

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105568	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Windsor Woods Rehab and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 13719 Dallas Dr 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49497</p> <p>Based on record review, interview, and record review, the facility failed to provide incontinent supplies to meet resident needs for five (Residents #73, #35, #22, #49, #61) of 47 residents sampled.</p> <p>Findings Included:</p> <p>1. An interview was conducted on 06/03/24 at 11:45 a.m. with Resident # 61. She stated staff ran out of incontinent briefs yesterday evening and she was not able to be changed. She stated staff only had a size small, and she wears an extra-large and/or extra extra-large and a small would not fit. She stated staff had to run to [local store] to pick up briefs for residents.</p> <p>Review of the electronic medical record (EMR) showed Resident #61 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder, bipolar disorder, unspecified convulsions, primary insomnia, and anxiety disorder.</p> <p>Review of Minimum Data Set (MDS) dated [DATE] showed:</p> <ul style="list-style-type: none"> - Section C Brief Interview Mental Status (BIMS) score of 14 indicating no cognitive impairment. - Section I with heading genitourinary marked yes for renal insufficiency, renal failure, end stage renal disease. - Section H revealed that resident is always continent of bowl and bladder. <p>On 06/06/24 at 9:05 a.m., an interview was conducted with Resident #22. She stated she was not able to get a clean pull up last Sunday. She stated staff told her they were out, and she would have to wait. She stated she did get one late that evening. She was unable to confirm the time.</p> <p>Review of the electronic medical record (EMR) showed Resident #22 was admitted to the facility on [DATE] with diagnoses that included irritable bowel syndrome, edema, anxiety disorder and Parkinsonism.</p> <p>Review of Minimum Data Set, dated dated [DATE]</p> <ul style="list-style-type: none"> - Section C Brief Interview Mental Status (BIMS) score of 11 indicating mild cognitive impairment. <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Section H revealed that resident is always continent of bowl and bladder.</p> <p>On 06/06/24 at 8:55 a.m., an interview was conducted with Resident #49. She stated the facility had all supplies well stocked, except incontinent briefs. She stated, We did not have any this past weekend.</p> <p>Review of the electronic medical record (EMR) showed Resident #49 was admitted to facility on 01/26/19 with diagnoses that included anxiety disorder, major depressive disorder, and parkinsonism.</p> <p>Review of Minimum Data Set, dated dated [DATE] revealed:</p> <p>- Section C a Brief Interview for Mental Status score of 15 indicating no cognitive impairment.</p> <p>- Section H showed resident is frequently incontinent of urine and always continent of bowel.</p> <p>An interview was conducted on 06/06/24 at 9:27 a.m. with Staff G, Certified Nursing Assistant (CNA), Scheduler, and Central Supply Coordinator. She stated she ordered supplies twice a week. She placed orders on Wednesday for Thursday delivery and Friday for Monday delivery.</p> <p>An interview was conducted on 06/06/24 at 10:25 a.m. with Nursing Home Administrator (NHA). She stated Staff G had an emergency and had to leave the building. She stated incontinent supplies were not received on Thursday because the order was not placed earlier in the week (Monday, Tuesday, Wednesday). It was overlooked as the NHA covered for central supply when Staff G was out. The NHA stated she did not approve the order, which was why there was no delivery on 05/30/24. She stated the Thursday delivery of incontinent supplies was what covered the resident's needs through the weekend. She stated she placed an order on Friday 05/31/24 with expected delivery on Monday 06/03/24. She stated when she received a call from staff on 06/02/24 stating they were low on briefs, she went to the store to purchase supplies to replenish stock until delivery on Monday.</p> <p>49227</p> <p>2. During an interview and observation, on 6/3/24 at 10:52 a.m. Resident #73 said, The Certified Nurses Assistants (CNAs) do not have what they need, brief shortage happens all the time, they put little briefs on big people. I am [my skin] is sensitive to the briefs they buy at the store.</p> <p>During an interview and observation on 6/05/24 at 9:33 a.m. Resident #73 said this weekend they ran out of diapers they used two small diapers, it was not comfortable.</p> <p>Review of Resident #73's Admission Record showed the initial admitted to the facility was on 11/28/21 with diagnoses to include morbid (severe) obesity.</p> <p>Review of Resident #73's quarterly Minimum Data Set (MDS), dated [DATE], Section H -Bladder and Bowel showed R #73 is always incontinent of urine and bowel.</p> <p>Review of R #73's active care plan dated 6/14/23, titled Activities of Daily Living (ADL) showed bowel and bladder incontinence.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #35's Admission Record showed the initial admitted to the facility was on 12/26/15 with diagnoses to include morbid (severe) obesity.</p> <p>Review of Resident #35's quarterly Minimum Data Set (MDS), dated [DATE], Section H -Bladder and Bowel showed Resident #35 is always incontinent of urine and bowel.</p> <p>Review of Resident #35's active care plan, Activities of Daily Living (ADL), dated 10/5/2020, showed bladder and bowel incontinence.</p> <p>During an interview on 6/6/24 at 8:50 a.m. Staff H, CNA said, sometimes the facility runs out of briefs they try their best.</p> <p>During an interview on 6/6/24 at 9:00 a.m. Staff I, CNA said the availability of supplies at the facility is moderate, when there is a low number of adult briefs available, before it is needed for resident care the briefs are available.</p> <p>During an interview and record review on 6/6/24 at 9:27 a.m., Staff G, CNA, Scheduler and Central Supply Coordinator said the facility ordered supplies on Wednesdays and Fridays. Supplies from the vendor were delivered on Mondays and Thursdays. Staff G said the types of supplies and the quantity ordered were based on the resident needs and the facility's census. The size of incontinent brief residents require was based on measurements obtained during admission to the facility. She said on the weekend when supplies were not available, staff would notify the Nursing Home Administrator (NHA) or the Director of Nursing (DON). Staff G said the facility would obtain supplies from the hospice thrift store, department stores or pharmacies.</p> <p>During an interview and record review on 6/6/24 at 10:10 a.m., Staff H, Housekeeping/Linen Manager confirmed the was the Manager on Duty (MOD) on 6/2/24. The MOD responsibilities included making sure there were no issues such as (technical, falls, etc.) in the facility. Staff H said on 6/2/24 no issues were reported everything was fine, [I] did not have to call anyone</p> <p>During an interview and record review with NHA on 6/6/24 at approximately 9:23 a.m., she said a grievance related to brief availability was started on 6/4/24. A review of the facility's Grievance/Concern Report showed the date received was 6/4/24, the section titled, print individual name (name of who is reporting) showed reported from Staff A, Licensed Practical Nurse (LPN), Unit Manager (UM) concern from surveyor. The section titled report the concern showed some residents saying they don't have the correct size briefs and signed by the NHA. The section titled, Documentation of facility follow-up, showed the DON and Staff were the individuals designated to take action, the assigned date was 6/4/24 and the resolved by date was 6/7/24. The NHA said supplies were not delivered on Thursday (5/30/24). Review of invoice the facility provided titled Supp-Incontinent Supplies revealed incontinent supplies were ordered on May 3rd, 6th, 10th, 13th, 17th 25th and 31st. Review of the May 2024 calendar showed there were five Wednesdays and five Friday's during that month.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49497</p> <p>Based on record review, interview, and record review, the facility failed to ensure the Level I readmission Screening and Resident Review (PASRR) was accurate for four residents (#15, #18, #68, #98) of 21 residents sampled for PASRR review.</p> <p>Findings Included:</p> <p>1. Review of the electronic medical record (EMR) revealed Resident #68 was admitted to the facility on [DATE] with diagnoses that included depression, and unspecified dementia. Review of the Level I PASRR dated 10/25/23 showed qualifying diagnoses were not checked or indicated, and that no Level II PASRR was required.</p> <p>An interview was conducted on 06/06/24 at 12:55 p.m. with Director of Nursing (DON). She stated Resident #68 PASARR dated 10/25/23 was incorrect as Depression was not marked under Mental Illness or Suspected Mental Illness and a Level II should have been completed as resident had a secondary diagnosis of dementia and diagnosis of depressive disorder. The DON stated this (PASRR) would need to be corrected.</p> <p>49227</p> <p>2. A review of the Admission Record showed Resident #98 was admitted to the facility on [DATE] with diagnoses that included but not limited to schizophrenia and anxiety disorder.</p> <p>Review of Resident #98's Level I PASRR dated 5/10/24, signed by the Director of Nursing (DON) showed, Section 1A. titled MI (mental illness) suspected MI check all that apply showed schizophrenia was not selected.</p> <p>During an interview on 6/6/24 at 1:07 p.m., the DON said PASRR's were reviewed during the facility's daily meeting and said the error was corrected on a PASRR dated 6/5/24.</p> <p>Review of Resident #98's Level I PASRR dated 6/5/24, signed by the Director of Nursing (DON) showed, Section 1A. titled MI (mental illness) suspected MI check all that apply showed schizophrenia and anxiety disorder was selected.</p> <p>50732</p> <p>3. Review of Resident #18's Admission Record showed he was admitted to the facility on [DATE] with diagnosis to include Anxiety Disorder. Review of the Level I Preadmission Screening and Resident Review Process (PASRR) for Resident #18, dated 04/13/2023, revealed an incomplete PASRR with the qualifying diagnosis not checked.</p> <p>On 06/06/2024 at 1:00 p.m., an interview was conducted with Director of Nursing who confirmed Major Depressive Disorder Diagnosis was listed on Resident #18's Facesheet, but was not checked appropriately on the PASRR.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>39438</p> <p>4. A review of the Admission Record for Resident #15 showed he was initially admitted to the facility on [DATE] with a primary diagnosis of spinal stenosis and had other diagnoses to include major depressive disorder, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, depression, anxiety disorder, and post traumatic stress disorder (PTSD).</p> <p>Section I Active Diagnoses of the Minimum Data Set (MDS) dated [DATE] showed the resident had diagnoses of anxiety disorder, depression, and PTSD.</p> <p>A review of Resident #15's PASRR Level I Screen dated 02/12/24 and completed by the Director of Nursing (DON) revealed no diagnosis or suspicion of serious mental illness or intellectual disability indicated and no Level II PASRR evaluation not required.</p> <p>The Level I Screen also indicated A Level II PASRR evaluation must be completed if the individual has a primary or secondary diagnosis of dementia or related neurocognitive disorder, and a suspicion or diagnosis of a serious mental illness, intellectual disability, or both.</p> <p>On 06/06/24 at 12:50 p.m., the Director of Nursing (DON) confirmed since Resident #15 had a diagnosis of dementia and a diagnosis of a serious mental illness a Level II should have been completed.</p> <p>The policy & procedure provided by the facility PASRR Requirements Level I & Level II revealed the following:</p> <p>Policy</p> <p>The screening is reviewed by Admissions for suspicion of serious mental illness & intellectual disability to ensure appropriate placement in the least restrictive environment & to identify the need to provide applicants with needed specialized services.</p> <p>Procedure</p> <p>2. Determine if a serious mental illness &/or intellectual disability or a related condition exists while reviewing the PASRR form completed by the Acute Care Facility. (Trigger for Level II Completion).</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49227</p> <p>Based on interview, observation, and record review, the facility did not ensure compression stockings were ordered for one (Resident #46) of one resident sampled for chronic right lower leg swelling.</p> <p>Findings included:</p> <p>On 6/3/24 at 10:45 a.m. during an interview and observation with Resident #46, he said his left leg swelling was constant because the compression stockings the facility provided was too small to fit his leg. Resident #46 presented a package of extra-large white compression stockings. (Photographic Evidence Obtained). Resident #46 said the swelling in his leg was making it difficult for him to walk. Observation of Resident #46's right lower leg and foot was noticeable larger than the left leg. (Photographic Evidence Obtained).</p> <p>A review of Resident #46's admission record showed diagnoses to include generalized muscle weakness, abnormalities of gait and mobility and fatigue.</p> <p>Review of the occupational therapy (OT) daily treatment note dated, 4/30/24 by Staff D, OT, showed attempted to see patient with left lower extremity (LLE) edema notices with nursing aware.</p> <p>On 6/4/24 at 11:20 a.m., during an interview with Staff A, Licensed Practical Nurse (LPN), Unit Manager (UM), he said he would follow-up with Resident #46 about compression stocking size.</p> <p>On 6/5/24 at 8:55 a.m., Staff A, LPN, UM said the facility ordered XXL compression stockings for the resident and the compression stockings were placed on his left leg on 6/4/24.</p> <p>On 6/5/24 at 3:02 p.m., an observation and Interview was conducted with Resident #46. Resident #46 was wearing a tan colored compression stocking on his right leg and said the facility provided the correct compression stocking. He said the compression stocking was comfortable and was helping the swelling. (Photographic Evidence Obtained).</p> <p>Review of the physical therapy (PT) daily treatment note dated, 6/5/24 by Staff E, PT showed, patient reports edema in the left lower extremity (LLE) and wants to use lighter weights today. He had the nurse place a compression stocking on the left lower extremity for the edema.</p> <p>Review of Resident #46's order dated 6/4/24 at 12:57 p.m. Staff A, LPN, UM showed instructions to apply compression to left lower extremity with a.m. care and remove at bedtime every day and evening shift for edema.</p> <p>Resource: Retrieved on 6/11/2024 https://www.ncbi.nlm.nih.gov/books/NBK554452/</p> <p>[NAME] A, [NAME] AS, [NAME] BS. Peripheral Edema. [Updated 2023 [DATE]]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK554452/</p>

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39438</p> <p>Based on record review and interviews, the facility failed to identify triggers related to Post Traumatic Stress Disorder (PTSD) which may retraumatize a resident and failed to develop and implement an individualized care plan with interventions that could minimize or eliminate the effect of the triggers for two (Resident #15 and #12) out of two sampled residents.</p> <p>Findings included:</p> <p>1. A review of the Admission Record for Resident #15 showed he was initially admitted to the facility on [DATE] with diagnoses to include major depressive disorder, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, depression, anxiety disorder, and post-traumatic stress disorder (PTSD).</p> <p>Section C Cognitive Patterns of the Minimum Data Set (MDS) dated [DATE] showed Resident #15 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicating cognitively intact.</p> <p>Section I Active Diagnoses of the MDS showed the resident had diagnoses of anxiety disorder, depression, and PTSD.</p> <p>Section 12. Trauma Informed Care of the Psychosocial History and assessment dated [DATE] showed the following:</p> <p>The resident had a diagnosis of PTSD due to the military (declined to discuss) and two children had passed away. He was followed by a psychologist and psychiatrist. The care plan was updated related to trauma informed care.</p> <p>There was no documentation that the staff attempted to reassess the resident to identify triggers.</p> <p>The care plan with the focus area of trauma informed care initiated on 01/26/24 revealed the following interventions:</p> <p>Coordinate psychology or psychiatric services on admission and as needed, coordinate support groups as requested, encourage to express feelings, concerns, and thoughts, know what triggers are and minimize exposure if possible, and observe for symptoms of a trigger.</p> <p>The care plan did not reflect individual interventions related to triggers for Resident #15.</p> <p>On 06/06/2024 at 9:40 a.m., an interview with Staff K, Licensed Practical Nurse (LPN), was conducted. He stated, The only psych diagnosis I know of was depression and the resident was on Celexa. He did not know Resident #15 had a PTSD diagnosis. Staff K, LPN, looked in the medical record and confirmed the resident had PTSD and stated he did not know Resident #15's triggers. When asked how he would know if there were triggers, he stated It would normally be on the care plan or charted.</p> <p>(continued on next page)</p>

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/06/2024 at 9:50 a.m., an interview with Staff P, Certified Nursing Assistant (CNA), was conducted. She reported Resident #15 was depressed sometimes but did not know he had a diagnosis of PTSD. He was much better now than when he first came here. Resident #15 was grumpy. Staff P, CNA, could not give specific triggers.</p> <p>On 06/06/24 at 1:04 p.m., the Director of Nursing (DON) reported a trauma informed care plan should be initiated and it should have specific triggers. They usually educate staff on the triggers if the resident can tell what the triggers are. Resident #15 reported to them that he was in the military but declined to give them specifics.</p> <p>48823</p> <p>2. Review of the admission record dated 6/6/2024 for Resident #12 revealed the resident was admitted on [DATE] with original date of admission 4/28/2010. Resident #12 was admitted with a diagnosis of Post-Traumatic Stress Disorder (PTSD) Chronic (4/28/2010) secondary diagnosis.</p> <p>Review of Psychosocial History and Assessment - V5 dated 5/2/2024 for Resident #12 revealed:</p> <p>Section 11 Mental Health - psychiatric diagnosis - treated with psychotropic medications for depression, bipolar and PTSD.</p> <p>Section 12 - Trauma Informed Care - has the resident ever been diagnosed with PTSD, had a life altering event or life changing event - the response - yes. If yes, what type of event - military.</p> <p>Review of care plan dated 11/3/2023 for Resident #12 revealed:</p> <p>Focus for Trauma informed care</p> <p>Goal - Staff will assist in managing the resident's response to the trigger</p> <p>Interventions - Coordinate psychology or psychiatric services, support groups, express feelings and know what the triggers are.</p> <p>The care plan does not identify the PTSD event or triggers.</p> <p>Review of the facility Policy and Procedure for Trauma Informed Care revealed:</p> <p>Policy: The facility will provide services for residents who have experienced mental or psychosocial adjustment difficulty, or who have a history of trauma or have a diagnosis of post-traumatic stress disorder (PTSD). Trauma-Informed Care is care provided by staff who understands and considers the trauma and promotes environments of healing and recovery minimizing re-traumatization.</p> <p>Purpose: To ensure residents who are trauma survivors receive culturally sensitive trauma-informed care in accordance with professional standards of practice and accounting for residents' experience and preferences in order to eliminate or mitigate triggers which may cause re-traumatization of the resident.</p> <p>Process:</p> <p>(continued on next page)</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Admission - Nursing - The admitting nurse will communicate the identified mental or psychosocial adjustment difficulty and/or PTSD to team using any of the following communication methods - twenty-four-hour report, shift to shift report, progress notes and Kardex.</p> <p>Social Services (SS) - The SS department will attempt to establish a rapport and conduct further psychosocial assessment of the resident's mental or psychosocial adjustment difficulty and/or PTSD and develop a comprehensive person-centered care plan which addresses the specific triggers and appropriate interventions.</p> <p>Activities - Complete the activities assessment and preferences and implement resident centered meaningful activities and nonpharmacological interventions. Coordinate support groups, spiritual groups and volunteers of interest.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39438</p> <p>Based on record review and interviews, the facility failed to ensure antibiotics were administered timely for one (Resident #87) out of six residents reviewed for unnecessary medications.</p> <p>Findings included:</p> <p>A review of the Admission Record for Resident #87 showed the resident was initially admitted to the facility on [DATE] with a primary diagnosis of encephalopathy.</p> <p>The lab report with an order date of [DATE] showed a wound culture was rejected on [DATE] at 1:01 p.m. due to unable to process specimen due to collection with expired supplies. Swab received expired on [DATE].</p> <p>The urinalysis with micro, reflux to urine culture lab report conducted on [DATE] showed preliminary results were received on [DATE] that showed the resident had >100,000 colony-forming unit per milliliter (cfu/ml) gram positive cocci possible enterococcus species identification and sensitivities to follow.</p> <p>The final report approved [DATE] showed >100,000 cfu/ml gram positive cocci enterococcus faecium this isolate is vancomycin resistant (VRE). There was note written on the report that showed, started on doxycycline 100mg daily for 10 days. There was a second note written on the report that showed, please discontinue doxycycline and start linezolid 600 mg two times a day for 14 days.</p> <p>The resident started on ciprofloxacin 250 MG on [DATE], but this antibiotic was resistant according to the sensitivity analysis on the lab report. Resident #87 did not start the appropriate antibiotic to treat this infection until [DATE].</p> <p>A review of the Order Summary Report with an order date range of [DATE] to [DATE] revealed the following:</p> <p>Diagnostic</p> <p>[DATE]- Collect wound culture for culture and sensitivity one time a day for 1 day</p> <p>Laboratory</p> <p>[DATE]- Urinalysis (UA)/ Culture and Sensitivity (C&S)</p> <p>[DATE]- Blood cultures one time a day for 1 day</p> <p>[DATE]- Wound cultures one time a day</p> <p>Pharmacy</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105568	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Windsor Woods Rehab and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 13719 Dallas Dr 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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>[DATE]-[DATE] Ciprofloxacin 250 milligram (MG)- Give 1 tablet by mouth (po) two times a day for urinary tract infection (UTI) for five days</p> <p>[DATE]-[DATE] Doxycycline Hyclate 100 MG- Give 1 capsule po one time a day for VRE UTI for 10 days</p> <p>[DATE]-[DATE] Lidocaine Injection- Inject 2.1 milliliters (ml) intramuscularly every 12 hours for VRE UTI for 10 days mix 2.1 ml with antibiotic</p> <p>[DATE]-[DATE] Linezolid Oral Tablet- Give 1 tablet po every 12 hours for VRE UTI for 14 days</p> <p>[DATE]-[DATE] Streptomycin Sulfate- Inject 1 gram intramuscularly every 12 hours for VRE UTI for 10 days</p> <p>The Medication Administration Record (MAR) dated [DATE] to [DATE] showed the following:</p> <p>[DATE]-[DATE] Doxycycline Hyclate 100 MG was not administered;</p> <p>[DATE] Ciprofloxacin 250 MG was administered ,d+[DATE]-,d+[DATE] per orders;</p> <p>[DATE]-[DATE] Lidocaine Injection was not administered;</p> <p>[DATE] Linezolid Oral Tablet was administered per orders; and</p> <p>[DATE]-[DATE] Streptomycin Sulfate was not administered.</p> <p>The Treatment Administration (TAR) dated [DATE] to [DATE] showed the following:</p> <p>[DATE] Weekly CBC/CMP every night shift every Sunday for monitoring (The order was not followed for , d+[DATE]. Labs were done on ,d+[DATE], ,d+[DATE], and ,d+[DATE]);</p> <p>[DATE] UA C&S was done on ,d+[DATE];</p> <p>[DATE] Blood cultures were done on ,d+[DATE];</p> <p>[DATE] Collect wound culture for C&S was done on ,d+[DATE]; and</p> <p>[DATE] Wound culture was done on ,d+[DATE].</p> <p>The MAR dated [DATE] to [DATE] showed Linezolid was administered per order.</p> <p>The TAR dated [DATE] to [DATE] showed CBC and CMP was done as ordered.</p> <p>A review of the Progress Notes dated [DATE] to [DATE] revealed the following:</p> <p>[DATE] 11:08 a.m. Resident noted to be more lethargic and increased confusion at this time. Received order for blood cultures and start cipro 250 mg two times a day for 5 days after blood cultures are drawn.</p> <p>(continued on next page)</p>		

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

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>[DATE] 15:30 (3:30 p.m.) Medical doctor notified facility. New order to discontinue doxycycline and start streptomycin 1 gram intramuscular daily for 10 days with lidocaine.</p> <p>[DATE] 15:21 (3:21 p.m.) U/A culture received this shift. Medical doctor notified. Received order for doxycycline 100 mg daily for 10 days.</p> <p>[DATE] 10:44 a.m. Received order from medical doctor. Discontinue streptomycin and lidocaine and start linezolid 600 two times a day for 14 days.</p> <p>On [DATE] at 12:19 p.m., the Director of Nursing (DON) reported the labs ordered were just routine labs. They had just started with this lab company on [DATE]st [2024] and they had all new supplies provided to them by the lab. The DON stated she reached out to her point of contact regarding the expired vial and he only stated the lab told him that the vial was expired. She did not know who took the culture. The labs were initially ordered on [DATE]. The nurse collected it on [DATE] and the lab company came to pick it up on , d+[DATE]. The DON confirmed there was a delay in getting the culture done due to the expired vial. Nurses should be checking the dates on the vial. They had to get a new order to repeat the culture and the results were not received until [DATE]. She was not sure when the preliminary results were received. She said there were results prior to ,d+[DATE] but the doctor does not start anything until you have a sensitivity. The order for doxycycline was put in on [DATE] at 15:12 (3:12 p.m.) and was discontinued on [DATE] at 15:24 (3:24 p. m.). The linezolid was put in on [DATE] in the morning and the first dose was administered on 2100 (9:00 p. m.) on [DATE]. Streptomycin Sulfate was ordered on [DATE] at 15:30 (3:15 p.m.), none was administered, and was discontinued on [DATE] at 10:42 am. None of the doxycycline was given. It was 29 hours before the first dose of antibiotic was administered after receiving the results of the labs.</p>

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NAME OF PROVIDER OR SUPPLIER Windsor Woods Rehab and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 13719 Dallas Dr Hudson, FL 34667	
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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>49227</p> <p>Based on observations and record review, the facility failed to ensure the medication error rate was less than 5.00%. Forty-two medication administration opportunities were observed, and three errors were identified for two residents (#38 and #7) of five residents observed. These errors constituted a 7.14% medication error rate.</p> <p>Findings included:</p> <p>On 6/5/24 at 9:00 a.m., Staff N, LPN was observed preparing and administer administering Resident #38's medications. She prepared and administered the following medications aspirin Low dose 81 mg, hydrochlorothiazide Oral Tablet 12.5 mg, vitamin D and Tylenol regular str 325 mg. A review of Resident #38's physician orders revealed aspirin EC tablet delayed release 81 mg was ordered (photographic evidence obtained) and not administered as prescribed.</p> <p>On 6/5/24 at 9:15 a.m., Staff N, LPN was observed preparing and administer administering Resident #7's medications. She prepared and administered the following medications Aricept 10 mg, Aspirin EC Tablet Delayed Release 81 mg, vitamin B-12 1000 mcg, Claritin 10 mg, Colace 100 mg, Effexor XR 150 mg, famotidine 20 mg, Lasix 40 mg, Plavix 75 MG, Proslight 1 tablet, spironolactone 25 mg, Probenecid 500 mg, tizanidine 2 mg, and trifluoperazine 10 MG. A review of Resident # 7's Medication Administration Record (MAR) showed Aricept 10 mg was scheduled to be administered at 8:00 a.m. During medication preparation, Staff N, LPN did not prepare MiraLAX 17gram's and during medication administration medication was not discussed with the resident. A review of the Resident #7's MAR showed MiraLAX was refused.</p> <p>Review of facility policy titled, Section 7.1 Medication Administration General Guidelines 09/19, General Guidelines policy include medications are administered as prescribed in accordance with manufacturers' specification, good nursing principles and practices Guidance listed in the procedures section showed 3. Prior to administration, review and confirm medication orders for each individual resident on the medication administration record (MAR). Compare the medication and dosage schedule on the resident's MAR with the medication label. If the label and MAR are different, and the container is not flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the prescribers' orders are checked for the correct dosage schedule. The Medication Administration section showed 1) medications are administered in accordance with written orders of the prescriber. 9) verify medication is correct 3 times before administering the medication a) when pulling medication package from Med cart b) when dose is prepared c) before doses is administered. 14) medications are administered within 60 minutes of scheduled time, except before or after meal orders.</p> <p>F</p>		