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
	AL11969020	A. BUILDING: _____ B. WING _____	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDERMERE MEMORY CARE INC	7901 KIPLING ST 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 complaint survey for complaint numbers 2023011575 and 2023003700 was conducted from to at Windermere Memory Care Inc in Pensacola, FL. At the time of the survey, deficiencies were identified.	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969020	A. BUILDING: _____ B. WING _____	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDERMERE MEMORY CARE INC	7901 KIPLING ST 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 025	Continued From page 1 (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide care and services appropriate to resident needs for 2 of 4 sampled residents at the facility. (Residents #1 and #2) The findings include: Resident #1 On at approximately 3:30 PM, an interview was conducted with the Facility Administrator (FA) regarding Resident #1. She	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969020	A. BUILDING: _____ B. WING _____	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDERMERE MEMORY CARE INC	7901 KIPLING ST 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 025	Continued From page 2 explained that Resident #1's husband took her to the orthopedist for the treatment of a bone. The FA was unable to explain what bone was or what treatment Resident #1 received at the orthopedist . She mentioned that the facility staff thought the resident was going to have orthopedic surgery but Resident #1 returned to the facility with husband later in the day on with a brace in place. The FA indicated that Resident #1 returned with some sort of brace or sling in place along with order for , but no other care instructions. The surveyor asked if the brace was a immobilizer. The FA indicated that she was not sure what kind of brace it was. The FA further explained that Resident #1 was good at taking things apart and she was unsure if the brace had all the necessary pieces. The surveyor asked if there were any other instructions provided for monitoring, care, or , management, after fixation of the . The FA explained that, other than a sheet and an order for , the facility had no further information. She explained that they considered giving a discharge notice to the Resident's husband because they had ongoing troubles getting information after he took her to medical . The FA was asked if there were attempts to contact the orthopedist or any medical provider for aftercare instructions. She indicated that no one from the facility attempted to contact the resident's husband, the orthopedist, or any medical provider to obtain follow up instructions after Resident #1 her . The FA was asked to provide the most recent 1823 and all documentation and incident reports regarding Resident #1's treatment for a on and documentation regarding	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969020	A. BUILDING: _____ B. WING _____	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDERMERE MEMORY CARE INC	7901 KIPLING ST 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 025	Continued From page 3 emergency treatment that occurred when she collapsed at the facility on . The FA provided a copy of an encounter from . The form had a contact phone number and address on it. The form indicated that Resident #1 had received treatment of a displaced of the lateral end of the right . The form was electronically signed by the resident's Advanced Practice Registered Nurse (APRN). There was also a referral for a Physical , to evaluate and treat for range of motion (ROM) of the right and , as tolerated, times a week for 4 weeks. Resident #2 On , an interview was conducted with Staff Member C, a Medication Technician. She explained that Resident #2 was able to walk when she first arrived at the facility but eventually needed a wheelchair. She currently needs with showers and often requires 2 staff members to help the resident bathe. The resident also has significant behaviors. The resident has kicked, hit, and bitten the staff during care. At times, she would throw herself on the floor. The surveyor asked if the resident needed extra help because her level of functioning declined or because of her behaviors. Staff Member C explained it took two staff to assist because her general condition and level of functioning declined and because of her behaviors. The surveyor asked if Resident #2's needs for assistance with bathing and locomotion were being met in the assisted living setting. Staff Member C said, "I do not think she belonged here after she declined." Staff member C explained that Resident #2 probably needed a higher level of care. She was hard to assist with bathing and mobility and probably needed more services than	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969020	A. BUILDING: _____ B. WING _____	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDERMERE MEMORY CARE INC	7901 KIPLING ST 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 025	Continued From page 4 the facility could provide. On [redacted], an interview was conducted with Staff Member A, a Patient Care Technician. She was asked to explain the assistance Resident #2 required with locomotion and bathing. Staff Member A explained that Resident #2 could walk short distances and utilized a wheelchair to get around. For bathing, she would sit in a shower chair while staff members bathed her. Staff members helped her get dressed as well. A review of notes for Resident #2 was conducted. The facility provided an 1823 dated and signed by the resident's Advanced Practice Registered Nurse (APRN). The form indicated that Resident #2 was independent in ambulation, [redacted], grooming and transferring. A review of the Resident Observation Logs revealed, on , that Resident#2's walking declined. Home health care was ordered. An entry written on indicated Resident #2 had been discharged from home health services. The note indicated that the resident needed to restart [redacted] services again due to a decline in walking. On , a note indicated that the med tech informed Resident #2's representative that she had a cut during a visit but the resident's representative refused to send her out to the emergency room. A note entered on stated that the facility had increased checks for Resident #2 from every 2 hours to every hour on overnight shift. A progress note entered on explained that Resident #2 was refusing to use her walker to walk. The note also mentioned that a request for care of a [redacted] on the residents [redacted] was faxed. On [redacted], an interview was conducted with the Facility Administrator (FA). She was asked about	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969020	A. BUILDING: _____ B. WING _____	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDERMERE MEMORY CARE INC	7901 KIPLING ST 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 025	Continued From page 5 the resident's decline in mobility, wheelchair use, and requirement for 2 staff members to assist with bathing. The FA explained that the resident did have a decline in mobility after admission. She was receiving , , , , via home health services for assistance with walking. She explained that staff at the facility had troubles with the resident refusing assistance with Activities of Daily Living (ADL) care. They had contacted the resident's son regarding the refusals to bathe to no avail. The FA explained that the facility had several meetings about getting Resident #2 sent to another type of facility. When the FA was asked about the on the resident's , the FA explained that the resident was in a wheelchair when she scraped her . The FA was shown the facility note dated that stated the resident had a cut. The note indicated that the resident's representative refused to send the resident out for treatment. The FA was asked to explain how the facility obtained treatment of the cut. The FA explained that they could not send Resident #2 for treatment because the resident's representative refused. The FA provided no documentation of treatment for the cut. No documentation was provided that anyone at the facility made a second attempt to follow up with the POA. There was no documentation provided that anyone at the facility sought evaluation from the facility medical provider. During this same interview, the surveyor asked if the facility had gotten the 1823 updated to accurately reflect Resident #2's decline in functioning. The FA explained that they requested an updated 1823 on but the facility APRN was out on leave for 2 -3 weeks. The administrator was asked if they contacted Resident #2's medical provider for an	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969020	A. BUILDING: _____ B. WING _____	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDERMERE MEMORY CARE INC	7901 KIPLING ST 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 025	Continued From page 6 updated 1823. The Administrator was also asked if the facility had a backup medical provider covering for the [redacted] APRN. The FA indicated that they made no attempt to contact another medical provider for an updated 1823. Class III	A 025		
A 075	429.255( ) FS Use of Personnel; Emergency Care ( ) (3)(a) An assisted living facility licensed under this part with 17 or more beds shall have on the premises at all times a functioning automated external defibrillator as defined in s. 768.1325(2)(b). (b) The facility is encouraged to register the location of each automated external defibrillator with a local emergency medical services medical director. (c) The provisions of ss. 768.13 and 768.1325 apply to automated external defibrillators within the facility. (4) Facility staff may withhold or withdraw [redacted] or the use of an automated external defibrillator if presented with an order not to [redacted] executed pursuant to s. 401.45. The agency shall adopt rules providing for the implementation of such orders. Facility staff and facilities may not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing [redacted] or use of an automated external defibrillator pursuant to such an order and rules adopted by the agency. The absence of an order not to [redacted] executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing	A 075		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969020	A. BUILDING: _____ B. WING _____	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDERMERE MEMORY CARE INC	7901 KIPLING ST 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 075	Continued From page 7 or use of an automated external defibrillator as otherwise permitted by law. (5) The agency may adopt rules to implement the provisions of this section relating to use of an automated external defibrillator. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to make available and implement the use of the Automated External Defibrillator ( ) during the provision of for 1 of 1 residents who received ( ) at the facility. (Resident #1) The findings include: On at approximately 10:40 AM, an interview was conducted with Staff Member A, a Patient Care Technician (PC). She was asked to describe what occurred on when Resident #1 was found unresponsive and required at the facility. She explained that Staff Member B, another PC, found the resident laying outside on the grass. Staff Member B called for help. When Staff Member A arrived, Staff Member B had initiated . Staff Member B was not certified to provide , so Staff A took over the provision of . Staff Member C, a Medication Technician, called 911. When the ambulance arrived, they took over . The surveyor asked if staff from the facility utilized the defibrillator during provision of . Staff Member A explained that no one at the facility remembered to get the for utilization during the provision of . She explained that Emergency Medical Services ( ) applied a defibrillator immediately upon arrival and that the resident received shocks via the defibrillator. Staff Member A was asked if she	A 075		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969020	A. BUILDING: _____ B. WING _____	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDERMERE MEMORY CARE INC	7901 KIPLING ST 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 075	Continued From page 8 was . certified. She indicated that she had a current certification. She was asked if she was trained during . training to utilize an . . . She explained that she was trained to apply and use the . Staff Member A explained that the medication technician would normally bring the . . . out because it was kept locked up in the medication room. She explained that Staff Member C notified . . but did not bring the . . . and no one else at the facility remembered to ask for or utilize the . . . . On . . . . . at approximately 11:30 AM, an interview was conducted with Staff Member C, a Medication Technician. She was asked to describe what occurred when Resident #1 required . at the facility on . . . . . She explained that Staff Member B found the resident and called Staff Member A for help. Staff Member A took over because she was certified. She explained that she was the med technician the day that Resident #1 required . She did not see the resident until after . . arrived. She explained none of the staff working at the facility that day remembered to get or utilize the . . . . . during the provision of to Resident #1. The surveyor asked Staff Member C if she was certified to provide and if the training included use of the . . . Staff Member C indicated that she was certified to provide and the certification training had included use of the . Staff Member C was asked to unlock the medication room and accompany the surveyor to observe the defibrillator. The defibrillator was locked in the medication room on a shelf in the corner. The machine was functioning with pads attached and a green light indicating it was ready for use. On at approximately 1:30 PM, an	A 075		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969020	A. BUILDING: _____ B. WING _____	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDERMERE MEMORY CARE INC	7901 KIPLING ST 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 075	Continued From page 9 interview was conducted with Staff Member B, another PC. She explained that she found Resident #1 unresponsive on the ground. She called Staff Member A to help. Staff Member A took over CPR when she arrived. She explained that she went to get Staff Member C and Staff Member C called the ambulance. Staff Member B said, "When EMS arrived, they shocked her a couple of times and gave her medicine to try to get her heart going." She explained that, after doing CPR for awhile, EMS discontinued CPR and pronounced Resident #1 as expired. On 10/04/2023, an interview was conducted with the Facility Administrator (FA). The FA confirmed that the defibrillator is kept locked up in the medication room. Additionally, she confirmed that the facility's defibrillator was not utilized by facility staff during the provision of CPR to Resident #1 on 09/20/2023. She explained that they had provided training regarding defibrillator use during provision of CPR at previous staff meetings both before and after 09/20/2023. The FA was asked to provide copies of training regarding defibrillator use, a copy of the facility policy for the provision of CPR, defibrillator use and emergency response, along with copies of CPR cards for staff members A, B, C, D, E, F, G, H, I and J. On 10/04/2023, a review of the CPR sheet for Resident #1 was conducted. The CPR sheet indicated that the resident wished to have [illegible] On 10/04/2023, a review was conducted of the facility training regarding defibrillator use. The FA provided a copy of a training roster sign in sheets from 08/01/2023, 08/02/2023, and 08/03/2023. Each of the training roster sign in sheets had CPR written in as a topic. Defibrillator use was not written in	A 075		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969020	A. BUILDING: _____ B. WING _____	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDERMERE MEMORY CARE INC	7901 KIPLING ST 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 075	Continued From page 10 anywhere on the training roster sign in sheets or mentioned as a topic on any of the training sheets. There was no curriculum or minutes attached to any of the training sheets. The FA provided a copy of the facility's Advance Directive and . . . . . Policy and Procedure. The policy contained no information regarding provision of . . . or use of the defibrillator use during the administration of . There were no other policies or staff training provided during the survey. Review of certification cards revealed that Staff Member A had received Adult First Aid, , and certification by American Safety and Health Institute on . . . . . Staff Member C had received Adult First Aid, , and certification by American Safety and Health Institute on . Class III	A 075		