STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105332	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winter Park Care and Rehabilitation	2970 Scarlett Rd Winter Park, FL 32792

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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (continued on next page)

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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an appropriate wheelchair was provided to accommodate the needs and preference of 1 of 1 resident reviewed for resident rights, of a total sample of 30 residents, (#82). Findings:Resident #82 was admitted to the facility from an acute care hospital on 2/24/25 with diagnoses that included wedge compression fracture, history of falls, muscle wasting with atrophy, and need for assistance with personal care. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed resident #82 had a Brief Interview of Mental Status (BIMS) of 15/15 which indicated she was cognitively intact and able to make her needs known. She had no upper or lower limitations in range of motion and utilized a wheelchair for mobility.On 7/07/25 at 11:45 AM, resident #82 was observed in her room sitting up in a transport wheelchair watching television. She stated she was a private person and preferred to do activities in her room but sometimes wanted to move around the room or go out into the hallway. She continued that she was unable to do those things because she did not have an appropriate wheelchair. Resident #82 said she had asked staff for a different wheelchair but was told she could not have it, and she did not know why. According to the National Association of Senior Fitness, a standard wheelchair is a chair with oversized rear wheels and rotating handrails that were designed to help individuals with mobility issues to steer themselves unaided. In contrast, a transport chair was compact and required a second person to push the user from behind. Furthermore, a standard wheelchair had padded seats and hand/leg rests which allowed for all day use, but a transport chair was not recommended for all day use due to lack of comfort, (retrieved on 7/11/25 from www.seniorfitness.net).Review of resident #82's Physical Therapy (PT) progress report for dates of service 3/28/25-4/10/25, revealed she was weight bearing as tolerated, utilized a walker and wheelchair for mobility, and her mobility function score was 11 out of 12, with 12 being the highest function. On 7/09/25 at 10:24 AM, the Therapy Director said resident #82 was on the restorative program because she had reached a plateau for PT. She stated she was unaware that resident #82 had been provided with a transport wheelchair for daily use and not aware the resident wanted a standard wheelchair. She said resident #82 liked staying in her room and did not express a desire to leave the room. She believed it was not abnormal for a resident to receive a transfer wheelchair and explained the facility did not assign wheelchairs to residents unless they needed a specialized chair. She explained that all staff had the ability to obtain a wheelchair for a resident from where they were stored. The Therapy Director confirmed that resident #82 had not received a standard wheelchair until yesterday, almost five months since she was admitted . She acknowledged that residents were unable to independently maneuver a transport wheelchair, which limited their independence. On 7/09/25 at 2:22 PM, Licensed Practical Nurse (LPN) B explained that on admission the nurse would review the State Agency transfer form 3008, which included the resident's mobility status. The nurse said if the resident was weight bearing, the facility could provide a wheelchair for independent mobility but if the mobility status was not provided, the resident would need to be evaluated by PT before a wheelchair could be provided. She confirmed all staff had access to the storage room where wheelchairs were kept. Review of the State Agency transfer form 3008, dated 2/24/25, revealed that resident #82 required assistance with ambulation but was full weight-bearing. On 7/09/25 at 2:41 PM, resident #82 explained she had been at another long-term care facility prior to being hospitalized and while there had a wheelchair for independent mobility. She said when she was admitted to the current facility she was given the transport chair which limited her ability to independently move around the facility. Review of resident #82's care plan with revision date 3/27/25, revealed she had potential for pain related to compression fractures, and impaired mobility. The goal was to prevent decline in overall function and one intervention was to encourage mobility and physical activity as tolerated. There was no care plan to show the family wanted the resident in a transport chair. On 7/09/25 at 04:18 PM, the Director of Nursing (DON) stated she was aware of the difference between a transport wheelchair and a regular wheelchair. She said a transport wheelchair was inappropriate for a resident to use daily, especially if they were able to move around independently. She said she was unaware resident #82 was given a transport wheelchair because she was new to the facility and the resident had been admitted prior to her hire date. The DON explained she was informed that the resident did not receive the correct wheelchair until 7/08/25 after the resident had asked for it again, and the survey was in process. She agreed that providing an inappropriate wheelchair to a resident that could independently ambulate limited their right to independence and could potentially cause a

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurate for nutritional approaches for 1 of 3 residents reviewed for nutrition, of a total sample of 30 residents, (#84).Findings:Resident #84 was initially admitted to the facility on [DATE] for strengthening following a hospital stay and a new lymphoma diagnosis. Resident #84 was discharged home with family and hospice services on 6/02/25. On 6/12/25 the resident was readmitted to the facility with generalized weakness and edema. The resident's diagnoses included diffuse large B-cell lymphoma (cancer), muscle wasting and atrophy, urinary tract infection, and stage 2 chronic kidney disease. Review of the admission MDS assessment with Assessment Reference Date of 6/19/25 revealed resident #84's nutritional approaches included parenteral or intravenous (IV) feeding while a resident and a mechanically altered diet which required a change in texture of food or liquids on admission. Under the section listed percent intake by artificial route the resident's proportion of total calories received through parenteral, or tube feed was documented as 25% or less while a resident and during the entire seven day look back. The resident was also documented as having received an average fluid intake per day by IV or tube feeding documented as 500 cubic centimeters (cc) /day or less while a resident and during the entire seven days. Under the section special treatment procedures and programs, the resident was documented as having no IVs. Parenteral nutrition is defined as feeding intravenously or through a vein. Parenteral nutrition bypasses your entire digestive system, from mouth to anus. It may include different amounts of essential nutrients such as water, carbohydrates, proteins, fats, vitamins and minerals, (retrieved from https://my.clevelandclinic.org on 7/11/25).Review of the resident's current diet order revealed regular/no added salt (NAS) diet with regular texture and thin consistency. The order indicated the resident was on an 1800 milliliter (ml) fluid restriction and fortified food with all meals. Review of all diet orders since initial admission on [DATE] revealed at no time was the resident on a parenteral, IV feeding or mechanically altered diet. On 7/09/25 at 12:32 PM, the Dietitian confirmed the resident's diet was a regular diet with regular textures and thin liquids. After reviewing the resident's medical record, he confirmed that at no time were there physician orders for a mechanically altered diet during either of her stays at the facility. He stated she never received nutrition from an IV feeding or tube feed. On 7/09/25 at 1:58 PM, the Certified Dietary Manager (CDM) revealed she was responsible for parts of the swallowing and nutritional status section of the MDS assessment. She confirmed that on the resident's admission MDS dated [DATE] she incorrectly coded the resident as having a mechanically altered diet. The CDM acknowledged the resident requiring a mechanically altered diet was a miscoding of the assessment. She stated the resident wasn't on a mechanically altered diet and hadn't been since admission. On 7/09/25 at 12:40 PM, the MDS Coordinator indicated the resident's current diet order was a regular diet with regular consistency. She confirmed that at no point during the resident's stay at the facility was she on a mechanically altered diet. She confirmed the admission MDS dated [DATE] listed the resident as having a mechanically altered diet. The MDS Coordinator then confirmed the resident was coded on the same assessment as having received parenteral or IV feeding. She acknowledged the resident has had no parenteral or IV feeding upon admission nor while a resident at the facility. The MDS Coordinator was unable to explain how she determined the proportion of total calories the resident received thru parenteral or tube feeding as 25% or less and the resident's intake was 500cc/day or less. The facility's job description dated August 2021 for MDS Coordinator under the section Essential Duties and Responsibilities indicated the MDS Coordinator was responsible for reviewing MDS assessments prior to closing and transmitting to ensure all sections were complete and accurate according to Federal Regulations. The facility policy and procedure titled Resident Assessment - Resident Assessment Instrument (RAI) (n date) states that it's the policy of the facility to adhere to the following procedures related to the proper documentation and utilization of a resident's Minimum Data Set (MDS)to ensure a comprehensive and accurate assessment of residents.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the intravenous (IV) catheter dressing was changed every seven days per physician order for 1 of 1 resident reviewed for IV therapy, of a total sample of 30 residents, (#142).Findings:Resident #142 was admitted to the facility on [DATE] with diagnoses including fracture of neck, intraspinal abscess and spinal stenosis-cervical region. Review of resident #142's electronic medical record (EMR) revealed a Brief Interview for Mental Status (BIMS) assessment dated [DATE]. The assessment indicated he had a BIMs score of 15/15 which meant he was cognitively intact.A care plan initiated 7/07/25 indicated resident #142 received IV therapy related to antibiotic therapy administration. Interventions included, Observe dressing. Change dressing and record observations of site. Review of resident #142's EMR revealed physician orders were added on 7/07/25 for the care of the IV insertion site. The orders included directions to observe the site every shift, before/after medication administration and with dressing changes for redness, swelling, warmth and/or loosening or soiled dressing every shift and to change the site dressing as needed. An additional order dated 7/07/25 gave instructions to change the site dressing every week with transparent dressing on the night shift every Sunday and was scheduled to begin on 7/13/25. Review of the Medication Administration Record (MAR) for July 2025 revealed four nurses documented they had observed the IV site between 7/07/25 and 7/09/25. There was no documentation on the MAR or progress notes to indicate any licensed staff member had changed the dressing. On 7/07/25 at 10:58 AM, resident #142 was observed in bed with head of bed elevated watching television. An IV pole was observed next to the bed, but no medications were present. Resident #142 stated he received an antibiotic due to an infection from a recent surgery. The IV insertion site was not visible and resident #142 did not wish to show it at that time.On 7/08/25 at 8:55 AM, resident #142 was observed in bed. He allowed a Registered Nurse surveyor to observe the IV dressing which was located on his right upper arm. The IV dressing was dated 7/01/25. On 7/09/25 at 3:24 PM, Licensed Practical Nurse (LPN) B went to administer IV medications to resident #142. She observed the transparent IV dressing and verified it was dated 7/01/25, eight days prior. LPN B continued with her task of administering medication. LPN B did not express why the IV dressing was not changed for over a week, nor did she attempt to change the dressing. On 7/09/25 at 3:41 PM, LPN A reviewed the physician orders for resident #142. She verified she entered the orders for care of the IV site and dressing on 7/07/25. LPN A reviewed the IV dressing change order and confirmed the IV dressing was scheduled to be changed on Sunday, 7/13/25. She explained a transparent IV dressing should be changed every seven days. LPN A stated the dressing should have been changed when resident #142 was admitted and then every seven days thereafter. She was informed the date on the dressing was 7/01/25 which was verified by LPN B. LPN A acknowledged 7/13/25 would be almost two weeks since the dressing was changed. She stated she should have looked at the dressing prior to entering the order and scheduling the initial date for it to be changed. LPN A acknowledged the dressing change was missed and had not been done for over a week. On 7/09/25 at 4:16 PM, the Director of Nursing (DON) acknowledged the date on resident #142's IV dressing, that the dressing had not been changed and that it was not scheduled to be changed until 7/13/25. The DON stated the IV dressing should have been changed within seven days of the date on the dressing. She was not sure why it had not been changed or why the order was initiated for change on 7/13/25 instead of seven days from the date on the IV dressing. The DON acknowledged the order was wrong and that the dressing change was missed.The facility's policy and procedure for Guidelines for Preventing Intravenous Catheter-Related Infection revised August 20014 indicated the purpose was to reduce the risk of infection associated with indwelling intravenous catheters. The policy clarified that transparent semipermeable membrane dressings should be changed every five to seven days and as needed if damp, loosened or visibly soiled.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview, and record review, the facility failed to ensure the Quality Assessment & Assurance (QAA) / Quality Assurance and Performance Improvement (QAPI) committee conducted performance improvement activities to ensure prior improvement measures were sustained. Findings: Review of the facility's QAPI Plan revealed the facility must take actions aimed at performance improvement and measure its success and track performance to ensure that improvements were realized and sustained. The facility would develop and implement policies addressing how the facility would monitor the effectiveness of its performance improvement activities to ensure that improvements were sustained. The facility had deficiency cited at F641 during the previous recertification survey conducted 2/12/24 to 2/17/24 for accuracy of assessments. During this survey, the facility was found to again be in noncompliance with F641 for accuracy of assessments regarding Minimum Data Set (MDS) assessments. As a result of the repeat deficiency, it was identified there was insufficient auditing and oversight to prevent the citation.On 7/10/25 at 11:53 AM, the Administrator stated that with the transition between new employees in management roles, as well as the MDS role, maintaining accuracy of documentation must have fallen thru the cracks.