STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105559	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Good Samaritan Society-Kissimmee Village	1500 Southgate Drive Kissimmee, FL 34746

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review and interview the facility failed to ensure potentially hazardous food was at the correct holding temperature, staff followed practices to prevent physical contamination of food and make sure cookware & equipment are clean and sanitary. Finding: On 12/8/25 at 11:22 AM, the initial kitchen inspection was conducted. In the dishwashing room there was a dietary aide with a beard putting away Dome Pellet Covers. The aide was not wearing a beard guard. He indicated his beard guard had fallen off, time unknown, but failed to explain why he had not donned a new guard. Several minutes later the Kitchen General Manger and Registered Dietitian (RD) arrived, and they said they both round in the kitchen and oversight of the staff. In the three-compartment sink, dishes were observed floating in the sanitizer water. The RD confirmed that the dishes need to be completely submerged in the sanitizer. On a clean storage rack there was an 8-inch frying pan with a significant amount or carbon buildup. The buildup was so pronounced; it was difficult to determine if this was a stainless-steel frying pan or frying pan with a non-stick coating that was disintegrating. As the RD said the pan would be replaced, the General Manger threw the pan away in the garbage can. The facility used a bag-in-the box juice and beverage dispenser. Observations of the dispensing gun and nozzle revealed it was not clean & sanitary. The nozzle was removed and a beige and pink like sludge was on the inside of the nozzle and dispensing gun. The staff, including the General Manager and RD could not explain when the dispensing gun and nozzle had been cleaned & sanitized. Review of the facility menu revealed Homemade Meatloaf was the lunch main entree on 12/11/25. The lunch tray line was observed on 12/11/25 at 11:15 PM. There was dietary aide taking the hot holding temperature of the food on the steam table. The hot holding temperature of potentially hazardous foods needed to be at 135 degrees Fahrenheit or above. The aide was using a digital stem bayonet style instant read thermometer. She plunged the thermometer through several pieces of meatloaf and indicated the temperature was above 135 degrees Fahrenheit. The aid was instructed to take the internal temperature of only one slice of meatloaf; the temperature was 127.9 degrees Fahrenheit. The aide stated the holding temperature was too low.

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, record review and interview, the facility failed to follow the menu for mashed potato portion size. The facility's non-compliance had the likeliness to potentially affect residents who prefer mashed potatoes. Findings:Review of the facility's menu revealed garlic mashed potatoes would be severed for lunch on 12/11/25. The Diet Spreadsheet noted a number 8 scoop was to be used to portion the garlic mashed potatoes, which means residents would receive a 4-ounce portionOn 12/11/25 at 11:15 AM, the lunch tray line was observed. After the staff completed taking the hot holding temperatures on the steam table, serving utensils were placed near each food item and the staff started plating the meals. The staff had used a number 10 scoop for the garlic mashed potatoes instead of a number 8 scoop. A number 10 scoop is a 3.2-ounce portion which was contrary to the facility's menu. The staff present could not explain why the wrong size scoop was used even though there was oversight provided by the kitchen manager and registered dietitian.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received an accurate assessment that was reflective of their status, needs, and areas of decline for 2 of 2 residents reviewed for resident assessments, of a total sample of 49 residents (#10 and #119).1.Resident #10 was admitted to the facility on [DATE] with diagnoses that included dementia, Alzheimer's disease, mild cognitive impairment, anxiety, adjustment disorder, and chronic obstructive pulmonary disease. Review of the Minimum Data Set (MDS) Quarterly assessment dated [DATE] revealed resident #10 received treatment and services for hospice care, dialysis, tracheostomy care, mechanical ventilator, radiation, and oxygen therapy. Review of resident #10's medical record revealed no physician orders or care plans related to the need for dialysis, hospice, radiation, oxygen therapy, or tracheostomy care. There was no documentation in the medical record other than in the MDS Quarterly assessment that resident #10 received dialysis, hospice, radiation, oxygen therapy or tracheostomy care. 2. Resident #119 was admitted to the facility on [DATE] and readmitted [DATE] with diagnosis including type 2 diabetes, anemia, hyperlipidemia and chronic kidney disease stage 3. Review of the MDS Significant Change assessment dated [DATE] revealed resident #119 had renal insufficiency and received dialysis while a resident in the facility. Review of resident #119's medical record revealed no physician orders related to the need for dialysis and no care plan for dialysis services or treatment. There was no documentation in the medical record pertaining to resident #119 receiving dialysis services or treatment while at the facility. On 12/11/25 at 12:59 PM, the MDS Coordinator reviewed Section O – Special Treatments, Procedures and Programs for resident #10's MDS quarterly assessment dated [DATE] and resident #119's MDS significant change assessment dated [DATE]. She verified the coding for each was incorrect and did not accurately reflect each resident's status. She was unable to recall what happened that day or why the assessments were miscoded. The MDS Coordinator acknowledged the assessments were inaccurate and needed to be modified. Review of the facility's policy and procedure for MDS 3.0 Resident Assessment Instrument dated 10/27/25 revealed during the observation period, each team member would review the electronic medical record to determine if there was accurate documentation to support coding for the MDS.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to complete a new Preadmission Screening and Resident Review (PASARR) level I screening to ensure other mental health services were not required for 2 of 2 residents reviewed for PASARR, of a total sample of 49 residents, (#11 and #107).Findings: 1.Resident #107 was initially admitted to the facility on [DATE] with diagnoses that included anxiety, epilepsy, and migraine. From 2015 to 2025 other diagnoses were added to include Alzheimer's disease, dementia, mood disorder, schizoaffective disorder, major depression, altered mental status, cognitive communication deficit, and psychotic disorder. Review of the Minimum Data Set (MDS) Quarterly assessment dated [DATE] revealed resident #107 was severely, cognitively impaired. Resident #107's Order Summary Report dated 12/11/25 revealed she was on Depakote sprinkles twice per day for mood disorder, Remeron at bedtime for depression, and Trazodone twice a day for depression. Review of the Comprehensive Care Plan for resident #107 revealed a care plan for behaviors initiated on 1/04/23 and revised 4/01/25 which indicated the resident had behavior symptoms related to dementia. The care plan described the resident could be argumentative at times, had history of making threats to others, grabbed, yelled, talked loud to others at times, had physical outbursts, and imitated other's behaviors. Review of the PASARR level I form for resident #107 dated 1/03/23 revealed there had been no Mental Illness (MI) diagnosis provided; therefore, the screening was incomplete and did not accurately assess whether the resident received the appropriate services based on her diagnoses. Resident #107's medical record revealed a psychiatric note dated 11/14/25 that detailed she was being seen for anxiety, reported low energy and poor concentration. She also reported feeling anxious and excessively worried, with symptoms occurring several times. A previous psychiatric note dated 11/06/25 revealed the resident was being treated for depression, dementia, mood disorder, and schizoaffective disorder. During that visit it was noted that staff had reported the resident was yelling, screaming, and crying all day. 2. Resident #11 was admitted to the facility on [DATE]. Facility staff completed the Preadmission Screening and Resident Review (PASARR) on 6/17/25 and noted the resident had depressive disorder, a form mental illness. On or about 8/27/25 the bipolar disorder, another form of mental illness, was added to the resident #11's list of diagnoses. Further record review revealed that the resident's PASARR was not updated. On 12/11/25 at 5:20 PM, RN (X) indicated she was responsible for the residents' PASARRs. She said PASARRs both residents #107 and #11, needed to be updated to reflect the diagnoses of anxiety and bipolar disorder, respectively.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide an ongoing activity program for 3 of 3 residents reviewed for activities, of a total sample of 30 residents, (#5, #8, #135) Findings: 1. Resident #135 was admitted to the facility 11/09/23 and placed under Hospice Care 10/25/24. admission diagnoses included unspecified dementia, depression and hypothyroidism. The Minimum Data Set Quarterly assessment dated [DATE] references resident #135 had a staff assessment for Mental Status due to resident #135 rarely/never understood. The staff assessment for Mental Status rated resident #135 as having severe cognitive impairment, being fully dependent on staff for all activities of daily living and transport. Activity preferences in the assessment included music, activities with groups of people, and outside visits. The activities care plan initiated 9/02/24 and revised 10/23/25 indicated resident #135 had a potential for activity deficit and unable to self-pursue activity interest, initiating stimulation, socialization, and dependent on staff for activity. The goal for her is to maintain involvement in cognitive and sensory stimulation, and social activities. The care plan, initiated 1/08/25, indicates resident #135 prefers listening to 60's, 70's and 80's music. Documented interventions include music therapy, stress ball, aroma therapy, manicure, sensory blankets, dolls, and outdoor strolls. Additional intervention includes assisting to and from locations as needed to attend scheduled activities, birthday celebrations, special events, music entertainment, and encourage to take part in activities to maintain current level of cognitive functioning and to slow decline. Review of Resident #135's medical record revealed an 'Intervention/Task' Activities log for the month of December 2025. Resident #135's Activity log from December 1st through December 11th, 2025, revealed days of a single activity per day focusing on Sensory Stimulation. The Sensory Stimulation entailed 5 out of 11 days of television, 2 out of 11 days of radio/iPod, and 1 day out of 11 sitting outside. Two days were without activities. On 12/8/25 at 10:59 AM, resident #135 was sitting at the #3 Nursing Station with her eyes open but did not respond to questions. There were 4 other residents in the hallway at the # 3 Nurse's Station, doing no activity other than listening to Christmas music playing from hallway. No other interaction from the staff or activity observed. At 2:00 PM, resident #135 was still sitting in#3 Nursing Station with 3 other residents, her position was unchanged. No staff interaction or other activity was observed. On 12/9/25 at 11:15 AM, resident #135 was in dining area at table alone. She was slightly reclined in Geri-chair. CNA's were standing in hallway of dining area conversing with each other while 11 other residents were sitting in the dining area. No staff interaction or activity observed. At 2:45 PM, resident #135 was again in #3 Nursing Station with two other residents. sitting in the same position in her Geri-chair. There was no staff interaction or activities taking place except Christmas music playing from the nearby Christmas tree. On 12/9/25 at 2:50 PM, Certified Nursing Assistant (CNA) L stated she was not familiar with the activities of resident #135 and said she usually checked the iPad to see activities and assistance (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed for residents. On 12/10/25 at 9:45 AM, resident #135 in #3 Nursing Station with three other residents. There was no staff interaction or activity observed besides some Christmas music playing from nearby Christmas tree. After lunch at 2:20 PM, resident in #3 Nursing Station with three other residents. Christmas music playing and no staff interaction or activity observed. On 12/11/25 at 9:30 AM, resident #135 observed in #3 Nursing Station with three other residents. Position unchanged, Christmas music playing and no staff interaction or activity observed. On 12/11/25 at 2:15 PM, Nurse L stated she cared for resident #135 multiple times and said sometimes she got her days and nights confused. The nurse stated 'Activities' staff take resident #135 to activities that are scheduled during day. The nurse stated the facility had a lot of activities. The nurse did not say why resident #135 was observed over the past four days only sitting in #3 Nursing Station and not participating in activities. On 12/11/25 at 3:30 PM, resident #135 in room eyes closed, lying on right side towards wall. Room is quiet with no TV or music. On 12/11/25 at 3:53 PM, the Activities Director explained sensory stimulation activity included, aroma therapy, hand massage, foam puzzles, music therapy, sensory blanket, butterfly garden, and sitting outside. She stated activities are documented daily in the plan of care. She stated #3 Nursing Station if primarily hospice patients and were usually included in activities in the morning and afternoon because the residents were more awake. She stated her staff was responsible for bringing residents to activities. Resident activity log reviewed for past two weeks and reflected resident #135 was not present on the attendance log for attending any activities. 2. Resident #5 was admitted to the facility on [DATE] and her diagnoses included Sequelae of Cerebral Infarction, Hemiplegia, Hemiparesis, Adjustment Disorder, Anxiety and was Hospice. On 2/9/25 at 12:55 PM the resident was in a high back wheelchair sitting in front of Nurse's Station 3. The resident's head hung down with her face in her right hand. There was Christmas music coming from a Christmas tree and she sat there with other residents. There were not any staff to engage the residents, and the residents did not interact amongst themselves. Review of the resident's admission Minimum Data Set (MDS) dated [DATE] noted she scored a '0 on the Brief Interview for Mental Status (BIMS), which means the resident's cognition was severely impaired. The MDS noted resident #5's customary routine & activities in Section F. This section noted music, doing favorite activity(s) and going outside for fresh air were very important to the resident #5. The resident's care plan noted the resident had left eye visual impairment, communication and mobility problems. The care plan noted the resident alteration in activity involvement as she participates in one-to-one conversation and prefers time in room. The activity care plan goal read, .will express satisfaction with Bingo and maintain involvement. The activity care plan approaches indicated the resident #5's preference for classic/Christian music, outdoor strolls, play bingo and watching TV channels 62 and 18. On 8/15/25 the resident's music preference was updated to merengue, bachata and R&B music. On 12/10/25 at 2:03 PM, resident #5 was in her wheelchair, sitting across from Nurse's station 3. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Christmas music was playing and there were several other residents in the area. Again, there were not any staff to engage the residents, and the residents did not interact amongst themselves. The residents in this area appeared to be of poor cognition. Resident #8 was admitted to the facility on [DATE] and his diagnoses included Alzheimer's disease, Chronic Obstructive Pulmonary disease, Schizoaffective disorder, Dementia and was currently on Hospice. On 12/9/25 at 1:06 PM, resident #8 was in his [NAME]-chair, which was parked against the wall, across from Nurse's station 3. There were 5 other residents in the area, and they were not conversing with each other and there were no staff to engage the residents in an activity. Christmas music was coming from the Christmas tree. Review of resident #8's annual MDS dated [DATE] noted the resident cognition was severely impaired. Section F, Customary Routine/Activities, noted it was very important for the resident #8 to do things with groups of people and do his favorite activity. The resident's care plan noted he had a communication problem related to his disease state and he is unable to express his wants/needs. However contrary to his communication problem, his activity care plan goal read, Resident will attend/participate in activities of choice 3- 5 times weekly. The approaches on the resident's activity care plan were revised on 5/1/25 and his preferred activities were upbeat Spanish music, singing, watching horse videos, garden stroll, rummaging through sensory box, sensory items. On 12/10/25 at 12:35 PM, resident #8 was in his Geri-chair and it was slightly reclined. His chair was parked across from Nurse station 3, with the back of the chair up near the wall, next tot the water cooler. Christmas music was coming from the Christmas tree and there were 8 other residents in the area. The residents did not engage each other; they sat in their chairs as the Christmas music played on a continuous loop. On 12/11/25 at 3:45 PM residents #5 and #8 were sitting in their chairs across from Nurse's station 3. Christmas music was playing from the Christmas tree and there were several residents in the area, just sitting in their chairs. A few minutes later, at 3:53 PM, the Activities Director gave an explanation/overview of the facility's Activity Program. She stated she could not determine if he likes Christmas music, but he would get agitated if he does not like something. When asked why resident's #5 & #8 were not provided Spanish style music based on each of their activity care plans, the Activity Director stated that she needed more activity staff. When resident #5's care plan goal for bingo was discussed, the Activity Coordinator said, Bingo is on the weekends. However, she could provide documented evidence when resident #5's most recent bingo participation. She stated the music box that comes with the Christmas tree on a continuous loop, and the same Christmas music is played. When asked why the residents, which included #5, #8 and # 135, were situated near Nurse's station 3, she said station 3 is primarily Hospice residents. She could not explain why each Department Manager could not take a few minutes out of their day, on a rotating schedule, to engage the low cognitive aware residents and ensure all residents have meaningful activities.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 prevent medication administration error rate of 5% or greater for 1 of 13 residents sampled for medication administration, (#87). There were 2 medication errors in 25 opportunities for a medication error rate of 8%. Findings:Resident #87 was admitted to the facility on [DATE] with diagnoses that included dementia, insomnia, anxiety, depression, restlessness and agitation, moderate protein-calorie malnutrition, and generalized muscle weakness. On 12/10/25 at 10:48 AM, Registered Nurse (RN) A was observed during medication administration for resident #87. She pulled up Morphine Sulfate 0.25 milliliters (ml) liquid solution into a medication cup and Lorazepam 0.5 ml liquid solution into another cup. RN A proceeded to resident #87's room to administer the medication. He was lying in bed with his eyes closed in a semi-reclined position with the hospice nurse sitting at the bedside. RN A brought the medication cups to the resident's lips and poured the contents of both cups into his mouth. It was unable to ascertain whether the resident swallowed the medication or if he was holding it in his mouth. Review of resident #87's active physician orders for 12/10/25 revealed he had been receiving hospice services since 8/22/25. He had orders for Morphine Sulphate (concentrate) oral solution 0.25 ml sublingually (under the tongue) every 2, 4, and 6 hours for shortness of breath and Lorazepam oral concentrate 0.5 ml under the tongue every 2 and 4 hours for shortness of breath. On 12/10/25 at 12:05 PM, the hospice nurse was at the bedside with resident #87 and confirmed he was on crisis care, which meant a hospice nurse would be at the bedside 24 hours per day during the resident's decline or active dying process. She said she observed when RN A administered the medications to resident #87 and noted they had not been properly administered under the tongue as ordered. She said it was important to administer these medications under the tongue to ensure they were absorbed into the body and not left sitting in the resident's mouth due to difficulty with swallowing. She said she did not educate the nurse because she was aware that the facility did not have the supplies needed to administer the medication in the correct way. On 12/10/25 at 12:12 PM, RN A said she was aware the medications had been administered incorrectly and that they were supposed to be administered sublingually. She explained the pharmacy provided an insulin syringe with the medication, but the syringe had the measurements scratched out from multiple uses and she had not requested a new syringe from the pharmacy. She said the correct way to pull up the medications was to pull them up into two syringes and administer them under the tongue instead of using the medication cups which would not allow for them to be placed under the tongue of the resident. The nurse stated she had not let her supervisor or Director of Nursing (DON) know she did not have the needed supplies to appropriately administer the medications per the physician order. She agreed that she should have held the medication until she was able to administer it appropriately and notified the physician. On 12/10/25 at 2:28 PM, the DON said RN A was new to the facility and was not aware there were extra syringes available for her to administer the medications. The DON indicated the nurse should have asked a supervisor. She explained her expectation was for medications to be administered per physician's order.