AGENCY FOR HEALTH CARE ADMINISTRATION

PRINTED: 10/11/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	55292	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER PALMS	830 NORTH SHORE DR NE SAINT PETERSBURG, FL 33701

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

0000 INITIAL COMMENTS

NURSING HOME

Unannounced Annual state licensure survey was conducted at Westminster Palms had deficiencies at the time of the survey. License: 1422096

0090 Pharmacy Policies and Procedures

Based on observation, record and policy review and interviews, the facility failed to ensure accurate dispensing and administration of drugs and biologicals for 3 of 10 sampled residents related to not documenting the administration of as needed (PRN) medications for resident's #3, #4, and #6 on the resident's Medication Administration Record (MAR).

Findings included:

1. Per record review resident #3 was admitted to the facility on for long term care (LTC) associated with diagnoses that included chronic pain and an , per the facesheet. Resident #3 was prescribed and for associated diagnoses according to the , 2016 Physician's orders.
Per review of the resident chart on , there was a Nursing Note, dated 16, that stated, "1:10 a.m. during patient care resident complain of having generalized discomfort and 0.25mg given along with assess resident appeared to be restless with some grimacing unable to voice exactly where the pain was located."
Per review on of resident's MAR for the month of , Resident #3 received the on at 5:58 p.m. and at 11:10 p.m. There was no notation of the resident receiving the per the MAR on .
During Interview with resident #3 on at 2:18 p.m. she stated that she thinks she's been at the facility for about a year. She was asked if she was informed of her rights as a resident and stated she believes she has been. She was subsequently asked if she chooses her physician and she said yes. The resident then asleep.
Resident #3 was observed on at 2:18 p.m. lying in bed under her blanket. She did not appear to be in any distress and there were no odors present. Her call light was attached to her sweater.
Resident #3 was observed on lying in bed asleep at 10:07 a.m. Resident did not appear distressed.

2. Resident #4 was observed on at 2:30 p.m. in the 2nd floor activities/dining area with 3 other residents sitting in their wheelchairs watching TV. The resident appeared clean and there were no

Delafuente Administrator 10/21/2016
Deanna de la Cruz

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WESTMINSTER PALMS	830 NORTH SHORE DR NE SAINT PETERSBURG, FL 33701

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odors present.
An interview was attempted with Resident #4 on at 2:30 p.m. by asking the resident how long she had been living at the facility and she advised that she has been at the facility about a year. Then the resident advised that she wants to go to Maine as that is where her family was located.
Per record review on , Resident #4 was admitted to facility on with a di es that included an and . Resident #4 was prescribed 0.5mg tablets of PRN for and 325mg tablets of PRN for pain, per the and , 2016 Physic an's orders.
Per chart review of the Nursing Notes, the resident received for on , 16, and , as well as receiving the as needed (PRN) 325mg tablet on .
Per review of Nursing Notes on there was an entry from at 12:16 a.m. that "resident complained of having jitters with generalized discomfort Xanax 0.5mg for 325mg tablets given for comfort. By: Staff. " There was also a late entry from that stated, "Resident comes out of ; "I ' m just so wired up and I can ' t relax is there something I can have? ( ) 0.5mg on tablet given by mouth for . By: _____ LPN "
Review of resident #4's Medication Administration Record (MAR) for the month of , 2016 reflected that no PRN or were administered.
Resident #4 was observed on at 10:04 a.m. sitting in a chair in . The tray was in front of the resident and the resident did not appear to be in any distress nor were there any odors present.

3. Resident #6 was admitted to the facility on for LTC related to a self-care and progression of Parkinson ' s , per the facesheet.
Per the latest quarterly MDS, dated , the resident was described as "severely -never/rarely made decisions" as it related to cognition skills for daily decision making. The Resident required related to functional status related to and Parkinson's .
An attempt to interview Resident #6 was made on at 10:15 a. . in the 4th floor activities room. The resident was pleasant and smiled. She was asked a few questions and responded only with a s and head shake. In the resident s chart there was a Nurses' Note on that reads, "4:18 a.m. Saturday and Sunday around the same time 12:00a.m. resident had voiced , I have a head ache, 352mg 2 tablets given with good results."
Per review of the MAR for the month of , 2016, the resident received on Saturday 8/ 16 but not on .

4. Staff Member B was interviewed on at 2:55 p.m. regarding the facility policy and procedure for medicine administration. She reported that the first step in administering medications was to open the electronic MAR or eMAR, and select the drug to be administered. She then added that once

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you open the eMAR you must then unlock the medication cabinet and measure dose. She says after that you would administer and confirm on the computer and after that the information would be available on the MAR. She was then asked if the information was not on the MAR was there a record that it was actually administered and she answered no.

5. Per review of documents provided by the DON on at 11:52 a.m. titled Policy 6.2: Medication Administration- General Guidelines states: The facility maintains equipment and supplies necessary for the preparation and administration of medications to residents. Under procedures:

22. After administration, return to car and document administration on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR).

The other document, Policy 6.3: Documentation for Medication Administration reflected: The facility maintains equipment and supplies necessary for the documentation of medications to residents. Under procedure for this policy it states:

1. The individual who administers the medication does records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medication report off-duty without first recording the administration of any medications.

3. When PRN medications are administered, the following documentation is provided:

A. Date and time of administration, does, route of administration (if other than oral), and, if applicable, the injection site.

B. Complaints or symptoms for which medication was given.

C. Results achieved from giving the dose and time results were noted.

D. Signature or initials of person recording administration and signature or initials of pers recording effects, if different from the person administering the medication, should be documented on paper medication administration records.

Class III

0201 Right to Adequate and Appropriate Health Care

Based upon observation, interview, and record review, the facility failed to ensure that protective and support equipment for were monitored as devices to alert staff of resident movement related to one (#7) of two residents identified with a history of and with injury and who was care planned for devices.

Findings included:

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3. When PRN medications are administered, the following documentation is provided:
A. Date and time of administration, does, route of administration (if other than oral), and, if applicable, the injection site.
B. Complaints or symptoms for which medication was given.
C. Results achieved from giving the dose and time results were noted.
D. Signature or initials of person recording administration and signature or initials of person recording effects, if different from the person administering the medication, should be documented on paper medication administration records.

Class III

5261 **Right to Adequate and Appropriate Health Care**

Based upon observation, interview, and record review, the facility failed to ensure that protective and support equipment for were monitored as devices to alert staff of resident movement related to one (#7) of two residents identified with a history of and with injury and who was care planned for devices.

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The nurse's notes of at 3:59 PM reflected a for Resident #7 documented as "late entry for , 7:30 PM. Resident was in bed and of a sudden we heard the clip alarm go off, when arrived we found resident lying on her back on the floor, right next to the foot of the bed, had her left leg flexed upward and she was hold her left , did refuse her vitals taken, expressing that was in pain on her left hip, and yelling get off the floor, reassured her and redirected her that paramedics will be called. Dr., daughter, and DON were notified. Paramedics took resident to _____hospital." The resident was readmitted to the facility on at 7:44 AM, "s/p ." The next day, on at 10:45 PM, the nurses' notes reflected, " to floor while trying to walk on her own. alert to self only. denies pain and no facial grimacing noted while assisting off of floor back to wheel chair. Pt. ' and to be watched the rest of the shift as she tried repeatedly to get up out of her chair to .....

Per the facesheet, Resident #7 was admitted in , 2016 with pertinent diagnoses of: Unspecified without behavioral disturbance; Aneurysm without and Osteoporosis with current
Current (, 2016) Doctor's orders included: " 0.5 mg Tab, give one tablet by mouth 3x daily for ; caltrate 600 + D Soft Chew tab; give one tablet by mouth every day for supp ent. kydrocodon- 5-325-give one tab by mouth every four hours as needed for Med Pass 2.0, Regular diet, 10 mg tablet, give one tablet by mouth daily for ."
The current care plan included identified problems of:
Self Care
Risk for skin integrity
Scheduled Care Tasks (Onset of /): Padded hip undergarment to be on during the day and off at night (C.N.A.), Bath day-fluid intake. stop and watch; personal hygiene.
AT risk for hydration: Assess skin
Frequent : HISTORY OF WITH INJURIES. ONSET / . Encourage resident to call for assistance prior to attempting to transfer; USE OF HIP PROTECTORS WHEN AWAKE AND OFF WHEN IN BED AT HS. USE OF WHEELCHAIR TO PREVENT ; FREQUENT OBSERVATION OF RESIDENT BY STAFF MEMBERS. Check alarm frequently to ensure it is working. Thought Processes Onset of / : Uses repetitive questions about " why " am I here? "

Annual MDS Evaluation:
BIMS score of . Resident was unable to complete.
"Has non- 's ."

MDS CONTINUED: j1700A: HISTORY: DURING MONTH BEFORE ADMISSION/REENTRY = YES.

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J1700B: HISTORY: HISTORY: 2-6 MONTHS BEFORE ADMISSION/REENTRY = YES.
J1700C: HISTORY; FROM 6 MONTH PRE-ADMIT= YES
J1800: since admit/reentry/prior asmt: any = yes.
J1900: since admit/reentry/prior asmt: injury (not major) = none.
J1900 C: since admit/reentry/prior asmt: major injury.

A nurses' note of 5:06PM reflected: "LATE ENTRY TO . Time is 1415. Had just given resident her medication. She was sitting in dining at TV. Walked across hall to another other resident when phone rang. It was her daughter. Walked across hall and asked someone give her the phone and they stated she ' s not there. She was in her , sitting on her bed adjusting her clothing. The self release belt did not alarm, not did the movement alarm in her room alarm. She safe, had not or injured herself. Time between seeing her and coming back was approximately 3 minutes." Signed by Staff member B.

On at 09:00 AM an interview with staff member B was conducted regarding the event of 0 ....en the resident returned to her , unnoticed. Staff member B confirmed that the equipment did not work to alert staff of the resident ' s movement. She confirmed the self-release belt did not alarm, nor the movement alarm in her . She also stated that the movement alarm in her even if she turns over in bed and that the sensor alarm is always on. The staff member stated the sensor alarm alerts at the Medication cart.

" 02:56 PM Behavior. Slept until 1045 AM ....only behaviors for today was she ambulad alone to her dining room ...this writer had just walked away from her 2 minutes. d a call from her daughter. Went to give her the phone and she was gone. Found her sitting on her bed adjusting her clothes; took her to the returned to wheelchair in dining room. No other behaviors today. " By: Staff member B.

at 02:19 PM : Resident up in wheelchair. Pleasant and . No negative behaviors noted at this time, to left continues, dressing dry and intact, no drainage noted at this time, no signs or symptoms of noted, no complaints of pain or discomfort voiced at this time. No signs or symptoms of distress noted. " Staff member D.

The 01:29 PM: MDS Notes: "... ... ...self ambulates with staff assist in the hallways to continue strength and mobility. IS UNSTABLE DURING TURNS AND DURING TRANSFERS REQUIRING ASSIST AT ALL TIMES. RESIDENT IS ABLE TO ASSIST IN SOME ADLS WITH CUEING. ... ... .PRECAUTIONS REMAIN-SELF RELEASING BELT WHILE IN WHEELCHAIR AND MOTION SENSOR WHILE IN BED WITH GOOD EFFECT. RESIDENT IS

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UNAWARE OF SAFETY RISK AND CAN BE IMPULSIVE AT TIMES. RESIDENT REMAINS PLEASANT WITH TIMES AND REPEATED QUESTIONING OF " CAN I GO HOME NOW. " PROPELS SELF ON THE UNIT WITH FEET. UNABLE TO FOLLOW COMMANDS TO USE HANDS ON WHEELCHAIR TO PROPEL AND IS ABLE TO USE FEET TO PROPEL WHERE RESIDENT PREFERS. STAFF SUPERVISION IS NEEDED AT ALL TIMES TO MAINTAIN SAFETY."

The AT 10:45 am CARE PLAN NOTES: "Resident care plan held today. Resident and daughter did not attend. Daughter updated as she is out of town. ... ...Resident was taken off of hospice as she has no significant declines and is very stable. Weight is stable and she remains on a regular diet. ...Resident comes to meals in the dining . She has been more active with activity like sorting, crafts, reading, and chats. The activity has helped with resident redirection. She is ambulating with assist from staff during the day to maintain her functioning. RESIDENT SELF-RELEASE W/C BELT FUNCTIONING AND MOTION ALARM WHEN IN BED. BOTH ARE ASSISTING IN RESIDENT PREVENTION PLAN. SHE HAS HAD A RE... ION IN HER SINCE HER MEDICATION INCREASE TO A ROUTINE DOSE OF . SHE IS NOT ... OR SHOWING ANY SIGNS OF OVER MEDICATION. RESIDENT IS SLEEPING WELL AT NIGHT."

The 10:21 pm NURSES NOTES reflected: EXIT SEEKING THIS TOUR. KEPT TRY... TO GO OUT OF DOOR THAT LEADS TO STAIRS SHE WANTS TO GO HOME. BEHAVIOR WORSENED BY PHONE CALL FROM DAUGHTER. PT ATE SMALL PORTION OF PM MEAL AND TOOK MEDICATIONS BUT CONTINUES TO TRY AND LEAVE. EVENTUALLY BECAME TIRED AND AGREED TO SLEEP IN IF SHE COULD LEAVE TOMORROW."

The AT 03:35 PM NURSES NOTES reflected: "MEDICATIONS NOT GIVEN UNTIL NOON AS SHE SLEPT UNTIL LUNCH TIME .....DID NOT WANT TO BE BOTHERED. UP IN CHAIR WITH SELF RELEASE BELT ON, CONSTANTLY TAKING APART AND STATING SHE NEEDED TO GO HOME. KEPT SAFE THROUGHOUT THE DAY." Signed by Staff member B.

The 06:45 am NURSES NOTES reflected: "6 AM RESIDENT CONFUSED YELLING OUT WHERE' S MY DADDY, ATTEMPTING TO STAND AND GET OUT OF BED STAFF DRESSED HER IN WHEEL CHAIR NEAR NURSING STATION. LPN."

The 1:10 pm NURSES NOTES reflected: "RESIDENT IN MY CARE FROM 12:30 PM TO ...10 pm. CONTINUOUSLY ASKED, " CAN I GO HOME? " BECOMING WANTED TO CALL HER MOTHER. BELIEVES SHE IS IN HER LATE 20 ' S. CAN NOT RECALL WHAT SHE HAD FOR LUNCH. RELEASED SELF-RELEASING BELT TIMES 1 WHILE IN MY CARE. ... ...CONTINUED TO BECOME AGITATED. ATTEMPT TIME 1 TO CALL DAUGHTER TO TRY TO CALM

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RESIDENT. NO ANSWER ON CELL. RESIDENT LEFT VOICEMAIL. RESIDENT NOW UNDER THE CARE OF ACTIVITIES."

On , at 11:40 AM., Resident #7 was observed in the dining lunch pizza and chips. The Social Worker moved wheelchair closer to the table and locked the wheels so resident could reach the pizza. The Surveyor went into resident review monitoring devices. The bed was noted to be in the low position with a bed alarm in the center of the bed. Also noted was a motion sensor on top of a chest of drawers directly at the foot of the bed. The surveyor stepped in front of the sensor and it started ringing at the med cart directly outside of the resident 's . The sound was that of a ding, ding, ding. During lunch, the resident was observed with an alarm to the back of the wheelchair.

10:30 AM On , an interview was conducted regarding the monitoring of equipment for Resident #7 with Staff member E. The staff member was asked about equipment monitoring. The conversation with Staff member B at 9 am that morning was referenced, wherein the nurse said that neither her alarm on the wheelchair and the alarm sounded on when the resident was found in her . Staff member E stated that staff would record on the TAR (Treatment Administration Record). Minutes prior to the meeting, Staff member A was asked about monitoring and she deferred to Staff member E.

Review of the , , and 2016 TARS provided to the survey team by administrative staff for Resident #7 reflected no entries or recording of monitoring for movement equipment for Resident #7, despite the resident's history of and injury.

Class III

0433 **Nursing Home Guide Posted**

Based on observation and interviews, the facility failed to post or make accessible to residents and the public a copy of the most recent version of the Florida Nursing Home Guide.
Findings included:
During interview with Staff Member G, who was over medical records, on at 4:05 p.m., the staff member stated that the Guide was located with the last survey on the information board across from the nursing station. She added that if it were not there then she was not able to get a copy as its difficult to copy off of the Agency for Health Care Administration (AHCA).
On at 4:15 p.m. attempted to locate the facility book containing the facility 's survey results as well as the Florida Nursing Home Guide. On the 2nd floor where the nursing home is located, the Survey results were prominently displayed on the board directly in front of the Nursing Station visible and accessible to all residents and visitors. The most current Nursing Home Guide, however, was not located

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RESIDENT. NO ANSWER ON CELL. RESIDENT LEFT VOICEMAIL. RESIDENT NOW UNDER THE CARE OF ACTIVITIES."

On 09/20/2016 at 11:40 AM., Resident #7 was observed in the dining or lunch room eating pizza and chips. The Social Worker moved wheelchair closer to the table and locked the wheels so resident could reach the pizza. The Surveyor went into resident 's review monitoring devices. The bed was noted to be in the low position with a bed alarm in the center of the bed. Also noted was a motion sensor on top of a chest of drawers directly at the foot of the bed. The surveyor stepped in front of the sensor and it started ringing at the med cart directly outside of the resident 's . The sound was that of a ding, ding, ding. During lunch, the resident was observed with an alarm to the back of the wheelchair.

10:30 AM On , an interview was conducted regarding the monitoring of equipment for Resident #7 with Staff member E. The staff member was asked about equipment monitoring. The conversation with Staff member B at 9 am that morning was referenced, wherein the nurse said that neither her alarm on the wheelchair and the pvement alarm sounded on 09/25/2016 when the resident was found in her room unexpectedly. Staff member E stated that staff would record on the TAR (Treatment Administration Record). Minutes prior to the meeting, Staff member A was asked about monitoring and she deferred to Staff member E.

Review of the July, , and 2016 TARS provided to the survey team by administrative staff for Resident #7 reflected no entries or recording of monitori for movement equipment for Resident #7, despite the resident's history of and injury.

Class III

0433 Nursing Home Guide Posted

Based on observation and interviews, the facility failed to post or make accessible to residents and the public a copy of the most recent version of the Florida Nursing Home Guide.
Findings included:
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in the on the bulletin board during two of two survey days (and).

Class III

[illegible]53 Adverse Incidents Defined

Based on record review and interview, the facility failed to identify 2 (#5, #7) of 3 reviewed adverse incidents to the State agency.

Findings included:

A review of the facility's incidents was conducted on , two incidents were found not to have been reported to the state as Adverse incidents. An interview was conducted at 2:00 p. , on , with the Director of Nursing (DON) stated that incidents/events are usually reported to the nurse first. He also stated the nurse is the first to investigate the situation and the nurse writes the incident report. All incidents are reported to the Risk Manager and the Unit Manager which in turn are included in the log. The DON stated that he fills out the adverse incident report with the initial investigation, which then is s to corporate. Corporate reviews the investigation and decides if it is adverse or not. Then Corporate enters the Adverse incident report on line if it is decided that it is reportable.

The DON was asked to explain how the following two events listed on the facility log were deemed reportable or not:
Resident #5 was listed on the facility log as having an event, on at 8:25 a.m. This was noted as a " with head injury, Hematoma, Closed head injury-superficial. " Under the column labeled Reportable it was answered NO. The DON stated they did not feel the was preventable since he had not had a in a long time. He further stated this was an observed -the CNA was going into the alarm was going off and the resident was on the floor, he had a history of . The staff spoke with the doctor, he was sent to the hospital ER and came back around night. The DON then looked at his report and stated it should have been reported.
Per the facility log, Resident #7 had a without a head injury, on /16 at 7:30 p.m. The Type of Injury was listed as a , the Disposition was listed as Hospital admission and under Reportable was listed NO. During the interview the DON stated the Adverse Incident Report was sent to Corporate. Corporate reviewed the incident and found it not adverse. When reminded that the resident was admitted to the hospital he stated" we should have reported. "

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Class III

0913 Adverse Incidents Defined

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Findings included:

A review of the facility's Incidents was conducted on , two incidents were found not to have been reported to the state as Adverse incidents. An interview was conducted at 2:00 p.m., on , with the Director of Nursing (DON) stated that incidents/events are usually reported to the nurse first. He also stated the nurse is the first to investigate the situation and the nurse does the incident report. All incidents are reported to the Risk Manager and the Unit Manager. Which in turn are included in the log. The DON stated that he fills out the adverse incident report with the initial investigation which then is s to corporate. Corporate reviews the investigation and decides if it is adverse or not. Then Corporate the Adverse incident report on line if it is decided that it is reportable.

The DON was asked to explain how the following two events listed on the facility log were deemed reportable or not:
Resident #5 was listed on the facility log as having an event, on at 8:25 a.m. This was noted as a " ...| with head injury, Hematoma, Closed head injury-superficial. " Under the column labeled Reportable it was answered NO. The DON stated they did not feel the was preventable since he had not had a in a long time. He further stated this was an observed -the CNA was going into the room the alarm was going off and the resident was on the floor, he had a history of . The staff spoke with the doctor, he was sent to the hospital ER and came back around midnight. The DON then looked at his report and stated it should have been reported.
Per the facility log, Resident #7 had a without a head injury, on at 7:30 p.m. The Type of Injury was listed as a , the Disposition was listed as Hospital admission and under Reportable was listed NO. During the interview the DON stated the Adverse Incident Report was sent to Corporate. Corporate reviewed the incident and found it not adverse. When reminded that the resident was admitted to the hospital he stated" we should have reported. "

AGENCY FOR HEALTH CARE ADMINISTRATION

PRINTED: 10/11/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	55292	09/28/2016
NAME OF PROVIDER OR SUPPLIER **WESTMINSTER PALMS**	STREET ADDRESS, CITY, STATE, ZIP CODE **830 NORTH SHORE DR NE** **SAINT PETERSBURG, FL 33701**	

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

Class III

Based on record review and interview, the facility failed to report 2 (#5, #7) of 3 reviewed adverse incidents to the State agency.

Findings included:

A review of the facility's incidents was conducted on , two incidents were found not to have been reported to the state as Adverse incidents. An interview was conducted at 2:00 p.m., on , with the Director of Nursing (DON) stated that incidents/events are usually reported to the nurse first. He also stated the nurse is the first to investigate the situation and the nurse does the incident report. All incidents are reported to the Risk Manager and the Unit Manager. Which in turn are included in the log. The DON stated that he fills out the adverse incident report with the initial investigation, which then is sent to corporate. Corporate reviews the investigation and decides if it is adverse or not. Then Corporate enters the Adverse incident report on line if it is decided that it is reportable.

The DON was asked to explain how the following two events listed on the facility log were deemed reportable or not:
Resident #5 was listed on the facility log as having an event, on at 8:25 a.m. This was noted as a " ... with head injury, Hematoma, Closed head injury-superficial. " Under the column labeled Reportable it was answered NO. The DON stated they did not feel the was preventable since he had not had a ....l in a long time. He further stated this was an observed ...-the CNA was going into the room the alarm was going off and the resident was on the floor, he had a history of falls. The staff spoke with the doctor, he was sent to the hospital ER and came back around midnight. The DON then looked at his

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	55292	09/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER PALMS	830 NORTH SHORE DR NE SAINT PETERSBURG, FL 33701

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

report and stated it should have been reported.
Per the facility log, Resident #7 had a without a head injury, on at 7:30 p.m. The Type of Injury was listed as a , the Disposition was listed as Hospital admission and under Reportable was listed NO. During the interview the DON stated the Adverse Incident Report was sent to Corporate. Corporate reviewed the incident and found it not adverse. When reminded that the resident was admitted to the hospital he stated " we should have reported. "
Class III

0915 **Adverse Incident**

Based on record review and interview, the facility failed to complete a thorough investigation and submit adverse incidents for 2 (#5, #7) of 3 residents reviewed for accidents.

Findings included:

1. Resident #5 was diagnosed with with behavior disturbances per his diagnosis listed on his front sheet. His annual minimum data set (MDS) related staffs for daily decision making was severely and noted that the resident interview should not be done as the resident is rarely understood. His care plans noted onset: Agitation related to and lack of sleep; interventions included administer medications, monitor for over-sedation assist resident to bed when tired...Ensure personal alarm is on and functioning for safety reminders. Resident #5 was listed on the facility log as having an event on at 8:25 a.m. This was noted as a " with head injury, Hematoma, Closed head injury superficial, " The nurses notes stated on at 1:49 AM. "11 PM while on report at the nurses station staff heard (Resident #5's) alarm go off. Entered was already sitting on the floor. No injuries no observed at the time denies pain. Stating I want to go to the bathroom. Pointing at the . Assisted by two staff members to wheelchair..."
The record was then silent until /2016 at 2:01 AM: "2 PM pod resident is asleep at this time alarm is functioning well..." On 8/1/2016 at 3:49 PM was noted "1240 returned from (local hospital) ER ...report received from nurse at (hospital) had laceration Left back of head with internal and 7 staples, to be removed in 7-10 days. Laceration (shred like) inside left ear with "Gut" suture. Hematoma Left Eye No Cerebral , no of skull or extremities."
The DON stated in an inter view at 2:00 p.m. on that they did not feel the fall was preventable since the resident had not had a in a long time. He further stated this was an observed fall-the CNA was going into the alarm was going off and the resident was on the floor, he had a history of falls. The staff spoke with the doctor, he was sent to the hospital ER and came back around midnight. The DON then looked at his report and stated it should have been reported.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER PALMS	830 NORTH SHORE DR NE SAINT PETERSBURG, FL 33701

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

report and stated it should have been reported.
Per the facility log, Resident #7 had a [redacted] without a head injury on 9/29/16 at 7:30 p.m. The Type of Injury was listed as a [redacted], the Disposition was listed as Hospital admission and under Reportable was listed NO. During the interview the DON stated the Adverse Incident Report was sent to Corporate. Corporate reviewed the incident and found it not adverse. When reminded that the resident was admitted to the hospital he stated " we should have reported. "
Class III

3915 Adverse Incident

Based on record review and interview, the facility failed to complete a thorough investigation and submit adverse incidents for 2 (#5, #7) of 3 residents reviewed for accidents.

Findings included:

1. Resident #5 was diagnosed with [redacted] with behavior disturbances per his diagnosis listed on his front sheet. His [redacted] annual minimum data set (MDS) related [redacted] skills for daily decision making was severely [redacted] and [redacted] noted that the resident interview should not be done as the resident is rarely understood. His care plans noted [redacted] onset: Agitation related to [redacted] and lack of sleep; interventions included administer medications, monitor for over-sedation; [redacted] assist resident to bed when tired...Ensure personal alarm is on and functioning for safety reminders. Resident #5 was listed on the facility log as having an event, on [redacted] at 8:25 a.m. This was noted as a " [redacted] with head injury, Hematoma, Closed head injury-superficial. " The nurses notes stated on [redacted]/2016 at 1:49 AM. "11 PM while on report at the nurses station staff heard (Resident #5's) alarm go off. Entered [redacted] was already sitting on the floor. No injuries no [redacted] observed at the time denies pain. Stating I want to go to the [redacted]. Pointing at the [redacted] Assisted by two staff members to wheelchair..."
The record was then silent until [redacted] at 2:01 AM: "2 PM post [redacted] resident is asleep at this time alarm is functioning well..." On [redacted] at 3:49 PM was noted "1410 returned from (local hospital) ER ...report received from nurse at (hospital) had laceration Left back of head with internal [redacted] and 7 staples, to be removed in 7-10 days. Laceration (shred like) inside left ear with "Gut" suture. Hematoma Left Eye [redacted] No [redacted], no [redacted] of skull or extremities."
The DON stated in an inter view at 2:00 p.m. on [redacted] that they did not feel the [redacted] was preventable since the resident had not had a [redacted] in a long time. He further stated this was an observed [redacted] the CNA was going into the [redacted] alarm was going off and the resident was on the floor, he had a history of falls. The staff spoke with the doctor, he was sent to the hospital ER and came back around midnight. The DON then looked at his report and stated it should have been reported.

AGENCY FOR HEALTH CARE ADMINISTRATION

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

2. Resident #7 had diagnosis listed including Unspecified without behavior disturbance. Her care plan also indicated he had a history of . Under the Problem Frequent it stated the resident had a history of with injuries, onset . Noted under interventions was "frequent observation of resident by staff members."
Per the facility log, Resident #7 had a without a head injury, on at 7:30 p.m. The Type of Injury was listed as a , the Disposition was listed as Hospital admission and under Reportable was listed NO. The nurses notes indicate on 3:59 PM "Late entry for 7:30 pm. Resident was in bed and all of the sudden we heard the clip alarm go off, when arrived we found resident lying on her back on the floor, right next to the foot of the bed, had her left leg flexed upward and she was holding her , did refuse her vital signs taken, expressing that she was in pain on her left hip, and yelling get off the floor, reassured her and redirected her that paramedics will be called." Resident was taken to the hospital. The next nurses note is from 11:19 PM "Admission Nurse note=Resident arrived at the facility at 6:30 PM...when assessed resident's skin intact except for fading on left side of her back and left arm, also small that she suffered during while moving her..."
During an interview, on at 2:00 p.m., the DON stated the Adverse Incident Report was sent to Corporate. Corporate reviewed the incident and found it not adverse. When reminded that the resident was admitted to the hospital he stated " we should have reported. "

Class III

2614 Background Screening Clearinghouse

Based on record review and interview the facility failed to maintain an accurate and up to date employee roster with the Background Screening Clearinghouse for one employee, Staff Member A.
Findings included:
During review of the facility employee roster and files on 9/28/2016, Staff Member A was found not to be listed on the facility roster on the Background Screening Clearinghouse website.
Per review of the documents received from the DON on 9/2 at 4:30 p.m., titled " HC Support Personnel by Department," it lists the Staff Member as the Health Administrator with an original hire date of and a last hire date of / . During the entrance interview with administrative staff on at 09:45 A.M., Staff member A presented her business card with the title, "NHA" during introductions.

Unclassified

AGENCY FOR HEALTH CARE ADMINISTRATION

PRINTED: 10/12/2[illegible]
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	55292	09/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER PALMS	**830 NORTH SHORE DR NE SAINT PETERSBURG, FL 33701**

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

[redacted] Resident #7 had diagnosis listed including Unspecified [redacted] without behavior disturbance. Her care plan also indicated he had a history of [redacted]. Under the Problem Frequent [redacted] it stated the resident had a history of [redacted] with injuries, onset [redacted]. Noted under interventions was "frequent observation of resident by staff members."
Per the facility log, Resident #7 had a [redacted] without a head injury, on [redacted]/16 at 7:30 p.m. The Type of Injury was listed as a Skin tear. Disposition was listed as Hospital Admission and under Reportable was listed NO. The nurses notes indicate on [redacted] 3:59 PM Late entry for [redacted] 7:30 pm. Resident was in bed and all of the sudden we heard the clip alarm go off, when arrived we found resident lying on her back on the floor, right next to the foot of the bed, had her left leg flexed upward and she was holding her [redacted], did refuse her vital signs taken, expressing that she was in pain on her left hip, and yelling get off the floor, reassured her and redirected her that paramedics will be called." Resident was taken to the hospital. The next nurses note is from [redacted] 11:19 PM "Admission Nurse note=Resident arrived at the facility at 6:30 PM...when assessed resident's skin intact except for fading [redacted] on left side of her back and left arm, also small [redacted] that she suffered during [redacted] while moving her..."
During an interview, on [redacted] at 2:00 p.m., the DON stated the Adverse Incident Report was sent to Corporate. Corporate reviewed the incident and found it not adverse. When reminded that the resident was admitted to the hospital he stated " we should have reported. "

Class III

Z814 **Background Screening Clearinghouse**

Based on record review and interview the facility failed to maintain an accurate and up to date employee roster with the Background Screening Clearinghouse for one employee, Staff Member A.
Findings included:
During review of the facility employee roster and files on [redacted], Staff Member A was found not to be listed on the facility roster on the Background Screening Clearinghouse website.
Per review of the documents received from the DON on [redacted] at 4:30 p.m., titled " HC Support Personnel by Department," it lists the Staff Member as the Health Administrator with an original hire date of [redacted] and a last hire date of [redacted]. During the entrance interview with administrative staff on [redacted] at 09: 45 A.M., Staff member A presented her business card with the title, "NHA" during introductions.

Unclassified

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Westminster Palms
830 North Shore Dr NE
Saint Petersburg, FL 33701

Dear Administrator:

This letter reports the findings of a state Licensure and Life Safety Code survey that was conducted on 27-28, 2016 by representative(s) 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 surveyor(s). Should you have any questions please call Freed at 727-552-2000.

Sincerely,

Patricia Reid Caufman
Field Office Manager

PRC/eah
Enclosure

XG90

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525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone:(727) 552-2000; Fax:(727) 552-1162
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