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
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

A complaint investigation #2018010841 was conducted on and in addition to complaint investigation #20180011278 and the re-licensure survey. The Westchester of Winter Park license # 7289 had deficiencies at the time of the visit pertaining to this complaint.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observations, record reviews and interviews the facility failed to ensure it provided Care and services appropriate to the needs of residents (#7, #8, #10 & #16) and did not provide assistance with toileting to resident #7, did not follow a healthcare provider's order for a therapeutic diet that included fluid restriction, did not obtain an order for the use of , held medications without an order for resident #8, and did not properly follow order for for resident #10 , there was no written evidence of interventions in place to prevent elopement for resident #16, did not inform the health care provider when resident #2 gained 12 pounds in 3 months, and there was no documentation of a significant change for resident #14 who was placed on hospice

Findings:

1. On at 11 AM upon reaching the of resident # 7 a powerful smell was noted. Observations noted resident #7 was in bed, a strong smell of filled the . The resident asked to please close the curtains, as no one came in his yesterday (the night before) and he slept with the curtain open, with the light shining in. He stated he needed help to get changed. His bedding and clothing were soaked with . He said that no one came to his yesterday, they gave him 2 pull ups (adult briefs) to wear at the same time. He added that there was no service here (facility). He said he did not call for help because the staff would not come anyway. He said he did not use the call bell because no one would come any way. He said the staff told him that he ran out of pull -ups. The Agency representative handed him the call bell button and asked him to press. There were 2 call buttons. He tied up the call button to the half-bedrail. He rung the call button at 11: 05 AM. The Agency representative pressed the other call button at 11:10. The resident said "See nobody comes". There was no answer to either call. At 11; 15 the Agency representative walked to the administrator's office and explained to her that resident # 7 needed help, that he was very soiled/wet; she replied the resident a lot.

2. Resident record review for resident #8 revealed a health assessment report 1823 dated listed diagnoses of , , and , failure and was legally . The diet was indicated as controlled (average 60-75 ounces per/meal), , 2 x day, and fluid

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restrictions 16600 ounce per day. He needed supplement at night. Primary care provider visit dated 9/1 listed additional diagnoses of and lower leg ( ). The review revealed no evidence to confirm the facility obtained a health care provider's order for the use of the which included how many litters per minute and frequency/duration. Observations on at 2 PM noted the concentrator was at 2 liters per minute.

In an interview with the health and wellness nurse on at 2:45 PM who said there was no healthcare provider's order for the use of the .

There was no written evidence to confirm the facility followed the healthcare provider's dietary and fluid restriction orders. There was no system to ensure that input and output was measured and that dietary staff was aware of the needed controlled diet. There was no evidence the resident had been counseled and refused the orders and if so there was no evidence the healthcare provider was aware of his refusal.

The 2018 MOR listed 5 mg, 100 mg, eye drops, , discus and all indicated "on hold" from to . There was no evidence to confirm the healthcare provider ordered the medications to be held. The MOR also listed 50 mg twice a day at 9 AM and 9 PM. On at 9 AM and from to at 9 PM the MOR had staff initials circled, ON at 9 AM and 9 PM was blank as well as to in AM. The back page of the MOR indicated that on , , , and indicated awaiting on pharmacy". Continued review revealed no evidence to confirm that a healthcare provider's order to hold the medications was obtained

3. Resident #2's record contained a facility admission date of . An 1823 health assessment form, dated , indicated her diagnoses included Acute Failure, muscle , , , , Hyponatremia, , , and of .

Resident #2's recorded weights revealed that on she weighed 153.4 pounds (lbs.) on she weighed 164 lbs. and on she weighed 176 lbs. She had a weight gain of 12 lbs. between 2018 and 2018.

Resident #2's record did not contain documentation to indicate the facility contacted a health care provider when she had the weight gain.

On at 1:05 p.m. the administrator confirmed the findings and was unable to provide additional

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documentation.

4. 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 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 12:45 PM, 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.

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5. Review of the Medication Observation Record (MOR) for ... and ... for resident #10 revealed they both noted the following:
... 100 units, inject 3 units daily with meals plus sliding scale:
151-200=2 units (U)
201-250=4U
251-300=6U
301-350=8U
351-400=10U
Greater than 400 or less than 70 call MD

On ... and ... at 9 PM- on both days the ... Sugar (BS) results were noted as 190, the space used to documented the coverage amount (amount of ... given) was marked "0", 2 units were required.
On ... at 9 PM the BS result was 201 and the space for the coverage amount was marked 2U, 4U were required.
On ... at 9 PM the BS result was 203 and the space for the coverage amount was marked 2U, 4U were required
On ... at 9 PM the BS results was 268 and the space for the coverage amount was marked 2U, 6U were required.
On ... at 11 AM, the administrator confirmed the incorrect amount of ... was marked as given.

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

Record review for resident #14 revealed there was no documentation found that noted the resident's decline that resulted in the need of the hospice services.

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

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observations records review and interviews the facility failed to honor the resident's rights to be treated with consideration and respect and with due recognition of personal dignity, individuality and

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did not answer call bells timely for 3 sampled residents 7, 8, 17 and ; did not did respond to dietary grievances (#3).

Findings:

1. On at 11 AM upon reaching the door the resident #7 a powerful smell was noted. Observations noted resident #7 was in bed, a strong smell of filled the . The resident asked to please close the curtains, as no one came in his yesterday (the night before) and he slept with the curtain open, with the light shining in. He stated he needed help to get changed. His bedding and clothing were soaked with . He said that no one came to his yesterday, they gave him 2 pull ups (adult briefs) to wear at the same time. He added that there was no service here (facility). His shower was once weekly and he had not taken one in a week.

The Agency representative asked if he had pressed the call bell. He replied no, because no one would come any way. He said the staff told him that he ran out of pull -ups. He asked the Agency representative to look in his closet and see if there were some pull ups. Observations noted there were 2 cases. He asked for 2 briefs as he would attempt to change himself. The call button hung on the floor and unreachable by the resident. The Agency representative handed him the call bell button and asked him to press. There were 2 call buttons. He tied it up the call button to the half-bedrail. He rung the call button at 11: 05 AM. The Agency representative pressed the other call button at 11:10. The resident said "See nobody comes". There was no answer to either call. At 11: 15 the Agency representative walked to the administrator's office and explained to her that resident # 7 needed help, that he was very soiled/wet; she replied the resident a lot.

In an interview with the administrator on at 11:20 AM with the administrator who said when the call button was pressed, it rang in nurse's station, as well as a light went on the panel, which identified the resident's . The person at nurses station was to call the resident, and then call a caregiver by warlike- talkie, the staff would then go assist the resident. If there was no one at the station, the nurse or staff who came in answer the call. There was no person assigned to man the nurse's station at all times. If the nurse was out the , then the call would remained UN answered until someone came back to the . She added that possible his call bell was not working properly.

Observations on at 11:25 AM noted a nurse was in the nurse's station and said no one had called. The Agency representative pointed out a light was on the call bell panel. She then called a caregiver staff.

Observation on at 11:30 noted the resident was in his bed, still soaked in . He said no

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one had called or come.

On at 12 PM the Agency representative pressed the resident's call bell and a staff answered and asked what was needed. The call bell work, did not need repairs. The resident was out of bed and clean.

Resident record review for resident #7 revealed a facility assessment dated that indicate the resident needed assistance with personal hygiene, frequent toileting with some assistance.

2. In an interview with resident #8 on at 10 AM who said there are 4 or so called CNA (certified nursing assistants), they walk by you like you are not there. They do not answer the call bell you may wait three quarters of an hour especially after 6 PM. Sometimes they don't come at all.

3. Interview 3:15 PM resident #17 said that the administration really did not care too much for residents they only care about corporate and added "I do my own ADLS (activities of daily living). You call and they don't come they ignore me".
4. During interviews with residents on it was revealed that meetings were held to discuss the meals and other concerns they may have and did not receive responses to the questions.
Review of the resident council minutes for and revealed the following:
In the meeting a resident stated the 4th of cookout was excellent. However the food is not being served warm. We are still not getting what we order off the menu. Still getting dirty dishes.
The reply was the dishwasher man was here so hopefully the dirty dishes are resolved-only response was regarding dishwasher.
The next question was Why are we running out of food or being told were are out of food?
The reply was Ask manager if you are told we are out of something.
Next question was Why can't we maintain order in the dining ?-no reply
Next comment was Baked Ziti was -no reply

The minutes were review and there were not responses for some of the comments or questions asked as follows:

Question: "Why are we running out of Raisin Bran and stuff?"-No reply
Comment: (Resident name listed) says she has not gotten my yogurt.-no reply
Question: Why do other people eat off of other peoples plates?-no reply
Question: When something is special on the menu we do not get it why?-no reply
Comments: Make sure meds are ordered and gotten, when you call for a nurse you wait 45 minutes, they need 2 nurses at night-no reply noted

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Question: When can we get coffee pot back in cafe?-no reply
Comment: More variety-The response was "head dietician does menu and we can't change." The resident replied back and said "don't care we want something different.

On at 2 PM, the administrator said they residents are answered. She said the staff should not have told the residents that the menu could not be changed because they were currently working with the dietitian to make changes to the menu and some changes were made.

On at 10:45 a.m. resident #3 said sometimes he had to wait longer than 1 hour for staff to respond to his call bell.

Class III

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

Based on resident record review, Medication Observation Record (MOR) review and interview, the facility failed to ensure medications were filled in a timely manner for 1 of 11 sampled residents (#8).

Findings

In an interview on at 10 AM with resident #8 who said the facility staff gave him his medications.

Resident record review for resident #8 revealed a health assessment report 1823 dated listed diagnosed of , and , failure and was legally .

The 2018 MOR listed 5 milligrams(mg), , 100 mg, eye drops, , discus and all indicated "on hold" from to . There was no evidence to confirm the healthcare provider ordered the medications to be held. The MOR also listed 50 mg twice a day at 9 AM and 9 PM. On at 9 AM and from to at 9 PM the MOR had staff initials circled, on at 9 AM and 9 PM was blank as well as to in AM. The back page of the MOR indicated that on , , , and indicated "med not available". The back page of the MOR that listed discus and indicated on "waiting on pharmacy".

There was no written evidence to confirm the healthcare provider was made aware the resident did not have the mediations, what attempts were made to obtain the medications from another pharmacy or

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samples from the healthcare provider, attempts to contact family to resolve or made them aware the resident did not have all his medications.

In an interview with the administrator on . . . . . at 11:45 AM who said the resident was a new admission at the time and were awaiting clarification from the healthcare provider,

Class III