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	10/31/2024

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40892 Based on interview, and record review, the facility failed to honor residents' rights to choose their preferred bathing preferences for 1 of 2 residents reviewed for choices, of a total sample of 29 residents, (#55). Findings: Review of the medical record revealed resident #55 was admitted to the facility on [DATE] from the hospital. His diagnosis included Parkinson's disease, osteoarthritis, right hip pain, and bilateral inguinal hernia. Resident #55's Admission Minimum Data Set with an assessment reference date of 10/16/24 revealed the resident scored 14 out of 15 on the Brief Interview for Mental Status, indicating he had no cognitive impairment. The MDS assessment also indicated resident #55 was dependent on bathing; it was somewhat important for him to choose between a shower and bed bath, and he participated in the assessment and goal setting. The assessment also revealed the resident did not exhibit behavior symptoms or rejection of care necessary to achieve the resident's goals for health and well-being. Resident #55's Resident Preferences Evaluation dated 10/11/24 noted the resident prefers showering. A review of resident 55's Certified Nursing Assistant (CNA) Kardex with an admitted [DATE] noted the resident preferred a shower on Tuesdays, Thursdays, and Saturdays in the evening. The bathing task report indicated resident #55 received no showers from 10/10/24 to 10/30/24. The report noted that the resident received bed baths on 5 of the 22 days since admission. On 10/28/24 at 10:41 AM, resident #55 stated he was only given bed baths but preferred showers. He said he told the staff he preferred showers, but they only gave him bed baths which was not his preference. On 10/28/24 at 2:07 PM, resident #55 explained had not had a shower in over a month until earlier that day when he had a shower with therapy. On 10/30/24 at 1:59 PM, Registered Nurse (RN) B stated it was a lot for the resident to shower, so staff offered him a bed bath which he accepted. RN B explained after two weeks, resident #55 started to say he had not had a shower. The nurse did not recall writing a note about it. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 4:46 PM, CNA A explained that they looked in the computer and checked to see who had showers scheduled that day. The CNA said if the resident refused to shower, it was reported to the nurse and would let the nurse know if the resident requested a bed bath instead of the scheduled shower. On 10/31/24 at 12:47 PM, the Director of Nursing (DON) confirmed the Kardex and Preference Evaluation indicated the resident's bathing preference was for showers on Tuesdays, Thursdays, and Saturdays. The DON confirmed the bathing task report indicated the resident had not received showers. The DON expressed that the resident's choices were not honored and confirmed that resident #55 should have received showers instead of bed baths. She acknowledged the importance of ensuring the resident received his preferred means of bathing, as it was the resident's right. The facility's Activities of Daily Living policy dated 6/2023 indicated the facility would, ensure a resident's abilities in Activities of Daily Living did not deteriorate unless deterioration was unavoidable, based on the resident's comprehensive assessment and consistent with the resident's needs and choices,. Care and services would be provided for the following activities of daily living: bathing, dressing, grooming, and oral care . _____

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131 Based on interview, and record review, the facility failed to provide a written summary of the Baseline Care Plan as required for 1 of 2 residents reviewed for Care Planning, of a total sample of 29 residents, (#869). Findings: Resident #869, an [AGE] year-old female was admitted to the facility on [DATE]. Her diagnoses included sepsis, atrial fibrillation, hypertension, generalized muscle weakness, hyperlipidemia, and a personal history of pneumonia. On 10/28/24 at 12:20 PM, resident #869 stated she was admitted to the facility for therapy, had been at the facility since 10/24/24, had not had any therapy, and did not know about or have a copy of her care plan. The resident said she did not think she signed anything regarding her plan of care. Review of the resident's clinical records revealed a Baseline Care Plan which indicated resident #869's admitted was 10/24/24. The summary and signatures areas, revealed the document was not signed until 10/28/24 by the resident and the Unit Manager . On 10/29/24 at 3:04 PM, the Registered Nurse Minimum Data Set (MDS) Coordinator stated baseline care plans were initiated on admission, or on the day following a resident's admission. He explained that all the disciplines completed their sections, the baseline care plan was then printed, reviewed with the resident, signed, a copy would be given to the resident, then scanned into the resident's electronic medical record. He stated the goal was for the process to be completed within 48 hours. Resident #869's baseline care plan was reviewed with the MDS Coordinator. He acknowledged the resident was admitted on [DATE], the baseline care plan was initiated on 10/24/24, but the signatures to indicate the baseline care plan was reviewed, and a copy provided to the resident was not until 10/28/24. He said this was not within guidelines. On 10/29/24 at 3:31 PM, the Assistant Director of Nursing/Unit Manager (ADON/UM) for Birch and Gibbion Units, stated a baseline care plan initiated on admission by the Admission nurse, was to be completed within 48 hours, and the resident/family signed and received a copy. The resident's baseline care plan was reviewed with the ADON/UM. She acknowledged the resident was admitted on [DATE], and documentation indicated the baseline care plan was reviewed with the resident, signature obtained, and a copy provided to the resident on 10/28/24. On 10/29/24 at 3:48 PM, the Director of Nursing (DON) stated that in lieu of the baseline care plan, a comprehensive care plan was completed for resident #869 on 10/25/24. She confirmed a written summary would be provided to the resident, but the DON could not verbalize the process at the facility. She acknowledged that a written summary of the resident's baseline care plan was not signed, and a copy was not provided to the resident until 10/28/24, three days after completion of the comprehensive care plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy, Baseline Care Plans reviewed/revised 7/2023 indicated, The baseline care plan will: Be developed within 48 hours of a resident's admission . A written summary of the baseline care plan shall be provided to the resident and representative .The person providing the written summary of the baseline care plan shall obtain a signature from the resident/representative to verify that the summary was provided.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131 Based on interview, and record review, the facility failed to ensure resident and/or their representative were invited/involved in the development of their care plan for 1 of 2 residents reviewed for care planning, of a total sample of 29 residents, (#38). Findings: Resident #38, an [AGE] year-old female was admitted to the facility on [DATE]. Her diagnoses included malignant neoplasm of unspecified left bronchus or lung, dementia, diabetes type II, chronic diastolic (congestive) heart failure, chronic atrial fibrillation, hypertension, anxiety disorder and cardiomegaly. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the resident's cognition was intact, with a Brief Interview For Mental Status score of 15 out of 15. Section F for preference of the resident's annual MDS dated [DATE] revealed it was very important for the resident to have family/close friend involved in discussion about her care. On 10/28/24 at 4:42 PM, resident #38 stated she had not attended any care plan meetings. When asked who goes, she said probably my son because she certainly has not, but, would like to know what was going on. On 10/29/24 at 3:22 PM, the Registered Nurse MDS Coordinator, explained that the Social Services Director invited residents/family members to their care plan meetings, via telephone. He stated that a care conference sheet was completed and signed by all the persons in attendance at the care plan meeting. The document would then be placed in the resident's physical chart. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24 at 3:37 PM, the Assistant Director of Nursing/Unit Manager (ADON/UM) for the Birch and Gibbion Units stated the Social Services Director arranged care plan meetings through a combination of letters, telephone calls, or emails. The ADON/UM said residents were invited to their care plan meetings and were reminded on the day of the meeting. She stated an Interdisciplinary Care Conference Summary would be completed with the signatures of all persons in attendance, including the resident/family, and placed in the resident's physical chart. The resident's physical chart was reviewed with the ADON/UM and revealed two Care Conference Summaries. One summary dated 8/08/23 had signatures for the Director of Nursing (DON), and the Social Services Director. There was no documentation/ signature to indicate the resident, or her family/representative were in attendance. The second summary was dated 5/07/24 and revealed the resident's name written in at the top, and signatures for members of the Interdisciplinary Team in attendance. The ADON stated the most recent care plan meeting for the resident was on 8/06/24, and the resident or her family was not in attendance. She could not say if the resident was invited and verbalized that the Social Services Director was responsible to invite residents/families to their care plan meetings. The ADON said the resident's son did not attend the care plan meetings, stating it was hard to get a hold off him. She explained that care plan meetings were held to review the overall plan of care for the resident(s), so the residents/families could discuss the resident's status, review the plan of care, to ensure care plans were resident centered, and the resident's preferences were honored. When asked how care plans could be developed as resident centered if the resident/representative were not involved in the decision, the ADON had no response. There was no other documentation to indicate resident #38 or her representative were invited or participated in her care plan meetings. This was acknowledged by the ADON. On 10/29/24 at 4:32 PM, in a telephone call to the resident's family member initiated by the Administrator, the family member stated he attended a care plan meeting via telephone about one week ago. However, there was no documentation in the medical record regarding this. The last care plan meeting held for the resident was on 8/06/24, and there was no documentation to indicate the resident/family member attended the care plan meeting. The facility's policy Care Planning-Resident Participation revised 7/2023 read, the facility supports the resident's right to be informed of, and participate in, his or her care planning and treatment .The facility will encourage and assist the resident and/or resident representative to participate in choosing care and treatment options .The facility will honor the resident's choice in individuals to be included in the care planning process If the participation of the resident and /or resident representative is determined not practicable for the development of the resident's care plan, an explanation will be documented in the resident's medical record.