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
	AL11967710	A. BUILDING: _____ B. WING _____	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR AT CAPE CORAL	831 SANTA BARBARA BLVD CAPE CORAL, FL 33991

(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 investigation for #2024011654, #2025000418, #2025009929 and an emergency power plan monitoring survey was conducted at The Windsor at Cape Coral on Complaint #2024011654 was not substantiated. Complaint #2025000418 was substantiated at A032. Complaint #2025009929 was not substantiated. Deficiencies were identified at the time of the survey.	A 000		
A 032	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response	A 032		

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A 032	Continued From page 1 policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement	A 032		

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A 032	Continued From page 2 drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record review, observation, and interviews, the facility failed to make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that included their name, the facility's name, address, and telephone number for 2 (Resident # 2 and #13) of 2 residents determined at risk for elopement. The facility failed to ensure all direct care staff and administrators participate in a minimum of two elopement drills a year, and document participation in the drills, which must include a review of the facility's procedures to address resident elopement pursuant to Section 429.41(1)(k), F.S. The findings included: Review of employee list provided by the facility listed 55 employees worked in the facility. 35 were direct care staff. On review of documentation of elopement drills conducted by the facility revealed: An elopement drill was conducted on 12:45 p.m. a total of 6 staff participated. An elopement drill was conducted on at 5:00 a.m. A total of 6 staff participated. An elopement drill was conducted on at 3:15 p.m. A total of 8 staff participated. A total of 8 staff out of 35 direct care staff participated in the drills provided.	A 032		

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A 032	Continued From page 3 On review of the facility policy -0050P Elopement or Missing Resident, does not contain the requirement that at risk residents have identification on their persons that included their name, the facility's name, address, and telephone number. On at 2:00 p.m. during a phone interview, the Executive Director said, "We have done the elopement drills for 2025. The Health Care Director does the Elopement Drills. They quit 2 weeks ago. I am getting them from our corporate office and will email them to you." No evidence of elopement drills conducted for 2025 was provided by the facility. On during observation of the memory care unit, Resident #2 was observed walking around the common area. Resident #2 did not have any identification (ID) on her person that included her name, the facility name, address and telephone number. Resident #13 was observed sitting in a wheelchair in the memory unit common area. Resident #13 did not have identification on his person which included his name, the facility name, address and telephone number. On at 3:08 p.m. during a phone interview the Executive Director said, " We tried ID they didn't work. They find different ways to take them off. They didn't keep them on. They wear a pendant that will call the facility. It only works in the facility." On at 9:48 a.m., During an interview Staff H (Licensed Practical Nurse (LPN) said, "We don't do IDs on the residents."	A 032		

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A 032	Continued From page 4 On at 9:40 a.m., during an interview Staff A(caregiver) said, "None of the residents have ID bracelets on. They have markers on the door to their rooms. We don't do that here." On at 10:48 a.m., during an interview Staff B (caregiver) said, "The residents don't have any identification on them. They have it in their room" Class III .	A 032		