STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105728	A. Building B. Wing	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orlando Health and Rehabilitation Center	830 West 29th Street Orlando, FL 32805

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to protect the resident's right to be free from physical abuse by a Certified Nursing Assistant (CNA) for 1 of 5 residents reviewed for abuse, of a total sample of 12 residents, (#6). The facility's failure to protect resident #6 resulted in actual harm when the resident sustained injuries to his right hand and left forearm.Findings: Cross Reference F609 Review of resident #6's medical record revealed he was originally admitted to the facility on [DATE] and readmitted on [DATE] after hospitalization. His diagnoses included dementia with behavioral disturbances, mood disorder, history of urinary tract infections, weakness, reduced mobility, anxiety, repeated falls, and stroke. Review of the Minimum Data Set (MDS) significant change in status assessment with Assessment Reference Date of 8/02/25 revealed resident#6 had impaired hearing and vision, unclear speech and rarely understood verbal content. A Staff Assessment for Mental Status was completed due to poor comprehension. The MDS assessment noted behavioral physical symptoms such as hitting or scratching self, pacing, rummaging, or verbal/vocal symptoms like screaming, disruptive sounds not directed toward others which occurred one to three days but did not interfere with his care or participation of activities. The MDS assessment showed this behavior did not put others at risk and did not intrude on the privacy of others. The MDS assessment revealed no rejection of evaluation or care necessary to obtain goals for health and well-being and no wandering. The assessment noted he needed substantial assistance from staff with Activities of Daily Living (ADLs) such as eating and oral hygiene. He was dependent on staff for transfers, toileting hygiene, shower/bath, upper & lower body dressing, put on/off footwear, and personal hygiene. Resident #6 had functional limitations in range of motion on his bilateral upper and lower extremities. The MDS assessment revealed resident #6 sustained falls since the prior assessments, two resulting in no injuries and two with injuries.Review of resident #6's medical record revealed a care plan for impaired cognitive function/dementia, revised on 8/06/25. Another care plan for behaviors, revised on 10/07/25 revealed resident #6 was on one to one (1:1) supervision, combative with staff, impulsive and refused care and medications at times. The interventions directed staff to speak softly and clearly when communicating and allow time to communicate effectively.Review of resident #6's Kardex (care plan used by CNAs) revealed interventions such as to observe and report changes including resistance to care.Review of Progress Notes in resident #6's medical record showed the following entries:*9/30/25 at 6:33 AM - Resident alert with confusion, several attempts to get out of the bed; became agitated and combative when redirected. *10/01/25 at 8:25 PM - Resident restless, required PRN (as needed) medications. *10/02/25 - 10/03/25 - Continued 1:1 observation for behavioral concerns; resident resisted care and attempted to strike staff.*10/05/25 at 6:29 AM - Resident combative during the care, attempting to hit staff, and refusing hydration.*10/05/25 at 5:16 PM - At approximately 3:30 PM, resident was observed screaming at other residents and staff, then struck the nursing station plexiglass partition. Nurse notified Supervisors, Physicians, family and 911 was called. The resident was transferred to the hospital for evaluation.*10/05/25 at 8:13 PM - Resident returned to the facility. Hospital records showed bilateral hand x-rays were negative for fractures; a right-hand laceration required no sutures. Resident was restless and reported pain in the right hand. Tramadol was administered. A Transfer Form dated 10/05/25 revealed the reason for transfer to the hospital was behavioral symptoms (e.g. agitation, psychosis). Review of ED (Emergency Department) Provider Notes dated 10/05/25 revealed resident #6 presented to the ED by EMS (Emergency Medical Services) from [facility's name] after they reported he was punching plexiglass and sustained lacerations to both of his hands. The document included, On initial evaluation of the patient he stated that he was locked up and was not allowed to go to the bathroom for an hour and a half. Patient stated that this frustrated him and he hit his hands on the door. He is unable to provide any other meaningful history. Review of the psych provider note dated 10/06/25 read, Patient is a [AGE] year old male . able to make needs known. He is unable to answer some questions during assessment due to cognitive impairment secondary to dementia. Patient was transferred to ER (Emergency Room) last night, returned to facility after a few hours, no change in psychotropics. Patient is unable to recall event, and when prompted denies any negative mental or emotional effect from event. Nursing reports agitation, combativeness, restlessness, and physically aggressive behavior worse at night. Nursing reports frequent attempts to get up independently to urinate at night, agitation with redirection attempts. On 10/13/25 at 8:54 AM, during a telephone interview, Registered Nurse (RN) J stated resident #6 was combative at

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to report an allegation of physical abuse to the Agency for Health Care Administration (AHCA) in a timely manner for 1 of 5 residents reviewed for abuse, of a total sample of 12 residents, (#6). The failure to immediately report prevented prompt protective measures to residents and delayed the reporting to state authorities.Findings: Cross Reference F600 Review of resident #6's medical record revealed he was originally admitted to the facility on [DATE] and readmitted on [DATE] after hospitalization. His diagnoses included dementia with behavioral disturbances, mood disorder, history of urinary tract infections, weakness, reduced mobility, anxiety, repeated falls, and stroke. Review of the Minimum Data Set (MDS) significant change in status assessment with Assessment Reference Date of 8/02/25 revealed a Brief Interview for Mental Status score was not obtained because resident #6 was rarely or never understood. The MDS assessment noted behavioral symptoms not directed toward others which did not interfere with his care or participation of activities. The MDS assessment showed this behavior did not put others at risk and did not intrude on the privacy of others. The MDS assessment noted resident #6 needed substantial assistance from staff for eating and oral hygiene and was dependent on staff for transfers, toileting hygiene, shower/bath, upper & lower body dressing, put on/off footwear, and personal hygiene. Resident #6 had functional limitation in range of motion on his bilateral upper and lower extremities. Review of resident #6's medical record revealed a care plan for impaired cognitive function/dementia, revised on 8/06/25. Another care plan for behaviors, revised on 10/07/25 revealed resident #6 was on one to one (1:1) supervision, combative with staff, impulsive and refused care and medications at times. The interventions directed staff to speak softly and clearly when communicating and allow time to communicate effectively. Review of resident #6's Kardex (care plan used by Certified Nursing Assistants (CNAs)) revealed interventions such as to observe and report changes including resistance to care. Review of Progress Notes in resident #6's medical record showed the following entries:*10/05/25 at 6:29 AM - Resident combative during the care, attempting to hit staff, and refusing hydration.*10/05/25 at 5:16 PM - At approximately 3:30 PM, resident was observed screaming at other residents and staff, then struck the nursing station plexiglass partition. Nurse notified Supervisors, Physicians, family and 911 was called. The resident was transferred to the hospital for evaluation.*10/05/25 at 8:13 PM - Resident returned to the facility. Hospital records showed bilateral hand x-rays were negative for fractures; a right-hand laceration required no sutures. Resident was restless and reported pain in the right hand. Tramadol was administered. Review of ED (Emergency Department) Provider Notes dated 10/05/25 revealed resident #6 presented to the ED by EMS (Emergency Medical Services) from [facility's name] after they reported he was punching plexiglass and sustained lacerations to both of his hands. The document included, On initial evaluation of the patient he stated that he was locked up and was not allowed to go to the bathroom for an hour and a half. Patient stated that this frustrated him and he hit his hands on the door. He is unable to provide any other meaningful history. On 10/13/25 at 8:54 AM, during a telephone interview, Registered Nurse (RN) J stated resident #6 returned from the hospital around 8:00 PM and CNA A continued the 1:1 with him until 11:00 PM. She stated the hospital paperwork showed resident #6 sustained no fractures and no stitches were required. She mentioned when she returned to work the following night, she learned the video footage reviewed by management showed CNA A smashed resident #6's hand with the door, staff in the unit did not intervene, and someone was arrested. On 10/13/25 at 12:10 PM, during a telephone interview, CNA D confirmed she saw CNA A trying to close the door for resident #6's room from the outside and when she released the door, he came out holding a brief. She recalled the nurse told CNA D to close the door and it was the assigned 1:1 staff to deal with whatever. She stated the resident she was assigned to care for asked her to close the door too because it was too noisy. She explained she received a call from the facility the following day asking for details of what happened on Sunday. She shared on Tuesday she received another call and was informed she was suspended and last night she learned she was terminated. She stated she could not understand their reason as she was not supposed to leave her assigned 1:1 resident and she reported what she saw to the nurse. CNA D indicated the Executive Administrator (ENHA) and Executive Director of Nursing (EDON) told her she was supposed to report what she saw to them, but she claimed she did not know. On 10/13/25 at 12:35 PM, RN G confirmed she was one of the weekend supervisors on duty on 10/05/25. She recalled entering resident #6's room and observing two nurses dressing resident's hands. She stated resident #6 was agitated