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	08/14/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to formulate an advance directive and did not ensure a current copy was in the resident's medical record for one resident (#45) of twenty-six residents sampled.Findings included: Review of the admission record revealed Resident #45 was admitted to the facility on [DATE]. Review of the advanced directives revealed the resident was a FULL CODE status and did not have documentation for the designated POA (Power of Attorney) and the primary decision-maker for care. Review of an admission MDS (Minimum Data Set) assessment, dated 7/17/2025, revealed Resident #45 had a Brief Interview for Mental Status (BIMS) assessment that was not scored, but revealed short-term (ST)/long-term (LT) memory problems with Severely Impaired Decision-Making Skills. An interview was conducted with Staff G, a social worker, on 08/12/2025 at 2:50 p.m. She reviewed the social assessment form that was completed for Resident #45. The form was completed by the resident's spouse on July 14, 2025. The documentation revealed that the spouse has a Power of Attorney (POA) document, and that they would provide the facility with a copy of the POA documentation. Staff G could not find the POA documentation or any evidence that the resident's spouse had been contacted any further to provide the document.An interview was conducted with the social services director, Staff H, on 08/13/2025 at 9:00 a.m. When asked about Resident #45's advanced directive, Staff H attempted to find the information in the electronic medical record. She confirmed that Resident #45 did not have a POA in the record. She stated that the resident's spouse was the emergency contact and has been responsible for the resident's care. Staff H confirmed the spouse reported there was a POA, and that no one from the facility had reached out to get the POA documentation.A follow up interview was conducted with Staff G, social worker, on 08/14/2025 at 9:17 a.m. She stated that the social services office could not find any further documentation relating to the Advance Directive or the Power of Attorney. At 9:20 a.m., a follow up interview was conducted with Staff H. She stated that the resident's spouse was called during the survey period, and a voicemail was left on 08/13/25 at approximately 9:30 a.m. to request the POA documentation.A follow up interview was conducted with Resident #45's spouse at 11:01 a.m. The spouse confirmed they had discussed the Advanced Directive and the Power of Attorney documentation during the initial admission session. The spouse confirmed Staff H called on 08/13/2025 to inquire about the POA. The spouse notes that pictures of the POA were texted to the facility on the morning of 08/14/2025.A review of the facility policy and procedure titled Residents' Rights Regarding Treatment and Advanced Directives with a revision date of 6/2025, revealed: On admission, the facility will determine if the resident has executed an advanced directive, and if not, determine whether the resident would like to formulate an advanced directive. Should the resident have an advanced directive, copies will be made and placed on the chart as well as communicated with staff.

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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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to complete and update the Pre-admission Screening and Resident Reviews (PASARRs) for residents with qualifying mental health diagnoses for two residents (#3 and #10) of 6 residents reviewed for PASARRs. Findings included: Review of the admission record showed Resident #10 was admitted to the facility on [DATE] with a primary diagnosis of dementia on – 4/14/23 and secondary diagnoses with onset dates, mood disorder - 4/14/23, depression - 4/14/23 irritability and anger - 4/14/23 bipolar - 4/14/23 anxiety - 4/14/23 and failure to thrive - 4/14/23. Review of a level I PASARR for Resident #10 dated 5/28/24 revealed all the qualifying diagnoses were not checked. The review showed the Level I PASARR was incomplete, and a level II was not submitted for consideration following qualifying diagnoses. Review of the admission record showed Resident #3 was admitted to the facility on [DATE] with a primary diagnosis of cerebral infarction on – 2/19/25 and secondary diagnoses with onset dates, depression – 2/19/25 dementia – 2/15/25 psychotic disorder - 2/15/25. Review of level I PASARR for Resident #3 dated 5/28/24 revealed the qualifying diagnoses were not checked. The review showed the Level I PASARR was incomplete, and a level II was not submitted for consideration following qualifying diagnoses. An interview was conducted on 8/13/25 at 08:42 a.m. with Staff H, Social Services Director (SSD). After reviewing Resident #10's Level I PASARR, Staff H stated, “If I had reviewed the PASARR, I would have referred the resident for a Level II.” An interview was conducted on 8/13/25 at 11:55 a.m. with Staff H. After reviewing Resident #3's Level I PASARR, Staff H stated, “I should have triggered a level 2.” Review of an unsigned policy dated 5/2025 titled, Resident Assessment-Coordination with PASARR Program, showed the facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. (continued on next page)

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F 0676 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 observations, record review and interviews, the facility failed ensure timely assistance with Activities of Daily Living (ADLs) consistent with the assessed and care planned toileting needs for one resident (#48) of three residents sampled.Findings included: On 8/12/ 2025 at 11:30 a.m., Resident #48 was observed lying down in bed, with no signs of distress. The resident reported concerns with his care because a couple of days ago he was placed on a bed pan and left on it for approximately 45 minutes. An interview was conducted on 08/13/2025 at 2:36 p.m. with Resident #48 stating having had to wait about two hours to receive assistance after being placed on the bed pan. He said Staff T, certified Nursing Assistant (CNA) came to his room around 8:00 a.m. and told the resident she was not able to assist him because she could not find his bed pan and she had to go to the dining room. He said he waited for about 15 minutes then he put his call light back on. Another unidentified CNA answered the call light, but she told him she was not qualified to assist him with the bed pan. Resident #48 stated the nurse came to his room and looked everywhere and they were not able to find a bed pan for him. The resident confirmed not receiving toileting assistance and being placed on the bed pan until 10:00 a.m. Resident #48 waited approximately two hours to receive toileting assistance. Review of Resident # 48 admission record dated 08/14/2025 revealed he was admitted to the facility on [DATE] with diagnoses to include but not limited to encounter for orthopedic aftercare following surgical amputation, acquired Absence of left leg below knee, type 2 diabetes mellitus with hyperglycemia.Review of a Minimum Data Set (MDS) dated [DATE] revealed Resident #48 had a Brief Interview Mental Status (BIMS) score of 15 which indicated intact cognitive abilities.On 08/13/2025 at 3:00 p.m., an interview was conducted with Staff T, CNA. Staff T said she went to Resident #48's room around 8:05 a.m., but she was not able to assist him when he asked her to put him on the bed pan because she had to assist in the dining room. She stated she looked around his room but was not able to find his bed pan. She said she offered to transfer him on the toilet, but he told her he was not comfortable with her transferring him. Staff T stated the facility process is whenever they are assigned to the dining room they have to go, and they cannot leave the dining room until dining is finished. Staff T said while she was in the dining room someone came to tell her Resident #48 still needed to go to the bathroom. She said she told the person she could not leave the dining room. Staff T stated she was able to assist Resident #48 on the bed pan at 10:00 a.m.On 08/13/2025 at 5:30 p.m., an interview was conducted with Staff U, Registered Nurse, RN. Staff U said at approximately 8:30 a.m., Resident #48 told her he asked Staff T, CNA if she could assist him on the bedpan. Staff U stated the resident told him she could not assist him because she was not able to find his bed pan, and she had to assist in the dining room. Staff U, RN said she went to the dining room to ask Staff T if Resident #48 asked her to assist him on the bed pan. She stated Staff T replied, Yes, she told Resident #48 she could not find his bed pan, and she had to assist in the dining room. Staff U said whenever someone is assigned to the dining room they have to go. Staff U, RN said she looked all around Resident #48 room, but she was not able to find his bed pan. Staff U stated, I think someone threw the bed pan in the trash. Staff U said she asked her supervisor to ask if she can bring her a new bed pan for Resident #48 around 9:16 a.m. She stated the supervisor brought the bed pan up to the unit around 9:30 a.m. Staff U said she placed the bed pan in the resident's room and left the room to tell the CNA Resident #48 had a bed pan now and was ready to be assisted. Staff U said there was another CNA on the floor that answered Resident #48's call light, but she did not feel comfortable assisting Resident #48 by herself. Staff U confirmed Resident #48 did not receive timely assistance with toileting due to the bedpan not being found and the CNA having to assist in the dining room.On 08/13/2025 at 5:54 p.m., an interview was conducted with Staff Q, License Practical Nurse (LPN)/ Interim Assistant Director of Nurses (ADON). Staff Q confirmed receiving a text message from Staff U at approximately 9:16 a.m., asking her if she can bring her a bariatric bed pan. Staff U said she went to central supply and brought the bed pan up to Staff U at approximately 9:30 a.m. Staff Q, ADON said she was not aware Resident #48 had to wait so long to be put on the bed pan. Staff Q , ADON stated if an aide has to report to the dining room, then the other aide covering the floor should have assisted the resident with the help of the nurse.On 8/13/2025 at 5:58 pm. an interview was conducted with the Director of Nurses, DON. The DON said the first issue was that the staff did not provide Resident #48 with toileting as requested. The DON stated the second CNA, and the nurse could have assisted Resident #48 on the bed pan while the other aide was in the dining room. The DON said If the aide is assigned to the dining room but

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide meal assistance for two residents (#39 and #45) of thirty-four sampled residents during two of three meal observations on 8/11/2025 and 8/13/2025. Findings included: 1.8/11/2025 at 12:30 p.m. Resident #39 was observed seated in the third-floor dining room at a table and with two other residents. By 12:34 p.m. the other two table mates were served and set up with their lunch meal tray. A staff member was observed to serve one of the three residents at the same table and sat down in a chair and proceeded to assist that resident with eating activities. Resident #39 was still observed at the table and had no meal tray in front of her. The other two were eating as Resident #39 watched. Resident #39 was observed to fall asleep twice but would open her eyes from time to time and looked at her table mates. Resident #39 was not interviewable and would not be able to answer questions related to her medical care and day’s activities. At 12:50 p.m. a staff member then placed an uncovered meal tray in front of Resident #39 and walked away. The other two residents at the table were still eating or being assisted with eating from a staff member. Resident #39 sat at the table with her meal tray in front of her and was not able to self-feed and required eating assistance from staff. At 1:08 p.m., Staff B, Registered Nurse (RN) walked into the dining room and looked around and then grabbed a chair and sat next to Resident #39 and began to assist her with eating. She brought a loaded fork of bites of food items to the resident’s mouth, and the resident accepted the food. Resident #39 sat at a table with no food in front of her while other table mates ate for 24 minutes, from 12:34 p.m. to 12:50 p.m. and then waited 18 minutes with her meal tray placed in front of her with no staff assistance from 12:50 p.m. through to 1:08 p.m. Resident #39 waited a total of 42 minutes at the table while others at the table were eating, and she was not able to eat at the same time. On 8/11/2025 at 12:58 p.m. an interview with Staff B,RN who sat down and assisted the resident with eating, revealed she had just walked into the room to take over for Staff A, Licensed Practical Nurse (LPN)/Supervisor who had to leave the room. Staff B confirmed when she came into the room she noticed Resident #39 had her uncovered meal tray placed in front of her and others at the table were already eating. Staff B stated she was not sure why Resident #39 was not assisted with her meal at the same time as her table mates. Staff B, RN confirmed Resident #39 should not have waited that long to be served and assisted with her meal. On 8/12/2025 an interview with Staff A, LPN revealed he was in the dining room the day before on 8/11/2025 during the lunch meal service and he was overseeing the lunch meal service in the dining room. He confirmed he had sufficient staff to serve and assist with meals, and he had sat down to assist a resident with eating. He confirmed about halfway to the end of the meal service, he had to leave the dining room, and another nurse, Staff B came in the room to supervise. He confirmed he had seen Resident #39 at a table with other table mate’s, and he saw that she was continuing to nod off and had her meal tray in front of her. He confirmed Resident #39 does required eating assistance from staff and he had just missed her and was not able to get to her timely. He confirmed she should not have sat with her meal placed in front of her for a long period of time while others at the table were eating and being assisted with eating. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #39’s medical record revealed she was admitted to the facility on [DATE] with diagnoses to include but not limited to: Dementia, Senile Degeneration of the brain, Adult failure to thrive, Weakness, Mood disorder, Anxiety, History of falls, Depression. Review of the current Physician’s Orders dated August 2025 revealed Resident #39 received a regular diet, regular texture, regular thin liquid (order date 9/8/2023). Review of a Significant Change Minimum Data Set (MDS) assessment dated [DATE], revealed the following- Cognition: Brief Interview Mental Status (BIMS) score – Not scored. The MDS revealed the resident had short term and long-term memory problems with severely impaired decision-making skills and required substantial/maximal assistance with eating. Review of the nurses progress notes dated 6/1/2025 through to current 8/12/2025 revealed there were no notes to indicated behaviors of refusing meals, refusing meal assistance. Review of the Therapy screen assessment dated [DATE] revealed; Resident screened in dining room. Resident has food in front of her, however, not awake. Aides demonstrated good understanding of not feeding her when she is not alert. Oral care attempted. No reports of difficulty in chewing or swallowing when awake and alert. No further speech therapy at this time. Review of the current care plan with a next review date 9/19/2025 revealed a focus- Current Functional Performance with interventions to include but not limited to: – Limited assist/two-person physical assist with eating. Focus - Impaired communication related to: Cognitive loss, sometimes makes needs known, sometimes understands others, with interventions in place as reviewed. 2. On 08/11/2025 at approximately 12:25 p.m., Resident #45 was observed seated in the third-floor dining room. Resident #45 appeared slightly agitated and constantly moved the left leg. At 12:35 p.m., Resident #45 received a meal tray and did not attempt to eat any of the food. None of the staff were observed to approach the resident for ten minutes. Staff A, Licensed Practical Nurse (LPN)/Supervisor, began to feed Resident #45 after he was asked about the resident’s status. While assisting Resident #45, Staff A fed the resident several bites and then he would leave and assist other residents. Staff A left the dining area at 1:08 p.m., and he was replaced by Staff B, Registered Nurse (RN). She sat down and began to help another resident. Staff B did not assist Resident #45 with his meal any further. Resident #45 still had over half of the food left to finish on his plate at 1:10 p.m. The resident was not assisted for a total of 25 minutes during this observed mealtime. On 08/13/2025 at 9:15 a.m., an interview was conducted with Staff D, Certified Nursing Assistant (CNA). She stated that the resident needed hands-on care due to dementia. Staff D stated that the resident will self-feed but requires encouragement. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/13/2025 at 12:33 p.m. Resident #45 was observed in the third-floor dining room. The resident appeared slightly agitated with a bowl of soup and a disposable juice cup in front of him. He was seated at a table with one other resident. Resident #45 did not attempt to eat the soup. Staff E, Speech Therapist (ST), sat down next to the resident at 12:35 p.m. to assist the other resident. He did not encourage Resident #45 to eat or attempt to feed the resident. At 12:45 p.m., the resident received his tray of food. At 12:52 p.m., the resident reached for his soup spoon and then stopped. At 12:58 p.m., a CNA, Staff F, helped the resident bring the food to his mouth and help cut up his food. At 1:00 p.m., Staff F poured his juice into a glass, and the resident began to drink it. An interview was conducted with Staff F at this time. She stated Resident #45 did not need assistance with his meal, but he does need encouragement to eat. Staff F stated she was unsure about the resident’s care plan, but she was told he needed assistance by one of the therapists. During this observed mealtime, Resident #45 was not assisted for a total of 25 minutes during this observed mealtime. Review of the admission record revealed Resident #45’s diagnoses to include but not limited to: Other Pulmonary embolism without acute COR pulmonale, Aphasia and Dysphagia following cerebral infarction and Unspecified dementia, unspecified severity without behavioral disturbance. Review of the current Physician’s Order Sheet for Resident #45 dated July 2025, revealed related to diet, - No added sugar diet, regular texture, regular thin liquids consistency. (7/11/2025) and Malnourished per Mini Nutritional Assessment (MNA) score of 7, indicates malnourished from stress related to hospital stay. BMI is above 23. A diagnosis of Dementia, CVA, Aphasia, with Albumin level of 3.2 on 7/12/2025, and requires assistance to eat. Review of the current care plan with a next review date 10/11/2025, revealed a focus - Current Functional Performance with Interventions to include but not limited to: Eating – Limited assist/one-person physical assist. A secondary focus revealed Resident #45 has impaired mobility and self-care deficits, with interventions to include the use of task segmentation and verbal cues as needed to promote resident participation and completion of tasks. A review of the current Minimum Data Set (MDS) assessment for Resident #45 dated 7/17/2025, section GG revealed the resident needs assistance with eating – The ability to use utensils to bring food and/or liquid to the mouth- the resident needed supervision or touching assistance. Review of a Speech Therapy Discharge Summary with dates of service 7/14/2025 through 8/13/2025, revealed the resident required set up for meals, and encouragement to initiate self-eating meals. Most of the time, resident required someone to set the fork up for the first few bites, and place the fork in the resident’s hand, and then 50% of the time or greater the resident will continue self-feeding, but not all of the time. On 08/13/2025 at 1:09 p.m. an interview was conducted with Staff C, ST. She stated if she loaded the fork for the resident and used verbal cues, then Resident #45 will begin to feed himself. Staff C stated the verbal cues must be specific. She stated she was unsure about what requirements were listed in the resident’s care plan. Staff C took Staff F’s place in assisting Resident #45 at 1:15 p.m. Staff C began to encourage the resident to eat, and he began to eat more of his meal. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Staff A, LPN Supervisor, on 8/13/2025 at 1:17 p.m. He stated he wanted Resident #45 to feed himself as much as he could during the meals. He stated he was not sure about the required assistance that was listed in the care plan. When asked who was in charge in the dining room, Staff A stated that he was not in charge. Staff A reviewed Resident #45’s care plan and stated the aides should ask one of the nurses if they were unsure about the residents’ required care. Staff A stated the aides can also use their Kardex (a file that gives a brief overview of each patient), to review the resident’s nutrition care requirements. Staff A reviewed a copy of the Kardex, which showed Resident #45 required limited assistance/one-person physical assistance for eating. A follow-up interview was conducted with Staff C, ST, at 1:30 p.m. She confirmed the resident will often get distracted and may need to be helped during the meal. She stated once she cued Resident #45 to eat during lunch, he then continued to eat. She agreed that the resident should have been cued to eat his meal earlier. A telephone interview was conducted with Resident #45’s spouse on 08/13/2025 at 3:34 p.m. The spouse stated the resident gets distracted when eating. The spouse stated the resident can self-feed but will often lose train of thought. The resident is a slow eater and needs “management” during meals. The spouse stated this had been discussed with the staff. On 08/14/2025 at 9:40 a.m., an interview was conducted with Staff B, RN. She confirmed Resident #45 needs assistance with eating. Staff B said the resident will usually not self-initiate and will need someone to help get the meal started. She confirmed the aides should know the resident’s needs by reviewing the task bar in the record. Staff B stated that the kitchen staff oversees the food and knows the meal plans. She stated that the nurse present in the dining room is the supervisor of the aides and monitoring the residents. She stated the nurses will also assist with feeding residents if help is needed. An interview was conducted with the Director of Nursing (DON) on 08/14/2025 at 10:03 a.m. He stated the nurses and nursing aides can use the Kardex to find out the assistance needs for any resident in the dining room. He confirmed the nurses oversee the residents care in the dining room. Review of the facility policy titled, “Meal Supervision and Assistance” with a revision date of 5/2025 revealed the following under Compliance Guidelines section 4: -Assemble equipment and supplies needed. Do not serve the meal until the attendant is ready to assist the resident.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, record reviews, and interviews, the facility failed to ensure the medication error rate was less than 5%. Thirty-two medication opportunities were observed, and six errors were identified for Resident #29 resulting in an error rate of 18.75%.Findings included: On 8/11/25 at 10:45 a.m., Staff P, Registered Nurse (RN) was observed administering medications to Resident #29. Staff P, RN administered the following medications: Pregabalin 25 mg, Amlodipine 5 mg, Aspirin 81mg, Zoloft 50 mg, Potassium chloride ER 10 meq and Tamsulosin 0.4 mg. Following the medication administration observation, a review of Resident# 29's Medication Administration Record (MAR) revealed the Pregabalin, Amlodipine, Aspirin, Zoloft, Potassium Chloride, and Tamsulosin was scheduled to be administered at 9:00 a.m.On 8/13/25 during an interview Staff O, Licensed Practical Nurse (LPN), said nurses are allowed to administer medications between one hour before and one hour after the scheduled medication administration time. On 8/13/25 at 2:56 p.m. during an interview the Director of Nursing interview (DON) said medications are expected to be administered one hour before and one hour after the time the medication is scheduled. Review of the facility's policy titled Medication Administration, reviewed/revised date 7/2023 revealed the following: Policy- Medications are administered by licensed nurses . in accordance with professional standards of practice . Policy Explanation and Compliance Guidelines .11b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician.

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	106030	A. Building B. Wing	08/14/2025

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. (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	08/14/2025

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Westminster Point Pleasant	1533 4th Ave W Bradenton, FL 34205

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observations, staff interviews and facility record review, the facility failed to operate and maintain the dish washing machine per manufacturer's specifications related to the wash cycle not meeting temperature requirements for one machine of one dish washing machine observed. Findings included: During a kitchen tour on 8/11/2025 at 9:49 a.m., the Kitchen Manager indicated the facility operates a High temperature type dish washing machine and revealed the wash should reach at least 160 degrees Fahrenheit (F.) and a final rinse should reach 190 degrees F. He revealed all staff in the kitchen are trained on how to operate the machine and log temperatures. Review of the specification plate on the dish machine revealed the machine was operating as a high temperature dish washing machine and the wash temperature should reach 160 degrees F., and the Rinse temperature should reach 180 degrees F. The Kitchen Manager confirmed the machine's operations specificationsOn 8/11/2025 at 9:52 a.m., the Kitchen Manager and Staff K, Dining Services Technician, both confirmed they had been operating the machine for about ten to fifteen minutes and had already ran many crates of soiled dishes/eating utensils through the machine. The Kitchen Manager confirmed his staff had already primed the machine by running several empty crates through the machine to ensure appropriate wash and rinse temperatures were met.On 8/11/2025 at 9:56 a.m. Staff K was asked to run a crate of soiled dishes through the machine to show operation and temperature demonstration. He turned on and ran the machine through its wash cycle. The machine's wash analog temperature gauge reached a maximum temperature of 145-degrees F. before ending the wash cycle. The machine's analog rinse cycle temperature gauge read 195 degrees F. The Kitchen Manager confirmed both wash and rinse temperature and revealed the internal temperature of the machine is over 160 degrees F., and that is making the machine operate effectively. He confirmed the analog Wash temperature gauge would only reach 145 degrees F. The Kitchen Manager was asked how he was able to determine that, and he lifted the machine door and pointed downward into the machine. There was no thermometer in the inside of the machine. He closed the door and explained the heat booster is set to over 160 degrees F. and stated that was the temperature reaching the dishes that were running through the machine. The Kitchen Manager confirmed himself and his staff use the machine's analog wash and rinse temperature gauges on the topside of the machine, and he confirmed he goes by what the heating booster is set to. The Kitchen Manager was asked how he and his staff take temperatures of the dish machine operation during each meal service, and he only would say that the heating booster is set to 160 degrees F. and that the machine's outside service maintenance person will speak to that. During this observation, the wash temperature was fifteen degrees lower than the requirement.A second wash cycle revealed maximum temperature reached was 139 degrees F. and the rinse was 197 degrees F. It was found the wash cycle was not meeting the dish washing machines' specifications to reach at least 160 degrees F during the wash cycle and the temperature was twenty-one degrees lower than the requirement. During this tour, it was observed the previously washed dishes were not re-ran through the dish washing machine, nor were they properly cleaned though other cleaning/sanitizing methods. The Kitchen Manager revealed should the machine not run at proper specifications, he had other means of washing the dishes/utensils by way of three compartment sink cleaning and he could use paper and plastic. However, he was not observed to use these methods and his staff continued to utilize the dish washing machine to run soiled dishes through the dish machine's wash cycle readings were 139 degrees F.On 8/11/2025 at 3:50 p.m. a telephone interview was conducted with Staff N, an outsourced maintenance personnel. He revealed he received a complaint related to a possible wash temperature not reaching the machine's specifications. Staff N confirmed the machines specification plate was correct, revealing the machine operates at High temperature and that the wash cycle needs to reach at least 160 degrees F., and the Rinse cycle needs to reach at least 180 degrees F. Staff N revealed he had been to the facility and ran the machine. Staff N stated he found the wash cycle was not reaching at least 160 degrees F and stated he had to increase the temperature on the water heater booster for the machine, so the wash cycle can reach at least 160 degrees F. He revealed upon running the machine several times there was a thirty-degree deficit, and he needed to increase the booster to remove the deficit. Staff N explained another reason the machine was not reading the appropriate wash temperature was due to an internal side curtain not operating effectively and that he may need to replace it in the long term. Staff N confirmed staff needed to read the external analog wash and rinse temperature gauges to know what the cycle's temperature is at. He confirmed having the booster set to a certain degree does not mean the actual