STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105471	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bedrock Rehabilitation and Nursing Center at Orlan	9311 S Orange Blossom Trl Orlando, FL 32837

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, and interview, the facility failed to ensure residents were treated with dignity by standing while assisting them to eat for 1 out of the 5 residents observed for dining assistance, of a total sample of 38 residents, (#34).Findings:Resident #34 was admitted the facility on 7/10/17 for Parkinson's disease, diabetes mellitus type II, seizures, depression, anxiety, and psychotic disorder. Resident #34's care plan indicated he had a deficit in activities of daily living (ADL's) and required maximum to total assistance for eating meals related to risk for nutritional decline and history of weight loss with a low Body Mass index. The most recent quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed resident #34's Brief Interview for Mental Status score was 6/15, which indicated severe cognitive impairment.On 7/23/25 at 12:13 PM, Certified Nursing Assistant (CNA) F was observed standing in the main dining room as she assisted resident #34 with lunch. At 12:19 PM, CNA F explained she had stood while assisting the resident with his meal in case she needed to move and do something else during the meal. She added she sat while assisting residents with their meals in their rooms but did not sit down in the dining room. CNA F acknowledged she was supposed to sit when she assisted residents with meals. A short time later at 12:22 PM, the Business Office Manager stated she monitored the dining room to ensure residents were taken care of and staff were doing what they were supposed to. She confirmed CNA F was standing while assisting resident #34 with his lunch and said she saw her do the same at breakfast as well. On 7/24/25 at 3:00 PM, the facility's Administrator stated staff were expected to sit while assisting residents with their meals as doing so communicated to the residents, they and their meal, was important and was not to be rushed; and it was a matter of dignity for the residents. The Administrator stated the facility did not have a policy on staff sitting while assisting with meals but said it would fall under resident's rights to be treated with dignity.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, and interview, the facility failed to provide residents a homelike dining environment for meals eaten in two of two dining rooms.Findings: On 7/21/25 at 12:10 PM, 13 residents were observed in the main dining room eating their meal with the dishes still on their trays. Tablecloths were on the tables, but they had no centerpieces as decoration. On 7/23/25 at 8:10 AM, four residents in the west wing dining room were seated in chairs throughout the room. There were six meals left on meal trays on the tables, all of the tables were otherwise bare, without tablecloths or centerpieces. Certified Nursing Assistant (CNA) N assisted one resident with their meal and explained the breakfast trays which arrived about 10 minutes earlier were being held there for residents who got up later. The main meal plates were covered by an insulated lid which sat over the ceramic plate, but there was nothing under the ceramic plates to help keep the food warm. On 7/23/25 at 12:13 PM, approximately 26 residents were observed eating in the main dining room. Nine residents were observed eating their lunch meals with the dishes remaining on their trays. Other residents in the dining room were observed to have their dishes removed from their trays and placed on the tables. At 12:22 PM, the Business Office Manager stated she was monitored the dining room to ensure residents were taken care of and staff were doing what they were supposed to. She stated she was unsure why the nine residents, who ate at the two long tables in the dining room still had the dishes on their trays while other residents seated elsewhere in the dining room had their dishes set directly on the tablecloth for dining. On 7/24/25 at 12:20 PM, three residents in the west wing dining room were observed as they ate their meals from dishes on their trays. CNA N explained the facility never had tablecloths or removed the dishes from the trays in this dining room. The [NAME] Wing Unit Manager acknowledged it was important to make the resident's environment as home-like as possible because the facility was their home. On 7/24/25 at 3:00 PM, the Administrator acknowledged from her first day at the facility she had noticed residents ate from trays and the room was not decorated or homelike. She explained they searched the facility for some table centerpieces but discovered previous decorations had been discarded. The Administrator added that a homelike environment was a resident right, and their goal was to provide it; even though the facility had no specific policy to address this.

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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)

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F 0610 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 conduct a thorough investigation for an injury of unknown origin for one of one resident reviewed for falls, of a total sample of 38 residents, (#3).Findings:Resident #3 was admitted to the facility on [DATE] for atrial fibrillation, dementia, muscle wasting and atrophy, disorders of bone density and structure, and repeated falls added on 6/02/25. She had an order for an anticoagulant medication due to her atrial fibrillation. On her most recent quarterly Minimum Data Set (MDS) assessment dated [DATE], her Brief Interview for Mental Status score was determined to be 14 of 15, which indicated an intact cognitive status.Resident #3 had a care plan with a focus area dated 6/03/25 which described the resident had a fall. The care plan intervention was to determine and address causative factors of the fall, which did not happen.On 7/22/25 at 10:02 AM, resident #3 said about two months ago an aide was pushing her too fast in the wheelchair and she fell forward onto a concrete patio. She added she had told the staff member to slow down, but she fell and spent a couple days in the hospital after the fall.A progress note dated 5/28/25 by the night Nursing Supervisor indicated at approximately 7:04 PM, he was notified by a nurse that resident #3 was on the floor face down in the smoking area. He documented when he entered the area, he saw the patient on her back with a large blood-filled bruise on her right forehead. The note indicated the resident was unable to verbalize any sentences, and she was groaning. The Supervisor described a 911 call was made, and the resident's physician was notified of the emergency transfer. The Emergency Medical Services (EMS) team arrived at approximately 7:10 PM, she was transferred to the hospital on a stretcher, and the facility's Director of Nursing (DON) was notified. The medical record showed the resident was readmitted on [DATE] at approximately 2:41 PM.A progress note dated 6/03/25 from the Interdisciplinary team (IDT) noted the fall incident was discussed and resident #3 was unable to describe what occurred as her baseline mentation was altered and at the time, she was only able to moan. The plan was for IDT to evaluate the wheelchair position and to have the resident continue with Occupational Therapy (OT) and her plan of care. A progress note dated 6/03/25 by the Nursing Supervisor indicated the resident was seen by a wound doctor and an ointment was ordered for her right frontal forehead. A skilled nursing note written dated 6/03/25 at 2:41 PM, by the Advanced Practice Registered Nurse (APRN) indicated the resident was oriented to person and place and that monitoring for fall and safety precautions were to continue along with strengthening and gait training. On 7/22/25 at approximately 4:00 PM, a request was made to the Regional Nurse to review a copy of the facility's investigation of the incident/fall from 5/28/25. Two days later, on the morning of 7/24/25 at approximately 9:30 AM, the Regional Nurse was again asked for a copy of the investigation for review, which was provided a few hours later by the DON. Review of the investigation report included three staff interviews, of which none actually witnessed the incident/fall. The facility was asked to provide interviews or witness accounts from anyone who actually witnessed the incident, but the DON later reported the facility did not have any additional documentation for that. On 7/24/25 at approximately 2:30 PM, Certified Nursing Assistant (CNA) K stated she could not remember who the other CNA was who she helped and as the conversation progressed, she stated there was not another CNA there. CNA K stated once all of the residents were in the outdoor smoking area, she went back into the facility to the smoking box which was located just inside the glass door. CNA K said she gathered cigarettes to bring to residents when she heard a commotion outside and turned around and saw the resident lying on the ground.Review of CNA K's witness statement indicated she was in the smoking area helping another CNA monitor the smokers at the time of the incident. Her statement indicated she did not witness the incident because she was helping someone else when the resident fell on the ground.In a joint interview on 7/24/25 at approximately 4:30 PM, with the Regional Nurse, Administrator, and Director of Nursing (DON), the facility's investigation into the event of 5/28/25 was reviewed. The DON stated the facility went by the information CNA K gave in her statement and acknowledged they did not follow up with other staff working at the time to determine if what she said was accurate. They confirmed that although CNA K said there was another CNA present at the time of the incident, they never attempted to find out who the staff was and get a statement from the staff member; nor did they interview any of the residents present outside in the smoking area as part of their investigation. They did not explain why they did not interview the resident herself after she returned from the hospital to get her version of what happened. The Regional Nurse, Administrator and DON were informed that resident #3 reported facility staff were pushing her too fast in a wheelchair when the incident occurred

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were administered according to physician orders to prevent medication errors for 1 of 4 residents observed during the medication administration task, of a total sample of 38 residents, (#45). There were 3 errors in 28 opportunities for a medication error rate of 10.71%.Findings:Review of the medical record revealed resident #45 was admitted to the facility on [DATE] with diagnoses including hypertension, Chronic Obstructive Pulmonary Disease (COPD), schizophrenia, psychotic disorder with delusions, type 2 diabetes, chronic pulmonary edema, and chronic viral hepatitis C.On 7/22/25 at 9:04 AM, Registered Nurse (RN) A checked resident #45's blood pressure with an electronic wrist cuff and showed the reading of 124/81. She checked the electronic medical record and explained she would not administer the resident's scheduled 7:00 AM to 11:00 AM Losartan Potassium and Sotalol HCl due to parameters given by the physician. When preparing resident's Furosemide 40 milligrams (mg), RN A dropped the pill into the medication cart drawer. RN A stated the Furosemide medication card for that resident had no more pills and did not attempt to retrieve the medication from another source or call the physician. Review of the Medication Review Report revealed resident #45 had a physician order dated 3/30/25 for Sotalol HCl 80 mg oral tablet by mouth two times a day for hypertension. The order included a parameter to hold the drug if the resident's systolic blood pressure was less than 110 millimeters of mercury (mm Hg) and/or diastolic blood pressure less than 60 mmHg. The resident also had an order dated 5/17/25 for Losartan Potassium 50 mg oral tablet by mouth daily for hypertension. This order included a parameter to hold the drug if the resident's systolic blood pressure was less than 110 millimeters of mercury (mm Hg). Review of Medication Review Report revealed an order dated 6/12/25 for Furosemide 40 mg to give 0.5 tablets by mouth one time a day for edema.The American Heart Association indicates blood pressure is recorded as two numbers, the first or upper number, the systolic blood pressure (SBP), measures how much pressure blood exerts against artery walls when the heart contracts. The diastolic blood pressure is the second number, which measures the pressure your blood is pushing against your artery walls while the heart muscle rests between beats, (retrieved on 7/30/25 from www.heart.org).Review of resident #45's care plan revealed a focus of a risk for cardiovascular distress related to diagnosis of hypertension initiated 3/06/25. In addition, the resident had a care plan for diuretic therapy related to edema which was initiated 6/13/25 with an intervention to administer diuretic medications as ordered by physician and monitor for side effects and effectiveness each shift.On 7/22/25 at 10:28 AM, RN A was interviewed with the assistance of the Director of Nursing (DON) for translation for RN A as needed. RN A acknowledged she omitted the Losartan and Sotalol for resident #45 and replied she held the medications due to the parameters. The DON translated that these medications should not have been held due to SBP being higher than 110 and DBP higher than 60, RN A replied okay but did not supply an explanation as to why she decided to hold it. As translated by the DON, RN A stated the resident only had one 40 mg Furosemide tablet left in his card and confirmed when she went to administer the medication the tablet fell into the medication cart drawer. RN A was unable to explain why she did not check the backup medication supply or call the physician or pharmacy for further instructions. The DON explained the procedure for missing medication was to check the backup medication supply first, then call the pharmacy and notify the physician. In addition, she said nurses were expected to inform the resident and/or representative if applicable. Facility policy revised 2/21/23 titled Administering Medications states that the purpose of the policy is to ensure that medications are administered in a safe and timely manner and as prescribed. Medications are to be administered in accordance with prescribed order and current standards of practice.

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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, and interview, the facility failed to ensure the snack/nourishment refrigerators on the nursing units had food items labeled and dated with open and use by dates and failed to ensure outdated foods were discarded to prevent the potential for foodborne illness, on two of two nursing units of the facility. This had the potential to affect all 110 residents at the facility.Findings:On 7/24/25 at 2:00 PM, on a tour of the west wing nourishment room, the west wing Unit Manager (UM) verified three large cartons of thickened juice were undated as to when they had been previously opened. In addition to the juice the refrigerator contained a package of unlabeled and undated cheese, previously opened bologna, three undated containers of peaches, one container of applesauce, two undated containers of unidentified leftover resident food and a package of undated salami. The UM stated nursing staff were responsible for labeling and dating the resident's food items when received and labeling food items when opened. She said it was the dietary department's responsibility to monitor the resident leftovers and discard them when expired or outdated.On 7/24/25 at 2:30 PM, in the east wing nourishment room the Certified Dietary Manager (CDM) verified the refrigerator contained undated cartons of thickened water and Med Pass nutritional supplement. In addition, numerous food items were expired, and/or unlabeled/undated; a sandwich was dated 7/02/25 (22 days prior); an unlabeled and undated loaf of bread; an undated bag of a resident's food items; an unlabeled bag of food items, was expired, dated 7/02/25; a plastic container of leftover chicken was dated 6/23/25 (32 days prior), a plastic container of rice and beans and a container of a casserole were labeled for a resident and dated 6/26/25, (28 days prior); and leftover pizza was dated 7/19/25 (6 days prior). The Assistant Director of Nursing verified the food items and confirmed it was nursing staff's responsibility to label and date the items when opened and the dietary department's responsibility to dispose of outdated food items.The facility's policy entitled Foods Brought by Family/Visitors dated March 2022, indicated food items held for residents were to be labeled with the resident's name, food item, and the use by date. The policy added, nursing staff would discard perishable foods on or before the use by date.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, and interview, the facility failed to dispose of garbage properly by keeping dumpster lids closed and the area surrounding the dumpster free of debris which had the potential to affect all 112 residents residing at the facility.Findings:On 7/21/25 at 10:30 AM, rubbish was observed scattered on the ground around the three dumpsters in the dumpster area. The Certified Dietary Manager (CDM) stated the housekeeping department was responsible for keeping the dumpster area clean.On 7/22/25 at 5:00 PM, Housekeeper C was observed throwing garbage in the facility's garbage dumpster without shutting the lid. He stated he was aware he needed to shut the lid but just didn't do it. He stated it was important to keep the lids closed to keep pests/animals out of the dumpster.On 7/23/25 at 10:50 AM, [NAME] B and Dietary Aide D were observed throwing garbage in the dumpster but did not close the lid when finished. They stated the lid was already opened before they threw their trash in it. They acknowledged they were supposed to close the lid to the bin after using it. [NAME] B and Dietary Aide D stated they knew it was important to keep the lids closed on the garbage bins, so animals did not get in.On 7/23/25 at 2:10 PM, Laundry Aide E was observed throwing trash into the garbage dumpster and did not close the lid when finished. He stated he was aware he was supposed to close the lid after putting trash in it but just didn't do so this time. He stated it was important to keep the lid closed because it has a lot of bacteria. Two other staff members, including the CDM were present at the time of this conversation and assisted with translating in Spanish, so Laundry Aide E was sure to understand the issue. He then went and shut the lid on the dumpster.On 7/23/25 at 2:43 PM, Laundry Aide E was observed throwing trash in the dumpster and leave the lid open. A few minutes later, the Environmental Services Regional Manager was informed of the concerns with the dumpster and said there was no excuse for not closing the lid to the dumpster. He added, it was a safety issue and important to keep the dumpster area free of debris and the lids on the dumpsters closed to prevent pests from getting in.The facility's policy entitled Dispose of Garbage and Refuse dated August 2017, indicated all garbage would be disposed of in a safe and efficient manner. The policy directed the CDM and Director of Maintenance to coordinate and ensure the area surrounding the exterior dumpster was maintained in a manner free of debris and other rubbish.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview, and record review, the facility failed to ensure the Quality Assessment & Assurance (QAA) / Quality Assurance and Performance Improvement (QAPI) committee conducted performance improvement activities to ensure prior improvement measures were sustained. Review of the facility's QAPI Policy and Procedure dated 4/01/22 revealed, The facility will take actions aimed at performance improvement. It will measure the success of these actions and track performance to ensure that improvements are realized and sustained. The facility had deficiencies cited at F759 for medication error rate over five percent, and F867 for QAPI during the previous recertification survey conducted 1/07/24 through 1/11/24. During this survey, the facility was again found to be in noncompliance with F759, and F867. As a result of the repeat deficiencies, it was identified there was insufficient auditing and oversight to prevent the citation. On 7/24/2025 at 4:48 PM, the Administrator stated the facility had a QAPI committee that met monthly. She explained the committee reviewed department audits which addressed departmental concerns such as grievances, infection control, falls, weight loss, etc. The Administrator said a Performance Improvement Plan (PIP) would be put into place for areas of concern identified. The PIP would include the problem identified, goals and approaches which could include audits, medical record reviews, interviews and education. Findings from the current survey were reviewed with the Administrator. She verified she was employed at the facility during the previous survey but not as the Administrator. She explained she left to pursue her career and returned as the Administrator of the facility two days ago. She confirmed she was aware of the citations from the previous recertification survey and acknowledged there were repeat citations. The Administrator stated she only returned a few days ago and was unable to say where the process failure occurred. She explained there was a recent change in ownership as well as administrative changes. The Administrator expressed focus could have been lost due to those changes in staff. She acknowledged the performance improvement process should continue even with staff changes for the benefit of the residents and staff.