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
	AL11911328	A. BUILDING: _____ B. WING _____	02/18/2026

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

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A 000	Initial Comments Two (2) complaint investigations #2026001997, #2026002047 and generator monitoring was conducted at Westminster Towers Orlando Assisted Living Facility on & . The facility had a deficiency at the time of the survey visit.	A 000		
A 025 SS=D	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 025		

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A 025	Continued From page 1 (a) Monitoring of the quantity and quality of 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 facility documentation, record reviews and interviews, the facility failed to maintain written thorough documentation, and the facility failed to conduct a thorough investigation in providing appropriate supervision to prevent alleged by resident #1 from staff (Licensed Practical Nurse, LPN A) allowing LPN A to return to work as the only overnight nurse working in the assisted living facility before ensuring safe protocols of were implemented for all the residents. Findings:	A 025		

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A 025	Continued From page 2 The facility reported an incident on , and on that same day at 5:03 AM, resident #1 had reported that staff LPN A came into her room and slapped her in the , after resident #1 had pushed her call pendant for assistance to the bathroom. A review of the facility's incident report documented a call made to the hotline and law enforcement on . The facility also notified resident #1's primary physician and Hospice. There was no documented evidence that the family was notified of the incident. The facility did not have any written documentation or did not have facility notes documenting a thorough investigation conducted after learning about this incident to ensure safety from to resident #1 by LPN A, as well safety from for the remaining 56 residents living in the facility cared for by LPN A while working during this allegation with resident #1. A review of the facility's , neglect and , policies & procedures dated documented on page 2 for policy explanation and compliance guidelines #3 states that the facility will provide ongoing oversight and supervision of staff to ensure that its policies are implemented as written. In further review, on page 3, section III prevention of , neglect and , on letter H states assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff. A review of the physician's assessment completed on (next day) documented there was no evidence of any , no	A 025		

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A 025	Continued From page 3 redness, no , no and no found. Resident #1's vitals were stable. A review of resident #1's record revealed date of admission . The 1823 Health Assessment listed medical history of a female on Hospice care, diagnosis of , past medical history of infarcts with encephalomalacias, , with a , risk and . She needs a wheelchair for long distances. Assistance in all activities of daily living and needs assistance with self-administration of medications. On at 3:03 PM, there was a telephone interview with resident #1's private sitter. The private sitter said that she has been working for resident #1 about 3 years while she lived in her home prior but needed more supervision so the family admitted her into the facility. The private sitter stated that she comes to facility 7 days a week, within hours 11AM-3PM hired by the family. The private sitter said that resident #1 was and on Hospice care but she is still sharp in the mind, it is her physical body that fails her. The private sitter said that when she showed up to work on at 10:50 AM that Caregiver F had told her what resident #1 had said that early morning around 5 AM, resident #1 said that LPN A came into her room and slapped her in the and Caregiver F reported to LPN B immediately. The private sitter stated that she asked resident #1 to tell her what happened to her. Resident #1 said that she rang her call bell for help to the bathroom and LPN A came into her room and told resident #1 that you have some to wake me up, it's too early. Resident #1	A 025		

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told LPN A that I was told that when I need help to the bathroom to press my button and the LPN A replied again well it's too early for that and you need to go to bed. Resident #1 went to reach for her blanket to cover herself and LPN A just slapped resident #1 in her and LPN A said that will teach you to not to wake me up early. The private sitter said this broke her and she went and reported it to LPN B and called the family about the incident. The private sitter stated that LPN B told her that she already informed the Director of Assisted Living and they will handle it from here. Furthermore, the private sitter said that the upcoming week she had to go out of state for personal business and would be gone and asked a friend who used to work for resident #1 at her home to cover her shift for the week, and to keep an , on resident #1. The private sitter said that she did not observe any marks and /redness on resident #1's .

On at 3:23 PM, an interview with the friend, of the private sitter that was covering private sitter's work shift for this week, was asked did resident #1 tell her about LPN A slapping her in the . The friend answered yes that resident #1 told the friend that LPN A came into her room early Sunday morning about 4 AM-5 AM because resident #1 needed help to go to the bathroom and LPN A slapped her in the and told her that was what she got for waking her up to help her. The friend provided the telephone number for the private sitter that normally works every day with resident #1 to call also.

On at 3:31 PM, an interview with LPN B said that she was told by Caregiver F that resident #1 reported to her that LPN A had slapped her. LPN B immediately called the Director of Assisted Living, and the Administrator

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directed LPN B to immediately complete a body assessment for resident #1. LPN B stated that she did not see any visible marks or no on , , , arms, and abdomen. LPN B asked resident #1 what happened and resident #1 told her that LPN A came in this morning when I called for help to the bathroom and when LPN A got to her room, LPN A said that she hated resident #1 and slapped her in the for waking LPN A up so early in the morning. LPN B said that resident #1 denied any , at the time. LPN B further said that resident #1 repeated the same story with the other staff and her family member. LPN B wrote a statement about the incident.

A review of the staff work schedule for documented that LPN A worked 11 PM-7 AM (overnight) shift, same shift time of the alleged LPN A slapped resident #1 in the .

A review of the call pendent history on at 5:03 AM, that resident #1 pressed for help to go to the bathroom and at 5:06 AM it was cleared and reset.

On at 3:38 PM, a telephone interview with the family member stated that they were very upset with how the facility handled resident #1's from LPN A on Sunday morning . The family member said that the facility did not immediately call and inform them about what had happened. It was found out when another family member had visited resident #1 at 9 AM on , Sunday morning and resident #1 told the family member what happened that LPN A slapped her in the . The visiting family went to the Director of Assisted Living to ask her what happened and the Director of Assisted Living said that an investigation was in progress and that

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they had called law enforcement and reported it to the hotline. The family member continued to say that nothing was heard from the facility, the Administrator or any staff until 9AM on Wednesday morning by the Director of Assisted Living calling her and told her that the facility completed a full investigation and had suspended LPN A and there was no findings and LPN A was returning to work but would no longer work with resident #1 and not go into resident #1's room. The family member said that was a slap in the and was not comfortable with that decision and how would they stop LPN A from sneaking into resident #1's room and retaliate against resident #1. The family member was very thankful that the licensing agency was investigating allegations along with law enforcement. The family member stated that she was at ease knowing that a thorough investigation was going to be completed. The family member stated that law enforcement and hotline had already been in contact regarding resident #1.

On at 3:45 PM, an interview with the Administrator confirmed that an investigation was completed in suspending LPN A for the week and concluded with no findings, and the facility's investigation decision was to allow LPN A to return to work on but with stipulations, not work directly or go into resident #1's room. It was asked if law enforcement close the case. The Administrator said no it was still pending.

A review of the staff work schedule dated & documented that LPN A was scheduled to return to work on Saturday and Sunday for the overnight shift 11 PM-7 AM.

On at 3:47 PM, an interview with the

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A 025	Continued From page 7 Administrator confirmed that LPN A did work as the only nurse on and , the overnight shift 11 PM-7AM both days. On at 3:52 PM, an interview with resident #1 who said that LPN A came into her room on the past Sunday morning about 4am-5am and slapped her in her . Resident #1 said that she rang her emergency pendent for assistance to the bathroom and LPN A came to her room and said, "why you calling me and waking me up"? LPN A told her to go to bed, and she put the blanket over me and then slapped me in my and said that is what you get for waking people up. On at 10:55 AM, an interview with the Director of Assistant Living about the allegation from LPN A to resident #1 occurred on . The Director of Assisted Living stated on Sunday morning, not sure of time that LPN B called her and informed her about what resident #1 had reported LPN A had slapped her in the . The Director of Assisted Living told LPN B to call the family and to complete a body assessment on resident #1. The Director of Assisted Living said that on Monday morning she had a conference in person with the daughter. The Director of Assisted Living said that she did not document the conference and called LPN A to email her about what happened on in the morning. The Director of Assisted Living received an email on at 3:32 PM, hours later after LPN A shift were over. LPN A works on Saturday and Sunday, the overnight shift 11PM-7AM. Later, the Director of Assisted Living said she received LPN A's written statement of what occurred between LPN A and resident #1.	A 025		

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A 025	Continued From page 8 On at 1:59 PM, an interview with LPN C asking if she knew any details about the incident on early morning of LPN A slapping resident #1 in the ? LPN C answered no, she was not working at the time, but she heard something had happened and minded her business. On at 2:50 PM, an interview with LPN E asking if she knew about LPN A slapping resident #1 in the on . LPN E said no, she did not know anything about it. On at 3:39 PM, a telephone interview with law enforcement detective working on this case said that this is an active pending investigation and he was going to the facility on Friday, to interview staff and residents. On at 3:55 PM, an interview with Caregiver F stated that she reported to work on at 7:30 AM and she was responsible for waking residents up and getting them ready for breakfast. Caregiver F said that she went to resident #1's room and resident #1 was sleeping in her recliner chair and Caregiver F touched resident #1 to wake her up to get ready and Caregiver F always ask resident #1 how was your night last night? Resident #1 asked Caregiver F who was the nurse that worked last night. Caregiver F answered LPN A and then Resident #1 said that LPN A was a terror and she slapped me in my early this morning. Caregiver F said that she immediately reported to LPN B about the incident and did not see any visual redness or on resident #1's . Caregiver F was in tears because she said that resident #1 telling her that LPN A hurt her was hurtful. Caregiver F said that resident #1 is and on Hospice care, why would	A 025		

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anyone want to hurt her like that. It was further asked of Caregiver F how was LPN A's and demeanor was that morning? Caregiver F said that LPN A said hi to her earlier shift check-in, but LPN A made an odd statement to Caregiver F "I think resident #1 put a curse on me." Caregiver F said she thought that odd but shrugged off the statement because Caregiver F did not know what a "curse" means and this odd statement was earlier at shift check in before resident #1 had told Caregiver F about the slapping in her incident. Caregiver F said that she was new, only hired for about 3 weeks today so she doesn't really know her coworkers that well. Caregiver F said that she provided a written statement to management.

On at 4:20 PM, an attempted telephone call to LPN A and there was no answer, left a voicemail message.

On at 5:15 PM, a second attempted telephone call to LPN A and again there was no answer, another voicemail message left.

On at 6:50 PM, an exit conference with the Administrator, Executive Director and the Regional Health Services Director and they all agreed to the findings and further confirmed that mandatory staff training was scheduled for next week.

(Photographic Evidence Obtained)

Class III