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
	55113	A. BUILDING: _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR WOODS REHAB AND HEALTHCARE CENT	13719 DALLAS DR HUDSON, FL 34667

(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
N 000	INITIAL COMMENTS An unannounced Recertification Survey and complaint investigation for #2020010865 and #2021002669, was conducted at Windsor Woods Rehab and Healthcare Center to . The Windsor Woods Rehab and Healthcare Center had deficiencies identified at the time of the visit. Complaint # 2020010865 resulted in a citation of N407 Complaint # 2021002669 resulted in a citation of N201	N 000		
N 201 SS=D	400.022(1)(l), FS Right to Adequate and Appropriate Health Care The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on interviews with facility staff and Center's staff, and review of Resident #87's medical record, including Center's documentation of the resident's treatments, the facility failed to ensure adequate and appropriate health care and protective and support services for one resident (#87) of two residents reviewed receiving services, regarding ongoing assessment and care of a surgical identified as being by the outside provider of .	N 201	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. N 201 1) Resident #87 was safely discharged	

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	55113	A. BUILDING: _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR WOODS REHAB AND HEALTHCARE CENT	13719 DALLAS DR HUDSON, FL 34667

(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
N 201	Continued From page 1 Findings included: Resident #87 was admitted to the facility on from the hospital after having a placed in the right . Physician orders for the surgical site dated , included "cleanse right AC ( ) surgical site with NS (normal), cover with dry q (every) day shift." Review of the Treatment Administration Record (TAR) revealed documentation included a check mark for every day, except for a "9" documented on . The Chart code legend on the TAR revealed that "9" indicated "other, see nurse notes". Review of the nurse's note from written at 14:30 revealed, "cleanse right AC surgical site with NS and cover with dry every day shift." The next nurse's note , also written on at 14:30 , read "cleanse left lower with NS, apply , , and cover with dry QD (every day) every day shift. resident currently at ." The nurse's note for did not explain the documentation in the TAR for the change at the right AC. A Skin Grid had been documented on for the resident's surgical site described as "right with 10 intact staples." One week later, on , the Skin Grid was updated and noted for the length and width having remained the same as the week prior, with the tissue type identified as E (,), bed color pink and staples intact. A review was conducted of the Post Treatment Reports provided by the center to the facility after each treatment. Review of the Post Treatment Report dated	N 201	home prior to the survey. 2) DON/designee reviewed and assessed all residents receiving services to ensure resident/s are free from any sign or symptom of . DON/designee will monitor surgical and/or port sites of resident/s to ensure residents are free of any sign or symptom of . 3) Licensed Nurses were educated on observing resident's surgical and port sites for signs and symptoms of , documenting findings and reporting changes to the physician as indicated. Licensed nurses were educated on appropriate treatment documentation and any omissions to be reflected in medical record. 4) DON/designee will audit each resident surgical and/or port site daily x 1 week, then weekly x 4 weeks, and monthly x 2 months. The results of these audits will be reported to the QAPI committee monthly by NHA/designee for 3 months or until substantial compliance is met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	55113	A. BUILDING: _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR WOODS REHAB AND HEALTHCARE CENT	13719 DALLAS DR HUDSON, FL 34667

(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
N 201	Continued From page 2 . . . . . revealed that the Pre-treatment Data Collection & Assessment found that the patient's right arm was . . . . and the staples at the site showed signs of . The note indicated the facility and doctor were notified. On . . . . . , documentation on the Pre-treatment Data Collection & Assessment read, "right FA (. . .) / 1+ ( ); redness noted to site on RFA (right . . . .), staples with yellow drainage." The Post-treatment Data Collection & Assessment documentation on . . . . . read, "RFA site red with yellow drainage noted on . . . . . Doctor notified during treatment, BC (cultures) x 2 and culture completed. . . . . 1 gram ( ) x 1 given per doctor's order." On the Pre-treatment Data Collection & Assessment read, "RFA . . . improving, staples were removed yesterday per patient. No drainage noted on . . . . ." Further review of the Post Treatment . . Reports revealed the resident received . . . . beginning on and was added on for the positive . . . . culture. The facility had received Post Treatment Reports until . . . . . and both . . . . . continued through to that date. An interview was conducted with the Center's Facility Administrator (FA) on . . . . . beginning at 10:05 a.m. The FA confirmed that the resident had started . . . . at her facility in mid and on the following Thursday (. . . . .) the . . . . nurse noted the on the surgical site was dated from the previous Monday (. . . . .). She reported that usually the Center does not remove the . . . . from surgical sites, but the nurse removed this as it was several days old	N 201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	55113	A. BUILDING: _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR WOODS REHAB AND HEALTHCARE CENT	13719 DALLAS DR HUDSON, FL 34667

(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
N 201	Continued From page 3 and the resident's arm was . The nurse documented the staples at the site looked and she notified the facility. The FA reported that the resident's course of ended on . The FA confirmed that the Post Treatment Reports did not document that the resident had a temperature on any of the reports, from until . A further review of the facility's nursing notes and Treatment Administration Record did not reveal that the order to change the to the resident's surgical site had been missed, which had been reported by the Center's FA. An interview was conducted with the resident's nurse, LPN A , on beginning at 1:45 p.m. LPN A remembered the resident and confirmed that one day she had documented before she had performed a change at the resident's surgical site. She said that something happened and she wasn't able to get to the resident to change the before he left for . She reported that she had asked the oncoming nurse to change the but the oncoming nurse hadn't changed the either. She reported that the next day she changed the , but due to what the center reported, she must have put the wrong date on the . She reported that she was aware that the center notified the facility of an surgical site and that the right arm was , but she said she did not see that the surgical site was or that the arm was . An interview was conducted with RN B, the Unit Manager on beginning at 1:50 p.m. He confirmed he had seen the site but never	N 201		

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
	55113	A. BUILDING: _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR WOODS REHAB AND HEALTHCARE CENT	13719 DALLAS DR HUDSON, FL 34667

(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
N 201	Continued From page 4 thought it looked . . . . . He confirmed that residents' temperatures were taken three times a day and Resident #87's never spiked a temperature. He reported that once when he entered the resident's room he saw the resident's wife removing a , but he couldn't remember if the was at the surgical site or at a the resident had on his lower . A review of the nurse's notes did not include either LPN A's report of having missed a change or RN B's report of having seen the resident's wife removing a . Class III	N 201		
N 407 SS=D	400.141(1)(i), FS Dietary Services Every licensed facility shall comply with all applicable standards and rules of the agency and shall: (i) If the licensee furnishes food service, provide a wholesome and nourishing diet sufficient to meet generally accepted standards of proper nutrition for its residents and provide such therapeutic diets as may be prescribed by attending physicians. In making rules to implement this paragraph, the agency shall be guided by standards recommended by nationally recognized professional groups and associations with knowledge of dietetics. This Statute or Rule is not met as evidenced by: Based on observation of the residents at meals, observation of the lunch tray line on , interview with the resident and facility staff and review of the resident's medical record and facility	N 407	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	55113	A. BUILDING: _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR WOODS REHAB AND HEALTHCARE CENT	13719 DALLAS DR HUDSON, FL 34667

(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
N 407	Continued From page 5 documents, the facility failed to ensure that one resident (# 31) received her Therapeutic diet at two meals observed on , of two residents observed for receiving a diet, and one of one resident in the facility who received , . Findings included: Resident #31 was initially admitted to the facility on with diagnoses that included . She had been assessed (Minimum Data Set Quarterly Assessment) on as having moderately , cognition (= 9), receiving , , and being able to eat her meals independently after set up. Review of Resident #31's medical record revealed her diet order was for a diet, mechanical soft texture with thin liquids. Review of a note written by the Registered Dietitian on confirmed that the resident's diet was , mechanical soft texture with thin liquids. On at approximately 9:00 a.m., the resident was observed lying in bed, with the of the bed up. She was observed having slid down in the bed and was leaning to her right, supported by a narrow enabler bar in the up position. She said she had just had a great breakfast - pancakes and Canadian bacon - and had eaten all of it. She said she was ready for a nap. Review of the posted menu confirmed the breakfast had been planned to include pancakes and Canadian bacon. At lunch on at approximately 12:40 p.m. the resident was observed being served her lunch by an aide. The resident had received	N 407	that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. N407 1) Resident #31 was assessed with no adverse effects noted. MD/RP was notified. 2) Audits were conducted by CDM/designee to ensure dietary employees are preparing and delivering all diets as prescribed and in accordance to the meal spread sheet. CDM/designee will monitor the tray line to ensure accurate specialized diets are delivered. 3) CDM/Designee educated all dietary employees on specialized/modified diets, serving according to menu specifications, meal spread sheet, and validating that all specialized diet trays are accurate. CDM/Designee will audit specialized diet trays to validate effectiveness of education. 4) CDM and/or designee will audit tray lines for specialized diets to ensure accuracy daily x 2 weeks, weekly x 4 weeks, then monthly x 2 months. The results of these audits will be reported to the QAPI committee monthly by NHA/designee for 3 months or until substantial compliance is met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	55113	A. BUILDING: _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR WOODS REHAB AND HEALTHCARE CENT	13719 DALLAS DR HUDSON, FL 34667

(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
N 407	Continued From page 6	N 407		

fried chicken on the bone, which the aide was cutting off of the bone for her. She also had Calico beans (a mix of dried beans), a scoop of a pureed yellow mixture which the resident identified as tasting like corn, a cup of chocolate milk which the resident said had some medicine mixed into it, a cup of apple juice and a cup of coffee. For dessert the resident had been served a Tropical fruit salad.

At 1:20 p.m. the resident was observed sitting in bed with her over bed table across her , and her lunch tray still in place. The plate, the bowl which held the fruit cup and the cups which held the chocolate milk and coffee were all empty. The resident reported, while smiling, that it was all very good. The resident's diet slip was on the meal tray and was noted to list what the resident should have received. The diet slip listed the diet as , mechanical soft, thin liquids. Listed as the lunch meal for Resident #31 on was baked chicken, pureed corn, soft mashable green beans, peach slices, and lemonade and cranberry juice to drink.

An interview was conducted with the Registered Dietitian (RD) (on beginning at 1:30 p.m.) to discuss Resident #31 and what she had received for breakfast and lunch on . The RD confirmed that the yellow pureed dish on Resident #31's lunch entree plate was probably the cornbread which had been pureed since the resident was on a mechanical soft diet.
The RD referred to the spread sheet for the lunch meal and confirmed that the diet did not include the Calico beans, the cornbread or the milk. She reported that usually a cup of milk is not served at lunch, due to the restriction for milk in the diet.
The RD confirmed that the diet was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	55113	A. BUILDING: _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR WOODS REHAB AND HEALTHCARE CENT	13719 DALLAS DR HUDSON, FL 34667

(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
N 407	Continued From page 7 planned to provide scrambled eggs with toast at breakfast and said the resident should not have received the pancakes and the Canadian bacon. She reported that she would have to inservice the dietary staff about referring to the diet slip during the tray line when they are creating the individual resident meal trays. The Dietary Manager provided a copy of the spread sheet that showed the menu changes for Therapeutic and Modified Consistency diets. For the . . diet, the spread sheet confirmed that the resident should have received scrambled eggs with toast at breakfast , and chicken with soft green beans and white bread for lunch. The pancakes and Canadian bacon and the Calico beans and pureed cornbread were not included in the . . diet. During the observation of the tray line on . . . . . which began at 11:40 a.m., Cook C was heard to correct the Dietary Manager when she reported that the green beans were the alternate vegetable. Cook C reported that the green beans were the vegetable for the . . diet as the . . diet did not allow the Calico beans - which were made from dried beans. Class III	N 407		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105568	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR WOODS REHAB AND HEALTHCARE CENTER	13719 DALLAS DR HUDSON, FL 34667

(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) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Recertification Survey and complaint investigation for #2020010865 and #2021002669, was conducted at Windsor Woods Rehab and Healthcare Center to . The facility was not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Complaint # 2020010865 resulted in a citation of F808 Complaint # 2021002669 resulted in a citation of F698	F 000		
F 698 SS=D	CFR(s): 483.25(l) §483.25(l) The facility must ensure that residents who require receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interviews with facility staff and Center's staff, and review of Resident #87's medical record, including Center's documentation of the resident's treatments, the facility failed to ensure one resident (#87) of two residents reviewed for receiving services, received ongoing assessment and care of a surgical which was identified as being by the outside provider of . Findings included: Resident #87 was admitted to the facility on from the hospital after having a	F 698	cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. F 698 1) Resident #87 was safely discharged home prior to the survey. 2) DON/designee reviewed and assessed all residents receiving	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed /2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105568	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR WOODS REHAB AND HEALTHCARE CENTER	13719 DALLAS DR HUDSON, FL 34667

(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) COMPLETION DATE
F 698	Continued From page 1 ... placed in the right ..... Physician orders for the surgical site dated , included "cleanse right AC ( ) surgical site with NS (normal ...), cover with dry ... q (every) day shift." Review of the ... Treatment Administration Record (TAR) revealed documentation included a check mark for every day, except for a "9" documented on . The Chart code legend on the TAR revealed that "9" indicated "other, see nurse notes". Review of the nurse's note from ... written at 14:30 revealed, "cleanse right AC surgical site with NS and cover with dry ... every day shift." The next nurse's note , also written on at 14:30 , read "cleanse left lower ... with NS, apply ... , and cover with dry ... QD (every day) every day shift. resident currently at ... ." The nurse's note for did not explain the documentation in the TAR for the ... change at the right AC. A Skin Grid had been documented on for the resident's surgical site described as "right with 10 intact staples." One week later, on ..., the Skin Grid was updated and noted for the length and width having remained the same as the week prior, with the tissue type identified as E (,), bed color pink and staples intact. A review was conducted of the Post Treatment ... Reports provided by the ... center to the facility after each ... treatment. Review of the Post Treatment Report dated ... revealed that the Pre-treatment Data Collection & Assessment found that the patient's right arm was ... and the staples at the site	F 698	services to ensure resident/s are free from any sign or symptom of . DON/designee will monitor surgical and/or port sites of ... resident/s to ensure residents are free of any sign or symptom of . 3) Licensed Nurses were educated on observing resident's ... surgical and port sites for signs and symptoms of ..., documenting findings and reporting changes to the physician as indicated. Licensed nurses were educated on appropriate treatment documentation and any omissions to be reflected in medical record. 4) DON/designee will audit each resident ... surgical and/or port site daily x 1 week, then weekly x 4 weeks, and monthly x 2 months. The results of these audits will be reported to the QAPI committee monthly by NHA/designee for 3 months or until substantial compliance is met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105568	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR WOODS REHAB AND HEALTHCARE CENTER	13719 DALLAS DR HUDSON, FL 34667

(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) COMPLETION DATE
F 698	Continued From page 2 showed signs of . The note indicated the facility and doctor were notified. On , documentation on the Pre-treatment Data Collection & Assessment read, "right FA ( ) / 1+ ( ); redness noted to site on RFA (right), staples with yellow drainage." The Post-treatment Data Collection & Assessment documentation on read, "RFA site red with yellow drainage noted on . Doctor notified during treatment, BC (cultures) x 2 and culture completed. 1 gram ( ) x 1 given per doctor's order." On the Pre-treatment Data Collection & Assessment read, "RFA improving, staples were removed yesterday per patient. No drainage noted on ." Further review of the Post Treatment Reports revealed the resident received beginning on and was added on for the positive culture. The facility had received Post Treatment Reports until and both continued through to that date. An interview was conducted with the Center's Facility Administrator (FA) on beginning at 10:05 a.m. The FA confirmed that the resident had started at her facility in mid , and on the following Thursday ( ) the nurse noted the on the surgical site was dated from the previous Monday ( ). She reported that usually the Center does not remove the from surgical sites, but the nurse removed this as it was several days old and the resident's arm was . The nurse documented the staples at the site looked	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105568	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR WOODS REHAB AND HEALTHCARE CENTER	13719 DALLAS DR HUDSON, FL 34667

(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) COMPLETION DATE
F 698	Continued From page 3	F 698		

and she notified the facility. The FA reported that the resident's course of ended on . The FA confirmed that the Post Treatment Reports did not document that the resident had a temperature on any of the reports, from until .

A further review of the facility's nursing notes and Treatment Administration Record did not reveal that the order to change the to the resident's surgical site had been missed, which had been reported by the Center's FA.

An interview was conducted with the resident's nurse, LPN A , on beginning at 1:45 p.m. LPN A remembered the resident and confirmed that one day she had documented before she had performed a change at the resident's surgical site. She said that something happened and she wasn't able to get to the resident to change the before he left for . She reported that she had asked the oncoming nurse to change the but the oncoming nurse hadn't changed the either. She reported that the next day she changed the , but due to what the center reported, she must have put the wrong date on the . She reported that she was aware that the center notified the facility of an surgical site and that the right arm was , but she said she did not see that the surgical site was or that the arm was .

An interview was conducted with RN B, the Unit Manager on beginning at 1:50 p.m. He confirmed he had seen the site but never thought it looked . He confirmed that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105568	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR WOODS REHAB AND HEALTHCARE CENTER	13719 DALLAS DR HUDSON, FL 34667

(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) COMPLETION DATE
F 698	Continued From page 4 residents' temperatures were taken three times a day and Resident #87's never spiked a temperature. He reported that once when he entered the resident's room he saw the resident's wife removing a [illegible], but he couldn't remember if the [illegible] was at the surgical site or at a [illegible] the resident had on his lower [illegible]. A review of the nurse's notes did not include either LPN A's report of having missed a [illegible] change or RN B's report of having seen the resident's wife removing a [illegible].	F 698		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation of the residents at meals, observation of the lunch tray line on [illegible], interview with the resident and facility staff and review of the resident's medical record and facility documents, the facility failed to ensure that one resident (# 31) received her Therapeutic diet at two meals observed on [illegible], of two residents observed for receiving a [illegible] diet, and one of one resident in the facility who received [illegible]. Findings included:	F 808	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. F 808 Therapeutic Diet Prescribed by physician	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105568	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR WOODS REHAB AND HEALTHCARE CENTER	13719 DALLAS DR HUDSON, FL 34667

(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) COMPLETION DATE
F 808	Continued From page 5 Resident #31 was initially admitted to the facility on [redacted] with diagnoses that included [redacted]. She had been assessed (Minimum Data Set Quarterly Assessment) on [redacted] as having moderately [redacted] cognition ([redacted] = 9), receiving [redacted], and being able to eat her meals independently after set up. Review of Resident #31's medical record revealed her diet order was for a [redacted] diet, mechanical soft texture with thin liquids. Review of a note written by the Registered Dietitian on [redacted] confirmed that the resident's diet was [redacted], mechanical soft texture with thin liquids. On [redacted] at approximately 9:00 a.m., the resident was observed lying in bed, with the [redacted] of the bed up. She was observed having slid down in the bed and was leaning to her right, supported by a narrow enabler bar in the up position. She said she had just had a great breakfast - pancakes and Canadian bacon - and had eaten all of it. She said she was ready for a nap. Review of the posted menu confirmed the breakfast had been planned to include pancakes and Canadian bacon. At lunch on [redacted] at approximately 12:40 p.m. the resident was observed being served her lunch by an aide. The resident had received fried chicken on the bone, which the aide was cutting off of the bone for her. She also had Calico beans (a mix of dried beans), a scoop of a pureed yellow mixture which the resident identified as tasting like corn, a cup of chocolate milk which the resident said had some medicine mixed into it, a cup of apple juice and a cup of	F 808	1) Resident #31 was assessed with no adverse effects noted. MD/RP was notified. 2) Audits were conducted by CDM/designee to ensure dietary employees are preparing and delivering all diets as prescribed and in accordance to the meal spread sheet. CDM/designee will monitor the tray line to ensure accurate specialized diets are delivered. 3) CDM/Designee educated all dietary employees on specialized/modified diets, serving according to menu specifications, meal spread sheet, and validating that all specialized diet trays are accurate. CDM/Designee will audit specialized diet trays to validate effectiveness of education. 4) CDM and/or designee will audit tray lines for specialized diets to ensure accuracy daily x 2 weeks, weekly x 4 weeks, then monthly x 2 months. The results of these audits will be reported to the QAPI committee monthly by NHA/designee for 3 months or until substantial compliance is met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105568	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR WOODS REHAB AND HEALTHCARE CENTER	13719 DALLAS DR HUDSON, FL 34667

(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) COMPLETION DATE
F 808	Continued From page 6	F 808		

coffee. For dessert the resident had been served a Tropical fruit salad.

At 1:20 p.m. the resident was observed sitting in bed with her over bed table across her , and her lunch tray still in place. The plate, the bowl which held the fruit cup and the cups which held the chocolate milk and coffee were all empty. The resident reported, while smiling, that it was all very good. The resident's diet slip was on the meal tray and was noted to list what the resident should have received. The diet slip listed the diet as , mechanical soft, thin liquids. Listed as the lunch meal for Resident #31 on was baked chicken, pureed corn, soft mashable green beans, peach slices, and lemonade and cranberry juice to drink.

An interview was conducted with the Registered Dietitian (RD) (on beginning at 1:30 p.m.) to discuss Resident #31 and what she had received for breakfast and lunch on .
The RD confirmed that the yellow pureed dish on Resident #31's lunch entree plate was probably the cornbread which had been pureed since the resident was on a mechanical soft diet.
The RD referred to the spread sheet for the lunch meal and confirmed that the diet did not include the Calico beans, the cornbread or the milk. She reported that usually a cup of milk is not served at lunch, due to the restriction for milk in the diet .
The RD confirmed that the diet was planned to provide scrambled eggs with toast at breakfast and said the resident should not have received the pancakes and the Canadian bacon. She reported that she would have to inservice the dietary staff about referring to the diet slip during the tray line when they are creating the individual

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105568	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR WOODS REHAB AND HEALTHCARE CENTER	13719 DALLAS DR HUDSON, FL 34667

(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) COMPLETION DATE
F 808	Continued From page 7 resident meal trays. The Dietary Manager provided a copy of the spread sheet that showed the menu changes for Therapeutic and Modified Consistency diets. For the diet, the spread sheet confirmed that the resident should have received scrambled eggs with toast at breakfast , and chicken with soft green beans and white bread for lunch. The pancakes and Canadian bacon and the Calico beans and pureed cornbread were not included in the diet. During the observation of the tray line on which began at 11:40 a.m., Cook C was heard to correct the Dietary Manager when she reported that the green beans were the alternate vegetable. Cook C reported that the green beans were the vegetable for the diet as the diet did not allow the Calico beans - which were made from dried beans.	F 808		