

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER Westminster Baldwin Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2653 Lake Baldwin Lane Orlando, FL 32814	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview, and record review, the facility failed to provide assessment, and notification of physician for a symptomatic resident having chest pain after cardiac surgery, for one of one resident reviewed for hospitalizations, out of a total sample of 21 residents, (#20).Findings: Resident #20 was admitted to the facility from an acute care hospital on [DATE] following aortic heart valve repair surgery. She had diagnoses that included coronary artery disease (CAD), atrial fibrillation (A-Fib), pulmonary fibrosis, asthma, and generalized muscle weakness. Review of State Agency Form 3008 dated 10/29/25, revealed resident #20 was capable to make her own healthcare decisions and was transferred to the skilled care facility for continuation of care and rehabilitation services post aortic valve replacement. Review of resident #20's medical record revealed a care plan initiated on 10/30/25 for risk of cardiac complications related to diagnoses that included of A-Fib, CAD, arteriosclerotic heart disease, arrhythmia, and post cardioversion. The goal was for the resident to have no symptoms of acute cardiac event and interventions included monitoring vitals and observation of the resident for symptoms of cardiac complications, such as chest pain, abnormal pulse, and abnormal blood pressure. The care plan did not specify what staff needed to do if the resident displayed cardiac complications. On 1/21/26 at 12:17 PM, resident #20 stated, via phone interview, that she was admitted to the facility for rehabilitation services and skilled nursing care after cardiac surgery. She said she believed the facility was not appropriate for the level of care that she required. Resident #20 recalled on the early morning of 10/30/25 she was not feeling well, and her heart rate was elevated. She said she informed the nurse and when her vitals were taken her blood pressure and heart rate were elevated. She said the nurse told her they would wait to see if the blood pressure came down on its own, but the nurse did not seem concerned. She stated she contacted her cardiologist, who recommended she go to the emergency room right away, so she called emergency services (EMS) 911 and was transferred to the hospital. She said she preferred not to return to the facility. Review of resident #20's vitals summary dated 1/22/26, revealed on 10/29/25 at 7:41 PM, her blood pressure (BP) was 123/62, heart rate (HR) 72, and oxygen saturations (O2 sats) on room air was 94%. On 10/30/25 at 10:50 AM, her BP was 150/100, HR 133, and O2 sats at 7:20 AM were 91%. Signs of a failing heart valve replacement were usually similar to those experienced prior to receiving a new valve. Some of the most common signs included: chest pain or discomfort, fainting or lightheadedness, rapid heartbeats, and shortness of breath. It was recommended for patients to call 911 immediately as these could be signs of a medical emergency, (retrieved from www.healthline.com on 2/02/26). (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 106118
		If continuation sheet Page 1 of 5

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER Westminster Baldwin Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2653 Lake Baldwin Lane Orlando, FL 32814	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's medical record revealed there was no change of condition assessment documented or a nursing progress note to show the physician was notified, family was notified, and emergency services were called after the abnormal vital signs on 10/30/25. The facility was unable to provide any documentation regarding the event other than a baseline care plan and a handwritten order from the Advanced Practice Registered Nurse (APRN) dated 10/30/25, that indicated, sent to ER (emergency room) for evaluation of chest pain/hypertensive crisis. On 1/22/26 at 11:00 AM, the Director of Nursing (DON) stated resident #20 was evaluated by the nurse when she complained of chest pain and was transferred to the hospital immediately. She acknowledged there was no documentation to show an assessment was completed by the nurse or that the nurse notified the physician, family, and emergency services. She stated her expectation was for staff to recognize changes in condition and prevent delays in care. Review of the hospital records for resident #20 dated 10/31/25, revealed she arrived via EMS after she called them due to heart palpitations. The facility did not have a policy on changes in condition.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER Westminster Baldwin Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2653 Lake Baldwin Lane Orlando, FL 32814	
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain accurate and complete medical records for 2 of 5 residents reviewed for hospitalization, of a total sample 21 residents, (#7 and #20). Findings: Cross reference F684 1. Resident #7 was admitted to the facility on [DATE] with diagnosis including one-sided paralysis and weakness following stroke affecting left non-dominant side, , spontaneous hypotension, nerve pain and osteoporosis. A review of the resident's electronic medical record revealed a progress note dated 1/14/26 at 3:40 AM, indicating that the resident was found kneeling on her floor mat beside her bed. The resident stated she was trying to go to the bathroom, and she thought she could make it herself. The note detailed the resident had no injuries and noted neurological checks were initiated. Another progress note made later that day, on 1/14/26 at 11:54 AM, revealed the resident was transferred to the hospital in an ambulance. A review of resident #7's assessments revealed no change in condition or Situation, Background, Assessment, and Recommendation (SBAR) assessment present that documented the event leading up to the hospitalization on 1/14/26. On 1/22/26 at 9:53 AM, the Director of Nursing (DON) acknowledged there was no documentation in the resident's electronic medical record to describe the series of events that led up to the resident's transfer to the hospital on 1/14/26. The DON stated that the resident had an acute change of altered mental status with difficulty in her speech and was therefore transferred to the hospital. She confirmed there was no change in condition assessment, nor a progress note documented about the event until it was brought to their attention during the survey. The DON said her expectation was for the nursing staff to document a change in condition assessment or a SBAR assessment at the time of the event. The DON explained that the residents' medical record should tell a story and contain all of the information needed to tell the entire story. 2. Resident #20 was admitted to the facility from an acute care hospital on [DATE] following aortic heart valve repair surgery. She had diagnoses that included coronary artery disease (CAD), atrial fibrillation (A-Fib), pulmonary fibrosis, asthma, and generalized muscle weakness. Review of State Agency Form 3008 dated 10/29/25, revealed resident #20 was capable to make healthcare decisions and was transferred to the skilled care facility for continuation of care and rehabilitation services post aortic valve replacement. Review of resident #20's medical record revealed a baseline care plan dated 10/31/25 which stated, resident transferred to the ER (emergency room) 10/30/25, verbal consent given. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER Westminster Baldwin Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2653 Lake Baldwin Lane Orlando, FL 32814	
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physician orders in resident #20's electronic medical record revealed no orders to transfer the resident to the hospital ER. During the survey, on 1/21/26 a paper copy of an order was provided by the DON which had not been scanned into the system. The order, which was dated 10/30/25 and signed by the Advanced Practice Registered Nurse (APRN) stated, Sent to ER for evaluation of chest pain/hypertensive crisis. Resident #20's medical record revealed no skilled assessment, progress note, change of condition, or hospital transfer note that provided an explanation for the resident's change of condition. The medical record did not identify when the physician was made aware of resident #20's change in condition or whether family was notified of her transfer to the ER. On 1/22/26 at 11:00 AM, the DON acknowledged there was no documentation to show that an assessment was completed by the nurse or that the nurse notified the physician, family, and/or emergency services. She said the expectation was for staff to ensure documentation was accurate and complete. The facility policy, Documentation Policy last revised June 2025, indicated each resident's medical record should contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate and timely documentation.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER Westminster Baldwin Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2653 Lake Baldwin Lane Orlando, FL 32814	
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 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 observation, interview, and record review, the facility failed to adhere to proper infection control practices related to transmission-based precautions and personal protection equipment (PPE) use for 1 of 5 residents reviewed, of a total sample of 21 residents, (#4). Findings: Resident #4's was admitted to the facility on [DATE] with diagnoses including infection to the skin and subcutaneous tissue, methicillin resistant staphylococcus aureus (MRSA) infection, type 2 diabetes with nerve pain, bacteremia (bacteria in the blood), and chronic kidney disease stage 3A. Review of a physician consult from 12/29/25 revealed at the hospital prior to admission the resident's right ankle wound was cultured and tested positive for MRSA infection. Review of resident #4's physician orders revealed an order to maintain contact isolation for MRSA in the right foot which started on 12/24/25. MRSA is a type of staphylococcus bacteria that can be resistant to several antibiotics and can be spread through contact from one person to another. MRSA can live on hands and objects in the environment. Interventions like Contact Precautions aim at decreasing the transmission of the bacteria to other residents or staff. Based on the current evidence, CDC recommends the use of Contact Precautions for MRSA-colonized or infected patients, (retrieved from https://www.cdc.gov/mrsa/about/index.html on 1/23/26). On 1/21/26 at 7:54 AM, Registered Nurse (RN) A was observed at her medication cart outside resident #4's room. On the wall outside the resident room was a contact precaution sign and a plastic container with PPE. The sign outside the room stated that everyone must wear a gown and gloves before entering the resident room. RN A knocked and entered resident #4's room without donning gloves nor a gown. She then placed the resident's cup of medication down on top of his dresser which was located in the middle of the room. Resident #4 was seated in his wheelchair next to the dresser. RN A then walked back towards the door, applied hand sanitizer and then donned gloves. She then retrieved a gown from the plastic bin located on the outside of the room. After donning the gown, she returned to the medicine cup on top of the dresser and administered the medications to the resident. The nurse then disposed of the medicine cup and doffed PPE into a trashcan located by the residents door and exited the room. On 1/21/26 at 8:53 AM, RN A stated for residents on contact isolation, staff were required to don gloves and a gown before entering the room in order to prevent the spread of infection. She acknowledged she applied a gown and gloves after she had already entered resident #4's room and placed his medication cup on top of his dresser. She stated her hands were full so she needed to place the meds down before she could gown up. She acknowledged she should have applied the gown before entering the room. On 1/22/26 at 1:18 PM, while observing the location of the dresser in the residents room, the Director of Nursing (DON) acknowledged RN A should have been wearing a gown and gloves before entering the resident's room and placing the medication cup on top of his dresser. The facility policy titled Transmission-Based (Isolation) Precautions (TBP) revised June 2025 indicated it was the facility's policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogens' modes of transmission. TBP referred to the precautions implemented in addition to standard precautions that are based upon the means of transmission in order to prevent or control infections. Contact precautions referred to the 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.		