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 02/27/2017

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 SKILLED NURSING FACILITY An unnanounced complaint survey CCR#2017000440 was conducted on WINDSOR WOODS REHABILITATION HEALTHCARE was not in compliance with 42 CFR 483, Requirements for Long Term Care Facilities.	F 000		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are	F 323		

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

Electronically Signed

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.

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F 323	Continued From page 1 appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of the " & Injury Management" policy, and family interview, the facility failed to provide adequate supervision to prevent , needed assistive devices and offer interventions that would prevent for one resident (# 2), who had a history of in the facility; out of three sampled residents who were reviewed for . While the resident's was acknowledged by the facility and interventions implemented, it was not investigated thoroughly and the interventions planned were not realistic or effective to prevent additional and harm to Resident #2, who 3 times in four days, the third resulted in two requiring surgical repair. Findings Included: Resident #2 was admitted on , with Diagnoses including: , , and . Record of the facility's log revealed Resident #2 had two on , one at 02:57 a.m. and another at 4:30 p.m. Per the resident's record there was a third that occurred on that was not on the log. Review of the Progress Note, dated , 02:57 revealed: "Resident found sitting on the floor sorting through suitcase. When asked what she was doing she stated "packing". Then asked how she got on the floor she stated she . No apparent injury. States she has "No pain". Lifted	F 323	Preparation and execution of the plan of correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State law. Resident #2 discharged. Current residents at risk for were reviewed by the interdisciplinary team to ensure a thorough investigation was completed and verify current interventions were appropriate and least restrictive per investigation for each resident to reduce /minimize injury related to . Director of Nursing/Designee in-serviced nursing staff on the clinical program for preventing ./implementing least restrictive individualized interventions. Director of Nursing and Unit Managers will monitor to assure interventions to reduce ./minimize injury are in place accordingly. NHA and IDT in-serviced on completing a complete and thorough investigation including, statement, MARS & TARS, progress notes, in-services, root cause and care plan. Director of Nursing/Designee will complete audits to ensure residents at risk for have individualized interventions in place to reduce	

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F 323	Continued From page 2 to chair with assist of three and brought to nursing station for closer monitoring. Dr. notified, family number is disconnected. DON notified." A facility listing of noted a second on at 4:30 p.m. There was no Progress note of the second . A third occurred on , at 3:10 a.m. The resident's record was silent regarding the at 4:30 p.m. on . Further review of the Progress notes, dated , revealed that Resident #2 had a at 3:10 a.m. The Progress note, documented that the resident was heard calling for help by the Nurse. The Nurse observed the resident on the floor." Resident stated, "I came down hard on my side" Resident was assessed; range of motion was performed without difficulty with the exception of the right hip area. Hoyer lifted resident to the bed with the assistance of two C.N.A's." Record review of the Progress Note on at 11:18 a.m., stated, "Obtained orders from MD to send resident to ER to evaluate and treat to rule out any injuries status post to ." Per record review, of the Progress notes resident sustained a on at 3:10 a.m. The physician ordered Resident #2's x-ray and the Nurse called for the x-ray to be done by the mobile x-ray company. The x-ray company did not arrive. The resident was transferred to the hospital at 11:30 a.m. on . After arriving at the hospital, the x-ray revealed the resident had sustained a to her right hip and right femur. Record review of the Risk Management report	F 323	./minimize injury, Weekly x 4 weeks, monthly x 3 months and results of the audits will be reported to the QAPI committee monthly for review and revision for 3 months and then as needed to ensure compliance. NHA and/or designed will complete audits of incidents and verify events were thoroughly investigated to include a root cause weekly x 4 weeks then monthly x3 months and results of the audits will be reported to the QAPI committee monthly for review and revision for 3 months and then as needed to ensure compliance.	

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F 323	Continued From page 3	F 323		

dated . . . . . at 16:27 revealed the Nursing description: Resident on the floor with her feet facing head of the bed, sitting on her butt. No visible injuries at this time. No complaints of pain or discomfort. Resident stated, "While going through her suitcase, went to turn and slipped off the bed." Immediate Action Taken: Education on using the call light when help is needed, added . . . . . floor mats. Resident picked up by two staff members using Hoyer lift. Bed in low position. Note Text: Upon entering . . , resident was found sitting on the floor next to the bed at 16:25 p.m. resident states she did not hit her head and has no injury. Skin assessment done, no new skin areas noted. Resident placed back in bed with Hoyer lift and two nurses to get her off the floor. . . . . floor mats placed, reminded resident to use call light for assistance.

Interview
During an interview, with the Director of Nurses (DON) at 4:21 p.m. on , she stated there was no MDS or . . score on this resident.

In a telephone interview at 8:46 a.m. on , with the daughter of the Resident #2, she stated that she requested side rails multiple times before her mother's first ; which was on . . . . ; but was told they were a no side rails facility. Observations conducted during the survey revealed there were side rails noted on beds throughout the facility.

Record review of the Nursing Admission Assessment, dated . . . . . at 10:28, completed in the facility the facility assessed the resident as: . . : . . in the last 90 days: yes. Does the resident require side rails: No.

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F 323	Continued From page 4	F 323		

Interventions initiated by the facility on [redacted]: [redacted] floor mats to sides of bed when resident in bed. Encourage wearing Non-skid socks/shoes when out of bed; initiated [redacted]. Lock brakes on bed, chair, etc. before transferring. Remind and reinforce safety awareness. Educate/remind resident to request assistance prior to ambulation. Adaptive device: wheelchair; [redacted].

Record review of the Care Plan for Resident #2 revealed: Focus: resident was at increased risk for [redacted] related to [redacted], use of [redacted] medications; initiated [redacted]. Goal: Will minimize the risk of [redacted]; date initiated [redacted]. The Interventions put into place after [redacted] were [redacted] floor mats to sides of bed when resident in bed. Encourage to wear Non-skid socks/shoes when out of bed; initiated [redacted]. Lock brakes on bed, chair, etc. before transferring. Remind and reinforce safety awareness. Educate/remind resident to request assistance prior to ambulation. Adaptive device: wheelchair; [redacted]. OT (Occupational [redacted]) referral for screen and treatment. The resident was evaluated and assessed and has diagnoses of [redacted] and [redacted]. There was no documentation of follow-up to show that resident would remember and understand the interventions. The resident did not use the call light for the first, second, or third [redacted]. During the third [redacted] the resident was heard, by the nurse, calling out for help [redacted].

Record review of the policy and procedure titled "[redacted] & Injury Management" undated; the Overview states: The facility strives to reduce the

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F 323	Continued From page 5 risk of . . and injuries by promoting the implementation of the and Injuries Program. Data is collected on residents/patients for risk factors. The Interdisciplinary team works with the resident/patient and family to identify and implement appropriate interventions to reduce the risk of .... or injuries while maximizing dignity and independence.	F 323		

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 02/27/2017

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N 000	INITIAL COMMENTS SKILLED NURSING FACILITY An unnanounced complaint survey CCR#2017000440 was conducted on with findings of a Class II deficiency at N201 WINDSOR WOODS REHABILITATION HEALTHCARE had a deficiency at the time of the visit. (License #16090961).	N 000		
N 201 SS=G	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 record review, staff interview, and review of the " & Injury Management" policy, and family interview, the facility failed to provide adequate supervision to prevent , needed assistive devices and offer interventions that would prevent for one resident (# 2), who had a history of in the facility; out of three sampled residents who were reviewed for . While the resident's was acknowledged by the facility and interventions implemented, it was not investigated thoroughly and the interventions planned were not realistic or effective to prevent	N 201	Preparation and execution of the plan of correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State law. Resident #2 discharged. Current residents at risk for were	

AHCA Form 3020-0001

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

Electronically Signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 201	Continued From page 1 additional and harm to Resident #2, who 3 times in four days, the third resulted in two requiring surgical repair. Findings Included: Resident #2 was admitted on , with Diagnoses including: , and . Record of the facility's log revealed Resident #2 had two on , one at 02:57 a.m. and another at 4:30 p.m. Per the resident's record there was a third that occurred on that was not on the log. Review of the Progress Note, dated , 02:57 revealed: "Resident found sitting on the floor sorting through suitcase. When asked what she was doing she stated "packing". Then asked how she got on the floor she stated she . No apparent injury. States she has "No pain". Lifted to chair with assist of three and brought to nursing station for closer monitoring. Dr. notified, family number is disconnected. DON notified." A facility listing of noted a second on at 4:30 p.m. There was no Progress note of the second . A third occurred on , at 3:10 a.m. The resident's record was silent regarding the at 4:30 p.m. on . Further review of the Progress notes, dated , revealed that Resident #2 had a at 3:10 a.m. The Progress note, documented that the resident was heard calling for help by the Nurse. The Nurse observed the resident on the	N 201	reviewed by the interdisciplinary team to ensure a thorough investigation was completed and verify current interventions were appropriate and least restrictive per investigation for each resident to reduce /minimize injury related to . Director of Nursing/Designee in-serviced nursing staff on the clinical program for preventing /implementing least restrictive individualized interventions. Director of Nursing and Unit Managers will monitor to assure interventions to reduce /minimize injury are in place accordingly. NHA and IDT in-serviced on completing a complete and thorough investigation including, statements, MARS and TARS, progress notes, in-services, root cause and care plan. Director of Nursing/Designee will complete audits to ensure residents at risk for have individualized interventions in place to reduce /minimize injury, Weekly x 4 weeks, monthly x 3 months and results of the audits will be reported to the QAPI committee monthly for review and revision for 3 months and then as needed to ensure compliance. NHA and/or designee will complete audits of incidents and verify events were thoroughly investigated to include a root cause weekly x 4 weeks then monthly x 3 and results of the audits will be reported to the QAPI committee monthly for review and revision for 3 months and then as needed to ensure compliance.	

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N 201	Continued From page 2	N 201		

floor." Resident stated, "I came down hard on my side" Resident was assessed; range of motion was performed without difficulty with the exception of the right hip area. Hoyer lifted resident to the bed with the assistance of two C.N.A's."

Record review of the Progress Note on at 11:18 a.m., stated, "Obtained orders from MD to send resident to ER to evaluate and treat to rule out any injuries status post to ..."
Per record review, of the Progress notes resident sustained a .. on ..... at 3:10 a.m. The physician ordered Resident #2's x-ray and the Nurse called for the x-ray to be done by the mobile x-ray company. The x-ray company did not arrive. The resident was transferred to the hospital at 11:30 a.m. on . After arriving at the hospital, the x-ray revealed the resident had sustained a . to her right hip and right femur.

Record review of the Risk Management report dated at 16:27 revealed the Nursing description: Resident on the floor with her feet facing head of the bed, sitting on her butt. No visible injuries at this time. No complaints of pain or discomfort. Resident stated, "While going through her suitcase, went to turn and slipped off the bed." Immediate Action Taken: Education on using the call light when help is needed, added floor mats. Resident picked up by two staff members using Hoyer lift. Bed in low position. Note Text: Upon entering , resident was found sitting on the floor next to the bed at 16:25 p.m. resident states she did not hit her head and has no injury. Skin assessment done, no new skin areas noted. Resident placed back in bed with Hoyer lift and two nurses to get her off the floor. floor mats placed, reminded

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N 201	Continued From page 3 resident to use call light for assistance. Interview During an interview, with the Director of Nurses (DON) at 4:21 p.m. on [redacted], she stated there was no MDS or [redacted] score on this resident. In a telephone interview at 8:46 a.m. on [redacted], with the daughter of the Resident #2, she stated that she requested side rails multiple times before her mother's first [redacted]; which was on [redacted]; but was told they were a no side rails facility. Observations conducted during the survey revealed there were side rails noted on beds throughout the facility. Record review of the Nursing Admission Assessment, dated [redacted] at 10:28, completed in the facility the facility assessed the resident as: [redacted]: [redacted] in the last 90 days: yes. Does the resident require side rails: No. Interventions initiated by the facility on [redacted]: [redacted] floor mats to sides of bed when resident in bed. Encourage wearing Non-skid socks/shoes when out of bed; initiated [redacted]. Lock brakes on bed, chair, etc. before transferring. Remind and reinforce safety awareness. Educate/remind resident to request assistance prior to ambulation. Adaptive device: wheelchair; [redacted]. Record review of the Care Plan for Resident #2 revealed: Focus: resident was at increased risk for [redacted] related to [redacted], use of [redacted], medications; initiated [redacted]. Goal: Will minimize the risk of [redacted]; date initiated [redacted]. The Interventions put into place after [redacted] were [redacted] floor mats to sides of bed	N 201		

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N 201	Continued From page 4 when resident in bed. Encourage to wear Non-skid socks/shoes when out of bed; initiated . Lock brakes on bed, chair, etc. before transferring. Remind and reinforce safety awareness. Educate/remind resident to request assistance prior to ambulation. Adaptive device: wheelchair; . OT (Occupational , ,) referral for screen and treatment. The resident was evaluated and assessed and has diagnoses of , , , , , and , . There was no documentation of follow-up to show that resident would remember and understand the interventions. The resident did not use the call light for the first, second, or third . During the third the resident was heard, by the nurse, calling out for help . Record review of the policy and procedure titled " & Injury Management" undated; the Overview states: The facility strives to reduce the risk of and injuries by promoting the implementation of the and Injuries Program. Data is collected on residents/patients for risk factors. The Interdisciplinary team works with the resident/patient and family to identify and implement appropriate interventions to reduce the risk of or injuries while maximizing dignity and independence. Class II	N 201		