

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                                    |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969388</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/16/2020</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**WINDSOR AT CELEBRATION**

**1370 CELEBRATION BLVD  
CELEBRATION, FL 34747**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| {A 000}                  | Initial Comments<br><br>A revisit to a biennial survey was conducted at Windsor At Celebration on 12/16/2020. Deficiencies were identified at the time of survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | {A 000}             |                                                                                                                          |                          |
| {A 008}<br>SS=D          | 429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment<br><br>429.26<br>(5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes a permanent part of the facility's record of the resident and must be made available to the agency during inspection or upon request. An assessment that has been completed | {A 008}             |                                                                                                                          |                          |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                                    |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969388</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/16/2020</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**WINDSOR AT CELEBRATION**

**1370 CELEBRATION BLVD  
CELEBRATION, FL 34747**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| {A 008}                  | Continued From page 1<br><br>through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6.<br>(6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and must be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or, if not possible, a nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the | {A 008}             |                                                                                                                          |                          |

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                                    |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969388</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/16/2020</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**WINDSOR AT CELEBRATION**

**1370 CELEBRATION BLVD  
CELEBRATION, FL 34747**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| {A 008}                  | <p>Continued From page 2</p> <p>resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of _____ require such assistance.</p> <p>59A-36.006</p> <p>(2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a _____ to _____ medical examination completed by a health care provider as specified in either paragraph (a) or (b) of this subsection.</p> <p>(a) A medical examination completed within 60 calendar days before the individual's admission to a facility pursuant to section 429.26(4), F.S. The examination must address the following:</p> <ol style="list-style-type: none"> <li>1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations,</li> <li>2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living,</li> <li>3. Any nursing or _____ services required by the individual,</li> <li>4. Any special diet required by the individual,</li> <li>5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication,</li> <li>6. Whether the individual has signs or symptoms of _____ or any other communicable _____, which are likely to be transmitted to other residents or staff,</li> <li>7. A statement on the day of the examination that, in the opinion of the examining health care provider, the individual's needs can be met in an assisted living facility; and,</li> <li>8. The date of the examination, and the name,</li> </ol> | {A 008}             |                                                                                                                          |                          |

Agency for Health Care Administration

|                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                 |                                                                                                                          |                                                                    |
|-------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969388</b>                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/16/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WINDSOR AT CELEBRATION</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1370 CELEBRATION BLVD<br/>CELEBRATION, FL 34747</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| {A 008}                                                           | Continued From page 3<br><br>signature, address, telephone number, and license number of the examining health care provider. The medical examination may be conducted by a health care provider licensed under chapter 458, 459 or 464, F.S.<br>(b) A medical examination completed after the resident's admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, _____, which is incorporated by reference and available online at: <a href="http://www.flrules.org/Gateway/reference.asp?No=Ref-09170">http://www.flrules.org/Gateway/reference.asp?No=Ref-09170</a> . Faxed or electronic copies of the completed form are acceptable. The form must be completed as instructed.<br>1. Items on the form that have been omitted by the health care provider during the examination may be obtained by the facility either orally or in writing from the health care provider.<br>2. Omitted information must be documented in the resident's record. Information received orally must include the name of the health care provider, the name of the facility staff recording the information, and the date the information was provided.<br>3. Electronic documentation may be used in place of completing the section on AHCA Form 1823 referencing Services Offered or Arranged by the Facility for the Resident. The electronic documentation must include all of the elements described in this section of AHCA Form 1823.<br>(c) Any information required by paragraph (a), that is not contained in the medical examination report conducted before the individual's admission to the facility must be obtained by the administrator using AHCA Form 1823 within 30 days after admission.<br>(d) Medical examinations of residents placed by | {A 008}                                                                                         |                                                                                                                          |                                                                    |

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                                    |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969388</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/16/2020</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**WINDSOR AT CELEBRATION**

**1370 CELEBRATION BLVD  
CELEBRATION, FL 34747**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| {A 008}                  | <p>Continued From page 4</p> <p>the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of section 429.26, F.S. and this rule. (f) Any orders issued by the health care provider conducting the medical examination for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility may be attached to the health assessment. A health care provider may attach a DH Form 1896, Florida Form, for residents who do not wish to be administered in the case of _____ or _____.</p> <p>(g) A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission.</p> <p>This Statute or Rule is not met as evidenced by:<br/>DEFICIENCY REMAINED UNCORRECTED</p> | {A 008}             |                                                                                                                          |                          |

Agency for Health Care Administration

|                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                       |                                                                                                                          |
|-------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969388</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/16/2020</b>                                                       |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WINDSOR AT CELEBRATION</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1370 CELEBRATION BLVD</b><br><b>CELEBRATION, FL 34747</b> |                                                                                                                          |
| (X4) ID<br>PREFIX<br>TAG                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |
| {A 008}                                                           | <p>Continued From page 5</p> <p>Based on record review and interview the facility did not obtain an accurate Resident Health Assessment form AHCA form 1823, for 1 of 4 resident (#4).</p> <p>Findings:</p> <p>Resident record review for resident #4 revealed she was admitted on . . . . . The health assessment report 1823 available for review listed diagnoses . . . . . and . . . . . according to the report she needed assistance with all activities of daily living. Continued review revealed the health assessment was not dated.</p> <p>In an interview with the administrator on . . . . . at 4 PM, who confirmed the findings.</p> <p>Class III</p> | {A 008}                                                                                               |                                                                                                                          |