STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105365	A. Building B. Wing	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Altamonte Springs	989 Orienta Ave Altamonte Springs, FL 32701

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide documented evidence that grievances were resolved promptly, and residents/family members were apprised of progress toward a resolution of grievances for 1 of 3 residents reviewed for grievances, of a total sample of four residents, (#2).Resident #2 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease, muscle weakness, abnormalities of gait and mobility, depression, dependence on supplemental oxygen and need for assistance with personal care. Review of the Minimum Data Set (MDS) significant change assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status score of 14/15 which indicated she was cognitively intact. The assessment indicated she needed substantial to maximum assistance from the staff to perform her activities of daily living, was frequently incontinent of urine and occasionally of bowel. On 7/15/25 at 9:30 AM, resident #2 was sitting up in bed, she was able to say what state she originally came from as well as the type of work she used to do. She verbalized concerns that she frequently had to wait up to two hours for her call bell to be answered, on all shifts and explained by the time staff got there she was soaked with urine. The resident said it happened all the time and detailed repeated complaints made to facility staff by herself and her family members. Resident #2 expressed the call bell response time had not gotten any better. On 7/15/25 at approximately 5:00 PM, Assistant Director of Nursing (ADON) C provided a copy of an email sent from resident #2's family regarding their concerns to the following staff: ADON B, ADON C, Executive Director (ED), Assistant ED, Staff Development Nurse, and the Director of Nursing (DON). The facility could not provide any evidence that a grievance was ever initiated in June or July 2025 regarding the expressed ongoing family concerns about resident #2's care and their need for clear communication, transparent protocols, compassionate professional responses, and concrete actions, not simply reassurances of education. A review of the grievance log for resident #2 showed six grievances in nine months regarding care and quality of life concerns dated 10/14/24, 10/29/24, 2/06/25, 3/19/25, 4/07/25, and 5/22/25. The grievances showed the resident and or family voiced repeated concerns regarding the following:* 5/22/25- Resident light has been on for four hours* 4/07/25- Call light not in reach and response time too long* 3/19/25-Call light not in reach and needed to be changed* 2/06/25- Call light response time poorOn 7/15/25 at 3:09 PM, the Social Services Director (SSD) explained she filled out all the forms for the numerous concerns made by resident #2 and her family. The SSD explained that most of the concerns for resident #2 had been focused on call light accessibility and response times. She responded that the facility had done audits and training with the staff. The SSD explained the facility did not do physical audits but most of the residents seemed happy with the response times. She explained they interviewed other residents. The SSD verified she was not aware of any staff coming into the building on various shifts and going into rooms without the staff knowledge to time staff response to call lights. The SSD said resident #2's family had a concern on 2/06/25 regarding poor call bell response time. The SSD verified she did not interview the resident to see what shift or exactly how long it took for her call light to be answered. Her investigative findings indicated no concern with other residents on the unit, however only two of the three residents interviewed used the call lights. The facility action was to remind staff to answer call lights as soon as possible which only included two staff who signed a preprinted form on 2/06/25 that read, When I am working on my assignment, I answer my call lights as soon as possible. If a call light is on and I answer it, If I cannot assist at the moment, I inform my resident I will be there as soon as I can. The form did not have any specific details regarding reasonable time frames to answer call lights or to ask another staff person to assist if they were too busy. The SSD could not provide any sign-in sheets regarding education provided or on what topic. On 2/07/25 the facility documented the concerned party was satisfied but did not record any specifics to the situation or their response/what did they say. The concerns dated 3/19/25 were then reviewed with the SSD who verified another issue with the call light on the floor, the resident needed to get changed, staff not wearing name tags, and air freshener taken away. ADON C was assigned and provided education to staff regarding wearing name tags, answering timely call lights, and placing call bell in reach. Resident #2 was informed about the facility policy on air fresheners. The SSD documented concerned party satisfied on 3/21/25 and did not document exactly what the response was at the time or were there any other concerns. Review of a concern dated 4/07/25 from family revealed the problem was the call light again was not in reach and response time was too long. No one asked the resident or family what shift, or which staff was involved

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to administer Oxygen (O2) therapy as ordered by the physician for 2 of 2 residents reviewed for respiratory care, of a total sample of 4 residents, (#2 and #4). 1. Resident #2 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD), muscle weakness, hypertension, dependence on supplemental oxygen and need for assistance with personal care. Review of the Minimum Data Set (MDS) significant change assessment with assessment reference date (ARD) of 6/03/25 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated she was cognitively intact. The MDS assessment noted the resident required substantial to maximum staff assistance with dressing/personal hygiene care and received oxygen therapy. The assessment also noted the resident did not exhibit behavior symptoms or rejection of care necessary to achieve the resident's goals for health and wellbeing. Review of resident #2's medical record revealed a care plan revised on 1/30/24 which indicated the resident received oxygen to be administered per respiratory medication orders. Supplemental oxygen therapy helps people with COPD, COVID-19, emphysema, sleep apnea and other breathing problems get enough oxygen to function and stay well. Low blood oxygen levels (hypoxemia) can damage organs and be life-threatening, (retrieved on 7/18/25 from www.myclevelandclinic.org).Resident #2's Order Summary Report showed an active physician's order dated 5/30/25 for oxygen at 2 liters per minute (LPM) via NC to maintain SPO2 (peripheral oxygen saturation) at 92% and for the nurses to check the oxygen delivery every shift for SOB (shortness of breath). On 7/15/25 at 9:30 AM, resident #2 was observed sitting up in bed with O2 delivered through a nasal cannula (NC). The O2 tubing was connected to a concentrator set to deliver 4 LPM. Resident #2 was alert and oriented to person, place, and time. The resident denied adjusting her O2 concentrator settings. Later that day on 7/15/25 at 11:34 AM, resident #2 was sitting up in a wheelchair with oxygen administered through a nasal cannula. The oxygen tubing was connected to an O2 concentrator set at 4 LPM. 2. Resident #4 was admitted to the facility on [DATE] with diagnoses of congestive heart failure, chronic kidney disease, dependence on supplemental oxygen, atrial fibrillation, diabetes type 2, and COPD. Review of the MDS Annual assessment with ARD of 5/23/25 revealed the resident had a BIMS score of 13/15, which indicated she was cognitively intact. The MDS assessment noted the resident required substantial to maximum staff assistance with dressing/personal hygiene care and received oxygen therapy. The assessment also noted the resident did not exhibit behavior symptoms or rejection of care necessary to achieve the resident's goals for health and wellbeing. Review of resident #4's medical record revealed a care plan revised on 1/26/24 which indicated a resident focus for Respiratory Risk which included an intervention to apply oxygen therapy as per order via nasal cannula with the goal that she would not experience acute respiratory distress. Resident #4's current active physician order dated 9/06/24 was for oxygen at 2 LPM continuously via nasal cannula. On 7/15/25 at 11:25 AM, resident #4 was lying in bed with O2 administered through a NC. The O2 tubing was connected to a concentrator set at 3.5 LPM. On 7/15/25 at 11:38 AM, Licensed Practical Nurse (LPN) A explained she was assigned to residents #2 and #4 and checked both of their oxygen liter flow rates earlier today but could not remember specifically their flow rate orders. LPN A relied on LPN E who was seated at the nurses' station to check her orders in the electronic medical record. LPN E said, both residents were supposed to be on 2 LPM of oxygen. On 7/15/25 at 11:40 AM, LPN A observed and acknowledged both residents #2 and #4 were not getting their oxygen as ordered. She was observed changing resident #2's oxygen flow rate from 4 LPM to 2 LPM and resident #4's from 3.5 LPM to 2 LPM. Post observation the nurse verified she did not check the residents' flow rates when passing her 9:00 AM medications to ensure they were getting it as prescribed by the physician. On 7/15/25 at 12:51 PM, The Director of Nursing (DON) and Assistant DON B said the nurses were supposed to check oxygen liter flow rate at eye level at least every shift. The DON verbalized the expectation that nurses should check the physician's order and give what was ordered. She acknowledged that although the order for resident #2 indicated for staff to keep her SPO2 level at a certain rate there were no parameters given other than 2 LPM. The DON confirmed the nurse should have clarified the order with the physician. ADON B explained that giving too much oxygen could cause toxicity in some residents and good nursing practice was to check every time they went in the room to ensure residents were getting what was ordered by the physician. Review of the facility's Oxygen Administration policy revised 4/08/25 indicated, The facility must ensure that resident who needs respiratory care, is provided such care