

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105854	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/14/2025
NAME OF PROVIDER OR SUPPLIER  Westminster Oaks		STREET ADDRESS, CITY, STATE, ZIP CODE  4449 Meandering Way Tallahassee, FL 32308	
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based upon observations, interviews, and record review, the facility failed to implement care plan interventions for safe transfer with a mechanical lift for 1 out of 24 residents reviewed. (Resident #27)The findings include:On 8/13/25 at 08:25 AM, an observation of Resident #27 was conducted. Resident #27 was observed in a mechanical lift sling, suspended midair over the bed. Staff Member B (a Certified Nursing Assistant (CNA)) present in the room, retrieving Resident #27's wheelchair, removing the leg rest that was sitting on wheelchair seat. Staff Member B was interviewed at this time and stated, I'm getting her up now. When asked about the protocol for transferring Resident #27, Staff B stated, we always use two person assist when using a mechanical lift, but the other CNA and nurse were busy down the hall, so I did it myself. An interview was conducted with the Administrator and Director of Nursing on 8/13/25 at 09:00 AM. They acknowledged that transfers with a mechanical lift require a two person assist at all times. Resident #27's plan of care revealed a self-care performance deficit due to dementia, confusion, activity intolerance, and impaired balance, with a goal to continue to participate with self care throughout the review period. Interventions include transfer using a full body mechanical lift for all transfers with 2 staff person assist.The facility policy for safe resident handling and transfers states, .it is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe secure and comfortable experience for the resident while keeping employees safe in accordance with current standards and guidelines. The facility-wide education on use of mechanical lifts dated 2/28/25 (which included a signature by Staff Member B) states, Two staff members must be utilized when transferring residents with a mechanical lift. (photographic evidence obtained)</p>		

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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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on observations, interviews and records review, the facility failed to review and revised the care plan to address the needs of 1 of 1 residents reviewed. (Resident #120)The findings include: On 08/12/25 at approximately 10:35 AM, Resident #120 was observed resting in her room with an external heart monitor taped to her upper chest, displaying a red blinking light.On 08/12/25 at approximately 3:00 PM, an interview was conducted with Resident #120. She reported that on 08/11/25, she attended a follow up appointment with her cardiologist, during which an external heart monitor was placed to evaluate her for possible atrial fibrillation. Upon returning to the facility, she provided the related paperwork to a staff member.On 08/13/25 at approximately 8:30 AM, the receptionist confirmed that Resident #120 had a follow-up appointment outside the facility on 08/11/25.On 08/13/25 at approximately 12:33 PM, an interview was conducted with Staff A, Registered Nurse. She explained that, when a resident returns to the facility from a physician's appointment with new orders, the nurse on duty will verify the orders and document a progress note in the resident's record.On 08/13/25 at approximately 12:40 PM, an interview was conducted with the Director of Nursing. She acknowledged that the resident had a physician's appointment on 08/11/25. She stated that she did not become aware until today that the resident had a heart monitor, and this is the first time the staff has knowledge of it. She explained that it is the facility's expectation to have the resident assessed and a progress note entered into the resident's record upon return. She further confirmed that, for approximately 48 hours, the facility was not aware of the heart monitor and therefore did not implement monitoring of the device or update the care plan.A shower and skin monitoring sheet, dated 08/12/25 for Resident #120, was reviewed. There is no acknowledgment of the heart monitor (Photographic evidence obtained).Progress notes for Resident #120 from 08/11/25 and 08/12/25 were reviewed. There are no entry notes from the nursing staff regarding the new heart monitor.On 08/13/25 the care plan for Resident #120 was reviewed. The care plan was not updated to reflect the heart monitor device (Photographic evidence obtained).</p>		