STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105431	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyards of Orlando Care Center and Rehab	1900 Mercy Drive Orlando, FL 32808

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 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 develop an individualized care plan with interventions to address the resident's preference and needs for administration of oxygen for a resident who smokes, for 1 of 1 resident reviewed for respiratory care, of a total sample of 45 residents, (#40).Findings: Resident #40 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), tachycardia (fast heartbeat), and mood disorder. Review of the quarterly Minimum Data Det, (MDS) assessment dated [DATE], revealed the resident was assessed to be cognitively intact. On 8/11/25 at 10:54 AM, resident #40 was sitting in bed wearing a nasal cannula connected to an oxygen concentrator set to deliver oxygen at 5 liters per minute (LPM). Resident# 40 explained he liked to go out to smoke and felt he was comfortable without oxygen during that time. He continued that he had been on 5 LPM of oxygen for a few weeks, but explained he needed it more when he exerted himself. On 8/11/25 at 1:30 PM, resident #40 was sitting comfortably outside on the smoking patio, not wearing his oxygen while he smoked. The next day, on 8/12/25 at 1:54 PM, resident #40 was in his wheelchair comfortably wheeling down the 200 Hallway without oxygen. He was at ease and not in any distress without the oxygen. Review of the medical record revealed physician's orders for resident #40's oxygen was for 3 LPM, continuously via nasal cannula. Resident #40 had a care plan for smoking dated 4/23/25 that included, the resident was assessed as able to smoke with supervision, resident/responsible party informed of the facility smoking policy. Further review revealed no care plan focus or interventions related to resident #40's use of oxygen including his preference to not use oxygen so he could go outside to smoke, nor a care plan for any behaviors for rejection of care or non-compliance. On 8/14/2025 at 10:22 AM, assigned Licensed Practical Nurse (LPN) J verified resident #40's oxygen concentrator was set at 5 LPM. LPN J confirmed the resident's order was always for 5 LPM of oxygen since admission but said he adjusted the flow rate himself. The nurse explained to the resident that the physician's order was for 3 LPM, not 5 LPM and that the facility would have to inform the physician if they desired to change the order. She conveyed she was aware the resident went outside to smoke without the use of oxygen; therefore, he did not use the oxygen continuously as it was ordered by the physician. In interviews on 8/14/25 at 10:30 AM, and on 8/14/25 at 12:49 PM, the Director of Nursing (DON) in regard to resident #40's oxygen usage said that the resident often adjusted the amount by himself therefore he was noncompliant with the oxygen order. She was unable to show documentation of the noncompliance in the medical record. The DON explained the staff who was responsible to update care plans was no longer here, but that everyone helps with them. She said the expectation was for nurses to assess resident #40 and update the care plan as needed. The DON acknowledged resident #40's care plan was not personalized regarding his preference to smoke and not use oxygen as the physician had ordered it. The Facility's Policy on Comprehensive Assessments and Care Plans dated 4/01/22 indicated the standard of the facility was to make an accurate and comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, which would be reviewed and revised by the interdisciplinary team regularly.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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F 0677 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, medical record review, and facility policy review, the facility failed to provide the necessary assistance with Activities of Daily Living (ADL) for one of three residents reviewed for ADL care, of a total sample of 45 residents, (#75). This failure resulted in resident #75 not receiving timely and adequate support for personal grooming and hygiene, which could contribute to a decline in the resident's physical and psychosocial well-being. Findings: On 8/11/25 at 11:40 AM, resident #75 was awake, lying in his bed. His fingernails on both hands were elongated with brown debris visible under the nails. The resident stated he spoke Creole. He was able to answer yes/no questions appropriately, and able to gesture. Resident #75 indicated he preferred to keep his fingernails long by shaking his head to gesture no and showing his elongated fingernails. On 8/12/25 at 9:25 AM, resident #75's fingernails on both hands continued to be elongated with brown debris visible under the fingernails. The resident permitted photos to be taken of his fingernails. (Photographic evidence obtained) On 8/13/25 at 1:00 PM, resident #75 was in bed, and awake. The fingernails on both hands were elongated with visible brown debris under the nails. On 8/14/25 at 10:00 AM, resident #75 was awake and in bed. His fingernails on both hands remained elongated with brown debris visible under the nails. On 8/14/25 at 10:05 AM, Certified Nurse's Assistant (CNA) B, stated activities personnel provided fingernail care including cleaning and trimming for residents. She conveyed all CNAs including herself could provide fingernail care to residents. CNA B confirmed she was assigned to resident #75 that day but had not ever provided fingernail care to the resident. She said she used assistance from other staff to communicate with the resident in his preferred language (Creole). The CNA explained she provided fingernail care weekly. At that time CNA D entered the resident's room and asked the resident if he'd like to have his fingernails cleaned and trimmed in his preferred language. CNA D stated the resident replied, Yes, I am here for you to help me. I cannot do that myself. On 8/14/25 at 10:15 AM, Licensed Practical Nurse (LPN) C, confirmed she was assigned to care for resident #75 today. She stated the CNAs provided fingernail care including cleaning and trimming to residents, unless they were diabetic then a podiatrist would do it. She denied the podiatrist trimmed residents' fingernails and explained the nurses trimmed the fingernails for diabetic residents. LPN C stated a schedule for when the care would be provided was kept in the chart, but explained if the nails were long or dirty, staff should just provide the care, regardless of the schedule. Review of resident #75's medical record revealed her diagnoses included diabetes mellitus type 2, Alzheimer's Disease, and seizures. Review of the quarterly Minimum Data Set assessment dated [DATE], revealed moderately impaired cognitive function, and no behavioral symptoms present including refusals of care. Review of resident #75's progress notes from 7/22/25 thru 8/14/25 did not reveal any notations of refusal of care of any type. Review of the person-centered care plan initiated 1/30/19 and revised 2/28/22, for resident #75 revealed a focus for risk for self-care deficit in ADLs related to need for assistance with daily care. The care plan indicated resident #75 required some assistance with dressing and bathing due to weakness and cognition and impaired communication (Creole speaking) and he was at risk for decline in functional status. The care plan interventions detailed the resident required assistance of one staff with dressing, hygiene and bathing. On 8/14/25 at 10:52 AM, the Administrator stated the expectation was for fingernails to be cleaned and trimmed per the resident's preference, with care provided by direct care CNAs and Activities staff. The Administrator explained each resident was assessed at admission to determine if they need assistance with the task, and whether the resident allowed it. She expressed staff should try to reapproach at a different time, or with different staff, if a resident refused care, and the behavior should be documented in the medical record. The Administrator stated it would be part of the resident's care plan, and refusals of care should also be documented in the Minimum Data Set assessments. A review of the facility policy titled ADL Care and Assistance dated 4/01/22 revealed, the facility's policy was to provide the resident with ADL care and assistance while attempting to maintain the highest practicable level of function for the resident.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 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 interview, and record review, the facility failed to follow physician orders for medication administration for 5 of 5 residents reviewed for medication administration, of a total sample of 45 residents, (#112, #3, #94, #5, and #67).Findings:1. Resident #112 was admitted to the facility on [DATE] with diagnoses including esophagitis (inflammation of the esophagus) without bleeding, other psychoactive substance dependence, hypertension, nicotine dependence, chronic pain syndrome, opioid dependency, and anxiety. Review of the resident's care plan initiated 6/26/25 revealed a focus related to antianxiety medication use with an intervention to administer medication as prescribed. During a phone interview with the resident on 8/13/25 at 11:17 AM, he stated he had missed medications while at the facility. Review of resident #112's physician orders revealed an order for Xanax 1 milligram (mg) to be given twice a day for anxiety with a start date of 6/26/25 and end date of 7/10/25. Review of the Electronic Medical Record (EMAR) revealed the following:On 7/07/25 at 9:00 AM, the resident did not receive the morning dose of medications with no progress note documentation as to the reason.On 7/07/25 at 5:00 PM, the resident did not receive the afternoon dose of medications with a progress note which read, ‘pharmacy' as the reason documented.On 7/08/25 at 9:00 AM, the resident did not receive the morning dose of medications with no progress note documentation for the reason the medication was not given.On 7/08/25 at 5:00 PM, the resident did not receive the afternoon dose of medications with no progress note documentation for the reason the medication was not given. On 8/13/25 at 12:24 PM, the DON explained the investigation of resident #112's missed medication was initiated on 7/16/25 when the Department of Children and Families investigator came to the facility in regard to allegations of neglect due to the resident's concerns over not receiving his Xanax. The facility acknowledged at the time the resident missed four doses of the medication due to it needing a new prescription for it to be refilled. Further review of the medical record revealed a physician order for Xanax 1 mg by mouth now to be given three times day for anxiety starting on 7/10/25. Review of the EMAR revealed the following:On 7/16/25 at 9:00 AM, the resident did not receive the medications with no progress note documentation for the reason it was not given.On 7/26/25 at 2:00 PM, the resident did not receive the afternoon dose of medication with no progress note documenting the reason it was not given.On 7/26/25 at 9:00 PM, the resident did not receive the medication, but contained a note that documented, on order for the reason it was not given. A progress note written on 7/26/25 at 10:00 PM, revealed resident #112's Xanax was not available to be administered. The note indicated the pharmacy notified the facility that a new prescription was needed in order for the medication to be refilled. 2. Resident #3 was admitted to the facility on [DATE] with diagnoses including anxiety disorder, polyneuropathy (nerve pain), hypertension, and stroke complications. Resident #3's care plan initiated 3/07/25 revealed a focus for the risk of abnormal bleeding related to the use of anticoagulants with an intervention to administer medications as ordered. The resident also had care plan focus for the potential for adverse side effects related to use of psychotropic medications, potential of complications related to alteration in cardiac function due to diagnosis of hypertension and potential for alteration in comfort related to stroke, generalized discomfort and impaired mobility. The interventions listed included administering medications as ordered. On 8/12/25 at 1:20 PM, resident #3 stated it seemed she had a problem with availability of medication every month, but not always with the same medication being unavailable. The resident reported yesterday she was told the facility was out of her Lyrica medication. Lyrica is a prescription medication used to treat nerve pain for neuropathy and other disorders. Take exactly as prescribed by your physician, at the same time each day, Do not stop using Lyrica suddenly, (retrieved on 8/27/25 from www.drugs.com). A self-reported grievance filed on 6/09/25 by resident #3 revealed a concern that Xarelto was not available to be given. Review of the grievance revealed the investigation found the resident was out of the medication which was to be delivered that day. The resolution indicated the medication arrived the next day on 6/10/25 and education was provided to staff, that nurses were to reorder medications within five days of stock depletion, and if the medication was not present, nurses were to call the provider to either place the medication on hold or obtain a substitute. Although this education was noted on the grievance, resident #3 continued to miss doses of her medication due to it not being available per the EMAR. Xarelto is a prescription medication used mainly to prevent blood clots. It blocks the action of substances in the blood to prevent formation of blood clots. Do not stop taking Xarelto without your doctor's advice, it can increase your risk for blood clots or stroke, (retrieved on 8/27/25 from www.drugs.com). Review of the medical record

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F 0778 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident make transportation arrangements to and from radiology services. (continued on next page)

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F 0778 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 interview, and record review, the facility failed to assist in making transportation arrangements to diagnostic and physician's appointments for 1 out of 1 resident reviewed for choices, of a total sample of 45 residents, (#97).Findings: A review of the electronic medical record revealed resident # 97 was admitted to the facility on [DATE] with diagnoses which included acute embolism and thrombosis (blood clot) of other specified deep vein of the right lower extremity, paraplegia (partial paralysis), hyperlipidemia, and unspecified heart transplant status. Resident #97 's quarterly Minimum Data Set with an assessment reference date of 7/12/25 revealed the resident scored 15 out of 15 on the Brief Interview for Mental Status which indicated he was cognitively intact. A review of resident #97 's plan of care revealed he had the potential for complications related to an alteration in cardiac function due to his diagnoses, heart transplant status initiated on 4/23/25. Interventions included labs and diagnostic tests as ordered; update physician of results initiated 4/23/25. On 8/11/25 at 11:48 AM, resident #97 was in bed, alert and oriented to person, place and time. He stated he had missed several doctor's appointments and an echocardiogram (cardiac test) due to transportation not being arranged. The resident continued that he had appointment cancellations due to the lack of communication between facility staff and the transport coordinator. Review of the medical record progress notes from the B Wing Unit Manager (UM) revealed the following: On 6/11/25 the UM documented, Called resident transplant coordinator on last week, received message of (coordinator), being out on vacation. Attempted to reach on 6/10 to received appointment updated information for resident. Unable to reach. Left voice mail. Called this am 6/11, and was able to reach coordinator, informed to call for updated scheduling information. Unable to get receptionist online. Left message will reattempt call in 1 hour.On 8/01/25 the UM documented, resident states he received call for appointment cancellation of ECHO [echocardiogram]. Nurse attempted to call office to receive follow up time and date for makeup appointment. Message left with answering service. Awaiting response from [name of hospital] transplant office. Transplant coordinator. A review of the medical record progress notes and documents written by the Advance Practice Registered Nurse (APRN) revealed the following excerpts: On 6/21/25 and 7/19/25, the APRN documented, NO acute issues. Per resident, he went to have a bone scan last month and was told by ID [infectious disease] doctor that, everything looks good for Echo/transplant f/u [follow up] on 7/31/25. On 8/12/25 the APRN wrote, Wound care rendered by nurse, r/o [rule out] cellulitis/infection. I called the transplant center to schedule a follow up appointment. Apparently, he had missed 3 f/u visits due to dates not entered to PCC. I left a message to the answering service, Awaiting return call. On 8/13/25 at 3:31 PM, in a joint interview with the Social Worker (SW) and Director of Nursing (DON) they explained the team including the UMs, and Staffing and Transportation Coordinator had an app (application) they used to coordinate the facility's van and arrange transportation. This app was used to manage arrangements to transport residents to and from doctor's appointments or for any other transport within the community. The SW and DON described that residents who relied solely on their insurance for transportation, still had access to the facility's van because sometimes those services were unreliable. The DON and SW acknowledged resident #97 had missed some appointments with his physician at his heart transplant center as well as an echocardiogram appointment that was cancelled because no transportation was arranged. The DON explained she believed the resident had an outside coordinator to arrange transportation; however, she acknowledged the UM, and nurses were responsible for following up to ensure the arrangements were made. The DON stated they dropped the ball on this one. The DON was unsure if resident #97's echocardiogram was ever rescheduled. On 8/13/25 at 4:10 PM, in a joint interview with the SW and the Transportation Coordinator, the Transportation Coordinator explained she would get the appointment paperwork from nurses or on the resident's return from an appointment. She would then place it in the transport book, and the nurses would log the appointment in the computer. She said she would call the physician's offices and make appointments for residents who were unable to. The Transportation Coordinator described that for residents who made their own appointments but did not have transportation the facility would set transportation up through her. She explained for resident #97, she believed he made his own appointments, and the facility had never taken him anywhere. The SW said that even though the resident made the appointments himself, he communicated to nurse, and the nurse would have to put the appointment into the computer. The SW was unable to find any information that the missed echocardiogram was rescheduled. On 8/13/25 at 4:22 PM, the B Wing UM acknowledged she was aware

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy review, the facility failed to ensure proper handling and food safety practices when staff failed to sanitize a food thermometer between checking food items, and ice bath calibration. The deficient practice had the potential to affect all residents who received a regular or puree diet by increasing the risk of cross-contamination and foodborne illness. Findings: On 8/13/25 at 11:10 AM, kitchen preparation for the lunch service began with cook G and Dietitian F present. At 11:37 AM, cook G used a food thermometer to check food temperatures of the prepared foods held on the steam table line prior to plating the food for service. The cook did not sanitize the food thermometer prior to placing the tip of the thermometer inside the pureed garlic bread, the regular garlic bread, and then the ziti bake. The cook said she cleans the thermometer between each food items. She acknowledged she did not sanitize the thermometer prior to checking the food items, nor had she cleaned it between the food items. The cook explained it was her practice to clean the thermometer between food items but said, We run out of them [the alcohol wipes] so fast, I'm constantly using them. On 8/13/25 at 11:47 AM, Dietitian F explained the process for checking the temperature of foods on the steam table. She stated, All foods are checked for their temperature before service is started. They are supposed to clean the thermometer with a sanitizing wipe in between each food item, that's the proper way. The Dietitian acknowledged she did not notice when cook G did not sanitize the thermometer between the food items in preparation for the lunch service. On 8/13/2025 at 11:50 AM, Kitchen Supervisor E explained the facility process for checking the temperature of foods on the steam table. She confirmed staff should check each food item, record the reading of the thermometer, and then clean the thermometer with an alcohol wipe between each food item.On 8/13/25 at 5:00 PM, in the kitchen, preparation for the dinner service commenced. Kitchen Supervisor E checked the temperature of a tray of turkey ranch wraps (a cold sandwich item) with a food thermometer. She then calibrated the food thermometer in an ice bath but did not sanitize the thermometer between checking the temperature of the wraps and inserting the thermometer in the ice bath. Kitchen Supervisor E proceeded to use the same un-sanitized thermometer to check the puree turkey wrap (a hot item) temperature without sanitizing the thermometer. On 8/13/25 at 5:15 PM, Kitchen Supervisor E acknowledged she had not sanitized the thermometer between checking the temperature of the cold turkey ranch wrap and the ice bath calibration, then again between the ice bath and checking the temperature of the (hot) puree turkey wrap. Kitchen Supervisor E stated, Oh I thought I did, and acknowledged she did not sanitize the thermometer between the food items and the ice bath calibration. Review of the facility policy, Final Cooking Temperatures, revised 10/01/23, revealed food was to be cooked to specific temperatures and times to mitigate the presence of dangerous microorganisms. The policy continued that food thermometers used to check food temperatures should be clean, sanitized, and calibrated for accuracy.