

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967748	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/21/2022
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER WINDSOR OF VENICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 CENTER RD VENICE, FL 34292
--------------------------------------------------------------	-------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	<p>Initial Comments</p> <p>An unannounced revisit survey was conducted on ... through ... at Windsor of Venice, an assisted living facility in Venice, Florida.</p> <p>This was a follow-up to the complaint survey conducted on ...</p> <p>The following is a description of the uncorrected deficiency.</p>	{A 000}		
{A 052}	<p>429.256(); 59A-36.008(3) Medication - Assistance with Self-Admin</p> <p>429.256</p> <p>(3) Assistance with self-administration of medication includes:</p> <p>(a) Taking the medication, in its previously dispensed, properly labeled container, including an ... syringe that is prefilled with the proper dosage by a pharmacist and an ... that is prefilled by the manufacturer, from where it is stored, and bringing it to the resident.</p> <p>(b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change.</p> <p>(c) Placing an oral dosage in the resident's ... or placing the dosage in another container and helping the resident by lifting the container to his or her ...</p>	{A 052}		

AHCA Form 3020-0001 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X8) DATE
----------------------------------------------------------------------------------------------	-------	-----------

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967748	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/21/2022
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER WINDSOR OF VENICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 CENTER RD VENICE, FL 34292
--------------------------------------------------------------	-------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 052}	<p>Continued From page 1</p> <p>(d) Applying ... medications.</p> <p>(e) Returning the medication container to proper storage.</p> <p>(f) Keeping a record of when a resident receives assistance with self-administration under this section.</p> <p>(g) Assisting with the use of a ..., including removing the cap of a ..., opening the unit dose of ... solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the ...</p> <p>(h) Using a ... to perform ... level checks.</p> <p>(i) Assisting with putting on and taking off ... stockings.</p> <p>(j) Assisting with applying and removing an ... but not with titrating the prescribed ... settings.</p> <p>(k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device.</p> <p>(l) Assisting with measuring vital signs.</p> <p>(m) Assisting with ... bags.</p> <p>(4) Assistance with self-administration does not include:</p> <p>(a) Mixing, ..., converting, or ... medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.</p> <p>(b) The preparation of syringes for injection or the administration of medications by any injectable route.</p> <p>(c) Administration of medications by way of a tube inserted in a ... of the body.</p> <p>(d) Administration of ... preparations.</p> <p>(e) The use of irrigations or debriding agents used in the treatment of a skin condition.</p>	{A 052}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967748	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/21/2022
--------------------------------------------------	-----------------------------------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER WINDSOR OF VENICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 CENTER RD VENICE, FL 34292
--------------------------------------------------------------	-------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 052}	<p>Continued From page 2</p> <p>(f) Assisting with _____ or _____ preparations.</p> <p>(g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication.</p> <p>(h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.</p> <p>(5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003.</p> <p>59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION.</p> <p>(a) Any unlicensed person providing assistance with self-administration of medication must be _____ or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule.</p> <p>(b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of</p>	{A 052}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967748	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 06/21/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR OF VENICE		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 CENTER RD VENICE, FL 34292			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{A 052}	Continued From page 3 the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S.	{A 052}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967748	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/21/2022
--------------------------------------------------	-----------------------------------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER
WINDSOR OF VENICE

STREET ADDRESS, CITY, STATE, ZIP CODE
**1600 CENTER RD
VENICE, FL 34292**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

{A 052} Continued From page 4

(g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition.

(h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication.

This Statute or Rule is not met as evidenced by: Based on record review, and staff interview, the facility failed to follow physician's orders when providing assistance with self-administration of medication according to medications orders for 11 (Residents #4, #8, #15, #18, #19, #20, #21, #22, #23, #24, #25) of 11 residents reviewed.

The findings included:

Record review of the facility incident log report revealed multiple medication errors on

Record review of the Medication Administration Record (MAR) for _____ for Resident #4 failed to show documentation resident #4 received _____ 10 mg, _____ 0.5 mg, _____ 3 mg, _____ Tart 25 mg, _____ 40 mg, _____ 0.4 mg on _____

Record review of the Medication Administration Record (MAR) for _____ for Resident #15 failed to show documentation resident #15 received _____ 3 milligrams (mg), _____ 50 mg, _____ Cream 5% on _____

Further review of the _____ MAR for resident #15 revealed the _____ Cream 5% was not

{A 052}

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967748	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/21/2022
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER WINDSOR OF VENICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 CENTER RD VENICE, FL 34292
--------------------------------------------------------------	-------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 052}	<p>Continued From page 5</p> <p>given on, and, and 0.3 mg was not given on as the medications were marked not available.</p> <p>Record review of the Medication Administration Record (MAR) for for Resident #18 failed to show documentation resident #18 received 500 mg, 81 mg, 10 mg, 5 mg, 10 mg and D3 50 micrograms (mcg) on</p> <p>Record review of the Medication Administration Record (MAR) for for Resident #19 failed to show documentation resident #19 received 600 mg, 15 mg, Preservision Areds 2 mini capsules and Ocusoft Retaine MGD on</p> <p>Record review of the Medication Administration Record (MAR) for for Resident #20 failed to show documentation resident #20 received 0.2 mg, 3 mg, 20 mg, 100 mg, 50 mg, C 500 mg, and Cream 4% on</p> <p>Record review of the Medication Administration Record (MAR) for for Resident #21 failed to show documentation resident #21 received 0.005% solution, P solution 0.1% and 100 mg on</p> <p>Record review of the Medication Administration Record (MAR) for for Resident #22 failed to show documentation resident #22 received 500 mg, Advance Relief Solution B & L, 10 mg, 75 mg, 5 mg,</p>	{A 052}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967748	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/21/2022
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER WINDSOR OF VENICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 CENTER RD VENICE, FL 34292
--------------------------------------------------------------	-------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 052}	<p>Continued From page 6</p> <p>10 mg, 20 mg, 220 mg, Preservision Areds 2 mini capsules, Bal Restore, 0.4 mg and 10000 on Further review of the MAR for resident #22 revealed 1000 mcg was not given on and 200 mg was not given on and 5 mg was not given on as the medications were marked not available.</p> <p>Record review of the Medication Administration Record (MAR) for for Resident #23 failed to show documentation resident #23 received 500 mg at 2:00 p.m. and 10:00 p.m., and 20 mg on</p> <p>Record review of the Medication Administration Record (MAR) for for Resident #24 failed to show documentation resident #24 received Health 10 mg, 10 mg, and 30 mg, on</p> <p>Record review of the Medication Administration Record (MAR) for for Resident #25 failed to show documentation resident #25 received ER (extended release) 180 mg, 10 mg, 10 mg, 20 mg, and 20 mg, on Further review of the MAR for resident #25 revealed 500 mcg was not given on, Certavite and 20 mg was not given on, 20 mg, 10 mg, 10 mg was not given on, and 20 mg was not given on and as the medications were marked not available.</p>	{A 052}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967748	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/21/2022
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER WINDSOR OF VENICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 CENTER RD VENICE, FL 34292
--------------------------------------------------------------	-------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

{A 052}	<p>Continued From page 7</p> <p>Record review of the Medication Administration Record (MAR) for _____ for Resident #8 revealed _____ 10 mg was not given on _____ through _____ D3 25 mcg was not given on _____ and _____ B-_____/Ultra B 100 was not given on _____, _____ 1000 mcg was not given on _____ through _____ as the medications were marked not available.</p> <p>On _____ at 12:38 p.m., Administrator confirmed the medications errors documented on the incident report log on _____ occurred when an agency nurse did not administer bedtime medications.</p> <p>On _____ at 2:20 p.m., Staff B Licensed Practical Nurse (LPN) stated there are times when the residents don't always have the medications in the cart and he would place his initials on the MARs, circle it and mark the medication as being unavailable, and the resident does not get the medication. Staff B confirmed there are issues still with some of the medications not being in the cart at times when they are to be given.</p> <p>On _____ at 8:20 a.m., Healthcare Director stated she is not sure why some of the residents MARS are marked with medications not available she would have to look into it. Healthcare Director confirmed if the medication is marked as not being available then the resident would not have received the medications.</p> <p>Interview on _____ at 8:46 a.m., the Executive Director confirmed there is no training for agency staff when working in the facility, using the computer software system and administering</p>	{A 052}		
---------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------	--	--

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967748	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/21/2022
--------------------------------------------------	-----------------------------------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER WINDSOR OF VENICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 CENTER RD VENICE, FL 34292
--------------------------------------------------------------	-------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 052}	<p>Continued From page 8</p> <p>medications to the facility residents.</p> <p>On at 10:32 a.m., Healthcare Director confirmed medications were not administered to multiple residents on, and there is no specific training for agency staff when coming to work at the facility.</p> <p>On at 11:26 a.m., Medication Technician Staff D confirmed agency staff are not being trained, there is no orientation training for agency staff when working at the facility, and residents are not being given medications as they are not in the medications cart and not being ordered.</p> <p>On at 11:45 a.m., Licensed Practical Nurse Staff E confirmed there are times when she works the medication cart and needed medications are not in the cart she is using, she looks in the other cart and does not find it. Staff E confirmed there are times when medications are on the MAR and not in the cart.</p> <p>Class III</p>	{A 052}		