STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910349	09/18/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Westminster Woods On Julington	**25 State Road 13 Jacksonville, FL 32259**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0090 - 58a-5.0191(11) Fac - Training - S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced biennial licensure survey was conducted at Westminster Woods on Julington on 2014. Deficiencies were identified.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on record review and staff interview the facility failed to provide adequate supervision to know the general whereabouts for 1 of 16 sampled residents (Resident #15).

The findings include:

On a record review of Resident#15 revealed an elopement assessment dated had a score of 9, indicating she was at risk for elopement.

Further record review of Resident #15 health assessment dated revealed her status as alert and oriented x 1 with agitation due to change in environment, wandering which is not usual for her. Review of physician ' s orders dated revealed to check wander-guard to ensure it is working daily.

On at 1:26 PM an interview with Employee F revealed, that the secretary from the building called us to let us know Resident #15 was at the administrative building. She said Resident #15 has done this several times. She said the first time was a few months ago. She said the administrative office is across the street. She said I am pretty busy and a lot of times she doesn't where Resident #6 is. She said Resident #15 is "my only wanderer." She said security has had to bring her back.

On at 2:54 PM an interview with Employee G revealed that Resident #15 gets . She said she will wander away and leave the campus. She said she goes to the gate if she wants to go shopping. She said the gate is by the street. She said she walks on her own a lot. She said the facility calls the family all the time to tell them she wandered away. She said the director has met with her son and they discussed moving her over to a different building which is a locked building for wanderers.

On at 3:10 PM an interview with Employee A revealed Resident #15 went across the street to the administration building. She said she wasn't wandering. She said she was not there when it happened. She said that Resident #15's cognition is good, she has expressive aphasia. She said she has never met with Resident #15's family to discuss moving her to the other building that is alarmed. She said the boundaries' of the facility are all of the acres throughout the campus. She said beyond the fence/gates of the assisted living is considered on campus. She stated the administrative office is considered on campus. She said Resident #15 was free to walk

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around all of the grounds of the campus. Employee A stated there are no incident reports or adverse reports for Resident #15 because she isn ' t wandering.

Record review of nurses notes dated revealed Resident #15 son was notified because of her " walk ", stated he was reassured of her location and she was not " lost " . Resident #15 was counseled to remain within gates for safety.

Review of the facility's 24 hours shift to shift report dated revealed a notation that stated " 6:20 PM Resident #15 was at the corner of San Jose Blvd, the front desk called security, they brought her back, Resident #15 son was notified.

Review of the facility policy for Resident Observation and Whereabouts: Elopement dated revealed the assisted living staff will have general knowledge of the whereabouts of each assisted living resident.

On at 9:00 AM revealed there are gates and a fence on the perimeter of the assisted living. There is a public road outside the gate and across the public road are the administrative building and doctor's office.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on observation, interview and record review the facility failed to ensure medications were ordered timely for 1 of 3 sampled residents, and failed to follow Resident #5 physician order to follow parameters prior to giving medication for 1 of 3 sampled residents (Resident #11).

The findings include:

1) On at 11:06 AM a review of medication cart in the Ilex building, Employee D revealed a box of Diskus that had a post-it note that read, "Completely Out". Employee D stated that the Diskus has been out for a few days. She said it was ordered a few times.

On a record review of Resident #5 Medication Observation Record dated 2014 revealed the Diskus one puff twice daily was circled from 8:00 AM on through , symbolizing that the medication was not given.

On Medication Observation Record (MOR) for Resident #11 had special instructions listed to obtain and pulse daily, hold if <100 or Pulse < 60. Review of the MOR dated 2014 for revealed to "see Flow Sheet for (B/P) and pulse daily." On through the MOR was circled and the back of the MOR revealed Resident #11 refused all medications. On , and the , and pulse were not recorded as obtained. The MOR revealed the medication was given on , and .

On at 11:50 AM an interview with Employee E stated if a resident refuses medication we let the nurse know so she can call the doctor. She said we record the B/P on this sheet only. She said if she refuses Vital Signs

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or medications, we document it on the back of the Medication Observation Record.

On at 11:46 AM an interview with Employee A stated the facility labels the MOR with the doctors name, resident name, the dosage, and the pharmacy name. She stated for Resident #11 the medication technicians should have recorded her B/P and Pulse prior to giving the . She said for Resident #5 she spoke with the doctor about re-ordering the Diskus. She said the pharmacy said it needed a new prescription and I had to call the doctor. She said she found out yesterday and called the pharmacy to request it be delivered.

Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC
Based on a review of resident records, and interview with staff, the facility failed to provide or arrange for the required training in emergency procedures and elopement response to 3 of 4 sampled employees (Employees B, C and D) within 30 days of hire.

The findings include:

A personnel file review conducted for Employee B, a Medication Technician (MT) and Certified Nursing Assistant (CNA), found she was hired on . There was no indication she received the required training in the facility's emergency procedures and chain of command relating to emergency evacuation. Further review of the employee file found no evidence that she received a copy of the policies and procedures, or the required training, in the facility's policies on response to resident elopements.

A personnel file review conducted for Employee C (a Personal Care Assistant), found she was hired on . There was no documentation indicating she received the required training in the facility's emergency procedures and chain of command relating to emergency evacuation. Further review of the employee file found no evidence that she received a copy of the policies and procedures, or the required training, in the facility's policies on response to resident elopements.

A personnel file review conducted for Employee D (a Licensed Practical Nurse), found she was hired on . There was no documentation indicating she received the required training in the facility's emergency procedures and chain of command relating to emergency evacuation. Further review of the employee file found no evidence that she received a copy of the policies and procedures, or the required training, in the facility's policies on response to resident elopements.

An interview and employee file review was conducted with the ALF Coordinator on at 3:12 PM. She was unable to provide proof of the required trainings for Employees B, C or D. She acknowledged the requirements for training in emergency procedures and elopement response specific to the facility and it's residents.

Class III

0090-Training - 58A-5.0191(11) FAC
Based on a review of employee files, and interview with staff, the facility failed to ensure that 3 of 4 sampled employees (Employees B, C, and D) received the required training in the facility's policies and procedures regarding ( ).

The findings include:

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A personnel file review conducted for Employee B, a Medication Technician (MT) and Certified Nursing Assistant (CNA), found she was hired on . There was no documentation in the personnel file that Employee B had received the required training in the facility's policies and procedures regarding 's.

A personnel file review conducted for Employee C (a Personal Care Assistant), found she was hired on . There was no documentation in the personnel file that Employee B had received the required training in the facility's policies and procedures regarding 's.

A personnel file review conducted for Employee D (a Licensed Practical Nurse), found she was hired on . There was no documentation in the personnel file that Employee B had received the required training in the facility's policies and procedures regarding 's.

An interview and employee file review was conducted with the ALF Coordinator on at 3:12. She was unable to provide proof of the required trainings in for Employees B, C or D. She acknowledged the requirements for the training for all employees.

Class III

0162-Records - Resident 58A-5.024(3) FAC
Based on resident record review and interview with the administrator, the facility failed to maintain biannual weights for 2 of 10 sampled resident charts for weights (Resident #9,#11).

The findings include:

On a record review of Resident #9 revealed the last weight recorded for this resident was .

On a record review of Resident #11 revealed the last recorded weight on her weight record sheet was dated .

On at 12:05 PM an interview with Employee A stated, the weights recorded in the record are the only weights. We do not have a separate weight book.

On at 12:10 PM an interview with Employee I said we take weights every 6 months. We have a master weight list somewhere. She brought a weight list dated 2014. Resident #11 weight was recorded on this as 175. Employee I said this is the last weight we have on her.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Westminster Woods On Julington
25 State Road 13
Jacksonville, FL 32259

Dear Administrator:

This letter reports the findings of a state biennial licensure survey that was conducted on , 2014 by representatives 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 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 surveyors. Should you have any questions please call this office at -4201.

Sincerely,

Jana Meyering, QIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

LL/JM/sm
Enclosure

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