STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967010	**06/04/2019**
NAME OF PROVIDER OR SUPPLIER **VIEW AT WINTER PARK (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **1047 PRINCESS GATE BLVD** **WINTER PARK, FL 32792**	

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

0000 - Initial Comments

The re-licensure survey was conducted at The View at Winter Park on . . . . . Deficiencies were identified at the time of the visit.

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

Based on observation, record review and interview, the facility failed to provide care and services to meet the needs for 2of 2 residents sampled and did not maintain a written record of significant changes or illness that required medical attention or the provision of additional services, or notification of the healthcare provider and family (#3 & 5).

Findings:

1. Observation of resident #3 revealed a bandage/wrap on her right . . . The resident stated her " . popped open" several years ago and was treated and doing well. She said more recently she bumped a chair and it reopened and she had to go to the hospital. She was unsure of the dates. She did state a nurse comes to change the bandages and a doctor comes once in a while as well.

On at 11:00AM, the administrator stated the resident had done "something to her but did not tell anyone right away. A caregiver went to see her and there was . . . . everywhere and the resident was trying to clean it up." He stated they sent her to the hospital.

Review of the record for resident #3 revealed she was admitted to the facility on . The current 1823, dated . . . , did not document any . . . . . Further review of the record did not reveal any notes or observations of any events or changes leading to the hospitalization, whether her personal physician or family were notified. There were no facility notes of any kind available for review from her admission through the date of the survey.

The home health sign-in log kept in the facility noted the dates that care was provided, with most entries noting " . . . care." There were no notes from the home health agency in the record, or available in the facility. The administrator was able to get the agency to fax the initial assessment for treatment of the . . . . The assessment by a registered nurse was dated . . . . and noted it to be a " . . . , non-, on top of right ."

2. Review of the record for resident #5 revealed she was admitted to the facility on . The facility was unable to locate the admission 1823. The earliest assessment available for review was dated

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documented it was provided after a hospital stay for a . There were no facility notes or observations available for review that documented any events or changes leading to the hospitalization, whether her personal physician or family were notified. The current 1823 was dated and had a hospital sticker/bar code on the bottom of each page. No notes were available to review indicating what occurred to require that hospital stay, what was done in the facility, or who was notified. There were no notes of any kind available for review from her admission through the date of the survey.

On at 2:45PM, the administrator confirmed they did not have any observation or progress notes for their residents.

Class III

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

Based on medication pass observation, medication observation record (MOR) review and interview, the facility failed to maintain a complete and accurate MOR for 1 of 2 residents sampled (#2).

Findings:

Observation of the medication pass for resident #2 on at 9:00 AM revealed staff A read the label aloud and then gave resident #2 one 70mg pill. Prescription label on the box read take one pill by weekly. The zip lock bag the box was stored in had handwritten instructions to only give on Tuesdays.

Review of the MOR for resident #2 found the was signed as being given on , and .

On at 9:30 AM, the administrator confirmed the MOR was signed off when the medication was not to be given. He then checked the number of pills available and said the correct number remained in the box and he was confident the MOR was marked even though the medication was not given.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on dietary record review and interview, the facility failed to document substitutions before or when a meal was served and did not maintain a list of substitutions made to the menu in the previous 6 months.

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Findings:

Review of the dated menu posted in the facility revealed it was approved by a licensed dietician on . They were serving week 3 of the 4-week rotational cycle. The lunch on the date of the survey was to be soup of the day, 3 ounces lean cuts on 2 slices of bread with lettuce and tomato and cup pudding for dessert. Observation of the lunch served at 12:30PM revealed a homemade soup containing chicken, shrimp, mixed vegetables and beans. The soup was served with crackers. Applesauce or cookies were offered for dessert.

Request to review the substitution log found the facility did not maintain a log.

On at 1:30PM the administrator confirmed the finding.

Class III

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

Based on observation, resident record review and interview, the facility failed to 1) record semi-annually for 2 of 2 sampled residents (#3 & #5) who required assistance with Activities of Daily Living (ADL), 2) retain the original health assessment (form 1823) for 1 of 2 residents (#3 & #5) obtain documentation of the of a Power of Attorney for 2 of 2 residents (#3 & #5), as required in 58A-5.024(3) FAC.

Findings:

1. Review of the record for resident #3 revealed she was admitted on . Her most recent health assessment was dated and documented she required assistance with ADLs. There were documented on the original and updated 1823s, but no facility record was available for review. documented on the health assessments were: - , - , - , - . There were no since .

Review of the residency contract for resident #3 revealed it was not signed by the resident. Further review did not find documentation for the appointed legal Power of Attorney for resident #3.

2. Review of the record for resident #5 revealed she was admitted on . Her most recent health assessment was dated and documented she required assistance with ADLs. There were

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documented on the original and updated 1823s, but no facility record was available for review. documented on the health assessments were: There were no other documented in the facility.

The admission 1823 was not available for review.

Review of the residency contract for resident #5 revealed it was not signed by the resident. Further review did not find documentation for the appointed legal Power of Attorney for resident #5.

On at 2:10 PM, the administrator confirmed he did not have records available for the residents. He stated he was unable to find the admission 1823 for resident #5. He also confirmed he did not have documentation for POA for either resident.

Class III