

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER Bedrock Rehabilitation and Nursing Center at Orlan		STREET ADDRESS, CITY, STATE, ZIP CODE 9311 S Orange Blossom Trl Orlando, FL 32837	

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)
<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>50401</p> <p>Based on interview, and record review, the facility failed to act promptly upon Resident Council group concerns with appropriate responses and rationale for facility decisions.</p> <p>Findings:</p> <p>On 8/07/24 at 3:18 PM, the Resident Council President stated there were issues brought up in resident council meetings for many months that were still unresolved. The first issue was a long response time to call lights by staff. He stated staff often told the residents; they would be right back but then forgot to return. He added staff would say, That's not my section, when asked to answer a call light or pass meal trays when the assigned Certified Nursing Assistant (CNA) was busy. The Resident Council President explained there were other ongoing issues such as late meals, cold food due to the plate warmer being broken for months, and residents not being able to get ice. He explained the Resident Council had concerns about language barrier issues with staff, and smoking issues. The Resident Council President stated the group was concerned the Activities Director had at times invited staff to the resident council meetings without the knowledge or invitation of the group and the group meeting location was not private enough. The Resident Council President explained there were told by the facility Administration that their concerns were being worked on but no details, progress updates, or results were provided. He stated he often wondered why the Resident Council group met at all, because residents felt like they were ignored.</p> <p>On 8/07/24 at 3:00 PM, the Activities Director stated she helped run the Resident Council and the Food Committee meetings. She acknowledged sometimes she invited other facility staff to attend the Resident Council meetings.</p> <p>On 8/07/24 at 4:30 PM, Resident Council meeting minutes dated January 2024 to July 2024 which included many unresolved issues. The 2/06/24 meeting minutes indicated the old business regarding medication pass issues were, In process and still being worked on. Regarding the issue of call lights, the action plan on these minutes stated call lights should be answered within 5 minutes, the head nurses would monitor call lights, and all department heads could answer a call light and assist that resident. In addition, new concerns about ice were raised. Call light response times concerns were brought up repeatedly at meetings on 3/05/24, 4/02/24, 5/07/24, 6/04/24 and 7/02/24. The feedback given was the resolution was, In progress. Late meals delivery was brought up as an issue at meetings on 4/02/24, 5/07/24, 6/04/24 and 7/02/24 and an issue of room checks not being conducted during night shifts was brought up on 5/07/24, 6/04/24, and 7/02/24. These items were still unresolved with their resolution noted in the meeting minutes also, In progress.</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 105471
		If continuation sheet Page 1 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER Bedrock Rehabilitation and Nursing Center at Orlan		STREET ADDRESS, CITY, STATE, ZIP CODE 9311 S Orange Blossom Trl Orlando, FL 32837	
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)		
<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/08/24 at 2:15 PM, the Certified Dietary Manager (CDM) stated they were still having difficulty with late delivery of meals. He confirmed the plate warmer had been broken for about a month. He stated the Director of Maintenance was ordering a part for it. The CDM stated the ice machine was not broken but it did not produce a sufficient amount of ice. He said the repair company stated the ice machine was working as it should. The CDM was not aware residents had complained about not having enough ice.</p> <p>On 8/08/24 at 6:00 PM, the Administrator stated the facility investigated and addressed grievances from residents as they arose. The Administrator stated a grievance regarding call light response time had an action plan to audit the response times. Three audits were completed in February and March 2024 and the Administrator stated call light response times were not deemed to be an issue any longer after this. The Administrator acknowledged the call light complaints brought up at the Resident Council meetings from February 2024 through July 2024. He also acknowledged the action plan which indicated the correction was In progress. The Administrator explained call light issues would never be corrected. He stated he probably should pay more attention to issues brought up by the Resident Council.</p> <p>The facilities Resident's Rights policy dated April 1, 2022 states resident groups have the right to meet in a private space with other staff and visitors only attending only at the group's invitation. It also states the facility must consider the views and recommendations of the group and act promptly on the grievances and recommendations of the group. It states the facility must be able to demonstrate its response and the rationale for it. It was not evident this policy is being followed effectively.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER Bedrock Rehabilitation and Nursing Center at Orlan		STREET ADDRESS, CITY, STATE, ZIP CODE 9311 S Orange Blossom Trl Orlando, FL 32837	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192</p> <p>Based on interview and record review, the facility failed to report an allegation of verbal abuse to State agencies as required for 1 of 2 residents reviewed for abuse, of a total sample of 8 residents, (#1).</p> <p>Findings:</p> <p>Review of the medical record revealed resident #1 was readmitted to the facility on [DATE] with diagnoses including encephalopathy (brain dysfunction), paraplegia (paralysis of lower body) and dementia. Her medical record showed her daughter was her Power of Attorney (POA) and responsible party. Resident #1 was discharged from the facility on 6/30/24.</p> <p>Review of the Minimum Data Set (MDS) Annual assessment with assessment reference date of 5/27/24 revealed resident #1 had unclear speech but sometimes understood and responded adequately to simple, direct communication only. The assessment showed a Brief Interview for Mental Status (BIMS) was not conducted because she was rarely or never understood. The MDS assessment showed resident #1 had no behavioral symptoms and did not reject evaluation or care necessary to achieve her goals for health and well-being. Resident #1 was totally dependent on staff for all activities of daily living. The assessment revealed her preferred language was Creole and she needed an interpreter to communicate with a doctor or health care staff.</p> <p>Review of the care plan with a focus area of little community life involvement revised on 11/05/23 revealed resident #1 was French Creole speaking and needed a translator. Another focus revised on 1/19/23 was communication problem related to dementia and language barrier, Creole speaking.</p> <p>Review of the Monthly Grievance Log from February to August 2024 showed resident #1's POA had filed 7 grievances. The June log included a grievance/concern dated 6/10/24 for customer service/nursing care which was assigned to the Unit Manager on 6/11/24 and the resolution noted education of customer service to Certified Nursing Assistants (CNAs). The Grievance Report on 6/10/24 read, [resident #1's daughter name] called today 6/10/24 stating she came in yesterday, Sunday 6/09/24. Her mother told her that either on Friday or Saturday a CNA was yelling and cursing at her mother in Creole. The CNA was calling her a witch and said that is why your body is like that. The mother was very upset and crying, she didn't even want to eat. [Resident #1's name] even told her to stop talking on her behalf because people are now being mean.</p> <p>Review of the facility abuse log since did not show any entries for resident #1 over the past 3 months, including June 2024.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER Bedrock Rehabilitation and Nursing Center at Orlan		STREET ADDRESS, CITY, STATE, ZIP CODE 9311 S Orange Blossom Trl Orlando, FL 32837	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/07/24 at 2:46 PM, the Social Services Director stated she was the Grievance Officer. She shared the grievance process included reviewing the new grievances, assigning the grievance to the appropriate department and ensuring they were resolved within five days. Later on 8/08/24 at 4:40 PM, the SSD reviewed resident #1's grievance dated 6/10/24. The Social Services Director read the grievance out loud as requested by the surveyor. When she finished reading the statement, she stated resident #1's BIMS was zero, which indicated her cognition was severely impaired. She indicated the grievance form was completed by her assistant, but she was also in the office when the call came in. The Social Services Director stated she mentioned the grievance the next morning in their daily meetings with the Administrator and other management, but she did not discuss the concerns thoroughly. She explained the only thing discussed during those meetings was a new grievance was received for resident #1 and which was given to the Unit Manager for follow up. When asked, the Social Services Director stated she did not know who the abuse coordinator was. She did not consider this grievance an abuse allegation because it was not that a CNA hit her. The SSD re-read the grievance and acknowledged it described verbal abuse, but said this was one sided, because her mom doesn't talk. She added, In that instance, who are we to believe? It is all one sided because her mom doesn't talk.</p> <p>On 8/07/24 at 4:53 PM, the Administrator joined the interview with the Social Services Director and indicated he was the abuse coordinator. He stated he was, a little confused when he read the grievance dated 6/10/24. The Social Services Director interjected and said resident #1 did not talk. The Social Services Director told the Administrator the grievance was about the daughter saying what allegedly resident #1 told her. The Administrator read the grievance out loud. He stated he did not recall if he learned about this grievance before. He explained abuse could be physical or verbal. He added, Sounds like that could be a verbal abuse allegation that we would investigate. He explained they would have tried to identify the CNA and suspend her/him and filed an immediate report for verbal abuse. He indicated the investigation would include interviewing some of the surrounding residents in the CNA assignment or in the same area and concluded submitting a 5-day report with their findings. He stated they took all abuse allegations seriously and reported within the required time frames. Later on 8/08/24 at 5:39 PM, the Administrator stated the Assistant Director of Nursing (ADON) had investigated it quickly and found out there was no Creole speaking staff assigned, to resident #1 on the dates noted. He mentioned the best course of action was to do a customer inservice with staff. When asked for the copy of the staff assignments for that weekend and results of the quick investigation he said the ADON did not keep copies or documentation of what she reviewed.</p> <p>Review of the facility's policy and procedure titled Abuse: Florida, dated 4/01/22, revealed reports of abuse were promptly and thoroughly investigated. The document included abuse allegations were to be reported per Federal and State Law, immediately but not later than two hours after the allegation was made if it resulted in serious body injury or not later than 24 hours if no serious body injury occurred. The document indicated the facility was required to comply with external reporting requirements including the State Agency and law enforcement.</p> <p>Review of the facility's policy and procedure titled Grievance Program, dated 4/01/22, revealed concerns related to alleged abuse would be handled according to state and federal guidelines.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER Bedrock Rehabilitation and Nursing Center at Orlan		STREET ADDRESS, CITY, STATE, ZIP CODE 9311 S Orange Blossom Trl Orlando, FL 32837	

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)
<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>43192</p> <p>Based on interview and record review, the facility failed to ensure implementation of policies to the extent of including thorough monitoring of previously identified areas of concern and adequately tracking performance to ensure prior improvement measures were realized and sustained.</p> <p>Findings:</p> <p>Cross reference F565 and F609</p> <p>Review of the facility's survey history revealed deficiencies related to Resident Council's grievances and recommendations to improve residents' care had not been considered or acted upon and an allegation of abuse was not reported were identified during the current survey ending on 8/08/24.</p> <p>The facility had deficiencies at F565 and F609 for similar concerns with Resident Council and reporting of abuse allegations from the last Recertification survey dated 1/11/24.</p> <p>Review of the Plan of Correction (POC) which serves as the facility's allegation of compliance with the citations, approved by the Quality Assurance and Performance Improvement (QAPI) committee on 2/15/24 included education to the Interdisciplinary team for understanding of the QAPI process. The POC mentioned implementation of appropriate plans of action to prevent repeat deficiencies. The POC mentioned identifying areas for continuous quality monitoring using tools to conduct quality reviews which would be reviewed in QAPI for identification of areas that could potentially affect resident outcomes.</p> <p>On 8/08/24 at 9:33 AM, the Administrator stated he was responsible for overseeing all areas in the facility. He explained his main function was to manage the different departments and ensure compliance. He shared his passion was for residents to be treated fairly and received the best quality of life they could get. The Administrator stated when he took the position in January, he met with the Resident Council and had a crowd of about 30 residents. He stated he informed them he would walk around the first few weeks, to see what resident saw and address those issues, which he did. He stated they were currently working on quality measures, and he stated he was surprised about the survey findings.</p>