STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105879	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Winter Park	1111 S Lakemont Ave Winter Park, FL 32792

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 36489 Based on interview and record review, the facility failed to notify the physician and/or resident representatives of changes in condition related to development of a pressure ulcer and performance of a surgical procedure for 1 of 4 residents reviewed for pressure injuries, of a total sample of 27 residents, (#5). Findings: Review of the medical record revealed resident #5, a [AGE] year-old female, was admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included metabolic encephalopathy (brain disorder), altered mental status, non-traumatic bleeding inside the brain, right carotid artery occlusion, left side weakness and paralysis, and generalized muscle weakness. The Resident Information sheet was updated to show the resident acquired a Stage III pressure ulcer during her stay in the facility. The document indicated resident #5's husband was Power of Attorney (POA) for health care and her daughters were emergency contacts #1 and #2. The National Pressure Injury Advisory Panel (NPIAP) defines a pressure injury or pressure ulcer as, localized damage to the skin and underlying soft tissue usually over a bony prominence. The injury is caused by prolonged pressure and can present as either intact skin or an open ulcer (retrieved on 6/05/24 from https://cdn.ymaws.com/npiap.com/resource/resmgr/NPIAP-Staging-Poster.pdf). Review of the Minimum Data Set Admission (MDS) assessment with assessment reference date of 5/02/24 revealed resident #5 had severely impaired cognitive skills for daily decision-making. The document indicated it was very important for the resident to have family or a close friend involved in discussions about her care. The resident was determined to be at risk for developing pressure ulcers, but the document showed she had no wounds, ulcers, or other skin problems on the date of the assessment. The document revealed a family member, not the resident, was the active participant in the MDS assessment process. A Skin/Wound Note dated 5/09/24 at 11:34 PM, read, Resident was observed to have [an] open wound on her coccyx found by CNA (Certified Nursing Assistant). I cleansed with normal saline, applied skin protectant and bordered gauze. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #5's medical record revealed no change in condition form or associated progress note to indicate resident #5's physician, representatives, or emergency contacts were informed of the newly identified wound. On 5/16/24 at 4:36 PM, Assistant Director of Nursing (ADON) F reviewed resident #5's medical record and confirmed there was no evidence the nurse who identified the open wound on 5/09/24 notified the physician or family as required. ADON F acknowledged she became aware of the wound on 5/13/24, but as of the present day, she still had not notified the family. Review of the Initial Wound Evaluation & Management Summary dated 5/16/24 revealed the wound physician assessed resident #5 and discovered a pressure ulcer on her coccyx. The progress note indicated the wound physician performed a surgical excisional debridement procedure to remove the nonviable tissue from the wound. The document read, Treatment options-risks-benefits and the possible need for subsequent additional procedures on this wound were explained on 5/16/24 to the health care surrogate; [name of husband] . who agreed to the procedure. On 5/17/24 at 8:06 AM and 12:40 PM, in telephone interviews, resident #5's daughter stated she visited the facility on 5/15/24 and noted a new mattress on her mother's bed so she assumed there was a skin concern. The resident's daughter stated she was never informed her mother had a Stage III pressure ulcer with full-thickness skin loss. She stated she had no idea the wound was surgically debrided by a wound physician yesterday. She emphasized, I was never told. The daughter was informed that her mother's medical record showed the husband/POA was told about the procedure. The daughter explained the husband lived out-of-state and she was joint POA and emergency contact #1. She stated she usually spoke to or texted with the husband daily and neither of them had knowledge of the wound, a wound consult, or a surgical procedure. On 5/17/24 at 4:54 PM, ADON F stated residents' attending physicians usually had standing orders for specialist consults as indicated. She said, Usually, I do notify the family of wound consult and findings. I never notified this family. When asked about failure to obtain consent for resident #5's surgical procedure, ADON F explained on admission to the facility, all residents signed a Consent to Treat form. She asked, Isn't that enough? The facility's policy and procedure for Notification of Changes, dated August 2023, read, The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. The document listed the circumstances that required notification to include changes in status such as clinical complications, and the need to initiate a new treatment. The policy revealed if a resident was not capable of making decisions, the representative would make decisions.

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F 0686 Level of Harm - 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** 36489 Based on observation, interview, and record review, the facility failed to provide care and services, according to professional standards of practice, to promote skin integrity and prevent the development and worsening of pressure injuries for 2 of 4 residents reviewed for pressure injuries, out of a total sample of 27 residents, (#5 and #7). The facility's failure to implement preventative interventions and ensure timely and adequate care and treatments for pressure injuries resulted in actual harm, for two dependent residents who were deemed at risk for development of wounds. Resident #5 acquired a pressure injury that was not thoroughly assessed when identified, to determine appropriate approaches to prevent the wound from worsening. Resident #7 developed two pressure injuries, suffered severe wound and bone infections that required hospitalization , and subsequently died on hospice services. Findings: 1. Review of the medical record revealed resident #7, an [AGE] year-old female, was admitted to the facility on [DATE] and readmitted from the hospital on [DATE]. The Resident Information form listed her diagnoses including heart disease, osteoporosis, chronic pain, type 2 diabetes with a foot ulcer, and a Stage III sacral pressure ulcer. The document indicated resident #7 was discharged to an acute care hospital on [DATE]. The National Pressure Injury Advisory Panel (NPIAP) defines a pressure injury or pressure ulcer as localized damage to the skin and underlying soft tissue usually over a bony prominence. The injury is caused by prolonged pressure and can present as either intact skin or an open ulcer, usually at the site of bony prominences such as heels, hips, sacrum, and coccyx or tailbone. According to NPIAP, a stage I pressure injury is a localized area of non-blanchable redness on intact skin. However, blanchable redness may precede visual changes. Stage II pressure injuries show partial-thickness skin loss with an exposed pink or red wound bed. A Stage III pressure injury shows full-thickness skin loss with visible fat and/or granulation tissue. Slough and eschar (types of dead tissue) may be present but does not obscure the depth of tissue loss. A stage IV pressure injury involves full-thickness loss of skin and tissue that leaves muscle or bone exposed. A deep tissue pressure injury (DTI) is a persistent non-blanchable deep red, maroon or purple discoloration or a blood-filled blister that is covered with intact or non-intact skin. An unstageable pressure injury involves full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed as it is hidden by dead tissue (retrieved on [DATE] from https://cdn.ymaws.com/npiap.com/resource/resmgr/NPIAP-Staging-Poster.pdf). Review of the Minimum Data Set (MDS) Discharge Return Anticipated assessment with assessment reference date (ARD) of [DATE] revealed resident #7 had modified independence with cognitive skills for daily decision-making. The document indicated she did not exhibit any behavioral symptoms or reject evaluation or care necessary to achieve her goals for health and well-being. Resident #7 was totally dependent on staff for bathing, toileting hygiene, personal hygiene, bed mobility, and transfers. She was always incontinent of bowel movements. The MDS assessment showed resident #7 had one unhealed Stage III pressure ulcer not present on admission to the facility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #7 had a care plan for bowel incontinence, initiated on [DATE]. The approaches indicated the resident used disposable briefs. The document instructed licensed nurses and Certified Nursing Assistants (CNAs) to check and change the resident as required after episodes of bowel incontinence. A care plan for diabetes, initiated on [DATE], instructed nursing staff to check the resident for breaks in skin integrity, treat promptly per physician orders, inspect her feet daily for open sores, pressure areas, or redness, and report any signs and symptoms of infections to open areas. A care plan for the potential for additional skin breakdown was initiated on [DATE]. The goals were resident #7 would show signs of healing and not develop skin infection. The interventions included an air mattress, heel protector pads to both feet when in bed, offloading boots, assist with bed mobility and repositioning on rounds during care and as needed, clean promptly after incontinence episodes, and treatment to right heel diabetic wound and non-pressure ulcer to the sacrum. A care plan for the potential for additional pressure ulcers, initiated on [DATE], instructed nurses to assist resident #7 with toileting tasks and incontinence care, observe skin during routine care, observe for signs and symptoms of infection, apply treatment to her pressure ulcer on the coccyx, and follow recommendations of the wound physician. Resident #7 had a care plan for antibiotic therapy for a wound infection, initiated on [DATE]. The goal was the resident's wound infection would resolve without complications. The interventions included give antibiotic therapy as ordered, obtain and monitor lab and diagnostic work as ordered, report the results to the physician, and follow up as needed. A care plan for activities of daily living (ADL) self-care performance deficit, initiated on [DATE], indicated resident #7 required assistance from two staff for transfers with a mechanical lift, assistance from one to two staff for bed mobility, and assistance of one staff for personal hygiene. The care plan instructed nursing staff to encourage the resident to use the call bell to call for assistance. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In telephone interviews and conference calls on [DATE] at 10:32 AM, [DATE] at 11:05 AM, and [DATE] at 1:10 PM, resident #7's family explained she developed wounds on her heel and bottom while in the facility, which they believed were treated with only the bare minimum of care. The family stated staff did not provide necessary ADL care, such as regular turning and repositioning or prompt incontinence care to prevent development and worsening of their mother's wounds. During the months preceding their mother's transfer to the hospital, they recalled multiple conversations with the 1st Floor Unit Manager, Assistant Director of Nursing (ADON) F, during which they requested bloodwork, additional testing, and intravenous (IV) antibiotics. The family explained they were all in agreement regarding aggressive treatment of the wounds, but lab work was never ordered, and they were told wound culture samples were either lost, improperly tested , contaminated, or inaccurate. They said, We asked [name of ADON F] to get a [Computed Tomography (CT)] scan and they kept on saying they were treating her adequately in the facility. They never suggested hospitalization . The family stated the wounds on their mother's right heel and tailbone gradually worsened and the right heel wound became infected. They explained the facility finally arranged for an Infectious Disease specialist to assess her on [DATE] as different antibiotics and treatments were not effective. However, later that day, the family became more concerned about their mother's declining status and called 911 themselves. According to the family, their mother was diagnosed with right heel osteomyelitis (a bone infection), in the hospital and the physicians who treated her confirmed her wounds were avoidable and preventable if proper measures had been in place. They shared that diagnostic testing performed in the hospital showed her wounds were not caused by circulatory issues. The family members stated they attended a care plan meeting with the facility via telephone on Monday [DATE], while their mother was in the hospital. They informed the Director of Nursing (DON) and ADON F their mother had osteomyelitis and discussed how her care would be handled if she returned to the facility on IV antibiotics. The family recalled they informed the DON and ADON F of concerns related to their mother not being turned, repositioned, and cleaned adequately to prevent and heal her wounds. They stated they mentioned staff often ignored their mother or did not respond to the call light in a timely manner when she needed care. During the care plan meeting, the family complained that on two occasions a nurse who was in the room to do their mother's wound dressing refused to provide incontinence care as it was not her job. As a result, their mother had to wait for over an hour for the bowel movement to be cleaned from her skin. The family explained despite receiving IV antibiotics in the hospital, their mother's infection was so severe that she never recovered. They stated their mother died on hospice services two weeks later, on [DATE]. Review of an Order Summary Report revealed resident #7 had physician orders for three courses of oral antibiotics to treat her right heel wound infection. She received Doxycycline 100 milligrams (mg) twice daily from [DATE] to [DATE], and the drug was re-ordered from [DATE] to [DATE]. The physician then ordered Clindamycin HCl 300 mg every eight hours from [DATE] to [DATE]. The medical record showed no bloodwork was ordered between [DATE] and [DATE]. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the medical record revealed Wound Evaluation & Management Summary notes documented by the wound physician regarding his weekly visit assessment findings, treatment orders, and recommendations. A note dated [DATE] revealed resident #7 had a diabetic wound of the right heel of greater than a 106-day duration, that measured 1.0-centimeter (cm) x 0.9 cm x 0.7 cm. The area around the wound was red and there was a moderate amount of clear, watery drainage. The document indicated 15% of the wound tissue was slough. The wound physician wrote treatment orders and his recommendations included float heels in bed, off-load wound, reposition per facility protocol, turn from side to side in bed every one to two hours if able, offloading heel elevator cushion, and the oral antibiotic Doxycycline for ten days. The document indicated the resident's Stage III pressure wound on her coccyx, of duration greater than eight days, was resolved. A note by the wound physician dated [DATE] revealed resident #7's right heel wound had increased in size and measured 1.1 cm x 1.1 cm x 0.7 cm, continued with peri wound redness, and had light purulent drainage or pus. The slough tissue was increased to 20% and the wound progress was not at goal. The wound physician obtained a sample of tissue and/or fluid from the heel wound for wound culture lab testing, to determine if there was an infection, to identify the causative organism, and to select the most effective antibiotic therapy if indicated. The wound physician's recommendations emphasized the importance of off-loading pressure to the wound. A wound progress note dated [DATE] revealed the size of the right heel wound had decreased slightly, but purulent drainage and slough was unchanged although she had completed ten days of oral Doxycycline. The wound physician wrote, Lab performed only aerobic culture, will send anaerobic culture. Aerobic bacteria are usually found in superficial wounds and anaerobic bacteria are usually found in deeper wounds and abscesses. A wound culture order is only for aerobic bacteria, and an anaerobic culture order must be requested separately (retrieved on [DATE] from www.biologyonline.com/dictionary). Review of a Health Status Note effective [DATE] revealed the facility called the lab to request an anaerobic culture as only an aerobic culture was requested. A wound progress note dated [DATE] read, Lab only performed aerobic culture again. Will send another culture for anaerobes; patient has moderate growth of skin flora from aerobic culture, will start Doxycycline. A wound progress note dated [DATE] revealed resident #7's wound measured 0.7 cm x 0.5 cm x 0.5 cm but was not at goal. The wound still had light purulent drainage, peri wound redness, and 20% slough tissue. The wound physician noted there was no growth in the wound culture, but due to the presence of pus and redness he would submit yet another culture for anaerobes and aerobes. The plan of care indicated resident #7 remained on oral Doxycycline 100 mg twice daily. Review of a Health Status Note dated [DATE] revealed resident #7 had an open area on her coccyx. The note indicated the assigned nurse called the hospice agency for treatment orders, and the area was cleansed, and a dry dressing applied. Review of the medical record revealed a treatment order was initiated two days later on [DATE]. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A wound progress note dated [DATE] showed over the previous seven days, resident #7's wound increased in size to 1.1 cm x 1.4 cm x 0.9 cm. The surface area of the wound increased from 0.35 cm squared to 1.54 cm squared and the wound care physician noted moderate purulent drainage, peri wound redness, and that slough tissue increased from 20% to 40%. The note read, Wound progress exacerbated due to infection.Lab has lost cultures again; will send cultures for anaerobes and aerobes again. The physician ordered another oral antibiotic, Clindamycin 300 mg three times daily. The progress note indicated lab work related to the resident's blood sugar control over the previous months was pending as of [DATE], but review of the medical record revealed the test was never ordered. During the visit, the wound physician noted resident #7 developed a stage III pressure wound on her coccyx that measured 3.7 cm x 5.1 cm x 0.3 cm, with a surface area of 18.87 cm squared. The wound had a moderate amount or clear drainage, the edges were macerated, and it had 30% slough tissue. The physician noted resident #7 had an open area of moisture-associated skin damage on her sacrum, above the coccyx wound, that measured 4.7 cm x 6.5 cm x 0.1 cm. A wound progress note dated [DATE] revealed resident #7's right heel wound had significantly increased in size to 1.4 cm x 4.5 cm x 1.2 cm. During the week since the wound was last assessed by the wound physician, the wound's surface area increased from 1.54 cm squared to 6.3 cm squared. The peri wound redness remained, and the wound now had heavy purulent drainage, 40% thick necrotic tissue, and 20% slough. The note indicated the wound progress was exacerbated due to infection. The wound physician noted the facility's lab provided a culture result of moderate growth of normal skin flora with no specific organisms or antibiotic sensitivities. As a result, he decided to test the validity of the result by sending a culture to another lab as the condition of the wound continued to deteriorate. The wound physician obtained a sample by debriding the membrane that covered the heel bone and removed dead tissue. The note revealed he recommended a consultation with an Infectious Disease specialist for initiation of IV antibiotics. The document indicated over the previous week, resident #7's Stage III pressure ulcer on her coccyx had also increased in size to 4.5 cm x 6.5 cm x 0.3 cm, with a surface area that changed from 18.87 cm squared to 29.25 cm squared. Review of nursing progress notes from [DATE] to [DATE] revealed no documentation by facility nurses that reflected awareness of the worsening conditions of resident #7's wounds. There was no evidence nurses who completed daily wound care notified ADON F, the DON, the attending physician, the hospice physician, the hospice nurse, or the wound physician when the wound drainage changed from clear to light purulent and then moderate purulent during the 6-week period preceding the resident's hospitalization . The progress notes showed no evidence of cohesive and comprehensive care planning discussions that involved all stakeholders including the resident, hospice staff, family members, facility staff, and the physicians, to determine the goals and extent of treatment, as the status of the infected heel wound worsened. On [DATE] at 4:49 PM, ADON F stated resident #7 had a pressure ulcer on her coccyx and a diabetic ulcer on her right heel. She recalled on [DATE], the resident's heel wound was deteriorating and had quite a lot of purulent drainage. ADON F stated the wound physician recommended a more aggressive approach, an Infectious Disease consult and IV antibiotics. She added, There was always a conflict with hospice. ADON F stated the resident was sent to the hospital on [DATE], at the family's request, and on [DATE], the family informed the facility that resident #7 had right heel osteomyelitis. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 10:24 AM, in a telephone interview, the wound physician explained heel wounds were usually caused by either trauma or pressure. He stated resident #7's diabetic right heel wound was actually secondary to pressure, but the terminology indicated her diabetes diagnosis affected wound healing. The wound physician stated the primary preventative measure for these types of wounds was to alleviate pressure on bony prominences. He stated he placed a strong emphasis both in his documented recommendations and verbal discussions with staff regarding the importance of offloading and skin care in preventing and healing pressure ulcers. The wound physician acknowledged resident #7's heel wound started to decline in [DATE] and worsened significantly after brewing for weeks. When asked about his assessment and treatment of the resident's wound, he said, The problem I had with escalating things was that her family had her on hospice, and families are not always aware of how that affects care and services. The feeling I got from the facility was that she was on hospice so aggressive treatment was not the goal. The wound physician acknowledged he only visited the facility once a week, but the attending physician(s) should be made aware of any significant decline between his visits. He explained for concerns related to osteomyelitis, he would usually order additional testing, but he was always told that hospice needed to approve aggressive care. The wound physician said, I would have ordered much more if she was not on hospice. If Infectious Disease was engaged, she would have been on IV broad-spectrum antibiotics. In the last two weeks, hospice was the huge reason for delay in care. The wound physician added he had significant concerns regarding the facility's lab provider, as the entity lost numerous samples for multiple residents and provided possibly inaccurate results over the last eight to twelve months. He stated he reported his concerns to the Administrator and DON. When the wound physician was informed resident #7 was diagnosed with osteomyelitis in the hospital, he said, I am not surprised at all. You only have so much soft tissue between skin and [the heel bone]. On [DATE] at 11:00 AM and 4:57 PM, ADON F stated she rounded weekly with the wound doctor and always reminded him if residents received hospice services. She explained under those circumstances, she would have to notify the hospice agency if the wound physician wanted to consult other specialists or proceed with aggressive treatments. ADON F stated she spoke to the hospice nurse about IV antibiotics for resident #7, but she could not recall the date of the conversation. ADON F stated during rounds, the wound physician described the wounds and discussed treatments with her. She explained after he left, she reviewed the sections of his notes that pertained to new orders, the treatment plan, and wound measurements. ADON F was informed the wound physician's progress notes repeatedly indicated he did not receive requested lab results in a timely manner and/or was not confident the results were accurate. She acknowledged the lab did not initially perform anaerobic wound cultures as the physician was not specific, and she requested only aerobic cultures. ADON F stated to her knowledge, the lab provided the results requested from later samples. She said, I don't look at the entire note or read anything else. I did not know that he was writing that he did not have the culture results. ADON F could not explain why she was unaware of the wound physician's concerns related to wound cultures if she rounded with him weekly and participated in discussions specific to the status of each resident's wound(s). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 11:34 AM, the DON stated she did not recall any conversations with the wound physician regarding his dissatisfaction with the lab provider's services. She stated accuracy of the wound culture was outside the facility's scope and they trusted the lab to do its testing properly. The DON explained the facility continued to treat resident #7 with oral antibiotics while awaiting culture and sensitivity results from the lab. She acknowledged five weeks was a long time to wait for lab results while a wound infection worsened despite antibiotic therapy. The DON confirmed there was an interdisciplinary team process and the facility could have arranged a meeting with hospice staff, the resident's children and invited the wound physician to participate in discussions regarding approaches to wound treatment. She verified there was no documentation in the resident's medical record prior to [DATE] that showed consideration of transfer to the hospital for advanced testing and/or IV antibiotic therapy. In a telephone interview on [DATE] at 9:22 AM, in response to a telephone call made on [DATE] at 2:50 PM, resident #7's hospice Registered Nurse Case Manager (CM) stated she visited the facility regularly to assess the resident and ensure her comfort related to pain and anxiety. The CM reviewed the hospice medical record and stated hospice nurses visited the resident on [DATE], [DATE], [DATE], [DATE], and [DATE]. She stated the progress notes for those dates did not include documentation of discussions with or requests by the facility regarding more aggressive wound treatment such as an Infectious Disease physician consult, IV antibiotics, diagnostic testing, or hospitalization . The hospice agency's Executive Director (ED) explained the process was that recommendations by the facility's wound physician or Infectious Disease physician would be reviewed by the hospice's medical officer. She confirmed hospice authorized administration of IV antibiotics on a case-by-case basis. The CM and ED verified the facility never informed them of the possible need for IV antibiotics or advanced testing for resident #7's wound infection. On [DATE] at 1:46 PM, in a return telephone call received from the wound physician, he reiterated the facility was aware of his concerns about their lab provider as he had mentioned the issues to, several people, more than once. He confirmed his progress notes reflected the information he had regarding the cultures at the time the documents were completed. The wound physician checked resident #7's lab results in the facility's electronic medical record and stated the samples collected on [DATE] and [DATE] were processed for aerobic cultures only. He explained a culture collected on [DATE] showed no anaerobes were isolated, but due to the purulent wound drainage, he sent another sample for a repeat culture. The wound physician stated the sample collected on [DATE] showed an anaerobic organism, streptococcus intermedius. He read from the document, Susceptibilities are not routinely performed on this organism and explained that antibiotic sensitivities should have been determined by the lab. The wound physician indicated the next sample, collected on [DATE], showed no anaerobes were isolated. He explained he decided to seek confirmation from an outside lab as resident #7's wound continued to exhibit signs of infection although she remained on oral antibiotics. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #7's hospital record revealed she was admitted to the hospital with right heel and sacral pressure ulcers. Lab work done in the Emergency Department on [DATE] showed an elevated white blood cell count of 15.79 (normal range 4.4 to 10.5), which confirmed she had an infection, and she was started on IV antibiotics. A Wound/Ostomy Care Consult Note dated [DATE] revealed resident #7 had a sacral pressure ulcer that was present on admission to the hospital. The wound was described as an evolving DTI with slough. The provider noted the resident's right heel pressure ulcer was also present on admission to the hospital, the heel wound was described as unstageable, with mostly yellow slough, and redness to the peri wound area. A CT scan of the right foot with IV contrast, done on [DATE], revealed the resident had soft tissue swelling in the ankle and foot, an open wound, and osteomyelitis. The hospital record showed a wound culture was collected on [DATE] and resulted on [DATE]. The document indicated the organism Streptococcus intermedius was present in resident #7's heel wound, as noted in the lab culture collected in the facility on [DATE]. However, in contrast to the report from the facility's lab, the document included recommendations for antibiotics to which the organism was susceptible. The lab report indicated the organism was resistant to Clindamycin, the oral antibiotic that had been prescribed for resident #7 in the facility, thereby making the drug ineffective in treating the wound infection. A Podiatry Consult dated [DATE] revealed resident #7 was not a candidate for surgical intervention and would require IV antibiotics for six weeks. The hospital record showed the resident's infection progressed and she developed sepsis, a life-threatening complication of the body's extreme response to an infection (retrieved on [DATE] from ww. cdc.gov/sepsis/index.html). The Discharge Summary revealed resident #7 was transferred to an inpatient hospice unit on [DATE]. 2. Review of the medical record revealed resident #5, a [AGE] year-old female, was admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included metabolic encephalopathy (brain disorder), altered mental status, non-traumatic bleeding inside the brain, right carotid artery occlusion, left side weakness and paralysis, and generalized muscle weakness. The Resident Information sheet had been updated to show the resident acquired a Stage III pressure ulcer during her stay in the facility. Review of the MDS Admission assessment with ARD of [DATE] revealed resident #5 had severely impaired cognitive skills for daily decision-making. The document indicated she had no behavioral symptoms and did not reject evaluation or care that was necessary to achieve her goals for health and well-being. Resident #5 had functional limitation in range of motion related to impairments of one arm and both legs, and she used a wheelchair for mobility. The resident was totally dependent on staff for toileting hygiene, bathing, dressing, and personal hygiene. She required substantial to maximal assistance for bed mobility and was dependent for transfers between the bed and wheelchair. The MDS assessment revealed resident #5 had an indwelling urinary catheter and was always incontinent of bowel movements. The resident was determined to be at risk for developing pressure ulcers, but the document showed she had no wounds, ulcers, or other skin problems on the date of the assessment. Review of the medical record revealed resident #5 had a care plan for bowel incontinence, initiated on [DATE]. The interventions instructed CNAs to provide peri care after each incontinence episode. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A care plan for potential for impairment to skin integrity related to impaired mobility, incontinence, weakness, and protein-calorie malnutrition was initiated on [DATE]. The goals were resident #5 would show signs of healing and be free from skin infection. The interventions included assist with repositioning on rounds and as needed, follow facility protocols for treatment of injury, keep skin clean and dry, ensure placement of offloading boot on both feet when in bed. The document was updated on [DATE] to reflect application of a skin treatment to her sacral/coccyx open area. A care plan for risk for pressure ulcers was initiated on [DATE]. The goal was resident #5 would not develop any pressure ulcers. The interventions included apply topical preventative treatment if ordered, assist with bed mobility and repositioning on rounds and as needed, provide incontinence care promptly, observe the resident's skin condition during care, report any new findings, and perform skin assessments as indicated. Review of a Scale for Predicting Pressure Sore Risk form dated [DATE] revealed resident #5 had a score of 16. The legend indicated scores between 15 and 18 deemed residents at risk for developing pressure ulcers. Review of a Weekly Skin Inspection form dated [DATE] revealed resident #5's skin was intact. A form dated [DATE] indicated the resident's skin was not intact, due to a new area of skin breakdown. A Skin/Wound Note dated [DATE] at 11:34 PM, read, Resident was observed to have [an] open wound on her coccyx found by CNA. I cleansed with normal saline, applied skin protectant and bordered gauze. The document indicated the note was added to the facility's Shift Report and the 24-Hour Report. Review of the Order Summary Report for [DATE] revealed a physician order dated [DATE] to cleanse the open area with normal saline, pat dry, apply a Hydrocolloid, and cover with a border dressing twice daily. A Hydrocolloid dressing is usually used for superficial wounds with minimal drainage and is changed about every three days (retrieved on [DATE] from www.woundsource.com/blog/what-hydrocolloid-dressing). The order was discontinued on [DATE]. A new physician order dated [DATE] instructed nurses to apply Collagenase ointment 250 units per gram to the wound twice daily for slough, then apply collagen powder, Calcium Alginate, and cover with a dry dressing. Collagenase is used to treat skin ulcers by removing dead skin tissue from wounds to promote healing (retrieved on [DATE] from www.drugs.com/mtm/collagenase-topical.html). Alginate dressings are very absorbent and are often used in wounds with heavy drainage (retrieved on [DATE] from www.woundsource.com/blog/what-alginate-dressing). The Order Summary Report included physician orders dated [DATE] for a wound physician consult and an air mattress to promote wound healing. Review of the Initial Wound Evaluation & Management Summary dated [DATE] revealed the wound physician assessed resident #5 and discovered a Stage III pressure ulcer on her coccyx. The wound measured 4.0 cm x 1.0 cm x 0.3 cm and had a moderate amount of clear drainage. He noted 40% of the wound was nonviable tissue, which he removed surgically. The plan of care included recommendations to . Limit sitting to 60 minutes; Off-Load Wound; Reposition per facility protocol; Turn side to side in bed every 1 - 2 hours if able.Upgrade offloading chair cushion; Gel cushion. The note indicated the wound physician discussed the plan of care with nursing staff. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Progress Notes from [DATE] to [DATE] revealed no documentation regarding the size, characteristics, or stage of resident #5's wound either when it was identified or during the 7-day period prior to the wound physician's assessment. Changes in the types of treatments ordered indicated within four days, the wound worsened from an open area that required only a skin protectant cream to a pressure ulcer with slough and drainage. The medical record did not reflect follow up by nursing management on [DATE], although the new wound was documented on the Shift Report and the 24-Hour Report, to thoroughly assess the wound and ensure appropriate treatments and interventions were initiated in a timely manner. On [DATE] at 10:13 AM, resident #5 was seated upright in a high-back wheelchair in the 1st floor common area. The resident's body was centered in the chair and there were no positioning devices noted on either side of her body. On [DATE] at 1:39 PM, after the lunch meal, the resident remained seated upright in the wheelchair in the common area. She was still centered in the wheelchair, with her buttocks flat on the seat cushion, and there were no positioning devices beside or under her lower body. On [DATE] at 2:59 PM, resident #5 remained in her wheelchair in the 1st floor common area. Her position was unchanged. On [DATE] at 3:09 PM, CNA A confirmed she w[TRUNCATED]

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on observation, interview, and record review, the facility failed to provide sufficient licensed nurses on the 7:00 AM to 3:00 PM shift to meet medication administration needs, according to plans of care for residents on 2 of 2 floors (1st and 2nd floors); and failed to ensure sufficient Certified Nursing Assistants (CNAs) to meet person-centered needs for repositioning and incontinence care for 3 of 4 residents reviewed for activities of daily living (ADLs), out of a total sample of 27 residents, (#2, #5, and #7). Findings: 1. On 5/16/24 at 10:27 AM, Registered Nurse (RN) E explained she was administering scheduled 8:00 AM and 9:00 AM medications and still had twelve other residents on her assignment who had not yet received morning medications. She stated her assignment was split between two hallways and the other 1st floor nurse, Licensed Practical Nurse (LPN) C, had additional residents on the 2nd floor. She explained there were three nurses for both floors. When asked if split assignments across units and floors was normal, RN E stated it had been for a while. She said, They told us it was because of the census. RN E verified it was difficult enough to monitor residents on two different hallways, much less residents on two floors. On 5/16/24 at 10:51 AM, LPN C stated six of her assigned residents had not yet received their 8:00 AM and 9:00 AM medications. When asked if it was challenging to have residents on both floors, LPN C said, That is the assignment I have. They told us it is done by the census. She explained she was a new nurse, since March 2024, and supervisors were aware that when there were three nurses, it was difficult to complete the morning medication pass on time. Review of the Medication Administration Audit Report dated 5/16/24, revealed RN E and LPN C did not complete the administration of scheduled 8:00 AM and 9:00 AM medications until approximately 12:00 PM. On 5/16/24 at 1:55 PM, the Director of Nursing (DON) was informed of late medication administration and concerns related to one nurse with assigned residents on both floors. She explained late medication administration could possibly be a result of poor time management or incidents that required the nurses to pause medication pass. She stated she was not aware of any problems related to split assignments when the facility was staffed with three nurses instead of four. The DON stated there was an Assistant Director of Nursing (ADON) on each floor, so if the assigned nurse was on another floor, there was a nurse available to monitor the residents. The DON acknowledged the ADONs did not take a medication cart to ensure medication was administered on time. The DON explained, We have three nurses as the census is only 72. At 76 residents we can do four nurses. When asked if the facility's census was the driver for staffing, the DON verified the acuity of residents and assignments were considered. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/16/24 at 2:59 PM, RN D confirmed the afternoon shift was often staffed with three nurses, so one nurse had a split assignment between the 1st and 2nd floors. She explained the census decreased approximately four to five months ago, and said, It is driven by the census. She recalled she discussed the issue with the Evening Shift Nursing Supervisor, and he told her that the staffing ratio met State minimum requirements. On 5/17/24 at 12:43 PM, the Staffing Manager stated she based the facility's daily nursing staff ratios and hours on the census and resident acuity, with input from the Administrator, DON, and Admissions staff. She explained for a census of 73 residents, she would assign four nurses on the day shift, three nurses on the evening shift, and two nurses on the night shift. The Staffing Manager stated there were ADONs in the facility during the day shift, and one supervisor on the evening and night shifts. She acknowledged, Since the census plummeted about two months ago, we have been staffing the day shift with three nurses if the census is 72 residents or below. She denied knowledge of any concerns related to difficulty handling split assignments or inability to administer medications on time. The Staffing Manager said, The nurses I have are senior nurses and nobody has expressed to me that it is hard. She acknowledged that LPN C, who had the split assignment yesterday, was a new nurse with approximately two months experience. 2. Review of the medical record revealed resident #5, a [AGE] year-old female, was admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included bleeding inside the brain, left side weakness and paralysis, generalized muscle weakness, and a pressure ulcer on the coccyx. Review of the Minimum Data Set (MDS) Admission assessment with assessment reference date (ARD) of 5/02/24 revealed resident #5 had no behavioral symptoms and did not reject evaluation or care that was necessary to achieve her goals for health and well-being. Resident #5 had functional limitation in range of motion related to impairments of one arm and both legs, and she used a wheelchair for mobility. The resident was totally dependent on staff for toileting hygiene, bathing, dressing, and personal hygiene. She required substantial to maximal assistance for bed mobility and was dependent for transfers between the bed and wheelchair. The MDS assessment revealed she was always incontinent of bowel movements and was at risk for developing pressure ulcers Review of the medical record revealed resident #5 had a care plan for bowel incontinence, initiated on 3/28/24. The interventions instructed CNAs to provide peri care after each incontinence episode. A care plan for potential for impairment to skin integrity related to impaired mobility and incontinence was initiated on 3/28/24. The interventions included assist with repositioning on rounds and as needed and keep skin clean and dry. On 5/16/24 at 10:13 AM, 1:39 PM, and 2:59 PM, resident #5 was in the 1st floor common area. She was seated upright in her wheelchair, with no positioning devices at her sides or under legs to off-load her coccyx wound. On 5/16/24 at 3:09 PM, CNA A confirmed she did not return resident #5 to bed for incontinence care or off-loading of her wound since she got the resident up into her wheelchair at about 10:00 AM that morning. CNA A explained it required two staff members to transfer resident #2 as they had to use a mechanical lift. She recalled she checked the resident's brief before lunch, while she was seated in the wheelchair, and it was clean. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/16/24 at 3:25 PM, CNAs A and B transferred resident #2 back to bed with the mechanical lift. When CNA A removed the resident's brief, she discovered an extra-large bowel movement with loose and pasty stool on the resident's buttocks, gluteal folds, upper thighs, and groin. On 5/17/24 at 8:06 AM, in a telephone interview with resident #5's daughter, she shared concerns related to her mother's ADL care specifically timely incontinence care. She recalled on the evening of 5/01/24, she visited her mother before dinner time and found her seated in the wheelchair, with her brief full of diarrhea. She sated she asked CNAs to help with incontinence care before dinner, but the staff said they were busy. The daughter said, I couldn't find anyone to change her, so I took her to dinner. She stated her mother remained in the soiled brief for the dinner meal. The resident's daughter recalled she asked for assistance with incontinence care once again after dinner, but all CNAs were still too busy. She explained she waited for a while, eventually transferred her mother back to bed by herself, and cleaned up a significant amount of stool from her skin over the next hour. The daughter stated family members used to transfer her mother back to bed while they were there, to change her brief and allow her to lie down and rest, but the facility instructed them to discontinue that practice. The resident's daughter explained she would sometimes wait until 8:00 PM and her mother still be in her wheelchair from after breakfast, through lunchtime, until someone put her to bed for the night. She confirmed staffing appeared to be an issue, especially on the weekends as when she stood in the hallway looking for CNAs, there was nobody available. 3. Review of the medical record revealed resident #2, an [AGE] year-old female, was admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included left lung CA, type 2 diabetes, congestive heart failure, and chronic pain. Review of the MDS Annual assessment with ARD of 5/02/24 revealed resident #2 had a Brief Interview for Mental Status score of 14 which indicated she was cognitively intact. The document revealed the resident did not exhibit behavioral symptoms nor reject evaluation or care that was necessary to achieve her goals for health and well-being. The MDS assessment revealed resident #2 used a wheelchair and required substantial to maximal assistance for bathing and partial to moderate assistance for toileting hygiene. The resident was always incontinent of bowel and bladder and deemed to be at risk for developing pressure ulcers. Resident #2 had a care plan for skin breakdown with risk factors including total incontinence and the need for assistance with bed mobility and repositioning, initiated on 6/06/23. An intervention instructed CNAs to clean her promptly after incontinence episodes. Care plans for bladder incontinence of bladder, initiated on 6/06/23, and bowel incontinence, initiated on 8/31/23, also instructed CNAs to clean the resident promptly. Review of a care plan for ADL self-care performance deficit, initiated on 6/06/23, revealed resident #2 required assistance from two staff for transfers with a mechanical lift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/16/24 at 10:16 AM, resident #2 stated she had concerns related to call light response. She explained her roommate, resident #7, who was now in the hospital, also had the same issue. Resident #2 said, They do not always respond and come in here like they should. It can take hours. It's the same thing every day. It was the same for my roommate. The resident stated she also had concerns with timely incontinence care. She explained CNAs usually provided care at about 11:00 AM and got her out of bed at about 11:30 AM, in time for lunch in the dining area. The resident stated that would be the only and last time they changed her until bedtime. Resident #2 said, The last time I was changed was on the overnight shift at about 6:00 AM. The night shift changes me before they go home and now I'm soaked. She confirmed her assigned CNA had not yet offered to change her or provide incontinence care this morning. The resident explained it took a while to get her into or out of bed as the mechanical lift required two CNAs to be available at the same time. On 5/16/24 at 11:32 AM, CNAs A and B transferred resident #2 into her wheelchair with the mechanical lift. CNA B confirmed she had just completed incontinence care for the resident for the first time on the 7:00 AM to 3:00 PM shift. On 5/16/24 at 2:54 PM, almost four hours after providing incontinence care for resident #2, CNA B verified she was to check, change, and reposition her assigned residents every two hours. She went to the dining room and brought resident #2 back to her room. The resident had a surprised facial expression when CNA B informed her they planned to transfer her to bed to provide incontinence care. 4. Review of the medical record revealed resident #7, an [AGE] year-old female, was admitted to the facility on [DATE] and readmitted from the hospital on 3/14/24. Her diagnoses included heart disease, osteoporosis, chronic pain, type 2 diabetes with a foot ulcer, and a sacral pressure ulcer. Review of the MDS Discharge Return Anticipated assessment with ARD of 5/10/24 revealed resident #7 did not exhibit any behavioral symptoms or reject evaluation or care that was necessary to achieve her goals for health and well-being. Resident #7 was totally dependent on staff for toileting hygiene, personal hygiene, bed mobility, and transfers, and was always incontinent of bowel movements. Resident #7 had a care plan for bowel incontinence, initiated on 6/01/23. The approaches indicated the resident used disposable briefs. The document instructed licensed nurses and CNAs to check and change the resident as required after episodes of bowel incontinence. A care plan for the potential for additional skin breakdown was initiated on 8/24/23. The interventions included assist with bed mobility and repositioning on rounds during care and as needed, and clean promptly after incontinence episodes. A care plan for the potential for additional pressure ulcers, initiated on 12/26/22, instructed nurses to assist resident #7 with toileting tasks and incontinence care. A care plan for ADL self-care performance deficit, initiated on 2/20/23, indicated resident #7 required assistance from two staff for transfers with a mechanical lift, assistance from one to two staff for bed mobility, and assistance of one staff for personal hygiene. The care plan instructed nursing staff to encourage the resident to use the call bell to call for assistance. Review of the facility's Grievance Log from February to May 2024 revealed on 5/13/24 resident #7's family members made a complaint regarding her care. The grievance was investigated by the Director of Nursing (DON). On 5/17/24 at 11:34 AM, the DON explained the grievance made by resident #7's family was about a care issue related to one specific nurse. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In telephone interviews and conference calls on 5/16/24 at 10:32 AM, 6/03/24 at 11:05 AM, and 6/05/24 at 1:10 PM, resident #7's family explained she developed wounds on her heel and bottom while in the facility. The family explained they felt a significant contributing factor was the failure of nursing staff to provide necessary ADL care, such as regular turning and repositioning or prompt incontinence care. The resident's family recalled during a meeting on 5/13/24, they informed the DON of concerns related to their mother not being turned, repositioned, and cleaned adequately to prevent and heal her wounds. They stated they mentioned staff often ignored their mother or did not respond to the call light in a timely manner when she needed care. During the care plan meeting, the family complained that on two occasions a nurse who was in the room to do their mother's wound dressing refused to provide incontinence care as it was not her job. As a result, their mother had to wait for over an hour for the bowel movement to be cleaned from her skin. The family explained it was very common for their mother to wait for long periods to get her brief changed when there were not enough CNAs available, particularly on the evening shift after dinner and on the weekends. Review of the Facility Assessment, dated January 2024, revealed the facility could provide general care and services related to ADLs, mobility, bowel and bladder incontinence, and skin integrity. The document indicated the facility would determine CNA staffing assignments based on the number of residents and/or the level of acuity for CNA care needed such as ADL needs. The Facility Assessment read, For Nursing Assignments: The assignments are based on Professional Nursing care needed by the number of residents and/or resident acuity. to include consideration of the number of residents with higher acuity needs such as feeding tubes and dressing changes.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 36489 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to ensure timely medication administration in accordance with its policies, procedures and accepted standards of practice for 25 residents reviewed for medication administration, out of a total sample of 27 residents, (#3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, and #27). Findings: On 5/16/24 at 10:27 AM, Registered Nurse (RN) E stood at her medication cart on the 1st floor. Her computer screen displayed several residents' profiles in red and she explained the color indicated their scheduled morning medications were now late. RN E stated she had four residents left on one hallway and eight on the back hallways. She confirmed the twelve residents left all had medications scheduled for 8:00 AM and/or 9:00 AM. RN E explained her assignment was split between two hallways and the other 1st floor nurse, Licensed Practical Nurse (LPN) C's assignment was split between the 1st and 2nd floors. RN E verified late administration of medications was not isolated or recent but had been ongoing for a while. She stated the Unit Managers/Assistant Directors of Nursing (ADONs) did not take medication carts to assist with the morning medication administration task. On 5/16/24 at 10:51 AM, LPN C stood at her medication cart on the 2nd floor. She confirmed her assignment included residents on both floors. LPN C stated to her knowledge, she completed medication administration for all her assigned residents on the 1st floor. She counted the residents' profiles displayed on the computer screen in red and verified she still had six residents left, one of whom took medication via a feeding tube. LPN C stated when she completed the 2nd floor medications she would have to hurry to the 1st floor to complete pre-lunch blood glucose checks for three residents. When asked if she ever told any member of nursing management that she could not complete medication administration within the required timeframe of one hour before and one hour after the scheduled time, LPN C said, They know that. They just say I have to finish on time. On 5/16/24 at 10:59 AM, LPN C was observed as she administered resident #3's morning medication via feeding tube, two hours after the scheduled time. She crushed eight pills, one at a time, and placed them in individual cups and prepared one liquid medication. LPN C dissolved the medications and administered them with a water flush in between to clear the tube. When LPN C completed the time-consuming procedure, she continued down the hallway to the next resident's room. On 5/16/24 at 11:44 AM, RN E was at her medication cart on the 1st floor back hallway. She stated she was still administering scheduled morning medications. RN E showed a cup with numerous tablets and said, This one and the next have a lot of pills. When asked what time she would finish morning medication pass, RN E explained she still had two more residents, one of whom had a feeding tube. On 5/16/24 at 1:55 PM, the Director of Nursing (DON) was informed RN E and LPN C were observed administering scheduled 8:00 AM and 9:00 AM medications at almost 12:00 PM. She stated she was not aware nurses were having problems with medication administration within the required timeframe. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/16/24 at 2:44 PM, the 1st floor Assistant Director of Nursing (ADON) F stated she did not know the 1st floor nurses were sometimes unable to complete morning medication pass in the required timeframe. ADON F acknowledged if medications were given outside the accepted 2-hour window, the physicians who ordered the medications should be notified. The facility's policy and procedure for Medication Errors, dated June 2023, revealed observations of nurses would be conducted to evaluate medication administration practices. The document indicated nurses would verify information including the right times of administration to prevent medication errors and ensure safe administration. Review of the Medication Administration Audit Report for the day shift, 7:00 AM to 3:00 PM, on 5/16/24 revealed the following residents did not receive scheduled medications within the required timeframe: Resident #3 received eleven scheduled 9:00 AM medications between 11:02 AM and 11:34 AM. Resident #4 received six scheduled 8:00 AM and 9:00 AM medications between 12:00 PM and 12:02 PM. The medications included Nystatin suspension 5 milliliters scheduled for 9:00 AM and 1:00 PM. The doses were given at 12:02 PM and 2:00 PM, two hours apart. Resident #5 received one scheduled 7:30 AM dose of insulin at 8:44 AM, and ten scheduled 8:00 AM and 9:00 AM medications between 11:35 AM and 11:36 AM. Resident #6 received six scheduled 7:30 AM, 8:00 AM, and 9:00 AM medications between 10:13 AM and 10:16 AM. The medications included Ferrous Sulfate 325 milligrams (mg) which was scheduled at 7:30 AM and 12:00 PM. The doses were administered at 10:13 AM and 1:04 PM, less than three hours later. Resident #8 received one scheduled 9:00 AM medication at 11:38 AM. Resident #9 received thirteen scheduled 8:00 AM and 9:00 AM medications between 11:56 AM and 12:00 PM. The medications included Gabapentin 400 mg which was scheduled for 9:00 AM and 1:00 PM. Resident #9 received the first dose at 11:56 AM and the second dose approximately two hours later at 1:51 PM. Resident #10 received ten scheduled 8:00 AM and 9:00 AM medications between 11:45 AM and 11:47 AM. Resident #11 received four scheduled 8:00 AM and 9:00 AM medications at 12:00 PM. Resident #12 received eight scheduled 8:00 AM and 9:00 AM medications between 10:49 AM and 10:51 AM. The medications included Midodrine HCl 10 mg which was scheduled for 9:00 AM and 1:00 PM. Resident #12 received the first dose at 10:51 AM and the second dose approximately three hours later at 2:04 PM. Resident #13 received sixteen scheduled 8:00 AM and 9:00 AM medications between 10:38 AM and 10:42 AM. The medications included Carbidopa-Levodopa 25-100 mg which was scheduled for 8:00 AM and 2:00 PM. Resident #13 received the first dose at 10:38 AM and the second dose less than three hours later at 1:11 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105879	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Winter Park	1111 S Lakemont Ave Winter Park, FL 32792

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #14 received a scheduled 7:30 AM pre-breakfast dose of insulin at 9:52 AM. Her five scheduled 8:00 AM medications were administered at 9:55 AM. Her scheduled 11:30 AM pre-lunch dose of insulin was given at 12:42 PM, and the doses of Buspirone 10 mg scheduled at 8:00 AM and 2:00 PM were administered at 9:54 AM and 1:01 PM, approximately three hours apart. Resident #15 received five scheduled 9:00 AM medications between 11:41 AM and 11:44 AM. Resident #16 received sixteen scheduled 8:00 AM and 9:00 AM medications between 11:54 AM and 12:12 PM. Resident #17 received eleven scheduled 8:00 AM and 9:00 AM medications between 11:36 AM and 11:38 AM. Resident #18 received thirteen scheduled 8:00 AM and 9:00 AM medications between 9:43 AM and 10:13 AM. Resident #19 received six scheduled 8:00 AM and 9:00 AM medications between 10:23 AM and 10:27 AM. Resident #20 received six scheduled 8:00 AM and 9:00 AM medications between 11:19 AM and 11:23 AM. Resident #21 received eight scheduled 9:00 AM medications between 12:14 PM and 12:15 PM. Resident #22 received two scheduled 8:00 AM medications at 9:24 AM. Resident #23 received twelve scheduled 8:00 AM and 9:00 AM medications between 11:41 AM and 11:50 AM. Resident #24 received one scheduled 9:00 AM medication at 11:24 AM. Resident #25 received fourteen scheduled 8:00 AM and 9:00 AM medications between 11:27 AM and 11:32 AM. She received the scheduled 8:00 AM and 2:00 PM doses of Carbidopa-Levodopa 10-100 mg at 11:27 AM and 1:47 PM, less than three hours apart. Her scheduled 9:00 AM and 1:00 PM doses of Midodrine HCl 10 mg were given at 11:28 AM and 1:57 PM, less than two hours apart. Review of the Medication Administration Audit Report for all shifts on 3/23/24 revealed the following residents did not receive scheduled medications within the required timeframe: Resident #7 received thirteen scheduled 8:00 AM and 9:00 AM medications between 10:32 AM and 10:35 AM Resident #26 received six scheduled 8:00 AM and 9:00 AM medications at 11:27 AM. Resident #27 received six scheduled 8:00 AM and 9:00 AM medications at 11:32 AM. Review of the facility's policy and procedure for Medication Administration, dated July 2023, revealed medications would be administered by licensed nurses as ordered by the physician, according to professional standards of practice. The document read, Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by the physician. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Facility Assessment, dated January 2024, revealed the facility would provide general care for residents to include medication administration.