STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105926	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Suncoast	1095 Pinellas Point Dr S Saint Petersburg, FL 33705

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews the facility failed to provide the services ordered by a physician for one (#1) of three residents sampled for treatment of a non-pressure wound. The facility falsified documentation showing wound care had been completed during that time and failed to recognize wound care had not been completed for 8 days during a weekly skin assessment.Findings included: Review of Resident #1's admission Record showed the resident was admitted on [DATE] and included diagnoses not limited to metabolic encephalopathy, repeated falls, and unspecified dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. The resident was discharged to an acute care hospital on 6/21/25. Review of Resident #1's progress notes revealed a change in condition on 6/6/25. The note revealed the resident had a skin tear, neuro (checks) and fall protocol were implemented as staff had assisted resident up. Review of Resident #1's Fall Risk Evaluation, dated 6/6/25 revealed the resident had intermittent confusion, was chairbound, incontinent, and had a balance problem with standing. Review of Resident #1's Treatment Administration Record (TAR) showed an order instructing: - Treatment as follows: Cleanse skin tears on Right Lower Extremity (RLE) with normal saline (NS), pat dry, cover with xeroform and abdominal (ABD) pad, wrap with gauze every 2 days. The order was scheduled to completed on night shifts and started on 6/7/25. Review of Resident #1's TAR showed wound care had been completed to the RLE skin tear on 6/7, 6/9, 6/11, 6/13, 6/15, and 6/17/25. Review of Resident #1's weekly skin evaluation showed on 6/14/25 the resident's skin was not intact and the area(s) were not new. The progress notes dated 6/14/25 did not include further information related to the resident's skin evaluation, the old areas, or the appearance of the areas. Review of Resident #1's progress notes showed a Change in Condition evaluation was completed on 6/19/25 at 8:32 a.m. by the Director of Nursing (DON). The DON had reported an other change in condition. The nursing observations, evaluations, and recommendations were Reported that Dressing was not done as ordered, reported to MD, reported to Law enforcement, reported to Department of Children and Families (DCF), reported to Agency for Healthcare Administration (AHCA). The note showed family were notified and was awaiting a return call. An order was obtained from the primary care provider to (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	start prophylactic antibiotic, start (liquid protein) twice a day, vitamin c, zinc daily, and treatment was updated. Review of the progress notes on 6/18 and/or 6/19/26 did not reveal staff had documented the appearance of the wound, the dressing found, and/or notification to the DON. Review of Resident #1's late entry progress note dated 6/19/25 at 8:45 p.m. showed the DON had spoken with family about dressing being missed and reported. Review of Resident #1's late entry progress note dated 6/19/25 at 8:46 p.m. revealed the residents family had returned call to DON and had discussed event in length. During an interview on 2/25/26 at 2:09 p.m. the Director of Nursing (DON) reviewed the incident regarding Resident #1. The DON stated the resident's dressing was supposed to be changed every other day and two nurses had signed the change had been completed on 6/13, 6/15, and 6/17 however on 6/19 it was reported to her that the dressing was dated 6/11, which she witnessed and had confirmed. The DON reported the resident had weekly skin checks done but staff were looking for anything new, saw the dressing but didn't pay attention to the date. The DON stated weekly skin checks are done head to toe but the point of the skin checks was to see if there was anything new. Review of Resident #1's TAR showed one nurse had documented the RLE wound care had been administered on 6/13 and 6/15/25 and another nurse had documented the wound care had been completed on 6/17/25. The documentation showed two nurses had falsely documented the wound care to the resident's lower extremity had been completed. Review of Resident #1's care plan showed the resident was at risk for skin breakdown related to needs assistance with bed mobility and repositioning, nutritional risk, 5/5/25 posterior hand skin tear, and 6/9/25 right lower extremity skin tears. The interventions included but not limited to: - monitor steri strips to left hand for signs and symptoms of infection, assigned to licensed nurses - observe resident's skin condition during routine care every shift and report any findings to nurse, assigned to Certified Nursing Assistant(s) (CNAs). - Treatments as ordered, assigned to licensed nursing staff - Weekly skin checks, assigned to licensed nursing staff. The intervention did not instruct staff to only look for new areas. An interview was conducted on 2/25/26 at 11:04 a.m. with Staff E, Restorative CNA. The staff member reported working with the nurses regarding wound care. If the dressing was not dated correctly would get the nurse, if it was dirty and coming off would let the nurse know and they come in with me. Review of Abuse, Neglect, and Exploitation, revised 5/2025, revealed It is the policy of this facility to provide protections for the health, welfare, in rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The policy defined neglect as the Failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	avoid physical harm, pain, mental anguish, or emotional distress. The compliance guidelines included but not limited to: 1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. 3. The facility will provide ongoing oversight and supervision of staff in order to ensure that its policies are implemented as written. The prevention of abuse, neglect, and exploitation showed The Facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and expectation that achieves: F. Providing residents, representatives, and staff information on how and to whom they may report concerns, incidents, and grievances without the fear of retribution; And providing feedback regarding the concerns that has been expressed. Review of the policy – Wound Treatment Management, revised 5/2025, revealed To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. The policy explanation and compliance guidelines included but not limited to: 1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. 3. Dressing changes may be provided outside the frequency parameters in certain situations: a. Feces has seeped underneath the dressing. b. The dressing has dislodged. c. The dressing is soiled otherwise, or as wet. 7. Treatments will be documented on the treatment administration record or in the electronic health record. 8. The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include: a. Lack of progression towards healing. b. Changes in the characteristics of the wound (see above). Review of the policy – Documentation in Medical Record, revised 6/2025, revealed Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the residents progress through complete, (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accurate, and timely documentation. 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the residence medical record in accordance with state law and facility policy. 2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. 4. Principles of documentation include, but are not limited to: a. Documentation shall be factual, objective, and resident centered. i. False information shall not be documented. ii. Record descriptive and objective information based on first-hand now edge of the assessment, observation, or service provided. b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the residence care and/ or responses to care.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, and interviews the facility failed to ensure wound care was completed as ordered for two (#1 and #6) of three residents sampled for the treatment of non-pressure wounds, failed to ensure accurate and timely assessments were completed for two (#5 and #6) of three residents sampled for skin assessments. Findings included:1.Review of Resident #1's admission Record showed the resident was admitted on [DATE] and included diagnoses not limited to metabolic encephalopathy, repeated falls, and unspecified dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. The resident was discharged to an acute care hospital on 6/21/25. Review of Resident #1's progress notes revealed a change in condition on 6/6/25. The note revealed the resident had a skin tear, neuro (checks) and fall protocol were implemented as staff had assisted resident up. Review of Resident #1's Treatment Administration Record (TAR) showed an order instructing:Treatment as follows: Cleanse skin tears on Right Lower Extremity (RLE) with normal saline (NS), pat dry, cover with xeroform and abdominal (ABD) pad, wrap with gauze every 2 days. The order was scheduled to completed on night shifts and started on 6/7/25. The review showed wound care had been completed on 6/7, 6/9, 6/11, 6/13, 6/15, and 6/17/25. Review of Resident #1's Weekly skin evaluations showed on 6/14/25 the resident's skin was not intact and the area(s) were not new. The progress notes dated 6/14/25 did not include information on the resident's skin evaluation and the old area(s). Review of Resident #1's progress notes showed a Change in Condition evaluation was completed on 6/19/25 at 8:32 a.m. by the Director of Nursing (DON). The DON had reported an other change in condition. The nursing observations, evaluations, and recommendations were Reported that Dressing was not done as ordered, reported to MD, reported to Law enforcement, reported to Department of Children and Families (DCF), reported to Agency for Healthcare Administration (AHCA). The note showed family were notified and was awaiting a return call. An order was obtained from the primary care provider to start prophylactic antibiotic, start (liquid protein) twice a day, vitamin c, zinc daily, and treatment was updated. Review of the progress notes did not reveal documentation of the appearance of the wound, the dressing found, and/or notification to the DON. Review of Resident #1's late entry progress note dated 6/19/25 at 8:45 p.m. showed the DON had spoken with family about dressing being missed and reported. Review of Resident #1's late entry progress note dated 6/19/25 at 8:46 p.m. revealed the residents family had returned call to DON and had discussed event in length. During an interview on 2/25/26 at 2:09 p.m. the Director of Nursing (DON) reviewed the incident regarding Resident #1. The DON stated the resident's dressing was supposed to changed every other day and two nurses had signed the change had been completed on 6/13, 6/15, and 6/17 however on 6/19 it was reported to her that the dressing was dated 6/11, which she witnessed. The DON reported the resident had weekly skin checks done but staff were looking for anything new, saw the dressing but didn't pay attention to the date. The DON stated weekly skin checks are done head to toe but the point of the skin checks was to see if there was anything new. Review of Resident #1's TAR showed an order instructing staff to Monitor steri-strips to left (L) hand for signs/symptoms (s/s) of infection every shift for skin tear the order was scheduled for day, evening, and night shifts and was included on the day shift of 6/1/25. The review revealed staff had documented 9 on the day shift of 6/11, and on the evening shift on 6/15, staff had left the night shift on 6/12 blank. According to the TARs chart codes 9 = other/see progress notes. Review of Resident #1's progress notes showed on 6/11/25 at 2:41 p.m. nursing staff had documented wound care provided by wound care nurse in response to monitoring of steri-strips. The notes on 6/11, 6/12, and 6/13 did not reveal why the monitoring of the steri-strips had not been (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completed during the night shift on 6/12. The progress note on 6/15/25 at 3:48 p.m. revealed staff had not observed the steri-strips to Resident #1s left hand. Review of Resident #1's Fall Risk Evaluation, dated 6/6/25 revealed the resident had intermittent confusion, was chairbound, incontinent, and had a balance problem with standing. Review of Resident #1's care plan showed the resident was at risk for skin breakdown related to needs assistance with bed mobility and repositioning, nutritional risk, 5/5/25 posterior hand skin tear, and 6/9/25 right lower extremity skin tears. The interventions included but not limited to:monitor steri strips to left hand for signs and symptoms of infection, assigned to licensed nursesobserve resident's skin condition during routine care every shift and report any findings to nurse, assigned to Certified Nursing Assistant(s) (CNAs).Treatments as ordered, assigned to licensed nursing staffWeekly skin checks, assigned to licensed nursing staff. The intervention did not instruct staff to only look for new areas. An interview was conducted on 2/25/26 at 11:04 a.m. with Staff E, Restorative CNA. The staff member reported working with the nurses regarding wound care. If a dressing was not dated correctly would get the nurse, if it was dirty and coming off would let the nurse know and they come in with me. 2.On 2/25/26 at 9:37 a.m. an observation was conducted with Staff F, Licensed Practical Nurse/Unit Manager (LPN/UM) of Resident #6's left wrist dressing. The staff member stated the dressing change was every other day. The dressing was dated 2/23(/26). Review of Resident #6's Treatment Administration Record (TAR) showed an order started on 2/13/26 and scheduled for evening shift for Treatment: cleanse left wrist with normal saline (NS) and apply xeroform and dry sterile dressing (dsd) every (q) day until resolved every evening shift for skin tear treatment. The order was completed on 2/13 - 2/18/25 and discontinued on 2/19/25 at 5:32 p.m. The documentation for 2/19 was blank. Review of Resident #6's TAR revealed an order started on 2/20 and scheduled for the day shift for Treatment: cleanse left wrist with normal saline (NS) and apply xeroform and dry sterile dressing (dsd) every (q) day until resolved every day shift for skin tear treatment. The order was completed and discontinued on 2/20/26. Review of Resident #6's TAR showed the treatment to Resident #6s left wrist was not completed on 2/19/26. The TAR revealed the treatment to the resident's left wrist continued every other day with dressing changes completed on 2/21, 2/23, and 2/25/26. Review of Resident #6's Weekly skin inspections, dated 2/14 and 2/21/26 revealed the resident's skin was intact. Review of Resident #6's care plan showed the resident had a potential for skin impairment related to (r/t) decreased mobility, impaired cognition, incontinence, and on 2/16/26 a left wrist skin tear. The interventions showed licensed nursing staff were to provide treatments as ordered but did not include if the resident was to receive weekly skin evaluations. During an interview on 2/25/26 at 3:15 p.m. the Director of Nursing stated the weekly skin check should say skin was not intact and hopefully nurses weren't putting a dressing on a resolved wound, had told staff not to but some nurses want the wound nurse to discontinue the treatment. 3.On 2/25/26 at 9:29 a.m. an observation was conducted with Staff F, LPN/UM of Resident #5's dressing on right wrist. The dressing was dated 2/24/26 and the resident stated they change it frequently. The staff member stated the dressing changes were every other day. Review of Resident #5's summary for provider note, dated 2/19/26 at 4:47 p.m. showed the Assistant Director of Nursing had received an order from the primary care physician for wound care follow up, cleanse with normal saline (n/s), pat dry, apply xeroform, and dry dressing x 4 days. Review of Resident #5's Treatment Administration Record (TAR) revealed the following: skin tear to right fore arm outer aspect cleanse woth [sic] n/s pat dry apply xero form, and boarder fome [sic] x 4 days in the evening for skin tear.The TAR showed the order started on 2/19/26 and the resident had received dressing changes daily for 6 days (2/24/26) and as of 2/25/26 at 5:42 p.m. the treatment did not have an end date. Review of Resident #5's electronic (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	clinical record showed Weekly Skin Inspection: 2 days overdue - 2/23/2026. The notification was a red-colored banner showing the next assessment due. The review showed the last completed weekly skin inspection was done on 2/16/26, nine days prior to the review on 2/25/26. Review of Resident #5's care plan revealed the resident had a Potential for skin breakdown related to episodes of incontinence, history of skin breakdown, needs assistance with bed mobility & repositioning, nutritional risk, 2/20/26 skin tear to right forearm outer aspect, and 2/23/26 excoriation/moisture associated skin damage (MASD) to buttock. The interventions included but not limited to weekly skin checks assigned to licensed nursing staff. During an interview on 2/25/26 at 3:08 p.m. the Director of Nursing stated the weekly skin checks for Resident #5 were going to be scheduled differently because the resident had recently moved from the 100 to 200 hall. The DON acknowledged the record showed the weekly skin check was from Monday and was 2 days overdue. Review of the policy - Wound Treatment Management, revised 5/2025, revealed To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. The policy explanation and compliance guidelines included but not limited to:1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change.3. Dressing changes may be provided outside the frequency parameters in certain situations: a. Feces has seeped underneath the dressing. b. The dressing has dislodged. c. The dressing is soiled otherwise, or as wet.7. Treatments will be documented on the treatment administration record or in the electronic health record.8. The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include: a. Lack of progression towards healing. b. Changes in the characteristics of the wound (see above).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to ensure medications were stored securely and not accessible by unauthorized staff, visitors, and residents related to:1. medications left unattended on a medication cart on two (300/400) of three units; 2. medications left unattended in a resident's room for one resident (#7) who was not assessed to self-administer medications out of one resident sampled for self administration of medications.Findings included: 1. An observation on 2/25/26 at 8:05 a.m. showed a bag of Vancomycin 1 gram/200 milliliter (mL) sitting on top of an unattended medication cart parked outside of residents rooms on the 400 hall. The observation showed Staff A, Registered Nurse (RN) was in a resident room on the 300 hall. The staff member returned to the medication cart and reported the medication should not have been left on top of the cart. During an interview on 2/26/26 at 2:09 p.m. the Director of Nursing stated medications should not be left unattended on the carts. 2. On 2/25/2026 at 7:10am Resident #7 was observed with a medication at bedside. Staff G, Registered Nurse (RN) walked into Resident #7's room and abruptly went to the medications at Resident #7's bedside to administer the remaining medication to the resident. Resident #7 stated the medication had been at their bedside for at least 30 minutes and said the staff always leaves their medications at bedside for the resident to be able to take at a later time. Staff G, RN made no comment on the occurrence at hand and took the empty medication cup after the resident finished taking their medication. A review of Resident #7's admission record revealed an admission date of 2/11/2026 with diagnoses to include fracture of unspecified part of neck of left femur, subsequent encounter for closed fracture with routine healing, pain in left hip, hypertensive urgency, other specified anxiety disorders, and major depressive disorder, recurrent, moderate. A review of Resident #7's Quarterly Minimum Data Set (MDS) assessment, dated 2/18/26, in section C - cognitive patterns revealed a Brief Interview Mental Score (BIMS) of 15, indicating Resident #7 was cognitively intact. In Section N- Medications revealed that Resident #7 is taking antianxiety, antidepressant, anticoagulant, opioids, and antiplatelet medications. A review of Resident #7's orders revealed the following: Buproplon HCl Oral Tablet 100 milligram (MG): 1 Tablet by mouth one time a day for depression Busprione HCl Oral Tablet 5 MG: 1 Tablet by mouth one time a day for anxiety Levotheyroxine Sodium Oral Tablet 88 MCG: 1 Tablet by mouth one time a day for Hypothyroidism (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Lisinopril Oral Tablet 5 MG: 1 Tablet by mouth one time a day for Hypertension Pravastatin Sodium Oral Tablet 40 MG: 1 Tablet by mouth one time a day for Hyperlipidemia Wallbutrin SR Oral Tablet Extended Release 12 Hour: 1 Tablet by mouth one time a day for depression/anxiety A review of Resident #7's progress notes revealed the following no indication of resident requesting to take medications at a later time or advisory to the physician and family. A review of Resident 7#'s Care Plan revealed no behavior related to Resident #7 having a tendency to want to take medications at a later time than what is prescribed or wanting to hold medications. On 2/25/26 at 11:12am, an interview with Staff H, RN revealed no medications should ever be left unattended with a resident, and the protocol is to stay with the resident till they take all of their medications. If a resident requests to take their medication at a later time, then the process is to take back the medications and hold them with the resident's medication label attached to the medication up till the resident is ready to take the medication. Staff H, RN stated if medications are late, the physician is to be notified. On 2/25/26 at 2:45pm an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) revealed it is not the expectation for medications to be left at residents' bedside at any time unattended by staff. The DON explained the process is for the resident's medication to be removed and for the medication cup to be labeled with the [NAME] pack so it is identifiable, then to attempt the resident at a later time with the medications with the physicians 'OK' and orders. A review of the facility's Medication Administration policy revealed the following: Observe resident consumption of medication. Review of the policy – Medication Storage, revised 5/2025 showed It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/ or medication rooms according to the manufacturers recommendations insufficient to ensure proper sanitation, temperature, light, then relation, moisture control, segregation, and security. The General guidelines included: a. All drugs and biologicals will be stored in compartments (i.e. Medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. c. During a medication pass, medications must be under direct observation of the person administering medications or locked in the medication storage area/ cart. (Photographic evidence obtained)

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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. Based on interviews and record review, the facility failed to maintain medical records with accurate documentation for one resident (#4) of three residents reviewed for incontinence care. Findings include:A review of Resident #4's admission record revealed an initial admission date of 8/7/25, with diagnoses to include need for assistance with personal care, difficulty in walking, speech and language deficits following unspecified cerebrovascular disease, and major depressive disorder, recurrent, moderate.A review of Resident #4's Quarterly Minimum Data Set (MDS) assessment, dated 5/22/25 in Section C - cognitive patterns revealed a Brief Interview Mental Score (BIMS) of 9, indicating moderately impaired cognition.A review of Resident #4's Bowel and Bladder tasks revealed incontinent care was not provided on 8/28/25 for the 3-11 shift, 9/8/25 for the 7-3 shift, 9/11/25 for the 11-7 shift, 9/12/25 for the 3-11 shift, 9/30/25 for the 11-7 shift, and 10/5/25 for the 3-11 shift for Resident #4.On 2/25/26 at 2:45 p.m. an interview with the Director of Nursing (DON) revealed none of the resident's bowel and bladder tasks should be blank, and staff should notate No bowel or bladder movement if there is no care needing to be provided. The DON expressed for the end of every shift, every task for residents should be documented on by care staff.A review of the facility's CNA Job Description revealed the following: Preserves residents' dignity, honors resident's rights, provides good customer service, communicates appropriately, and adheres to federal and state compliance regulations. Comply with all applicable rules, policies, standards and guidelines related to employments with Westminster Services and its communities. Practice infection prevention and control measures in compliance with Federal, State and facility requirements. Make routine and frequent rounds to ensure those safety precautions/equipment are in place and in working order. Avoid development of skin problems or skin breakdown by providing timely incontinent care and frequent repositioning of residents that need assistance.Review of the policy - Documentation in Medical Record, revised 6/2025, revealed Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the residents progress through complete, accurate, and timely documentation.1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the residence medical record in accordance with state law and facility policy.2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred.4. Principles of documentation include, but are not limited to: a. Documentation shall be factual, objective, and resident centered. i. False information shall not be documented.ii. Record descriptive and objective information based on first-hand now edge of the assessment, observation, or service provided.b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the residence care and/ or responses to care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105926	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Suncoast	1095 Pinellas Point Dr S Saint Petersburg, FL 33705

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews the facility failed to implement an effective infection control program related to ensuring staff members donned appropriate Personal Protective Equipment (PPE) to prevent the transmission of communicable conditions for two (#9 and #10) of five residents with physician orders for contact precautions.On 2/25/26 at 7:39 a.m. an observation showed Staff C, Certified Nursing Assistant CNA) dressed in wine-colored scrubs standing in front of Resident #9 (sitting in wheelchair) and speaking with the resident. The staff member left the room. Staff B, Licensed Practical Nurse (LPN) confirmed a Contact Precautions sign was posted on the resident's door and no Personal Protective Equipment (PPE) was available at the doorway. Review of the Contact Precaution sign posted on Resident #9's door Instructed, STOP CONTACT PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. The sign was from the United States (U.S.) Department of Health and Human Services - Centers for Disease Control and Prevention (CDC). An interview was conducted on 2/25/26 at 7:49 a.m. with Staff C. The staff member stated Resident #9 did not have any precautions. Staff B stated the facility was attempting to obtain a stool sample for Clostridium difficile (C. diff) due to the resident having loose stools. On 2/25/26 at 7:51 a.m. an observation was conducted with Staff B and Staff C of the sign posted on Resident #9's door. Staff C observed the sign and stated PPE was required when giving care to the resident and confirmed being in the room without PPE. Review of Resident #9's admission Record showed the resident was admitted on [DATE]. The record revealed diagnoses not limited to multiple fractures of ribs left side subsequent encounter for fracture with routine healing, generalized muscle weakness, and unspecified convulsions. Review of Resident #9's active, as of 2/25/26 at 5:31 p.m., physician orders revealed an order dated 2/23/26 for Contact Isolation every shift for possible cdiff for 5 days. The order was to end on 2/28/26. An order dated 2/23/26 showed staff were to obtain stool for cdiff and ova and parasites (O & P) one time only for loose stool for 3 days. 2.On 2/25/26 at 10:51 a.m. an observation showed Staff D, Activity Assistant enter Resident #10's room without donning PPE and shut the door. The observation revealed a Contact Precaution sign was posted on the door and no PPE was available in the hallway directly outside the resident's room. The staff member left the room approximately one minute later. Staff D reported being educated on (transmission-based) precautions and PPE use. Staff D stated they should wear gloves, (face) mask, gown, and face shield for contact precautions. The staff member PPE was used when there are signs on the door so you know. The staff member read the sign posted on Resident #10's door and said it says soap and water. Review of the sign posted on Resident #10's door instructed STOP CONTACT PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. The sign included handwritten instructions for soap & water. The sign was from the United States (U.S.) Department of Health and Human Services - Centers for Disease Control and Prevention (CDC). Review of Resident #10's admission Record showed the resident was admitted on [DATE]. The record included diagnoses not limited to methicillin susceptible staphylococcus aureus infection as the cause of diseases classified elsewhere (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and hypertensive emergency. Review of Resident #10's active (as of 2/25/26 at 5:32 p.m.) physician orders revealed orders for:-Contact Isolation every shift for staph aureus to wound until 3/31/26 at 2:59 p.m., dated 2/19/26 and ending 3/31/26.-Enhanced Barrier Precautions related to (r/t) intravenous access and coude foley cath: staff to wear gloves and gown while performing high contact care activities. No isolation required, dated 2/24/26 with no end date. Review of the facility-provided list of residents with contact precautions orders showed a total of five residents including Resident #9 and Resident #10. The list showed contact precautions were implemented for Resident #9 for possible C.diff and Resident #10 for staph aureus to wound. Review of the Centers of Disease Control and Prevention (CDC) guidance Transmission-Based Precautions, Infection Control Basics, Healthcare Providers, dated April 3, 2024 revealed Transmission-Based Precautions Are the second tier of basic infection control in RTUB used in addition to standard precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission. The recommendation details instructed Use contact precautions for patients with known or suspected infections that represent an increased risk for contact transmission.Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patients environment. Donning PPE upon room entry and properly discarding before exiting the patient room has done to contain pathogens. Review of the CDC guidelines for Isolation Precautions: Appendix A, Healthcare Providers, dated February 7, 2025 (https://www.cdc.gov/infection-control/hcp/isolation-precautions/appendix-a-type-duration.html#C) revealed the types and duration of precautions:Clostridium difficile (See Gastroenteritis, C. difficile) - Type of Precaution: Contact + Standard for the Duration of illness. The guideline did not include additional precautions/comments for this condition.Gastroenteritis - Type of precaution: Standard. Precaution/Comments: Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks for gastroenteritis caused by all the agents below. Gastroenteritis - C. difficle: Discontinue antibiotics if appropriate. Do not share electronic thermometers; [853, 854] ensure consistent environmental cleaning and disinfection. Hypochlorite solutions may be required for cleaning if transmission continues [847]. Handwashing with soap and water preferred because of the absence of sporicidal activity of alcohol in waterless antiseptic handrubs [983]. The guideline did not include directives related to methicillin susceptible staphylococcus aureus (MSSA infection). Review of the policy - Infection Prevention and Control Program, revised 11/20/25, revealed This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards in guidelines.The policy explanation and compliance guidelines included:2. All staff are responsible for following all policies and procedures related to the program.4. Standard Precautions: All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE.5. Isolation Protocol (Transmission-Based Precautions):a. A resident with an infection or a communicable disease shall be placed on transmission based precautions as recommended by current CDC guidelines. Review of the policy - Transmission-Based (Isolation) Precautions, revised 6/2025, revealed It is our policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogens modes of transmission. For training and quick referencing purposes, a summary of precautions is contained at the end of this policy.The policy defined contact precautions as Refer to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment.1. Facility staff will (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	apply transmission based precautions coming in addition to standard precautions, to residents who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission.Contact precautions:a. Intended to prevent transmission of pathogens that are spread by direct or indirect contact with the resident or the resident's environment.c. Healthcare personnel caring for residents on contact precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment.d. Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination (e.g. vancomycin-resistant enterococcus (VRE), C.difficile, noroviruses, and other intestinal tract pathogens, (and) respiratory syncytial virus (RSV)). The recommendations for PPE related to contact precautions included: Gloves: Whenever touching the patients intact skin or surfaces in articles in close proximity to the patient (e.g. medical equipment, bed rails). Done gloves upon entry into the room or cubicle. Gowns: Whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental services or equipment in close proximity to the patient. Down gown upon entry into the room or cubicle.The policy showed type and duration of transmission-based precautions for selected infections and conditions related to Clostridioides difficile was contact precautions for the duration of illness with hand hygiene with soap and water. The selected infections and conditions did not include TBP directives for methicillin susceptible staphylococcus aureus (MSSA infection).