| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11910374 | 03/08/2016 |
| NAME OF PROVIDER OR SUPPLIER<br>**WINDSOR COURT** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**3700 N. FLAGLER DR**<br>**WEST PALM BEACH, FL 33406** | |

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

**0000 Initial Comments**

An unannounced biennial Relicensure survey was conducted on 7-8, 2016 at Windsor Court. The facility had deficiencies at the time of the visit.

**0050 Medication - Self Administered Medications**

Based on resident record review and interviews, the facility failed to obtain a physician order to allow for self-administration of medications without assistance for 1 out of 5 residents (Resident #17).

The findings included:

Review of Resident #17's AHCA Form 1823 reveals the resident needs assistance with self-administration of medications. Review of Resident #17's 2016 Medication Observation Record (MOR) reveals current presciptions for , Proair, and , inhalers and noted as "self-administered". However, no physician order or documentation to allow for self-administration without assistance of the inhalers was found.

Upon request for proof of a physician order, Employee B stated on at 12:40 PM, "We received one a long time ago, but I am not sure where it is now." Employee B confirmed Resident #17 does keep these inhalers in his possession. The facility was unable to produce a physician order for self-administration of inhalers for Resident #17 at time of the survey.

These findings were acknowledged by the Assistant Administrator during interview at 2:30 PM on ; no further documentation was provided for review.

Class III

**0052 Medication - Assistance with Self-Admin**

Based on observation, staff interview and resident record review, facility staff failed to 1) assist residents with self-administered medications in accordance with proper state regulatory procedures, and 2) follow universal hand hygiene precautions as outlined in mandatory annual training for assistance with self-administered medication (Staff B).

The findings included:

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On 3/07/16 at 9:43 AM, Staff B removed , from the box, which had the keys left in the lock. While popping the pill out of the bubble pack, Staff B picked up the pill with her gloved hand. The glove worn on Staff B's right hand had not been changed after providing medications to prior residents.

For each of the 5 residents observed during assistance with self-administered medications on beginning at 9:40 AM, and again on / beginning at 9:12 AM, the following procedure was performed by Staff B:

a) Removed the residents' medications from an unlocked medication cart;
b) Removed pills from properly labeled medication container and placed into small medication cups;
c) Initialed the Medication Observation Record (MOR) prior to giving the resident their medications;
d) Took the small cups containing the residents' medications to the residents seated at dining in the main dining , and handed the residents the cup of pills without identifying each of the medications provided;
e) Failed to wash/sanitize hands before and after assisting each resident with their medications.

Even though Staff B had a latex disposable glove on her right hand (left hand was ungloved), the staff member did not remove glove, wash or sanitize her hands and apply new glove(s) between resident contact and medication passes.

These findings were acknowledged by the Assistant Administrator during interview at 2:30 PM on .

Class III

**0054 Medication - Records**

Based on resident record review, and interview, the facility failed to maintain an accurate and up-to-date daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications, for 2 out of 5 residents whose medication records were reviewed (Resident #13 and Resident #4).

The findings included:

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1) Review of Resident #13's AHCA Form 1823 reveals Resident #13 is assessed as needing assistance with self-administration of medications. During interview with Resident #13 on / / at 12:48 PM, he stated that the staff hands him his and stated "I give myself my injections in my belly."

During interview with Staff B on / at 12:15 PM, she stated, "We have no physician order for this resident to self-administer his . Since the Resident gives himself his own injections, he is self-administering and we don't have to keep track of his injections on the MOR." When asked if she stores the medication for the resident, hands the to the resident, and supervises his injections, she answered, "Yes." When asked how this is different from any other medication the facility stores or provides for the resident, she responded that since she could not give injections, the resident "self-administered" so they "didn't have to track it".
The facility was unable to provide a physician order for self-administration of without assistance at time of the licensure survey.Review of Resident #13's 2016 MOR contains no record of each time his is taken, any missed dosages, refusals to take medications as prescribed, or medication errors.

These findings were acknowledged by the Assistant Administrator during interview at 2:30 PM on / /.

2) During review of the 2016 MOR for Resident #4, it was revealed that the injections provided twice a day were documented by a home health agency nurse. The MOR for the injections was kept in a separate binder used by the home health agency staff to document administration of the . Upon review of the MOR, it was revealed that the home health agency nurses had failed to document administration of on 1-8, 2016 for the 7:30 AM dose and , 5, and 6, 2016 for the 4:30 PM dose.

These findings were acknowledged by the administrator during interview after she contacted the home health agency nurse on , 2016 at 1:30 PM.

Class III

**0055 Medication - Storage and Disposal**

Based on observation and staff interview, the facility failed to:
1) Keep all medications secured in a locked storage receptacle at all times;

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2) Refrigerate medication per manufacturer's instructions;
3) Store opened medication at , per manufacturer's instructions, and
4) Dispose of medications within 30 days of of expiration date.

The findings included:

1) On 3/07/16 at 9:40 AM and on 3/08/16 at 9:12 AM, upon entering the facility's medication area located in a corner of the main dining room, all of the 4 medication carts, medication storage cabinets and 2 of the medication refrigerators were found unlocked. The drawers on 3 of the carts were not fully closed, and the keys were seen left unattended in the lock of the box in one of the medication carts. There were also several residents' medications sitting unsecured on top of one of the medication carts (see photo evidence obtained).

On / at 9:12 AM, several plastic containers filled with medications were seen sitting outside of medication cabinet, unsecured (see photo evidence obtained).

On at 9:40 AM and / at 9:12 AM, Staff B was observed actively passing medications, which involved walking to the opposite side of the dining , often with her back to the medication storage areas.

2) An unopened Humolog Kwik Pen was observed stored at in a drawer of Medication Cart #4 (far left underneath medication cabinets on the wall). Storage instructions for unopened are that the kwik pen should be stored in a refrigerator (36° to 46°F [2° to 8°C]).
3) An opened Humolin Kwik Pen was being stored in the unlocked refrigerator when storage instructions for opened kwik pens state on medication box, "store at , ".
4) A box of Lantus , prescribed to a resident who is no longer residing at the facility, had an expiration date of / . This medication was located in a drawer of unlocked medication cart #4 among medications of current residents (see photo evidence).
On at 11:45 AM, the printed storage instructions for were shown to Staff B, and she acknowledged the instructions at this time.
On at 1:15 PM, the administrator acknowledged the medication concerns noted during observations.

Class III

**0056 Medication - Labeling and Orders**

Based on observation, resident record review and interview, the facility failed to follow physician orders,

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for 3 out of 5 residents observed during assistance with self-administered medications (Resident #20, #16 and #18).

The findings included:

1) On at 9:40 AM, Staff B provided Resident #20 her morning medications. The morning medications are noted on the 2016 Medication Observation Record (MOR) to be given at 7:30 AM. Resident #20's morning medications were given at 9:40 AM, 2 hours after specified. It was also noted that one of Resident #20's medications, 145 mcg, is to be given "before breakfast". At the time the medication was provided, Resident #20 was finishing her breakfast.

2) On at 9:50 AM, Staff B provided Resident #16 her morning medications. When verifying medications observed given with the medications listed on the 2016 MOR, it was noted Resident #16 had not been given her daily dose of 5 mg, yet there were staff initials in the box next to this medication for the date of . The staff initials did not appear to be Staff B's.

When Staff B was questioned about the medication, she located the packaged medication among the PM (evening) medications. She stated the resident used to get this medication twice a day, but the order had been changed to once a day (change order / / ), so they were using up the evening medication packages. She stated the "evening" medication package should have received a "morning" sticker and also a sticker signifying a change in the order. Staff B placed the stickers on the packaged medication. On / at 11:00 AM, Staff B confirmed Resident #16 did not receive the dose of 5 mg during the morning medication pass.

3) On at 9:12 AM, Staff B provided morning medications to Resident #18. One of Resident #18's medications, 20 mg , was to be given twice a day before breakfast and dinner. This medication was provided at the end of Resident #18's breakfast.

On at 1:20 PM, the administrator was informed of the concerns found during assistance with self-administered medication observations.

Class III

**0077 Staffing Standards - Administrators**

Based on an interview and record review, the facility failed to ensure a qualified Manager was

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designated for the operation of the Administrator's third facility.

The findings included:

On 3/8/16, the personnel files were reviewed and no designation of a Manager was present. On 3/16/16 at 4:00 PM, the Assistant Administrator stated that there was no designated Manager of this facility. During review of the Agency's database, it was revealed that the Administrator is currently the administrator of three ALF's (assisted living facilities).

Class III

**Z815 Backaround Screenina: Prohibited Offenses**

Based on record review and an interview, the facility failed to ensure 1 out of 3 sampled staff had a Level II criminal background screening redone within the required timeframe (Staff B).

The findings included:

On , the personnel file for Staff B was reviewed for current eligibility with a Level II criminal background screening. The screening on file documented the staff member was "eligible" on . The Agency's background screening website indicated the staff member was "eligible" dated / . However, the current regulation requires all staff who obtained a Level II background screening between , 2009 and , 2011 "must be rescreened by , 2015. This staff member had not obtained a new screening as of / . These findings were acknowledged by the Assistant Administrator during interview at 2:30 PM on .

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Windsor Court
3700 N. Flagler Dr
West Palm Beach, FL 33406

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by a representative 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dmb
Enclosure: AHCA Form 5000-3547

XG90

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