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
	AL11970487	A. BUILDING: _____ B. WING _____	08/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER BALDWIN PARK	2645 LAKE BALDWIN LN ORLANDO, FL 32814

(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) COMPLETE DATE
A 000	Initial Comments A complaint investigation (2026010627) and a generator monitoring were conducted at Westminster Baldwin Park on and . A deficiency was identified at the time of the survey.	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision and ensure safety through proactive measures to minimize the potential for for 2 of 5 sampled residents (#6, #7). Findings: Review of Resident #6's record revealed a facility admission date of . The Resident's medical history included 's . A health assessment form (1823), dated ,	A 025		

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A 025	Continued From page 2 documented the Resident had a gait disturbance and memory loss. The form documented the Resident was independent with ambulation, toileting, and transferring and needed supervision with bathing and . Two 1823s, dated and , documented the Resident had and forgetfulness. The form documented that she needed supervision with ambulation, bathing, , grooming, toileting, and transferring and ambulated with a four wheeled walker. Review of the morse risk assessment used by the facility revealed that high risk was a score of 45 and higher. On , the Resident scored 90. On and , she scored 70. On and , she scored 46. On and , she scored 75. A facility note, dated at 10:17 AM, showed the Resident was found on the floor next to her bed. The note showed the Resident attempted to go into her bathroom. The note showed the Resident complained of right and was sent to a hospital where she was admitted with a . A facility note, dated at 11:33 AM, showed the Resident returned from the hospital. A facility note, dated at 6:30 PM, showed the Resident was observed sitting on the floor next to her bed. A facility note, dated , showed that at approximately 6:15 PM, the Resident was observed lying on the floor in the doorway to her	A 025		

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A 025	Continued From page 3 room. A facility note, dated , showed that at approximately 3:45 PM, staff heard the Resident calling for help and found the resident laying on the floor. The note showed the Resident did not remember what she was doing prior to the . A facility note, dated at 10:19 AM, showed the Resident was heard yelling for help. The note showed the Resident said she heard someone yelling for help, got out of bed to help, slipped, and landed on her . A facility note, dated at 3:19 PM, showed the Resident had a during activities when she missed the chair. A facility note, dated at 9:06 AM, showed the Resident had an unwitnessed in her room. The note showed the Resident said she lost her balance and landed on her . A facility note, dated , showed the Resident was sent to a hospital earlier that morning after she reportedly slipped from her bed. The note showed the Resident complained of . . The note showed the Resident returned to the facility at approximately 11 AM with a diagnosis of T12 , . . A facility note dated at 8:16 PM showed the Resident was found on the floor next to her bed. A facility note, dated at 10:02 PM, showed the Resident was observed sitting on the floor in front of another Resident's room in the hallway.	A 025		

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A 025	Continued From page 4 A facility note, dated at 9:29 PM, showed the Resident was found on the floor in a seated position at the of her bed. A facility note, dated at 9:40 PM, showed the Resident was sitting on the floor in her room. The note showed the Resident said she slid out of bed. A facility note, dated at 4:35 PM, showed the Resident was found on the floor in another Resident's bathroom. A facility note, dated at 12:50 PM, showed the Resident had a while attempting to sit on her raised toilet seat. The note showed the Resident was taken to a hospital. A facility note, dated , showed that at 7:20 PM the Resident returned from the hospital. A facility note, dated , showed that at approximately 4:45 PM the Resident was transferred upstairs to the skilled nursing center. On at 2:20 PM, certified nursing assistant (CNA) B, said the Resident did not ask for help to use the bathroom. CNA B said that if the Resident was in the common area and CNA B saw the resident get up, CNA B helped the resident. On at 2:25 PM, licensed practical nurse (LPN) D said that one time he had to prop the Resident's room door open and sit outside her room. LPN D said the Resident was weak. LPN D explained the staff did their best to supervise the Resident, but they could not do so all the time. On at 2:41 PM, CNA F said that after 3 PM	A 025		

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there were not enough staff to supervise all the residents. CNA F explained that a nurse gave medications and while the one CNA was providing care in a room, no staff were available to supervise the residents and those in the common area. CNA F said that Resident #6 was and got up and walked around looking for her mother. CNA F said the Resident could not be supervised all the time. CNA F said she sat in the common area to listen to the Resident stirring in her room because the Resident was in and out of bed during the night.

On at 3:56 PM, CNA E said Resident #6 declined fast and she did not wait for help before doing things herself. CNA E said the Resident oftentimes looked for her mom and dad. CNA E explained the staff could not be with the Resident all the time because they had other residents to care for.

On at 8:35 AM, the Administrator said staff were not placed only with Resident #6 because other interventions were put in place. The Administrator explained that staffing levels were not increased because she believed the interventions were effective. The Assistant Executive Director of the campus added that staffing levels included activities staff and housekeepers.

On at 10:56 AM, CNA A said Resident #6 exhibited at times, forgetting her walker and shoes. CNA A explained that the Resident needed encouragement to come out of her room and she into other resident rooms. CNA A said there were not enough staff to adequately supervise Resident #6.

On at 11:08 AM, the Memory Support

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A 025	Continued From page 6 Director said she instructed the staff to toilet Resident #6, to bring the Resident to activities, and to check on the Resident more often during the night because the Resident got up during the night. On . . . at 11:22 AM, LPN G said Resident #6 was weak and had in her , which made it difficult for her to push up from a sitting position. LPN G said the Resident was very . and needed a lot of redirections. LPN G explained that the Resident sometimes forgot where her room was and slept a lot, so staff checked on the Resident often. LPN G said that although staff helped the Resident, oftentimes she got herself up and went to the bathroom without help. On at 1:06 PM, LPN H said they would benefit from having another CNA during the 3 PM-11 PM shift, especially because the nurse passed medications while the one caregiver assisted the residents with care. LPN H explained that she noticed a recent decline in the Resident and that she was getting up and down a lot. LPN H said it was difficult to closely supervise the Resident with the number of staff. 2. Review of Resident # 7's record revealed a medical history of 's, unspecified primary diagnosis, unspecified , unspecified severity, without behavioral disturbance, , , disturbance, disturbance. The record showed the resident requires assistance with activities of daily living. The resident lived in a secure memory care unit. A facility note dated at 6:38 PM showed Resident #7 was walking slower than normal. Was assisted to her room and had a large soft	A 025		

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A 025	Continued From page 7 movement. Post shower started walking normally. A facility note dated at 10:42 AM showed at 8:30 PM during routine rounding Resident #7 was observed seated on the floor next to the couch in her bedroom. Incident was unwitnessed. Resident was transferred to the hospital. A facility note dated at 9:04 PM showed Resident #7 returned from the hospital and was ambulating without difficulty. No signs and symptoms of , or discomfort noted. , decreased from 20mg to 15mg. A facility note dated at 5:00 PM showed Resident #7 has a very slight with a slight , of the left orbital rim. A facility note dated showed CNA reported to nurse station Resident #7 was observed on the floor lying on her on the bathroom floor by CNA. No obvious sign of injury. Resident had , and tremors was called and was transferred to hospital. risk assessments dated and identified Resident #7 as a moderate risk for falling. Care plan dated does not include interventions based upon evaluation and investigation. On at 1:01 PM the Administrator Care said the care plan was not updated because she had a moderate risk but still walked independently. Class III	A 025		