

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105618	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Regents Park of Winter Park		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on observation, interview, and record review, the facility's Quality Assurance and Performance Improvement (QAPI) program failed to identify a repeated deficiency and area of systemic non-compliance with Intravenous (IV) catheter care. The deficient practice had the potential to affect more than a limited number of residents by not ensuring consistent monitoring and follow-up of identified problems. Findings: Review of the facility's survey history revealed repeat deficiency concerns for IV catheter care. The survey history revealed the facility was issued a Centers for Medicare & Medicaid Services (CMS) Enforcement that included F694 Parenteral/IV Fluids during the 10/23/24 recertification survey and again during the current recertification survey. On 6/04/26 at 5:45 PM, the facility's Administrator discussed the facility's QAPI program. The Administrator was unable to show evidence the facility had a Process Improvement Plan (PIP), or current audits in effect for parenteral/IV fluids. The Administrator acknowledged the facility had received a citation for parenteral/IV fluids during the last recertification survey but give an explanation for the repeat concerns with IVs. From 6/01/26 to 6/04/26, a recertification survey was conducted, and deficient practice was again identified for F694 Parenteral/IV Fluids. The facility did not implement an ongoing, systematic QAPI program to ensure that identified problems were corrected and prevented from recurring. The failure of the facility to maintain complete monitoring documentation and address repeated deficiencies demonstrated the QAPI program was not effective. Review of the facility's undated standards and guidelines titled, 2026 Quality Assurance & Performance Improvement Plan read, it was designed to establish and maintain an organized facility-wide program that is data-driven and utilizes a proactive approach to improving quality of care and services throughout the facility. The document listed multiple objectives of the QAPI Plan which included to address gaps in system or processes and multiple goals of the QAPI Plan which included no previously cited tags in the past three (3) years.		

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement and maintain an effective infection and prevention control program to provide a sanitary environment to prevent the development and transmission of communicable diseases and infections related to laundry services in one of one laundry room of the facility. Additionally, the facility failed to ensure staff implemented and adhered to infection prevention and control practices for transmission-based, and enhanced barrier precautions for a midline intravenous (IV) catheter for one of two residents reviewed for IV antibiotics, of a total sample of 38 residents, (#128, and #127). Findings: 1. On 6/04/26 at 12:06 PM, a laundry room tour with the Housekeeping Manager revealed wet floors with standing water between two large washers. The Housekeeping Manager said the floor had been like this for a few days now. He said he was not sure if it was coming from the washer and needed to call the vendor. Broken tiles were on the floor, which the Maintenance Director explained he was aware of. The Housekeeping Manager said there may be an issue with the bleach dispensing into the wash. He explained there may be something stuck in the tubing because the Laundry Attendant told him that the linen did not smell right but he needed to call the vendor. He indicated there was no alarm or alert on the screen of the washer that let them know if there was a problem with the bleach or detergent. The manager said he assumed it was cleaning the laundry because the vendor checked it. The Housekeeping Manager said they had a contract with a company to provide that service, and they came monthly and as needed to check that everything was working. He said he had a manual for the washers but did not have it close by. An Air Conditioner (AC) vent located above the clean linen area was not covered and visible dust was observed blowing through the vent. He confirmed the AC vent needed a cover. (Photographic evidence obtained) On 6/04/26 at 12:41 PM, the Infection Preventionist (IP) acknowledged the issues observed in the laundry room with the Housekeeping Manager could cause cross contamination. The IP acknowledged she was responsible for ensuring the laundry room followed infection control standards for proper handling and sanitization of everything that came through the laundry room for cleaning and sanitization. She confirmed staff should not rely on their sense of smell to determine if the laundry was properly sanitized. On 6/04/26 at 1:56 PM, a second tour of the laundry room was conducted with the Maintenance Director and the IP. The Maintenance Director said he thought the water leak was coming from the washer, but he was not previously aware of this issue. A few minutes later at around 2:03 PM, Laundry Attendant E was folding clean linen and shook a bed sheet without wearing a gowns or gloves. When she shook the sheet, it touched her chin, clothing and upper chest. The IP acknowledged this could lead to cross contamination and said staff should hold the linen away from their face and avoid shaking linens. The facility's undated policy on Infection Control- Linen Management states It is the policy of the facility to ensure that linens are handled in a way to prevent cross contamination and the spread of infection in accordance with State and Federal Guidelines. The procedure showed clean linens were to be kept covered and protected from dust, should not come into contact with staff clothing and laundry equipment should be properly maintained according to the manufacturer's instructions. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Review of resident #128's medical record revealed she was admitted to the facility on [DATE] with diagnoses including acute pyelonephritis (kidney infection), bacteremia (bacteria in the blood), urinary tract infection, extended spectrum beta lactamase (ESBL) resistance and dementia. Hospital paperwork dated 5/28/26 showed an Infectious Disease consult for ESBL Klebsiella bacteremia originating from a urinary source. The consult noted left-sided pyelonephritis, and the bacteria were susceptible to ertapenem, which was ordered. Extended-spectrum beta-lactamase ESBL-producing Enterobacterales are resistant to common antibiotics and require complex treatment. These organisms, including Klebsiella pneumoniae, can cause urinary tract and bloodstream infections, leading to increased morbidity and hospitalization (retrieved from CDC on 6/05/26). Physician orders dated 5/31/26 directed Ertapenem sodium 1 gram, reconstituted, to be administered intravenously daily for seven days. The resident's care plan included IV access for ESBL bacteremia and the need for contact isolation. On 6/01/26 at 10:44 AM, a Social Service Assistant entered resident #118's room without donning personal protective equipment (PPE), despite signage indicating contact isolation. PPE was present outside the room. On 6/01/26 at 10:52 AM, Licensed Practical Nurse (LPN) B confirmed resident #128 remained on contact isolation for ESBL and had a midline catheter. On 6/01/26 at 10:57 AM, the Social Service Assistant acknowledged she did not don PPE before entering the resident's room. She explained she was not aware the resident was on contact isolation and did not notice the contact isolation sign before going into the room. On 6/04/26 at 12:30 PM, the Director of Nursing (DON) acknowledged the Social Service Assistant did not don PPE before entering resident #128's room. The DON stated all staff were educated upon hire and yearly about transmission based precautions and infection control. She said staff were expected to adhere to those precautions. Review of the undated policy titled Central Venous Catheter Access and Maintenance revealed the intent is to ensure appropriate infection control prevention and control measures were taken to prevent the spread of infection. 3. Resident #127 was admitted on [DATE] with diagnoses which included cerebrovascular disease, urinary tract infection, chronic sinusitis, pneumonia, and dementia without behavioral disturbances. Review of the resident's discharge hospital paperwork dated 5/26/26 revealed the resident was treated for chronic sinusitis, and urinary tract infection. On 6/01/26 at 12:21 PM, resident #127 was in bed with a single lumen midline IV to her left upper arm. The resident did not have any signage or instructions related to transmission based precautions outside of the room that indicated if PPE was needed. Review of resident's clinical record revealed no physician orders related to transmission based (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	precautions, isolation or enhanced barrier protection. On 6/3/26 at 12:23 PM, the Infection Preventionist (IP) stated any resident who was admitted to the facility with an IV line such as a midline should be placed on enhanced barrier precautions due to it being a potential portal of entry for infections. The IP confirmed resident #127 did not have an order for enhanced barrier precautions but should have. Review of the undated facility policy titled Central Venous Catheter Access and Maintenance revealed the intent was to ensure appropriate infection prevention and control measures were taken to prevent the spread of infection.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to inform and provide written information to residents and/or their representatives about their right to accept or refuse medical or surgical treatment and to formulate an Advance Directive (AD) for five dependent residents' representatives, (# 1, # 11, #12, #15, and #116) and 15 residents able to make their own decisions for healthcare, (#1, #4, #5, #6, #7, #8, #10, #11, #12, #13, #15, #16, #57, #108, and #116), of a total sample of 38 residents. Specifically, the facility failed to ensure residents or their representative acknowledged receipt of verbal and written information about AD and failed to ensure AD acknowledgment forms were complete. Findings: 1. Resident #1 was admitted to the facility on [DATE] with diagnoses of malignant neoplasm of lung, secondary malignant neoplasm of bone, pneumonia, and chronic obstructive pulmonary disease with exacerbation. Review of the Minimum Data Set (MDS) assessment with assessment reference date (ARD) of [DATE] indicated he had a BIMS of 12 out of 15, which meant his cognition was moderately impaired. Review of resident #1's care plan showed an intervention dated [DATE] to discuss AD with the resident and/or appointed health care representative. Review of the AD acknowledgement form revealed the form was incomplete with no date or signatures to indicate the resident/resident representative acknowledged receipt of written information about their right to accept or refuse medical surgical treatment and formulate an AD. 2. Resident #15 was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease, schizoaffective disorder bipolar, and chronic obstructive pulmonary disease. Review of the MDS with ARD dated [DATE] indicated she had a BIMS of 2 out of 15, which meant her cognition was severely impaired. Review of resident #15's care plan showed an intervention dated [DATE] to discuss AD with the resident and/or appointed health care representative. Review of the AD acknowledgement form revealed the form was incomplete with no date or signatures to indicate the resident/resident representative acknowledged receipt of written information about their right to accept or refuse medical surgical treatment and formulate an AD. 3. Resident #116 was admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy (brain dysfunction), hemiplegia and hemiparesis, type 2 diabetes mellitus, major depressive disorder, and dysphagia (trouble swallowing). Review of the MDS with ARD of [DATE] indicated she had a BIMS of 03 out of 15, which meant her cognition was severely impaired. Review of resident #116's care plan showed an intervention dated [DATE] to activate resident's AD (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	as indicated, provide AD education and materials including state forms provided, and allow opportunities for expression of feelings and ask questions. There was no mention to provide the same materials to the resident representative and resident #116 was unable to make her own decisions. Review of the AD acknowledgement form revealed the form was incomplete with no date or signatures to indicate the resident/resident representative acknowledged receipt of written information about the right to accept or refuse medical surgical treatment and formulate an AD. 4. Resident #11 was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbances, brief psychotic disorder, respiratory failure and cerebrovascular disease. The admission MDS assessment dated [DATE], revealed the resident was unable to complete the Brief Interview for Mental Status (BIMS) and was severely impaired related to cognitive skills for daily decision making. Review of the AD acknowledgement form revealed the form was incomplete and had no resident nor representative signature acknowledging they had been informed in writing of their rights and rules regarding decisions for medical care. 5. Resident #12 was admitted to the facility on [DATE] with diagnoses of stroke, metabolic encephalopathy, both hands were contracted, and she had aphasia (difficulty speaking). The MDS assessment dated [DATE] indicated she had unclear speech, had a BIMS of 6/15, meaning impaired cognition therefore she was unable to make her own healthcare decisions. Review of resident #12's care plan showed an intervention dated [DATE] to discuss AD (to decide if the resident would be revived in case of an emergency) with the resident's family. The Electronic Medical Record revealed the resident had a blank AD form in her chart, with no date, signatures, or indication of code status. [DATE] at 10:25 AM, the Administrator provided documentation dated [DATE] that showed the facility sent an e-sign readmission Agreement for AD to resident #12's guardian. The Administrator stated the form was not returned. On [DATE] at 1:30 PM, the Social Services Assistant explained if residents were confused or unable to talk, they contacted the family to confirm for AD to determine if they would like to be Full Code or Do Not Resuscitate. She said they attempted to contact the family until they got in communication and documented the attempts in the progress notes. On [DATE] at 1:54 PM, the 200-hallway Unit Manager stated when a new admission came in, the facility used the code status off the hospital paperwork until they contacted the family or guardian, and they made a note in the chart. She commented that staff attempted to get a hold of resident #12's (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	family three times, and they followed up with code status wishes in the care plan meetings. The facility was unable to provide any progress notes to indicate any further attempts had been made to contact resident #12's representative regarding AD. On [DATE] at 9:43 AM, the Social Services Director discussed code status review, and said if a resident was confused, they tried to document if a family member didn't answer. She explained her assistant followed up with guardians they were unable to get in touch with. On [DATE] at 10:18 AM, Licensed Practical Nurse C said she left a voicemail with the Power of Attorney, tried to contact someone else on the emergency contact list, and noted it in the chart if a resident's representative didn't answer. Additionally, a review of the AD acknowledgment forms for residents #4, #5, #6, #7, #8, #10, #13, #16, #57, and #108 revealed the forms were incomplete. Specifically, responses were missing for questions pertaining to AD, and all applicable checkboxes had been left blank. The questions and checkboxes included whether the resident/resident representative had or had not chosen to formulate and issue any Advanced Directives. On [DATE] at 1:18 PM, the Director of Nursing (DON) said she was responsible for checking charts and verifying orders for newly admitted residents. She explained at morning meetings they went over the admission checklist and made sure there were consents, and orders, then followed up on those at the care meetings. The DON remarked it was important to document the initiation of care, and that the family was contacted. She confirmed the admission Coordinator was to follow up if they were unable to reach the guardian. The facility's Advance Directives Policy revised [DATE] indicated the admitting nurse should verify the resident's code status upon admission with the resident/resident representative to determine resident wishes for medical intervention should their heart stop beating or they stop breathing. This step was to ensure the facility honored the resident's right to decide whether to prolong life in accordance with federal and state regulations.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure completion and accuracy of Level I Preadmission Screening and Resident Reviews (PASARRs) on admission, and/or failed to make referrals for newly evident or possible mental disorders, to evaluate the need for specialized mental health services or alternate placement for 7 of 7 residents reviewed for PASARR, of a total sample of 38 residents, (#4, #6, #7, #8, #10, #62, and #66). Findings: 1. Review of the medical record revealed resident #4 was admitted to the facility on [DATE] with diagnoses including bipolar disorder, anxiety, major depressive disorder, obsessive-compulsive disorder (OCD) and paranoid schizophrenia. Review of the State of Florida Agency for Health Care Administration Preadmission Screening and Resident Review (PASARR) Level I screen dated 1/22/25 and signed by the admitting hospital Social Worker, revealed Section I for decision making listed mental illness or suspected mental illness as bipolar disorder and schizoaffective disorder. A psychiatry evaluation note dated 5/07/26 revealed the resident was on medication to treat and manage mental health diagnoses. This included the medication Buspirone for anxiety, Fluvoxamine for OCD, Trazodone for depression and Lyrica and Zyprexa for schizophrenia. Review of the resident's medical record revealed no updates had been made to the PASARR form to include these mental illnesses. 2. Review of the medical record revealed resident #6 was admitted to the facility on [DATE] with diagnoses including cerebrovascular disease, dementia with agitation, and brief psychotic disorder. The resident's PASARR form dated 5/04/26 was completed prior to admission to the facility. The form incorrectly indicated no diagnoses listed under Section IA, Mental Illness or suspected Mental Illness. A psychiatry evaluation note dated 5/12/26 revealed the resident had a diagnosis of brief psychotic disorder and suffered from psychotic symptoms that were not consistent and long lasting. The note indicated the disturbance was not attributable to the physiological effects of a substance or another medical condition. Review of resident #6's medical record revealed no updates had been made to the PASARR form to include these mental illnesses. 3. Resident #8 was re-admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (brain dysfunction), alcoholic liver cirrhosis of liver with ascites, bipolar disorder, major depressive disorder, generalized anxiety disorder and post-traumatic stress disorder (PTSD). Review of the most recent Minimum Data Set (MDS) quarterly assessment with assessment reference date (ARD) of 5/07/26 revealed the resident had a Brief Interview for Mental Status (BIMS) Score of 15 out of 15 which indicated her cognition was intact. The MDS listed anxiety disorder, depression, bipolar disorder and PTSD as active diagnoses listed under Psychiatric/Mood Disorders. (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the PASARR Level I Screen for Serious Mental Illness (SMI) and/or Intellectual Disability or Related Conditions (ID) For Medicaid Certified Nursing Facility revealed resident #8 was screened by the facility's current MDS/Resident Assessment Coordinator on 7/25/25 but did not include the diagnoses of depression nor PTSD. 4. Resident # 62 was re-admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes, acute kidney failure, paranoid schizophrenia, bipolar disorder, anxiety disorder, autistic disorder, major depressive disorder and PTSD. Review of the most recent MDS quarterly assessment with ARD of 3/11/26 revealed the resident had a BIMS score of 13 out of 15 which indicated her cognition was intact. The MDS listed anxiety disorder, depression, bipolar disorder, schizophrenia and PTSD as active diagnoses listed under Psychiatric/Mood Disorders. A review of the PASARR Level I Screen revealed resident #62 was screened by a Registered Nurse from the facility on 5/08/24 but the screen did not include the diagnosis of PTSD. On 6/03/26 at 4:58 PM, the MDS/Resident Assessment Coordinator acknowledged resident #8 and #62's Level I PASARRs did not include the correct and most recent mental illnesses and needed to be updated. 5. Resident #66 was re-admitted to the facility on [DATE] with diagnoses that included fibromyalgia, major depressive disorder, and Parkinson's disease. Review of the most recent MDS quarterly assessment with ARD of 4/09/26 revealed the resident had a BIMS score of 13 out of 15, which indicated her cognition was intact. A review of the PASARR Level I Screen for SMI and/or ID or Related Conditions for Medicaid Certified Nursing Facility revealed resident #66 was screened by the hospital on 8/02/25 but the diagnosis of major depressive disorder was not checked and sections I.A. and I.B on page 2 of 5 were blank. 6. Resident #7 was admitted to the facility on [DATE] with diagnoses of bipolar disorder, diabetes, stroke, and congestive heart failure. Review of resident #7's electronic medical record revealed a PASARR Level I screen dated 11/19/25 completed at the hospital that indicated she had diagnosis of bipolar disorder. The facility completed another PASARR Level I screen on 4/17/26 that included diagnoses of anxiety and depression but omitted bipolar disorder. The MDS assessment dated [DATE] revealed resident #7 had a BIMS score of 15 out of 15, which indicated she was cognitively intact. The assessment detailed the resident required moderate to substantial assistance from staff, and diagnoses listed were depression and bipolar disorder. Review of resident #7's current physician orders showed she took Depakote for depression and anxiety, also used to treat bipolar disorder. A psychiatry note dated 5/22/26 indicated the resident went through a period of depression, had little appetite, low energy, and psychomotor changes. (continued on next page)		

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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 adhere to accepted standards of practice for intravenous (IV) catheters, including midlines for 1 of 2 residents reviewed for IV antibiotics, of a total sample of 38 residents, (#128). Findings: 1. Review of resident #128's medical record revealed she was admitted to the facility on [DATE] with diagnoses including acute pyelonephritis (kidney infection), bacteremia (bacteria in the blood), urinary tract infection, extended spectrum beta lactamase (ESBL) resistance and dementia. Hospital paperwork dated 5/28/26 showed an Infectious Disease consult for ESBL Klebsiella bacteremia originating from a urinary source. The consult noted left-sided pyelonephritis, and the bacteria were susceptible to ertapenem, which was ordered. Extended-spectrum beta-lactamase (ESBL)-producing Enterobacterales are resistant to common antibiotics and require complex treatment. These organisms, including Klebsiella pneumoniae, can cause urinary tract and bloodstream infections, leading to increased morbidity and hospitalization (retrieved from CDC on 6/05/26). Physician orders dated 5/31/26 directed Ertapenem sodium 1 gram, reconstituted, to be administered intravenously daily for seven days. On 6/01/26 at 10:52 AM, Licensed Practical Nurse (LPN) B confirmed resident #128 had the midline IV catheter but had no physician orders for midline catheter monitoring or dressing changes. On 6/03/26 at 9:02 AM, LPN A was preparing Ertapenem Sodium reconstituted 1 gram (gm) in a 100 milliliter (ml) bag to be administered IV. LPN A set the dial flow rate to 100 ml/hour. After the nurse completed administration and disposed of used supplies including her PPE, LPN A verified the pharmacy administration instructions written on the IV bag. LPN A acknowledged she had set the flow rate incorrectly and the rate should have been 200 ml/hour instead of 100 ml/hour. She explained the IV antibiotic should run for a total of 30 minutes and the previous flow rate of 100 ml/hour would have run over an hour. LPN A could not say why she set the rate incorrectly and acknowledged she should have verified the pharmacy instructions and physician's order before setting the flow rate. On 6/04/26 at 12:30 PM, the Director of Nursing (DON) acknowledged resident #128 did not have orders related to monitoring and maintaining the midline catheter until after the start of survey. She explained the facility process was for the admitting nurse to enter the orders for the IV. She said a second check was performed during their clinical meeting on Monday morning to make sure all associated orders were in the resident's chart. The DON acknowledged she was aware LPN A administered the IV antibiotic for resident #128 at the incorrect rate. She stated the pharmacy determined the rate at which the antibiotics should be run based on multiple factors and nurses were expected to read and follow those instructions. Review of the undated policy titled Medication Administration revealed medications were to be verified before administration. Verification of the medication included reviewing the medication name and label.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105618	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Regents Park of Winter Park		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure residents who were trauma survivors received culturally competent, trauma-informed care in accordance with professional standards of practice that accounted for residents' experiences and preferences to mitigate triggers to avoid re-traumatization of the resident, for 2 of 2 residents diagnosed with Post Traumatic Stress Disorder (PTSD), of a total sample of 38 residents, (#8, and #62). Findings: 1. Resident #8 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (brain dysfunction), alcoholic liver cirrhosis with fluid buildup, bipolar disorder, major depression, anxiety, and PTSD. The most recent Minimum Data Set (MDS) quarterly assessment with an Assessment Reference Date (ARD) of 5/07/26 showed the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, intact cognitive function. The MDS listed PTSD as an active diagnosis for resident #8 under psychiatric or mood disorders. On 6/01/26 at 1:32 PM, resident #8 stated she did not sleep well and sometimes had nightmares. Review of psychiatrist progress notes from 2/26/26, 5/26/26, and 5/07/26, included, The history suggests that this patient has suffered from significant trauma resulting into nightmares, flashbacks, and hypervigilance in the past. The symptoms have caused significant distress and functional impairment to the patient. The symptoms have lasted for more than one month(s) and have occurred without any substance use or organic brain pathology Care Plan for PTSD diagnosis: Trauma: Reports childhood emotional, physical and sexual abuse by family members Triggers: Male resident resembling father, trauma related nightmares, Care Plan: Started Prazosin, increased Sertraline refer to psychotherapy, staff to use trauma informed approach, monitor distress around triggers. A review of resident #8's Comprehensive Care Plan showed a focus for a risk for trauma related to medical settings but did not include a care plan that listed her specific trauma triggers. On 6/03/26 at 10:25 AM, resident #8's assigned Certified Nursing Assistant (CNA) F said the resident needed minimal assistance with activities of daily living, and she was not aware of any special care or instructions when caring for resident #8. CNA F explained as she reviewed the Kardex on her computer that there were special instructions for resident #8. On 6/03/26 at 10:45 AM, resident #8's assigned Registered Nurse (RN) D said the resident refused medication at times and preferred going outside to smoke. He said he did not know of any special instructions or precautions for resident #8 care. 2. Resident #62 was admitted to the facility on [DATE] with health diagnoses that included Type 2 diabetes, acute kidney failure, paranoid schizophrenia, bipolar disorder, anxiety disorder, autistic disorder, major depression, and PTSD. The most recent MDS quarterly assessment with an ARD of 3/11/26 showed the resident had a BIMS score of 13 out of 15, meaning her cognition was mostly intact. The MDS listed PTSD as an active diagnosis under psychiatric or mood disorders. A psychiatrist's note from 3/10/26 documented, The history suggests that this patient has suffered from significant trauma resulting into nightmares, flashbacks, and hypervigilance in the past. The symptoms have caused significant distress and functional impairment to the patient. The symptoms have lasted for more than one month[s] and have occurred without any substance use or organic brain pathology Care Plan for PTSD diagnosis: Trauma: Being stabbed by niece at age [AGE] Triggers: Discussing past trauma, Care Plan: monitor for nightmares or emotional triggers maintain supportive environment. Review of resident #62's Comprehensive Care Plan revealed the resident had a risk for emotional distress related to a history of abuse, PTSD, and trauma. However, the care plan did not include her triggers and did not reflect the psychiatrist's suggestions. On 6/01/26 at 3:25 PM, resident #62 was upset and stated she did not want to leave her room while it was being deep cleaned. She said she had trouble sitting near another resident in the dining room who coughed a lot. On 6/03/26 at 10:25 AM, the assigned CNA F said she knew the resident who was able to communicate her needs. CNA F stated she was not aware of any special instructions or precautions for the resident. On 6/03/26 at 10:45 AM, resident #62's assigned RN D said he would check her (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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NAME OF PROVIDER OR SUPPLIER Regents Park of Winter Park		STREET ADDRESS, CITY, STATE, ZIP CODE 558 N Semoran Blvd Winter Park, FL 32792	
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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications and lithium level labs whenever she showed certain behaviors, but he did not know of any other special care instructions or precautions to take around her. On 6/03/26 at 3:38 PM, in a joint interview, the Social Services Director (SSD) and Social Services Assistant (SSA) said the SSA completed the Trauma-Informed Care Assessment for new or returning residents. They explained, if psychiatric services were needed, a referral was made, and they followed the psychiatrist's recommendations. The SSD said she reviewed care plans but was unsure about trauma-informed care plans. She said their department completed assessments, and the MDS team helped with care planning. On 6/03/26 at 3:58 PM, the MDS Coordinator said the User Defined Assessment (UDA) for trauma was completed by the SSD, and she helped with it. She explained that no specific triggers were added to care plans because residents often did not talk about them. She said she was not the only one responsible, as the whole Interdisciplinary Team (IDT) worked on care planning. On 6/03/26 at 4:10 PM, in a joint interview with the Nursing Home Administrator (NHA), Director of Nursing (DON), SSD, and MDS Coordinator, the DON said the IDT was responsible for trauma-informed care plans. She said there was poor communication between the psychiatrist and the team, which caused the triggers listed in the psychiatrist's notes to be missed. After comparing the psychiatrist's notes for residents #8 and #62, to their mutual care plans, the DON agreed the care plans were not resident centered. The DON said she expected better communication so the staff could avoid triggers for residents with PTSD. On 6/04/26 at 9:18 AM, in a joint interview with the Psychiatric Advance Practice Registered Nurse, and DON, they agreed that trauma-informed care plans should include the resident's triggers and steps for staff to prevent re-traumatization. She said all staff should know this information and that she expected the team to read her notes but confirmed their communication had broken down. The facility's Trauma-Informed Care policy, revised 7/27/22, indicated the facility would provide care that met professional standards, respected culture and preferences, and avoided triggers or re-traumatization. The guidelines said that even if a trauma survivor did not want to share their history, the facility should still try to identify triggers and create care plan steps to reduce or remove them.		