

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the _____ are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic _____ submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; _____; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on review of the facility's employee background screening clearinghouse and interview, the facility failed to report the initial employment status within 10 business days for 2 of 6 sampled staff (dietary manager & director of nursing).	CZ814			

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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
CZ814	Continued From page 1 Findings: Review of the Dietary Manager's personnel record revealed a hire date of . Review of the Director of Nursing's (DON) personnel record revealed a hire date of Review of the facility's employee Background Screening Clearinghouse on . . . at 12 P.M. revealed both the Dietary Manager and the DON were not on the roster. On . . . at 12:15 PM, the Human Resource Director confirmed the findings. Unclassified	CZ814			
A 000	Initial Comments A Relicensure survey with Limited Nursing Service (LNS), Complaint Investigation #2022008053, and a Generator Monitoring were conducted from . . . /22. Windsor at Celebration had deficiencies at the time of the survey.	A 000			
A 010 SS=D	429.26(. . .) FS: 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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 010	Continued From page 2 resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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 010	Continued From page 3 physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical _____ 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a _____-to-_____ medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule	A 010		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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 010	Continued From page 4 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a _____ may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner; 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A _____, ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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 010	Continued From page 5 interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility inappropriately retained 1 of 13 sampled residents who developed an (#3), 1 of 13 sampled residents who developed a _____, and failed to ensure 2 of 13 sampled residents had a _____-to-_____ medical examination by a health care practitioner following a significant change (#3 & #4). Findings: 1. Resident #3's record revealed a facility admission date of _____. The resident's diagnoses were _____ with _____ type 2, _____ with _____	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/25/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WINDSOR AT CELEBRATION

**1370 CELEBRATION BLVD
CELEBRATION, FL 34747**

(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 010	Continued From page 6 behavioral disturbances, _____, and _____ of _____ of lower _____. An 1823 health assessment form, dated _____, indicated the resident did not have a _____. A facility communication to a health care provider, dated _____, indicated the resident had a half-dollar sized _____ on his left heel that was hard and dark brown in color. A health care provider's order, dated _____, ordered home health skilled nursing for a left heel _____ that was _____ due to a scab. A facility note, dated _____, indicated an order was received for home health for _____ care to a left heel _____. A health care provider ordered Septra DS, an _____, one tablet by _____ twice a day for five days on _____. A facility note, dated _____, indicated the resident received the _____ for a left heel _____. A _____ doctor's visit note, dated _____, indicated the resident had a left heel _____ pressure injury obscured full-thickness skin and tissue loss pressure that had a status of not healed. The _____ had a small amount of _____ drainage that had no odor. The _____ bed had 76-100% _____. The skin around the _____ was red, moist, and warm. _____ is "a _____ of tissue in, or _____ out from, living tissue." (medical-dictionary.the freedictionary.com). Observations of the _____ with Nurse G on _____	A 010		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/25/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WINDSOR AT CELEBRATION

**1370 CELEBRATION BLVD
CELEBRATION, FL 34747**

(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 010	Continued From page 7 at 10:45 AM revealed the measured approximately 6 centimeters (cm) by 5 cm. The bed had 25% black-colored and 75% yellow-colored Resident #3's record did not contain either an updated 1823 assessment form or a-to-..... medical examination by a health care practitioner that contained all of the information on the 1823 form. 2. Resident #4's record revealed a facility admission date of The resident's diagnoses were and An 1823 form, dated, indicated the resident did not have a and required total assistance with bathing,, grooming, toileting, and transferring. The resident was alert and non-verbal. A health care provider's note, dated, indicated the resident had a diagnoses of and of the of the lower A facility note, dated, indicated the resident had a fluid-filled on her right ankle/heel. Home health was notified, and a nurse came to the facility and covered the area with a A health care provider's note, dated, indicated the resident had a on her right heel. There was a moderate amount of drainage, which had no odor. The bed was % covered with and 51-75% with bright red The skin around the was moist and macerated and did not exhibit signs of tissue is reddish connective tissue	A 010		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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 010	Continued From page 8 that forms on the surface of a _____ when the is healing." (_____, net). Observations made of the _____ with Nurse G on _____ at 10:40 AM revealed it was an _____ that measured approximately 4 cm by 4 cm. 100% of the _____ bed was covered with pale yellow _____. On _____ at 12:15 PM, a request was made of the DON to provide any additional 1823 assessment forms or health care provider assessments. On _____ 1:40 PM, the findings for both resident #3 and #4 were discussed with the Administrator, the Assistant Administrator, and the DON, including the inappropriate continued residency for both due to the _____ and that neither resident had an updated 1823 assessment form when they each developed the _____, which was a significant change. The Administrator said he knew both residents had a _____ but he believed they were either a _____ or 2. Class III	A 010			
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of _____ or _____ or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such _____ or _____. The notification must occur within 30 days after the	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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 025	Continued From page 9 acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making _____ for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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 025	Continued From page 10 (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to give 1 of 13 sampled residents a physician prescribed medication (#5), and failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision to 2 of 13 sampled residents who eloped from the facility (#11 & #16). Findings: 1. Review of resident #5's record revealed a facility admission date of . The resident's diagnoses were . 's , and The resident required assistance with self-administration of medications. A facility report indicated that resident #5 did not receive her . medication since it was first ordered on The report indicated that a nurse overlooked the order, and pharmacy neither sent the medication nor put the order into the charting system. The report indicated the error was caused due to a failure to follow proper admission protocol and process by the nurse. "is used to treat , certain conditions (. phase of) " (www.msn.com/en-us/health/drugs/).	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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 025	Continued From page 11 A facility note, dated _____ at 1:17 P.M., indicated the resident returned to the facility following a hospital stay. An 1823 health assessment form, dated _____, had an order for _____ DR 500 milligrams tablet, give one tablet by _____ twice a day for _____. Review of resident #5's _____ medication observation record (MOR) revealed the first dose of _____ was not given until _____. During an interview with the DON on _____ at 10:21 A.M. she confirmed the _____ was not given as ordered. She said that she now reviewed new admission 1823's and medication lists. She said training on the admission process was provided to the facility's nurses. 2. Resident #16's record revealed he was admitted on _____ but physically arrived at the facility on _____. He was admitted into the secure Memory Care unit. A Resident Health Assessment form (1823) dated _____ revealed he required supervision with bathing, _____ grooming, and toileting. He was independent with ambulation, eating, and transferring. The 1823 was incomplete. The elopement risk was blank for resident #16. His diagnoses included _____, _____, and _____. Review of the facility notes revealed: On _____ at 6:45 PM, resident #16 arrived at the facility. On _____, the resident was exit-seeking on the _____ shift. He opened the exit door on 2 occasions. On _____ at 1:56 PM, resident #16 was	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/25/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WINDSOR AT CELEBRATION

**1370 CELEBRATION BLVD
CELEBRATION, FL 34747**

(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 025	Continued From page 12 exit-seeking. On _____ at 6:41 AM, the resident was _____ and exit-seeking. On _____ at 9:34 PM, the resident was exit-seeking. On _____ at 9:06 PM, the resident was with a one-to-one sitter for the shift. On _____ at 12:15 PM, the resident was discharged with his sibling. On _____ at 4:15 PM, during an interview with the agency licensed practical nurse (LPN) who worked with resident #16 on _____ on the 3 to 11 shift. She said the resident was a new admission and he was _____ around the memory care unit on _____ and trying to exit. He opened the exit door a couple of times and went outside on the sidewalk. She said she brought him _____ in both times and reset the alarm. After resident #16 went out the door twice, she said he sat with a staff member in the Memory Care dining room. She could not recall the name of the staff member who sat with him. On _____ at 5 PM, the Director of Wellness confirmed she did not have any further documentation regarding resident #16's elopement from the facility and being brought _____ into the facility by the agency LPN. 3. Resident #11's record revealed an admission date of _____. The last 1823 Health Assessment was dated _____. The resident was identified as an elopement risk. She was independent with ambulation, _____, transferring and toileting, and needed assistance with self-administration of medications. On _____ at 1:50 PM, the resident ambulated with unstable gait without any assistive devices, and needed supervision with bathing, eating, and	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/25/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WINDSOR AT CELEBRATION

**1370 CELEBRATION BLVD
CELEBRATION, FL 34747**

(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 025	Continued From page 13 grooming. Resident #11's record revealed that on at 7:06 PM, the resident eloped from the secured Memory Care unit fire exit door near Nurse F heard the alarm to the fire exit door sound and immediately brought resident #11 inside the facility. Resident #11 was found about 100 away from the fire exit door to the parking lot. Resident #11's record revealed that on at 6:47 PM, resident #11 eloped again from the secured Memory Care unit fire exit door near Nurse F heard the alarm sound to the fire exit door, ran to the fire exit door, and retrieved resident #11 into the facility. Resident #11 was found about 100 away from the fire exit door to the parking lot. Photographic evidence was obtained. On at 1:53 PM, an attempted interview with resident #11 but she was not aware. She knew her name, but she and walked off in mid-conversation. On at 1:57 PM, the fire exit door near was observed. The fire exit door alarm will sound off and open easily when your or arm was placed on the fire exit door's handle. On at 1:58 PM, the Memory Care Director revealed she only has been working at this facility for two weeks and was only aware of the recent elopement for resident #11 on * On at 3:24 PM, Nurse F assisted with testing the fire exit door and alarm. After five (5)	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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 025	Continued From page 14 separate tests, it was determined that it takes the fire exit door 30 seconds for the door handle to unlock and open widely for a person to go outside to the parking lot located in the of the facility. During this time, Nurse F confirmed that she found resident #11 on both elopements on and . Nurse F stated that during both dates, resident #11 said she wanted to go home. During the testing of the fire exit door, the fire alarm did not sound loudly in the Memory Care unit during these five (5) separate testings. Nurse F stated that it was not working properly because the fire alarm did not sound loudly as it should, it just buzzed with a low tone at the fire exit door. Residents and staff working in the Memory Care unit did not hear the fire alarm sound. On at 3:50 PM, observation of the outside the fire exit door would take a person into the parking lot located in the of the facility. Adjacent to the parking lot was a high weed swamp area and then Highway Interstate 4. On at 4:21 PM, an email was sent to the Fire Inspector at Osceola County Fire and Rescue Department requesting the requirement and regulation documentation for having a fire exit door in a secured Memory Care facility. On at 11:54 AM, a telephone call was received from the Fire Inspector at Osceola County Fire and Rescue Department requesting an email address to send the documentation and regulations that it was allowed to have the fire exit door in the secured Memory Care unit. The facility did not have any documentation to provide appropriate supervision preventing an elopement to ensure resident #11 did not elope from the secured Memory Care unit and had no	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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 025	Continued From page 15 plan of how to keep resident #11 safe after two separate elopements occurred within 3 months. On _____ at 2:30 PM, the Memory Care Director and Director of Nursing (DON) confirmed the findings. Class II	A 025			
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2) (a), F.A.C., this requirement is satisfied. 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 this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement	A 032			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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 032	Continued From page 16 at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on the facility's documentation and interview, the facility failed to make a daily effort to check for identification for 1 of 13 sampled residents (#11) identified as an elopement risk on their person that included their name, facility's	A 032			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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 032	Continued From page 17 name, facility's address, and facility's telephone number as required, and failed to ensure that 1 caregiver participated in two (2) elopement drills per year as required (A). Findings: 1. Resident #11's record revealed an admission date The last 1823 Health Assessment, dated, listed a medical history of decline with, and condition. She was identified as an elopement risk. She was independent with ambulation,, transferring and toileting, and needed assistance with self-administration of medications. On at 1:50 PM, the resident ambulated with unstable gait without any assistive devices, and needed supervision with bathing, eating, and grooming. Resident #11's record revealed that on at 7:06 PM, the resident eloped from the secured Memory Care unit fire exit door near Nurse F heard the alarm to the fire exit door sound and immediately brought resident #11 inside the facility. Resident #11 was found about 100 away from the fire exit door to the parking lot. Resident #11's record revealed that on at 6:47 PM, resident #11 eloped again from the secured Memory Care unit fire exit door near Nurse F worked that evening and heard the fire alarm sound to the fire exit door, ran to the fire exit door, and retrieved resident #11 into the facility. Resident #11 was found about 100 away from the fire exit door to the parking lot.	A 032			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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 032	Continued From page 18 Photographic evidence was obtained. On at 2:45 PM, an interview with the Memory Care Director confirmed the findings. 2. Review of Caregiver A's personnel record revealed a hire date of On at 1:44 PM, Caregiver A said she had not participated in a resident elopement drill since being hired. Review of the facility's documented resident elopement drills revealed they were conducted on Caregiver A was not listed as a participant on any of them. On at 1:45 PM, the maintenance director, who said he conducted elopement drills, confirmed that caregiver A was not a participant during any of the drills. Class III	A 032			
A 052 SS=D	429.256(); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers.	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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 19 (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. (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 (d) Applying medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (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 (4) Assistance with self-administration of medication does not include: (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. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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 20 inserted in a _____ of the body. (d) Administration of _____ preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with _____ or _____ preparations. (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. (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. (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. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (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. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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 21 self-administration of medication includes, orally advising the resident of the name and dosage of 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	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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)	
A 052	Continued From page 22 medication does not include the activities detailed in Section 429.256(4), F.S. (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 observations, record reviews, and interview, the facility failed to ensure the unlicensed staff, who assisted 1 of 13 sampled residents with medications, followed the correct procedures (#19). Findings: Observations made during a medication pass for resident #19 on 8/25/2022 at 2 PM revealed that Medication Technician (Med Tech) E placed the medication cart outside of resident #19's room. She unlocked the cart and removed a medication package. While standing at the cart, she opened the package and poured the tablet into a cup. She took only the cup to the resident's room. She identified the resident by name then said the name of the medication aloud. The resident took the pill without help. The Med Tech returned to the cart and signed the Medication Observation Record (MOR). The Med Tech did not take the med pack from the cart to the resident and prepare it in the resident's presence, as required. Following the medication pass observation, the	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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)	
A 052	Continued From page 23 Med Tech confirmed that she did not follow the proper procedure. Class III	A 052		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication.	A 054		

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WINDSOR AT CELEBRATION

1370 CELEBRATION BLVD
CELEBRATION, FL 34747

AHCA Form 3020-0001

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/25/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WINDSOR AT CELEBRATION

**1370 CELEBRATION BLVD
CELEBRATION, FL 34747**

(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 054	Continued From page 25 pharmacy was not filling them on time. Resident #9 provided a list that she documented of medications missed on the days. She said these are "life and medications" that she must take every day. The list of missing medications and dates included: - "No _____, left message 2 days no pills. On _____ spoke to DON (Director of Nursing)." - "3 times possibly no _____" - "No _____ for _____ and _____." - "No _____ and no _____" - "No _____ and _____" - "Went to nurse station and they forgot the _____ at 11:30 AM and it was a new person." Photographic evidence was obtained. On _____ at 11:10 AM, the DON stated that resident #9 mentioned to her only once about not receiving medication. She was not aware of any of the other medications and was not aware of her concerns. The following MORs had unmarked signatures as medication not given as follows: _____ had blanks in MORs because resident #9 was self-administering all of her medications that included _____ 100 mg; _____ ER 25 mg, _____ HCl 8 mg, _____ ER 500 mg, _____ 81 mg; _____ 10 mg, CoQ10 100 mg, _____ 20mg, _____ 50 mg, and some _____ creams, and Trelogy _____ 200 microgram (mcg) inhaler. MORs had unmarked signatures for _____ 500 mg every 12 hours at 9 AM given and 5 PM on _____	A 054		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/25/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WINDSOR AT CELEBRATION

**1370 CELEBRATION BLVD
CELEBRATION, FL 34747**

(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 054	Continued From page 26 , and MORs had unmarked signatures on for 50 mg twice daily, 500 mg every 12 hours, and for 25 mg on, and Photographic evidence was obtained. On at 3 PM, the DON confirmed the findings. Class III	A 054		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if	A 055		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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 055	Continued From page 27 kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from	A 055			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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 055	Continued From page 28 medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, resident record review and interview, the facility failed to keep centrally stored medications in a locked cabinet, locked cart or other locked storage receptacle, room or area at all times as required for 1 of 13 sampled resident (#6). Findings: Resident #6's record revealed an admission date of . The last 1823 Health Assessment, dated . . . , listed a medical history of . . . on	A 055			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/25/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WINDSOR AT CELEBRATION

**1370 CELEBRATION BLVD
CELEBRATION, FL 34747**

(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 055	Continued From page 29 and She needs assistance with self-administration of medications and no assistance with activities of daily living, was independent with all except needing supervision for bathing, and ambulates with a walker. On at 10:32 AM, over the counter (OTC) medications of D3 and were found in in resident #6's room not centrally stored and locked safely. Photographic evidence was obtained. On at 10:32 AM, resident #6 stated she was very capable of taking her herself, but the nurse brings her all her prescription medications every day to take. On at 10:37 AM, the Director of Nursing confirmed the findings. Class III	A 055		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1169388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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 078	Continued From page 30 when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable, such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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 078	Continued From page 31 and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff _____ by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interviews, the facility failed to ensure the personnel record for 1 of 6 sampled staff contained documented evidence of a negative _____ () exam on an annual basis (Administrator), and failed to ensure 1 of 6 sampled staff submitted a written statement from a health care provider documenting freedom from communicable _____ within 30 days after beginning employment (D). Findings: 1. Review of the Administrator's personnel record revealed a hire date of _____. The record contained a negative _____ exam that was dated _____. The record did not contain documentation of a negative _____ exam for 2022. On _____ at 3:50 PM, the Wellness Nurse provided documentation that indicated she administered a _____ skin test on that day and said the result was pending. 2. Review of Staff D's personnel record revealed	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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 078	Continued From page 32 he was hired on A written statement from a health care provider documenting he did not have any signs or symptoms of communicable was not found in the record. On at 1:07 PM, the Human Resources representative confirmed there was no communicable statement for Staff D in his file. Class III	A 078			
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011() FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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 081	Continued From page 33 training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in _____ control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its _____ control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to _____ borne _____ may be used to meet this	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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 081	Continued From page 34 requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident neglect, and The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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 081	Continued From page 35 and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interview, the facility failed to ensure 1 of 6 sampled staff received the required in-service training as described in 59A-36.011 () FAC (Administrator). Findings: Review of the Administrator's personnel record revealed a hire date of . The record did not contain documentation to indicate the Administrator received in-service training regarding the facility's resident elopement response policies and procedures within thirty days of employment. On at 3 PM, the findings were discussed with the Memory Care Director and an opportunity was given to provide additional documentation, however, none was ever provided. Class III	A 081			
A 082 SS=D	59A-36.011(4) FAC Training - / (4) (/). Pursuant to section 381.0035, F.S., all facility employees, with the	A 082			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/25/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WINDSOR AT CELEBRATION

**1370 CELEBRATION BLVD
CELEBRATION, FL 34747**

(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 082	Continued From page 36 exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on _____, including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. This Statute or Rule _____ is not met as evidenced by: Based on personnel record reviews and interview the facility failed to ensure 1 of 6 sampled staff completed a one-time education course on _____ (_____) within 30 days of employment (Administrator). Findings: Review of the administrator's personnel record revealed a hire date of _____. The record did not contain documentation to indicate the administrator completed a one-time education course on _____ and _____ within thirty days of employment. On _____ at 3 PM, the findings were discussed with the Memory Care Director and an opportunity was given to provide additional documentation, however, none was ever provided. Class III	A 082		
A 083 SS=D	59A-36.011(5) FAC Training - First Aid and _____ (5) FIRST AID AND _____. A staff member who has completed courses in First Aid and _____ and _____	A 083		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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 083	Continued From page 37 holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on review of staffing schedules and interview, the facility failed to ensure a staff member who was trained in () was in the facility at all times. Findings: Upon reviewing the facility's staffing schedule on at 4 PM, a request was made to see proof that someone trained in was in the facility during each shift on On at 5:15 PM, the Director of Nursing could provide proof of for only 7 AM to 11 PM. Therefore, the facility did not have someone trained in from 11 PM to 7 AM on	A 083			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/25/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WINDSOR AT CELEBRATION

**1370 CELEBRATION BLVD
CELEBRATION, FL 34747**

(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 083	Continued From page 38 Class III	A 083		
A 086 SS=D	59A-36.011(10) FAC Training - ADRD (10) AND RELATED ("ADRD") TRAINING REQUIREMENTS. Facilities which advertise that they provide special care for persons with ADRD, or who maintain secured areas as described in Chapter 4, Section 464.4.6 of the Florida Building Code, as adopted in rule 61G20-1.001, F.A.C., Florida Building Code Adopted, must ensure that facility staff receive the following training. (a) Facility staff who interact on a daily basis with residents with ADRD but do not provide direct care to such residents and staff who provide direct care to residents with ADRD, shall obtain 4 hours of initial training within 3 months of employment. Completion of the core training program between and shall satisfy this requirement. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. Initial training, entitled " and Related Level I Training," must address the following subject areas: 1. Understanding 's and related ; 2. Characteristics of ; 3. Communicating with residents with 's ; 4. Family issues; 5. Resident environment; and, 6. Ethical issues. (b) Staff who have successfully completed both the initial one hour and continuing three hours of ADRD training pursuant to sections 400.1755, 429.917 and 400.6045(1), F.S., shall be	A 086		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/25/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WINDSOR AT CELEBRATION

**1370 CELEBRATION BLVD
CELEBRATION, FL 34747**

(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 086	Continued From page 39 considered to have met the initial assisted living facility and Related Level I Training. (c) Facility staff who provide direct care to residents with ADRD must obtain an additional 4 hours of training, entitled " and Related Level II Training," within 9 months of employment. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. and Related Level II Training must address the following subject areas as they apply to these : 1. Behavior management, 2. Assistance with ADLs, 3. Activities for residents, 4. Stress management for the care giver; and, 5. Medical information. (d) A detailed description of the subject areas that must be included in an ADRD curriculum which meets the requirements of paragraphs (a) and (b) of this subsection, can be found in the document "Training Guidelines for the Special Care of Persons with 's and Related ," dated , incorporated by reference, available from the Department of Elder Affairs, 4040 Esplanade Way, Tallahassee, Florida 32399-7000. (e) Direct care staff shall participate in 4 hours of continuing education annually as required under section 429.178, F.S. Continuing education received under this paragraph may be used to meet 3 of the 12 hours of continuing education required by section 429.52, F.S., and subsection (1) of this rule, or 3 of the 6 hours of continuing education for extended congregate care required by subsection (7) of this rule. (f) Facility staff who have only incidental contact	A 086		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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 086	Continued From page 40 with residents with ADRD must receive general written information provided by the facility on interacting with such residents, as required under section 429.178, F.S., within three (3) months of employment. "Incidental contact" means all staff who neither provide direct care nor are in regular contact with such residents. (g) Persons who seek to provide ADRD training in accordance with this subsection must provide the department or its designee with documentation that they hold a Bachelor's degree from an accredited college or university or hold a license as a registered nurse, and: 1. Have 1 year teaching experience as an educator of caregivers for persons with _____, or related _____, or 2. Three years of practical experience in a program providing care to persons with _____, or related _____, or 3. Completed a specialized training program in the subject matter of this program and have a minimum of two years of practical experience in a program providing care to persons with _____, or related _____. (h) With reference to requirements in paragraph (g), a Master's degree from an accredited college or university in a subject related to the content of this training program can substitute for the teaching experience. Years of teaching experience related to the subject matter of this training program may substitute on a year-by-year basis for the required Bachelor's degree referenced in paragraph (g). This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to maintain the four (4) hours annual update for _____'s _____ and Related _____ (ADRD) training for 2 of 6 sampled staff (A & C), and failed to obtain the	A 086			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/25/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WINDSOR AT CELEBRATION

**1370 CELEBRATION BLVD
CELEBRATION, FL 34747**

(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 086	Continued From page 41 minimum requirement of four (4) hours Level 1 ADRD training for the Administrator as required. Findings: 1. Caregiver C's personnel record revealed a hire date of She completed her 4-hour Level 1 training on, and 4-hour Level 2 training on There was no documented evidence in the file that the 4-hour annual training was completed in 2020, 2021 and 2022. On at 4 PM, the Business Office Manager confirmed the findings. 2. Review of Caregiver A's personnel record revealed a hire date of The most recent documented 4-hour ADRD annual training in the record was dated The record did not contain documentation to indicate the caregiver completed 4-hour annual training during 2021. On at 1:07 P.M., the Human Resource Director said Caregiver A did not receive ADRD training during 2021. 3. Review of the Administrator's personnel record revealed a hire date of The record did not contain documentation to indicate the administrator completed 4-hour ADRD Level 1 training within 3 months of employment. On at 3 PM, the findings were discussed with the Memory Care Director and an opportunity was given to provide additional documentation, however, none was provided. Class III	A 086		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/25/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WINDSOR AT CELEBRATION

**1370 CELEBRATION BLVD
CELEBRATION, FL 34747**

(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 090	Continued From page 42	A 090		
A 090 SS=D	59A-36.011(11) FAC Training - (11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interview, the facility failed to have documented evidence to indicate 1 of 6 sampled staff received at least one hour of training in the facility's policy and procedures regarding () that included information in Rule 59A-36.009, FAC (Administrator). Findings: Review of the Administrator's personnel record revealed a hire date of . The record did not contain documentation to indicate the administrator received at least one hour of training in the facility's policy and procedures regarding On at 3 PM, the findings were discussed with the memory care director and an opportunity	A 090		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/25/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WINDSOR AT CELEBRATION

**1370 CELEBRATION BLVD
CELEBRATION, FL 34747**

(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 090	Continued From page 43 was given to provide additional documentation however, none was ever provided. Class III	A 090		
A 093 SS=D	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.frules.org/Gateway/reference.asp?No=Ref-04003 , and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%202014.pdf . Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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 093	Continued From page 44 nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER WINDSOR AT CELEBRATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1370 CELEBRATION BLVD CELEBRATION, FL 34747		
(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 093	Continued From page 45 notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of _____ the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on _____. (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has _____ with residents to serve, must be on _____ at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation, review of menus, and interview the facility failed to utilize menus reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969388	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/25/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WINDSOR AT CELEBRATION

**1370 CELEBRATION BLVD
CELEBRATION, FL 34747**

(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 093	Continued From page 46 ensure the meals meet nutritional standards. Findings: On at 12:10 PM, observation of the residents' lunch meal service revealed the food served was not indicated on the facility menu. On at 2 PM, the Dietary Manager was unable to provide the current menu because he did not know what week they were using. He also said he could not provide any substitution logs. On at 12 PM, the Dietary Manager said he was working off menus he brought with him from the previous facility where he worked. He said it was a better menu and the residents liked it better. He confirmed he did not have the menus reviewed by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian or a licensed nutritionist. Class III	A 093		