

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910753	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/30/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WINDSOR PLACE RETIREMENT HOME

**1850 NE 26TH STREET
WILTON MANORS, FL 33305**

(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 licensure complaint survey, complaint number 2019016121, was conducted on _____ at Windsor Place Retirement Home. The facility had deficiencies at the time of the survey.	A 000		
A 030 SS=D	59A-36.007(6) FAC; 429.28() FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; _____, Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida _____ Hotline, 1(800)96-_____ or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents	A 030		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910753	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/30/2019
NAME OF PROVIDER OR SUPPLIER WINDSOR PLACE RETIREMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1850 NE 26TH STREET WILTON MANORS, FL 33305		
(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 030	Continued From page 1 and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. _____ and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident _____, neglect, and _____. 6. Administrative and housekeeping schedules and requirements; 7. _____ control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910753	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/30/2019
NAME OF PROVIDER OR SUPPLIER WINDSOR PLACE RETIREMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1850 NE 26TH STREET WILTON MANORS, FL 33305		
(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 030	Continued From page 2 429.41(1)(k), F.S., the use of physical _____ by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical _____. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from _____ and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community.	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910753	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/30/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WINDSOR PLACE RETIREMENT HOME

**1850 NE 26TH STREET
WILTON MANORS, FL 33305**

(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 030	Continued From page 3 (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910753	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/30/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WINDSOR PLACE RETIREMENT HOME

**1850 NE 26TH STREET
WILTON MANORS, FL 33305**

(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 030	Continued From page 4 relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (1) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, . . . , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder . . . Hotline operated by the Department of Children and Families, and, if applicable, . . . Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910753	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/30/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WINDSOR PLACE RETIREMENT HOME

**1850 NE 26TH STREET
WILTON MANORS, FL 33305**

(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 030	Continued From page 5 call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated or under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on interviews, and records review, the facility failed to ensure that 2 of 2 sampled residents (Resident #1 & Resident #2) right for a safe living environment was ensured. The facility also failed to provide evidence of a grievance policy and procedure indicating how allegations and/or concerns voiced by residents residing in the facility are investigated and some form of resolution implemented. The findings included:	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910753	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/30/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WINDSOR PLACE RETIREMENT HOME

**1850 NE 26TH STREET
WILTON MANORS, FL 33305**

(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 030	Continued From page 6 On an investigation was conducted at the facility alleging resident to resident The complainant alleged that there have been multiple altercations that have taken place between the complainant (Resident #1) and an alleged , , (Resident #2). In an interview conducted with the Administrator on at 10:45 AM, she was asked to provide her incidents and grievance documentation. The Administrator said that she had no records/incident reports of residents. However, she reported that last night Resident #1 sprayed perfumes in the , , of Resident #2. The Administrator was asked to provide the documents of her investigation, she motioned that she did not conduct an investigation and did not create an incident report. When asked if she had any policies for investigating , , or incidents, she said that she does not have a policy for those things because she never had problems at her facility. "We have been here for twenty-five years, our people are pretty good" she added 10:45 AM. The Administrator was asked how did she know about the incident that had occurred the night before? She stated that Employee A told her that Resident #1 sprayed perfumes in the , , of Resident #2. She then explained that Staff A was coming in to work at 3:00 PM, Resident #2 stood at the gate to open it for Staff C. Then, Resident #1 opened her door, got out of her room and sprayed Resident #2 while asking Resident #2 "why are you in front of my door? ... you are not allowed to come in front of the building". The Administrator said that Resident #1 had also told her that Resident #2 is not allowed to be in front of the building and that Resident #1 wants Resident #2 to move out. The Administrator	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910753	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/30/2019
NAME OF PROVIDER OR SUPPLIER WINDSOR PLACE RETIREMENT HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1850 NE 26TH STREET WILTON MANORS, FL 33305		
(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 030	Continued From page 7 informed this writer that she told Resident #1 that Resident #2 has been living at this facility for 18 years, he is not going anywhere. The Administrator further added that Resident #1 is very aggressive, and difficult. They offered to have Resident #1 move upstairs away from Resident #2, but Resident #1 refused. Resident #1 said "I am not going anywhere". The Administrator stated, that Resident #1 wants to control the place. The Administrator said she does not keep a record of the conversations she had with Resident #2 and, she said that she did not communicate with Resident #1 because after the incident Resident #1 refuses to speak to her. During an interview with Resident #2 on at 11:20 AM. The following information was revealed. "I went to open the gate at 3:00 PM to meet Employee C who works in the kitchen. I stood in front of the gate, and Resident #1 was screaming "get away from the gate" then, Resident#1 sprayed me with something that was like Mace. I had my glasses on, so a little bit of it got into my right . . . It burnt my right . . . Employee A looked for something special to wash my . . . she could not find it. I had to wait until the . . . go away". The resident then said that "I did not go to the doctor, there was no need to go the hospital". Resident #2 continued and said that "I was a Baltimore PD for 18 years and retired after I lost my right . . . sight. I then stopped because I could no longer fire a rifle or . . . gun. Resident #2 added that Resident #1 has serious mental illness and has been trying to get me . . . for a long time. But the police never listened to her. Resident #1 is sick, motioned Resident #2. Resident #1 continuously has problems with me. It started with verbal, now Resident #1 is using	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910753	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/30/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WINDSOR PLACE RETIREMENT HOME

**1850 NE 26TH STREET
WILTON MANORS, FL 33305**

(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 030	Continued From page 8 chemical, soon it might be a gun. Every time something happens, I report it to the staff on duty. I feel threatened by Resident #1. Resident #1 is getting very , , . I always open the gate for Employee C, she is a good cook. I also open the door for Employee E when she comes to work at 11:00 PM. I have been opening the doors for the workers every time they come in to work. I am , , . Resident #1 needs serious , , , help. Resident #1 needs some kind of medications to calm her down. "I am an ex-cop, but I am not an expert of mental illness". Resident #2 said that he gets along fine with everybody and has not had any altercations with anyone else. Review of Resident #2's health assessment (AHCA form 1823) dated revealed the following diagnoses: 's , , , Functional Decline, Loss of vision in the right , ; and , , . Resident #2 requires assistance for all activities of daily living and general oversight of his whereabouts daily. During an interview with Staff A, a licensed practical nurse (LPN) at 11:41 AM, on , , , she said that she has been working at this facility for 10 years. She usually works from 6:00 AM to 6 PM. She reported that she worked from 6:00 AM to 6:00 PM on . At 3:00 PM Resident #2 went to open the door for Staff C who comes at 3:00 PM, she is a certified nursing assistant (CNA). Staff A continued and said, "I did not witness it". Resident #1 told me that Resident #2 was walking in the common area by the gate to open the gate; Resident #1 said that she felt threatened and sprayed Resident #2. Staff A pointed out that Resident #2 had glasses on, so it blocked the spray.	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910753	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/30/2019
NAME OF PROVIDER OR SUPPLIER WINDSOR PLACE RETIREMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1850 NE 26TH STREET WILTON MANORS, FL 33305		
(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 030	Continued From page 9 Staff A further indicated that Resident #2 had also reported the incident to her. However, Resident #2 refused to go to the hospital and to receive first aid care. Moreover, Employee A reported that the problem between Resident #1 and Resident #2 has been an ongoing issue. She indicated that a couple weeks prior there was an altercation between the two residents and that Resident #1 had alleged that Resident #2 had hit Resident #1 causing Resident #1's glasses to break. To her knowledge continued Staff A neither one of the two residents has had issues with other residents. In an interview conducted with Resident #1 on at 4:15 PM, the following was revealed. She reported that the first incident between her and Resident #2 happened because she noticed that her roommate was being taken advantage of. She said another resident is selling soda at the facility and the owner told her not to. Her roommate went to buy soda from her, she stopped her, and she took the money from her. Resident #2 came while she was telling the lady to stop selling soda and " me". Resident #1 said, I was standing in front of the lady's door when Resident #2 started to punch me. I turned around and told Resident #2 to stop. He left and went to stand by the gate. As I was heading to my room, I told Resident #2 if he ever touches me again, I will call the cop on him. Then, Resident #1 punched me in the ... and broke my glasses. Resident #1 said she reported the incident to Staff E, and she notified the Owner. The owner then called me and said not to call the police. I told her I will then file a restraining order against Resident #2. The Owner/Administrator told me that I could not do that in an ALF. So, I hung up the phone and called the police. When the owner returned to the facility, I told her that I had called the police, she told me to move	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910753	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/30/2019
NAME OF PROVIDER OR SUPPLIER WINDSOR PLACE RETIREMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1850 NE 26TH STREET WILTON MANORS, FL 33305		
(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 030	Continued From page 10 upstairs or move out. Review of Resident #1 health assessment (AHCA form 1823) revealed the following diagnoses: _____ and history of _____. Resident #1 has poor judgement and requires daily oversight of her whereabouts. Review of the Police report dated _____ (the date of the incident) revealed that Resident #2 admitted having hit Resident #1 with a water bottle only after Resident #1 has been verbally _____ to him. The report indicated that Resident #2 informed the police that he acted in self-defense because he was afraid that Resident #1 was going to hit him. However, given the mental status of both residents and no witnesses, the police noted that a misdemeanor case to both parties was issued. Meanwhile, because Resident #1 realized that Resident #2 was not going to be _____, she requested ambulance to go to the hospital as per the police report. In addition, it was indicated in the report that Resident #1's claimed injury from this incident was contradicted by staff who reported that the injury on Resident #1's _____ was not caused by the incident and that, it was an old injury. Review of the Hospital records dated _____ revealed a negative assessment related to and _____. The report indicates that the resident had a history of _____ to the left temple region of the _____ in _____. During an interview with Resident #3 on _____ at 10:05 AM, she reported that she has resided at the facility for nearly 8 years. She acknowledged that she once had an altercation with Resident #2. She reported that she was going out about 8 months ago. As she	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910753	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/30/2019
NAME OF PROVIDER OR SUPPLIER WINDSOR PLACE RETIREMENT HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1850 NE 26TH STREET WILTON MANORS, FL 33305		
(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 030	Continued From page 11 approached the fence Resident #2 pushed her away and said, "I will get the fence opened for you, I am in charge of it". However, she added that Resident #2 has no longer acted that way against her since. Resident #3 also reported that Resident #1 was the initiator of the altercation that occurred on During an interview with Resident #4 on at 10:05 AM, he reported that Resident #2 is very violent. Resident #4 said that Resident #2 entered their rooms at 5:30 AM on day to wake another resident up for breakfast. When he told Resident #2 to get out and that he will take care of the other resident who has severe mental challenges. Resident #2 reposted and said, "Don't tell me what to do" and Resident #3 with a flash light. Resident #3 said that the Administration does not take their claim seriously when it comes to Resident #2. Resident #3 said that he therefore did not report the incident to them. Lastly, during a follow-up interview with the Administrator on at 1:32 PM, she reported that when the police came to the facility to investigate the incidents, she was not present at the facility. She also confirmed that Resident #2 does patrol the facility at night with a flashlight and believes that he is a security guard. Above all, the Administrator provided no evidence that a thorough investigation was ever conducted to determine the foundation of the incidents and to implement protective measures to ensure that both Resident #1 and Resident #2, and all other residents feel safe. Class III	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910753	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/30/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WINDSOR PLACE RETIREMENT HOME

**1850 NE 26TH STREET
WILTON MANORS, FL 33305**

(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 079 SS=D	Continued From page 12 59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: <table border="0"> <tr> <td>Number of Residents, Day Care Participants, and Respite Care Residents</td> <td>Staff Hours/Week</td> </tr> <tr> <td>0-5</td> <td>168</td> </tr> <tr> <td>6-15</td> <td>212</td> </tr> <tr> <td>16-25</td> <td>253</td> </tr> <tr> <td>26-35</td> <td>294</td> </tr> <tr> <td>36-45</td> <td>335</td> </tr> <tr> <td>46-55</td> <td>375</td> </tr> <tr> <td>56-65</td> <td>416</td> </tr> <tr> <td>66-75</td> <td>457</td> </tr> <tr> <td>76-85</td> <td>498</td> </tr> <tr> <td>86-95</td> <td>539</td> </tr> </table> For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there	Number of Residents, Day Care Participants, and Respite Care Residents	Staff Hours/Week	0-5	168	6-15	212	16-25	253	26-35	294	36-45	335	46-55	375	56-65	416	66-75	457	76-85	498	86-95	539	A 079 A 079		
Number of Residents, Day Care Participants, and Respite Care Residents	Staff Hours/Week																									
0-5	168																									
6-15	212																									
16-25	253																									
26-35	294																									
36-45	335																									
46-55	375																									
56-65	416																									
66-75	457																									
76-85	498																									
86-95	539																									

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910753	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/30/2019
NAME OF PROVIDER OR SUPPLIER WINDSOR PLACE RETIREMENT HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1850 NE 26TH STREET WILTON MANORS, FL 33305		
(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 079	Continued From page 13 must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and () and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least () must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in	A 079		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910753	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/30/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WINDSOR PLACE RETIREMENT HOME

**1850 NE 26TH STREET
WILTON MANORS, FL 33305**

(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 079	Continued From page 14 meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the	A 079		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910753	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/30/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WINDSOR PLACE RETIREMENT HOME

**1850 NE 26TH STREET
WILTON MANORS, FL 33305**

(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 079	Continued From page 15 minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on records review and interviews, the facility failed to provide an accurate staffing schedule that reflected its 24-hour staffing pattern. The findings included: Review of the staffing schedule on _____ indicated that Staff A, a licensed practical nurse (LPN) works at the facility from 11 PM to 7 AM every day except on Sunday, when she works 6	A 079		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910753	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/30/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WINDSOR PLACE RETIREMENT HOME

**1850 NE 26TH STREET
WILTON MANORS, FL 33305**

(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 079	Continued From page 16 AM to 7 PM, Saturday 6 AM to 11 PM and off on Friday. During an interview conducted with Staff A, on _____ at 11:41 AM, she reported that she has been working at this facility for 10 years. She usually works from 6:00 AM to 6 PM. She also reported that she worked from 6:00 AM to 6:00 PM on _____; whereas the schedule indicated that she worked from 11 PM to 7 AM. In an interview conducted with Staff B, a certified nursing assistant on _____ at 11:48 AM, she reported that she has been working at this facility for 22 years. She said that she resides at the facility, but her schedule is from 6 AM to 6 PM. She said that she did not work yesterday which was _____. That was her day off. Review of the staffing schedule revealed that Staff B works Monday through Saturday from 7 AM to 11 PM and is off on Saturday and Sunday. The schedule indicated meanwhile that Employee B worked on _____ the day she said that she was off. During a follow up interview with the Administrator on _____ at 1:32 PM, she acknowledged the findings and stated that she made an error in the schedule. However, review of the last six months of schedules showed no deviations in the employees working schedule pattern. Class III	A 079		