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	12/17/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 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 a high fall risk resident received timely post-fall assessment, pain management, and emergency medical intervention in accordance with professional standards of practice and the resident's comprehensive, person-centered care plan for one of four residents reviewed for falls, of a total sample of five residents, (#1).Findings: Review of resident #1's medical record dated 11/11/25 through 11/13/25 revealed she was admitted to the facility from an acute care hospital on [DATE] for short-term rehabilitation. Her diagnoses included Alzheimer's dementia, osteoporosis, chronic kidney disease, and a history of falls. Review of the admission Minimum Data Set assessment dated [DATE] showed the resident had a Brief Interview for Mental Status score of 4 out of 15, indicating severe cognitive impairment. The assessment revealed the resident required supervision and assistance for mobility and transfers. She was identified by the facility as a high fall risk. Review of resident #1's physical therapy notes dated 11/12/25, revealed she was admitted with weakness and mobility deficits. Physical, occupational, and speech therapy services were initiated on 11/12/25. Therapy documentation dated 11/12/25 indicated the resident required assistance at all times to participate in therapy. A nursing progress note dated 11/12/25 at approximately 10:15 PM, revealed Certified Nursing Assistant (CNA) A found the resident on the floor in her room with her head facing the bathroom and her left leg turned inward. On 11/12/25 Licensed Practical Nurse (LPN) B documented in a progress note she and two CNAs assisted the resident from the floor back into bed by picking her up off the floor. An in-turned leg after a fall may indicate the need for medical attention and appropriate treatment, (retrieved from www.hopkinsmedicine.org on 12/23/25). Review of a progress note dated 11/12/25 revealed LPN B documented further that resident #1 could move one leg but had limited movement of the other leg. The nurse assessed the resident's pain as 4 out of 10, and she documented she placed a pillow for comfort. The record contained no documentation of a full post-fall assessment or neurological assessment of resident #1. Additionally progress notes starting 11/12/25 showed that between approximately 10:30 PM and 1:00 AM on 11/13/25, in a time span of two and a half hours, multiple attempts were made by nursing staff to contact the on-call provider without success. A progress note written on 11/13/25 indicated the Licensed Practical Nurse contacted a portable X-ray service; however, she documented the service was unavailable until later in the day. Review of the Medication Administration Record from November 2025 revealed Tramadol was administered at approximately 1:25 AM on 11/13/25, over three hours after the fall. There was no documentation that Emergency Medical Services (EMS) were contacted during this time. A progress note dated 11/13/25 at approximately 2:20 AM, documented by LPN B indicated the on-call provider returned the call and ordered the resident to be transferred to the hospital. The note detailed EMS was called and the resident was transported to the hospital, over four hours after the fall occurred. On 12/17/25 at 10:15 AM, CNA A stated she found the resident on the floor at night on 11/12/25 and assisted in helping the resident back into bed. She confirmed the resident appeared to be in pain following the fall. On 12/17/25 at 10:45 AM, in an interview with LPN B, the nurse stated she assessed the resident after the fall, noted limited movement of one leg, and attempted multiple times to contact the on-call provider. The nurse stated she did not call 911 because she believed a provider order was required, even though she had noted the resident's leg was visibly turned inward after the fall. She did not say why she did not document a post fall assessment or a neurological assessment was completed. On 12/16/25 at 2:00 PM, in a phone interview, resident #1's daughter stated she was notified that her mother had fallen and was later informed she was being sent to the hospital. The daughter stated she was concerned that her mother remained in the facility for four hours after she had fallen and broken her hip. The daughter said the facility could not explain why it took so long to send her mother to the hospital for an emergency evaluation. The daughter expressed her displeasure with facility's delay in arranging higher-level care for her mother. On 12/17/25 at 3:00 PM, in a joint interview with the Director of Nursing (DON) and Assistant Director of Nursing, they acknowledged it was over four hours for the resident to be transported to the hospital. The DON confirmed licensed nurses should use their nursing judgment whether a resident needed to go the hospital and did not have to wait for a physician's order.