STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106030	A. Building B. Wing	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Point Pleasant	1533 4th Ave W Bradenton, FL 34205

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to implement timely their Abuse, Neglect and Exploitation policy and procedure related to reporting alleged abuse and neglect incidents for three residents (#1, #2, and #3) of three sampled for Abuse and Neglect. Findings included: 1. A review of the facility's Abuse Log showed Resident #1 had an incident, date notified of allegation was on 05/15/2025, reported to DCF (Department of Children and Families) on 05/15/2025. The incident was documented as Yes to being substantiated, and Yes it was an adverse related to Resident #1 did not receive medications for two days, which was communicated immediately to the Abuse Coordinator on 05/10/25, the date the event started. A review of Resident #1's admission Record documented an admission to the facility on [DATE]. Review of a progress note dated 05/08/2025 showed Resident #1 was transferred to a local hospital on [DATE] at 1312 (1:12 p.m.), for an evaluation and subsequently returned on 05/08/2025 at approximately 2000 (8 p.m.) The resident was transferred back to the hospital again on 05/10/2025. Her diagnoses list included but not limited to: Metabolic encephalopathy; Type 2 Diabetes mellitus without complication; dysphagia; cognitive communication deficit; difficulty in walking; cardiomegaly; elevated white blood cell count; anemia; polyneuropathy and severe chronic kidney disease stage 4. On 06/10/2025 at 1:27 p.m. an interview was conducted with the Nursing Home Administrator (NHA). The NHA stated the Interim Director of Nursing (IDON) became aware of the allegation when the Nurse Practitioner (NP) voiced a concern about Resident #1 not receiving her medications on 05/15/2025. The NHA stated, the IDON reported this to her that day at 1:46 p.m. The NHA said, I reported to DCF on 05/15/2025 at 2:06 p.m. For the investigation, we went back to look at the medical records to determine what happened when she left the building, what medications were ordered, and discussed with the NP her concern with the change in condition for the resident's trip to the hospital on 05/10. The NHA stated there were issues with documentation and their process for placing medications on hold was not followed. 2. A review of the facility's Abuse Log showed Resident # 2 had an incident, date notified of allegation was 06/01/2025 and DCF was notified on 06/03/2025. Incident was documented as not substantiated related to Resident #2's family member voiced an allegation of neglect on 06/01/25 at approximately 2:00 or 3:00 p.m. (continued on next page)

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
	106030	A. Building B. Wing	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Point Pleasant	1533 4th Ave W Bradenton, FL 34205

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #2's clinical record, the minimum data set, Significant Change assessment dated [DATE], documented an admission of 01/24/2025. Her diagnoses list included but not limited to: Anemia, atrial Fibrillation, Coronary Artery Disease, and heart failure. An interview was conducted on 06/10/2025 at 12:03 p.m. with the NHA. The NHA stated the allegation for Resident #2 was that the resident was not given medication when she had a high blood pressure. The NHA said, I received the allegation by way of a text on 06/01/2025 at approximately 2:00 p.m. or 3:00 p.m. Resident #2's family member reported the resident's blood pressure was high, a reading of 186, and he was concerned the nurse was not going to do anything. The NHA said, Yes, he used the word neglect. A review of the reportable event submitted by the NHA reflected the NHA reported online to the DCF the allegation of neglect on 06/03/2025 at 5:00 p.m. The NHA confirmed she was the abuse coordinator. She stated the expectation was to report immediately which means within 2 hours but, no later than 24 hours. The NHA confirmed the allegation for Resident #2 was reported late. 3. A review of the facility's Abuse Log showed Resident #3 had an incident, date notified 06/05/2025. DCF was notified on 06/08/2025. The incident was documented as in progress. The review showed the resident self-reported an allegation on 06/06/2025 at approximately at 7p.m. Documentation revealed the allegation was not reported until 06/08/2025 at 4:02 p.m. with the facility not implementing protection for the resident. A review of Resident #3's admission Record documented an admission of 06/05/2025. Her diagnoses list included but not limited to displaced communicated fracture of shaft of humerus, right arm, subsequent encounter for fracture with routine healing, repeated falls, difficulty in walking and unspecified atrial fibrillation. An interview was conducted on 06/10/2025 at approximately 11:45 a.m. with the NHA regarding Resident #3. The NHA stated, Resident #3 was admitted on [DATE]. The allegation was the resident did not get any pain medication until the next day. The NHA stated Resident #3 reported the allegation to her on 06/06/2025. The NHA stated the resident was not satisfied with the care up to that point and the pain was not being addressed with the medication she was taking. The NHA stated she spoke to Staff A, Licensed Practical Nurse (LPN) who reported he had worked on a Percocet prescription for Resident #3. Staff A, LPN reported Resident #3 came from the hospital with orders for the Percocet. The NHA stated the prescription did not come with her from the hospital and the provider wrote a new prescription which was not sent to the pharmacy due to a fax machine issue. The NHA reported she had asked for the medication at 8:00 a.m., and it was around noon that the staff could retrieve it from the Emergency Drug kit. The NHA stated the reportable event was a work in progress and she had not had a chance to speak with Staff B, Registered Nurse (RN) who was the admitting nurse. The NHA stated, No, I have not had the chance to talk to her. I do not know if she worked in the days after the 06/05/2025 shift. A review of the reportable event submitted by the NHA, reflected that she had reported online DCF the allegation of neglect on 06/08/2025 at 4:02 p.m., which was more than 24 hours after she had received the allegation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106030	A. Building B. Wing	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Point Pleasant	1533 4th Ave W Bradenton, FL 34205

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 06/10/2025 at 4:23 p.m. with Staff C, LPN. while reviewing Resident #3's clinical chart. Staff C, LPN confirmed she had worked on 05/10/2025 and Resident #1 was running a temperature. Staff C stated she called the NP who gave orders for Augmentin confirmed at 8:50 p.m. Staff C stated she found out Resident's #1 medications had been placed on Hold. Staff C stated Resident #1's family member was at the facility and was upset about the medications being on Hold. Staff C said, I was not going to tell the [family member] the medications that were not given to the resident for the last couple of days. Staff C stated she notified the NP. She reported the NP stated, Nobody ever puts medications on hold. If there was an issue, then the DON (Director of Nursing) needs to be notified. A review of the facility Abuse, Neglect and Exploitation policy and procedure, last reviewed/ revised 05/2025, documented the policy: it is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Included in the definitions: Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Policy Explanation and Compliance Guidelines: .2. The facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law. 3. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written. In section VI. Protection of Resident: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation. B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed. C. Increased supervision of the alleged victim and residents. D. Room or staffing changes, if necessary to protect the resident(s) from the alleged perpetrator. E. Protection from retaliation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106030	A. Building B. Wing	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Point Pleasant	1533 4th Ave W Bradenton, FL 34205

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In section VII. Reporting/ Response: A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specific time frames: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.