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	08/12/2025

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 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to administer Oxygen (O2) therapy as ordered by the physician for 2 of 4 residents reviewed for respiratory care, of a total sample of 4 residents, (#3 and #4). 1. Resident #3 was admitted to the facility on [DATE] with diagnoses of pneumonia, acute respiratory failure, chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF).Review of resident #3's medical record revealed a care plan revised on 8/07/25 which indicated the resident's oxygen to be applied, as ordered by physician, for respiratory complications related to CHF, COPD, and pneumonia.Supplemental oxygen therapy helps people with COPD, COVID-19, emphysema, sleep apnea and other breathing problems get enough oxygen to function and stay well. Low blood oxygen levels (hypoxemia) can damage organs and be life-threatening, (retrieved on 8/15/25 from www.myclevelandclinic.org).Resident #3's Order Summary Report showed an active physician's order dated 8/4/25 for oxygen at 1 liter per minute (LPM) via NC (nasal cannula) and an order for nurses to check the oxygen delivery rate every shift.On 8/12/25 at 9:35 AM, resident #3 was observed sitting up in bed with O2 delivered through a NC. The O2 tubing was connected to a concentrator set to deliver 3.5 LPM of oxygen. Resident #3 was alert and oriented to person, place and time, and denied adjusting her O2 concentrator settings herself. Later that day on 8/12/25 at 12:45 PM, resident #3 was in her room with O2 administered through the nasal cannula. The oxygen tubing was connected to an O2 concentrator still set at 3.5 LPM. On 8/12/25 at 12:50 PM, Registered Nurse (RN) A checked resident #3's medical record physician order and verified the oxygen was ordered by the physician for 1 LPM. The nurse confirmed she did not check the resident's oxygen settings today and said she should check every time she went in the room to ensure the resident was getting rate that was ordered by the physician. On 8/12/25 at 12:53 PM, the Assistant Director of Nursing (ADON) observed and acknowledged resident #3 was not getting her oxygen as ordered by the physician. The ADON confirmed the oxygen flow rate was ordered by the physician for 1 LPM. 2. Resident #4 was readmitted to the facility on [DATE] with diagnoses of cerebral infarction (stroke), hemiplegia (paralysis on side of the body), CHF, adult failure to thrive and quadriplegia (paralysis that affects all a person's limbs and body from the neck down). Review of resident #4's medical record revealed a care plan revised on 5/02/24 which indicated a resident focus for Respiratory Complications related to CHF and history of pneumonia which included an intervention to apply oxygen therapy as ordered with the goal that she would not have symptoms of respiratory distress. Resident #4's current active physician order dated 5/01/24 was for oxygen at 2 LPM continuously via nasal cannula. On 8/12/25 at 9:45 AM, resident #4 was lying in bed asleep with O2 administered through a NC. The O2 tubing was connected to an oxygen concentrator set at 1.5 LPM. Later that day on 8/12/25 at 1:00 PM, resident #4 was lying in bed asleep with oxygen administered through a nasal cannula. The oxygen tubing was connected to an O2 concentrator set at 1.5 LPM. On 8/12/25 at 1:05 PM, Licensed Practical Nurse (LPN) B explained she was assigned to resident #4 and verified the physician order for oxygen was for 2 LPM continuous. LPN B confirmed she did not check the resident concentrator yet today to ensure resident was getting the prescribed rate. LPN B went to resident #4's room and verified the resident was getting 1.5 LPM of oxygen via the setting on the concentrator. The nurse was observed standing over the oxygen concentrator trying to read the flow rate from above instead of at eye level.On 8/12/25 at 1:18 PM, the Director of Nursing (DON) said nurses were supposed to check oxygen liter flow rate at eye level at least every shift. The DON verbalized the expectation that nurses should check the physician's order and administer what was ordered. The DON added, good nursing practice was to check every time the nurse rounded on their residents to ensure they were receiving what was ordered by the physician. Review of the facility's Oxygen Administration policy revised May 2025 indicated, Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plan. Oxygen is administered under orders of a physician.