STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967710	01/30/2018
NAME OF PROVIDER OR SUPPLIER **WINDSOR OF CAPE CORAL**	STREET ADDRESS, CITY, STATE, ZIP CODE **831 SANTA BARBARA RD** **CAPE CORAL, FL 33991**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced biennial and limited nursing services survey was conducted through at Windsor of Cape Coral, an assisted living facility (license #11678) in Cape Coral, Florida.

The following is description of the deficiencies.

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on record review and staff interview, the facility failed to ensure 1 (Staff A) of 3 personnel records reviewed had the required training to perform their job duties.

The findings included:

A review of Staff A's personnel record showed she was hired on . The following is a list of training she received which shows the lack of time required for these trainings:

- Activities of Daily Living on for .5 hour (3 hours required)
- Accident/incident reporting on for .75 hour (1 hour required) and
- Safe food handling training on for .5 hour (1 hour required).

During an interview on at 11:00 a.m., the Administrator reviewed this personnel record and confirmed the lack of training for Staff A.

Class III

0082 - Training - / - 58A-5.0191(3) FAC

Based on record review and staff interview, the facility failed to ensure 1 (Staff A) of 3 personnel records reviewed had / training in the required time frame.

The findings included:

A review of Staff A's personnel record showed she was hired on . She received / training on .

During an interview on at 11:00 a.m., the Administrator confirmed Staff A did not receive the / training within 30 days of her hire date.

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SUMMARY STATEMENT OF DEFICIENCIES
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Class

0086 - Training - ADRD - 58A-5.0191(9) FAC

Based on record review and staff interview, the facility failed to ensure 1 (Staff C) of 3 personnel records reviewed had the required amount of 's Training I within the first 3 months of employment.

The findings included:

A review of Staff C's personnel record showed she was hired on . She received one hour of training for 's on and one hour training on . She did not receive 4 hours hour training within 3 months of employment.

During an interview on at 11:00 a.m., the Administrator reviewed Staff C's record and confirmed the lack of 4 hours of this training within 3 months of hire for Staff C.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on record review and staff interview, the facility failed to ensure 1 (Staff A) of 3 personnel records reviewed had training in ( ) within 30 days of hire.

The findings included:

A review of Staff A showed she was hired on . There was no documentation showing she had training.

During an interview on at 11:00 a.m., the Administrator confirmed this training is not documented in Staff A's personnel file.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and staff interview, the facility failed to document an adverse incident report for 1 (Resident #14) of 3 resident's files reviewed when he eloped from the facility and the local police were involved.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967710	**01/30/2018**
NAME OF PROVIDER OR SUPPLIER **WINDSOR OF CAPE CORAL**	STREET ADDRESS, CITY, STATE, ZIP CODE **831 SANTA BARBARA RD** **CAPE CORAL, FL 33991**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

The findings included:

During an interview on at 11:40 a.m., the Administrator said Resident #14 was brought back to the facility by local police on . Resident #14 was found across the street looking for his wife, who had , , . The Administrator had discussed this issue with corporate staff yesterday. Since Resident #14 was not identified as an elopement risk, they felt an adverse incident report was not necessary. However, interventions were put in place after this incident.

A review of Resident #14's record showed on his health assessment dated that he is forgetful. The progress note on showed that the staff noticed Resident #14 was missing. Resident #14 was located across the street, knocking on a door, and asking for his wife. The police were called by the neighbor and Resident #14 was assisted back to the facility by the police.

The facility did not submit a one day adverse incident report concerning Resident #14 eloping from the facility and the police were involved by bringing him back to the facility.

Class III