STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105546	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Orange Health and Rehabilitation Center	1730 Lucerne Terrace Orlando, FL 32806

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)
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. 32131 Based on observation, interview, and record review, the facility failed to ensure scheduled medications were administered as per physician's orders and according to accepted professional standards of practice for 8 of 8 residents reviewed for medication administration, of a total sample of 13 residents, (#6, #7, #8, #9, #10, #11, #12, and #13). Findings: On 12/10/24 at 10:01 AM, Registered Nurse (RN) A was at her medication cart preparing medications. The RN stated she still had morning medications to give and had just started giving medications on the short hallway. On 12/10/24 at 10:23 AM, RN A was observed still at her medication cart preparing medications. On 12/10/24 at 10:49 AM, RN A stated she was now giving her last resident their scheduled 9:00 AM medications. The RN said she was the Unit Manager and was working on a medication cart because they had a call out. She acknowledged that she was behind with the medications. On 12/11/24 at 10:28 AM, Licensed Practical Nurse (LPN) B was at her medication cart preparing medications, and stated she had to give 9:00 AM medications to five more residents. LPN B verbalized that she had one hour before and one hour after the scheduled time to give medications. On 12/11/24 at 11:03 AM, the Director of Nursing (DON) stated the protocol for medication administration, was that staff had a window of one hour before, and one hour after a medication's scheduled time in which to administer the medication. The DON stated if the medication was to be given at 9:00 AM, after 10:00 AM would be considered late. She said if nurses needed assistance, assistance would be provided. She verbalized that the facility had staggered medication times, so all medications were not scheduled for 9:00 AM. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/11/24 at 11:46 AM, LPN B stated staff had a medication administration window of one hour before and one hour after the scheduled time to give medications. The LPN stated that during medication administration time she often had to stop for various interruptions. She explained that if medications were going to be administered late, the nurse should notify the provider. LPN B said she prioritized the residents with high blood pressure, and the residents who received blood glucose monitoring, and gave those medications first, then concentrated on the other residents. She verbalized that she had completed administration of her 9:00 AM scheduled medications at approximately 10:50 AM. Review of the Medication Administration Audit Reports for the day shift on 12/10/24, and on 12/11/24 revealed the following: Resident #6 received his scheduled 9:00 AM medications late on 12/11/24 at 10:53 AM including Baclofen 5 milligram (mg) every (Q) morning and night (HS) for muscle spasms, and Lamictal 200 mg Q AM, and HS for seizures. Resident #7 received his scheduled 9:00 AM medications late on 12/10/24 at 10:50 AM, and on 12/11/24 at 11:00 AM including, Oxcarbazepine 150 mg twice per day (BID) for mood disorder, Glimepiride 4 mg daily (QD) for diabetes, Lisinopril 20 mg QD for high blood pressure, and Lisinopril-Hydrochlorothiazide 20-25 mg in the AM for high blood pressure. Resident #8 received her scheduled 9:00 AM medications late on 12/10/24 between 12:51 PM and 12:53 PM including, Trazadone 100 mg three times daily (TID) for depression/mood disorder, Lithium carbonate 150 mg in the morning for bipolar disorder, Anastrozole 1 mg QD for breast cancer, Tamsulosin 0.4 mg for urinary tract infection, Losartan Potassium 50 mg QD, and Amlodipine 5 mg QD for high blood pressure, and Divalproex sodium 500 mg QAM and HS for seizure. The resident's scheduled 1:00 PM Trazadone was administered at 12:52 PM, the same time as her scheduled 9:00 AM dosage. Resident #9 received her scheduled 9:00 AM medications late on 12/10/24 at 12:54 PM, including, Carvedilol 12.5 mg BID, and Losartan Potassium 25 mg- 2 tabs Q AM and HS for high blood pressure, Clopidogrel 75 mg QD for blood clot prevention, Gabapentin 100 mg TID for nerve pain, Escitalopram 15 mg QD for mood disorder, Isosorbide Mononitrate 5 mg BID for angina, and Furosemide 40 mg, give 0.5 tablet QD for fluid overload. Her scheduled 1:00 PM Gabapentin 100 mg was administered at 12:54 PM, the same time as her scheduled 9:00 AM dosage. On 12/11/24 at 1:08 PM, resident #9 stated that her 9:00 AM medications were not given on time. She said when the nurses got to her it was approximately 10:00 AM-10:30 AM. The resident stated she was on blood pressure medications, medication for her heart and stated she thought she was on a blood thinner, and that medications were late most of the time. Resident #9 said it would be nice to have her medications on time. Resident #10 received her scheduled 9:00 AM medications late on 12/10/24 at 11:08 AM, and on 12/11/24 at 10:14 AM including, Baclofen 10 mg BID for torticolis (twisted neck), Losartan Potassium 50 mg Q AM for high blood pressure, and Eliquis 5 mg BID for atrial fibrillation. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #11 received his scheduled 9:00 AM medications late on 12/10/24 at 11:04 AM, and on 12/11/24 at 10:30 AM including, Gabapentin 100 mg BID for neuropathy, Hydralazine 50 mg BID for high blood pressure, Trazadone ointment 50 mg TID for mood disorder, Sertraline 25 mg QD for depression, and Quetiapine Fumarate 25 mg- give 12.5 mg in the AM for psychosis. His scheduled 1:00 PM Trazadone dose was administered at 1:25 PM, 2 hours and 21 minutes after his 9:00 AM dosage. Resident #12 received her scheduled 9:00 AM medications late on 12/10/24 at 11:02 AM including, Pregabalin 50 mg QAM and Q HS for nerve pain, Lidocaine pain relief 4% patch Q 12 hours on at 9:00 AM off at 9:00 PM for shoulder pain, Levetiracetam 1000 mg Q AM and HS for seizure, and Sertraline 25 mg QD for mood disorder. Resident #13 received his scheduled 9:00 AM medications late on 12/10/24 at 11:01 AM including, Amlodipine 10 mg QD for high blood pressure, Eliquis 5 mg BID for blood clot prevention, and Methocarbamol 500 mg BID for muscle spasms. On 12/11/24 at 1:15 PM, resident #13 said he was not sure what time he actually received his scheduled 9:00 AM medications. On 12/11/24 at 3:30 PM, the DON stated the residents' providers should be notified if medications were administered late. She stated the Advanced Practice Registered Nurse (APRN) was in the facility at the time and had been made aware. However, no documentation of the communication was identified. This was acknowledged by the DON. The Medication Administration Audit Reports for the identified residents were reviewed with the DON. She acknowledged that medications were administered outside of the parameters of one hour before, and/or one hour after the medications' scheduled time. She verbalized that some nurses did not document in real time, and that would also be a violation, and not within professional guidelines. The policy Medication Administration implemented 11/2020, and reviewed/revised 10/2023 read, Medications are administered by licensed nurses, . as ordered by the physician and in accordance with professional standards of practice .Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by the physician.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131 Based on interview, and record review, the facility failed to ensure documentation was complete and accurate for 1 of 5 residents reviewed, of a total sample of 13 residents, (#5). Findings: Resident #5, a [AGE] year-old male was admitted to the facility on [DATE]. Review of the census showed the resident was discharged on [DATE]. Clinical record review revealed no progress note, change in condition documentation, no physician's order, or transfer documentation to indicate the resident's condition, reason for the discharge, or any care and services provided for the resident. An Orders Administration Note dated 11/06/24 at 7:04 PM, read hospitalized but did not give any further explanation. On 12/11/24 at 3:00 PM, the Director of Nursing (DON) stated if a resident was transferred to the hospital or discharged from the facility, the protocol was that staff should obtain a physician's order for transfer/discharge, document a change in condition, a transfer out note, and nurses were supposed to document a progress note. The resident's clinical records were reviewed with the DON, she acknowledged that documentation to indicate if the resident had a change in condition, reason for transfer, or a physician order for transfer could not be identified. She stated she could not recall why the resident was hospitalized . On 12/11/24 at 3:16 PM, Licensed Practical Nurse (LPN) C, stated she recalled resident #5, but did not recall sending him out to the hospital. The LPN stated she did not recall if she received report from the off going nurse regarding why the resident was sent out. She stated she did not see the resident on 11/06/24 but had to document a reason for not giving his medications, and entered the code on the Medication Administration Record, that triggered the Orders Administration Note dated 11/06/24 indicating the resident was hospitalized . LPN C stated that if she had to send a resident out to the hospital, she would document a note regarding the reason for the transfer, and add documentation addressing the resident's change in condition with the resident's Provider. She stated that usually a physician's order was needed for the resident to be sent out of the facility. On 12/11/24 at 3:52 PM, the DON stated she spoke with the Advanced Practice Registered Nurse (APRN), and was told the resident was sent to the hospital from a physician's office. The DON acknowledged that a note to indicate that the resident was out of the facility for an appointment, and that he was transferred to the hospital from the physician's office should have been documented. The facility's policy Documentation in Medical Record implemented 11/2020, and revised 11/2021 read, Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.