STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910374	07/12/2016
NAME OF PROVIDER OR SUPPLIER **WINDSOR COURT**	STREET ADDRESS, CITY, STATE, ZIP CODE **3700 N. FLAGLER DR** **WEST PALM BEACH, FL 33406**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

An unannounced licensure complaint survey, CCR# 2016007630, was conducted from 7/7/2016-7/12/2016 at Windsor Court Assisted Living Facility, License # 5943. The facility had deficiencies found at the time of the visit.

0008 Admissions - Health Assessment

Based on observation, interview and record, review the facility failed to properly complete the Resident Health Assessment, AHCA Form 1823, for 1 of 3 sampled residents,(Residents #1).

The findings include:

Record review of Resident #1 medical records,indicated the resident was admitted on . Review of the Resident Health Assessment Form dated on / / indicated that the resident had . Further review of the assessment form indicated that the resident was independent for ambulation and required supervision for toileting and transfers.

In an observation on at 7:30AM, Resident #1 was observed to ambulate with a walker for support. In an interview with a caregiver at that time, she stated that Resident #1 required the use of the walker for unsteady gait and to reduce risk.

Further review of Resident #1's assessment form indicated under the section listed as "nursing services, special precautions and elopement risk" was marked as non applicable for the resident. Review of the medical record indicated that Resident #1 had been receiving hospice services at home prior to her admission to the facility and that the resident had a history of wandering away from her home, when not supervised.

In an interview with the Administrator on at approximately 11:00 AM ,he reviewed the medical record and stated that he was aware that Resident #1 had a history of wandering but had not questioned the accuracy of the 1823 Health Assessment Form. He stated that the assessment form should be updated to reflect that Resident #1 is receiving hospice services and should demonstrate the extent of support the resident requires for her activities of daily living.

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Class III

0025 Resident Care - Supervision

Based on observation, interview and record review, the facility failed to provide care and services appropriate to meet the needs of the resident. This was evidenced by the failure to ensure the physical and well-being to 1 of 3 sampled residents, (Resident #1) who had with a known history of wandering which led to an elopement from the facility.

The findings include:

Review of Resident #1 ' s medical record indicated that the resident was admitted to the facility on with diagnoses of , upper extremity tremors, history of , knee pain, and . Review of the resident health assessment form dated / / indicated that the resident was independent for ambulation, and eating but required assistance with toileting, transfers, self- care, dressing and bathing. Review of the form indicated that the resident was not documented as requiring any special precautions, including elopement or risk and no nursing services. Further review of the facility census indicated that Resident #1 lived on the locked memory care unit located on the 2nd floor at the facility.

In an observation of Resident #1 on at 7:30AM, she was observed to ambulate with a walker from the facility elevator and escorted by facility staff member to the dining . The resident was alert and oriented to her name only. In an interview conducted at this time with Caregiver #2, she stated that Resident #1 required the use of her walker at all times due to her unsteady gait and history of . The caregiver stated that the resident lived on the memory care unit , had a prior history of wandering and required monitoring at all times.

In an additional observation of Resident #1 on at 8:20 AM, she was observed ambulating out of the dining the lobby area, where 8-10 other non-memory care residents were standing and sitting while waiting for their medications. Caregiver #C directed Resident #1 to go into the nurse ' s station to receive her daily medications but she did not follow the instruction initially and required the caregiver to physically direct the resident into the . The caregiver did not remain in the nurse ' s station with the resident.

Review of the facility 1- day AHCA Adverse Incident report dated on at 12:00 PM indicated that

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" staff were bringing several residents downstairs for lunch from the memory care unit via the elevator, to the dining room located on the first floor. " The report indicated that " Resident #1 exited the facility by the side door and staff was not aware that she was missing until all residents were seated in dining . When staff discovered that the resident was not at the lunch table, they began to search the building as the first step of the elopement policy. " The report indicated that a neighbor came to the building to alert staff that Resident #1 was outside and they went immediately to recover the resident and bring her back to building at around 12:15 PM. The report indicated that the neighbor had notified the police.

In a tour and observation conducted along with the Wellness Care Coordinator of the fire exit and stairwell leading outside to the street on at 7:35 AM, the fire exit door on the first floor south side was unlocked and had no alarm mechanism attached when opened by the surveyor. Further observations of the inside stairwell revealed 4 steps leading down to the ground level and to an outside fire door (see photographic evidence). The outside fire door had an alarm activation mechanism in place when opened per the Coordinator. Outside the fire exit door, a wrought iron gate was observed with a door which was secured with a piece of heavy gauge wire wrapped around the bars. The gate would have needed to be opened for Resident #1 to access the street. (See photos)
Observations were made of the fire exit leading to Flagler Street, a two- way street leading to an adjacent street which is located around the back of the facility and has no sidewalks. In an interview with the Administrator on at 10:00AM, he stated that the fire exit door alarm did not activate when Resident #1 exited the building. He stated that the fire door is not under any preventative maintenance agreement and he was not sure why the alarm did not activate properly on that day. He stated that he had personally checked the door and found it to be working properly after the elopement. He stated that if the fire door alarm had been activated, the facility staff would have been alerted about Resident#1 ' s elopement earlier.

Review of an incident report completed by the office manager dated on indicated that the facility staff were bringing residents down to the dining Resident #1 exited out the side door at 12:00PM. The report indicated that the resident ' s family member came to the facility around 12:10PM and inquired to staff where the resident was, since she was not in the dining he proceeded to go to the memory care unit to visit with the resident. The report further indicated that a man came to the facility at 12:14 PM to notify staff that a resident was outside and staff escorted the resident back to the facility at 12:15 PM.

Review of written statement from Caregiver #A on indicated that at lunch time on , she was escorting several residents to the elevator from the locked memory care unit and as she was assisting the residents in the elevator, one of the residents needed medical attention. The report indicated that the caregiver asked a housekeeping staff, who was present at the time to monitor the

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remaining residents. The residents were inside the elevator and the door closed, sending the residents down to the first level unaccompanied. The caregiver documented that she took the stairs down and went to the dining room only after she had cared for the ill resident and discovered that Resident #1 was missing. The report indicated that the caregiver informed her supervisor and began to look for the resident. Caregiver #A ' s report indicated that she observed a man, who came into the facility lobby and informed the staff that a resident was outside with a walker. The caregiver indicated that she along with Caregiver #B went outside, walked up the sidewalk and around behind the building, to find Resident #1 on the street. The report indicated that the police arrived and allowed the staff to bring Resident #1 back to the facility.

In an interview with Caregiver #A on at 4:15 PM, she stated that she worked the 7-3 pm shift daily on the memory care unit and was very familiar with Resident #1. Caregiver #A stated that all of the residents living on the memory care unit should have an identification (ID) on their body which included the residents name, facility name and telephone number. She indicated that on every shift the care staff are to check the ID and replace them if necessary. The caregiver stated that Resident #1 had a history of wandering, and required the use of a walker because she was unsteady, and unbalanced when attempting to ambulate without the walker. The caregiver stated that Resident #1 was more agitated on the morning of and kept stating she wanted " to go to find her son " . The Caregiver #A stated that around lunch time, she was escorting 4 memory care residents to the elevator on the 2nd floor, when one resident " became unwell and she was afraid he would so she escorted him back to the memory care unit " . She stated that before she could stop the elevator, the elevator door closed and the 3 other residents went down to 1st floor. She stated that she was caring for the ill resident and was unable to leave him alone. She stated that she was unaware that Resident #1 was missing until the dining noted the resident was missing at lunch. She stated she immediately started to search the building and a neighbor man came inside the facility to notify the staff that a resident was ambulating on the street. She stated that she and Caregiver #B went outside and found Resident#1 on the street " around back of the facility " . She stated that another staff drove the company car to pick up the resident. She stated that the police arrived when the staff were driving the resident back to the facility. She stated that she did not call the resident ' s physician and the resident ' s family member was already at the facility when the resident entered the facility with staff members. She stated that Resident #1 was not injured, but she was hot and her skin was reddened. Caregiver #A stated that she was puzzled how Resident #1 was able to push the heavy fire door open, go down 4 stairs in the stairwell with her walker, then open another fire door and exit to the street. The care giver stated that she could not recall if Resident #1 was wearing an ID bracelet on . Review of the resident ' s medical record indicated no facility documentation of ongoing resident monitoring or resident behaviors observed by the staff and any interventions implemented by staff was available for review.

In an observation of the facility video camera system, along with the facility office manager on

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at 1:00PM, the camera recording for 7/4/2016 showed Resident#1 exiting the elevator, behind 2 other residents at 11:50AM (the camera time stamp had not been adjusted for day light saving time, so it recorded as 10:50AM). The 2 residents were observed to walk straight, heading towards the dining , no staff was observed to meet or escort the residents. Resident #1 exited the elevator and made a sharp left turn, she did not hesitate and ambulated down the hallway towards the exit/ fire door. Resident #1was observed to push open the inside fire door and then move her walker into the stairwell. The fire door closed and no other camera images were available within the stairwell for review.
Further review of the camera image/ location within the facility showed at 12:10 PM, Caregivers #A and #B walked off the elevator with two residents and headed towards the dining . On another camera/ screen view, Resident #1 ' s family member was observed at 12:10PM to sign in at the front desk and walk to the dining for the resident. At 12:14 PM, the video camera screen showed a man walking into the facility lobby and speaking with a staff member. The camera screen at 12:15 PM showed several staff going taking the elevator to the 2nd floor searching for a resident. At 12:29 PM, the camera screen showed Resident#1 being wheeled into the nursing station by two caregivers. Review of the camera images with time stamps indicated that Resident #1 eloped from the facility on at 11:50 AM and was not identified as missing until 12:14 PM when caregivers were alerted that a resident was outside the facility. Review of the camera images indicated that Resident #1 had not been supervised and was at risk for injury for over 24 minutes during her elopement from the facility.

Review of the 2016 staffing schedule indicated that on there were 3 caregivers scheduled to work the 7am-3PM shift, along with a medication technician who worked 6:30AM-3:30PM. The schedule indicated that 2 employees were scheduled for housekeeping and 1 for laundry and 2 additional staff responsible for the kitchen and meal service only.

In an interview with the Wellness Care Coordinator on at 7:30AM, she stated that facility is staffed during the day shift 7-3:00PM with 4 caregivers. She stated that the memory care unit has 2 designated caregivers at all shifts and the other 2 caregivers are assigned for the remaining residents. The Coordinator stated that the 11 residents who are living on the 2nd floor memory care unit are escorted down to the 1st floor dining their meals. She stated that one caregiver stayed on the unit, while the other care giver escorted the residents in small groups to the dining all residents were brought downstairs. The Coordinator stated that since the elopement by Resident #1 on , the facility has assigned additional personnel to meet the residents when they travel downstairs to the 1st floor.

Review of staff training for elopement /missing resident policy and procedure indicated that " the administrator will conduct a preadmission evaluation regarding the risk potential for elopement to determine if resident is appropriate for facility. All staff will be made aware of the resident ' s needs and

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each resident will be provided identification with their name, facility name and phone number. Staff will monitor closely the residents who are identified as an " elopement risk " and will ensure daily that the resident is wearing their ID . After admission, if a resident is determined to be at risk for elopement, this information will be recorded on the 1823 resident health assessment form and the resident provided an ID ."

Review of " elopement sign-in sheet " indicated a space for the date/ name of resident #2/ name of resident #3 / ID present/ staff signature. Further review of this form indicated that Resident #2 and #3 were identified as an elopement risk and Caregiver #B had documented that she had checked the ID for the 2 residents. Further review of this form indicated that the ID were not checked daily as per policy. Resident #1 ' s name was not included on this list. During an interview with the Administrator on at 9:30AM, he reviewed the sheet and stated that he was unaware that the ID for the " at risk residents " were not being checked daily as per policy. He stated that when Caregiver #B was not scheduled to work, another care staff should be completing the log sheet. He stated that he was aware that on her admission, Resident #1 had a prior history of wandering from her home several times, which required police intervention, but he had not considered Resident #1 to be an elopement risk at the facility and he never questioned the admission assessment. He stated that since Resident #1 eloped on , she would be considered an elopement risk and would need an ID placed on her person at all times. He stated that all residents on memory care unit should have identification on their person and be monitored at all times.

In an interview with the hospice nurse on at 2:15 PM, she stated that Resident #1 had a diagnosis of and was alert to name only. The nurse stated that the resident was most of the time and was able to answer simple questions. She stated that the resident had expressed that she " wanted to leave the facility and to go look for her son " The nurse stated that the resident required the use of a walker since her gait was unsteady and she had history of . The nurse stated that she would consider the resident to be an elopement risk since she had a history of wandering when she lived at home. The nurse stated that the resident required 24- hour supervision since she had memory .

Review of the hospice physician note dated on / indicated that Resident #1 originally was admitted on to the hospice service for while living at home. The note indicated that Resident #1 had multiple elopements while at home, required 24-hour supervision and was considered an elopement risk. The note indicated that Resident #1 currently lived on the facility secured lockdown unit for memory care and left the unit only when escorted and monitored closely by facility staff, to and from the dining her meals.

In an additional interview with the Administrator on at 1:30PM, he stated that he was puzzled

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how Resident #1 had eloped from the facility since she required the use of a walker and had unsteady gait. He stated that the resident had a history of wandering prior to her admission and would be considered an elopement risk. The Administrator stated that all memory care residents should have ID on them at all times and this was not being monitored consistently. He stated that during the facility practice of escorting the memory care residents from the locked unit to the 1st floor dining then back to the 2nd floor, no residents had ever eloped. When questioned if he felt the numerous " trips " made by the residents to the 1st floor dining a safety risk for the residents, he stated that since the elopement of Resident #1, he would need to reevaluate the process. He stated that he felt all the residents were adequately supervised, even when the memory care residents mingled with the other residents in the various common areas. He acknowledged that situations can occur with one resident, then staff are distracted trying to meet the resident ' s needs and cannot be expected to be monitoring the remaining residents. He stated that in the recent past, the memory care residents were served their meals on the 2nd floor and they did not have to be escorted off the locked unit.

Class II

0032 Resident Care - Elopement Standards

Based on observation, interview and record review, the facility failed to effectively develop and implement a policy to monitor residents that are assessed at risk for elopement. This was evidenced by the failure to affix required identification to the resident and failure to provide required monitoring for safety and whereabouts to 1 of 3 sampled residents, (Residents #1,) who had prior history of wandering.

The findings included:

Review of Resident #1 ' s medical record indicated that the resident was admitted to the facility on with diagnoses of , upper extremity tremors, history of , knee pain, and . Review of the resident health assessment form dated / indicated that the resident was independent for ambulation, and eating but required assistance with toileting, transfers, self- care, dressing and bathing. Review of the form indicated that the resident was not documented as requiring any special precautions, including elopement or risk and no nursing services/ hospice services. Further review of the facility census indicated that Resident #1 lived on the locked memory care unit.

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In an observation of Resident #1 on 7/7/2016 at 7:30AM, she was observed to ambulate with a walker from the facility elevator and escorted by facility staff member to the dining room. The resident was alert and oriented to her name only. In an interview conducted at this time with caregiver #B, she stated that Resident #1 required the use of her walker at all times due to her unsteady gait and history of . The caregiver stated that the resident lived on the memory care unit and required monitoring at all times. During an additional observation on at 10:30AM memory care staff was observed to be placing an ID wrist on the resident.

Review of the hospice physician note dated on indicated that Resident #1 originally was admitted on to the hospice service for while living at home. The note indicated that Resident #1 had multiple elopements while at home, required 24-hour supervision and was considered an elopement risk. The note indicated that Resident #1 currently lived on the facility secured lockdown unit for memory care and left the unit only when escorted and monitored closely by facility staff, to and from the dining her meals.

Review of the facility 1- day Adverse Incident report dated on at 12:00 PM indicated that " staff were bringing several residents downstairs for lunch from the memory care unit via the elevator, to the dining on the first floor. " The report indicated that, " Resident #1 exited the facility by the side door and staff was not aware that she was missing until all residents were seated in dining . When staff discovered that the resident was not at lunch, they began to search the building as the first step of elopement policy. " The report indicated that a neighbor came to the building to alert staff that Resident #1 was outside. Staff went immediately to recover resident and brought her back to the building at around 12:15 PM. The report indicated that the neighbor had notified the police.

In an interview with the Wellness Care Coordinator on at 7:30AM she stated that facility is staffed during the day shift 7-3:00PM with 4 caregivers. She stated that the memory care unit has 2 designated caregivers at all shifts and the other 2 caregivers are assigned for the remaining residents. The Coordinator stated that the 11 residents who are living on the 2nd floor memory care unit are escorted down to the 1st floor dining . She stated that one caregiver staved on the unit while the other care giver escorted the residents in small groups to the dining all residents were brought downstairs. The Coordinator stated that since the elopement by Resident #1 on , the facility has assigned additional personnel to meet the residents when they travel downstairs to the 1st floor.

In an interview with Caregiver #A on at 4:15 PM, she stated that she worked the 7-3 pm shift daily on the memory care unit and was very familiar with Resident #1. Caregiver #A stated that all residents living on the memory care unit should have an identification (ID) on their body which included the residents name, facility name and telephone number. She indicated that on every shift the care staff are to check the ID and replace them if necessary. The caregiver stated that the

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Resident #1 had a history of wandering, and required the use of a walker because she was unsteady, and unbalanced when attempting to ambulate without the walker. The caregiver stated that Resident #1 was more agitated on the morning of and kept stating she wanted " to go to find her son " . The Caregiver #A stated that around lunch time, she was escorting 4 memory care residents to the elevator on the 2nd floor, when one resident " became unwell and she was afraid he would so she escorted him back to the memory care unit " . She stated that before she could stop the elevator, the elevator door closed and the 3 other residents went down to 1st floor. She stated that she was caring for the ill resident and was unable to leave him alone. She stated that she was unaware that Resident #1 was missing until the dining noted the resident was missing at lunch. She stated she immediately started to search the building and a neighbor man came inside the facility to notify the staff that a resident was ambulating on the street. She stated that she and Caregiver #B went outside and found Resident#1 on the street around back of the facility. She stated that another staff drove the company car to pick up the resident. She stated that Resident #1 was not injured, but she was hot and her skin was reddened. Caregiver #A stated that she was puzzled how Resident #1 was able to push the heavy inside fire door open, go down 4 stairs in the stairwell with her walker and then push open the outside exit door to the street. The care giver stated that she could not recall if Resident #1 was wearing an ID bracelet on .

Review of staff training for elopement /missing resident policy and procedure indicated that " the administrator will conduct a preadmission evaluation regarding the risk potential for elopement to determine if resident is appropriate for facility. All staff will be made aware of the resident ' s needs and each resident will be provided identification with their name, facility name and phone number. Staff will monitor closely the residents who are identified as an " elopement risk " and will ensure daily that the resident is wearing their ID . After admission, if a resident is determined to be at risk for elopement, this information will be recorded on the 1823 resident health assessment form and the resident provided an ID . "

Review of " elopement sign-in sheet " indicated a space for the date/ name of resident #2/ name of resident #3 / ID present/ staff signature. Further review of this form indicated that Resident #2 and #3 were identified as an elopement risk and Caregiver #B had documented that she had checked the ID for the 2 residents. Further review of this form indicated that the ID were not checked daily as per policy and Resident #1 ' s name was not included on this list. During an interview with the Administrator on at 9:30AM, he reviewed the sheet and stated that he was unaware that the ID for the " at risk residents " were not being checked daily as per policy. He stated that when Caregiver #B was not scheduled to work, another care staff should be completing the log sheet. He stated that he was aware that on her admission, Resident #1 had a prior history of wandering from her home several times, which required police intervention, but he had not considered Resident #1 to be an elopement risk at the facility and he never questioned the admission assessment. He stated that since

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Resident #1 eloped on 7/4/2016, she would be considered an elopement risk and would need an ID placed on her person at all times. He stated that all residents on memory care unit should have identification on their person and be monitored at all times.

In an additional interview with the Administrator on at 1:30PM he stated that he was puzzled how Resident #1 had eloped from the facility since she required the use of a walker and had unsteady gait. He stated that the resident had a history of wandering prior to her admission and would be considered an elopement risk. The Administrator stated that all memory care residents should have ID on them at all times which was not being monitored consistently. He stated that during the facility practice of escorting the memory care residents from the locked unit to the 1st floor dining then back to the 2nd floor, no residents had ever eloped. When questioned if he felt the numerous trips made by the residents to the 1st floor dining a safety risk for the residents, he stated that since the elopement of Resident #1 he would need to reevaluate the process. He stated that he felt all the residents were adequately supervised, even when the memory care residents mingled with the other residents in the various common areas. He acknowledged that situations can occur with one resident, when staff are distracted trying to meet the resident ' s needs and cannot be expected to be monitoring the remaining residents. He stated that in the recent past, the memory care residents were served their meals on the 2nd floor and they did not have to be escorted off the locked unit.

Class II

0055 Medication - Storage and Disposal

Based on observation and interview, the facility failed to appropriately secure prescribed resident medication. This was evidenced by the failure to centrally store medications and supplies for residents in the two medication carts located inside the nursing office at the facility.

The findings include:

In an observation of the facility nurses station on at 8:30AM, 5 residents were observed sitting in chairs and standing inside the small , as the medication technician (med tech) was assisting one resident at a time with daily medications. The 5 residents were observed to be listening to the med tech and each resident ' s conversation and interrupted her with questions about their own medications. Two medication carts were observed inside this , the med tech was standing in front of one of the medication carts, and was observed opening drawers and providing medications to a resident. The other medication cart was adjacent and positioned behind the med tech. The cart was observed with 3

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open/unlocked drawers, the lid to the storage box was open and medications exposed, and medication bottles and supplies were observed on top of the cart. (see photos). The med tech was observed to have her back to the open cart during the surveyor observation, and was unaware the surveyor was behind her.

In an interview with the med tech on at 8:40AM, when she was questioned about the observation of the open medication cart and exposed medications to a waiting residents, she stated that she was able to monitor both the open medication carts and exposed medications, even while she was providing medications to another resident.

In an interview with the Wellness Care Coordinator on at 8:41AM, she observed the medication carts and was questioned about the exposed medication,she stated that the medications should be secured at all times and no medications should be left out unattended since residents are near the carts. She instructed the med tech to immediately store all the medications inside the drawers and to lock the box. When questioned why numerous residents were inside the nurse station, she stated that the residents " just enter and sit, waiting for their medications." She stated that the current medication administration process should be reevaluated to provide privacy and safety to the residents.

Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observation and interview, the facility failed to ensure a safe living environment for all residents by not maintaining the fire exit door alarm system on the ground floor level. As evidenced by the alarm failure which resulted the lack of notification to staff that the exit door had been opened/ breached and that Resident #1 had eloped from the facility.

The findings included:

Review of the facility 1- day Adverse Incident report dated on at 12:00 PM indicated that " staff were bringing several residents downstairs for lunch from the memory care unit via the elevator, to the dining on the first floor. " The report indicated that " Resident #1 exited the facility by the side door and staff was not aware that she was missing until all residents were seated in dining When staff discovered that the resident was not at lunch, they began to search the building as the first step of elopement policy. " The report indicated that a neighbor came to the building to alert staff that

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910374	07/12/2016
NAME OF PROVIDER OR SUPPLIER **WINDSOR COURT**	STREET ADDRESS, CITY, STATE, ZIP CODE **3700 N. FLAGLER DR** **WEST PALM BEACH, FL 33406**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

Resident #1 was outside. Staff went immediately to recover resident and escorted her back to building at around 12:15 PM. The report indicated that the neighbor had notified the police.

In an observation of the facility video camera system along with the facility office manager on at 1:00PM, the camera recording for showed Resident#1 exiting the elevator, behind 2 other residents at 11:50AM (the camera time stamp had not been adjusted for day light saving time, so it recorded as 10:50AM). The 2 residents were observed to walk straight ahead towards the dining , no staff was observed to meet or escort the residents. Resident #1 exited the elevator and made a sharp left turn, she did not hesitate and ambulated down the hallway towards the exit/ fire door. Resident #1was observed to push open the inside fire door and then move her walker into the stairwell. The fire door closed and no other camera images were available within the stairwell for review.

In a tour and observation conducted along with the Wellness Care Coordinator of the fire exit and stairwell leading outside to the street on at 7:35 AM , the inside fire exit door on the first floor, south side was unlocked and had no alarm mechanism attached when opened by the surveyor. Inside the stairwell, 4 steps were observed leading down to the ground level and to another fire door (see photographic evidence). The fire door had an alarm activation mechanism in place when opened per the Coordinator. Outside the fire exit door, a wrought iron gate with door secured with a piece of heavy gauge wire wrapped around the bars was observed. The gate would have needed to be opened for Resident #1 to access the street. (See photos) Observations were made of the exit on Flagler Street, a two- way street leading to an adjacent street which is located around the back of the facility and has no sidewalks. In an interview with the Administrator on at 10:00AM he stated that the alarm did not activate on the outside fire door when Resident #1 exited the building. He stated that the fire door is not under any preventative maintenance agreement and he was not sure why the alarm did not activate properly. He stated that he had personally checked the door and found it to be working properly after the elopement. He stated that if the fire door alarm had been activated, the facility staff would have alerted about Resident#1 ' s elopement earlier.

Class III

Z814 Backaround Screenina Clearinahouse

Based on observation, interview and record review, the facility failed to maintain an employee roster with the employment status of all employees of the facility within the background screening (BGS) clearinghouse.

The findings include:
A record review of the employee roster for the facility on the Agency for Health Care Administration Care

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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SUMMARY STATEMENT OF DEFICIENCIES
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(AHCA) Provider Background Screening Clearinghouse website was conducted on 7/11/2016 at 8:50 AM. Only 4 names were listed under the facility roster, with only one employee name currently noted on the 2016 monthly staffing schedule.

Review of the facility staffing schedule for 2016 indicated that there are 25 care staff scheduled to work at the facility covering 3 shifts during the daily 24 hour period.

In an interview with the Administrator on / / at 11:20 AM, he stated that he was familiar with the AHCA Background Screening Clearinghouse website, but was not aware of the the requirement to maintain a current employee roster for the facility.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

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

Dear Administrator:

This letter reports the findings of a complaint inspection survey (CCR #2016007640) conducted on 7-12, 2016, by representatives of the Agency for Health Care Administration (Agency). Attacned 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 **10 business days** upon receipt of this hand delivered/faxed 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= Class II
St - A - 0032 - 58a-5.0182(8) Fac- Resident Care - Elopement Standards Class II

Directed Corrective Actions:

1. The Assisted Living Facility shall create and implement a new elopement/ missing person policy and procedure. The policy must contain, at a minimum, specific conditions and timeframes indicating when a resident absence is considered an elopement, specific timeframes for notifying law enforcement and family/ responsible party, and specific requirements for staff on tasks and documentation. Documentation verifying all current staff and future staff be trained in this policy must be kept on file at the facility, and available for agency review no later than , 2016.

2. The Assisted Living Facility is required to document any and all known whereabouts of all residents per shift in addition to the facility's Elopement Sign-In sheet which is completed daily for verification of ID placement. A designated staff member must be assigned responsibility for the documentation on the resident monitoring This must be implemented by , 2016.

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com

3. The facility administration will ensure that a health care provider who is familiar with the Florida Assisted Living Facility rules and regulations will conduct an elopement risk assessment, as well as a continued residency requirements assessment (based on the facility's ability to meet resident planned and unplanned needs) for all residents in the Assisted Living Facility. The facility will refer any resident to their Health Care Provider if their health condition status has changed since their last Health Assessment was performed. Documentation of these assessments must be maintained in each resident's file. This must be implemented by , 2016.

4. All Assisted Living Facility staff will be trained on the elopement procedures and will participate in elopement drills. These drills will be conducted on ALL shifts. This training and these elopement drills will be completed by no later than 3 days of receiving this letter. Documentation of the training and elopement drills, including content and sign-sheets must be available at any time for review by the Agency upon request.This must be implement by , 2016.

5. The Assisted Living Facility administration will develop policies and procedures on documentation which include at a minimum: requirements for all staff to document resident behaviors, changes in condition, as well as other factors that affect resident care and supervision when they become aware of these situations. This policy will include who is responsible for continued review of this documentation, what actions will be taken by the facility as a result of this documentation, what staff is responsible for these actions, and procedures for communicating this information to all staff. This will be completed by the Assisted Living Facility Administrator no later than , 2016.

6. Facility administration will create and implement a facility policy and practice of periodic checks of residents, with special emphasis on all new admissions, residents with significant changes, and residents with behavioral patterns of exit seeking. This will be completed by the Assisted Living Facility Administrator no later than , 2016.

7. The facility will develop and implement system(s) to ensure exit doors are monitored in order to minimize the risk of resident elopement. The Assisted Living Facility Administrator will continually evaluate the effectiveness of the system(s) utilized to monitor the facility exit doors and make changes when necessary to ensure that the system(s) are meeting the needs of the residents. There will be an effective system(s) in place to monitor all exit doors by no later than , 2016. Monitoring the effectiveness of the system(s) will be ongoing. Documentation of the monitoring must be available at any time for review by the Agency upon request.

8. The facility will develop and implement a new internal system to provide all meals to the memory care residents located on the 2nd floor no later than ,2016. This system must not require staff to escort the residents off the locked secure unit several times a day. The facility will immediately ensure that the memory care residents must not be left unattended at any time under any circumstance.

9. The facility must have documentation available that they have had a satisfactory fire inspection within the last 30 days, including verification that all fire doors and alarms are operational and that the facility is in compliance with all applicable fire codes.This must be

Windsor Court
, 2016

implemented by , 2016.

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

Should you have any questions, please contact Laura Manville, Assisted Living Facility Enforcement Team Manager at 727-552-1955 or Tikel Wedges-Phoenix, Assisted Living Facility Supervisor at 561-381-5840.

Sincerely,

T. Wedges-Phoenix, Supervisor

Arlene Mayo-Davis
Field Office Manager

AMD/jw

D7JR

Received by:

Facility Representative Title Date

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

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