STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105757	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Towers	70 West Lucerne Circle Orlando, FL 32801

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131 Based on observation, interview, and record review, the facility failed to ensure a physician's order was obtained for medications at bedside for 1 of 3 residents reviewed for pressure ulcer care, of a total sample of 8 residents, (#2). Findings: Resident #2, an [AGE] year-old male was admitted to the facility on [DATE]. His diagnoses included cellulitis to his right lower limb, diabetes type II, lymphedema, anxiety disorder, and stage III pressure ulcer to his right and left buttocks. Review of the resident's Minimum Data Set (MDS) admission assessment dated [DATE] revealed the resident's cognition was intact with a Brief Interview For Mental Status score of 14 out of 15. The assessment revealed the resident had impairment in functional limitation in range of motion on both sides of his upper and lower extremities. On 5/13/24 at 10:32 AM, resident #2 was sitting in his wheelchair in his room to the right of his bed. His tray table was positioned in front of him, and a tube of Ammonium lactate 12% cream, and a tube of Santyl ointment was noted on the resident's tray table. Ammonium Lactate is used to treat xerosis (dry or scaly skin) . it works by increasing skin hydration. (retrieved on 5/28/24 from www.medlineplus.gov) Santyl Ointment is an FDA (Food and Drug Administration) approved prescription medicine that removes dead tissue from wounds so they can start to heal. (retrieved on 5/28/24 from www.santyl.com). On 5/13/24 at 11:03 AM, Licensed Practical Nurse (LPN) C confirmed she was resident #2's primary nurse. She stated the resident was admitted to the facility with a pressure ulcer to his shin, had a facility acquired pressure ulcer to his buttock, and daily wound care was done by the resident's assigned nurse. Observation conducted with LPN C showed Santyl, and Ammonium lactate 12% on the resident's tray table. The findings were acknowledged by the LPN, and she stated medications should not be left at the resident's bedside. Review of the medical record revealed a physician's order dated 5/02/24 for the application of Santyl to the resident's right lateral shin wound daily and as needed. An order for self-administration of medication, or medication storage at bedside was not identified. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/24 at 11:10 AM, the 3rd floor Assistant Director of Nursing (ADON), stated LPN C made her aware of medications at the resident's bedside. She stated medications should not be at the resident's bedside unless the resident had a physician's order for self-administration of medication. The ADON acknowledged that a physician's order regarding self-administration, and bedside storage of medication was not identified for the resident. On 5/13/24 at 1:57 PM, the Director of Nursing (DON) stated Santyl was considered a treatment, and treatments were 'handled differently from medications. When asked about the protocol, the DON stated treatments could be stored at the resident's bedside if there was a physician's order in place for medications/treatments to be stored at bedside. Review of the resident's medical records revealed a physician's order for self-administration of medication, or for medication storage at bedside was not identified. This was acknowledged by the DON. The facility's policy Resident Self-Administration of Medication, reviewed/revised 6/23 read, A resident may only self-administer medications after the facility's interdisciplinary team determined which medications may be self-administered safely .The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment Form, which is placed in the resident's medical record . Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the other resident's rooms .The care plan must reflect resident's self-administration and storage arrangements for such medications.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131 Based on interview, and record review, the facility failed to ensure wound care for pressure ulcers was completed per physician's orders for 2 of 3 residents reviewed for pressure ulcers, of a total sample of 8 residents, (#1, and #2). Findings: 1. Resident #1, a [AGE] year-old male was admitted to the facility on [DATE]. His diagnoses included malignant neoplasm of tongue, gastrostomy, and pneumonia. Review of the Medical Certification For Medicaid Long-Term Care Services and Patient Transfer Form (3008) dated 1/02/24 revealed the resident had an unstageable pressure ulcer to his sacrum, and pressure ulcers to his left and right ischium, stages were not documented. Documentation on the Wound Physicians wound evaluation and summary management dated 3/14/24 revealed the resident had a stage IV pressure wound to his coccyx which measured 3.3 x 2.3 x 1.2 centimeters(cm) with undermining of 3.5 cm at 12 o'clock position. The dressing treatment plan was Gentamicin 1/4 strength Dakins solution, Santyl, and gauze roll twice daily. Documentation read, Please apply Santyl and Gentamicin directly to wound bed followed by Kerlix moistened with Dakin's. Surgical excisional debridement was performed to, Remove necrotic tissue and establish the margins of viable tissue. On 3/28/24 the pressure wound to the coccyx measured 6.0 x 3.9 x 1.5 cm, with undermining of 3.7 cm at 12 0' clock. The dressing treatment plan remained the same. The wound progress was documented as, Improved evidenced by decreased surface area, decreased undermining, decreased necrotic tissue, increased granulation. A non-pressure wound was identified to the sacrum, identified as moisture associated skin damage, measured 7.2 x 5.3 x 0.1 cm, and treatment was zinc ointment every shift. Review of the resident's physician orders revealed the following orders: on 3/14/24 Cleanse coccyx with normal saline, pat dry, apply Gentamicin, then Santyl to wound bed, then 1/4 Dakin's moistened gauze roll, cover with protective dressing daily every day and evening shift and as needed. On 3/28/24, cleanse sacrum with soap and water, pat dry, apply zinc ointment every shift. Review of the resident's Treatment Administration Record (TAR) showed missing entries on various dates, and no documentation to indicate wound care was provided as ordered. Coccyx wound care was not completed on 3/14/24, 3/15/24, was not completed on the evening shift on 3/20/24, and on the day shift on 3/27/24. The physician's order for the sacrum was not completed on the evening shift on 3/07/24, and on 3/20/24, and on the day shift on 3/14/24, and 3/27/24. On 5/14/24 at 11:20 AM, the resident's TAR was reviewed with the Director of Nursing (DON), and the Wound Care Registered Nurse (RN). They acknowledged there were missing entries (holes) in the resident's TAR on the dates identified. The DON stated Gentamycin for the resident's wound care was placed on the resident's MAR, due to pharmacy regulations, and stated at a minimum, dressings were done once per day. The DON acknowledged wound care was not provided for resident #1 as ordered/recommended by the wound care physician. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan for stage III pressure ulcer to the coccyx, and moisture associated skin damage wounds was initiated on 1/03/24. Interventions indicated staff was to administer treatments as ordered for pressure wounds. 2. Resident #2, an 86- year-old male was admitted to the facility on [DATE]. His diagnoses included cellulitis to his right lower limb, diabetes type II, lymphedema, anxiety disorder, and stage III pressure ulcer to his right and left buttocks. Review of the resident's physician orders revealed wound care orders dated 5/02/24 to cleanse right shin wound, and right lateral shin wound with wound cleanser, pat dry, apply 1 application of Santyl to wound bed then cover with dry protective dressing daily and as needeed (PRN). The physician's orders on 5/09/24 were, cleanse right and left buttock with normal saline (NS), pat dry, apply collagen powder then calcium alginate cover with protective dressing daily and PRN. Cleanse right lateral calf with NS, pat dry, apply collagen powder, then Xeroform, cover with dry protective dressing daily and PRN. Cleanse right lateral heel with NS, pat dry, apply Betadine daily and PRN. On 5/13/24 at 11:03 AM, Licensed Practical Nurse (LPN) C stated resident #2 was admitted with pressure ulcer to his shin, and had a facility acquired pressure ulcer to his buttock. The LPN stated the facility had a wound care physician who visited every Thursday, and daily wound care was completed by the resident's assigned nurse. On 5/14/24 at 10:47 AM, the Wound Care RN stated the resident was admitted to the facility with multiple wounds, that were classified as venous, non-pressure, and pressure related. The resident's TAR was reviewed with theWound Care RN, he acknowledged there was no documentation to indicate wound care was provided for the resident on 5/11/24 for the right buttock, right lateral calf, and right lateral heel. On 5/14/24 at 10:53 AM, the DON stated clinical records were reviewed in the morning clinical meetings and included review of TARs and Medication Administration Record for completeness. She stated there should not be any blank entries in the TAR. The resident's care plans for actual impairment to skin integrity related to multiple wounds was initiated on 5/03/24. An intervention was to provide wound care as ordered.

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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** 32131 Based on observation, interview, and record review, the facility failed to ensure a Peripheral Inserted Central Catheter (PICC) line dressing was changed as per physician's order, and professional standard of practice to prevent the potential for infection for 1 of 8 residents, (#2). A PICC is a thin, flexible tube that is inserted into a vein in the upper arm . It is used to give intravenous fluids, . chemotherapy, and other drugs. (retrieved on 5/31/24 from www.cancer.gov). Findings: Resident #2, an [AGE] year-old male was admitted to the facility on [DATE]. His diagnoses included cellulitis to his right lower limb, diabetes type II, lymphedema, anxiety disorder, and stage III pressure ulcer to his right and left buttocks. Review of the resident's Minimum Data Set admission assessment dated [DATE] revealed the resident's cognition was intact with a Brief Interview For Mental Status score of 14 out of 15. The assessment revealed the resident was on antibiotic therapy and had a central line for intravenous (IV) access. Review of the medical record revealed a physician order dated 5/03/24 to change the PICC line dressing every 7 days on the evening shift. On 5/13/24 at 10:32 AM, a PICC line was observed on the resident's right upper arm. The dressing to the PICC line was dated 5/04/24. On 5/13/24 at 11:03 AM, Licensed Practical Nurse (LPN) C confirmed she was resident #2 's assigned nurse. She stated the resident had a PICC line to his right upper arm, and the PICC line dressing should be changed every seven days by the resident's nurse. Observation of the resident's PICC line dressing was conducted with LPN C. She acknowledged the date on the dressing was 5/04/24. LPN C stated the resident's PICC line dressing should have been changed on 5/11/24. On 5/13/24 at 11:10 AM, observation of the resident's PICC line dressing was conducted with the 3rd floor Assistant Director of Nursing (ADON). She acknowledged the PICC line dressing was dated 5/04/24. Review of the resident's physician's orders conducted with the ADON, revealed an order to change the PICC line dressing every 7 days. The ADON stated PICC line dressings should be changed every Friday on the 3:00 PM to 11:00 PM shift and should have been done on 5/11/24. Review of the resident's Medication Administration Record, and the Treatment Administration Record revealed signatures by nurses, indicated the resident's PICC line dressing was changed on 5/03/24, and on 5/10/24. However, both the 3rd floor ADON, and LPN C acknowledged the actual date documented on resident #2's PICC line dressing was 5/04/24. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/24 at 1:57 PM, and 4:14 PM, the Director of Nursing (DON) stated she was made aware of resident #2's PICC line dressing dated 5/04/24. She stated there were two orders for the PICC line dressing in the system, dated 5/03/24, and 5/04/24, and she was in the process of clarifying the orders. She acknowledged whichever order was used, the PICC line dressing was not done every seven days as per the physician's orders and according to professional practice. The DON stated she expected nurses to read and complete tasks as ordered by the physician. Resident #2's care plans for IV antibiotic therapy for wound infection and admitted with wound infection/receiving IV antibiotic were initiated on 5/03/24. Interventions included PICC line to right arm . Change dressing and record observations of site as ordered and monitor and provide PICC care as ordered. The policy PICC/Midline/CVAD Dressing Change revised on 7/23 read, It is the policy of this facility to change peripherally inserted central catheter, midline or central venous access device (CVAD) dressings, weekly or if soiled, in a manner to decrease potential for infection and/or cross-contamination.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131 Based on interview, and record review, the facility failed to ensure medical records were accurate regarding a Peripheral Inserted Central Catheter (PICC) line dressing for 1 of 1 residents reviewed for PICC lines, of a total sample of 8 residents, (#2). A PICC is a thin, flexible tube that is inserted into a vein in the upper arm . It is used to give intravenous fluids, . chemotherapy, and other drugs. (retrieved on 5/31/24 from www.cancer.gov). Findings: 1. Resident #2, an [AGE] year-old male was admitted to the facility on [DATE]. His diagnoses included cellulitis to his right lower limb, diabetes type II, lymphedema, anxiety disorder, and stage III pressure ulcer to his right and left buttocks. Review of the medical record revealed a physician order dated 5/03/24 to change the PICC line dressing every 7 days on the evening shift. On 5/13/24 at 10:32 AM, a PICC line was observed on the resident's right upper arm. The dressing to the PICC line was dated 5/04/24. Review of the resident's Medication Administration Record, and the Treatment Administration Record (TAR) revealed signatures by nurses, which indicated the resident's PICC line dressing was changed on 5/03/24, and again on 5/10/24. However, the actual date on the PICC line dressing was 5/04/24. On 5/13/24 at 4:00 PM, the Registered Nurse (RN) Supervisor, confirmed he was resident #2's primary nurse. He was made aware of resident #2's PICC dressing dated 5/04/24. The RN Supervisor reviewed the resident's TAR and acknowledged signatures indicated the resident's PICC line dressing was changed on 5/03/24, and again on 5/10/24. He stated the expectation was for nurses to complete the task as ordered, and document when the task was completed. On 5/13/24 at 4:12 PM, the resident's TAR was reviewed with the Assistant Director of Nursing (ADON). She acknowledged the date observed on the resident's PICC line dressing was 5/04/24, revealing the PICC line dressing was not actually changed on 5/03/24, or on 5/10/24 as documented by nurses on the TAR. On 5/14/24 at 1:32 PM, Licensed Practical Nurse (LPN) C stated she did not change resident #2's PICC line dressing on 5/03/24, or on 5/10/24, but signed off on the resident's TAR on 5/10/24, thinking she was signing off on the standing order to ensure the PICC line dressing was dated. The policy Documentation in Medical Record reviewed/revised on 6/2023 read, Each resident's medical record shall contain an accurate representation of the actual experiences of the resident . Documentation shall be factual .False information shall not be documented . Documentation shall be accurate, relevant, and complete.