STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105843	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harborview Health Center West Altamonte	1099 West Town Parkway Altamonte Springs, FL 32714

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the resident's representative was informed of a change in condition for 2 of 2 residents reviewed for change in condition, (#1, and #4), and failed to notify the physician of the change in condition which had the potential to delay medical evaluation and treatment for 1 of 2 residents reviewed for notification of changes, (#4) .Findings: 1. Resident #1 was initially admitted to the facility on [DATE] from an acute care hospital with diagnoses that included metabolic encephalopathy (abnormal brain function), dysphagia (trouble swallowing), diabetes, sepsis, congestive heart failure, acute kidney failure, and adult failure to thrive. She was hospitalized on [DATE] due to a difficulty to arouse and labored breathing. Resident #1 returned to the facility on [DATE] with diagnoses of COVID-19, pneumonia, and acute respiratory failure. Review of the Agency for Healthcare Administration (AHCA) Long Term Care Medicaid Transfer form 3008, dated [DATE], revealed resident #1 required a surrogate for decision making. Resident #1's Discharge Minimum Data Set (MDS) assessment dated [DATE], revealed she was severely cognitively impaired, and indicated she required a surrogate for decision making. Review of resident #1's medical records revealed a change in condition progress note dated [DATE]. It was noted that on [DATE] (no specific time given) resident #1 was found unresponsive and had suffered a cardiac arrest. The note indicated she had orders for full code, so cardiopulmonary resuscitation (CPR) was initiated, 911 was called, and an order was obtained from the physician to transfer the resident to the emergency room. The record showed a transfer and discharge form was also completed on [DATE] which noted resident #1 herself was listed as the responsible party that was notified and included her cellphone number. There was nothing in the record to show any other emergency contacts had been notified. Resident #1's assigned nurse and the Nurse Supervisor working on [DATE] were unable to be reached for interview, after multiple attempts were made. In a telephone interview on [DATE] at 11:56 AM, Registered Nurse (RN) B confirmed she worked the 3-11 PM shift on [DATE]. The nurse stated on that day she assisted the assigned nurse during CPR for resident #1. She recalled the Nurse Supervisor was at the desk calling 911, the physician, and the family. RN B said when she returned to work for her shift the next day the former Director of Nursing (DON) called a meeting with her and the other two nurses involved with resident #1's code blue. She recalled the former DON told them that resident #1's daughter was upset because she had not been notified by the facility on [DATE] that her mother had been found unresponsive and transferred to the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	emergency room. In a phone interview on [DATE] at 12:53 PM, resident #1's daughter confirmed she was her mother's healthcare proxy. She stated that on [DATE] she was not notified by the facility her mother had been transferred to the emergency room after being found unresponsive. The daughter recalled she received a call from the hospital approximately 8:45 PM, asking if she had spoken with the facility, which she told them she had not. The hospital informed her resident #1 had suffered a cardiac arrest and CPR had been initiated at the facility. Resident #1's daughter said she asked the hospital to continue CPR in the hopes that she could make it on time to see her mother alive but a short time later they called back to inform her that her mother had passed away. The daughter said she told the former DON that night on the phone, she was upset about not being notified her mother had been found unresponsive and transferred to the emergency room. She remembered the former DON could not provide an explanation for how staff mixed up the phone numbers. She said the former DON told her they would investigate what occurred, but she never heard back about it. Review of resident #1's face sheet dated [DATE] revealed a list of contacts including the resident as the responsible party and noted her home phone number. Her daughter was listed as emergency contact #1 and resident #1's sister was listed as emergency contact #2. Both of their cellphone numbers were listed. Review of resident #1's medical record revealed during a previous hospitalization on [DATE] during the 7:00 AM to 3:00 PM shift, the resident's daughter had been notified by the facility that resident #1 had a change in condition and would be transferred to the emergency room. The record showed prior to the transfer, on [DATE], the facility called the daughter to ask about an ordered medication for resident #1, which the daughter refused, and the physician was notified of her choice. In a telephone interview on [DATE] at 12:27 PM, the former DON stated that she became aware of resident #1's code blue event and transfer to the hospital the next morning when she arrived at the facility. She said resident #1's assigned nurse for [DATE], informed her she had not called the daughter because she confused the phone numbers. The former DON explained the assigned nurse's first language was not English. She confirmed she had a conversation via phone with resident #1's daughter after the incident and the daughter complained about not being notified of her mother's transfer to the hospital and change in condition. The former DON acknowledged there was no investigation conducted after the incident because they felt there were no issues with how the facility staff conducted the code blue. She said she never spoke to the daughter again after that. She said the family was technically notified of the transfer during a phone conversation with resident #1's granddaughter who called the facility to complain that the family had not been notified, sometime after the resident had been transferred. She was unable to provide an exact time. Review of the facility's undated policy on Change in a Resident's Condition or Status indicated the facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's medical/mental condition and/ or status, which included a change in the level of care. The policy described staff were to implement the policy by ensuring the attending or on-call physician was notified when the resident was involved in an incident or accident, which included the discovery of injuries of an unknown source. Furthermore, the nurse would notify the resident's representative when the resident was involved in any incident or accident which resulted in an injury to include those of unknown source and notify when it was necessary to transfer the resident to a hospital/treatment center. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #4 had a respite admission to the facility on [DATE]. His admission diagnoses included stroke with right-sided deficit, right heel pressure ulcer, coronary artery disease, and pacemaker. The Discharge MDS assessment dated [DATE] revealed resident #4 had a Brief Interview for Mental Status score of 14/15, which indicated he was cognitively intact. The assessment showed the resident was independent for meals, dependent on staff for toileting, and was frequently incontinent. Review of resident #4's Baseline Plan of Care Summary dated [DATE] included self-directed activities, injury prevention, and potential for alteration in skin integrity. Interventions identified were to discuss preferences in activities, maintain a safe environment, and report skin redness or breakdown. Review of resident #4's admission Nursing Progress Note dated [DATE] at 11:42 PM, revealed skin assessment with no issues noted. Review of the physician's History and Physical dated [DATE] at 4:19 PM, reflected right foot ortho shoe on and resident #4 complaining of right heel pain. There was no documentation in the progress notes regarding arm or leg skin tears. Review of resident #4's Daily Nursing assessment dated [DATE] at 7:25 AM, revealed, No skin issues. Review of the Certified Nursing Assistant (CNA) Task List for skin observation on [DATE] at 12:58 PM, revealed no new skin condition but also noted, skin tear to arm. On [DATE] at 12:22 PM, the skin observation reflected no new skin condition and skin tear to leg. Resident #4's Discharge Summary for [DATE] indicated there were no skin issues at the time of discharge. In a telephone interview on [DATE] at 7:00 PM, resident #4's daughter recalled when she came to pick her father up at the facility upon discharge, she noticed a bandage on his leg. She said her father told her that the facility had taken some of residents out for lunch, and on the way back to the facility some unsecured wheelchairs fell and scratched his arm and put a gash in his leg. The daughter stated no one from the facility called to inform her of the incident or the skin impairments. The daughter stated she had called the Administrator multiple times and no one called back. She recalled she spoke with the Social Worker to voice her concerns and the Social Worker told her that she would ask the Administrator to call her back. The daughter stated she had not heard from anyone yet. On [DATE] at 2:00 PM, the Social Worker stated she did not recall the telephone call. Attempts were made by the survey team to interview the previous Activities Director, but were unsuccessful, the current Activities Director was unaware of resident #4 and had started at the facility that week. On [DATE] at 3:15 PM, the DON stated there should have been a Change in Condition for the skin tears to resident #4's leg and arm. She confirmed the nurse, doctor and daughter should have been notified of the change. Review of the facility's undated Change in a Resident's Condition or Status policy, indicated the facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's medical/mental condition and/ or status.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the baseline care plan was effectively implemented to include a plan for staff to provide effective and person-centered care, for 2 of 2 residents reviewed for respiratory care, (#1, and #3), and failed to ensure the resident or representative received a summary of the baseline care plan with the required information, for 1 of 2 residents reviewed for baseline care plans, (#1), of a total sample of 4 residents. Findings: 1. Resident #1 was initially admitted to the facility on [DATE] from an acute care hospital with diagnoses that included metabolic encephalopathy (brain dysfunction), diabetes, congestive heart failure, acute kidney failure, and adult failure to thrive. She was hospitalized on [DATE] due to a difficulty to arouse and labored breathing. Resident #1 returned to the facility on [DATE] with diagnoses of Coronavirus 2019 (COVID-19), pneumonia, and acute respiratory failure. Review of the Agency for Healthcare Administration (AHCA) Long Term Care Medicaid Transfer form 3008, dated 12/02/24, revealed resident #1 had a primary diagnosis of acute respiratory failure and congestive heart failure (CHF) exacerbation. The transfer form contained documentation the resident used oxygen at 2 liter per minute (LPM) delivered via nasal cannula and she required a surrogate for decision making. Resident #1's Discharge Minimum Data Set (MDS) assessment dated [DATE], revealed she was severely cognitively impaired, and required a surrogate for decision making. The assessment also indicated resident #1 was dependent on staff for bed mobility and getting dressed. The MDS assessment did not show the resident was utilized continuous oxygen therapy. Review of resident #1's current physician orders revealed she was on several respiratory treatments that included continuous oxygen, nebulizer treatments, steroids, and inhalers. Review of resident #1's baseline care plan with an admission date of 12/04/24 and re-admission date 12/21/24, revealed the facility did not include a plan to address the resident's respiratory needs/diagnoses. On 4/07/26 at 12:53 PM, resident #1's daughter stated her mother required continuous oxygen and the facility did not provide appropriate respiratory care. She explained her mother preferred to have the head of bed always elevated when she was in bed to help her breath better and she needed to be reminded not to remove her nasal cannula since she was often confused. The daughter conveyed that on a few occasions when she visited her mother, she noticed she was not wearing her nasal cannula and that the head of her bed was flat. She expressed that all staff needed to make sure they communicated about her mother's preferences and what would keep her comfortable in order to prevent her from declining. Resident #1's daughter confirmed she never received a copy of the initial plan of care nor had not met with anyone at the facility regarding her concerns related to her mother's respiratory status. On 4/08/26 at 4:18 PM, the MDS Director stated he was responsible for completing the comprehensive assessment and care plan, but explained the admitting nurse was responsible for completing the baseline care plan. He confirmed the baseline care plan guided the staff on how to treat the resident immediately upon admission. The Director conveyed the nurse would use the (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3008-transfer form, hospital records, resident interview, and family interview to create the baseline care plan. He further explained the resident or resident representative had to sign the care plan and provided with a copy for their records. The MDS Director reviewed resident #1's baseline care plans for both of resident #1's admissions and agreed respiratory care had not been mentioned nor the resident's need for continuous oxygen. He agreed there were no personalized interventions related to the resident's preference to have the head of bed elevated while in bed to assist with breathing. He added the baseline care plan form had been modified since the time of resident #1's admission and now included an area for the nurse to select if the resident was on oxygen. The MDS Director acknowledged the previous form also had areas where the nurse could document other areas of care not mentioned. He stated the expectation was for the baseline care plan to include whether the resident received oxygen therapy. On 4/08/26 at 3:13 PM, the DON explained upon admission the baseline care plan was created by the admitting nurse and was used as the road map in the care of the resident. She relayed the care plan was meant to direct staff to provide pharmacological and non-pharmacological interventions that supported the residents' needs and preferences. She acknowledged the previous electronic form utilized by the admitting nurse to complete the baseline care plan did not have a focus for respiratory care but said there were other areas that allowed the nurse to add notes. The DON acknowledged resident #1's baseline care plan dated 12/21/24 was mostly left blank besides a comment related to the resident 's behavior and diet order and did not include her need for continuous oxygen. She stated her expectation was for baseline care plans to be accurate and complete based on the residents' orders and care needs. Review of the facility's policy and procedure for Baseline Care Plan, last reviewed 3/01/25, revealed the policy was for the facility to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident in accordance with professional standards and quality of care. The policy described the baseline care plan had to be developed within 48 hours of resident admission and had to include the minimum healthcare information necessary to properly care for the resident, like initial goals based on admission orders and physician orders. The document indicated the admitting nurse or supervising nurse on duty should gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and representative. The policy specified the supervising nurse or MDS nurse was responsible for providing the written summary of the baseline care plan to the resident and representative, obtain their signature, and provide them with a copy. 2. Resident #3 was admitted to the facility on [DATE] from an acute care hospital with a past medical history of end stage renal disease on dialysis, cardiac arrest, congestive heart failure, acute and chronic respiratory failure, chronic obstructive pulmonary disease, colostomy secondary to perforated colon, and hypertension. He returned to the acute care hospital on 3/03/26 for a high potassium level and shortness of breath. Review of resident #3's hospital progress notes dated 3/05/26 reflected diagnoses of chronic obstructive pulmonary disease, chronic respiratory failure and oxygen dependency. The record revealed resident #3 returned to the facility on 3/10/26 with a primary diagnosis of acute respiratory failure. The admission Minimum Data Set (MDS) assessment for resident #3 dated 3/17/26 revealed he was cognitively intact, mobile with a walker, and independent for activities of daily living. The assessment (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did not indicate resident #3 required oxygen therapy. Review of the admission Baseline Care Plan dated 2/19/26 and the readmission Care Plan dated 3/10/26 revealed the care plans did not address resident #3's respiratory status, respiratory medical conditions, or chronic oxygen use. Review of resident #3's physician orders dated 2/19/26 showed orders for administration of three respiratory inhalers. Review of daily skilled nursing notes and vital signs reflected resident #3 used oxygen on the dates 3/13/26, 3/15/26, 3/17/26 and 3/19/26. On 4/08/26 at 4:18 PM, the MDS Director stated he was responsible for completing the comprehensive care plan and the admitting nurse was responsible for completing the baseline care plan. He stated the baseline care plan should be based on the resident's assessment, review of acute care hospital records, and interviews with the resident and family members. The MDS Director reviewed resident #3's baseline care plan for both admissions and agreed a respiratory assessment should have been completed, a care plan focus created, and interventions should have been placed. He explained resident #3 had a history of chronic obstructive pulmonary disease and the expectation for the interventions should have included oxygen as needed, monitoring, head of bed elevated, and observe for respiratory distress. On 4/08/26 at 3:15 PM, the Director of Nursing (DON) stated baseline care plans were completed by the admitting nurse to guide the care provided to residents. She confirmed she was familiar with resident #3 and had personally observed him with oxygen in the hallway and standing in the doorway to his room. The DON agreed resident #3's baseline care plans should have included a respiratory assessment and interventions for his care.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive care plan to address oxygen use which placed the resident at risk for potential respiratory complications, for 1 of 1 residents reviewed for Comprehensive Assessment, of a total sample of 4 residents, (#2).Findings: Resident #2 was admitted to the facility on [DATE]. admission diagnoses included end stage liver disease, hepatocellular carcinoma (liver cancer), diastolic congestive heart disease, chronic obstructive pulmonary disease (COPD), diabetes, and hypertension. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed resident #2 required oxygen therapy and had a Brief Interview for Mental Status score of 15/15, which indicated she was cognitively intact. The assessment specified the resident required full assistance from staff with toileting, hygiene, and transfers. Review of resident #2's medical record revealed physician orders dated 12/23/25 for oxygen two liters per minute (LPM) as needed, on 2/03/26 for one LPM of oxygen, and on 3/09/26 two to four LPM, as needed to maintain oxygen level greater than 92 percent. Review of resident #2's pulmonary physician Follow-up Progress Notes included, on 3/29/26 at 6:10 PM, documentation for staff to monitor oxygen saturation and titrate as needed. On 4/04/26 at 9:57 PM, the note directed the resident should receive, supplemental oxygen as needed to maintain oxygen saturation greater than 92 percent and at night while sleeping. Review of the Treatment Administration Record for December 2025 to March 2026, revealed a schedule for staff to change resident #2's oxygen tubing every week beginning 12/28/25. The Daily Skilled Nursing Documentation revealed on 2/21/26 at 10:31 AM, resident #2 was on one LPM of oxygen via nasal cannula and on 3/03/26 at 10:32 AM, documentation indicated the resident was on two LPM of oxygen via nasal cannula. On 4/07/26 at 8:51 PM, resident #2's vital signs included an oxygen saturation of 98 percent with oxygen via nasal cannula. Review of resident #2's care plan revealed there was no care plan for oxygen use. On 4/07/26 at 11:36 AM, resident #2 was in bed wearing a nasal cannula connected to an oxygen concentrator set at five LPM of oxygen. The concentrator was approximately three or four feet away from her bed. The resident stated she used oxygen because she was often short of breath (SOB), had liver cirrhosis, and would often get fluid removed from her abdomen. She stated she had COPD, and did not get out of bed often, since she was so tired. On 4/07/26 at 12:06 PM, Registered Nurse (RN) A confirmed resident #2's oxygen concentrator was set at five LPM of oxygen. The nurse acknowledged resident #2's order was for two to four LPM of oxygen as needed. She explained the resident or her son sometimes changed the rate of the oxygen. She said the resident needed oxygen due to her COPD and SOB. On 4/08/26 at 3:15PM, the Director of Nursing (DON) confirmed resident #2 used oxygen per physician orders. The DON acknowledged resident #2 had no oxygen care plan but should have had one. On 4/08/26 at 4:15 PM, the MDS Coordinator stated he reviewed all physician orders daily. He confirmed resident #2 had no care plan for his oxygen use and explained, we must have missed them. Review of the Comprehensive Care Plan Policy revised on 3/01/25, indicated, . to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.

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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** Based on interview, and record review, the facility failed to maintain complete, accurate, and consistent clinical records, compromising the reliability of the clinical record and the ability to ensure appropriate assessment, treatment, and continuity of care for 2 of 2 residents reviewed for resident records, of a total sample of 4 residents, (#1, #4).Findings: 1. Resident #1 was initially admitted to the facility on [DATE] from an acute care hospital with diagnoses that included metabolic encephalopathy (abnormal brain function), dysphagia (trouble swallowing), diabetes, sepsis, congestive heart failure, acute kidney failure, and adult failure to thrive. On [DATE] at 10:30 AM, Licensed Practical Nurse (LPN) C confirmed she was the Night Supervisor on [DATE]. She recalled when she arrived for her shift that night, she was told by 3-11 PM staff that resident #1 had been found unresponsive by an unidentified Certified Nursing Assistant (CNA) who had gone to the room to check on her. LPN C remembered the CNA reported this to the second shift Nurse Supervisor who then reported it to the assigned nurse and a code blue was called. She said after 911 was called, Emergency Medical Services (EMS) arrived and took the resident to the hospital. Several attempts were made to contact resident #1's assigned nurse and the second shift Nurse Supervisor but they did not return the calls and were not present at the facility during the survey. In a telephone interview on [DATE] at 11:56 AM, Registered Nurse (RN) B confirmed she had participated in the code blue for resident #1 on [DATE] during the 3-11 PM shift. She said she was at her cart passing medications when she heard the assigned nurse yelling for help in resident #1's room. RN B recalled the resident was unresponsive when she arrived at the room and the assigned nurse was performing Cardiopulmonary Resuscitation (CPR) on resident #1. She explained the assigned nurse and her were the only two staff members in the room during the code while the Nurse Supervisor called 911, the resident's family, and the attending physician. In a telephone interview on [DATE] at 12:27 PM, the former Director of Nursing (DON) stated she was not informed about resident #1's code blue until the next morning when she arrived at the facility on [DATE]. She recalled the assigned nurse told her that on [DATE] during the 3-11 PM shift she walked into the room to check resident #1's blood sugar and found her breathing abnormally, [NAME]-Stoking. The former DON remembered the assigned nurse stayed by the resident's side until she became unresponsive, at which time she called for a code blue. The DON said the second shift Nurse Supervisor was the only other person in the room during CPR and the assigned nurse was the one who made calls to 911, physician, and the family. The DON acknowledged there was no documentation in the medical record to accurately show what condition the resident was in when she was found nor to show what time the resident was found or by whom. She stated the change of condition form and transfer forms were complete and accurate. [NAME] Stokes breathing is when a person breathes deeply for a period, then gradually breathes more shallowly or sometimes stopping altogether for 5-30 seconds before the cycle repeats. This pattern of breathing could indicate severe illness and could appear in end-of-life stages, (retrieved on [DATE] from www.medical-dictionary.thefreedictionary.com). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #1's medical records revealed a change in condition note dated [DATE]. The note indicated on [DATE] (no specific time was given) resident #1 was found unresponsive and had suffered a cardiac arrest. The change in condition documentation showed the resident was a full code, so CPR was initiated, 911 was called, and an order was obtained from the physician to transfer the resident to the emergency room. Review of the document revealed it was incomplete as there was no documentation that indicated the condition of the resident prior to becoming unresponsive, who found her, or at what time. On [DATE] at 3:13 PM, the current DON acknowledged there was a lack of documentation related to resident #1's code blue. She stated the expectation was for staff to ensure a complete detail of the code blue was documented and included the staff involved, time of event, and the condition of the resident when they were found along with immediate actions that were taken. Review of the facility's policy on Documentation in the Medical Record dated [DATE], indicated each resident's medical record should contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. 2. Resident #4 was a respite admission to the facility on [DATE]. His admission diagnoses included a stroke with right-sided deficit, right heel pressure ulcer, coronary artery disease, and pacemaker. The Discharge Minimum Data Set (MDS) assessment dated [DATE] revealed resident #4 had a Brief Interview Status score of 14/15 which indicated he was cognitively intact. The assessment revealed he was independent for meals, dependent on toileting, and frequently incontinent. Record review of resident #4's Baseline Plan of Care Summary for [DATE] included self-directed activities, injury prevention, and potential for alteration in skin integrity. Interventions identified were to discuss preferences in activities, maintain a safe environment, and report skin redness or breakdown. In a telephone interview on [DATE] at 7:00 PM, resident #4's daughter stated a few months ago, when she came to pick her father up at the facility for discharge, she noticed a bandage on his leg. She expressed her father told her the facility had taken some of residents on an outing for lunch. The daughter explained her father told her that on the way back to the facility some unsecured wheelchairs fell, scratched her father's arm and put a gash in his leg. She recalled no one from the facility mentioned the new wounds or the incident to her. Review of the CNA Task Record revealed resident #3 refused activity participation in Group Events and Programs on [DATE] and [DATE]. There was no documentation for [DATE] through [DATE] of resident #4's participation in group events or programs. The CNA's skin observation documentation for resident #4 revealed observations of a not new skin condition, tear to the resident's arm dated [DATE] and on [DATE] the skin observation monitor documentation reflected a not new skin condition, tear to resident #4's leg. There was no documentation for skin observations completed for [DATE] through [DATE]. Review of resident #4's [DATE] Treatment Administration Record revealed no wound identification or treatment for the dates of [DATE] through [DATE]. Review of resident #4's physician orders from [DATE] through [DATE] revealed no wound (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105843	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harborview Health Center West Altamonte	1099 West Town Parkway Altamonte Springs, FL 32714

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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	identification or treatment orders. Review of resident #4's Progress Notes revealed an admission Nursing Progress note dated [DATE] at 5:58 PM, which identified the resident's skin assessment was fair condition and no skin issue noted. On [DATE] at 3:26 PM, the Advanced Practice Nurse Admit Visit documentation revealed resident #4's skin was warm and dry. The physician's History and Physical progress notes dated [DATE] revealed complaints of mild right heel pain and skin warm, dry, Other: right foot ortho shoe on. The medical record contained no documentation of notification to nursing, physician, or family of the wound mentioned in the skin observation note of [DATE]. Review of the medical record revealed no documentation of a change in condition regarding the incident and resulting skin impairments, a nursing assessment, or treatment, including a dressing for a wound prior to resident #4's discharge. Review of resident #4's discharge summary on [DATE] revealed No skin issues at the time of discharge. The former Activities Director and the assigned CNA were not available for interview and did not respond to request for interview. On [DATE] at 3:15 PM, the current DON stated she was not aware of resident #4's outing incident. She stated the CNA should have notified the nurse. The DON stated a change in condition should have been completed and documented for resident #4 which included a nursing assessment, provider and family notification, and treatment orders. She stated her expectation was for CNAs to communicate all changes they observe and incidents they had an awareness of to the nurse to ensure appropriate and consistent care. The DON further confirmed there should be documentation by the nurse of any old or new skin issues or conditions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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 interview, and record review, the facility failed to ensure implementation of their Quality Assurance and Performance Improvement (QAPI) program by failing to obtain feedback and data to identify issues and concerns with facility systems, as well as opportunities for improvement.Findings:Cross Reference F580, F655, F656, F842In a joint interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on 4/08/26 at 4:53 PM, the NHA stated he had only been at the facility for two days and had not been part of any QAPI meetings. The DON expressed she had started last year in June of 2025. The NHA and DON acknowledged the concerns related to notification of change in condition for residents, incomplete and inaccurate baseline care plans, incomplete comprehensive care plans that did not include respiratory care, and incomplete/inaccurate medical records. The DON stated she was not aware of the concerns and there were no active Performance Improvement Plans (PIP) related to these concerns. She explained during morning clinical meetings, each department head discussed concerns which would then be brought to the monthly QAPI meetings. These concerns were discussed by the committee and a PIP would be created. The NHA stated the purpose of the QAPI program was to ensure issues were identified, data was collected, and PIPs were created to help prevent systemic breakdown.Review of documentation provided by the NHA from previous QAPI meetings showed the facility had several ongoing PIPs with no supporting documentation, end date, or monitoring. In January of 2025 there was a PIP started for notification of changes in condition. This PIP was created after resident #1's representative was not informed she had been transferred to the hospital after her cardiac arrest. On 4/08/26 at approximately 5:00 PM, the NHA confirmed there was no documentation to show what had been done and how or if the action taken was being monitored. In April of 2025 there was a PIP related to risk management events such as incidents that occurred in the facility but there was no documentation of what had been done. In September of 2025 there was a PIP related to documentation and in June 2025 there was a PIP for care plans and baseline care plans. There was no corresponding documentation for any of these PIPs, which was confirmed by the NHA.Review of the Quality Assurance and Performance Improvement policy date 3/01/22, and revised on 8/01/25, revealed it was the policy of the facility to develop, implement and maintain an effective, comprehensive, data-driven QAPI program that focused on indicator of the outcomes of care and quality of life and addressed all the care and unique services the facility provided. The compliance guidelines included the facility develop and implement appropriate plans of action to correct identified quality deficiencies and regularly review and analyze data and act on the available data to make improvements. The guidelines and explanation indicated the facility would maintain documentation and demonstrate evidence of its ongoing QAPI program which may include but is not limited to a written QAPI plan, data collection and analysis at regular intervals, and documentation to demonstrate the development, implementation and evaluation of corrective actions or performance improvement activities.