STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105757	A. BUILDING _____ B. WING _____	C 10/07/2021

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WESTMINSTER TOWERS	**70 WEST LUCERNE CIRCLE ORLANDO, FL 32801**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Recertification survey and Complaint Investigation #2021014022 were conducted from to . The complaint was not substantiated but Westminster Towers was not in compliance with 42 CFR 483 and 488, requirements for Long Term Care Facilities from the Recertification survey.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to accurately complete the Minimum Data Set (MDS) assessment regarding hospice services for 1 of 3 residents reviewed for hospice services, of a total sample of 35 residents, (#17). Findings: Resident #17 was admitted to the facility on and was readmitted on . Her diagnoses included , , and . A physician order dated revealed the resident was on hospice services for diagnosis of . Review of the resident's clinical records revealed documentation by hospice staff of visits made, and services provided for the residents from . Documentation in the	F 641	"This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law". F641 Resident #17 MDS assessment was immediately modified to reflect hospice services and re-submitted with corrections. Audit completed of all other residents with hospice services and their MDS assessments to ensure they reflected hospice. No other residents found to be affected. DON will assign MDS Coordinators training courses on accuracy of MDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/2021

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.

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F 641	Continued From page 1 resident's physical chart revealed the name, the team number, and contact information of the hospice provider for services rendered to resident #17. The admission MDS assessment with ARD [redacted] revealed the question in section J1400 prognosis: "Does the resident have a condition or [redacted] that may result in a life expectancy of less than 6 months?" was coded "0" meaning "No." Hospice care was not checked in Section O- Special treatments, procedures, and programs. On [redacted] at 2:10 PM, Registered Nurse (RN) MDS Coordinator D stated assessments were completed by doing a 7 day look [redacted], review of the resident's physician orders, medication administration record (MAR), observation of activities of daily living (ADLs) as needed, and interviews of resident/family /nurse as needed. The MDS Coordinator stated if the resident was on hospice services, hospice documentation, contract, and certification would be reviewed. The resident's admission MDS was reviewed with the MDS Coordinator. She stated that section J1400 should have been coded "2' meaning "yes", and hospice care should have been checked in section O. She acknowledged the assessment was not accurate. The facility's policy "MDS 3.0 Completion" revised [redacted] read, "According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity."	F 641	assessments. Director of Nursing and/or designee will perform weekly MDS audits for accuracy for 30 days. Auditing will then transition to Monthly x 30 days to ensure substantial compliance. Minimum review time 3 months total. Results to be reported to QAPI committee.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan	F 656		

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F 656	Continued From page 2 CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and , , needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and , , well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. ( )In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 656		

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F 656	Continued From page 3 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a person-centered care plan for hospice and ensure care plans reflected the goals of hospice services for 1 of 3 residents reviewed for hospice services, (#17); and failed to develop a person-centered care plan for [redacted] for 1 of 1 resident reviewed for [redacted], (#34), of a total sample of 35 residents. Findings: 1. Resident #17 was admitted to the facility on [redacted] and was readmitted on [redacted]. Her diagnoses included [redacted], and [redacted]. A physician order dated [redacted] revealed the resident was on hospice services for diagnosis of [redacted]. Review of the resident's clinical records revealed documentation by a hospice agency of visits made and services provided for the resident from [redacted] through [redacted]. Documentation in the resident's medical record revealed the name, the team number, and contact information of the hospice agency that provided services for resident #17.	F 656	F656 Resident #17 and #34 care plans were immediately reviewed and updated on [redacted]. Audit completed of all other residents with hospice services and [redacted] to ensure care plans reflected such, no other residents effected. Director of Nursing and/or designee provided education and training to MDS Coordinators / staff nurses on timely development of resident centered care plan. Care plans will be reviewed as changes occur daily in morning meeting for timely updates to resident centered careplan. Director of Nursing and/or designee will perform daily audits on all admissions/readmissions for 30 days. Auditing will then transition to weekly x 30 days to ensure substantial compliance. Minimum review time 3 months total. Results to be reported to QAPI committee.	

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F 656	Continued From page 4 Progress notes dated . . . . . and . . . . . revealed the resident "Continued on hospice service." On . . . . . at 12:47 PM, the resident's family member stated she was on hospice care for comfort. On . . . . . at 1:54 PM, Registered Nurse (RN) B stated resident #17 was on hospice services and hospice staff visited her on a weekly basis. RN B stated hospice documentation was in the resident's medical record under the hospice tab along with their contact information On . . . . . at 2:10 PM, RN Minimum Data Set (MDS) Coordinator D stated care plans were developed using the Care Assessment Areas triggered by the MDS assessment, observation, and review and discussion of the resident's clinical record in the Interdisciplinary Team (IDT) meetings. She stated all care plans, except dietary, social services, and activities were developed by MDS staff. Resident #17's care plans were reviewed with the MDS Coordinator D, and a care plan for hospice services was not identified. She explained a care plan was usually developed for residents on hospice services. She stated social services would document hospice services, and the MDS coordinator would ensure a care plan was developed for hospice, and that other care plans for the resident were in line with the hospice agency's goals. MDS Coordinator D validated a hospice care plan was not developed for the resident, and her other care plans, specifically the care plan for , , did not incorporate or reflect hospice services. On . . . . . at 2:34 PM, the 2nd floor Assistant	F 656		

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F 656	Continued From page 5 Director of Nursing (ADON) stated MDS staff developed and updated care plans. The ADON reviewed resident #17's clinical records and confirmed although the resident was on hospice services, a care plan was not developed to reflect hospice services. On at 3:04 PM, the interim DON stated if the resident was on hospice services, a care plan for hospice should be developed. 2. Resident #34 was admitted to the facility on with diagnoses including , replacement for left , . The Quarterly MDS assessment dated indicated the resident was . On at 10:34 AM, during a , observation of resident #34 with the 3rd floor ADON, he validated the resident had a ( ) inserted in his right upper arm. Review of the physician orders reflected the was inserted on . Another order dated read, "Change every week and as needed." On at 11:20 AM, the Preventionist stated new orders were reviewed in daily clinical meetings. She explained the clinical ADON checked the orders to ensure they were entered correctly. She stated the MDS Coordinator would then create a care plan. The Preventionist said, "The care plan gives the nurses guidance on how to care for each	F 656		

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F 656	Continued From page 6 individual resident." A review of the resident's care plans noted no care plan was developed for care. On at 2:11 PM, MDS Coordinator RN J stated resident #34 should have a care plan with goals and interventions for the . She explained the care plan process involved review of new orders, and creation or revision and updating of care plans to reflect the resident's individual needs. MDS Coordinator RN J stated it was important to create and update care plans in a timely manner so that staff would have all information to provide necessary care and services for residents. The policy "Comprehensive Care Plans" reviewed in read, "The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team . . . will also be addressed in the plan of care." The document indicated each resident would have a comprehensive person centered care plan to meet all needs identified in assessments.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677		

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F 677	Continued From page 7 by: Based on observation, interview and record review, the facility failed to provide nail care for 1 of 4 dependent residents reviewed for activities of daily living (ADL) care, of a total sample of 35 residents, (#59). Findings: Resident #59 was admitted to the facility on with diagnoses including of both and his left upper arm, and with partial . The quarterly Minimum Data Set (MDS) assessment with assessment reference date of revealed resident #59's cognition was moderately , with a score of . Resident #59 was assessed as being totally dependent on staff for personal hygiene and he required with . Resident #59 had functional limitation in range of motion and of his upper and lower extremities on both sides. On at 9:57 AM, and on at 9:36 AM, resident #59 sat in his motorized wheelchair. The resident's on both were long and untrimmed, and there was a dark substance noted underneath the left thumbnail and the of his right . Resident #59 stated his needed trimming. On at 5:46 PM, the 2nd floor Assistant Director of Nursing (ADON) stated nail care was provided by the Certified Nursing Assistants	F 677	F677 The for Resident #59 were immediately trimmed and cleaned to ensure proper nail care. All residents screened to ensure proper nail care. No other residents noted to be affected. Director of Nursing to provide education to licensed and certified nursing staff to ensure residents receive proper nail care. Director of Nursing and/or designee will perform weekly audits over the next 90 days. Findings will be discussed during weekly Standards of Care meeting. Once compliance is obtained the audits will be completed monthly to ensure ongoing compliance. Results will brought to QAPI Committee for review and feedback by the NHA. (Minimum audit 3 months)	

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F 677	Continued From page 8 (CNAs), [illegible] staff, and nurses. On [illegible] at 5:55 PM, CNA G stated she worked on the 3 PM to 11 PM shift, and resident #59's nail care was scheduled to be done on the 7 AM to 3 PM shift. On [illegible] at 5:56 PM, the resident's [illegible] were observed with the ADON and CNA G. They both acknowledged his [illegible] were untrimmed and dirty. The ADON stated nail care was not "confined" to any specific shift and could also be provided upon the resident's request. Resident #59 again stated he wanted his [illegible] to be trimmed. On [illegible] at 10:15 AM, the Interim Director of Nursing stated nail care was provided by the CNAs. She explained there was no specific time scheduled for nail care, and nurses should supervise residents' ADL care to ensure the required care was provided. On [illegible] at 1:41 PM, CNA F stated resident #59 did not resist care and was able to make his needs known. CNA F confirmed nail care was a part of ADL care and should be provided as needed. She stated she was assigned to resident #59 on [illegible] but did not provide nail care for him that day. On [illegible] at 1:54 PM, Registered Nurse (RN) B stated resident #59 was alert and oriented, could make his needs known, and was dependent on staff for all his ADL care. RN B stated nail care was provided on shower days and as needed by CNAs or nurses, and the intervention should be in the resident's care plan.	F 677		

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F 677	Continued From page 9 The resident's care plan for self-care [illegible] related to diagnosis of [illegible], history of [illegible] with [illegible], and [illegible] was created [illegible]. The interventions included assist with grooming and provide nail care as needed. The policy "Providing Nail Care" reviewed/revised in [illegible] read, "Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. Routine nail care, to include trimming and filing, will be provided on a regular schedule. . . Nail care will be provided between scheduled occasions as the need arises."	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure wheelchair [illegible] were positioned correctly to prevent accidents for 1 of 5 residents reviewed for and accident hazards, of a total sample of 35 residents, (#44). Findings: Resident #44 was admitted to the facility on [illegible] with diagnoses including [illegible],	F 689	F689 Resident #44 [illegible] immediately corrected [illegible] to wheelchair on [illegible] conducted an audit of all residents with [illegible] and no other resident affected. [illegible] to train all staff regarding correct application of [illegible]. [illegible] manger and/or designee will perform weekly audits over the next 90	

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F 689	Continued From page 10 , , and . Review of the Quarterly Minimum Data Set (MDS) dated revealed a evaluation was not done because the resident was rarely or never understood. The MDS assessment noted resident #44 required of one staff member for transfers and locomotion on the unit and used a wheelchair for mobility. On at 3:34 PM, resident #44 was seated in his wheelchair in the third-floor common area. The of the resident's wheelchair had , , that were not positioned correctly. The , , devices were positioned upwards, pointing towards the ceiling instead of downwards, towards the floor. Wheelchair , , keep a wheelchair from tipping over backwards and prevent users from having accidents and being injured by falling over backwards (retrieved on from www.wheelchairparts.com). Further review of resident #44's medical record revealed there was no physician's order for the wheelchair , , nor were the , , addressed on the resident #44's /Accident care plan. On at 12:05 PM, resident #44 was seated in his wheelchair in the atrium. The wheelchair , , were still positioned incorrectly, pointing upwards towards the ceiling. On at 11:01 AM, the resident was again seated in his wheelchair in the atrium, with the wheelchair , , still incorrectly positioned.	F 689	days to ensure ongoing compliance. Findings will be discussed during weekly Standards of Care meeting and brought to QAPI Committee for review and feedback by the NHA. (Minimum audit 3 months).	

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F 689	Continued From page 11 On at 12:54 PM, during an observation of resident #44's wheelchair with the Manager (TM), he validated the were not in the correct position. He stated the should point downward, toward the floor. The Manager looked around the atrium and acknowledged resident #44 was the only resident in the area whose wheelchair were positioned incorrectly. He did not explain if nursing staff were responsible for ensuring residents' safety devices were in the correct position, and stated he could not "speak to that." He was not able to provide an explanation as to why resident #44's were not correctly placed.	F 689		
F 694 SS=D	/ Fluids CFR(s): 483.25(h) § 483.25(h) Fluids. fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide changes for a ( ) according to current professional standards of practice, for 1 of 1 resident reviewed for of a total sample of 35 residents, (#34). Findings: Resident #34 was admitted to the facility on with diagnoses including ,	F 694	F694 Resident #34 and was immediately discontinued per MD order. Audit completed of all other residents to ensure facility provided ( ) care and services according to standards of practice and plan of care. No other residents found to be affected. Nursing staff educated regarding providing ( ) care and services according to standards of	

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F 694	Continued From page 12 replacement for left The Quarterly Minimum Data Set (MDS) assessment dated indicated the resident was Review of the physician orders reflected a was inserted on . Another order dated read, "Change every week and as needed." A is inserted into a near the or upper arm and ends in a below the armpit. "A may allow you to receive long-term ( ) medicine or treatments. . ." (retrieved on from www.drugs.com). A review of the Medication Administration Record showed the resident's was marked with a check mark indicating the was changed on and . On at 10:34 AM, during a observation of resident #34 with the 3rd floor Assistant Director of Nursing (ADON), he validated the resident had a inserted in his right upper arm. The ADON confirmed the transparent at the site was dated and was loosely secured with surgical tape. He acknowledged the at the site should have been changed weekly to minimize , according to facility policy. The ADON stated resident #34's should have been changed on but it was not. Review of nursing progress notes revealed no documentation to show the resident's change was done after .	F 694	practice and plan of care. DON or designee to complete weekly audits to ensure ( ) care and services are provided according to standards of practice and plan of care. Weekly audits regarding outcomes will be brought to QAPI for review and feedback by the DON or designee until compliance is substantiated with a minimum of 90 days.	

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	105757	A. BUILDING _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER TOWERS	**70 WEST LUCERNE CIRCLE ORLANDO, FL 32801**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 694	Continued From page 13 On at 11:20 AM, the Preventionist stated the clinical ADONs were responsible for checking all residents with on their units. She explained a specialty nurse from an outside company came to the facility to insert . The Preventionist stated facility nurses were responsible for obtaining and entering physician orders for flushes and weekly changes. She stated orders would be transcribed to the medication and/or treatment administration records with specific days and shifts identified for each task. Review of the policy and procedure for " ," dated revealed,"6) changes will be done every 7 days and [as needed] per the doctors' orders. . . .10) documentation is recorded in the nurses' notes and or Medication Administration Record."	F 694		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 000	INITIAL COMMENTS Relicensure survey and Complaint Investigation #2021014022 were conducted from . . . . . to . The complaint was not substantiated but Westminster Towers had deficiencies from the Relicensure survey.	N 000		
N 071 SS=D	59A-4.109(1), FAC Components of Care Plan (1) Each resident admitted to the nursing home facility must have a plan of care. The plan of care must consist of: (a) Physician's orders, diagnosis, medical history, physical exam and rehabilitative or restorative potential. (b) A preliminary nursing evaluation with physician's orders for immediate care, completed upon admission. (c) A complete, comprehensive, accurate and reproducible assessment of each resident's functional capacity which is standardized in the facility, and is completed within 14 days of the resident's admission to the facility and every twelve months, thereafter. The assessment must be: 1. Reviewed no less than once every 3 months; 2. Reviewed promptly after a significant change, which is a need to stop a form of treatment because of adverse consequences (e.g., an adverse drug reaction), or commence a new form of treatment to deal with a problem, in the resident's physical or mental condition; and, 3. Revised as appropriate to assure the continued accuracy of the assessment. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to accurately complete the Minimum Data Set (MDS) assessment regarding hospice services for 1 of 3 residents reviewed for hospice	N 071	"This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission	

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 071	Continued From page 1 services, of a total sample of 35 residents, (#17). Findings: Resident #17 was admitted to the facility on and was readmitted on . Her diagnoses included , , and . A physician order dated revealed the resident was on hospice services for diagnosis of . Review of the resident's clinical records revealed documentation by hospice staff of visits made, and services provided for the residents from - , . Documentation in the resident's physical chart revealed the name, the team number, and contact information of the hospice provider for services rendered to resident #17. The admission MDS assessment with ARD revealed the question in section J1400 prognosis: "Does the resident have a condition or that may result in a life expectancy of less than 6 months?" was coded "0" meaning "No." Hospice care was not checked in Section O- Special treatments, procedures, and programs. On at 2:10 PM, Registered Nurse (RN) MDS Coordinator D stated assessments were completed by doing a 7 day look , review of the resident's physician orders, medication administration record (MAR), observation of activities of daily living (ADLs) as needed, and interviews of resident/family /nurse as needed. The MDS Coordinator stated if the resident was	N 071	that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law". N071 Resident #17 MDS assessment was immediately modified to reflect hospice services and re-submitted with corrections. Audit completed of all other residents with hospice services and their MDS assessments to ensure they reflected hospice. No other residents found to be affected. DON will assign MDS Coordinators training courses on accuracy of MDS assessments. Director of Nursing and/or designee will perform weekly MDS audits for accuracy for 30 days. Auditing will then transition to Monthly x 30 days to ensure substantial compliance. Minimum review time 3 months total. Results to be reported to QAPI committee.	

Agency for Health Care Administration

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N 071	Continued From page 2 on hospice services, hospice documentation, contract, and certification would be reviewed. The resident's admission MDS was reviewed with the MDS Coordinator. She stated that section J1400 should have been coded "2' meaning "yes", and hospice care should have been checked in section O. She acknowledged the assessment was not accurate. The facility's policy "MDS 3.0 Completion" revised [illegible] read, "According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity." [illegible] Class III	N 071		
N 072 SS=D	59A-4.109(2), FAC; 400.021(18), FS Comprehensive Care Plans 59A-4.109 FAC (2) The nursing home licensee develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and [illegible] needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and social well-being. The care plan must be completed within 7 days after completion of the resident assessment. 400.021 FS (18) "Resident care plan" means a written plan developed, maintained, and reviewed not less	N 072		

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N 072	Continued From page 3 than quarterly by a registered nurse, with participation from other facility staff and the resident or his or her designee or legal representative, which includes a comprehensive assessment of the needs of an individual resident; the type and frequency of services required to provide the necessary care for the resident to attain or maintain the highest practicable physical, mental, and well-being; a listing of services provided within or outside the facility to meet those needs; and an explanation of service goals. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to develop a person-centered care plan for hospice and ensure care plans reflected the goals of hospice services for 1 of 3 residents reviewed for hospice services, (#17); and failed to develop a person-centered care plan for for 1 of 1 resident reviewed for (#34), of a total sample of 35 residents. Findings: 1. Resident #17 was admitted to the facility on and was readmitted on . Her diagnoses included , and . A physician order dated revealed the resident was on hospice services for diagnosis of . Review of the resident's clinical records revealed documentation by a hospice agency of visits made and services provided for the resident from	N 072	N072 Resident #17 and #34 care plans were immediately reviewed and updated on . Audit completed of all other residents with hospice services and to ensure care plans reflected such, no other residents effected. Director of Nursing and/or designee provided education and training to MDS Coordinators / staff nurses on timely development of resident centered care plan. Care plans will be reviewed as changes occur daily in morning meeting for timely updates to resident centered careplan. Director of Nursing and/or designee will perform daily audits on all admissions/readmissions for 30 days. Auditing will then transition to weekly x 30 days to ensure substantial compliance. Minimum review time 3 months total. Results to be reported to QAPI committee.	

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N 072	Continued From page 4 through . Documentation in the resident's medical record revealed the name, the team number, and contact information of the hospice agency that provided services for resident #17. Progress notes dated and revealed the resident "Continued on hospice service." On at 12:47 PM, the resident's family member stated she was on hospice care for comfort. On at 1:54 PM, Registered Nurse (RN) B stated resident #17 was on hospice services and hospice staff visited her on a weekly basis. RN B stated hospice documentation was in the resident's medical record under the hospice tab along with their contact information On at 2:10 PM, RN Minimum Data Set (MDS) Coordinator D stated care plans were developed using the Care Assessment Areas triggered by the MDS assessment, observation, and review and discussion of the resident's clinical record in the Interdisciplinary Team (IDT) meetings. She stated all care plans, except dietary, social services, and activities were developed by MDS staff. Resident #17's care plans were reviewed with the MDS Coordinator D, and a care plan for hospice services was not identified. She explained a care plan was usually developed for residents on hospice services. She stated social services would document hospice services, and the MDS coordinator would ensure a care plan was developed for hospice, and that other care plans for the resident were in line with the hospice agency's goals. MDS Coordinator D	N 072		

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N 072	Continued From page 5 validated a hospice care plan was not developed for the resident, and her other care plans, specifically the care plan for , , did not incorporate or reflect hospice services. On at 2:34 PM, the 2nd floor Assistant Director of Nursing (ADON) stated MDS staff developed and updated care plans. The ADON reviewed resident #17's clinical records and confirmed although the resident was on hospice services, a care plan was not developed to reflect hospice services. On at 3:04 PM, the Interim DON stated if the resident was on hospice services, a care plan for hospice should be developed. 2. Resident #34 was admitted to the facility on with diagnoses including , replacement for left , . The Quarterly MDS assessment dated indicated the resident was . On at 10:34 AM, during a , observation of resident #34 with the 3rd floor ADON, he validated the resident had a ( ) inserted in his right upper arm. Review of the physician orders reflected the was inserted on . Another order dated read, "Change every week and as needed." On at 11:20 AM, the Preventionist stated new orders were reviewed in daily clinical meetings. She explained the clinical ADON checked the orders to ensure they were	N 072		

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N 072	Continued From page 6 entered correctly. She stated the MDS Coordinator would then create a care plan. The . . . . Preventionist said, "The care plan gives the nurses guidance on how to care for each individual resident." A review of the resident's care plans noted no care plan was developed for . care. On . . . . at 2:11 PM, MDS Coordinator RN J stated resident #34 should have a care plan with goals and interventions for the . . . . She explained the care plan process involved review of new orders, and creation or revision and updating of care plans to reflect the resident's individual needs. MDS Coordinator RN J stated it was important to create and update care plans in a timely manner so that staff would have all information to provide necessary care and services for residents. The policy "Comprehensive Care Plans" reviewed in , . . read, "The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team . . . will also be addressed in the plan of care." The document indicated each resident would have a comprehensive person centered care plan to meet all needs identified in assessments. Class III	N 072		

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N 201	Continued From page 7	N 201		
N 201 SS=D	400.022(1)(l), FS Right to Adequate and Appropriate Health Care (l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure resident safety needs, activities of daily living and treatments were being provided to ensure the highest practicable well being for 3 of 35 sampled residents, (#44, #34, #59). Finding: 1. Resident #44 was admitted to the facility on [redacted] with diagnoses including [redacted], and [redacted]. Review of the Quarterly Minimum Data Set (MDS) dated [redacted] revealed a [redacted] evaluation was not done because the resident was rarely or never understood. The MDS assessment noted resident #44 required [redacted] of one staff member for transfers and locomotion on the unit and used a wheelchair for mobility. On [redacted] at 3:34 PM, resident #44 was seated in his wheelchair in the third-floor common area. The [redacted] of the resident's wheelchair had [redacted] that were not positioned correctly.	N 201	N201 Resident #44 [redacted] immediately corrected [redacted] to wheelchair on [redacted]. [redacted] conducted an audit of all residents with [redacted] and no other resident affected. [redacted] to train all staff regarding correct application of [redacted]. [redacted] manager and/or designee will perform weekly audits over the next 90 days to ensure ongoing compliance. Findings will be discussed during weekly Standards of Care meeting and brought to QAPI Committee for review and feedback by the NHA. (Minimum audit 3 months) Resident #34 [redacted] and [redacted] was immediately discontinued per MD order. Audit completed of all other residents to ensure facility provided ( ) care and services according to standards of practice and plan of care. No other residents found to be affected. Nursing staff educated regarding providing	

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N 201	Continued From page 8 The devices were positioned upwards, pointing towards the ceiling instead of downwards, towards the floor. Wheelchair keep a wheelchair from tipping over backwards and prevent users from having accidents and being injured by falling over backwards (retrieved on from www.wheelchairparts.com). Further review of resident #44's medical record revealed there was no physician's order for the wheelchair nor were the addressed on the resident #44's /Accident care plan. On at 12:05 PM, resident #44 was seated in his wheelchair in the atrium. The wheelchair were still positioned incorrectly, pointing upwards towards the ceiling. On at 11:01 AM, the resident was again seated in his wheelchair in the atrium, with the wheelchair still incorrectly positioned. On at 12:54 PM, during an observation of resident #44's wheelchair with the Manager (TM), he validated the were not in the correct position. He stated the should point downward, toward the floor. The Manager looked around the atrium and acknowledged resident #44 was the only resident in the area whose wheelchair were positioned incorrectly. He did not explain if nursing staff were responsible for ensuring residents' safety devices were in the correct position, and stated he could not "speak to that." He was not able to provide an explanation as to why resident #44's were not correctly placed.	N 201	( ) care and services according to standards of practice and plan of care. DON or designee to complete weekly audits to ensure ( ) care and services are provided according to standards of practice and plan of care. Weekly audits regarding outcomes will be brought to QAPI for review and feedback by the DON or designee until compliance is substantiated with a minimum of 90 days. The for Resident #59 were immediately trimmed and cleaned to ensure proper nail care. All residents screened to ensure proper nail care. No other residents noted to be affected. Director of Nursing to provide education to licensed and certified nursing staff to ensure residents receive proper nail care. Director of Nursing and/or designee will perform weekly audits over the next 90 days. Findings will be discussed during weekly Standards of Care meeting. Once compliance is obtained the audits will be completed monthly to ensure ongoing compliance. Results will brought to QAPI Committee for review and feedback by the NHA. (Minimum audit 3 months)	

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N 201	Continued From page 9 2. Resident #34 was admitted to the facility on with diagnoses including , replacement of left , . The Quarterly Minimum Data Set (MDS) assessment dated indicated the resident was . Review of the physician orders reflected a was inserted on . Another order dated read, "Change every week and as needed." A is inserted into a near the or upper arm and ends in a below the armpit. "A may allow you to receive long-term ( ) medicine or treatments. ." (retrieved on from www.drugs.com). A review of the Medication Administration Record showed the resident's was marked with a check mark indicating the was changed on and . On at 10:34 AM, during a observation of resident #34 with the 3rd floor Assistant Director of Nursing (ADON), he validated the resident had a inserted in his right upper arm. The ADON confirmed the transparent at the site was dated and was loosely secured with surgical tape. He acknowledged the at the site should have been changed weekly to minimize , according to facility policy. The ADON stated resident #34's should have been changed on but it was not. Review of nursing progress notes revealed no documentation to show the resident's	N 201		

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N 201	Continued From page 10 change was done after . . . . . On . . . . at 11:20 AM, the . . . . . Preventionist stated the clinical ADONs were responsible for checking all residents with . . on their units. She explained a specialty nurse from an outside company came to the facility to insert . The . Preventionist stated facility nurses were responsible for obtaining and entering physician orders for flushes and weekly . . . . changes. She stated orders would be transcribed to the medication and/or treatment administration records with specific days and shifts identified for each task. Review of the policy and procedure for " , " dated revealed,"6) . . . changes will be done every 7 days and [as needed] per the doctors' orders. . . .10) documentation is recorded in the nurses' notes and or Medication Administration Record." 3. Resident #59 was admitted to the facility on . . . . . with diagnoses including . . . . . of both and his left upper arm, and . . . . with partial . . . . . The quarterly Minimum Data Set (MDS) assessment with assessment reference date of . . . . . revealed resident #59's cognition was moderately , with a . . . . . score of . . . Resident #59 was assessed as being totally dependent on staff for personal hygiene and he required . . . . . with . Resident #59 had functional limitation in range of motion and , of his upper and lower extremities on both sides.	N 201		

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N 201	Continued From page 11 On [redacted] at 9:57 AM, and on [redacted] at 9:36 AM, resident #59 sat in his motorized wheelchair. The resident's [redacted] on both [redacted] were long and untrimmed, and there was a dark substance noted underneath the left thumbnail and the [redacted] of his right [redacted]. Resident #59 stated his [redacted] needed trimming. On [redacted] at 5:46 PM, the 2nd floor Assistant Director of Nursing (ADON) stated nail care was provided by the Certified Nursing Assistants (CNAs), [redacted] staff, and nurses. On [redacted] at 5:55 PM, CNA G stated she worked on the 3 PM to 11 PM shift, and resident #59's nail care was scheduled to be done on the 7 AM to 3 PM shift. On [redacted] at 5:56 PM, the resident's [redacted] were observed with the ADON and CNA G. They both acknowledged his [redacted] were untrimmed and dirty. The ADON stated nail care was not "confined" to any specific shift and could also be provided upon the resident's request. Resident #59 again stated he wanted his [redacted] to be trimmed. On [redacted] at 10:15 AM, the Interim Director of Nursing stated nail care was provided by the CNAs. She explained there was no specific time scheduled for nail care, and nurses should supervise residents' ADL care to ensure the required care was provided. On [redacted] at 1:41 PM, CNA F stated resident #59 did not resist care and was able to make his needs known. CNA F confirmed nail care was a part of ADL care and should be provided as needed. She stated she was assigned to resident	N 201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	74830	A. BUILDING: _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER TOWERS	70 WEST LUCERNE CIRCLE ORLANDO, FL 32801

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N	Continued From page 12 #59 on . . . . but did not provide nail care for him that day. On at 1:54 PM, Registered Nurse (RN) B stated resident #59 was alert and oriented, could make his needs known, and was dependent on staff for all his ADL care. RN B stated nail care was provided on shower days and as needed by CNAs or nurses, and the intervention should be in the resident's care plan. The resident's care plan for self-care related to diagnosis of . . . . . , history of with , , and was created . . . . . The interventions included assist with grooming and provide nail care as needed. The policy "Providing Nail Care" reviewed/revised in . . . . . read, "Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. Routine nail care, to include trimming and filing, will be provided on a regular schedule. . . Nail care will be provided between scheduled occasions as the need arises. Class III	N 201		