STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105518	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winter Garden Rehabilitation and Nursing Center	12751 W Colonial Drive Winter Garden, FL 34787

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 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 treat residents in a dignified and respectful manner for 1 of 6 residents reviewed for resident rights of a total sample of 12 residents, (#5). Findings: Review of resident #5's medical record revealed he was admitted to the facility on [DATE] with diagnoses including atrial fibrillation, type 2 diabetes, orthostatic hypotension, and history of falling. Review of the Minimum Data Set (MDS) quarterly assessment with Assessment Reference Date (ARD) of 7/15/25 revealed resident #5 had a Brief Interview for Mental Status score of 15 out of 15 which indicated he was cognitively intact. Review of the MDS admission assessment with ARD of 7/15/25 revealed it was somewhat important for resident #5 to do things with groups of people and do his favorite activities. On 9/24/25 at 11:00 AM, resident #5 expressed frustration regarding the delivery of his meals. He stated that meals were not always served at the same time and when food arrived, it was often cold. He explained a few weeks ago the kitchen staff brought out the cart, but the nursing staff was not present in the dining room, so he got his tray and began serving others. He reported when staff saw what he was doing, he was told he was not permitted to serve the other residents. The resident recalled he got upset and yelled to get people's attention hoping staff would pass the meals to the residents. He mentioned, because of his behavior, the facility punished him with a four-week suspension requiring him to eat in his room. Resident #5 stated he had a week remaining of his suspension but planned to leave the facility next week to an Assisted Living Facility. The resident confirmed he had filed grievances about the meal delays but said he felt his concerns had fallen on deaf ears. Review of resident #5's medical record revealed a care plan dated 1/14/25 regarding his ability to make leisure needs and preferences known and participate in facility activities as desired. The care plan included resident #5 preferred a balance of social and independent leisure activities. Goals included expressing satisfaction with his leisure routine, engaging in independent activities, and participating in facility activities as desired. Interventions included staff encouraging participation in preferred activities and honoring resident #5's choices. Review of a Change in Condition Evaluation dated 8/29/25 revealed a change in resident #5's behavior and mood. The nursing observations and evaluation documented he exhibited increased abnormal behaviors and increased yelling, cursing, pushing furniture items around the room; he appeared infuriated regarding mealtime, and behavior was not easily directed. The form revealed the physician was notified and orders were received for a room change, blood work, and psychiatric consult. Review of a Grievance Form, dated 8/29/25, filed by resident #5 revealed he expressed concern about food not being served on time in the dining room and expressed concern for staff to be present and on time in the dining room for all meals. The Grievance Official Follow-up section read, Spoke with resident regarding concerns. Notified resident that staff was late to dining room due to an emergency on the unit. Staff re-educated that even when an emergency is occurring, at least one team member is to be present in the dining room. Resident expressed his appreciation. Stated he would take a break from attending dining room for a bit. Psych [psychiatric] consult and 30 min [minute] safety checks initiated. Resident provided with dining room coverage. On 9/29/24/25 at 4:33 PM, the Certified Dietary Manager (CDM) said For a period of time [resident #5] was not in the dining room for a problem that happened. She indicated she was not present when the incident occurred, but he would be allowed to return to the dining room the first week of October. She stated resident #5 previously ate meals in the dining room. She explained she learned about the incident during a meeting. The CDM stated in her three years at the facility, she had never seen any other residents restricted from eating in the dining room. On 9/25/25 at 1:09 PM, Restorative Certified Nursing Assistant (CNA) B stated she often saw resident #5 seated and interacting with others in the dining room whenever she worked. She recalled going to resident #5's room the day after the incident happened and learning he could not go to the dining room for 30 days. She recalled the resident explained to her that he became upset that day because he was hungry, and the food was taking too long to be served. On 9/25/25 at 2:02 PM, in a telephone interview, Registered Nurse (RN) C shared that on 8/29/25 after the incident occurred, she was surprised to learn about resident #5's behavior that night. She indicated he was probably upset about the service and just had enough. She stated the facility restricted him from eating meals in the dining room for 30 days. The nurse said she learned about the restriction from upper management, resident #5's former roommate and resident #5 himself. On 9/25/25 at 2:25 PM, resident #11 stated she had been the Resident Council President for one year and usually ate her lunch and dinner in the dining room. She confirmed some