Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969388	A. BUILDING: _____ B. WING _____	02/12/2026

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 000	Initial Comments A Complaint Investigation # 2025017749 and generator monitoring was conducted at Windsor at Celebration Assisted Living Facility & Memory Care with Limited Nursing Services (LNS) on . The facility had a deficiency at the time of the survey visit.	A 000		
A 025 SS=D	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 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 025		

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A 025	Continued From page 1 (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. (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 the resident record review and interview, the facility failed to maintain written documentation for significant changes (behaviors) and any updates and recommendations for 1 of 2 sampled residents (#2) as required. Findings: A record review for resident #2 revealed date of admission . The last 1823 Health Assessment dated listed medical history of with decline,	A 025		

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A 025	Continued From page 2 , a risk and behaviors. She needed assistance with activities of daily living (ADLs) in bathing, and grooming. The resident is independent in ambulating and transferring and required medication administration. A facility note dated at 4:28 PM by Licensed Practical Nurse A (LPN) documented an observation of behavior change that resident #2 was in the dining room and walked to the garbage can near the sink and pulled her pants down and got inside the garbage can. The LPN helped resident #2 out of the garbage can and cleaned her up. There was no documentation that the family and physician was notified about this behavior and this was the only documentation found of any behaviors for resident #2. On at 8:37 AM, a telephone family interview for resident #2 was conducted and the family member stated that on , the Assistant Director of Nursing (ADON) called him on the telephone demanding resident #2 needed a private sitter because she required more supervision with no further explanation of any incidents that occurred that brought the facility to this conclusion; because resident #2 was in the Memory Care unit. The family member explained that he had to keep calling the facility with no returned call to request a conference for further clarification and explanation of why resident #2 needed a private sitter. The family member stated he looked up the cost for a private sitter for 8 hours a day at $36/an hour for 30 days would cost an additional $8500.00/month on top of monthly contract agreement rate $5995.00/monthly. The family member stated that	A 025		

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A 025	Continued From page 3 resident #2 was not violent or combative and that the facility wanted to move resident #2 out because the cost of living increased since resident #2 had moved there in year 2021. Finally, the family member was scheduled for a -to- conference on with the Director of Nursing (DON) and the facility did not provide him with any evidence that resident #2 needed a private sitter and was only given the 1823 Health Assessment that did not document a private sitter was required. The family member said that he was not given a choice of resources for resident #2. On at 3:30 PM, an interview with the DON confirmed that only the 1823 Health Assessment was provided to the family member in the conference . The DON further said that it was explained to the family member of the behaviors of safety that was exhibited by resident #2, that the week before resident #2 was going into other resident's rooms and pulling out to the TV in the common area. There was no documentation of the to conference with the family member and no documentation of the recent behavior observed by resident #2 stated in the DON's interview above. The facility failed to maintain written documentation of any significant changes and updates regarding to resident #2. On at 3:45 PM, an interview with the DON confirmed all the findings. (Photographic Evidence Obtained)	A 025		

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A 025	Continued From page 4 Class III	A 025		