| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105568 | A. Building<br>B. Wing | 04/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Windsor Woods Rehab and Healthcare Center | 13719 Dallas Dr<br>Hudson, FL 34667 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br><br>Based on observation, interviews and record reviews, the facility failed to follow the comprehensive person-centered care plan related to providing toileting care with a two-person assist for one (#2) of eight sampled residents.<br><br>Findings included:<br><br>During an interview on 04/24/25 at 1:08 p.m. the Nursing Home Administrator (NHA) and the Director of Nursing (DON) stated Resident #2 initially told the 7 a.m. to 3 p.m. shift aide on 02/26/2025 about her finger hurting. The DON stated she went to Resident #2s room, and Resident #2 alleged a person (unknown at the time) came into her room the night before and hit her hand a couple hundred times. The NHA and the DON stated during their investigation Staff A, Certified Nursing Assistant (CNA) who cared for Resident #2 on the 11 p.m. to 7 a.m. shift on 02/26/2025 stated she provided incontinence care alone. The NHA stated Staff A, stated the resident was combative during care. The NHA stated during the investigation it was noted that Resident #2 was dependent for incontinence care or required 2 persons. The NHA stated Resident #2 was care planned for 2-person bed mobility. The NHA stated Resident #2 was dependent assist of two to turn and / or reposition which was for toileting / changing brief also. The DON and the NHA verified Staff A, CNA did not follow the care planning of needing 2 person to assist.<br><br>An observation on 04/24/25 at 11:58 a.m. revealed Resident #2 was sitting up in bed eating lunch. The resident was noted confused during the interview and could not answer questions related to her care needs.<br><br>Review of Resident #2's admission Record revealed the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses included but not limited to generalized osteoarthritis, dysphagia, Chronic Obstructive Pulmonary Disease, diabetes, anemia, seizures, pressure ulcers dementia, mood affective disorder, osteoporosis, neuromuscular dysfunction of bladder, psychosis, major depressive disorder, anxiety, and hypertension.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #2's quarterly Minimum Data Set (MDS) dated [DATE], Section C, Cognitive Patterns showed a Brief Interview for Mental Status (BIMS) score of 10 (moderately impaired). Section GG, Functional Abilities showed she was dependent for toileting hygiene: the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. Dependent meant helper does ALL of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity.<br><br>Review of the care plans showed Resident #2 required assistance with all ADLs (Activities of Daily Living). She was very poorly motivated. Resident #2 frequently refuses any and all ADL cares. She will adamantly refuse to allow staff to provide incontinence care, turn or reposition her and will refuse most staff. She chooses to get out of bed only once a week to get her hair done, date initiated was 12/06/2021 and revised on 09/24/2024. Interventions included but not limited to Resident was Total Dependent upon staff for ADLs. as of 12/27/2024. Resident was dependent for toileting as of 08/07/2021. Bed mobility was dependent on assist of 2 to turn and/or reposition as of 08/08/2017.<br><br>During an interview on 04/24/25 at 1:08 p.m. the Nursing Home Administrator (NHA) and the Director of Nursing (DON) stated during the investigation on 02/26/2025 it was noted that Resident #2 was dependent for incontinence care or required 2 persons. The NHA stated Resident #2 was care planned for 2-person bed mobility. The NHA stated Resident #2 was dependent assist of two to turn and / or reposition which was for toileting / changing brief also. The DON and the NHA verified Staff A, CNA did not follow the care planning of needing 2 person to assist.<br><br>Review of the facility's policy, Care Plan-Interdisciplinary Plan of Care from Interim to Meeting, effective February 2024 showed the facility shall support that each resident must receive, and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The facility shall assess and address care issues that are relevant to individual residents, to include, but may not be limited to, monitoring resident condition, and responding with appropriate interventions. The comprehensive care plan is an interdisciplinary communication tool. It includes measurable objectives and time frames and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan is reviewed and revised periodically, and the services provided or arranged are consistent with each resident's written plan of care. The overall care plan should be oriented towards: 1. Preventing avoidable declines in functioning or functional levels or otherwise clarifying why another goal takes precedence. Managing risk factors to the extent possible are indicating the limits of such interventions. Procedure 5. Comprehensive Plan of Care: B. The comprehensive care plan describes or includes: i. The services that are to be furnished and goals that reflect their residence wishes, choices, and exercise of rights. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure accurate and complete documentation related to Activities of Daily Living (ADLs) for toileting hygiene for four (#2, #4, #5, #6) out of four sampled residents.<br><br>Findings included:<br><br>During an interview on 04/24/2025 at 1:08 p.m. the Director of Nursing (DON) stated the aide staff works 8-hour shifts. The DON verified after reviewing the toilet hygiene documentation that the aides were not documenting every day, every shift they were providing incontinence care / toileting hygiene. The DON confirmed documentation was missing. The DON verified the incontinence care was to be documented under the toileting hygiene.<br><br>1. Review of Resident #2's admission Record revealed the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses included but not limited to generalized osteoarthritis, dysphagia, Chronic Obstructive Pulmonary Disease, diabetes, anemia, seizures, pressure ulcers dementia, mood affective disorder, osteoporosis, neuromuscular dysfunction of bladder, psychosis, major depressive disorder, anxiety, and hypertension.<br><br>Review of Resident #2's quarterly Minimum Data Set (MDS) dated [DATE], Section C, Cognitive Patterns showed a Brief Interview for Mental Status (BIMS) score of 10 (moderately impaired). Section GG, Functional Abilities showed she was dependent for toileting hygiene: the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. Dependent meant helper does ALL of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity.<br><br>Review of the care plans showed Resident #2 required assistance with all ADLs (Activities of Daily Living). She was very poorly motivated. Resident #2 frequently refuses any and all ADL cares. She will adamantly refuse to allow staff to provide incontinence care, turn or reposition her and will refuse most staff. She chooses to get out of bed only once a week to get her hair done, date initiated was 12/06/2021 and revised on 09/24/2024. Interventions included but not limited to Resident was Total Dependent upon staff for ADLs. as of 12/27/2024. Resident was dependent for toileting as of 08/07/2021. Bed mobility was dependent on assist of 2 to turn and/or reposition as of 08/08/2017.<br><br>Review of the Toileting Hygiene showed the following, 03/28/2025: 2 changes, 03/29/2025: 2 changes, 03/30/2025: 2 changes, 04/01/2025: 2 changes, 04/02/2025: 2 changes, 04/03/2025: 2 changes, 04/05/2025: 1 change, 04/06/2025: 2 changes, 04/07/2025: 2 changes, 04/10/2025: 2 changes, 04/11/2025: 2 changes, 04/12/2025: 2 changes, 04/13/2025: 2 changes, 04/14/2025: 2 changes, 04/15/2025: 2 changes, 04/16/2025: 2 changes, 04/17/2025: 1 change, 04/18/2025: 1 change, 04/19/2025: 1 change, 04/20/2025: 2 changes, 04/21/2025: 2 changes and on 04/22/2025: 3 changes.<br><br>2. Review of the admission Record showed Resident #4 was admitted on [DATE] with diagnoses included but not limited to quadriplegia, hypertension, recurrent depression, muscle disorder, Trans Ischemic Attack, chronic pain syndrome, and anxiety disorder.<br><br>(continued on next page) |

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| | 105568 | A. Building<br>B. Wing | 04/24/2025 |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the quarterly Minimum Data Set (MDS) dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 14 (cognitively intact). Section GG, Functional Abilities showed he was dependent for toileting hygiene: the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. Dependent meant helper does ALL of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity.<br><br>Review of the Activity of Daily Living (ADL) Care plan showed the Resident had an ADL Self Care Performance Deficit as evidence by diagnoses of quadriplegia, history of CVA, chronic pain, anemia as of 09/16/2024 and revised on 03/14/2025. Interventions included but not limited to bed mobility was dependent assist of 2 to turn and/or reposition as of 06/04/2021 and dependent for toilet use.<br><br>Review of the Toileting Hygiene showed the following, 03/26/2025: 1 change, 03/30/2025: 1 change, 03/31/2025: 2 changes, 04/03/2025, 2 changes, 04/04/2025: 1 change, 04/06/2025: 1 change, 04/08/2025: 2 changes, 04/10/2025: 1 change, 04/12/2025: 2 changes, 04/14/2025: 2 changes, 04/17/2025: 1 change, 04/18/2025: 1 change, 04/19/2025: 2 changes, 04/20/2025: 1 change, 04/21/2025: 2 changes, 04/22/2025: 2 changes and on 04/23/2025: 2 changes.<br><br>3. Review of the admission Record showed Resident #5 was admitted on [DATE] and readmitted on [DATE] with diagnoses included but not limited to COPD, heart failure, anxiety, depression, and mood disorder. Review of the significant change in status MDS dated [DATE] showed a BIMS score of 13 (cognitively intact). Section GG, Functional Abilities showed he was dependent for toileting hygiene: the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. Dependent meant helper does ALL of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity.<br><br>Review of the ADL care plan showed Resident #5 had an ADL self-care performance deficit related to weakness and impaired mobility due to diagnoses as of 10/26/2024 and revised on 03/03/2025. Interventions included but not limited to bed mobility was dependent assist of 2 to turn and/or reposition as of 08/20/2024. and dependent for toilet use as of 08/20/2024.<br><br>Review of the Toileting Hygiene showed the following, 03/26/2025: 1 change, 03/29/2025: 1 change, 03/30/2025: 2 changes, 03/31/2025: 2 changes, 04/01/2025: 2 changes, 04/02/2025: 2 changes, 04/03/2025: 2 changes, 04/05/2025: 1 change , 04/06/2025: 1 change, 04/09/2025: 2 changes, 04/10/2025: 2 changes, 04/12/2025: 2 changes, 04/14/2025: 2 changes, 04/15/2025: 2 changes, 04/16/2025: 1 change, 04/17/2025: 1 change, 04/18/2025,1 change, 04/19/2025: 1 change, 04/21/2025: 1 change, and on 04/23/2025: 1 change.<br><br>4. Review of the admission Record showed Resident #6 was admitted on [DATE] with diagnoses included but not limited to Cerebral Vascular accident (CVA) of traumatic brain injury, developmental disorder, spinal stenosis, bipolar, anxiety, contracture of left and right hand and left elbow, and depression. Review of the quarterly MDS dated [DATE] showed a BIMS score of 14 or cognitively intact. Section GG, Functional Abilities showed he was dependent for toileting hygiene: the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. Dependent meant helper does ALL of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the ADL care plane showed Resident #6 required assistance with bed mobility, transfers toileting secondary to history of traumatic brain injury with developmental mental disorder and history of progressive weakness, (L) hemiparesis, decreased range of motion bilateral upper extremities. Interventions included but not limited to bed mobility was dependent assist of 2 to turn and/or reposition as of 03/10/2025 and dependent for toilet use assist of 2 as of 12/27/2018.<br><br>Review of the Toileting Hygiene showed the following, 03/26/2025: 2 changes, 03/28/2025: 1 change, 03/30/2025: 1 change, 03/31/2025: 2 changes, 04/01/2025: 2 changes , 04/03/2025: 2 changes, 04/06/2025: 1 change, 04/08/2025: 2 changes, 04/09/2025: 2 changes, 04/11/2025: 2 changes, 04/12/2025: 2 changes, 04/13/2025: 2 changes, 04/14/2025: 1 change, 04/17/2025: 2 changes, 04/18/2025: 1 change, 04/19/2025: 2 changes, 04/20/2025: 2 changes and on 04/21/2025: 2 changes.<br><br>During an interview on 04/24/2025 at 3:01 p.m. the Director of Nursing (DON) verified the lack of documentation related to toileting for Residents #4, #5, #6. The DON stated the aides should be documented at least every shift. The DON stated the documentation should be under the toileting hygiene. She stated the perineal hygiene is the actual care.<br><br>Requested and did not receive a documentation expectation policy. |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure a hospice plan of care was developed and coordinated to include communication between the facility and hospice provider related to activities of daily living (ADLs) for one (#3) of three residents reviewed for hospice care.<br><br>Findings included:<br><br>Review of an event progress note for Resident #3 revealed on 4/21/25 at 1: 00 p.m., a Hospice CNA (Certified Nursing Assistant) reports to nurse that open areas occurred while giving [Resident #3] a shower. The resident has provided the following description of the event: Unable to say what happened. The following type of event is noted: Skin alteration - Details of the event are as follows: Hospice CNA was showering Resident when open areas were obtained and reported. Preventative interventions related to this event included - continue with protective sleeves.<br><br>A Change in Condition evaluation completed on 4/21/25 showed Resident #3's skin changes were - skin tear Left elbow, right forearm, and right ankle.<br><br>Review of Resident # 3's admission Record revealed an admission date of 2/2/24 with diagnoses to include encephalopathy, Idiopathic normal pressure hydrocephalus, senile degeneration of brain, unspecified dementia- unspecified severity without behavioral disturbance, mood disturbance and anxiety, Dysphagia -oral pharyngeal phase, Essential hypertension, Hyperlipemia, unspecified mood affective disorder, and history of falling,<br><br>Review of physician orders for Resident #3 dated 12/11/24 showed the resident was under (Name of Hospice provider) with a diagnosis of Senile Degeneration of the brain.<br><br>Review of a quarterly MDS (Minimum Data set) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 3, meaning severe cognitive impairment. Section GG of the MDS - Functional Abilities and Goals showed Resident #3 required substantial to maximal assistance to roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair bed to chair transfer, toilet transfer, and tub/ shower transfer. The MDS further revealed the resident was dependent on a wheelchair/scooter for mobility and was under hospice care.<br><br>Review of the plan of care for Resident #3 Focus- ADL showed the resident has an ADL self-care performance deficit in reference to recent hospitalization and decline in function, related to Dementia, S/P (status post) fall at home, decline expected as resident is under hospice services. The care plan was initiated on 1/11/24 with a revision date of 12/21/24. The goal of the care plan was documented as - will have ADL needs anticipated and met by staff through the next review date. Interventions included - transfer - Total Mechanical Lift to Chair of 2, date initiated 1/16/2024. Under Shower Device: standard shower chair, shower per schedule and as needed, see shower schedule for details date initiated 1/11/24.<br><br>(continued on next page) |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the plan of care for Resident #3 Focus titled -Terminal Diagnosis showed Resident #3 was diagnosed with a terminal condition and was at risk for loss of dignity during dying process (Name of Hospice provider) Diagnosis: Senile degeneration of the brain. An overall decline in status is anticipated r/t (related to) terminal diagnosis/ prognosis. Date initiated 12/12/2024, Revision on 3/26/25. The goal of this care plan showed the resident will be supported to promote comfort and dignity throughout the dying process, Date Initiated: 12/12/2024, Target Date: 06/24/2025. The resident's safety, dignity, and comfort will be maintained through the review date. Date Initiated: 12/12/2024 Revision on: 03/26/2025 Target Date: 06/24/2025. Interventions included to collaborate with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met and to coordinate continued services when appropriate.<br><br>An interview was conducted with the Nursing Home Administrator (NHA) on 4/24/25 at 10:31 a.m. The NHA stated Resident #3's plan of care was that she needed a Hoyer Lift for transfers. The NHA reported the hospice CNA did not follow that care plan expectation because they follow the hospice plan of care which does not document the level of assistance the patient needs. The NHA stated they (Hospice), have their own care plans, but their care plans do not document the specific assistance needed for the resident, it only showed the tasks to be performed. The NHA stated the Hospice Aide did not ask the facility staff what the resident's assistance needs are. She stated the nurses and the CNAs at the facility did not communicate to the hospice aides on the resident's ADL care needs.<br><br>On 4/24/25 at 2: 25 p.m. in a follow-up interview, the NHA stated there was no documentation in the facility of how often the Hospice aide comes and what care she provided to Resident #3.<br><br>An interview was conducted with the Director of Nursing (DON) on 4/24/25 at 2:25 p.m. She stated the Hospice provider told them there was a written plan of care with the hospice aide's assignment. She stated it was documented in Resident #3's record the resident received bed baths. The DON stated the Hospice Aide had reported wanting to give Resident #3 a good shower, and it was the first time she had given her a shower. The DON stated the Hospice Aide did not utilize the mechanical lift. and transferred the resident to the shower chair by herself which resulted in skin tears.<br><br>Review of a facility document titled Hospice Nursing Facility Service Agreement, with an effective date of July 24, 2023, signed by the nursing facility and hospice, revealed: under (d.) Coordination of Care - ( ii) Design of plan of care: In accordance with applicable federal and state laws and regulations, Facility shall coordinate with Hospice in developing a Plan of Care for each Hospice Patient. Hospice retains primary responsibility to determine each Hospice Patient's appropriate Plan of Care. Facility shall ensure that each Hospice Patient's plan of care includes both the most recent Hospice Plan of Care and a description of the Facility Services furnished by the Facility to attain or maintain the Hospice Patient's highest practicable physical, mental and psychosocial well - being as required by federal regulations.<br><br>On 4/24/25 at 4:20 p.m. The NHA stated the facility did not have a Hospice policy. |