STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910374	02/19/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Windsor Court	3700 N. Flagler Dr West Palm Beach, FL 33406	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0025 - 429.26(7) Fs; 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G

Specific Tag Findings:

0000-Initial Comments
An unannounced licensure complaint survey, CCR #2015000922, was conducted on through and at Windsor Court. The facility had deficiencies found at the time of the visit.

0025-Resident Care - Supervision 429.26(7) FS; 58A-5.0182(1) FAC
Based on interview and record review, it was determined the assisted living facility failed to provide care and services appropriate to meet the needs of residents accepted for admission for one of three sampled residents reviewed (Resident #1). Specifically, the assisted living facility failed to initiate on an unresponsive resident (Resident #1) when no was located in the resident's record in the facility. The failure of the facility to perform in the absence of a places all residents (66 residents without a in place out of 80 total residents) at immediate risk of harm.

The findings include:

A review of the facility's policy entitled, "Policy Advance Directives Do No Orders indicates the staff will follow the wishes of our residents as it relates to Advance Directives and

Record review revealed Resident #1 was admitted to the facility on Review of Resident #1's Resident Health Assessment form (AHCA form 1823) dated documented diagnoses of lung ; and Nursing services, special precaution and behavioral needs noted as . Further review revealed the resident was independent with all Actitivities of Daily Living (ADLs).

Staff B stated during interview conducted on beginning at approximately 6:25 AM that Resident #1 "looked drunk" when he arrived after 12:00 AM (midnight) to the facility on (resident had left the facility for unspecified amount of time earlier that day and went to unknown locations). According to Staff B, Resident #1 upon his return to the facility went out to the patio and sat down. He was observed by staff and residents on the smoking patio of the facility in the early morning hours of She also stated that a resident came to get her and told her that he thought this resident had out on the patio on at approximately 4:45 AM. She stated she went to check on him and he was stiff and and had no pulse, so she did not do She stated she called 911 and when the police arrived they did until the ambulance arrived. She was asked if she was aware if Resident #1 had a she stated she did not know what that was. She was asked if she had received any trainings related to or since the incident involving Resident #1 on She denied having received any training after A review of the sign-in sheet

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provided by the Facility Manager on ___ for the staff training noted to have covered ___ and ___ conducted on , which was almost one month after this incident, had Staff B's name written in with a notation ___ forgot to have her sign".

Review of Resident #1's record indicated he had declined a ___ on ___ and that he had received the facility's policies and procedures related to ___. This record also contained documentation that Resident #1 had received a copy of his Assisted Living Facility Residents' Bill of Rights. This document noted residents have the right to be free from neglect and to be provided with adequate and appropriate health care consistent with established and recognized standards (i.e. ___ when a ___ has not be executed). This resident was noted to have signed his own admission documentation, including these above noted documents. His health assessment (1823 form), dated noted under or behavioral status the condition of This resident was not noted to have any ___ at the time of admission. Resident #1's MOR (Medication Observation Record) indicated the only medication this resident was currently prescribed to receive was ___ 150 milligrams (mg) at bedtime. This document for the month of ___ 2014 reflected he had refused this medication since ___ There was no documentation to reflect the facility had notified this resident's physician that he had been refusing this prescribed medication.

During interview with the Administrator and the Facility Manager, conducted on ___ beginning at approximately 12:30 PM, they were asked how frequently Resident #1 was believed to be intoxicated. The Facility Manager stated almost every day. She stated that Resident #1's case manager was notified and that this resident had been provided a 45 day notice on ___ indicating he needed to relocate related to his failure to follow facility rules (which included no drinking of . The Administrator and Facility Manager was asked if Resident #1's physician was ever notified of this resident's ___ use relative to the potential of side effects with his prescribed medication . The Administrator replied that Resident #1 was on a type of insurance plan that he never saw the same doctor, so the case manager was made aware of this resident's drinking of ___ A telephone call was placed, at this time, to this resident's case manager. She acknowledged that she was aware of this resident's ___ use but that she had not personally informed his physician, but that Resident #1 had informed his physician and was considering getting assistance for his ___ use. Record review failed to indicate any notification of aforementioned to Resident #1's physician.

Review of the facility's 15 Day Adverse Incident Report, submitted on , reflected Resident #1 was observed by Staff B on ___ at 1:00 AM sleeping on the patio. He was noted to be snoring and fast asleep. At 3:00 AM Staff B was noted to have observed Resident #1 and he was still sleeping. At approximately 4:45 AM on ___ a resident came to Staff B to inform her that he believed Resident #1 to be ___ Staff B was noted to have gone to the patio and found Resident #1 unresponsive and ___.

A review of the police Incident/Investigation Report, reflected the officers responded on ___ at 5:07 AM. This report indicated that {name of the city} Fire Rescue had declared Resident #1 ___ at 5:14 AM on ___. This officer noted in this report that he interviewed witnesses. Resident #4

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advised the officer that he had observed Resident #1 on at approximately 1:00 AM walking around the residence aimlessly and highly intoxicated. This resident was noted to have found Resident #1 unresponsive with skin that was and moist. Resident #5 was interviewed by the officer and was noted to have observed Resident #1 at approximately 3:30 AM on and that Resident #1 was highly intoxicated and outside on the patio smoking cigarettes "but was so drunk that he was barely able to speak". The reporting officer indicated Resident #1's searched for medications and drug paraphernalia but that nothing was found. Resident #1 was transferred from the facility to the Medical Examiner's office. Another officer's written report indicated that when he/she arrived that another officer was already on scene and attempting to Resident #1. This officer was noted to assist the first responding officer until medics arrived.

Class II

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Windsor Court
3700 N. Flagler Dr
West Palm Beach, FL 33406

RE: CCR #2015000922

Dear Administrator:

This letter reports the findings of a complaint survey, CCR #2015000922, survey conducted on , 2015 through , 2015 and 2015 by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **five business days** of receipt of this hand delivered report.

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0025 - 429.26(7) Fs; 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G

Directed Corrective Actions:

1. The Assisted Living Facility is required to audit the records of each facility resident and compile an accurate list of residents with (hereinafter Your facility must then designate locations for the list of residents and the residents' and implement a system for staff to identify whether a resident has a This information must be communicated to direct care staff and the information must be accessible during each shift. This must be completed within 5 calendar days from the date of this letter.

2. The Assisted Living Facility is required to have a written policy on steps to take in emergency situations, including sudden illness of a resident. Your facility is directed to review and revise any current policies regarding emergency procedures, and resident to ensure they are consistent and do not contradict each other. The emerger policy must include: Directions for staff on the initation of Pulonary (hereinafter unless a resident has a Directions on calling emergency personnel. Directions on what staff in charge are to be notified and who are responsible for follow-up.
   A plan for making all resident records (including medical records, medication records, resident emergency contacts and
   available to direct care staff and emergency personnel, including. The location of the list of residents and the location of the hard copies of resident This must be completed within 5 calendar days from the date of this letter.

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Windsor Court
2015

3. The Assisted Living Facility is required to train staff on the facility's emergency policies including, and policy and procedures after the policies are written/revised. A roster of these employees and written verification of the training and training materials must be available for AHCA staff to review. This must be completed within 5 calendar days from the date of this letter.

4. The Assisted Living Facility is required to obtain training from an outside, reputable source regarding honoring advance directives in an emergency situation. This training must be provided to your Administrator, Health and Wellness Director, and Wellness Nurse, and any other similar personnel. This training must then be provided to all staff. Documentation of training provided must be available for review by AHCA. The Administrator is responsible to ensure compliance. The curriculum and original certificates for this training must be retained by the facility in the employees' records and are to be available for review within 5 calendar days from the receipt of this letter.

5. The Assisted Living Facility is required to to provide training to all staff regarding maintaining accurate and thorough written resident records, including but not limited to training on updating records of any significant changes, any illnesses that resulted in medical attention, and other changes that resulted in the provision of additional services. The curriculum and original certificates for this training must be retained by the facility in the employees' records and are to be available for review within 5 calendar days from the receipt of this letter.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact Laura Manville, Survey and Certification Support Branch, at (727) 552-1955, or Tikel Wedges-Phoenix, Health Facility Evaluator Supervisor, (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

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