Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964279	A. BUILDING: _____ B. WING _____	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPOINTE RETIREMENT COMMUNITY	5101 NORTHPOINTE PKWY PENSACOLA, FL 32514

(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
A 000	Initial Comments An unannounced abbreviated biennial re-licensure survey was conducted on [illegible] 2023 at Westpointe Retirement Community. Deficiencies were identified at the time of the survey.	A 000		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable [illegible] to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, [illegible] or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside	A 152		

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A 152	Continued From page 1 commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . . . . . . This Statute or Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide a safe living environment for 3 of 3 residents. (Residents #2, #4, and #9) The findings include: A tour was conducted on at approximately 10:45 AM in the dining room of the facility. The tiles in the dining room were noted to be cracked in areas. There were tiles on the dining room floor that were uneven, raised, and not grouted in several areas in the dining room. An interview was conducted on at approximately 11:15 AM with Resident #2. Resident #2 stated, "I not long ago in my room and broke my . . . . I was in rehabilitation for several weeks. I have never had a until I moved here. I in my room and in the dining room. They have replaced some of the tiles on the dining room floor. Some of the tiles do not even have grout on them. They are crooked and you will trip over them." Resident #2 stated the floor in the dining room is a hazard. A review of the Assisted Living Facilities incident report dated . . . . . completed by a nurse's aide revealed Resident #2 "tripped over, facing downward in the dining room". The report stated resident #2 had noted over his left	A 152		

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A 152	Continued From page 2 and noted [illegible] through his [illegible]. The report further stated that Resident #2 complained of [illegible] in his left [illegible]. Resident #2 was sent to the hospital. Record review revealed a note on [illegible] that Resident #2 had sustained a [illegible] in the bathroom trying to get into the shower. The resident complained of hitting his [illegible] on the floor and [illegible] on the toilet. The resident was sent out to the hospital at that time. Further review of Resident #2's record revealed a resident health assessment for assisted living facilities completed and signed on [illegible], following readmission to the facility. The medical history and diagnosis on this assessment revealed additional diagnosis from the primary admission to the facility to include a wedge [illegible] of the [illegible] (T11 and T12), [illegible] and collapse, [illegible] of the lier, [illegible] murmur, [illegible], and [illegible] of the [illegible] region. Resident #2 was to receive home health care at that time. He was also to always wear a Thoraco-lumbo- [illegible] (TLSO) brace when out of bed including showers. A tour was conducted on [illegible] at approximately 9:30 AM of resident rooms. The rooms of Residents #2, #4, and #9 were observed to have what appeared to be [illegible] termites in the windows. Resident #2's room had gaps between the window air conditioning unit placed in the window. The air conditioning unit was filled with heavy dirt and the appearance of insects. Resident #9 had a small [illegible] mouse wrapped in a paper towel in their room.	A 152		

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A 152	Continued From page 3 Resident #2 reported having "flying termites" in his room. Resident #2 stated a window air conditioning and heating unit was placed in his room. The resident stated that there are "cracks" between the window and the unit and that insects are entering his room. Resident #2 also reported mice in his room. He stated, "The mice have eaten holes in my closet doors." An interview was conducted on at approximately 11:45 AM with Resident #4. Resident #4 stated having termites and mosquitoes in his room. He stated, "You can see the termites crawling under the tile in my room." An interview was conducted on at approximately 9:00 AM with Resident #9. Resident #9 stated that she has termites in her room. Resident #9 stated, "I have my own can of bug spray. So, I just use that to kill them." Resident #9 stated she "killed a mouse" in her room. Resident #9 then pulled out a napkin and unwrapped it to reveal a small . . . . mouse. She stated, "I killed it myself with a book. I hate those things". An interview was conducted on . . at approximately 10:30 AM with the Assistant Administrator (AA). The AA stated she did the pest control for the building. She stated the facility has a contract with a local exterminator, but stated they only treat the kitchen. The AA stated that she personally had a certification to do pest control within the building and that she was doing pest control for all of the rooms within the building. The AA stated that "I haven't sprayed this month." An interview with was conducted on at approximately 11:00 AM with the Administrator.	A 152		

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A 152	Continued From page 4 The Administrator stated the dining rooms floors would be "repaired this week". The Administrator stated that the contract with the pest company was for the entire building, including the resident rooms. The Administrator stated the pest company was to come out to the facility to address the pest control complaints, to include termites and mice. A record review was conducted on at approximately 1:00 PM of an invoice and treatment completed on . The invoice stated there was a pest control treatment of Suspend Poly Zone 0.06% completed in the dining area, non-food storage area, receiving area, refrigerated area, stove (kitchen) under and behind. A pest control treatment of Alpine Roach Bait Gel 0.5% was used to treat the areas of the prep tables in the kitchen. The facility was unable to present a policy on pest control of the facility during the survey. Class III	A 152		
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences.	A 165		

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A 165	Continued From page 5 (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse	A 165		

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A 165	Continued From page 6 incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by:	A 165		

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A 165	Continued From page 7 Based on observations, interviews, and record review, the facility failed to develop and maintain an internal risk management and quality assurance program. The facility failed to investigate incident reports and develop a plan of action to correct any issues found. The findings include: An interview was conducted on at approximately 11:00 AM with the Administrator. The Administrator stated the facility had a Risk Management program. The Administrator stated that the facility did not meet as a group or document findings of investigations. He stated there is an incident report that is completed at the time of an incident, but there is no official investigation completed. The Administrator stated, "We all know what goes on inside the building". The Administrator stated the Resident Liaison does follow up with any resident sent out to the hospital for an update. The Administrator stated all events are documented on the . . . of the Medication Administration Record for staff "to know what is going on". An interview was conducted on at approximately 11:15 AM with Staff B, a Registered Nurse (RN). Staff B, RN, stated that she was not the risk manager but does enter all the adverse events. She stated, "I conduct the investigations into any adverse events at the facility. There have been no adverse incidents in the last 8 months." Staff B stated that Resident #2 did sustain a . in the dining room. She stated that resident #2 "Looked like he tripped over his own two . . . We did send him out to the hospital. His started pretty quickly after he . I was worried that he had something in his . He was gone for	A 165		

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A 165	Continued From page 8 a while." An interview was conducted on . . . . . at approximately 12:15 PM with the Assistant Administrator (AA). The AA stated she entered all adverse incidents into the State Reporting System. She stated Staff B does all of the investigations. The AA stated no adverse incidents have been reported in the last few months. The AA stated that the that Resident #2 had were not preventable, such as the occurring on . She stated, "I would not have reported any of those. The that Resident #2 had in the dining room was witnessed by Staff B. He tripped over his own , and he was not sent out to the hospital". However, facility documentation verified he did have to be treated at the hospital. An interview was conducted on at approximately 12:45 PM with the Resident Liaison (RL). The RL stated that he does follow up on any resident that is sent out to the hospital. He stated that he did not remember any that Resident #2 had in . . . . . He stated, "I may have had a call about his in . But I do not document those conversations anywhere. I just ask them for a discharge date or a plan". At the time of the survey, the facility was unable to provide a Risk Management plan or any follow up to reported incidents. The facility was also unable to produce reports made to appropriate agencies following an adverse incident. Class III	A 165		