STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942716	**09/25/2018**
NAME OF PROVIDER OR SUPPLIER **WESTCHESTER OF WINTER PARK**	STREET ADDRESS, CITY, STATE, ZIP CODE **558 N. SEMORAN BLVD.** **WINTER PARK, FL 32792**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

The re-licensure survey with Limited Nursing Service (LNS) was conducted on and . Westchester of Winter Park, license #7289, had deficiencies at the time of the survey.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record reviews and interviews, the facility failed to ensure an 1823 health assessment form was complete and accurate for 5 of 12 sampled residents (#3, 7, 8, 5 and 11).

Findings:

1. Resident #3's record revealed a facility admission date of . The record contained an 1823 health assessment form that was not dated by the examiner and page 5 of the form was incomplete. A fax date of was on the top of the form.

On at 3:20 p.m. the administrator confirmed the findings.

2. Record review for resident #7 revealed a health assessment report 1823 dated did not address the resident's needs regarding medications. The assessment did not indicate if she needed assistance with self-administration of medications, administration of medications or was able to self-administer her medications. That portion of the assessment was blank.

3. Record review for resident #8 revealed a health assessment report 1823 dated . There was an updated health assessment dated that did not address the resident's needs regarding medications. The assessment did not indicate if he needed assistance with self-administration of medications, administration of medications or was able to self- administer her medications. That portion of the assessment was blank.

In an interview on at 11:45 AM with the administrator who offered no comment.

4. Review of the record for resident #5 revealed she was admitted to the facility on . The admission health assessment (form 1823) was dated and documented Medication

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Administration was required. A new 1823 dated did not indicate what, if any, type of assistance for medications was required. This section was left blank.

On at 12:45 PM, the administrator confirmed the findings.

5. Record review for Resident #11 revealed an admission resident health assessment form 1823 that was dated (The next resident health assessment form was due).

Review of the facility's notes revealed she was admitted into the hospital on and was discharged on . The resident health assessment form that was attached to the hospital discharge paper work, did not include a date, address and telephone number of the medical examiner. Further review of the facility notes revealed on she admitted into the hospital. The resident health assessment form dated for the hospital admission did not have page 1, Page 2 did not include the type of diet she required, it was left blank, the section that noted if the resident was bedridden, had any , 3, or 4 pressure sores, pose a danger to self or other, required 24-hour nursing or , care all were left blank, On page 4 the address of the medical examiner was left blank.
On at 2 PM, the administrator confirmed the findings.

Class III

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record reviews and interviews, the facility failed to ensure 1 of 12 sampled residents (#14) who experienced a significant change had a face-to-face medical examination by a health care provider that was recorded on a health assessment form 1823 and retained a resident (#3) who exceeded the continued residency criteria in an Assisted Living Facility (ALF).

Findings:

1. Resident #3's record revealed a facility admission date of .

Facility notes indicated that on at 12:50 a.m. he was sent to the hospital for complaints of chest pain.

His record contained an 1823 health assessment form that was undated by the examiner however, a fax date on the top of the form was . The form indicated that he required total assistance with ambulation, toileting and transferring and he was bedridden, all of which exceeded the continued

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residency criteria in the facility. His record contained no documented evidence to indicate the facility issued a discharge notice or that he received hospice services.

On . . . . . at 3 p.m. caregiver B said resident #3 required total assistance with all of his Activities of Daily Living (ADLs) and transferring.

On at 3:20 p.m. the administrator confirmed the findings.

2. Review of the hospice record for resident #14 revealed he was admitted to hospice services on . . . . . .

Record review for resident #14 revealed, the record did not contain a resident health assessment form 1823 to indicate a face-to-face medical examination was completed by a health care provider when the resident was admitted to Hospice service, which was a significant change.

On at 11:15 AM, the administrator confirmed the findings.

Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on observation, interview and record review, the facility failed to follow their facility elopement policy and ensure precautions were in place for a resident with known elopement attempts (#16).

Findings:

During an interview with staff B on at 3:00 PM, she stated "we have an exit seeker here." She identified resident #16. She said he was exit seeking and looking for his car. He would go out the front door, in his wheelchair, to find his car in the parking lot. According to staff B, a staff member was usually watching the front door, but he seemed to know when he could get out. Staff would go out to find him and bring him back in.

On at 3:30 PM, Staff F, the receptionist, confirmed resident #16 was frequently trying to leave the facility. Staff F identified the resident who was seated in the common area.

Observation on . . . . . at 3:30 PM found the resident seated in the café in his wheelchair. He did not

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respond when greeted, but stared straight ahead with no expression. The resident did not have ID on his person at the time.

On at 4:00 PM, the administrator confirmed resident #16 was exit seeking. She stated he was doing it a while ago, but not recently, but just today he tried again to exit through the front door.

Review of the record for resident #16 found an admission health assessment (form 1823) dated and a current 1823 dated . Neither assessment identified the resident as an elopement risk. His diagnoses included: , , , and others. There was no photo ID found in the record. Further review of the record found observation notes that documented 2 attempts to exit the facility. An entry from read, ""resident went outside exit stating my cousin is coming for me." Resident was reoriented and escorted back to bed where he was left." Another entry on read, "Resident was founded [sic] outside in the parking lot two times, someone brought him in." There were no other notes describing other attempts to exit the facility in the record.

On at 12:45PM, review of the Medication Observation Record (MOR) for resident #16 revealed there was no photo ID present. Staff H stated she was not sure why they did not have one for him, since they had photos for quite a few of the residents.

On at 1:10 PM, the administrator confirmed resident #16 had attempted to elope on several occasions and confirmed the observation notes did not indicate all of the attempts made by resident #16. The administrator confirmed the resident was not given a 45 day notice of discharge as noted in the facility elopement policy. She stated they had spoken to the family, but confirmed there was no documentation regarding those conversations. She was unable to explain why the facility did not follow their elopement policy and place ID on the resident or put measures in place to routinely assure his whereabouts.

Class III

0052 - Medication - Assistance with Self-Admin - 429.256(3-4); 58A-5.0185 (3)

Based on observations, record reviews and interview, the facility failed to ensure the unlicensed caregiver (A) who assisted a resident (#12) with self-administered medications followed the correct procedure.

Findings:

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Observations made during a medication pass for resident #12 on at 12 p.m. revealed he was near the medication cart. Unlicensed caregiver A unlocked the medication cart then she told the resident he would receive two pills, one for his stomach and the other for . She popped the pills out of the package and into a cup. She handed the cup to the resident, who took them without assistance.

Caregiver A did not read the prescription labels aloud to resident #12, as required.

On at 12:15 p.m. caregiver A confirmed the findings.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record reviews and interview, the facility failed to ensure the Medication Observation Record (MOR) was updated for 2 of 11 sampled residents (#2 and #7) who required assistance with self-administered medications.

Findings:

1. Resident #2's record revealed a facility admission date of . A most recent 1823 health assessment form, dated , indicated that she required assistance with self-administered medications.

A health care provider's order, dated , for , 600 milligram (mg) tablet, take 1 tablet by mouth every 8 hours as needed for pain was not listed on resident #2's 2018 MOR. The record did not contain an order from a health care provider to discontinue the medication. In addition, an entry on the MOR for 0.1% cream, insert 2 grams , two times per week on Tuesday and Friday at bedtime was not signed as given on and . The MOR nor the resident's record contained documentation to indicate the reason.

On at 2 p.m. the administrator confirmed the findings and was unable to provide additional documentation.

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2. In an interview on at 11 AM with resident #7 who said the facility staff gave him his medications including .

Resident record review for resident #7 revealed the , 2018 MOR listed 6 Units before meals at 7:30 AM, 11:30 AM and 4:30 PM and bedtime. The MOR was blank on 9/8 and 9/9 at 9 PM. The , 2018 (updated) MOR listed 5 Units before meals at 7:30 AM, 11:30 AM and 4:30 was blank at 11:30 AM at 11:30 AM. There were no written notations on the back page of the MOR to explain why the medication was not marked as given.

In an interview on at 11:45 AM with the administrator who said most likely the resident got the medication but the staff forgot to sign the MOR.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on record reviews and interviews, the facility failed to make every reasonable effort to ensure that a prescription was filled in a timely manner for 1 of 12 sampled residents (#6) who received assistance with self-administered medications and failed to obtain a written medication order from a health care provider within 10 working days of receiving a telephone order for 1 of 12 sampled residents (#2) who received assistance with self-administered medications.

Findings:

Resident #2's record revealed a facility admission date of . A most recent 1823 health assessment form, dated , indicated that she required assistance with self-administered medications.

The record contained telephone orders from a health care provider dated on and . The record did not contain written medication orders from the health care provider for the telephone orders, as required.

On at 2 p.m. the administrator confirmed the findings and was unable to provide additional documentation.

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Review of the record for resident #6 revealed a health assessment dated . . . . . Diagnoses included , , , and , . The form indicate the resident was capable of self-administration of medications, however the facility was holding his medications in the central medication carts and providing assistance with self-administration of medications at the time.

A grievance report dated revealed resident #6 complained that his prescriptions he brought from the hospital on . . . . had not been processed by the facility. The resolution was the prescriptions were then faxed on and evidence was shown to the resident.

An observation note in the record documented the resident returned from hospital on around 6:10 PM. The note indicated he had some med changes and new orders for medications.

The prescription in the record was reviewed. Prescription written on . . . . for . . , . . 60 mg extended release, 1 tablet twice daily for treatment of high , and chest pain, and . . . . . 30 mg delayed release, 1 capsule daily for . , ... A handwritten note in the bottom right corner of the page documented "faxed ."

A review of the MOR for for resident #6 documents a hospital stay on 8/3 & 8/4.

On at 11:25AM, the administrator confirmed the findings and said the prescriptions were not faxed to the pharmacy until . . . . and she did not have any explanation as to why it took that long.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on personnel record reviews and interviews, the facility failed to ensure 1 of 5 personnel records (B) contained documentation of a negative . . . . . (.) exam on an annual basis and failed to ensure 1 of 5 staff (D) submitted a written statement from a health care provider documenting freedom from communicable . . . . . within 30 days after beginning employment.

Findings:

1. On . . . . at 2:45 p.m. nurse D identified herself as the registered nurse for the facility's residents who received a Limited Nursing Service (LNS.)

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Nurse D's personnel record revealed a hire date of . The record did not contain a written statement from a health care provider documenting freedom from communicable , as required.

On at 11:15 a.m. the administrator confirmed the findings and was unable to provide additional documentation.

Review of the personnel record for staff B, caregiver hired , revealed documentation that she was free from on . There were no statements from 2017 or 2018 found in the record.

On at 1:30 PM, the administrator confirmed the findings.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2-3) FAC

Based on personnel record reviews and interview, the facility failed to ensure that 1 of 5 sampled staff (E) received the required in-service training within 30 days of hire.

Finding:

Review of the personnel record for the administrator, staff E, hired revealed no certificates documenting training in the facility's policies and procedures regarding: 1) elopement and 2) emergency evacuation training including chain of command.

On at 2:00 PM, the administrator confirmed the finding.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on personnel record review and interview, the facility failed to ensure that direct care staff were trained in the facility's policies and procedures related to ( ) for 2 of 5 sampled staff (B & E).

Findings:

1. Review of the personnel record for staff B, caregiver hired , did not reveal documentation for

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training in the facility's policies and procedures regarding .

2. Review of the personnel record for staff E, administrator hired , did not reveal documentation for training in the facility's policies and procedures regarding .

On at 1:30 PM, the administrator confirmed the findings.

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on personnel record review and interview, the facility failed to ensure staff records included a copy of the job description given to each staff member pursuant to Rule 58A-5.019, F.A.C. for 1 of 5 sampled staff (E).

Findings:

Review of the personnel record for the administrator, staff E, hired revealed a job description for a Nursing Home Administrator. Further review did not find a job description for the administrator for an assisted living facility.

On at 2:00 PM, the administrator confirmed the finding.

Class

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record reviews and interviews, the facility failed to record a semi-annual weight for 3 of 3 residents (#2, #5 and #14) who received assistance with the Activities of Daily Living (ADLs).

Findings:

1. Resident #2's record revealed a facility admission date of . An admission 1823 health assessment form, dated , indicated that she required assistance with her ADLs.

The record contained recorded weights on , and . There were no additional weights recorded for the year 2017, as required.

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On at 2:45 p.m. the administrator confirmed the findings and was unable to provide additional documentation.
2. Record review for resident #14 revealed a resident health assessment form 1823 that was dated . The health assessment form noted he required assistance with bathing, dressing, , and toileting. Further record review revealed the only weights available for review was for and .The Resident Care Director said on at 1 PM, she could not locate any other weights. She stated there were no other weights available for 2018 and 2017.

3. Review of the record for resident #5 revealed she was admitted to the facility on . Her 1823 revealed diagnoses that included , , , , and . She required assistance with her ADL's. Her admission 1823, dated documented a weight of 170.3 lbs. On , the facility recorded a weight of 190 lbs. No other weights were available for this resident.

On at 12:45 PM, the administrator stated there were no other weights available for review.

Class III

0167 - Resident Contracts - 58A-5.025 FAC; 429.24 FS

Based on resident contract review and interview, the facility failed to ensure the resident agreement met regulations regarding frequency of required health assessments for 2 of 4 contract reviewed (#5 & #6).

Findings:

Florida Statute documents "residents must be assessed upon admission pursuant to subsection 58A-5.0181(2), F.A.C., and every 3 years thereafter, or after a significant change, pursuant to subsection (4) of that rule."

Review of the residency agreement for resident #5 revealed an admission date of . The contract was signed on .

Review of the residency agreement for resident #6 revealed an admission date of . The contract was signed on .

On page 4 of the contracts for resident #5 & #6, the second paragraph in the section entitled Health

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Policy documented, "At least annually thereafter, or upon request of the facility, you agree to undergo an examination by your physician (or other licensed provider as allowed by law), and provide the results of such examination to the facility."

On at 2:45 PM, the administrator reviewed the contracts and confirmed the finding. She stated these 2 residents had "the old contract" and the wording had since been changed to show a requirement of every 3 years or after a significant change.

Class

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on facility record reviews and interview, the facility failed to have an approval letter from the local emergency management agency for its Emergency Environmental Control Plan.

Findings:

On at 10 a.m. a request was made of the administrator to review the facility's approval letter from the local emergency management agency for its plan.

On at 4 p.m. the maintenance director said an approval letter could not be located.

Review of the website "FloridaHealthfinder.gov" revealed the facility's plan was approved on .

Class III

N278 - LNS - Records - 58A-5.031(3) FAC

Based on record reviews and interviews, the facility failed to maintain complete nursing progress notes and nursing assessments conducted by a registered nurse at least monthly for 1 of 2 residents (#2) who received a Limited Nursing Service (LNS.)

Findings:

On at 9:30 a.m. the wellness director identified resident #2 and said the resident received a LNS for a .

Resident #2's record contained an order from a health care provider, dated , to cleanse the ,

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pubic reddened site with normal , apply cream with powder twice daily until resolved and cover with a dressing. Pubic care every shift.

Resident #2's 2018 LNS nursing progress notes did not contain complete notes to describe the date, type, scope, amount, duration and outcome of the prescribed care and treatment.

In addition, on at 2:45 p.m. registered nurse D said the wellness director, who was a licensed practical nurse, completed resident #2's 2018 and 2018 monthly LNS assessments, documented her findings then nurse D made walking rounds with the wellness director to see if the assessments were accurate then nurse D signed the assessment form that was completed by the wellness director.

On at 3:20 p.m. the administrator confirmed the findings and was unable to provide additional documentation.

Class III

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on Agency background screening clearinghouse website review and interview, the facility failed to register and maintain the employment status of employees within the Agency's Background Screening Clearinghouse for 2 of 9 sampled staff employees (D & I).

Findings:

Review of the Agency's Background Screening website on at 9:30 AM revealed Staff D, the Limited Nursing Services (LNS) nurse and staff I, the maintenance director were not listed on the roster.

Further review found staff D, the LNS nurse had an eligible background screen on .

Further review found staff I, the maintenance director had an eligible background screen on .

On at 2:00 PM, the administrator confirmed the finding.

Unclassified

Z821 - Reporting Requirements; Electronic Submission - 59A-35.110 FAC

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Based on record review and interview the facility failed to submit an adverse report for 1 of 11 sampled residents (#7) when an event was reported to law enforcement.

Findings:

A Health Assessment dated for resident #7 listed diagnoses of Parkinson's , , high , and . A facility note dated at 6:30 PM indicated resident #7 had an altercation with sampled resident #14 in the dining . The Sheriff department was called. There was a late entry that documented "calmed down deputy spoke to him".

In an interview with the administrator on at 11:15 AM who said she had no adverse reports for 2018.

Unclassified