

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967748	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER WINDSOR OF VENICE			STREET ADDRESS, CITY, STATE, ZIP CODE 600 CENTER RD VENICE, FL 34292		
(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 These are the results of Complaint survey, CCR #2012013065, conducted on _____ at Windsor of Venice, An Assisted Living Facility. The complaint contained three allegations, one of which was substantiated.	A 000			
A 025	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, 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 individual. (c) 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; contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in	A 025			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0899

Z5S111

If continuation sheet 1 of 4

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A 025	Continued From page 1 the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to arrange the appropriate health care and service in a timely manner after recognizing 1 (Resident #2) of 3 residents reviewed had a health care need. The findings include: 1. A review of Resident #2's incident report (IR) revealed Resident #2 had an un-witnessed fall on the floor and was discovered on the floor at 11:30 p.m. The (IR) states, "[Resident #2] found on the floor next to bed. The (IR) reveals Resident #2's vitals were not taken until 6:30 a.m., on Resident #2 was not sent to the hospital until 9:30 a.m., on (10 hours after he was discovered on the floor). A review of Resident #2's Resident Notes confirmed the resident was not assessed until at 6:30 a.m., and revealed [Resident #2] after his . . . An entry in the Resident Notes (dated at 6:30 a.m.) states, "Received reports that resident was observed lying on floor next to bed last night and had on [right] knee, first aid was performed. Also received a report that resident has x2. This nurse evaluated resident. Vitals: Pulse 62, BS 232. Noted large bruise [right] arm/elbow area [no] complaints of discomfort but has some grimacing of face when moved." Further review revealed an entry in the Resident Notes made at 9:30 a.m., which states, "Resident's wife in facility encouraged wife to take [Resident #2 to] ER for eval R/T Vomiting, weakness, recent fall/ . . . Jent's	A 025			

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A 025	Continued From page 2 wife transported resident in personal vehicle to [a hospital]." There was no documentation in the chart as to what observations of the resident were made between 11:30 p.m. and 6:00 a.m. A review of Resident #2's the emergency (ER) notes confirms the facility became aware of the resident's condition. On the ER physician wrote, "I called the [the facility] at 1300 and spoke to the nurse, she explained that [Resident #2] was found at the side of his bed during rounds and was helped back into bed and had some of the scrapes dressed, head injury was not noticed at the time. A while later [Resident #2] two times (the CNA called it dark was then evaluated by the nurse this a.m. and sent to ER." 2. On at 1:16 p.m., an interview was conducted with Staff A. Staff A admitted Resident #2 before she arrived to the facility at 6:00 a.m., and confirmed he was not sent to the hospital until after Resident #2's wife arrived at approximately 9:30 a.m. (at least 3 hours after the resident. Staff A stated, "I just felt (Staff A paused) I just recommended that he should probably go [to the hospital]. He wasn't continuously when I was there he hadn't had any changes. She states she recommended Resident #2's wife take Resident #2 to the hospital. "Just because he had a ... and it was un-witnessed and we're not sure if he had hit his head." In regards to when Resident #2, Staff A stated, "I believe the overnight med tech told me [Resident #2] because I got there at 6:00 a.m. in the morning. After I evaluated him he seemed to fine." Staff A did not give a reason why Resident #2 was not sent to the hospital after his or after he was discovered to have twice.		A 025		

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A 025	Continued From page 3 3. On _____ at approximately 2:40 p.m., the Healthcare Coordinator was interviewed. She stated she was under the impression Resident #2 did not _____ until right before Staff A arrived at the facility (6:00 a.m.). She went on to say, "They called me at 11:30 p.m., to let me know that [Resident #2] had an _____ on his knees. They checked him all over so I said they didn't need to send him out, to just keep a close eye on him and if anything showed up or he had any complaints to let me know. At 6:00 a.m., I had them tell Staff A when she got here. She checked him over and all she found was the _____ on his knee and then he started _____ is that what it was?" The Healthcare Coordinator did not offer any explanations as to why the resident was not sent to the hospital after he immediately was discovered to have _____ Class III	A 025			



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Windsor of Venice
600 Center Road
Venice, Florida 34292

Dear Administrator:

Re: CCR #2012013065

This letter reports the findings of a complaint survey that was conducted on 2012 by a representative 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 these deficiencies 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 2013 to verify that the necessary corrections are in place to correct the deficiency 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. 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

