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 _____	10/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR OF CAPE CORAL	831 SANTA BARBARA RD 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 This is the report for Complaint survey CCR #2012011212 conducted at Windsor of Cape Coral, an Assisted Living Facility on [redacted] through [redacted]. The complaint contained 3 allegations, one of which was confirmed and resulted in a deficiency at A028. This complaint was conducted in conjunction with 2 follow up surveys and a Change of Ownership (CHOW) survey.	A 000		
A 028	58A-5.0182(4) FAC Resident Care - Activities of Daily Living (4) ACTIVITIES OF DAILY LIVING. Facilities shall offer supervision of or assistance with activities of daily living as needed by each resident. Residents shall be encouraged to be as independent as possible in performing ADLs. This Statute or Rule is not met as evidenced by: Based on a review of resident records and interview with administrative staff, the facility failed to ensure Activities of Daily Living care was provided to 2 (Residents #9 and #10) of 10 residents per their needs The findings include: 1. During the tour on [redacted] at approximately 10:00 a.m., Resident #9 was identified by the caretaker present in the [redacted] being [redacted]. The Caretaker indicated she is present with the resident for approximately 10 hours per day, but she leaves after supper. The facility must assist the resident with showering in the evening on those days the resident gets a shower, and	A 028		

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A 028	Continued From page 1 assisting with clothing removal, dressing for bed, and help with getting into bed. The caretaker indicated the resident is not always getting the shower. A review of the documentation for evening care for this resident revealed for the month of ..... for 29 possible times for care, the resident received care 11 times. This was confirmed with clinical staff on ..... at 1:00 p.m. 2. Resident #10 was interviewed on ..... The resident demonstrated a limited range of motion to the right should during the interview. The resident further indicated difficulty getting dressed in the morning and an inability to put undergarments on without much difficulty. During an interview on ..... at 1:30 p.m. the aide caring for this resident indicated she does not help this resident as she can do this herself. However, the aide did admit the resident had limited motion and probably did need help with dressing. The director of clinical services indicated she had helped this resident one time with the undergarments the resident could not apply without assistance. Review of the service delivery record for ..... for this resident revealed out of 30 potential times there was only 1 documentation indicating the resident had received assistance. Class III Correction Date:	A 028		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

2012

Administrator
Windsor of Cape Coral
831 Santa Barbara Road
Cape Coral, Florida 33991

Dear Administrator:

Re: CCR #2012011212

This letter reports the findings of a complaint survey that was conducted on , 2012 by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct the deficiency within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after 2012 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call this office at 239-335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

HW:ss
Enclosure: State Form
XG90

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