STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105618	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Park of Winter Park	558 N Semoran Blvd 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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40892 Based on interview, and record review, the facility failed to honor resident's right to choose their preferred bathing preferences for 1 of 4 residents reviewed for choices, of a total sample of 41 residents, (#78). Findings: Review of the medical record revealed resident #78 was admitted to the facility on [DATE] from the hospital. Her diagnosis included left lower extremity cellulitis, gangrene, dementia, and diabetes. Resident #78's Nursing Admit/Readmit screener dated 7/30/24 revealed the resident's preference for bathing was a shower on scheduled shower days during the day shift. Resident #78's Medicare 5-day Minimum Data Set (MDS) assessment with an assessment reference date of 8/1/24 revealed the resident scored a 3 out of 15 on the Brief Interview for Mental Status, which indicated severe cognitive impairment. The MDS assessment also indicated resident #78 required substantial/maximal assistance with bathing. Resident #78's Certified Nursing Assistant (CNA) Kardex, with admitted [DATE], noted the resident preferred showers on Mondays and Thursdays in the evening. A review of resident #78's medical record revealed an activity of daily living self-care performance deficit care plan was initiated on 10/13/24 and revised on 8/01/24 that noted the resident needed supervision/touch assistance with showers. The bathing task report for resident #78 showed she received only four showers from between 8/01/24 to 9/30/24 and once on 10/07/24. The report noted the resident instead received bed baths on 17 of 24 scheduled shower days since admission. On 10/20/24 at 12:44 PM, resident #78 stated she got bed baths but preferred showers. She conveyed she had told the staff she preferred showers, but they just washed her in the bed. Resident #81's daughter was present and agreed with her mother. The daughter stated she asked the facility to shower her mother on Monday and Thursday evenings. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/23/24 at 11:52 AM, the Bristol Unit Manager (UM) stated that CNAs must check the shower book to see who got a shower. The CNA was required to let the primary nurse know if a resident refused a shower. A progress note should be written by the nurse when a resident refused a shower. The UM accessed resident #78's medical record and confirmed the Kardex and the nursing admission assessment, indicating the resident's bathing preference was showers. She confirmed the Kardex listed shower preference for Mondays and Thursdays in the evenings. On 10/23/24 at 2:16 PM, the Director of Nursing accessed the resident's bathing task report. She acknowledged the resident received only five showers in the past 67 days, on 8/01/24, 8/19/24, 9/05/24, 9/30/24, and 10/07/24, with one day documented as refused to bathe and another scheduled day with no documentation. The DON expressed that the resident's choices were not honored and that resident #78 should have received showers instead of bed baths. She acknowledged the importance of ensuring the resident received her preferred means of bathing, as it was the resident's right.

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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** 35339 Based on observation, interview, and record review, the facility failed to provide appropriate care and services according to professional standards for monitoring and management of an intravenous (IV) therapy site for 1 of 1 residents reviewed for IV access, of a total sample of 41 residents, (#168). Findings: Review of the electronic medical record for resident #168 revealed she was admitted to the facility on [DATE], with diagnoses of displaced closed fracture of left femur, history of falling, diabetes, muscle weakness, abnormalities of gait, mobility and urinary tract infection. On 10/20/24 at 11:51 AM, observation of resident #168 while laying in bed, revealed an peripheral intravenous central catheter (PICC) line with no date in her left upper arm. A PICC line is a long thin tube that is inserted through a vein in the arm which is passed through to larger veins near your heart, used to give medications, (retrieved from www.mayoclinic.org on 11/04/24). Review of resident #168's medical record identified a completed IV insertion form dated 10/16/24 at 11:02 AM, with reason for visit showing new order for PICC line, inserted in the left arm. A completed IV insertion form dated 10/18/24 at 12:01 PM, with reason for visit listed as consult and note documented, Pt mid [midline] clogged/Unclogged . Further review of the medical record revealed there was no physician order for insertion, monitoring or flushing of the PICC line on 10/15/24, 10/16/24 or 10/17/24 documented on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR). The medical record showed shortly thereafter a weekly skin evaluation form dated 10/16/24 at 1:05 PM, did not list the PICC line in the left arm and resident #168 baseline careplan revealed no problem, goal or interventions for a left arm PICC line or IV therapy site. IV therapy management for nurses includes verifying physician orders, monitoring, inspecting, and flushing the IV catheter, (retrieved on 11/04/24, from https://www.ncbi.nlm.nih.gov/books). Review of resident #168's medical record identified a physician order to start Meropenem-Sodium Chloride (antibiotic) IV Solution 500 milligrams (mg)/50 milliliters (ml) every 12 hours for sepsis on 10/16/24. Review of the MAR for resident #168 showed multiple nurses administered Meropenem-Sodium Chloride IV medication on 10/16/24 at 9:00 AM, and 9:00 PM, for a total of five doses over two shifts with no physician orders for monitoring management or flushing the PICC line site. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/24 at 10:50 AM, the 200 hallway Unit Manager (UM) stated resident #168 should have normal saline flushes every shift, before and after IV antibiotic administration. She continued, the IV dressing change was after 24 hours and weekly after insertion, as well as monitoring of the IV therapy site every shift. She validated resident #168 did not have any of those physician orders. She stated the admission nurse was responsible for putting in the orders and the check system for new physician orders was completed the next day by the clinical team which consisted of the Unit Managers, Assistant Director of Nursing and the Director of Nursing. She acknowledged resident #168 did not receive the proper monitoring or sufficient care or service for IV therapy. On 10/22/27 at 2:07 PM, the Director of Nursing stated the initial nurse was supposed to add orders for changing the IV dressing, inspecting the site, and flushes. She stated IV sites were monitored and flushed every shift and confirmed the check system for new physician orders was reviewed by the nurse management clinical team daily. Review of the policy and procedure for Intravenous Therapy dated 8/02/22 revealed the facility should adhere to accepted standards of practice regarding infusion practices, IV sites should be checked every four hours or as per facility protocol, and nurses should confirm patency of the IV site per flushing protocols. Review of the policy for Flushing Midline and Central Line IV Catheters dated May 2022 showed Midline and Central Line IV catheters will be flushed to maintain patency .