

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 55292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/22/2017
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	<p>INITIAL COMMENTS</p> <p>An unannounced relicensure survey was conducted on through at Westminster Palms in conjunction with a complaint survey, CCR#2017012186 (Event ID: QD4N11). Westminster Palms had deficiencies found at the time of the visit. License: 1422096.</p>	N 000		
N 040 SS=D	<p>59A-4.106(2-3) FAC Facility Policies Required</p> <p>(2) Each nursing home facility shall adopt, implement, and maintain written policies and procedures governing all services provided in the facility.</p> <p>(3) All policies and procedures shall be reviewed at least annually and revised as needed with input from, at minimum, the facility Administrator, Medical Director, and Director of Nursing.</p> <p>This Statute or Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to implement their policy related to the identification and documentation of abnormal vital signs for two (Resident #1 and #2) of ten residents sampled.</p> <p>Findings included:</p> <p>A review of the facility's policy titled, "Resident Examination and Assessment," revised 2014 revealed the purpose was to examine and assess the resident for any abnormalities in health status, which provides a basis for the care</p>	N 040		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 55292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/22/2017
NAME OF PROVIDER OR SUPPLIER WESTMINSTER PALMS			STREET ADDRESS, CITY, STATE, ZIP CODE 830 NORTH SHORE DR NE SAINT PETERSBURG, FL 33701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 040	<p>Continued From page 1</p> <p>plan. Documentation: the following information should be recorded in the resident's medical record: 3. All assessment data obtained during the procedure. Reporting: 2. Notify the physician of any abnormalities such as, but not limited to abnormal vital signs.</p> <p>1. On _____ at 9:30 a.m. Resident #1 was observed as Staff B, a licensed practical nurse, administered her medications. Resident #1 stated that she felt like "the life is leaving my body ..." Staff B checked Resident #1's vital signs, and stated her _____ rate was 56. She confirmed this was an abnormal reading and was below the normal acceptable range.</p> <p>On _____ at 10:00 a.m., a clinical record review was conducted with the Director of Nursing (DON). He confirmed that there was no documentation in Resident #1's record of the lower than normal _____ rate that was noted the previous day during Staff B's assessment. He confirmed abnormal vital signs should be a part of the permanent clinical record. The DON pointed out that previously, Resident #1's vital signs had been within normal limits, and this one abnormal _____ rate was an _____ event. He confirmed there was always a starting point when abnormalities start to happen, and this should be documented in the clinical record for on-going monitoring and tracking of the resident's condition.</p> <p>On _____ at 10:45 a.m. a telephone interview was conducted with the consulting pharmacist. She confirmed that Resident #1 had a physician's order for the medication _____, which could potentially cause a lower than normal _____ rate. She confirmed that this should be documented in the clinical record for the appropriate monitoring</p>	N 040			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 55292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/22/2017
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 040	<p>Continued From page 2</p> <p>and tracking of abnormal vital signs, including when the first abnormal vital sign was noted.</p> <p>2. Review of Resident #2's medical record revealed the resident was admitted to the facility on _____ with diagnoses that included _____ and _____.</p> <p>Per review of Resident #2's medical record, the resident's _____ [the top #] was documented as being greater than 200 on _____, _____, & _____. Review of Nurse's Notes and Physician Progress notes revealed no documentation that the Physician was alerted regarding the resident's elevated _____.</p> <p>Per interview with the facility's Director of Nursing [DON] on _____ at 10:30 AM, the DON stated that the resident's physician "definitely" should have been contacted when the resident's _____ registered above 200 on the 3 occasions, and was not.</p> <p>Class III</p>	N 040		
N 054 SS=D	<p>59A-4.107(5), FAC Follow Physician Orders</p> <p>All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident's medical record during that shift.</p> <p>This Statute or Rule is not met as evidenced by: Based upon staff interview and record review, the facility failed to follow physician's orders regarding</p>	N 054		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 55292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/22/2017
--	--	---	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WESTMINSTER PALMS

**830 NORTH SHORE DR NE
SAINT PETERSBURG, FL 33701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 054	<p>Continued From page 3</p> <p>..... medications for two residents (#2 & #9) of 10 residents in the sample group.</p> <p>Findings included:</p> <p>1. Review of Resident #2's medical record revealed the resident was admitted to the facility on of 2017 with diagnoses that included and Per review of Resident #2's Physician Orders dated, the resident was ordered the medication to be given daily at 8:00 AM, and the medication to be given twice a day at 8:00 AM and 9:00 PM. Both medications were to be held if the resident's [the top #] was less than 110, or if the diastolic pressure [the bottom #] was less than 60.</p> <p>Per record review, Resident # 2's was lower than 110 on & On all the dates, the resident was given either one or both medications when they should have been withheld. Additionally, the resident was not given one or both medications when the resident's was not taken or was greater than 110 on &</p> <p>Per interview with the facility's Director of Nursing [DON] on at 10:30 AM, the DON confirmed between to of 2017, Resident #2 either was given or withheld medications contrary to the Physician's parameters on 8 separate occasions.</p> <p>2. Review of Resident #9's medical record revealed the resident was admitted to the facility in of 2017 with diagnoses that included and Per review of Resident</p>	N 054		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 55292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/22/2017
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 054	<p>Continued From page 4</p> <p>#9's Physician Orders dated _____, the resident was ordered the _____ medication _____, to be given daily at 9:00 AM. On _____, an order was written to monitor Resident #9's _____ prior to administering the _____.</p> <p>Per record review and interview with the facility's DON on _____ at 10:30 AM, the DON confirmed the resident was administered the _____ daily since it was ordered in early _____ of 2017 with no documentation that the resident's _____ was taken prior to administering the medication daily per the physician's order.</p> <p>Class III</p>	N 054		