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
	AL11967710	A. BUILDING: _____ B. WING _____	09/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR AT CAPE CORAL	831 SANTA BARBARA BLVD CAPE CORAL, FL 33991

(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 for #2026008423, #2026009998, #2026015797, #2026015805 and generator monitoring visit survey was conducted at Windsor at Cape Coral on through . Deficiencies were identified at the time of the survey.	A 000		
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. (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	A 052		

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A 052	Continued From page 1 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 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	A 052		

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A 052	Continued From page 2 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 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	A 052		

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A 052	Continued From page 3 resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (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 observation, record review, and interview, the facility failed to ensure staff assisting with self-administration of medications do so appropriately and perform hygiene	A 052		

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A 052	Continued From page 4 for 6 (Resident #4, #5, #6, #7, #8, #9, and #10) of 8 residents observed for medication pass. The findings included: Review of policy: Handwashing -0060. effective date . Procedure: 1. Staff should always wash their in the following situations: Before and after handling of any medications and or treatment..... Review of facility policy.. Procedure: Medication Pass: 2. Follow resident rights, prevention practices and safe administration guidelines to pass the medication. a. Perform hygiene prior to touching /preparing medications after administering to a resident. 1. On at 8:35 a.m., during observation of a medication pass, Medication Technician (MT) Staff D provided 75 micrograms (mcg) ( ), 40 milligrams (mg) ( ), 325 mg (,), 3.125 mg ( ), 10 mg ( ), 1 % gel (, relief), 30 mg ( ), Omega 3 1 gm (supplement), 500 mg (,), Torsemide 5 mg ( ) to Resident #4. MT Staff D did not measure the , for Resident #4 and failed to perform hygiene before, during, and after the medication pass. Record review of electronic medication administration records (EMAR), for Resident #4 showed the physician orders for 3.125 mg needed to be held and not given if the	A 052		

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A 052	Continued From page 5 , was below 100. 2. On at 8:52 a.m., during observation of a medication pass, Medication Technician (MT) Staff D provided 40 mg, 200 mg (rhythm), , 50 mg ( ), 24/26 mg ( ), 400 mg ( ), Vision Health Caps (supplement), D3 25 mcg (supplement), One a Day (supplement), 20 mg ( ), , 5 mg ( ), 80 mg (gas), Cream 5 % (skin), 0.01 ( ), and Jardiance 10 mg ( ) to Resident #5. MT Staff D failed to perform hygiene before, during, and after the medication pass. 3. On at 9:14 a.m., during observation of a medication pass, Medication Technician (MT) Staff D provided , 300 mg ( ), , 81 mg ( ), 12.5 mg, , 75 mg (,), 54 mg ( ), , 40 mg (,), 1000 mg ( ), D3 25 mcg (supplement), 220 mg (supplement) to Resident #6. MT Staff D failed to perform hygiene before, during, and after the medication pass. 4. On at 9:21 a.m., during observation of a medication pass, Medication Technician (MT) Staff D provided , 81 mg, , , 300 mg (,), 0.1 mg (,), , 75 mg, 500 mg, and 1000 mg (supplement) to Resident #7. MT Staff D failed to perform hygiene before, during, and after the medication	A 052		

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A 052	Continued From page 6 pass. 5. On at 9:32 a.m., during observation of a medication pass, Medication Technician (MT) Staff D provided Apiprazole 2 mg (,), / D3 600/400 mg (supplement), Thermotab (supplement), 100 mg (,), 10 mg ( ), Preservision Tab (supplement), 100 mg ( ), 50 mcg (spray), 10 mg ( ), and , 0.5 mg ( ) to Resident #8. MT Staff D crushed the / D3 and the Thermotab tablets and mixed them in yogurt separately and gave the spoon to Resident #8. Record review of Resident #8, revealed no documentation of physician orders to crush any medications for Resident #8. 6. On at 10:15 a.m., during observation of a medication pass, Medication Technician (MT) Staff D provided , 81 mg, 10 mg, , 25 mg, and 500 mcg to Resident #9. MT Staff D failed to perform hygiene before, during, and after the medication pass. 7. On at 10:23 a.m., during observation of a medication pass, Medication Technician (MT) Staff D provided 10 mg ( ), , 25 mg, Rosuvastatin 20 mg ( ), 8.6 (,), , 5 mg, and , 500 mg to Resident #10. MT Staff D mixed the pills into a cup of pudding with a spoon and directly fed the mixture into the of Resident #10. Staff D administered	A 052		

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A 052	Continued From page 7 Resident #10's medications, and failed to perform hygiene before, during, and after the medication pass. On at 10:35 a.m. during an interview, MT Staff D said she knows she needs to sanitize between each resident but she was running behind because they have to help in the dining room at 8 am. Staff D said she never takes the , because there's never a cuff available. She said that no one takes the , of Resident #4, and there's no room to document it. Staff D said she always gives Resident #10 her medication directly in her , as she has never taken it from her. Staff D said she knows that she can't directly administer but if she doesn't, then Resident #10 won't get her meds. Staff D stated, "everybody knows what the situation is." Staff D said Resident #8 will never take her medications without crushing them, and knows she should have a crush order. Staff D said and everybody does it, and she has told the nurse Resident #8 won't take the meds unless they're crushed. On at 2:50 p.m., during an interview, the Healthcare Director (HD) said when assisting with medications with holds dependent on , readings, they need to be checked prior to the medication pass, and staff has access to a , monitor. The readings have to taken and documented before the medication is given. The HD said there needs to be to have a crush order from the physician to provide that for residents. She acknowledged Staff D did not perform hygiene and said med techs cannot	A 052		

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A 052	Continued From page 8 directly administer medications and that they know that they shouldn't. 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	A 054		

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A 054	Continued From page 9 medication. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to properly update the medication observation record when a medications are offered/given and properly document and report medications that were delayed in being given for 2 (Resident #6, Resident #10) of 7 residents reviewed for medication pass. The findings included: 1. On at 9:14 a.m., during observation of a medication pass, Medication Technician (MT) Staff D provided , 300 milligrams (mg) ( ), , 81 mg ( ), 12.5 mg, , 75 mg ( ), 54 mg ( ), , 40 mg (,), 1000 mg ( ), D3 25 mcg (supplement), 220 mg (supplement) to Resident #6. Record review of the electronic medication administration records (EMAR), showed the , 300 mg was scheduled to be given at 6:00 a.m., 3 hours and 14 minutes prior to the actual time. Further review showed that a Injection 100 u/ml was documented as given by MT Staff D. 2. On at 10:23 a.m., during observation of a medication pass, Medication Technician (MT) Staff D provided 10 mg ( ), , 25 mg, Rosuvastatin 20 mg	A 054		

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A 054	Continued From page 10 ( ), 8.6 (,), , 5 mg, and , 500 mg to Resident #10. Record review of the electronic medication administration records (EMAR), showed the , 500 mg was scheduled to be given at 6:00 a.m., 4 hours and 23 minutes prior to the time of administration. On at 10:35 a.m. during an interview, MT Staff D said she is running behind pretty much every day and those 6 am meds should be given by the overnight staff because the morning staff can never make it on time. Staff D said she just checks off the box when she gives them whenever that may be, and she doesn't put a note in that they were late because she was never told to. MT Staff D said she checks off the meds that are administered by the nurse then follows up if she hasn't seen them, and she knows it's a bad idea, and the nurse that gives the injections should mark it off. On at 2:50 p.m., during an interview, the Healthcare Director (HD) said an hour before or an hour after is the timeframe for passing medications. The HD acknowledged that 3 hours plus is not ideal and needs to be documented as given late if that is the case. The HD stated, "if you don't administer the medications you can't sign them out as given." Class III	A 054		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52	A 081		

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A 081	Continued From page 11 (1)(a) 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. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (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 training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION.	A 081		

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A 081	Continued From page 12 (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 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	A 081		

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A 081	Continued From page 13 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 and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response	A 081		

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	AL11967710	A. BUILDING: _____ B. WING _____	09/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR AT CAPE CORAL	831 SANTA BARBARA BLVD CAPE CORAL, FL 33991

(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 14 policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide 2-hour preservice orientation training and 1 hour of recognizing and reporting /neglect and , based on the facility policies and procedures for 3 (Staff E, Staff F, Staff G) of 3 staff records reviewed. Failure to provide the required initial training may lead to adverse incidents and improper staff behaviors. The findings included: On , record review of employee files revealed Resident Assistant ( ) Staff E had a hire date of . Further review revealed documentation of certificate of completion for 1 hour of Florida Preservice Nursing Licensing and Services and 0.75 hours of , Neglect and , completed on through Relias, an on-line computer-based training system. The training completed was not based on the facility policies and procedures. On , record review of employee files revealed that Resident Assistant ( ) Staff F had a hire date of . Further review revealed documentation of certificate of completion for 1 hour of Florida Preservice Nursing Licensing and Services completed on and 0.75 hours of , Neglect and , completed on	A 081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 081	Continued From page 15 through Relias, an on-line computer-based training system. The training completed was not based on the facility policies and procedures. On , record review of employee files revealed that Resident Assistant ( ) Staff E had a hire date of . Further review revealed documentation of certificate of completion for 1 hour of Florida Preservice Nursing Licensing and Services and 0.75 hours of , Neglect and , were completed on through Relias, an on-line computer-based training system. The training completed was not based on the facility policies and procedures. On at 4:45 p.m., during an interview, the Residence Director said the trainings are done over the first few days of employment on the Relias platform. She said there is not a facility specific orientation done before they begin work. The Residence Director said that they utilize Relias for all of their initial trainings. Class III	A 081		