STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942716	10/28/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Westchester Of Winter Park	558 N. Semoran Blvd. Winter Park, FL 32792	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= G
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D

Specific Tag Findings:

0000-Initial Comments
Complaint inspection CCR# 2013007526 was conducted on and

Westchester at Winter Park had deficiencies found at the time of the visit.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on observation, record review and interview the nurse failed to ensure she followed the correct procedure of comparing the Medication Observation Record with the pharmacy label when administering injected rapid acting instead of long acting which resulted in a hospital admission for for 1 of 6 sampled residents (#1).

Findings:

The Agency for Health Care Administration received an Adverse Incident Report that stated resident #1 received the wrong type of

Record review for resident #1 revealed an Assisted Living Facility Health Assessment Form (1823) dated that stated diagnoses of type 2 and recurrent Review of the 1823 updated that stated see history and physical (H&P) for diagnoses. Review of the hospital's history and physical stated diagnoses of accidental injection of with It also stated the resident has a history of The 1823 stated the resident needed medications administered.

Review of the Medication Observation Record (MOR) revealed Lantus 30 units at bedtime was charted as given on at hour of sleep, initials were in the box. The back of the MOR stated on medication error, no Lantus 2200 (10:00 PM) given instead of Lantus Doctor notified.

Review of physician order dated stated Lantus 30 units (sq) at 9 PM and did not have an order for

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Review of physician order dated at 10:15 PM stated, sent to hospital for monitoring as recommended by on call physician.

Review of facility progress notes revealed:
at 10:30 PM stated, medication error on resident. The resident was given 30 units instead of Lantus 30 units. Medical Director called. Physician called. Physician advised to send to hospital. sugar at that time was 181. When 911 arrived it was 112, approximately 30 minutes past the time of the medication error. Family notified.
is a High Alert medication): The Institute for Safe Medication Practices includes this medication among its list of drugs which have a heightened risk of causing significant patient harm when used in error. Due to the number of preparations, it is essential to identify/clarify the type of to be used. is a rapid acting administered pre-meal as a component of the regimen. Lantus is a long acting , per the Dosage Handbook 12th Edition).
8 AM stated, phoned hospital, spoke to the nurse who stated the resident was stable and no adverse reactions to medication error noted. The nurse stated she was awaiting further physician orders.
at 5 PM stated, resident returned to the facility via ambulance in wheelchair. Alert and oriented. Several medication changes were made while at hospital. ordered for

Review of the History and Physical (H&P) dated stated:
"DATE OF ADMISSION:
CHIEF COMPLAINT: Accidental injection of 30 units of with
HISTORY OF PRESENT ILLNESS: The patient is an (age mentioned) year old female, resident of Westchester ALF, who states that yesterday she was given accidentally 30 units of and came into the emergency . The patient was admitted with an initial of, it says, 168 at midnight and then another test within 20 minutes was 59. The patient was admitted since then and has had a low sugar at 4 AM this morning of 60, feels fine, feels a little tired. No complaints of chest pain, or
MEDICATIONS AT HOME: Lantus
PLAN: We will continue to monitor the patient. She will continue her usual dose of (___blank) sic. We will not put her on sliding scale. If stable she will be discharged in the morning back to the ALF.
ASSESSMENT: accidental injection of with and history of

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SUMMARY STATEMENT OF DEFICIENCIES
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Review of signed statement by Staff A dated at 8:30 AM stated, she arrived at resident #1's 10 PM on She took an pen from the medicine drawer. She obtained the resident's sugar reading of 181. She dialed 30 units into the pen and gave the She proceeded to her med cart putting away her supplies at 10:15 PM and discovered another pen. She had given the wrong Neither pen was labeled with the patient's name but placed in a plastic bag at the time. She did see resident #1's name on a plastic bag with her Lantus pen inside. She had given the wrong type of to resident #1. She immediately called the physician, who advised her to send the resident to the hospital. She informed the resident of the error and that she would be transported to the hospital. She was alert, oriented and awake. Vital signs were taken pulse 62, 16 and temperature 97.8 and saturation 98. The family was notified. 911 arrived at 10:35 PM. They obtained a glucose reading of 112. She was transported to the hospital at 10:55 PM. Medical error due to not checking type with the MOR. Signed by Staff A.

Observation on at approximately 3:50 PM revealed there were 2 plastic bags, with resident #6's name written in black marker on the bag, in the medication cart. Plastic bag #1 contained a pen that did not have a pharmacy label on it. Plastic bag #2 contained a Lantus pen that did not have a pharmacy label on it. The pens were not labeled by the pharmacy and residents were still at risk of receiving the incorrect type of when the inspection was conducted.

Review of the facility's internal investigation revealed an " Event Report (Prepared In Anticipation of Litigation" form
Name of Resident involved in the event - resident #1 named
Date and times of the event - at 10 PM, not witnessed
Name of nurse assigned - Staff A ' s name mentioned
Medication variance - administered wrong type of to patient. Resident sent to hospital per physician for observation
Hospital admission checked
Signed by Staff A on
Signed by Risk Manager on
Is this a Reportable Incident - yes
Event Analysis Worksheet - Resident #1's name mentioned on at 10:30 PM
Clear Description of the event - nurse retrieved incorrect pen from the drawer on the medication cart and administered the incorrect to the resident. Nurse did follow the proper medicaiton administration procedure. Nurse did not check the medication with the MOR.

Corrective Actions Immediate by staff: physician and family informed. Resident sent to hospital for evaluation/observation. [illegible] sugar taken with in normal limits and again prior to ambulance pick up. Doctor suggested Emergency [illegible] evaluation despite availability of nurse to monitor [illegible] sugar in facility.
Additional interventions/actions: nurse re-educated on medication administration. Storage of [illegible] on med cart observed. [illegible] separated by type on med cart.

Review of the Adverse Incident Report dated [illegible] revealed, resident #1 received the wrong type of [illegible] from a nurse. The resident did not display any adverse reactions. The nurse identified it was the wrong medication when returning medications. The physician was notified and the resident was sent to the Emergency [illegible] (ER) for evaluation. The ER reported the resident was stable and remained under observation. The nurse was interviewed and was receiving remedial education. The facility verified all medications were labeled properly. Both [illegible]lin's were pens, had different colors and labeled with which type.

Review of the 15 Day Adverse Incident Report dated [illegible] stated, "At the conclusion of a thorough investigation which included record review, resident interview and staff interviews it is determined that the "condition that required the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident" was a recommendation by a covering physician who was unfamiliar with the resident.

The resident was transferred to Florida Hospital of Winter Park for observation. The resident was placed in a hold pattern in the emergency [illegible] observation only. At the conclusion of the observation the resident was returned to the facility in stable condition.

In conclusion, despite the transfer to a higher level of care related to a medication variance, the services provided in the hospital were able to be performed in the facility had the resident remained here. The transfer to the higher level of care occurred because the covering physician recommended the observation not because of a change in the resident's condition. Therefore, this allegation is unsubstantiated".

The facility determined that "after a complete investigation, the risk manager or authorized ALF representative determined that the incident was not an adverse incident".

The incident was an adverse incident as, due to the nurse injecting rapid acting [illegible] instead of long acting [illegible], which was a medication error. Resident #1 was transferred

from the facility to a unit providing more acute care (the hospital) due to the medication error, rather than the resident's condition before the incident.

Interview with the administrator on at approximately 2:40 PM who stated the on call physician was not familiar with the resident and ordered to send her out to the hospital. The facility was able to provide the care to the resident in the facility and the facility had determined that the incident was not an adverse incident.

Class II

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on observation and interview the facility failed to ensure all prescription drugs kept by the facility were properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C for 2 of 6 sampled residents (#1 & 6).

Findings:

The Agency for Health Care Administration received an Adverse Incident Report that stated resident #1 received the wrong type of

Record review for resident #1 revealed an Assisted Living Facility Health Assessment Form (1823) dated that stated diagnoses of type 2 and recurrent Review of the 1823 updated that stated see history and physical (H&P) for diagnoses. Review of the hospital's history and physical stated diagnoses of accidental injection of with and known history of The 1823 stated the resident needed medications administered.

Review of the Medication Observation Record (MOR) for resident #1 revealed Lantus 30 units at bedtime was charted as given on at hour of sleep, initials were in the box. The back of the MOR stated on medication error, no Lantus 2200 (10:00 PM) given instead of Lantus Doctor notified.

Review of physician order dated stated Lantus 30 units (sq) at 9 PM and did not have an order for

Review of physician order dated at 10:15 PM stated, sent to hospital for monitoring as recommended by on call physician.

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Review of facility progress notes revealed:
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is a High Alert medication: The Institute for Safe Medication Practices includes this medication among its list of drugs which have a heightened risk of causing significant patient harm when used in error. Due to the number of preparations, it is essential to identify/clarify the type of to be used. is a rapid acting administered pre-meal as a component of the regimen. Lantus is a long acting , per the Dosage Handbook 12th Edition).

Review of the History and Physical (H&P) dated stated:
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CHIEF COMPLAINT: Accidental injection of 30 units of with
HISTORY OF PRESENT ILLNESS: The patient is an (age mentioned) year old female, resident of Westchester ALF, who states that yesterday she was given accidentally 30 units of and came into the emergency . The patient was admitted with an initial of, it says, 168 at midnight and then another test within 20 minutes was 59. The patient was admitted since then and has had a low sugar at 4 AM this morning of 60, feels fine, feels a little tired. No complaints of , chest pain, or
MEDICATIONS AT HOME: Lantus
PLAN: We will continue to monitor the patient. She will continue her usual dose of (___blank) sic. We will not put her on sliding scale. If stable she will be discharged in the morning back to the ALF.
ASSESSMENT: accidental injection of with , and history of

Review of signed statement by Staff A dated at 8:30 AM stated, she arrived at resident #1 's 10 PM on . She took an pen from the medicine drawer. She obtained the resident 's sugar reading of 181. She dialed 30 units into the pen and gave the . She proceeded to her med cart putting away her supplies at 10:15 PM and discovered another pen. She had given the wrong . Neither pen was labeled with the patient ' s name but placed in a plastic bag at the time. She did see resident #1 ' s name on a plastic bag with her Lantus pen inside. She had given the wrong type of to resident #1. She immediately called the physician, who advised her to send the

resident to the hospital. She informed the resident of the error, and that she would be transported to the hospital. She was alert, oriented and awake. Vital signs were taken ... pulse 62, ... 16 and temperature 97.8, and ... saturation 98. The family was notified. 911 arrived at 10:35 PM. The obtained a ... glucose reading of 112. She was transported to the hospital at 10:55 PM. Medical error due to not checking ... type with the MOR. Signed by Staff A.

Observation on ... at approximately 3:50 PM revealed there were 2 plastic bags, with resident #6 ' s name written in black marker on the bag, in the medication cart. Plastic bag #1 contained a ... pen that did not have a pharmacy label on it. Plastic bag #2 contained a Lantus ... pen that did not have a pharmacy label on it. The ... pens were not properly labeled by the pharmacy to include: the name and address of the pharmacy, the date of dispensing, the serial number, the name of the patient, the name of the prescriber, the name of the drug dispensed, the directions for use and the expiration date. The ... pens were not labeled by the pharmacy and residents were still at risk of receiving the incorrect type of ... when the inspection was conducted.

Interview with the administrator on ... at approximately 4 PM who stated he was not aware the medication was not properly labeled.

Observation on ... at approximately 9:15 PM revealed there was one vial of ... ... without a pharmacy label in the locked refrigerator in the nursing station. Interview with the Wellness Nurse on ... at approximately 9:15 PM who stated the vial was ... and she was looking for the box with the pharmacy label for the vial. She was not aware the vial was in the refrigerator without a label.

Class II

0162-Records - Resident 58A-5.024(3) FAC
Based on observation, record review and interview the facility failed to ensure health care provider's orders were obtained to administer ... for 1 of 6 sampled residents (#5).

Findings:

Review the record for resident #5 revealed an Assisted Living Facility health assessment form (1823) updated on ... that stated diagnoses of ... left foot ... and stated the resident needed assistance with self-administration of medication.

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Interview with resident #5 on [redacted] at approximately 10:45 AM, who was alert and oriented, stated the nurse administered his [redacted] four times a day.

Review of physician orders dated [redacted] revealed [redacted] R [redacted] sliding scale before meals and at bedtime.

Record review revealed there was no physician order for the nurse to administer [redacted].

Interview with the Administrator on [redacted] at approximately 3:45 PM who stated he was unable to locate an order to administer [redacted].

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Westchester Of Winter Park
558 N. Semoran Blvd.
Winter Park, FL 32792

Dear Administrator:

RE: CCR #2013007526

This letter reports the findings of a state licensure survey that was conducted on , 2013 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after **, 2013,** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Lorraine Henry at .

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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