

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105757	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/21/2024
NAME OF PROVIDER OR SUPPLIER  Westminster Towers		STREET ADDRESS, CITY, STATE, ZIP CODE  70 West Lucerne Circle Orlando, FL 32801	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45646</b></p> <p>Based on interview and record review, the facility failed to report timely an alleged violation of neglect for 1 of 1 resident reviewed for neglect, of a total sample of 3 residents, (#1).</p> <p>Findings:</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia, abnormalities of gait and mobility and major depressive disorder.</p> <p>Review of the Minimum Data Set admission assessment with assessment reference date of 7/15/24 revealed resident #1 had a Brief Interview for Mental Status score of 10/15 which indicated she had moderate cognitive impairment. The document indicated she used a wander/elopement alarm daily.</p> <p>A care plan for wandering and at risk for elopement was initiated 7/08/24. Interventions included the use of a wander/elopement alarm daily.</p> <p>Review of resident #1's progress notes for the month of August 2024 revealed she was unable to be located on the morning of 8/07/24 during rounds by the 7:00 AM - 3:00 PM nurse. A facility search was initiated. The facility discovered resident #1 left the facility unsupervised and walked to a nearby hospital where she was located.</p> <p>On 8/21/24 at 11:00 AM, the Administrator confirmed he was responsible for filing reports of allegations of abuse or neglect per state and federal guidelines. The administrator recalled he was in the facility at the time resident #1 was discovered missing on 8/07/24 at 7:14 AM. He stated the immediate report of neglect was filed on 8/08/24 around 3:00 PM. The Administrator acknowledged the report was filed late but stated he wanted to be sure the investigation was complete before submitting.</p> <p>Review of the facility's policy and procedure for Abuse, Neglect and Exploitation revealed alleged violations would be reported no later than 24 hours after the allegation was made if the event did not involve abuse and did not result in serious bodily injury.</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45646</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent elopement for 1 of 1 resident reviewed for actual elopement, of a total sample of 3 residents reviewed for elopement, (#1).</p> <p>Findings:</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia, abnormalities of gait and mobility and major depressive disorder.</p> <p>Review of the Minimum Data Set admission assessment with assessment reference date of 7/15/24 revealed resident #1 had a Brief Interview for Mental Status score of 10/15 which indicated she had moderate cognitive impairment but did not exhibit disorganized thinking. The document indicated she used a walker for independent mobility and did not have any impairment to her upper or lower extremities. The assessment revealed resident #1 wore a wander/elopement alarm daily.</p> <p>Review of the medical record revealed an elopement evaluation dated 7/05/24. The evaluation indicated resident #1 wandered and had a history of elopement or attempted elopement.</p> <p>A care plan for wandering and at risk for elopement was initiated 7/08/24. Interventions included staff to distract from wandering by offering pleasant diversions, identify pattern of wandering and the use of a wander/elopement alarm daily applied to resident #1 and her walker.</p> <p>Review of the progress notes revealed resident #1 could not be located on the morning of 8/07/24. The code for missing resident was announced at approximately 7:14 AM. Resident #1's wander/elopement alarm was located in the top drawer of her dresser and her walker was located in another resident's room. The walker from the other resident's room was missing and was almost identical to resident #1's walker. The facility staff discovered resident #1 left the facility unsupervised and walked to a nearby hospital where she was admitted .</p> <p>In a phone interview on 8/20/24 at 5:47 PM, Registered Nurse (RN) A confirmed resident #1 was on her assignment the night of 8/06/24. She stated resident #1 usually walked the hallways in the evening after she ate and before going to bed. RN A recalled resident #1 usually sat with a particular resident during meals but that resident stayed in her room that day. She stated resident #1 asked about the other resident and then went to the other resident's room to visit between 7:30 PM to 7:45 PM. RN A recalled resident #1 came out, received her medications and went to her room. She reported resident #1 usually went to bed at 8:00 PM, closed her door and did not like to be disturbed after she went to sleep. She explained resident #1 usually had that same routine so she did not disturb her.</p> <p>On 8/19/24 at 3:12 PM, Certified Nursing Assistant (CNA) B confirmed she was assigned to resident #1 on 8/06/24. She recalled seeing resident #1 in the dining/common area in front of the nurse's station for most of the evening. CNA B explained she observed resident #1 in bed around 7:50 PM. Resident #1 told her to get out of her room, so CNA B left. She did not see resident #1 for the rest of the shift.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/19/24 at 5:59 PM, Dietary Aide E confirmed resident #1 got on the elevator with him on the night of 8/06/24. He explained he was taking the food cart back to the kitchen, opened the elevator and she followed him as he pulled the cart into the elevator. He stated from how she appeared/acted he was not aware she was a resident and no alarm sounded when she entered the elevator to let him know otherwise. Dietary Aide E recalled she exited the elevator behind him on the bottom floor but he did not see where she went. He explained he pulled the dietary cart toward the kitchen and could not see her due to the cart being tall and blocking his view.</p> <p>In a phone interview on 8/20/24 at 2:22 PM, CNA D verified she worked the night shift on 8/06/24. She stated her shift started at 11:00 PM. CNA D explained she performed her routine rounds and checked every room. She reported when she went to resident #1's room, the resident was out, the bed was made up and the room was tidy. She thought resident #1 may be leave of absence or at the hospital because the rooms were usually cleaned up and the bed made when a resident was out of the facility. She recalled the assigned nurse was late getting to work. She stated she assumed if there was an issue someone would have told her.</p> <p>In a phone interview on 8/20/24 at 3:36 PM, Licensed Practical Nurse (LPN) C confirmed she was assigned to resident #1 on the night shift on 8/06/24. She reported she arrived late, at about midnight and took over from RN A. She explained CNA D had made rounds and gave her a thumbs up when she asked if everything was okay. LPN C stated resident #1 was usually in bed when she started her shift and did not like to be disturbed. She recalled going into her room in the morning of 8/07/24 at approximately 4:30 AM and saw the bathroom light was on. LPN C stated she thought resident #1 was in the bathroom as she usually woke up at 5:00 AM. LPN C stated she was not aware resident #1 was not in her room or the bathroom until shift change when she made rounds with LPN F. LPN C acknowledged she had not checked on resident #1 throughout the night.</p> <p>On 8/20/24 at 12:24 PM, LPN F verified she worked the morning shift on 8/07/24. She recalled as she made rounds, she did not see resident #1. She explained they searched the unit but could not find her. LPN F stated she notified the night supervisor and immediately called the code for a missing resident. She helped in the search and recalled the resident was located at a nearby hospital. LPN F reported resident #1 returned to the facility later that day. She confirmed the walker resident #1 took from another resident was similar to hers in color and style, but did not have a wander alarm attached to it.</p> <p>In interviews on 8/19/24 at 2:29 PM, and on 8/20/24 at 3:52 PM, resident #1 was pleasant with clear speech. Resident #1 recalled leaving the facility and called it her, escape. She explained she missed her friend who lived next door at the Assisted Living Facility and decided to go outside for a walk. Resident #1 recalled she cut off her wander/elopement alarm so she could get out of the facility without the alarms sounding. She stated she stopped at the nearby hospital as she was tired and wanted something to drink. Resident #1 expressed she knew to cross a street at a crosswalk and not in the middle of the street. She explained she would either wait for a light to cross or would wait until no cars were coming before crossing.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a meeting with the Administrator and Director of Nursing (DON) on 8/21/24 at 10:34 AM, the Administrator reviewed the facility investigation and reported resident #1 was seen on camera on 8/06/24 at 7:58 PM, walking toward the elevator on her unit. She was observed following Dietary Aide E into the elevator on the third floor and was seen on camera exiting the elevator on the first floor at 8:00 PM. He reported she then exited the facility through the employee entrance/exit door. The Administrator explained, through their investigation, they discovered resident #1 cut her wander/elopement alarm bracelet off and hid it in her dresser drawer. She then swapped her walker with a walker that looked like hers before entering the elevator. The Administrator reported resident #1 walked into the hospital emergency room at approximately 9:00 PM per hospital records. He stated the expectation was staff should see each of their assigned residents every 2 hours at a minimum and more frequently if they were deemed to be at risk for elopement. He acknowledged alarms were not a substitute for supervision and the staff should have checked on resident #1 more frequently.</p> <p>Review of the policy and procedure, Elopements and Wandering Residents revealed an elopement occurred when a resident left the premises or a safe area without authorization and/or necessary supervision to do so. The document indicated alarms were not a replacement for necessary supervision.</p>