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	02/13/2025

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

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131 Based on interview and record review, the facility failed to provide a written copy/summary of the initial care plan to the resident/representative for 2 of 4 residents reviewed for care plans, of a total sample of 40 residents, (#2, #97). Findings 1. Resident #2, was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included chronic respiratory failure, pleural effusion, diabetes type II, difficulty walking, malignant neoplasm of nasal cavity, and repeated falls. Review of the resident's Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the resident's cognition was intact with a Brief Interview for Mental Status (BIMS) score of 14 of 15. On 2/10/25 at 10:18 AM, and on 2/12/25 at 9:37 AM, resident #2 stated he had not been to a care plan meeting and was not sure if his son or granddaughter received any invitation to a care plan meeting. The resident said he did not get a copy or summary of his initial care plan. Review of the resident's clinical records revealed no document pertaining to the resident's care plan meeting, or any documentation to indicate a summary/copy of the resident's initial care plan was provided to the resident/representative. (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/25 at 1:33 PM, and at 2:23 PM, the Registered Nurse (RN) MDS Coordinator stated invitations for care plan meetings were done either via mail, or hand delivered to residents and/or their representative, and a copy of the invitation would be included in the residents' Electronic Medical Record (EMR). She stated resident #2 was admitted to the facility in November 2024, and since November 7, 2024, the facility had not had care plan meetings for residents due to lack of staff. She explained care plan meetings were held on Admission, then quarterly. The RN/MDS Coordinator said at the admission care plan meeting, a copy of the resident's initial care plan, and medication list would be given to the resident/representative. The RN/MDS Coordinator said a summary/copy of the initial care plan could also be mailed or reviewed/discussed over the phone if the resident's representative was unable to attend the care plan meeting. She explained that when the resident was readmitted to the facility on [DATE], he should have had a care plan meeting, but the meeting was not held, and the last scheduled care plan meeting held by the facility, was on 11/07/24. The RN/MDS Coordinator said she spoke with the Medical Records personnel, reviewed documents in the file cabinet, the MDS file cabinet, and the resident's EMR, and could not identify any documentation to indicate a summary /copy of the resident's initial care plan was provided to the resident and/or his representative. 2. Resident #97, was admitted to the facility on [DATE], and readmitted on [DATE]. Her diagnoses included encephalopathy, diabetes type II, trigeminal neuralgia, bradycardia, anxiety disorder, and heart failure. Review of the resident's Medicare-5-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's cognition was moderately impaired with a BIMS score of 11 of 15. On 2/10/25 at 11:50 AM, the resident's son stated he was not invited to the resident's care plan meeting, and he did not receive a written summary/copy of the resident's initial care plan. On 2/12/25 at 1:51 PM, the RN/MDS Coordinator stated the last care plan meeting completed by the facility was on 11/07/24, so the resident would not have had a care plan meeting. Review of the resident's clinical records revealed no document pertaining to any care plan meeting, or documentation to indicate a copy/summary of the resident's initial care plan was provided to the resident/representative. On 2/12/25 at 2:23 PM, the RN/MDS Coordinator stated documentation to indicate a summary of the resident's initial care plan was provided to the resident/representative could not be identified. On 2/12/25 at 4:30 PM, the Administrator stated that on 11/08/24 the facility went down in personnel to one person in the MDS office. She stated that at that time, the facility's focus was on completing and submitting the MDS assessments timely. She verbalized that due to this focus, and lack of MDS personnel some care plan meetings were not completed. The Administrator said the new RN/MDS Coordinator completed her onboarding, and since the facility now had adequate staffing in MDS, a Performance Improvement Project (PIP) was initiated on 2/05/25 to get current on the care plan meetings, and to ensure all current residents received a care plan meeting at least every quarter and prn (as needed). She explained the team reviewed and identified the facility did not have a policy regarding care plan meetings, so the Governing Board developed a policy, which was completed and dated 2/07/25. The Administrator said the facility resumed care plan meetings on 2/11/25. However, the PIP did not address the provision of a copy/summary of the resident's initial care plan to be provided to the resident/representative. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled, Baseline Care Plan implemented on 11/03/2020, and reviewed/revised on 9/18/2023, read, A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51234 Based on observation, interview and record review, the facility failed to ensure enteral feeding was infused according to physician's orders for 3 of 8 residents reviewed for tube feedings from a total sample of 40 residents, (#42, #73, #84) Findings: 1. Review of resident #84's medical record revealed an admitted [DATE]. Her diagnoses included gastrostomy malfunction, unspecified protein-calorie malfunction, and unspecified dementia. Her quarterly Minimum Data Set assessment dated [DATE] indicated her cognitive skills for daily decision making were severely impaired and she rarely/never made decisions. Review of resident #84's medical record contained a physician's order dated 10/18/24 to receive Jevity 1.5 (nutrition) at a rate of 65 milliliters per hour (ml/hr) for 20 hours until 1300 ml infused and to receive free water at the rate of 20 ml/hr for 20 hours until 400 ml infused via tube feed. On 2/11/25 at 4:52 PM, resident #84's assigned nurse Licensed Practical Nurse (LPN) D verified that resident #84 should receive 20 hours of nutrition provided through her feeding tube in a 24 hour period. She verified the Jevity 1.5 bottles contained approximately 1000 ml of nutrition. She said the time off being provided nutrition was 10:00 AM to 2:00 PM each day. She verified the feeding pump was not on nor was the feeding tubing connected to resident #84, nor had it been providing nutrition nor free water since her shift began at approximately 3:00 PM and it was unknown if it had been off since 10:00 AM. She could not provide any explanation nor documentation in the resident's medical record of how the nursing staff ensured the physician ordered daily nutrition and water had been provided. On 2/11/25 at 5:00 PM, the North Unit Manager verified Jevity 1.5 bottles contained approximately 1000 ml of nutrition. LPN D requested support from the North Unit Manager to understand how much nutrition and free water had been infused over the past 20 to 24 hours for resident #84. The North Unit Manager then requested the Regional Nurse's support to understand how much nutrition and water had been provided over the past 20 or 24 hours. Both verified they were not sure how much nutrition and water had been infused for resident #84 over the past 20 to 24 hours. They could not provide any explanation nor documentation in the resident's medical record of how the nursing staff ensured the physician ordered daily nutrition and water had been provided. They both verified resident #84 was overdue in being provided nutrition through her feeding tube since the 4 hour off time was 10:00 AM to 2:00 PM. Review of resident #84's medication administration record (MAR) from 1/1/25 to 2/11/25 revealed the facility time code at 9:00 AM Jevity 1.5 at a rate of 65 ml/hr for 20 hours until 1300 ml was infused and free water at the rate of 20 ml/hr for 20 hours until 400 ml infused was signed by a nurse. There was no MAR entry when another bottle of Jevity 1.5 began its administration to complete the physician's order of administering 300 ml of nutrition within a 20 hour time period. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #84's medical record revealed a physician's order dated 2/11/25 at 5:19 PM for Jevity 1.5 to be provided via the resident's feeding tube at 5:00 PM at the rate of 65 ml/hr for 20 hours until a total volume of 1300 ml had been infused and free water 20 ml/hr for 20 hours until a total volume of 400 ml had been infused. On 2/12/25 at 9:13 AM, the North Unit Manager assigned as resident #84's nurse verified that resident #84's feeding pump was running and connected to resident #84's feeding tube and the flush rate was set at 20 ml every 0 hours. She said that someone on the night shift had not set the pump correctly and according to the physician's orders it should have been providing free water at a rate of 20 ml per hour. 2. Review of resident #73's record revealed an admitted [DATE]. His diagnoses included cerebral palsy, unspecified, unspecified severe protein-calorie malnutrition, muscle weakness generalized, quadriplegia unspecified, and unspecified convulsions. His quarterly Minimum Data Set assessment dated [DATE] indicated his cognitive skills for daily decision making were severely impaired and that he rarely/never made decisions. Review of resident #73's medical record contained a physician's order dated 2/4/2024 to administer Jevity 1. 5 (nutrition) at a rate of 85 ml/hr for 14 hours until 1200 ml was infused and to receive free water at the rate of 20 ml/hr for 14 hours by feeding tube. On 2/11/25 at 5:20 PM, LPN C said she did not know how to tell how much nutrition and free water had been provided to resident #73 through his feeding tube in the past 24 hours. She could not provide any explanation or documentation in the resident's medical record of how the nursing staff ensured the physician ordered daily nutrition and water had been provided. On 2/11/2025 at 5:28 PM, Registered Nurse (RN) A supervisor could not provide any explanation or documentation in the resident #73's medical record of how the nursing staff ensured the physician ordered daily nutrition and water had been provided through his feeding tube. Review of resident #73's MAR for 2/5/25 to 2/11/25 revealed time code at 5:00 PM Jevity 1.5 at a rate of 85 ml/hr for 14 hours until 1200 ml was infused and free water at the rate of 20 ml/hr for 14 hours infused was signed by a nurse. There was no MAR entry when another bottle of Jevity 1.5 began its administration to complete the physician's order of administering another 200 ml of nutrition within a 14 hour time period. 39943 3. Review of resident #42's medical record revealed resident #42 was admitted to the facility on [DATE] with diagnoses to include cerebral infarction (stroke), dementia, and anxiety. The quarterly MDS assessment dated [DATE] revealed resident #42 had severe cognitive impairment, was dependent on all activities of daily living care and had a feeding tube. The Care Plan dated 8/02/23 read, resident #42 required enteral feeding tube to meet nutrition and hydration needs. Interventions included, provide tube feeding as ordered. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Order Summary Report revealed the following physician orders: Osmolite 1.5 at 95 ml/hr for 20 hours dated 1/16/25, Osmolite 1.5 at 110 ml/hr. for 15 hours until 2/11/25, Osmolite 1.5 at 95 ml/hr. for 20 hours dated 2/11/24. On 2/10/25 at 11:00 AM, resident #42 was observed lying in bed with his eyes closed. Next to his bed was a feeding pump with Osmolite 1.5 feeding attached to the pump. The feeding was not attached to the resident and the feeding pump was off. On 2/10/25 at 4:22 PM, resident #42 was observed in bed with his tube feeding infusing at 56 ml/hr. Record review revealed the feeding should be 95 cc/hr. An interview with his nurse, LPN D confirmed the pump for the tube feeding infused at 56 ml/hr. She reviewed the order in the electronic record and acknowledged the tube feeding should have been set to infuse at 95 ml/hr. She replied she did not start the tube feeding, and added, it was started by the day shift nurse. The LPN explained that when she started her shift, she saw each of her residents to ensure they were okay. She then began her medication administration and verified the settings on the pumps. Review of the resident's MAR revealed the order for Osmolite 1.5 at 95 ml/hr. x 20 hours was signed off as given by LPN B. Review of the facility policy, Care and Treatment of Feeding Tubes read Ensuring that the administration of enteral nutrition is consistent with and follows the practitioner's orders. Periodic evaluation of the amount of feeding being administered for consistency with practitioner's orders. On 2/13/25 at 3:29 PM, the Director of Nursing stated her expectation was for the nurse to check the order for tube feedings and verify the rate. She noted there were times the nutritionist changed the rate.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51234 Based on observation, interview, and record review the facility failed to administer intravenous (IV) antibiotic and maintain an intravenous access site according to professional standards for 1 of 1 resident sampled for IVs, of a total sample of 40 residents, (#91). Findings: Review of resident #91's medical record revealed he was admitted to the facility on [DATE] with diagnoses of chronic osteomyelitis left ankle and foot, other specified noninfective gastroenteritis and colitis, generalized abdominal pain, pressure ulcer of left heel, unspecified stage. Review of resident #91's medical record revealed a physician's order dated 1/15/2025 for the antibiotic, Linezolid by intravenous 600 milligrams (mg) per 300 milliters (ml) over 120 minutes at a rate of 150 milliliters per hour (ml/hr) every 12 hours for chronic osteomyelitis for 34 days. On 2/10/2025 at 9:49 AM, resident #91 was seated in his wheelchair with his left upper arm intravenous catheter connected via tubing to a intravenous bag labeled, Linezolid 600 mg/300 ml. There was no flow device used to regulate the rate of the intravenous antibiotic being infused. On 2/10/2025 at 9:55 AM, resident #91's assigned nurse Licensed Practical Nurse, (LPN) B verified there was no device in use to regulate the flow of resident #91's intravenous infusion of Linezolid. She stated she was not sure how to calculate the infusion rate of the medication she was administering. She verified the physician ordered rate was 150 ml/hr. She confirmed resident #91 had a peripherally inserted central catheter (PICC) line in his left arm. She said resident #91 had expressed a desire to attend physical therapy so she increased the infusion rate to what she considered a faster rate to accommodate his wish to go to therapy. She acknowledged it was not appropriate to not know the rate of infusion nor change the rate of infusion based on resident preference rather than a physician's order. Review of the facility's Intravenous Therapy policy dated 8/2/22 revealed in the compliance guidelines section that when an infusion pump is not used, a mechanical flow device will be used. Review of resident #91's medical record revealed physician's orders dated 1/10/25 to measure arm circumference 3 inches above PICC insertion site with dressing change and as needed and measure the external central line catheter length with each dressing change and as needed. Both tasks were timed to be completed on the day shift every Friday. A physician's order dated 1/17/2025 noted to change PICC line dressing every week with transparent dressing and change the needless access device on the day shift every Friday. On 2/10/25 at 10:08 AM, LPN B verified the transparent dressing that covered resident #91 PICC line was dated 1/20/25. She said the evening nursing shift was responsible for changing the PICC line dressing. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/10/25 at 3:07 PM, LPN B acknowledged it was her signature initials on resident #91's medication administration record on 2/7/25 that indicated she had changed the PICC line transparent dressing and the needless access device. She verified the order to change the PICC line site dressing every week with transparent dressing and change the needleless access device were scheduled to be done on the day shift, when she had worked. She said she documented in error and she had not changed the PICC line dressing nor changed the needless access device on 2/7/25. She said she was afraid to do the PICC line dressing change. She said she had changed resident #91's PICC line's needleless access device since resident #91's admission but had not documented every time she did it nor did she do it with each dressing change. She confirmed she had never measured resident #91's arm circumference above his PICC line nor measured the external part of PICC line. She explained she had never done those tasks. She reviewed the medication administration records for January 2025 and February 2025 and confirmed that on 1/17/2025, 1/24/2025, 1/31/2025, and 2/7/2025 she was assigned to do those tasks. She noted there were blanks on the medication administration record that indicated the PICC line dressing changes were not done. She verbalized the tasks of measuring resident #91's arm circumference above the PICC line and measuring the external portion of the PICC line were important to verify and ensure resident #91 was not having any complications from the line such as inflammation of the vein, a blood clot, or an inappropriate change in placement.

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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** 51023 Based on observation, interview and record review, the facility failed to accurately document medications for 1 of 7 resident reviewed, out of a total sample of 40 residents, (#222). Findings: Resident #222 was admitted to the facility on [DATE] with diagnoses of nondisplaced fracture of the 7th cervical vertebra, hypertension, hypokalemia, atrial fibrillation, syncope, type 2 diabetes, and bradycardia. Review of the resident hospital records from 2/2/25 revealed the resident was admitted after sustaining a fall. The record showed the resident had Cervical 7 compression fracture. Surgical intervention was not recommended, and a cervical collar was ordered. On 2/13/24 at 12:27 PM, licensed practical nurse (LPN) A prepared resident #222's scheduled medications. She removed 1 tablet of Potassium Chloride extended release (ER) 20 milliequivalents (mEq), 1 table of Hydralazine 100 milligrams (mg), and 1 tablet of Methocarbamol 500 mg. When LPN A finished preparing the resident's medication, she proceeded to administer the medications to the resident who was in her room. Review of Resident #222's Medication Administration Record (MAR) for February 2025 revealed physician orders for the following medications, Potassium Chloride ER 20 mEq three times a day every Thu, Fri for hypokalemia for 2 Days with a start date of 2/12/25, Hydralazine 100 mg three times a day for high blood pressure with a start date of 2/7/25, Methocarbamol 500 mg four times a day for muscle spasms start date 2/7/25 Review of resident #222's MAR showed on 2/13/25 at 1:00 PM, Potassium Chloride ER 20 mEq was noted to be administered by the Unit Manager of North Wing. On 2/13/25 at 1:00 PM, Hydralazine HCl 100 mg was noted to be administered by the Unit Manager of North Wing. On 2/13/25 at 1:00 PM, Methocarbamol 500 mg was noted to be administered by the Unit Manager of North Wing. On 2/13/25 at 12:50 PM, the Unit Manager of North Wing revealed she was aware that LPN A had documented her medication administration under her name. The UM stated that LPN A was new and did not have her own login information yet. Interview on 2/13/25 at 3:14 PM with the Director of Nursing (DON) revealed that LPN A was still on orientation and that UM of North Wing was her preceptor. She stated that in the morning, the North Wing UM was more hands on with LPN A and that as the day went on the UM allowed LPN A to work on the medication cart alone. The DON stated there were no guidelines or policies for preceptors and that allowing an orientee to work alone was preceptor judgement. She stated that 2/13/25 was LPN A's third day of orientation and the first day out of the classroom. On the third day of orientation, management provided orientees with their logins for the computers. She explained they 'got busy' today and had not had time to obtain LPN A's login access. The DON stated that because the Unit Manager was precepting, it was okay for LPN A to document under the UM's name. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility had no policy on precepting, orientation or accuracy of documentation.