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
	AL11910760	A. BUILDING: _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	411 HAMILTON CRESCENT CLEARWATER, FL 33756

(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 Assisted Living Facility A second revisit to a complaint survey, CCR# 2013000803, was conducted on . The Windsor House, assisted living facility, had deficiencies found at the time of the visit.	{A 000}		
{A 030}	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (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 Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. (b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for 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 address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with , 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456. (d) The statewide toll-free telephone number of	{A 030}		

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
	AL11910760	A. BUILDING: _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	411 HAMILTON CRESCENT CLEARWATER, FL 33756

(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 the Florida ..... Hotline " 1(800)96- ..... or 1(800)962-2873 " shall be posted in full view in a common area accessible to all residents. (e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility ' s policies with respect to such issues, for example, as resident responsibilities, the facility ' s ..... and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements. (f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law. (g) The facility shall 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 shall not prohibit 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 shall be, at a minimum, an accessible telephone on each floor of each building where residents reside. (h) Pursuant to Section 429.41, F.S., the use of physical ..... shall be limited to half-bed rails, and only upon the written order of the resident ' s physician, who shall review the order biannually, and the consent of the resident or the	{A 030}		

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
	AL11910760	A. BUILDING: _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	411 HAMILTON CRESCENT CLEARWATER, FL 33756

(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	{A 030}		

resident ' s representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be 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 achieve the highest possible level of independence, autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident ' s representative, designee, surrogate, guardian, or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910760	A. BUILDING: _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	411 HAMILTON CRESCENT CLEARWATER, FL 33756

(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	{A 030}		

attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a 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) Access to adequate and appropriate health care 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 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.
(l) 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

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
	AL11910760	A. BUILDING: _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	411 HAMILTON CRESCENT CLEARWATER, FL 33756

(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 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. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to protect the rights of 11 of 14 sampled residents (Residents #1-4, 7-9 and #11-14), especially the right to live in a safe and decent living environment, free from neglect. Specifically, the facility failed to take necessary action to address an ongoing infestation of bedbugs at the facility, causing multiple residents to live in bedbug infested for several weeks, with the knowledge of facility staff. As a result, multiple residents required medical attention for bedbug bites. Findings include: During a tour of the facility conducted on with staff from the local county health department, the following was observed: In , on the second floor of the facility, where Resident #2 resided, a live bug was observed crawling on the wall next to the bed. Multiple stains, dark trails and bugs were observed on pieces of cardboard lying on the floor. The health department representative confirmed that the bugs observed (both live and) were bedbugs. was also observed to be very cluttered with clothing scattered on both beds and cardboard boxes on the furniture and the floor. Also on the second floor, in (belonging	{A 030}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910760	A. BUILDING: _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	411 HAMILTON CRESCENT CLEARWATER, FL 33756

(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	{A 030}		

to residents #1 and #3), a live bedbug was observed crawling on the wall by the nightstand near Resident #1's bed. Multiple brown trails were observed along the baseboards behind both beds and the representative from the health department confirmed that the trails were indicative of bedbug activity. There were large plastic bags containing multiple personal items belonging to both residents stored under the beds in .

In on the first floor of the facility (belonging to residents #7 and #8), multiple trails were observed on the wall behind both beds and a stain was observed on the bed used by resident #7.

In , also on the first floor, stains were observed on the pillow case on the bed used by resident #4. When the bed was moved away from the wall, multiple bedbugs were observed crawling on the wall and the baseboard directly behind the bed. bugs and trails were also observed along the windowsill.

During a confidential interview conducted on that same date at approximately 9:25 a.m., Resident #7 stated that she believed her ( ) still had bedbugs and that she was still being bitten. Resident #3 said she had a scab on her leg that she believed was the result of constant itching/scratching. Resident #3 was also observed to have bites on her arms and photos were taken.

On that same date at approximately 10:10 a.m., an interview was conducted with Resident #4. Resident #4 stated that his still infested with bedbugs. Resident #4 stated, "I'm afraid to go to sleep because I keep being bitten." Resident #4 further stated, "My 's not messy, I keep it neat but I still have bugs and they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910760	A. BUILDING: _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	411 HAMILTON CRESCENT CLEARWATER, FL 33756

(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	{A 030}		

know that." Resident #4 was observed to have multiple bites up and down his arms. Photos were taken.

On that same date at approximately 10:20 a.m., a representative from the local county health department stated that the facility's current pest control plan was "obviously not effective" in addressing the current infestation since the facility has had bedbugs for at least three months. The health department representative also stated that the clutter and debris in multiple resident was likely contributing to the ongoing infestation.

During an interview conducted that same date at approximately 12:45 p.m., a representative from the facility's pest control company said that earlier in the treatment process, he had recommended tenting the facility to treat the bedbugs and the administrator had not wanted to use this process because it would have likely requiring paying other facilities to relocate the residents temporarily. The representative from the pest control company also stated that it was crucial to minimize the clutter and keep the resident clean and free of debris to control re-infestation. The representative from the pest control company also said that the pest control company must be notified immediately whenever there are signs of infestation in any of the and said he had not been told that multiple residents were still being bitten by bedbugs.

When interviewed on that same date at approximately 12:50 p.m., the administrator acknowledged the findings and said he had not initially wanted to use either tenting or a heat treatment to treat the bedbugs because he did not believe the facility could absorb the cost of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910760	A. BUILDING: _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	411 HAMILTON CRESCENT CLEARWATER, FL 33756

(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 relocating the residents. On that same date at approximately 3:50 PM, a representative from the local hospital was interviewed by telephone. The representative stated that Resident #12 was currently hospitalized at their facility and had visible bites on her. Resident #12 had reported bedbugs at this facility and had previously been treated at the same hospital for bedbug bites in . The hospital representative said Residents #13 and 14 had also been treated at the same hospital in 2013 and 2013 for bedbug bites. Class I	{A 030}		
A 152	58A-5.023(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to Section 429.28(1)(a), F.S.; and 2. Must be maintained free of hazards; and 3. Must ensure that all existing architectural, mechanical, electrical and structural systems and appurtenances are maintained in good working order. (b) Pursuant to Section 429.27, F.S., residents shall be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress a comfortable height to ensure easy access by the resident; 2. A closet or wardrobe space for hanging clothes;	A 152		

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
	AL11910760	A. BUILDING: _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	411 HAMILTON CRESCENT CLEARWATER, FL 33756

(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 152	Continued From page 8 3. A dresser, chest or other furniture designed for storage of personal effects; 4. A table, bedside lamp or floor lamp, and waste basket; and 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility shall be free of tears, stains and not be This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a safe living environment, free of hazards for 14 of 14 sampled residents. Specifically, the facility failed to address an ongoing infestation of bedbugs at the facility, causing multiple residents to be bitten by bedbugs and to require medical treatment. The facility also failed to maintain the facility in a clean and sanitary manner based on the findings of the local county health department. Findings include: In , on the second floor of the facility, where Resident #2 resided, a live bug was observed crawling on the wall next to the bed. Multiple stains, dark trails and bugs were observed on pieces of cardboard lying on the floor. The health department representative	A 152		

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
	AL11910760	A. BUILDING: _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	411 HAMILTON CRESCENT CLEARWATER, FL 33756

(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 152	Continued From page 9	A 152		

confirmed that the bugs observed (both live and) were bedbugs. was also observed to be very cluttered with clothing scattered on both beds and cardboard boxes on the furniture and the floor. The also observed to have a thick layer of dust along the windowsill and on the piping in the .

Also on the second floor, in (belonging to residents #1 and #3), a live bedbug was observed crawling on the wall by the nightstand near Resident #1's bed. Multiple brown trails were observed along the baseboards behind both beds and the representative from the health department confirmed that the trails were indicative of bedbug activity. There were large plastic bags containing multiple personal items belonging to both residents stored under the beds in . The battery compartment for 's smoke detector was open and there was no battery inside.

In on the first floor of the facility (belonging to residents #7 and #8), multiple trails were observed on the wall behind both beds and a stain was observed on the bed used by resident #7. The overhead light in did not come on when the lightswitch or pull chain were used. The only operational light in the a lamp on the nightstand.

In , also on the first floor, stains were observed on the pillow case on the bed used by resident #4. When the bed was moved away from the wall, multiple bedbugs were observed crawling on the wall and the baseboard directly behind the bed. bugs and trails were also observed along the windowsill. The battery compartment for 's smoke detector was open and there was no battery

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910760	A. BUILDING: _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	411 HAMILTON CRESCENT CLEARWATER, FL 33756

(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 152	Continued From page 10	A 152		

inside.

On that same date at approximately 10:20 a.m., a representative from the local county health department stated that the facility's current pest control plan was "obviously not effective" in addressing the current infestation since the facility has had bedbugs for at least three months. The health department representative also stated that the clutter and debris in multiple resident was likely contributing to the ongoing infestation.

During an interview conducted that same date at approximately 12:45 p.m., a representative from the facility's pest control company said that earlier in the treatment process, he had recommended tenting the facility to treat the bedbugs and the administrator had not wanted to use this process because it would have likely requiring paying other facilities to relocate the residents temporarily. The representative from the pest control company also stated that it was crucial to minimize the clutter and keep the resident clean and free of debris to control re-infestation. The representative from the pest control company also said that the pest control company must be notified immediately whenever there are signs of infestation in any of the and said he had not been told that multiple residents were still being bitten by bedbugs.

When interviewed on that same date at approximately 12:50 p.m., the administrator acknowledged the findings and said he had not initially wanted to use either tenting or a heat treatment to treat the bedbugs because he did not believe the facility could absorb the cost of relocating the residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910760	A. BUILDING: _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	**411 HAMILTON CRESCENT CLEARWATER, FL 33756**

(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 152	Continued From page 11	A 152		

On that same date at approximately 3:50 p.m., a representative from the local hospital was interviewed by telephone. The representative stated that Resident #12 was currently hospitalized at their facility and had visible bites on her. Resident #12 had reported bedbugs at this facility and had previously been treated at the same hospital for bedbug bites in . The hospital representative said Residents #13 and 14 had also been treated at the same hospital in 2013 and 2013 for bedbug bites.

A report from the county health department dated notes the result of the inspection as unsatisfactory. The report indicates concerns with cleaning, lighting and infestation and states, in part: "Excessive dust build-up and debris accumulation was observed in the majority of and closets. Also, noted stained sheets and walls in some . Remove bugs and bug debris. " The report notes live bedbug infestation in seven and "complaints of problems with other in this facility by clients."

Class I

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Windsor House
411 Hamilton Crescent
Clearwater, FL 33756

Dear Administrator:

This letter reports the findings of a second state survey revisit that was conducted on , 2013, by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the uncorrected deficiencies that were 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. Both tags, A 030 & A 152 shall be corrected by . Staff from this office will conduct a review 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. Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State Form 3020

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone (727) 552-2000; Fax (727) 552-1161

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION
Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Boland-Cole Inc. d/b/a Windsor House
411 Hamilton Crest
Clearwater, FL 33756

Dear Administrator:

The Agency for Health Care Administration is imposing a directed plan of correction (DPOC). Windsor House agrees and accepts this DPOC. Should Windsor House fail to comply with the DPOC, submit an acceptable plan of correction, and/or achieve substantial compliance, the Agency for Health Care Administration may take administrative action including termination of it's Assisted Living license.

You are directed to perform the following:

1. All current residents will be relocated within 48 hours.
2. Resident's belongings/clothes that are taken with them when transferred, must be treated and be free of bed bug infestation to prevent additional spread of bedbugs to other facilities.
3. The entire facility must be tented and treated in the appropriate manner, with heat or a pesticide of the appropriate strength to kill/remove bed bugs.
4. The County Health Department must confirm, after treatment, the facility is free of bed bugs.
5. An approved plan of correction must be submitted to the Agency for Health Care Administration that outlines how the facility will monitor, on a daily basis, and maintain an environment free of bed bugs by , 2013.
6. The facility must develop a plan of correction that outlines how they will ensure residents admitted to the facility in the future do not bring bed bugs on to the premises by , 2013.
7. The facility shall not readmit any residents until documentation reflecting the facility is free of bed bugs has been obtained from the County Health Department and the plans of correction referenced herein have been received and approved by the Agency.

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone (727) 552-2000; Fax (727) 552-1162

8. The Agency for Health Care Administration shall issue written authorization to readmit any resident after review and approval of the above.
9. This DPOC ratifies and implements the agreement of the Parties in order to allow the Respondent an opportunity to promptly address conditions at the facility as identified by the Agency in its survey processes.
10. Should Windsor House violate this DPOC, the violation shall be deemed by the parties as a violation of a Moratorium on Admissions, and this DPOC shall operate as if the Agency had duly issued and served an Emergency Order of Immediate Moratorium on Admissions under the provisions of Florida law.

Thank you for the assistance provided to the surveyor(s). If you have questions, please contact Bronson Sievers, HFE Supervisor at (727) 552-2000.

Sincerely,

Patricia Reid Caufman
Field Office Manager

Accepted by:_____

Printed Name:_____

Title:_____

Dated:_____

PRC/brn