orders to do. We've been having issues with the Pharmacy and everyone's MORs have been off with the times. It's my fault. I guess I didn't get Resident #4's updated. The staff wouldn't know. On at 12:00pm the DON stated I don't have anything to show, the time should be 11:00am. So, we would have to go by the time on the MORs 1300 which is 1pm. That's more than one hour before or one hour after. (photographic evidence obtained)	A 056			

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A 056	Continued From page 10 Class III	A 056			