STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105868	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Metro West Nursing and Rehab Center	5900 Westgate Drive Orlando, FL 32825

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promote a dignified existence during dining for cognitively impaired residents in the special-focus dining area and failed to maintain dignity for one resident during transport through facility hallway, (#104), of a total sample of 43 residents.Findings: 1. Resident #123 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including aphasia (loss of speech), hemiplegia and hemiparesis (partial paralysis) following cerebral infarction affecting right dominant side, dysphagia (trouble swallowing) and unspecified dementia. Review of the Minimum Data Set (MDS) admission assessment with assessment reference date (ARD) of 8/26/25 revealed resident #123 had a Brief Interview for Mental Status (BIMS) score of 9/15 which indicated she had moderate cognitive impairment. The assessment indicated resident #123 required supervision or touching assistance for eating. 2. Resident #76 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, congestive heart failure, chronic kidney disease, anxiety disorder, dysphagia and unspecified dementia. Review of the MDS 5-Day Medicare assessment with ARD of 8/26/25 revealed resident #76 had a BIMS score of 5/15 which indicated she had severe cognitive impairment. The assessment revealed resident #76 required partial to moderate assistance for eating. 3. Resident #9 was admitted to the facility on [DATE] with diagnoses including unspecified dementia, essential hypertension, and atherosclerotic heart disease. Review of the MDS quarterly assessment with ARD of 7/29/25 revealed resident #9 had long-term and short-term memory problems and had severely impaired cognitive skills for daily decision making. The assessment indicated resident #9 required supervision or touching assistance for eating. 4. Resident #11 was admitted to the facility on [DATE] with diagnoses including dementia, dysphagia, hemiplegia and essential hypertension. Review of the MDS quarterly assessment with ARD of 6/26/25 revealed resident #11 had a BIMS score of 1/15 which indicated she had severe cognitive impairment. The assessment detailed resident #11 required set up or clean-up assistance for eating. 5. Resident #89 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, type 2 diabetes, acute kidney failure and heart failure. Review of the MDS significant change in status assessment with ARD of 6/27/25 revealed resident #89 had a BIMS score of 00/15 which indicated she had severe cognitive impairment. The assessment described resident #89 required substantial to maximal assistance for eating. On 8/25/25 at 12:35 PM, during meal observation in the special-focus dining area on the 100 unit, 17 residents were observed seated at tables in the area. Staff were observed serving meals to the residents. Meal trays were placed in front of each resident. The plates, cups, bowls and eating utensils remained on the tray and were not removed from the tray at the table. During the observation, it was noted that all residents at one table were not served at the same time. One tray was placed on a table between two residents which allowed resident #123 to remove items from the tray which belonged to resident #76. Resident #9 sat at the same table and began to eat with her fingers without staff intervention. At another table, resident #11 gave a drink from her tray to resident #89 who took the cup, drank a few sips from it and gave it back to resident #11. On 8/27/25 at 12:14 PM, during meal observation in the special focus dining area, resident #9 was observed eating lunch with the silverware still wrapped while Licensed Practical Nurse L assisted setting up a meal tray for resident #76, sitting at the same table. Resident #9 took several bites of the meal using the wrapped silverware. On 8/28/25 at 12:25 PM, 12 residents were observed seated in the special-focus dining area. Each resident had a meal tray in front of them with their meal, dinnerware and eating utensils on the tray. On 8/28/25 at 12:31 PM, the restorative certified nursing assistant (CNA) verified residents were usually served on a tray instead of the items being placed on the table. She explained they tried taking the items off the tray, but explained the residents were cognitively impaired and might get items confused. The CNA was not sure if a placemat would work to delineate each resident's meal but did not recall having used them before. On 8/28/25 at 1:41 PM, the Unit Manager for the 100 Wing stated the dining room was usually monitored by nurses and/or CNAs. She explained that the restorative CNA sometimes came to help as well. The Unit Manager stated she went to the dining room during lunch if there was no meeting. She verified she was in the dining area on 8/25/25 and acknowledged the residents were served on trays instead of placing the items on the table for a more home-like environment. 6. Resident #104 was admitted to the facility on [DATE] with diagnoses including other toxic encephalopathy (brain disorder), type 2 diabetes, congestive heart failure and cardiomyopathy. Review of the MDS quarterly assessment with ARD of 7/18/25 revealed resident #104 had a BIMS score of

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care 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 maintain oxygen flow rates as ordered by the physician for 1 of 2 residents reviewed for respiratory care, of a total sample of 43 residents, (#111). Findings:Review of the medical record revealed resident #111 was admitted to the facility on [DATE] from the hospital. Her diagnoses included chronic obstructive pulmonary disease, unspecified atrial fibrillation, altered mental status and chronic kidney disease. Review of the quarterly Minimum Data Set assessment with reference date 8/16/25 revealed resident #111's cognition was severely impaired. Resident #111's Order Summary Report showed an active physician's order for oxygen (O2) at 2 liters per minute (LPM) via nasal cannula dated 4/12/25. The medical record further revealed a care plan initiated on 2/29/24 that indicated the resident was to be administered oxygen via nasal cannula as ordered by the physician. The care plan did not indicate resident #111 had any behaviors of refusals nor adjusting the amount of oxygen as ordered. On 8/25/25 at 2:58 PM, resident #111 was sitting up in bed, using O2 administered through a nasal cannula connected to an O2 concentrator. The concentrator's flow rate was set at 3 LPM of O2. The assigned nurse, Licensed Practical Nurse (LPN) D, was standing nearby and verified resident #111's oxygen concentrator was set at 3 LPM. LPN D the concentrator flow rate was correct and should be 3 LPM of O2. A few moments later LPN D verified the physician's order in the medical record was actually for 2 LPM, not 3. The nurse acknowledged she should have verified the physician's order. The Staff Development Coordinator (SDC) who was in the immediate area, stated that the assigned nurse was a new nurse and that this was not her normal unit, she only floated here to take over an assignment from a nurse who called out sick, but she should have checked the orders. A few minutes later, the Director of Nursing (DON) who had been made aware of the situation, said nurses should always verify the orders. On 8/28/25 at 10:37 AM, the SDC said her expectation was for nurses to check and verify the physician's orders for oxygen at least once during the shift. The Facility's Policy for Oxygen Administration revised August 2023 indicated the procedure for setting up the O2 concentrator in section 2. The procedure directed staff to Turn to proper flow rate as ordered by the physician.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to administer blood pressure medication according to physician ordered parameters for 1 of 5 residents reviewed for unnecessary medications, of a total sample of 43 residents, (#89).Findings: Resident #89 was admitted to the facility on [DATE] with diagnoses including nonrheumatic mitral valve insufficiency, heart failure, essential hypertension and personal history of transient ischemic attack and cerebral infarction (stroke). Review of the Minimum Data Set (MDS) significant change assessment with assessment reference date (ARD) of 6/07/25 revealed resident #89's active diagnoses included anemia, heart failure and hypertension. Review of the electronic medical record (EMR) revealed resident #89 had a physician order for Amlodipine Besylate 10 milligrams (mg) to be given one time a day for hypertension. The order included parameters to hold the medication if resident #89's systolic blood pressure was below 110 millimeters of mercury (mmHg), diastolic blood pressure was below 60 mmHg or her heart rate was less than 60 beats per minute (bpm). The record also contained an order for Lisinopril Oral Tablet 20 mg to be given one time a day for hypertension. The order included parameters to hold the medication if resident #89's systolic blood pressure was below 110 mmHg, diastolic blood pressure was below 60 mmHg or her heart rate was less than 60 bpm. Review of the Medication Administration Record (MAR) for July 2025 and August 2025, revealed over a 59-day period in facility, four nurses administered both blood pressure medicine to resident #89 outside of specified parameters and one nurse administered blood pressure medication without consideration of parameters. Documentation showed resident #89 received blood pressure medications 11 times on 6 days. The medications were administered on 7/05/25 with a blood pressure of 123/56, on 7/06/25 with a blood pressure of 100/73, on 7/20/25 with a blood pressure 112/44, on 8/12/25 with a blood pressure of 108/51, on 8/18/25 with a blood pressure of 108/38 and on 8/22/25 with a blood pressure of 101/70. Resident #89 also received blood pressure medications 11 times with a blood pressure listed as not applicable (N/A) on 7/7/25, 7/12/25, 7/21/25, 7/26/25, 7/27/25, 8/04/25, 8/09/25, 8/10/25, 8/18/25, 8/23/25 and 8/24/25. Review of Progress Notes for July 2025 and August 2025 revealed no associated documentation for the above dates to explain why the blood pressure medications were given outside of the physician ordered parameters. On 8/28/25 at 2:01 PM, Registered Nurse (RN) P explained Amlodipine and Lisinopril were medications used to lower blood pressure. She reviewed resident #89's MAR for July 2025 and August 2025 and acknowledged she gave medications outside of the physician ordered parameters. RN P stated she rechecked resident #89's blood pressure before administering medication but was unable to show documentation that this had been done or of any new blood pressure results. She acknowledged that without the additional blood pressure reading, the MAR indicated the medication was administered outside of parameters. RN P explained that administering blood pressure medications to lower blood pressure when blood pressure was already low could cause a resident's heart rate to drop lower and the resident could become unresponsive. On 8/28/25 at 2:37 PM, the Director of Nursing (DON) reviewed the physician orders and MAR for resident #89. She acknowledged resident #89's blood pressure medications were given by nurses outside of physician ordered parameters. The DON stated her expectation was for staff to follow parameters ordered by the physician for medications.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide routine dental care services to 1 of 2 residents reviewed for dental care, (#101), of a total sample of 43 residents. Findings:Review of the medical record revealed resident #101, a [AGE] year-old female was admitted to the facility from an acute care hospital on 5/30/25 with diagnoses that included bipolar disorder, major depressive disorder recurrent, dysphagia (difficulty swallowing), hypotension (low blood pressure), hypertension (high blood pressure), and abdominal tenderness.The Modified Minimum Data Set admission 5-day Comprehensive Assessment with an Assessment Reference Date of 6/07/25 noted resident #101 scored 15 out of 15 on the Brief Interview for Mental Status which indicated she was cognitively intact and did not reject evaluation or care. Section L (Dental) was modified on 8/28/25 to indicate the resident had, obvious or likely cavity or broken natural teeth. The Care Plan Report included a focus initiated on 6/02/25 for risk for/has oral/dental health problems related to poor dentition and missing teeth. An intervention dated 6/02/25 showed resident #101 was to receive coordination arrangements for dental care, transportation as needed or ordered. The admission Data Set evaluation dated 6/02/25 noted the nurse assessed resident #101 with obvious or likely cavity or broken natural teeth.On 8/26/25 at 2:52 PM, resident #101 relayed she was supposed to see a dentist, but the facility had not made arrangements for her yet. She said, I need to see the dentist for my teeth.On 8/28/25 at 10:27 AM, resident #101 opened her mouth to reveal multiple missing and discolored natural teeth. Upon counting, she identified she had six remaining teeth. The resident pointed to her mouth and said, I only have six left; I need some dentures.In an interview, the 200 Unit Manager explained all referrals for dental services were handled by the Social Services Director.On 8/27/25 at 2:10 PM, the Social Services Director explained she was aware resident #101 needed dental services but because she was in a private pay/Medicaid pending status, there was an issue with who would pay for the services. She said all long-term care residents received an annual evaluation. The Social Services Director stated, it's kind of a weird gap, she explained once the resident's payment source changed, she could be enrolled in the Medicaid dental program.Review of the facility's contracted dental provider's list of residents noted resident #101 was listed however, an annual assessment was not done nor scheduled. The Payor Source read, Med Pending [Medicaid pending]. On 8/28/25 at 2:03 PM, the Director of Nursing explained that all residents had access to routine and emergency dental services regardless of their payor source and individual available benefits or the facility's onsite provider were utilized. She said if a resident needed services, the facility was responsible for providing the services, and stated, we will deal with the payment source later.On 8/28/25 at 6:15 PM, the Nursing Home Administrator conveyed the Social Services Director came to her two days prior and let her know she was unaware resident #101 needed services but she was now on their list.Review of the Facility assessment dated [DATE] noted the facility provided person-centered care and services based off their unique care plan. The Medical/Physician services included, Dentist.

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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 observation, interview, and record review, the facility failed to maintain accurate and complete medical records for 2 of 2 residents reviewed for discharge, (#127 and #126); and for 1 of 2 residents reviewed for hemodialysis, (# 100), of a total sample 43 residents.Findings: 1. Resident #127 was admitted to the facility on [DATE] and discharged to the hospital on 7/11/25. His diagnoses included syncope and collapse, cerebral cysts, dementia, anxiety and seizures. A review of the Discharge Return Anticipated Minimum Data Set (MDS) assessment with assessment reference date 7/11/25 revealed resident #127 had a Brief Interview for Mental Status Score of 9/15 which meant his cognition was moderately impaired. On 8/26/25 at 3:56 PM, the Director of Nursing (DON) explained the Change in Condition (CIC) form in resident #127's record dated 7/12/25 at 7:00 AM. According to the CIC form, it indicated the resident was discharged to the hospital on 7/12/25 for low oxygen however, on the census line in resident #127's electronic medical record it showed the resident was discharged the day before, on 7/11/25. The vital signs documented on the CIC form indicated they were from 7/10/25 at 9:26 PM and revealed the blood pressure was 128/76, pulse 68, respirations 18 and oxygen 97% SpO2 (blood oxygen saturation level). There was no indication from documentation in the medical record that resident #127 had a low percentage of oxygen saturation which caused him to be sent to the hospital as the CIC form detailed. The DON said she understood the form was unclear and stated she would try to gather as much information as she could because she was not on duty on 7/11/25. A few minutes later, the DON referred to her own notebook of residents discharged to the hospital, and said resident #127 was discharged on 7/11/25 and was noted to have a low oxygen saturation rate in the 70s and generalized weakness. She said the physician was called, and the resident was given oxygen, and the saturation level went up to 97%. She gave the vital signs that mirrored the vital signs documented in the CIC form. The DON confirmed the date on the CIC form was not accurate and did not provide a true description of what occurred with the resident. She confirmed the nurse should have documented the actual vital signs on the CIC form, written a progress note about the event and documented the findings accurately. SpO2 measures how much oxygen is circulating in your bloodstream for use by your cells. This can be measured with a pulse oximeter which is placed on your finger and gives a percentage of oxygen saturation in your blood. The normal percentage range for oxygen saturation is 90-100%, if it is low, you should call your physician, (retrieved on 9/12/25 from www.clevelandclinic.org). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/26/25 at 4:37 PM, in a joint interview with the DON, the Assistant DON (ADON), who was on duty on 7/11/25, the Unit 1 Manager (UM 1), and the Regional Nurse Consultant (RNC); the ADON explained that on 7/11/25 at approximately 8:30 AM he was summoned to resident #127’s room for help because the resident was diaphoretic and unarousable. The ADON said he immediately called a rapid response for help. He recalled he provided oxygen to the resident because “his oxygen was in the 70s and his blood pressure was low maybe 90/60.” The ADON continued that resident #127 ’s status improved, the oxygen level came up, and he became more alert, however, his wife insisted he should go to the hospital, so she called 911. The ADON remembered that the Emergency Medical Technicians arrived and said resident #127 was stable, but his wife asked for him to be transferred. The ADON explained he expected the assigned nurse to document the CIC form completely and accurately in the medical record when changes in condition occurred. The Unit 1 UM confirmed she actually documented the CIC form on 7/12/25 after the event as a late entry, even though she was not present when it happened. The Unit one Manager did not reply as to whether this was facility procedure to have someone document an event that had no actual knowledge of the event other than what they heard from someone else. The UM looked at the ADON, who shrugged and said, “I see.” The UM reviewed the transfer form on which she documented resident #127 was transferred to the hospital on 7/12/25 at 7:00 AM and did not reply as to whether the documentation concerning the transfer was inaccurate. The ADON was unsure who the actual nurse that was responsible to document about resident #127’s CIC when it occurred but thought it might be the Unit 2 UM. A few minutes later, the Unit 2 UM joined the interview and denied she assumed care of the resident and said she did not remember anything about the resident. The Unit 2 UM stated she believed the resident had already left the facility when she came on duty that morning, because she was called in to work due to a call out. The DON and RNC agreed that because of the inaccuracies and lack of documentation it appeared that no nurse was assigned to resident #126, but said it was “impossible. ” They said they needed to review the employees' timecards to find out who the actual assigned nurse when the CIC occurred was that should have documented the actual details of the event. On 8/27/25 at 10:50 AM, the Business Office Manager stated that based on her records, resident #127 was admitted on [DATE] at 3:29 PM, and discharged on 7/11/25 at 10:00 AM. On 8/27/25 at 11:25 AM, the Staffing Coordinator provided the names of the nurses who worked on the morning shift of 7/11/25; Licensed Practical Nurse (LPN) Q and LPN R. On 8/27/25 at 11:30 AM, Certified Nursing Assistant (CNA) N confirmed he worked on 7/11/25. He confirmed LPN R was assigned to resident #127 the day he was re-hospitalized . On 8/27/25 at 11:57 AM, the Unit 1 UM recalled she was at the facility on 7/11/25 but was not working on Unit 1. She said she was not involved with the rapid response for resident #127. She explained as the UM she took it upon herself to document the CIC form two days after it happened when the Interdisciplinary Team later realized that both the CIC form and the transfer to hospital form were not completed by the nurse. She acknowledged both forms were inaccurate and did not give a clear description of what transpired. The UM confirmed she should have asked the assigned LPN R to complete the CIC form when she learned it had not been done. Phone calls were made to LPN R resident #127’s assigned nurse, with no reply. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/25 at 2:56 PM, the ADON said he did not verify documentation was completed because he expected the assigned nurse to document the CIC and transfer form. The ADON acknowledged in hindsight, he should have documented what occurred himself as he was present. He explained he left for vacation the next day and did not return to the facility until 7/21/25. When he came back, he realized the forms had been completed. The ADON said he spoke to the physician about resident #127’s CIC but acknowledged the conversation was not documented. He repeated that the expectation was for the assigned nurse to complete the CIC and hospital transfer form. On 8/27/25 at 3:36 PM, LPN Q in a telephone interview said she remembered a little of what happened that day but was unsure if LPN R was assigned to resident #127. She said she heard an overhead page for a rapid response and assisted LPN R and the ADON. LPN Q explained since it was an emergency, they all were busy and worked together to help the resident. She did not recall the details of who did what and did not remember documenting any of the events. The nurse explained that because it was an emergency, they might have written down the vital signs on a glove or a piece of paper and it could have been lost since they were documented in the medical record. She was unsure who followed up with the paperwork because they were waiting on a nurse to come in that day. LPN Q explained she thought whoever came in should have documented or the assigned nurse. “When it’s your resident, you chart, in this building it’s the assigned nurse who should do the charting.” On 8/27/25 at 4:00 PM, the Nursing Home Administrator, the Medical Director, DON, RNC, and [NAME] President of Operations acknowledged the inaccuracies and incompleteness of resident #127’s medical record and CIC documentation. 2. Resident # 100 was admitted to the facility on [DATE] with diagnoses that included language deficits following cerebral infarction (stroke), encephalopathy (brain disorder) and dependence on renal dialysis. The admission MDS with reference date of 6/02/25 revealed resident #100 had severe cognitive impairment and received hemodialysis. Review of the medical record revealed physician’s orders for resident #14’s dialysis center on Mondays, Wednesdays, and Fridays; dialysis arteriovenous (AV) fistula: Left Arm; and no blood pressure (BP) in the left arm. An AV fistula or dialysis fistula is a connection made between an artery and a vein for hemodialysis access created by a surgeon. It is the most efficient was to access your bloodstream. It takes at least a few months for the fistula to heal in order to utilize for hemodialysis, it can last for several years but should be protected from squeezing of the arm, (retrieved on 9/12/25 from www.clevelandclinic.org). The medical record revealed nurses documented taking the resident’s blood pressure on the left arm when there were specific orders not to use this arm because of the dialysis fistula. A review of the vital signs documented for August 2025 revealed out of a total of 98 times the blood pressure was taken, nurses documented the blood pressure was taken on the left arm 37 times; right arm 28 times; and “other, ” 33 times. For the month of July 2025, out of a total of 121 times the blood pressure was taken, nurses documented the blood pressure on the left arm 24 times; on the right arm 58 times, and “other, ” 39 times. For June 2025, out of a total of 121 times the blood pressure was taken, nurses documented the blood pressure was taken on the left arm 54 times; the right arm 37 times and “other, ” 30 times. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/25 at 10:05 AM, resident # 100’s assigned nurse, LPN E explained she took the blood pressure on the right arm because of the fistula on the resident’s left arm. The Assistant Director of Nursing (ADON) present at the time, and LPN E verified in the medical record that different nurses documented the blood pressure was taken on the left arm. They both explained it was data entry error, and that the documentation was inaccurate. On 8/28/25 at 12:25 PM, in a joint interview, the ADON and DON acknowledged no weights were listed in the medical record after 6/23/25 for resident #100. The DON stated that the Restorative CNA and Dietician had resident weights, but acknowledged they were not entered in the medical record. On 8/28/25 at 1:45 PM, the DON said she was aware nurses’ documentation was inaccurate in regard to where the blood pressure was taken. She acknowledged it was contraindicated to take the blood pressure on the arm that had the AV fistula and it should be avoided. The facility had no policy on accuracy of documentation of medical records. 3. Resident #126 was admitted to the facility from the community on 6/20/25 with diagnoses including fracture of shaft of right tibia, fracture of left ring finger, paroxysmal atrial fibrillation and major depressive disorder. Review of facility incident reporting dated 7/31/25 revealed documentation from staff who interacted with the resident the night before his change in condition on 7/25/25. Per the incident report the evening shift staff on 7/24/25 noted the resident to be out of breath and sweating. The facility's report detailed that the nurse assessed the resident, obtained vital signs and administered a Covid-19 test. The facility reported the resident’s vital signs were within normal limits, his Covid-19 test was negative, and the resident had no further concerns throughout the night. A review of resident #126’s electronic medical record (EMAR) revealed a physician order to administer the Covid-19 testing as needed with a start date of 6/30/25. Review of the EMAR revealed the test was not documented as administered during the resident’s entire stay at the facility. A review of the residents’ progress notes revealed no documentation of the facility reported shortness of breath or of the Covid-19 test. Further facility incident reporting dated 7/29/25 included steps immediately taken by the facility in response to the incident on 7/25/25 during the day shift. This included resident #126 was dizzy and felt like he had a fever. They reported the resident's vital signs were taken at 8:55 AM, blood pressure of 102/89, pulse 124 beats per minute (bpm), temperature of 97.3 degrees Fahrenheit (F), respirations of 18, oxygen saturation of 91% SpO2. The facility detailed a Covid-19 test was administered which was negative. Review of the resident’s medical record revealed vital signs taken on 7/25/25 at 8:54 AM as blood pressure of 110/88, temperature of 97.5 degrees F, pulse of 92 bpm, respirations of 18, and oxygen saturation of 97% SpO2 on room air. Vital signs documented at 9:42 AM, were blood pressure of 102/89, pulse 124 bpm with new irregular onset, temperature of 97.3 degrees F, oxygen saturation of 91% SpO2 by nasal cannula. No respirations were documented at this time. The medical record revealed no documentation of a Covid-19 test being administered on 7/25/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105868	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Metro West Nursing and Rehab Center	5900 Westgate Drive Orlando, FL 32825

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility submitted incident reporting documentation dated 7/29/25 revealed the changes reported on the CIC evaluation were a functional decline and possible stroke/new neurological signs/symptoms. The reported positive findings included increased confusion, sleepy but easily arousable, decreased mobility, abnormal speech, and a question of right eye droop. The report detailed resident #126's smile was normal; his tongue midline and grasp strength was normal. The resident was noted to have low blood pressure (hypotensive), a high heart rate (tachycardic), diaphoretic (sweaty) and to have mild shortness of breath. The report indicated the physician was notified and gave an order for supplemental oxygen at 3 liters per minute. The document revealed a repeat oxygen saturation was taken, which was 96% SpO2 (normal), the shortness of breath had improved however the resident was still tachycardic and hypotensive. The facility noted the physician gave an order to send the resident to the emergency room for further evaluation and treatment. A review of resident #126's medical record revealed a CIC form dated 7/25/25 at 9:32 AM, which indicated the change in condition symptoms were functional decline and/or mobility and possible stroke/new neurological signs which started on 7/25/25 in the morning. The form listed the most recent vital signs taken after the change in condition to be a blood pressure of 110/88, pulse of 92 bpm, respirations of 18, temperature of 97.5 degrees F and oxygen saturation of 97% SpO2 on room air at 8:54 AM on 7/25/25. The evaluation of body systems section revealed the resident had abrupt increased confusion, difficulty walking, right sided facial drooping, slurred speech, and abnormal vital signs. There was no summary of observations, evaluations or recommendations documented on the form. The form detailed the primary care physician was notified at 9:30 AM on 7/25/25 but no physician recommendations were documented on the form. Further review of the medical record revealed there was no documentation of the initial notification to the physician of the resident’s condition or for the order for supplemental oxygen at 3 liters per minute. The resident medical record showed no documentation of that an oxygen saturation was repeated and read 96% SpO2. The improvement of the resident’s shortness of breath but not his tachycardia and hypotension was not reflected in the resident’s medical record. Additional facility incident reporting dated 7/31/25 included information about staff involved with the change in condition on the morning of 7/25/25. Review of the facility report revealed on the morning of 7/25/25 at approximately 9:15 AM, the assigned nurse responded to concerns over the resident's condition. The facility narrative described the resident was assessed by the nurse who initiated a rapid response after the assessment. The report indicated resident #126 was noted to be sleepy but arousable, hypotensive, tachycardic, diaphoretic and have a functional decline. The facility report detailed the resident had a slight right eye droop, but the rest of the neurological exam was normal. The resident’s vital signs were blood pressure of 110/88, temperature of 97.5 degrees F, respirations of 18, and oxygen saturation of 93% SpO2 on room air. The report described the resident’s oxygen saturation increased to 97% on 3 liters per minute of supplemental oxygen. Review of the resident’s medical record revealed there was no documentation of a rapid response being initiated in contrast to the facility's reporting. The medical record contained no documentation of the resident’s initial oxygen saturation of 93% on room air, nor a repeated oxygen saturation of 97% SpO2 on 3 liters per minute of supplemental oxygen. On 7/25/25 at 8:54 AM, the oxygen saturation was documented in the residents’ medical record by nurses as 97% on room air, not on supplemental oxygen as reported by the facility. On 7/25/25 at 9:42 AM, the oxygen saturation was documented as 91% SpO2 by nasal cannula. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/25 at 1:20 PM, the facility's incident investigation and incident reporting was reviewed with the DON. She said that through their investigation it was revealed that on 7/24/25 during the night shift the staff reported the resident felt warm and sweaty. The DON continued that staff took vital signs which were within normal limits and administered a Covid-19 test. The DON confirmed the order to administer a Covid-19 test was not documented as administered and the results were not recorded in the resident’s medical record. She confirmed two different dates, 7/24/25 and 7/25/25 were given in the report submitted to the state agency but she stated the test was administered on 7/24/25. The DON stated on the morning of 7/25/25 at approximately 9:00 AM, the resident was noted to be more lethargic and had a decline in function, a rapid response was initiated but she could not give a time. She continued, upon assessment of the resident, it was noted he was hypotensive, tachycardic and had a slight right eye droop, so the physician was notified, who gave an order to apply 3 liters per minute of supplemental oxygen. The DON confirmed the first notification to the physician and the order given for oxygen were not documented in the resident's medical record. She explained that after applying the 3 liters per minute of oxygen staff noticed the resident’s condition did not improve, so a second call was placed to the physician. The physician gave an order to send the resident to the emergency room. The DON stated the time of the call to the physician was 9:30 AM which was documented in the change in condition form. She confirmed there was no documentation that 3 liters per minute of oxygen was ineffective nor was there documentation of the further decline of the resident’s status which led to the second call to the physician. The DON conveyed the resident was sent to the emergency room with emergency medical services (EMS). She was unable to give details of what occurred including a time for when EMS was called, when they arrived or when they left the facility. The DON stated that typically they did not document those types of things. The DON acknowledged there were gaps in the resident's medical record which failed to show a full picture of the resident's change in condition, nor of staff interventions administered during that time. The facility's policy entitled “Physician Order’s” most recently updated 6/28/24 indicated the facility should ensure resident information was complete and accurate. The facility did not have a policy on medical records or documentation.

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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 - Some	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 the Quality Assessment & Assurance (QAA) / Quality Assurance and Performance Improvement (QAPI) committee conducted performance improvement activities to ensure prior improvement measures for medication administration were sustained. Findings:A review of the facility's QAPI plan revised October 2024, stated for their purpose, that it provided guidance for their overall quality improvement program and that the Administrator would ensure that the QAPI plan was reviewed minimally on an annual basis by the QAA committee and conduct at least one distinct performance improvement project annually. Ongoing revisions would be made to the plan, as the need arose, to reflect current practices within the center. The revisions would be made by the QAA committee.Their QAPI plan included the policies and procedures used to Identify and use Data to monitor our performance Establish goals and thresholds for our performance measurement Utilize resident, staff and family input Identify and prioritize problems and opportunities for improvement Systematically analyze underlying causes of systematic problems and adverse events Develop corrective action or performance improvement activitiesThe QAA committee will review data and input monthly to look for potential topics for Performance Improvement Projects (PIPs). The QAA will prioritize topics based on the current needs of the residents. Priority will be given to areas we define as high-risk to residents and staff, high prevalence, or high-volume areas, and areas that are problem prone.The facility had deficiency cited at F755 for pharmacy services and F842 for accuracy of medical records during the previous recertification survey conducted 2/22/24. During the current survey, the facility was found to be in noncompliance with F 755 and F 842. As a result of the repeat deficiency, it was identified there was insufficient auditing and oversight to prevent the citation.On 8/28/25 at 5:50 PM, the Nursing Home Administrator (NHA), the Director of Nursing (DON) and the Regional Nurse Consultant (RNC) explained the facility had two PIPS which they were actively working on, Elopement and the use of Mechanical Lifts. The NHA explained she did not know what to say about the repeat concerns but there were changes in leadership with Unit Managers, the facility did a lot of cleanup and there was high turnover for staff which was their biggest issue. The NHA continued to explain they needed strong competent staff but also needed the leadership team to keep on top of things. The NHA explained she thought the issue would have decreased, or maybe at one time, it just dropped off. The RNC mentioned that the issues identified were not the same, however they all acknowledged that the QAPI process is supposed to outlive the staff and it should have lasted but did not.