STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106118	A. BUILDING _____ B. WING _____	**09/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTMINSTER BALDWIN PARK	**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 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan for dementia care, and [MEDICAL CONDITION] medication for 1 of 5 residents reviewed for unnecessary medications, (#130). Finding: Resident #130 was admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Review of the physician orders [REDACTED]. [MEDICATION NAME] is known as an anti-psychotic drug. It works by helping to restore the balance of certain natural substances (neurotransmitters) in the brain. (WebMD.com) On 09/09/20 at 4:19 PM, Licensed Practical Nurse (LPN) A, stated that resident #130's [DIAGNOSES REDACTED]. On 09/09/20 at 4:21 PM, Registered Nurse (RN) B stated, that resident #130 usually stayed in his room. The RN said that for continuity of care, the same Certified Nursing Assistant (CNA) would be assigned to him to help decrease confusion. The RN stated that an individualized care plan should be initiated for residents with dementia. On 9/10/20 at 10:40 AM, the Director of Nursing (DON) stated that on admission, a baseline care plan would be initiated for residents based on their admission data, and physician orders. Resident #130's baseline, and admission care plans were reviewed with the DON. She said that a care plan for dementia care, and [MEDICAL CONDITION] medication was not initiated for resident #130. The DON indicated that on the baseline care plan/summary, there was an area under nursing/safety for key medications to be documented. The baseline care plan/summary did not show any documentation of the medication [MEDICATION NAME]. The DON stated, that a care plan for dementia care, and the [MEDICAL CONDITION] medication, [MEDICATION NAME] should have been developed and implemented for resident #130. On 09/10/20 at 11:18 AM, the Minimum Data Set (MDS) coordinator stated that baseline care plans were completed by nursing, therapy, and the social services director (SSD). The MDS coordinator, said baseline care plans should address key medications the resident was receiving. He verbalized that [MEDICATION NAME] was considered a key medication. The MDS coordinator noted that the resident's baseline care plan/summary did not address cognition issues and key medications. The facility's policy for Baseline Care Plan reviewed/revised 06/20 read, The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person- centered care of the resident that meet professional standards of quality care. The baseline care plan will: Be developed within 48 hours of a resident's admission. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: initial goals based on admission orders [REDACTED]. Interventions shall be initiated that address the resident's current needs . Review of the facility's policy, Use of [MEDICAL CONDITION] Drugs reviewed/revised 07/20, revealed the following: Residents are not given [MEDICAL CONDITION] drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s).
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, record review and interview, the facility failed to ensure that staff used hair nets and maintained food holding temperatures at 135 degrees Fahrenheit or higher. Findings: 1. On 9/8/20 at 11:08 AM, the Assistant Dietary Manager (ADM) was in the Kitchenette, standing next to a dietary aide. The dietary aide was transferring food from one pan to another pan. The ADM had a full beard and was wearing an N 95 filter mask that covered his nose and mouth. The filter mask did not fully cover the ADM's beard. At 11:16 AM, the Certified Dietary Manager was informed of the concern. She stated that the ADM should be wearing a beard net/guard. Section 2-402.11 of the Food and Drug Administration's (FDA) Food Code notes the use of hair restraints, including beard restraints, and that they are designed and worn to effectively keep employee hair from contacting food. 2. On 9/9/20 at 5:49 PM, the dinner tray line was observed on the first floor of the facility. The dietary aide was plating the food and the ADM stated that food holding temperatures had already been taken. He provided the food temperature log. The log noted all hot foods were being held above 135 degrees Fahrenheit or higher. The dietary aide stated they were at the 'midway point' and had a few more residents/rooms to serve. The ADM stated that the facility did not have a Policy and Procedure for checking the food holding temperatures after the start of the tray line, such as the 'midway point. The ADM was asked to check the food holding temperature on the steam table. All foods were above 135 degrees Fahrenheit expect the green beans which were at 126 degrees Fahrenheit. The ADM stated that the green beans were at the temperature for palatability. He could not provide any evidence that the residents at this facility preferred their green beans to be at 126 degrees Fahrenheit. The ADM stated that the facility policy for minimum hot food holding temperature was 135 degrees Fahrenheit. The ADM removed the green beans and reheated them in microwave/convection oven. He then rechecked the temperature which was 156 degrees Fahrenheit, and placed them back on the steam table. Chapter 3 of the FDA Food Code notes that the hot holding temperature of food should be 135 degrees Fahrenheit or higher. Chapter 3 also notes that food needs to be rapidly reheated to 165 degrees Fahrenheit. The danger zone for food is noted to be above 41 degrees Fahrenheit and below 135 degrees Fahrenheit. Previously cooked foods with temperatures in the danger zone, need to be rapidly reheated to 165 degrees Fahrenheit before they can be served to residents.

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

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.