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	AL11911229	**10/22/2018**
NAME OF PROVIDER OR SUPPLIER **WESTMINSTER WINTER PARK**	STREET ADDRESS, CITY, STATE, ZIP CODE **1111 S. LAKEMONT AVENUE** **WINTER PARK, FL 32792**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

The re-licensure survey with Extended Congregate Care (ECC) was conducted on . Westminster Winter Park, license #6503, had deficiencies at the time of the survey.

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

Based on record review and interview the facility did not obtain a complete and accurate resident health assessment form (AHCA form 1823) for 2 of 3 sampled residents (#2 and #7).

Findings:

1. Record review for resident #2 revealed a facility note that documented on - the resident's right did not appear to be getting any better after being on for 4 days. The health care provider came to evaluate the resident. She gave order to send the resident out to the hospital for further treatment.

On -resident was discharged from the hospital.

Review of the updated AHCA form 1823 that was dated revealed the health care provider did not indicate if the resident's needs could be met in an Assisted Living Facility, the type of assistance she required with medications and whether or not she was an elopement risk, those sections were all left blank. The health care provider did not document on page 1 the resident's medical history.

On at 3 PM, the assistant administrator confirmed the findings.

2. Review of the record for resident #7 revealed an admission date of . The most recent 1823 was dated . The form was not complete for the type of assistance required for medications. There was a check mark indicating "yes" the resident required assistance, but the section for the type of assistance was left blank.

On at 2:20 PM, the administrator and assistant administrator confirmed the findings.

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

Based on observations, record reviews and interviews, the facility failed to ensure 2 of 2 sampled residents (#7 and 12) who experienced a significant change had a -to- medical examination by a health care provider that was recorded on a health assessment form 1823.

Findings:

On at 10:15 a.m. assistant administrator E identified resident #12 and said she received home health skilled nursing for a .

Resident #12's record revealed a facility admission date of . Her admission health assessment form 1823 was thinned from the record and the only 1823 available in the record was dated .

Observations made with nurse F on at 1:46 p.m. revealed resident #12 had a on her right that measured approximately 2 centimeters (cm) x 1 cm.

Review of home health notes revealed the onset date of the was . Photographic evidence obtained.

Resident #12's record did not contain an 1823 that was completed at the onset of the , which was a significant change.

On at 3:47 p.m. assistant administrator E confirmed the findings and was unable to provide additional documentation.

2. Review of the record for resident #7 revealed admission date of . The record revealed she entered hospice care on . The most recent 1823 in the record was dated . A new health assessment was not obtained after the start of hospice care, which is a significant change.

On at 2:20 p.m. the administrator and assistant administrator confirmed a new health assessment had not been obtained.

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

Based on observations, record reviews and interviews, the facility failed to follow a health care provider's care orders for 1 of 2 sampled residents (#12), failed to notify a health care provider when 1 of 2 sampled residents (#12) experienced a significant gain and failed to document in the resident record for 1 of 2 sampled residents (#12) who was transferred to a higher level of care and who developed a .

Findings:

1. On at 10:15 a.m. assistant administrator E identified resident #12 and said she received home health skilled nursing for a .

Resident #12's record revealed a facility admission date of . An 1823 health assessment form, dated , indicated that she was independent with ambulation, transfers and toileting.

An ARNP's note, dated , indicated that she had a , on her . She was non-compliant with going to bed at night.

An ARNP's note, dated , indicated that her were worsening, she was non-compliant with and all were in agreement to transfer her to the health center to receive treatment to the .

An ARNP's note, dated , indicated that she was to be discharged to the assisted living facility and that her were resolved.

An ARNP's note, dated , indicated that she had a superficial on her right . Moisture .

An ARNP's note, dated , indicated that she had a , on her right that was recurrent. The measured 2 centimeters (cm) x 2 cm.

An ARNP's note, dated , indicated that she had a , on her right that was improved.

The resident's record did not contain facility documentation regarding the development of the , no facility documentation to indicate she was transferred to a higher level of care to treat the .

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and no facility documentation to indicate when she returned to the facility.

Observations made with nurse F on at 1:46 p.m. revealed resident #12 was sitting on a pressure reduction cushion in her recliner. She said she sleeps in her bed now and no longer in her recliner to aid in healing the . The nurse transferred her from the recliner with minimal assistance and the use of a walker. Her hospital bed had a pressure reduction overlay mattress. The nurse assisted her to the bathroom. Observations made of her revealed there was not a in place but rather the was covered with white powder. Nurse F said the powder was powder, which was the treatment applied by the facility's staff. Nurse F cleansed the area to reveal a on the right that measured approximately 1 cm x 1 cm. The resident said there was not a in place because she received a shower on the night before. Review of the facility's caregiver notes revealed that in fact, the resident did receive a shower on the night before.

On at 2 p.m. caregiver G said she did not apply the powder and when she reviewed resident #12's MOR, she was unable to say who did because the entry was discontinued on .

On at 2:03 p.m. nurse F said a home health nurse was last at the facility to perform care on .

Observations made on at 2:08 p.m. revealed the powder was in the top of the medication cart, stored with medications in current use and labeled with the resident's name, which made it still available for use by the staff. Caregiver G was present and confirmed the findings.

The most recent available home health nurse's note, dated at 2:34 p.m., indicated the nurse cleansed the with cleanser, patted it dry, applied skin prep to the peri- , applied Mepilex Foam then covered with a Tegaderm film. There was no documentation to indicate the nurse applied powder to the .

A health care provider's order for home health, dated , indicated the prescribed treatment was that which was conducted by the home health nurse on .

Review of home health nursing notes revealed that on , the measured 2 cm x 1 cm x 0.3 cm, on it measured 1 cm x 1 cm x 0.3 cm and on it measured 0.5 cm x 0.5 cm x 0.3 cm therefore, the documentation did indicate the was improving.

When the facility staff applied the powder to resident #12's , they failed to follow

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the health care provider's treatment order and there was no documentation to indicate the facility contacted the home health agency to make a visit when the was removed at the time of the resident's shower.

2. Resident #12's 1823 health assessment form, dated , indicated that she had a diagnoses of (.)

Her recorded indicated that on she and on she , which was an 8.4% significant gain.

Her record did not contain documentation to indicate the facility notified a health care provider when the significant gain occurred.

On at 3:47 p.m. assistant administrator E confirmed all of the findings and was unable to provide additional documentation.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observations, record reviews and interview, the facility failed to centrally store a discontinued medication separately from medication in current use for 1 of 2 sampled residents (#12).

Findings:

Review of resident #12's Medication Observation Record (MOR) revealed an entry for powder, apply , to twice a day. Documentation on the MOR indicated the was discontinued on .

Observations made on at 2:08 p.m. revealed the powder was in the top of the medication cart, stored with medications in current use and labeled with the resident's name, which made it still available for use by the staff. Caregiver G was present and confirmed the findings.

Class III

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

Based on personnel record review, staff schedule review and interview, the facility failed 1) to ensure a

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staff member was present at all times who had current certification in First Aid and , ( ), and 2) did not ensure that 2 of 5 staff reviewed had obtained annual documentation of freedom from ( ) (A), and had legible documentation of freedom from communicable (B).

Findings:

1. Staff schedule for revealed Staff C and staff H were schedule to work the 11pm-7am shift. Review of the record for staff C revealed no documentation of current certification in First Aid or .

On at 1:35PM, the assistant administrator confirmed the findings and was asked to provide the First Aid and certifications for staff H. At 2:30PM, the assistant administrator said she was unable to locate the certificates. When asked who would be working 11pm-7am who did have current certification, she was unable to locate any staff records with valid certification in both and First Aid.

At 4:45PM, the administrator and executive director of the attached skilled nursing facility (SNF) provided documentation that the night nurse in the SNF that evening would cover the assisted living side as well. He provided a copy of a valid certification in that expires .

The schedule on showed that staff C and staff I worked together that night from 11pm-7am. The facility did not have anyone with current First Aid and on that night.
On at 3:30PM, the administrator confirmed the findings.

2. Review of the personnel record for staff A, caregiver hired , revealed , results documenting freedom from dated . There was a staff-completed self assessment dated with an illegible signature at the bottom on the line for "reviewed by." The form did not indicate a licensed practitioner examined the employee for signs and symptoms of .

Personnel record review for staff B hired revealed a freedom from communicable statement that was dated . Further review of the statement revealed there was a signature that was not legible. There was no way to determine the name of the person completing the form or the person's credentials.

On at 4 PM the assistant administrator said she did not know who signed the form and would have to ask someone in the health center to determine who actually completed the form.

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

Based on personnel record review and interview, the facility failed to ensure that direct care staff had completed the minimum staff in-service training requirements within 30 days of employment for 4 of 4 sampled staff (A, B, C and D).

Findings:

1. Review of the personnel record for staff A, caregiver hired , did not reveal evidence of training in the facility's policies and procedures regarding emergency preparedness and evacuation, including chain of command, or safe food handling & nutrition. There was a certificate for online elopement training dated , but was not provided by the facility using their policies and procedures.

2. Review of the personnel record for staff C, caregiver hired , did not reveal evidence of training in the facility's policies and procedures regarding emergency preparedness and evacuation, including chain of command, or safe food handling & nutrition. There was a certificate for online elopement training dated , but was not provided by the facility using their policies and procedures.

3. Review of the personnel record for staff D, the administrator hired , did not reveal any certificates for training in the facility's policies and procedures regarding emergency preparedness and evacuation, including chain of command or elopement.

On at 2:30 PM, the assistant administrator confirmed the training documentation was not in the records.

4. Personnel record review for staff B, a caregiver, hired revealed an online training dated for preventing and responding to elopement. There was no documentation found to confirm that she had obtained facility specific training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. Further personnel record review revealed there was no evidence to confirm she had obtained an in-service training regarding the facility's emergency procedures including chain-of-command and staff roles relating to emergency evacuation. There was no documentation to confirm she had received a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices.

On at 3:30 PM, the assistant administrator confirmed the findings.

Class III

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0082 - Training - / - 58A-5.0191(4) FAC

Based on personnel record review and interview, the facility failed to ensure that direct care staff had completed a one-time education course on ( ) and (Acquired -Deficiency), including the topics prescribed in the Section 381.0035, F.S. within 30 days of employment for 1 of 4 sampled staff (A).

Findings:

Review of the personnel record for staff A, caregiver hired , did not reveal evidence of training in / within 30 days of employment.

On at 2:30 PM, the assistant administrator confirmed the findings.

Class III

0083 - Training - First Aid and - 58A-5.0191(5) FAC

Based on personnel record review, staff schedule review and interview, the facility failed to ensure that at least one staff member working in the facility had current training and certification in First Aid and ( ) for 3 of 3 sampled staff. (C, H & I).

Findings:

Review of the staff schedule found staff C & H were scheduled to work alone as caregivers in the facility on from 11PM- 7am.

1. Review of the personnel record for staff C, caregiver hired , did not reveal current certification in either First Aid or .

2. On at 1:35PM, the assistant administrator confirmed the findings and was asked to provide the First Aid and certifications for staff H. At 2:30PM, the assistant administrator said she was unable to locate any certificates. When asked who would be working 11pm-7am who did have current certification, she was unable to locate any staff records with valid certification in both and First Aid.

Review of the staff schedule for the previous week revealed on , staff C and staff I worked from 11pm-7am alone.

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3. At 3:30 PM, the assistant administrator stated she was unable to provide any documentation of current certification in First Aid for staff I. The assistant administrator confirmed the only documentation the facility had in staff I's record was a card that expired .

On at 4:00 PM, Staff I provided a copy of a current BLS Provider card that expires that she brought in from her car. The card documented the training was for and only. Staff I believed she had done First Aid training as well, but said she was only given the BLS card.

At 4:45PM, the administrator and executive director of the attached skilled nursing facility (SNF) provided documentation that the night nurse (LPN) in SNF that evening would cover the assisted living side as well. He provided a copy of a valid certification in that expires .

At 4:45PM on , the administrator confirmed that the LPN for skilled nursing could cover First Aid needs for the assisted living facility from 11pm-7am.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(6) FAC 429.52 (6), FS

Based on personnel record reviews and interview, the facility failed to ensure that 3 of 4 sampled staff (A, B and C) received the required training and annual updates regarding assisting with self-administration of medications.

Finding:

1. Review of the personnel record for staff A, caregiver hired , and who provided assistance with self-administration of medications, revealed a 6 hour initial training certificate dated and a 2 hour update training dated . Continued review of the record did not reveal any certificates for the annual 2 hour training update for 2018.

2. Review of the personnel record for staff C, caregiver hired , and who provided assistance with self-administration of medications, revealed a 2 hour update training dated . Continued review of the record did not reveal any annual 2 hour training update for 2018. A certificate for the initial 4 or 6 hours of -on training was not found.

On at 2:30 PM, the assistant administrator confirmed the findings.

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3. Personnel record review for staff B who provided assistance with the self administration of the residents medications revealed there was a certificate in her record that was dated that noted she had successfully completed a 6 hour medication administration F.A.C 65G-7 in compliance with the Agency for Persons with . There was no documentation to confirm she had obtained the 4 hour initial training in providing assistance with self-administered medications and safe medication practices in an Assisted Living Facility (ALF) found in her record.

On at 3:30 PM, the assistant administrator confirmed the findings.

Class III

0086 - Training - ADRD - 58A-5.0191(10) FAC

Based on personnel record review and interview the facility maintained a secure area and provided special care for persons with 's and related (ADRD), failed to ensure that 2 of 4 sampled staff (A and B) who provided direct care to persons with 's and Related (ADRD) obtained 4 hours of initial training (Level I) within 3 months of employment and the additional 4 hours of training (level II) within 9 months that was provided by an approved ADRD Trainer and 1 of 4 sampled staff (D) did not obtain 4 hours of initial training within 3 months of employment and 1 of 4 sampled staff (C) did not obtain 4 hours of continuing educations annually.

Findings:

1. During an interview with staff B on at 12:30 PM, she stated she worked in the secured memory care unit.

Personnel record review for staff B, a caregiver hired on had no documentation to confirm she had obtained 4 hours of initial training (Level I) within 3 months of employment and the additional 4 hours of training (level II) within 9 Months that was provided by an approved ADRD Trainer .

On at 3:30 PM, the assistant administrator confirmed the findings.

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2. Review of the personnel record for staff A, caregiver hired , and who provides direct care to residents, did not reveal any certificates for 's Training Level I within 3 months of hire, and no certificates for training in 's Training Level II within 9 months of hire.

3. Review of the personnel record for staff C, caregiver hired , and who provides direct care to residents, revealed a certificate for 's Training Level I dated , and a certificate for Training Level II dated . Further review of the record did not find any certificates for the 4 hours of continuing education annually as required under section 429.178, F.S.

4. Review of the personnel record for staff D, the administrator hired , who had daily contact and interaction with residents, did not reveal any certificates for 's Training Level I within 3 months of hire.

On at 3:00 PM, the administrator confirmed the findings.

Class III

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

Based on personnel record review and interview the facility failed to ensure that 3 of 4 sampled staff (A, B,C and D) had at least one hour of training in the facility's policies and procedures regarding ('s) that included information in Rule 58A-5.0186, F.A.C. within 30 days after employment.

Findings:

1. Personnel record review for staff B a caregiver hired had no documentation to confirm she had at least one hour of training in the facility's policies and procedures regarding ('s) that included information in Rule 58A-5.0186, F.A.C. within 30 days after employment.

On at 3:30 PM, the assistant administrator confirmed the findings.

2, Review of the personnel record for staff A, caregiver hired , did not reveal any certificates for training in the facility's policies and procedures regarding ( ) as required within 30 days of hire.

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3. Review of the personnel record for staff C, caregiver hired , did not reveal any certificates for training in the facility's policies and procedures regarding ( ) as required within 30 days of hire.

4. Review of the personnel record for staff D, the administrator hired , did not reveal any certificates for training in the facility's policies and procedures regarding ( ) as required within 30 days of hire.

On at 3:00 PM, the administrator confirmed the findings.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observations and interviews, the facility failed to provide and maintain a home-like and decent environment in which to provide a safe living environment in the room of 1 of 12 sampled residents (#1).

Findings:

Observations made while conducting an interview with resident #1 on at 10:25 a.m. revealed the presence of a black substance on the ceiling tiles in her bedroom.

On at 10:57 a.m. the maintenance supervisor and maintenance director were both shown the ceiling tiles. They both confirmed the findings and said the black substance was as a result of condensation from the air conditioner. Photographic evidence obtained.

Class III

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

Based on record reviews and interview, the facility failed to ensure the record for 1 of 2 sampled residents (#12) who received assistance with self-administered medications from unlicensed staff, contained a written informed consent.

Findings:

On at 10:05 a.m. assistant administrator E said the facility utilized unlicensed staff to assist residents with self-administered medications.

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Resident #12's 1823 health assessment form, dated , indicated that she required assistance with self-administered medications. Her residency agreement nor her record contained a written informed consent from the resident or family allowing unlicensed staff to assist with medications.

On at 3:47 p.m. assistant administrator E confirmed the findings and was unable to provide additional documentation.

Class

E203 - ECC - Staffing Requirements - 58A-5.030(3) FAC

Based on review of the facility's profile on the facility health finder website and interview, the facility failed to provide or contract the services of a registered nurse to perform monthly nursing assessments for Extended Congregate Care (ECC) residents.

Findings:

Review of the Florida Health Finder website on at 12 p.m. revealed the facility was licensed to provide ECC services.

On at 10:15 a.m. the administrator said the facility did not employ nor contract the services of a registered nurse to perform the required monthly ECC nursing assessments.

Class III

E210 - ECC - Training - 58A-5.0191(8) FAC

Based on personnel record review and interview, the facility failed to ensure that 3 of 4 sampled staff (A, B, and C) had completed at least 2 hours of Extended Congregate Care (ECC) training, provided by the facility administrator or ECC supervisor, within 6 months of beginning employment in the facility.

Findings:

1. Personnel record review for staff B, a caregiver hired had no documentation to confirm she had completed at least 2 hours of ECC training, provided by the facility administrator or ECC supervisor, within 6 months of beginning employment in the facility.

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On at 3:30 PM, the assistant administrator confirmed the findings.

2. Review of the personnel record for staff A, caregiver hired , did not reveal any training certificates for Extended Congregate Care (ECC) as required within 6 months of hire.

3. Review of the personnel record for staff C, caregiver hired , did not reveal any training certificates for Extended Congregate Care (ECC) as required within 6 months of hire.

On at 3:00 PM, the administrator confirmed the findings.

Class III