STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105379	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kissimmee Health and Rehabilitation Center	320 N Mitchell St Kissimmee, FL 34741

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Minimum Data Set (MDS) assessments accurately reflected prognosis of life for 1 of 1 resident reviewed for hospice services, (#11) and failed to accurately reflect a treatment for skin impairment for 1 of 1 resident reviewed for skin conditions, (#54), out of a total sample of 23 residents.Findings: 1. Review of resident #11's medical record revealed he was admitted to the facility on [DATE] and readmitted from an acute care hospital on [DATE]. His diagnoses included Alzheimer's disease, dementia, and heart disease.Review of the medical record for resident #11 revealed a certification form dated 3/10/26 from hospice. The document included a verbal certification given by the physician that read, Based on the information available, I believe that the patient has a life expectancy of 6 (six) months or less if the disease takes its natural course. Review of resident #11's quarterly MDS assessment with Assessment Reference Date (ARD) of 3/19/26, Section J - Health Conditions, included an inquiry regarding prognosis. J1400 read, Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? It was answered, No. 2. Review of resident #54's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included dementia human immunodeficiency virus, heart disease, and type 2 diabetes.Review of resident #54's physician orders revealed an order for Hydrocortisone External Cream 2.5% to be applied to both arms and legs topically two times dated 3/31/26. Review of resident #54's Treatment Administration Records (TAR) for April 2026 showed the cream was applied daily. Review of resident #54's quarterly MDS assessment with ARD of 4/14/26 revealed Section M - Skin Conditions included Skin and Ulcer/Injury Treatments and required the selection of treatments in placed that applied to the resident. The list included, Application of ointments/medications other than to feet which was not selected. On 5/28/26 at 11:58 AM, the MDS Coordinator stated she was responsible for completing MDS assessments. She reviewed resident #54's quarterly MDS assessment with ARD of 4/14/26 and indicated resident #54 had an ointment applied during the lookback period which should had been captured in the MDS. She stated she referred to the TAR when reviewing this section, but missed the Hydrocortisone cream treatment. On 5/28/26 at 1:28 PM, the MDS Coordinator reviewed resident #11's quarterly MDS with ARD of 3/19/26. She explained that for residents who received hospice services, the pertinent questions were found in Section J and Section O of the MDS assessment. She acknowledged the prognosis question in section J was answered incorrectly and stated it should have been answered, Yes. She confirmed the information was included in the hospice certification. Review of the facility's policy titled MDS 3.0 Completion, revised on 9/19/22, revealed the facility conducted initial and periodic comprehensive, accurate and standardized assessments of each resident according to federal regulations using the Resident Assessment Instrument specified by the State.

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to resubmit an accurate Preadmission Screening and Resident Review (PASRR) upon admission and after a change in condition for a resident diagnosed with Serious Mental Illnesses (SMI) and Intellectual Disability (ID) for 1 of 1 residents reviewed for PASARR, out of a total sample of 23 residents, (#46).Findings:Review of resident #46's medical record revealed she was admitted to the facility on [DATE] with diagnoses including mood disorder, psychotic disorder, and intellectual disability. Review of resident #46's annual Minimum Data Set (MDS) with Assessment Reference Date 3/20/26 revealed she had a Brief Interview for Mental Status score of 10 out of 15 which indicated moderate cognitive impairment. The MDS assessment revealed a Mood Interview was conducted and resident #46 reported feeling down, depressed, or hopeless 7 to 11 days during the lookback period. She also indicated she sometimes felt isolated. The assessment noted no rejection of care necessary to achieve goals for her health and well-being. The assessment showed behavioral symptoms including verbal/vocal symptoms such as screaming and disruptive sounds not directed toward others occurring 1 to 3 days during the lookback period. The MDS assessment also revealed resident #46 received routine antipsychotic medications. Review of resident #46's medical record revealed a State of Florida Agency for Health Care Administration Preadmission Screening and Resident Review (PASRR) Level I Screen form dated 3/21/25. Section I. A, Mental Illness (MI) or suspected MI, (check all that apply), was left blank. Under section I. B., ID or suspected ID, the option onset prior to [AGE] years of age was selected. Section IV, PASRR Screen Completion indicated No diagnosis or suspicion of SMI or ID (Intellectual Disability) indicated. Level II PASRR evaluation not required was checked. The form was electronically signed by a hospital Registered Nurse (RN). A second PASRR form in the medical record dated 4/16/25 was signed by the facility's Director of Nursing (DON). Section I, A. selected Psychotic Disorder and Other: other specified persistent mood disorders. Under Section I. B., none of the listed ID conditions were selected. Section IV again indicated, No diagnosis or suspicion of SMI or ID (Intellectual Disability) indicated. Level II PASRR evaluation not required.Review of resident #46's care plan revealed a focus for the potential for psychosocial well-being problems related to suicidal ideation initiated on 4/22/26. Interventions included hourly checks. Review of a behavioral care plan initiated on 8/21/25 and revised on 4/07/26 revealed resident #46 had the potential to display behaviors including becoming upset when other residents sat at the same table, throwing dentures on the floor, and stating she was pregnant when her abdomen was swollen. Review of the resident's care plan initiated on 3/27/25 and revised on 4/23/26 revealed resident #46 had the potential for adverse effects related to the use of psychotropic medications. Review of a Psychiatry Evaluation Note dated 3/19/25 revealed resident #46 was admitted to the facility with a diagnosis of mood disorder and psychosis. The note showed she was taking Depakote and Risperidone to treat her SMI. Review of a Psychiatry Note dated 4/22/26 revealed the evaluation was completed because resident #46 made some inappropriate comment such as wanted to end her life. If she had a knife, she will cut herself with it. The note further indicated, Patient had been bullied by a few other resident at the facility .Patient stated she has no plan however she's still depressed. The resident was placed on one-to-one (1:1) observation per facility request for safety purposes.Review of a Psychiatry (psych) Subsequent Note dated 5/01/26 indicated resident #46 was seen to assess tolerability and effectiveness after recent medication changes. The note included summaries of prior psychiatric notes which indicated:*1/02/26 Patient had psychosis. Patient had hallucinations of hearing and seeing people. No medication changes. *2/13/26 Patient was psychotic. Patient saw things. No medication changes. *4/22/26 Patient had mood disorder. Medications included Melatonin, Buspirone, Depakote and Risperdal. Started Trileptal at 150 mg twice a day for one month and Lithium 150 mg daily for 2 (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weeks. *5/01/26 Patient was at baseline. No active psych symptoms. No medication changes.The Plan of Action included Melatonin for insomnia, Lithium and Trileptal for suicidal ideations, Depakote for mood disorder, Buspirone for anxiety and Risperdal to treat psychosis. The note also indicated, Patient has vague symptoms of anxiety, but they are causing distress. Review of resident #46's Interdisciplinary Care Notes revealed the following:*4/22/26 resident with suicidal ideations, 1:1 initiated, Psych Nurse Practitioner evaluated resident with new orders for Lithium and Trileptal. Another note on the same day mentioned the physician was informed and resident to receive plastic utensils with meals. *4/24/26 remained on 1:1. No medication changes during Gradual Dose Reduction meeting with the interdisciplinary team (IDT). *4/27/26 continued on 1:1 with no signs or symptoms of suicidal ideations or behaviors noted.*4/28/26 continued on 1:1 with no signs or symptoms of suicidal ideations.*4/29/26 IDT met to discuss 1:1 supervision for suicidal ideations. No behaviors noted. 1:1 discontinued and 30-minute safety checks initiated.*5/19/26 No signs or symptoms of suicidal ideations. Every 30-minute safety checks changed to hourly. There was no evidence in the medical record a new PASRR Level I was completed or submitted following the resident's change in condition, suicidal ideations, behavioral symptoms, or psychiatric medication changes. On 5/27/26 at 4:30 PM, the Social Services Director (SSD) stated she reviewed PASRR forms upon admission for completeness and accuracy. She explained she reviewed newly admitted residents' diagnosis and psychotropic medications to ensure they matched the PASRR forms. She stated if a resident had SMI, the resident was evaluated by psychiatry. She further stated if psychiatry added a new diagnosis, a new Level I would be completed. The SSD stated when resident #46 was admitted to the facility, she received psychotropic medications and had psychiatric diagnoses that were not reflected on the hospital PASRR form. She explained she completed a new PASRR form, added the missing information, and provided the form to the DON for review and signature. She confirmed the PASRR form signed by the DON on 4/16/25 reflected that process. The SSD further indicated resident #46 exhibited new behaviors such as talking to herself and later experienced suicidal ideations which were addressed by psychiatry with medication adjustments. She acknowledged a new PASRR Level I was not completed or submitted to the State when the facility identified the missing SMI diagnoses or following the resident's behavioral changes and medication adjustments. The SSD stated she was not familiar with the electronic PASRR submission process or the agency responsible for determining whether a Level II was required.On 5/27/26 at 6:14 PM, the DON stated only the Nursing Home Administrator (NHA) had access to the State PASRR website. She explained if a PASRR required revision, she received the completed form from the SSD, reviewed it, and signed it. She stated she had never entered a Level I into the State system. The DON indicated a new PASRR Level I was required if there were changes to psychotropic medications or psychiatric diagnoses. When asked whether a new PASRR Level I was submitted following resident #46's change in condition, the DON stated she did not believe one was submitted. She could not explain why it was not submitted or the purpose of the PASRR evaluation. On 5/28/26 12:36 PM, the NHA stated newly admitted residents arrived with a PASRR Level I form completed by the hospital. He indicated all newly admitted residents were evaluated by psychiatry. He explained if a PASRR required revision, he would submit it through the State website with assistance from the SSD. He stated he had not been aware revisions were required to be electronically submitted. He confirmed neither the PASRR form signed by the DON on 4/16/25 nor a revised PASRR following resident #46's behavioral changes were submitted to the State. He added up to this day, he was the only individual with access to the PASRR website in the facility but had requested access for the DON as well. Review of the facility's policy titled, Resident Assessment - Coordination with PASRR Program, revised January 2026, revealed the facility coordinated assessments with the PASRR program under Medicaid to ensure individuals with mental disorders, intellectual disabilities, or related conditions received care and services in the most integrated setting appropriate to their needs. The policy further indicated the SSD was responsible for tracking each resident's PASRR screening status and referring residents to the appropriate authority. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy additionally revealed, Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Examples include: A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to revise a comprehensive person-centered care plan for 1 out of 23 residents reviewed for care plans, of a total sample of 23 residents, (#3).Findings:Resident #3 was admitted to the facility on [DATE] with diagnoses of end stage renal disease, diabetes, and stroke.The Minimum Data Set (MDS) assessment dated [DATE] revealed resident #3 had a Brief Interview for Mental Status of 15 out of 15, which meant he was cognitively intact.Review of the facility's incident log showed the resident fell on [DATE], and again on 12/24/25.An Agency for Health Care Administration Transfer form dated 12/24/26 indicated resident #3 had an unwitnessed fall, hit his head, and was transferred to the hospital. Review of a Physician's progress note dated 2/17/26 revealed the resident had a cervical spine fracture, he refused surgery, and the doctor ordered a neck brace to be worn at all times. A cervical spine fracture is a break to one of the neck bones. Often a doctor recommends a hard collar to support, protect, and limit movement in the neck to keep alignment and allow healing. This device supports the weight of the head and minimizes further damage or injury to the neck. (Retrieved 5/29/26 from https://www.cuh.nhs.uk/patient-information/wearing-a-cervical-hard-collar-a-guide-to-collar-care-for-patients-re Resident #3 had a Care Plan with an intervention dated 1/07/26 that instructed staff to assist the resident with his neck collar. On 5/27/26 at 8:23 AM, resident #3 was observed in the common area listening to music on his phone and bobbing his head, he was not wearing the neck brace. He stated he didn't like to wear the collar while he ate. On 5/27/26 at 11:28 AM, the Administrator said resident #3 sometimes took the collar off. On 5/28/26 at 11:30 AM, the Director of Nursing said if the resident didn't want to wear a neck brace, the doctor should be notified, and the refusal should be documented. The facility was unable to provide any documentation the resident refused the neck collar. On 5/28/26 at 12:00 PM, the MDS Coordinator stated the facility's expectation was that care plans should be updated to include interventions and goals for safety.Review of the facility's Positioning Devices Policy revised January of 2026, noted if a resident refused to use an assistive device to support body alignment, it should be documented in the medical record. According to the facility's Standards and Guidelines for Care Plans, resident assessments should be ongoing, and care plans should be updated as situations change. Residents have the right to refuse treatment, and that refusal should be documented according to the facility's policy.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate assessment, treatment, and implement ordered interventions for 1 of 1 resident reviewed for skin conditions, out of a total sample of 23 residents, (#54). Findings: Review of resident #54's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included dementia, human immunodeficiency virus (HIV), major depressive disorder, heart disease, and type 2 diabetes. Review of resident #54's quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date of 4/14/26 revealed a Brief Interview for Mental Status score of 10 out of 15 which indicated moderate cognitive impairment. The MDS assessment showed resident #54's speech was clear with distinct intelligible words, he made himself understood, and usually understood others, missing some part or intent of message but comprehending most conversations. The MDS assessment indicated resident #54 did not reject evaluation or care needed to achieve his goals for health and well-being. The resident required setup assistance for eating, partial/moderate assistance for oral hygiene, and substantial/maximal assistance for toileting hygiene, shower/bathing, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. He required partial/moderate assistance to roll from lying on back to left and right side in bed and was dependent on staff for transfers. Resident #54 was always incontinent of bladder and bowel. Review of resident #54's Progress Notes revealed a Change in Condition note dated 3/31/26 documenting old scabs on both arms and legs. The form showed the physician was notified and a new order for Hydrocortisone 2% cream twice daily was obtained. Review of resident #54's physician orders revealed an order dated 3/31/26 for Hydrocortisone External Cream 2.5% to be applied to the arms and legs twice daily. Review of resident #54's Treatment Administration Records (TAR) for April and May 2026 showed the cream was documented as applied daily. On 5/26/26 at 11:48 AM, resident #54 was lying in bed and stated he was itchy all over. He was observed scratching his chest and his right armpit. Red areas were noted on his left arm. When asked how long he had been itchy, he could not say. When asked if he had received a cream that day, he stated he had not. On 5/27/26 at 9:53 AM, resident #54 was again lying in bed and stated he was not feeling better because he continued to itch all over. He again stated he had not received the cream. Multiple small red round areas were observed on his arms, and he was scratching under his right arm. On 5/27/26 at 12:17 PM, Certified Nursing Assistant (CNA) B stated he informed the nurses about any changes in eating, pain, or skin condition for his assigned residents. He shared resident #54 was able to express his needs but frequently refused care, preferred to remain in bed, did not like to wear a shirt, and did not participate in activities. CNA B stated resident #54 only allowed bed baths. CNA B stated the resident did not have wounds but itches a lot. CNA B further stated the resident had some open small bumps on his back and his thighs and frequently requested cream application. CNA B shared he informed the nurse when this occurred. He recalled the resident's skin looked the same for at least four days the prior week and the resident continued scratching. He stated the resident's bed sheets were changed once or twice daily because he bled from scratching. Review of resident #54's physician orders revealed an order for Benadryl 25 milligrams every 6 hours as needed for itching. Review of the TAR showed the Benadryl had not yet been administered. On 5/27/26 at 5:17 PM, Registered Nurse (RN) C stated resident #54 had a cream treatment for his skin and was doing well. She mentioned the facility had a dermatologist who visited residents and believed resident #54 had been evaluated. When asked whether she noticed the resident continued scratching and complaining of itching, she validated she had noticed and stated she would attempt to call the physician later to discuss changing the cream because it did not appear effective. Later at 5:37 PM, RN C assessed resident #54's skin with this surveyor and indicated he had a skin rash throughout his body with visible scratch marks. Multiple red and inflamed bumps, some opened, were observed on the resident's arms, legs, thighs, and chest. On 5/27/26 at 5:49 PM, the Director of Nursing (DON) stated (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she was not aware of resident #54's skin condition. She indicated she expected changes in condition and physician communication to be documented in the medical record. The DON confirmed the medical record lacked evidence of recent physician notification regarding the resident's skin condition and continued complaints of itching. Review of resident #54's Progress Notes revealed an Interdisciplinary Care Note dated 5/19/26 which indicated a Standard of Care meeting had been held that day with the interdisciplinary team (IDT). The documented medications were reviewed and no behaviors, falls or wounds were noted. The care plan was reviewed and remained appropriate. There was no evidence resident's skin condition and itching was discussed with the IDT. Review of resident #54's Progress Notes revealed a Narrative Note dated 3/31/26 which documented complaints of itching to both arms and legs with multiple areas of old scabbing on the bilateral upper and lower extremities. The note indicated the skin was dry with evidence of previous scratching and no active bleeding or open wounds observed at that time. The resident reported intermittent itching more noticeable during rest periods. The note indicted no redness, warmth, swelling, or drainage was observed. Nursing staff documented they would continue monitoring the condition and report changes. Another Narrative note dated 2/24/26 documented a 2 centimeter (cm) by 2 cm skin tear to the resident's left forearm with slight bleeding. The resident reported the lesion occurred after scratching due to itching. The note indicated resident #54 was educated regarding avoidance of scratching and the area continued to be monitored for signs of infection. Review of resident #54's medical record revealed the last time he was seen by Infectious Disease evaluation occurred on 1/26/26 and there was no evidence the resident had been evaluated by Dermatology prior to 5/27/26. Review of the following Weekly Skin Evaluations revealed:5/26/26 Continue treatment as ordered for itching5/21/26 Continue treatment for itching5/19/26 No new skin issue, continue Hydrocortisone External Cream 2.5 % for itching5/14/26 Itching - treatment in place5/08/26 Continue cream to bilateral legs/arms5/05/26 Receiving treatment for itching4/30/26 Continue with treatment for itching4/23/26 Treatment in place - Hydrocortisone External Cream 2.5 %4/16/26 Treatment in place - Hydrocortisone External Cream 2.5 % Review of resident #54's care plan revealed a focus for skin impairment risk revised on 11/24/25. The care plan indicated he was at risk for skin impairment related to decreased mobility, incontinence and dependence on staff assistance for transfers and mobility. Interventions directed CNAs to observe the skin during hygiene care and report abnormalities to nursing staff. On 5/28/26 at 8:55 AM, the Wound Nurse stated she performed wound care for all wounds in the facility and completed skin assessments for newly admitted residents. She stated she rounded weekly with a wound care provider. The Wound Nurse stated resident #54 was sleeping when she applied the Hydrocortisone cream that morning and she also applied the cream to his back after he turned to his side and he reported no discomfort. She recalled assessing resident #54 approximately two weeks earlier and noted dry skin and scratching. She stated the physician had previously been contacted and ordered Hydrocortisone cream. The Wound Nurse reviewed the skin evaluation notes she completed on 4/07/26 and 5/12/26 and stated the skin was not opened at that time. She stated she instructed the assigned nurse to contact dermatology because the condition would be more appropriately managed by dermatology rather than wound care. The Wound Nurse acknowledged the Hydrocortisone treatment had been in place since April 1st and resident #54 continued to complain of itching with visible red marks on his skin. She confirmed she was the assigned nurse from 7:00 AM to 3:00 PM on 5/28/26 and acknowledged she did not contact the physician or review the effectiveness of the treatment during her shift. She stated she assumed the Unit Manager (UM) was addressing the issue but did not verify this. She further stated resident #54's HIV diagnoses increased his risk for infection because he was immunocompromised. On 5/28/26 at 10:06 AM, the UM stated resident #54's Hydrocortisone cream was ordered based on a nursing assessment completed on 3/31/26. She stated she believed the Wound Nurse applied the cream daily. The UM stated she rounded with resident #54's physician on Tuesday, and the physician ordered Benadryl because the resident was scratching. She indicated she entered the Benadryl order at 1:38 PM and instructed RN D to administer it immediately. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The UM reviewed resident #54's MAR and confirmed it showed Benadryl was only administered on 5/27/26 at 6:15 PM. She acknowledged the medical record did not show resident #54 received Benadryl on 5/26/26 as ordered by the physician. The UM stated she instructed RN D twice to administer and document the medication. She further stated she and the physician completed a head-to-toe assessment of resident #54 while he was actively scratching himself. When asked why there was no documentation of the physician assessment or her observations, she stated she did not have time to complete documentation because surveyors arrived that day. She stated resident #54 was not bleeding and he received cream treatment.On 5/28/26 at 10:31 AM, RN D stated she cared for resident #54 on Monday and Tuesday of that week. She stated she was not aware the physician evaluated the resident on Tuesday. RN D indicated she applied the Hydrocortisone cream throughout the resident's body and acknowledged the order specified application only to the arms and legs. She stated she administered the Benadryl on 5/26/26 based on the UM's instruction but did not verify the order or document the administration. She stated she believed the UM had documented the medication administration. On 5/28/26 at 1:43 PM, the DON stated the physician had not yet completed his 5/26/26 progress note. The DON indicated she assessed resident #54 the previous evening and observed redness on the resident's neck, chest, abdomen, arms, and legs. She stated nurses were expected to review physician orders and document medications after administration. The DON further stated staff should follow transmission-based precautions when caring for resident #54 because of his increased infection risk. On 5/28/26 at 2:26 PM, resident #54's physician stated he came to the facility approximately three times weekly or as needed and was the resident's primary care physician. He indicated this was the first time he observed resident #54's skin in that condition. He mentioned staff informed him the resident complained of pain and dry skin. The physician stated the resident's skin appeared excoriated and dry and the condition appeared longstanding. He said he instructed the UM to discontinue the Hydrocortisone cream because prolonged steroid use could further dry the skin and initiate Benadryl for itching. He explained prolonged use of steroid cream could worsen dryness. The physician further stated he instructed the UM to arrange follow up with Infectious Disease due to the resident's HIV diagnosis and discussed a dermatology consultation. He indicated he expected nursing staff to notify him or his office regarding changes in residents' conditions. When informed Benadryl administration was not documented on 5/26/26, the physician said, If it is not documented it is not done. He further stated, Even if the patient cannot request it (the medication), they should see that he needs it. Review of a Progress Note from the Dermatology Nurse Practitioner dated 5/27/26 revealed the resident had experienced itching and eruption about 3 weeks. The resident rated the itching as 8 out of 10. The note documented generalized intermittent pruritus erythematous diffuse eruption with pickers nodules noted on arms and legs. The note also documented concern for bacterial and fungal skin infections related to the resident's immunocompromised status due to HIV. The treatment plan included Cipro, Fluconazole, and Hydroxyzine. Review of the facility's policy titled Medication Administration revised on 1/2025 revealed medications were to be administered as ordered by the physician and in accordance with professional standards of practice. The policy directed nursing staff to review the MAR before administration and sign the MAR following administration. Review of the facility's policy titled Documentation in Medical Record not dated revealed each resident's medical record was required to contain an accurate representation of the resident's condition through complete, accurate, and timely documentation.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to provide pharmaceutical services related to accurate interpretation of a physician order, and inaccurate administration and documentation of medications for 1 of 4 residents reviewed for medication pass, (#47); and failed to appropriately dispose of medications, (#67), for 1 of 4 residents reviewed for medication pass, out of a total sample of 23 residents.Findings:1. On 5/26/2026 at 10:06 AM, Registered Nurse (RN) E stated she was administering the 9:00 AM medications, which could be given one hour before or one hour after the scheduled administration time. She prepared the following medications for resident #47: Aspirin 81 milligrams (mg), Cranberry 450 mg, Iron 325 mg, Acetaminophen 500 mg, Memantine 5 mg, Isosorbide 30 mg, Donepezil 5 mg, Amlodipine 5 mg, and Hydralazine 10 mg. At 10:16 AM, RN E entered resident #47's room and administered the medications.Review of resident #47's Medication Administration Record (MAR) revealed 9:00 AM medications included: Aspiring 81, Cholecalciferol 5000 international units, Cranberry 450 mg, Donepezil 5 mg, Ferrous Sulfate (Iron) 325 mg, Isosorbide 30 mg, Turmeric 500 mg, Amlodipine 5 mg, Memantine 5 mg, Tylenol (Acetaminophen) 325 mg, Eldertonic 15 milliliters, and House supplement 2.0 calorie. Hydralazine 10 mg was scheduled for 8:00 AM. Review of resident #47's Medication Admin Audit Report dated 5/26/26 revealed Hydralazine was documented as administered at 10:55 AM. The medications scheduled for 9:00 AM were documented as administered at 10:56 AM. On 5/26/26 at 1:11 PM, RN E was asked about the documentation time and the additional medications documented as administered during the medication pass observation. RN E stated she was expected to document medications after observing the resident take them and acknowledged she did not document the medications immediately after administration at 10:16 AM. She explained she did not always document medications immediately after administration because she sometimes ran late and later documented them all at the same time. RN E acknowledged the medical record would not accurately reflect the actual administration times. She stated the medications were administered timely, but her documentation did not always reflect the exact time they were administered. RN E further stated the Eldertonic was administered earlier because it was an appetite stimulant. She explained resident #47 preferred Turmeric mixed into pudding, so she opened the capsule and mixed the contents into the resident's breakfast pudding earlier that morning. She also stated resident #47 did not like taking the House Supplement with medications, so she administered the supplement after the medication pass observation. Review of the medical record revealed no documentation of medication administration preferences for resident #47 nor evidence the physician was notified regarding alternative medication administration practices or administration times that differed from the physician's orders.On 5/27/26 at 2:32 PM, the Staff Educator stated the nurses were expected to document medications at time of administration. 2. On 5/26/26 at 10:35 AM, RN D prepared medications for resident #67, which included: Allopurinol 100 mg, Amlodipine 5 mg, Aspirin 81 mg, Duloxetine 60 mg, Tamsulosin 0.4 mg, Triamterene/ Hydrochlorothiazide 37.5-25 mg, Rexulti 1 mg, Donepezil 5 mg, Vitamin B-12, and Dorzolamide/Timolol eye drops. When asked how many pills she had prepared in the medication cups, RN D counted them and stated she had prepared 8 pills, which did not match the 9 oral medications observed by the surveyor. After attempting to reconcile the medications by comparing the bubble packs and medication bottles to the pills in the medication cup, RN D stated she preferred to start over because she did not want to make a mistake and could not identify the discrepancy. RN D then discarded the medications into a small open trash bin attached to the medication cart and began preparing the medications again. She added 2 tablets of Tylenol 325 mg because the resident had complained of pain. After reconciliation, RN D administered the medications and exited resident #67's room. On 5/26/26 at 11:09 AM, when asked the process for discarding unused medications, RN D stated she was supposed to discard medications in a different container and not in the trash bin. She searched the drawers of the medication cart and stated she (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105379	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kissimmee Health and Rehabilitation Center	320 N Mitchell St Kissimmee, FL 34741

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could not locate the medication disposable bottle she was supposed to use. RN D could not explain why medications should not be discarded in the trash and stated she only knew they were not supposed to be discarded there. On 5/27/26 at 6:19 PM, the Director of Nursing (DON) stated nurses were expected to document medications immediately after residents received them. She indicated documentation should not occur later because the medical record would not accurately reflect medication administration. The DON further stated medications should never be discarded in regular trash because individuals passing by could retrieve them. She acknowledged RN D improperly disposed of the medications and confirmed it was a concern. Review of the facility's policy titled Medication Administration, revised 1/2025, revealed medications were to be administered as ordered by the physician and in accordance with professional standards of practice. The policy included ensuring the six rights of medication administration, including right time and right documentation. The policy also read, Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician, and directed staff to sign the MAR after medication administration.Review of the facility's policy titled Documentation in Medical Record, undated, revealed each resident's medical record was required to contain an accurate representation of the resident's actual experiences through complete, accurate, and timely documentation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow appropriate hand hygiene during medication administration in accordance with infection control standards to prevent the spread of infection for 1 of 4 nurses reviewed for medication administration, (Registered Nurse E). Findings:On 5/26/26 at 10:02 AM, Registered Nurse (RN) E entered resident #47's room, obtained a pair of gloves, donned the gloves, took the resident's blood pressure, then removed the gloves and exited the room without performing hand hygiene. At 10:06 AM, RN E obtained 3 medication cups and prepared oral medications without performing hand hygiene. After preparing the medications, RN E entered the resident's room at 10:16 AM and administered the medications. At 10:19 AM, when asked about when hand hygiene was expected to be performed, RN E stated it should be done before and after medication administration. She said, I guess I skipped points. RN E explained hand hygiene was important for patient safety and prevention of infection. She acknowledged she should have performed hand hygiene before preparing and before administering the medications. On 5/27/26 at 2:32 PM, the Infection Preventionist (IP) stated nurses were expected to perform hand hygiene prior to donning gloves, before entering a resident's room, after removing gloves, and gloves were to be discarded inside the resident's room. The IP indicated hand hygiene was required prior to medication preparation. The IP shared RN E was a PRN (as needed) nurse but received the same education as full-time staff. On 5/27/26 at 6:19 PM, the Director of Nursing stated nurses were expected to perform hand hygiene every time they had resident contact and before preparing medications. Review of the facility's policy titled Medication Administration, revised 1/2025, revealed medications were to be administered in a manner to prevent contamination or infection. The policy guidelines included washing hands prior to administering medication perf facility protocol. Review of the facility's policy titled Hand Hygiene, revised 1/2025, read, All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. The policy further indicated glove use did not replace hand hygiene and, when gloves were required, hand hygiene was to be performed prior to donning gloves and immediately after glove removal. A Hand Hygiene Table within the policy indicated hand hygiene was required prior preparing or handling medications.