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	08/21/2025

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

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, and interview, the facility failed to thoroughly investigate and document a skin injury that occurred for 1 of 3 residents sampled for non-pressure related skin conditions, (#124), of a total sample of 63 residents.Findings:Review of resident #124's medical record revealed an admission date of 3/27/25. Her diagnoses included rheumatoid arthritis, unspecified; other lack of coordination, unspecified abnormalities of gait and mobility, and hemiplegia (paralysis) and hemiparesis (muscle weakness) following nontraumatic intracerebral hemorrhage (stroke) affecting left dominant side. Review of resident #124's Quarterly Brief Interview for Mental Status (BIMS) score dated 6/30/25 was a 12/15, which indicated moderate cognitive impairment. Review of the facility's incident list revealed resident #124 sustained a skin related injury incident on 4/15/25.Review of the skin related injury incident dated 4/15/25 at 6:55 PM, revealed the description indicated it occurred around 4:55 PM, when the nurse was asked by a certified nursing assistant (CNA) to assess resident #124's legs. The nurse indicated she noticed a skin tear on resident #124's right lower leg. The document described resident #124 said the incident happened after coming back from the dining room when the CNA transferred her from chair to bed and her leg got caught under the bed.On 8/20/25 at 1:15 PM, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON)/Risk Manager reviewed resident #124's skin related injury documentation that occurred on 4/15/25. Th nurses verified they had no statements nor any other documentation of CNA's accounts regarding the event but confirmed documentation should have been present. The DON explained the nurse as well as the Unit Manager would be involved in investigating the situation, then the Assistant Director of Nursing would review the event documentation. The DON said the D Unit Manager should have done an investigation regarding the event, gotten statements from staff involved or had knowledge of what happened, and documented the findings of the investigation. At 2:04 PM, the D Unit Manager joined the interview, but she could not recall the 4/15/25 skin tear incident.On 8/21/25 at 2:29 PM, the ADON/Risk Manager verified she did not know how many CNAs were involved in the transfer from chair to bed as resident #124 described nor how many CNAs may have had knowledge of the situation for the event on 4/15/25. She verified there was no documentation of the time of when details of the event occurred, only a description that it was after coming back from the dining room. On 8/21/25 at 3:33 PM, the Unit D Manager recounted, with DON and ADON present, there were two CNAs who were involved with the transfer that resulted in the skin injury to resident #124's right lower leg on 4/15/25. She expressed that one CNA had left employment with the facility and could not recall who the other CNA was. She recalled she spoke with the two CNAs on 4/16/25 about the incident but confirmed she had no additional documentation regarding the investigation. The Unit D Manager did not offer an explanation about why she did not obtain statements nor why she did not ask for additional documentation from staff who were involved in the incident. She verified she herself did not document the additional information that was gathered during her investigation, such as how CNAs transferred resident #124. The Unit D Manager did not offer an explanation on what was the most likely cause of the event. She said she did not verify through observation whether the CNAs which were involved in resident #124's skin tear were using proper transfer techniques in the transfer of residents. On 8/20/25 at 6:08 PM, the Wound Care Nurse verified the facility was still providing physician ordered wound care for the wound sustained on 4/15/25, and the skin injury had not resolved.Review of the facility's policy titled Incident and Reportable Event Management with a most recent revision of 5/4/23 indicated that after an incident/injury the licensed nurse should obtain as much detail as possible including interview statements from whoever who discovered the issue, those who were present during the event, and any other persons who could provide vital information. In the investigation section of the policy, it detailed that the licensed nurse should perform a quick initial investigation to determine the most likely cause of the event.

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide timely assessment, treatment, and management of pain for 1 of 1 resident reviewed for pain, of a total sample of 63 residents, (#228). The facility's failure to follow the physician's orders and treat pain and discomfort resulted in actual harm.Findings:Review of the medical record revealed resident #228 was admitted to the facility on [DATE] with diagnoses including wedge compression fracture of the third lumbar vertebra, low back pain, and osteoarthritis. Review of the admission Minimum Data Set (MDS) assessment with Assessment Reference Date of 8/11/25 revealed resident#228's Brief Interview for Mental Status score was 15 out of 15 indicating intact cognition. The MDS assessment noted no behaviors or rejection of evaluation or care necessary to obtain goals for health and well-being. The MDS assessment noted she received PRN (as needed) and scheduled pain medications in the last five days. The assessment noted pain was present daily, which affected sleep and therapy participation. The MDS indicated resident #228 was in pain occasionally and the pain occasionally affected her sleep but rarely affected her participation in therapy, during the five day lookback. The pain intensity was rated moderate. The assessment revealed resident #228 received opioid pain medication during the last seven days or since admission.Review of the Florida Agency for Health Care Administration 5000-3008 Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form dated 8/07/25 revealed resident #228 was ambulatory with assistive device and required assistance for transfers. The document indicated the resident was alert, oriented, and followed instructions. The Pain Assessment section showed a pain level of 5 out of 10 and the last pain medication was administered at 7:45 AM.Review of resident #228's hospital records showed the last administration of Oxycodone-Acetaminophen 5-325 milligrams (mg) prior to her transfer to the facility occurred on 8/07/25 at 4:06 PM. Review of the After Visit Summary from the hospital dated 8/07/25 instructed to continue Hydrocodone-Acetaminophen (Norco) and included a printed prescription to obtain the medication from a pharmacy.Review of the hospital Discharge summary dated [DATE] revealed resident #228 had a history of chronic left knee pain with gait instability and cervical spine injury. Resident #228 presented to the emergency room via ambulance after being pushed by a bystander at a pool landing on her back which resulted in an acute L3 endplate and T12 compression fractures. Resident #228 underwent a kyphoplasty of the L3 vertebral body on 8/01/25. Kyphoplasty is a procedure that treats compression fractures in the spine. Bone cement is added to the affected area to help relieve pain, (retrieved from www.webmd.com on 8/26/25). Review of the Admission/readmission Collection Tool form dated 8/07/25 revealed the pain level was 0 at 7:41 PM. The form included moving around made the pain worse and the resident's acceptable pain level was 3/10. The areas of quality of life that were affected by pain was identified as Sleep and rest. The form revealed opioid medication was used to manage her pain. The progress note section showed resident #228 arrived at the facility at approximately 4:30 PM on 8/07/25, from the hospital. Review of resident #228's physician orders revealed an order entered on 8/07/25 at 10:36 PM, for Hydrocodone-acetaminophen 5-325 mg every six hours as needed (PRN) for pain. Review of resident #228's Baseline Care Plan form dated 8/07/25 showed she was asked, What do you perceive are barriers to your healthcare needs and recovery? Her response was pain.Review of resident #228's Care Plan for potential of pain related to impaired mobility, diabetes, vertebral compression fractures of C3, T12, L3, L4, wedge compression fracture of 3rd lumbar vertebra, osteo-arthritis, low back pain, and chronic left knee pain was revised on 8/14/25. The goal was to minimize pain as much as possible when present. The interventions included administering medications that help manage pain as per order and to offer PRN pain medication as per physician's order for complaints or observation of pain/discomfort. An intervention instructed nursing staff to anticipate the resident's need for pain relief and respond immediately to any complaint of pain.On 8/18/25 at 12:28 PM, resident #228 stated she had to wait a prolonged period of time for pain medication after her admission on [DATE]. She explained she was admitted on a Thursday at approximately 5:00 PM and did not get pain medication until Friday at approximately 3:30 PM. She recalled she was in severe pain by the time she received the first dose in the facility, but that the pain medication did not provide relief. She requested additional pain medication before 9:00 PM but was told the medication was not due and had to wait until 9:15 PM for her second dose. She said during that time she was crying and in excruciating pain. She mentioned she asked to speak to anyone in charge, but no one came, so she called her dad, and he called the facility but was unable to speak with the nursing staff. She stated her dad drove to

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the medical record reflected the correct site for blood pressure (BP) measurement for 1 of 2 residents reviewed for dialysis, of a total sample of 63 residents, (#10). Findings: Review of the medical record revealed resident #10 was admitted to the facility on [DATE] with diagnoses including end stage renal disease requiring dialysis, type 2 diabetes, and bacteremia. Review of the Order Summary Report revealed a physician order dated 1/07/25 which included resident #10 received dialysis on Monday, Wednesday, and Friday and specified no BP on the right arm with fistula/shunt. Review of the Blood Pressure Summary report from 7/19/25 to 8/19/25 revealed documentation of BP obtained on the right arm 13 times: 7/19/25 at 3:10 PM, 7/22/25 at 9:00 PM, 7/25/25 at 6:07 PM, 7/26/25 at 9:21 AM, 7/26/25 at 5:47 PM, 7/27/25 at 9:41 AM, 8/02/25 at 9:38 AM, 8/02/25 at 4:56 PM, 8/03/25 at 5:31 PM, 8/08/25 at 9:01 PM, 8/10/25 at 4:00 PM, 8/18/25 at 9:04 PM, and 8/19/25 at 7:16 PM. On 8/21/25 at 9:44 AM, during a telephone interview, Licensed Practical Nurse E indicated vital signs were obtained by the Certified Nursing Assistants and she entered them in the medical record. When asked about documentation of the BP on the right arm on 8/10 at 4:00 PM, she stated she probably just picked an arm when documenting it. On 8/21/25 at 12:30 PM, Registered Nurse (RN) F stated he did not recall which arm he used to take resident #10's BP but may have documented it incorrectly because of rushing. He confirmed he documented BP on the right arm incorrectly on 7/19/25 at 3:10 PM and 7/27/25 at 9:41 AM. He explained he would have checked the physician orders prior to obtaining the BP for a dialysis resident, and some residents even alerted him if he had not noticed. On 8/21/25 at 1:54 PM, the D-Wing Unit Manager validated resident #10's medical record was inaccurate when BP was documented on the right arm but taken on the left. She stated she did not audit vital sign records. Review of the facility's Medical Record Organization policy reviewed on 2/27/25 read, All medical records must be complete, accurately documented, readily accessible, and systematically organized.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. (continued on next page)

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F 0919 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 ensure a resident was able to call for staff assistance through a call bell system for 1 of 1 resident reviewed for call bells, of a total sample of 63 residents, (#229).Findings: Review of resident #229's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included secondary malignant neoplasm of the brain, mobility abnormalities, muscle weakness, need for assistance with personal care, and rheumatoid arthritis. Review of the Minimum Data Set (MDS) admission assessment with Assessment Reference Date of 8/06/25 revealed resident #229's Brief Interview for Mental Status score was 14 out of 15 which indicated she was cognitively intact. The MDS assessment noted no behaviors or rejection of evaluation or care necessary to obtain goals for health and well-being. The assessment showed no vision, hearing or speech impairment. Resident #229 had functional limitation in range of motion (ROM) on an upper extremity and used a wheelchair for mobility. The MDS assessment noted resident #229 needed partial assistance from staff for eating and was dependent on staff for toileting hygiene, personal hygiene, dressing, bathing and donning and doffing footwear. She was also dependent on staff for transfers. She was occasionally incontinent of bladder and continent of bowel. Review of resident #229's care plan initiated on 8/12/25 showed a self-care deficit with Activities of Daily Living (ADL) which required limited to extensive assistance of one to two staff related to impaired mobility, decreased endurance and strength, limited ROM to the left upper extremity (LUE), and episodes of incontinence. Review of resident #229's care plan showed resident #229 was at risk for falls due to impaired mobility, self-care deficits, decreased endurance and strength, episodes of incontinence, use of pain medications, use of psychotropic medications, history of falls, use of diabetic medication, and limited ROM to LUE revised on 8/12/25. Interventions directed staff to assist with transfers and encourage/remind resident #229 to call for assistance before getting up to transfer. On 8/19 at 11:03 AM, staff was observed in resident #229's room attempting to draw blood. A short time later on 8/19/25 at 11:14 AM, resident #229 was sitting in her wheelchair with a bedside table in front of her while eating her lunch in her room. The call light cord was wrapped around the bedside rail and not within reach. Later, at 12:15 PM, resident #229 remained in her wheelchair, still without access to her call light. The resident's room door was closed, and her television was on. The lunch tray had been removed from her room. Resident #229 stated she needed to go back to bed and be changed. She shared she needed to have the gadget (call light) near her to call the nurse for assistance with toileting needs. She shared she had been sitting in the wheelchair while after working with therapy. On 8/19/25 at 12:22 PM, Certified Nursing Assistant (CNA) H reported she checked residents hourly and ensured call lights were in reach. She acknowledged it was important for safety and fall prevention. CNA H stated resident #229 was acting differently today and she reported the change in behavior to her nurse. Later at 12:30 PM, CNA H and the State Surveyor walked into resident #229's room and the resident shared she wanted to get back to bed. CNA H indicated resident #229 went to therapy at 10 AM. CNA H stated she brought in her lunch tray and picked the lunch tray up. CNA H validated the call light was not within resident #229's reach and stated she did not notice it the times she went into the room. On 8/20/25 at 5:21 PM, Licensed Practical Nurse (LPN) J stated laboratory staff came to draw blood for resident #229 on 8/19/25. She shared other nursing staff were assisting with obtaining the blood work, so she stepped out of the room. LPN J stated she obtained a blood sugar sample at 11:31 AM. She indicated she did not notice resident #229's call light was not within her reach. She shared when residents did not have a way to call staff, they could attempt to stand up by themselves, which placed them at risk for falls, or might make them anxious if they couldn't call for help. On 8/21/25 at 2:07 PM, the D-Wing Unit Manager stated it was everyone's responsibility to ensure the residents had their call lights within reach. Review of the facility's policy and procedure titled Resident Call System reviewed on 1/15/24 read, The call light should be positioned within reach of the resident. The call system must be accessible to residents while in their bed or other sleeping accommodations within the resident's room.