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	06/20/2025

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

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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, and record review, the facility failed to ensure residents were afforded dignity during meals for 2 of 20 residents reviewed for dining, of a total sample of 103, (#99, & #206). Findings: 1. Resident #99 was admitted to the facility on [DATE] and had diagnoses that included dementia, anxiety, disorder of the brain, inability to speak and poor muscle coordination after stroke. The annual Minimum Data Set (MDS) dated [DATE] indicated resident #99 was rarely or never understood and her cognitive abilities were severely impaired. Resident #99 had a care plan that indicated she was totally dependent on staff for eating and most other activities of daily living (ADL's). 2. Resident #206 was admitted on [DATE] with diagnoses that included muscle disorders, depression, anxiety, degenerative nerve disease, and trouble swallowing. Her annual MDS assessment dated [DATE] indicated the resident was rarely or never understood, and her cognitive abilities were severely impaired. Resident #206 had a care plan which indicated she was totally dependent on staff for eating and most other ADL's. On 6/16/25 at 5:11 PM, Certified Nursing Assistant (CNA) G was observed standing while assisting resident #206 with her dinner meal. CNA G stated she couldn't find a chair to use while feeding the resident, and acknowledged she was supposed to sit to assist the residents with eating. She explained the room used to have a chair in it, but it was moved about two weeks ago. On 6/17/25 at 12:17 PM, the lunch meal trays were on the bedside tables of both residents #206 and #99. Physical Therapist (PT) I worked with resident #99 on bed stretches/exercises. At 12:25 PM, CNA E entered the room to assist resident #206 with her lunch and stood while she assisted the resident with her meal. At approximately 12:30 PM, PT I finished providing therapy services to resident #99 and began to assist her with her lunch while standing over the resident. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/17/25 at 12:43 PM, PT I stated she did not typically provide meal assistance to residents and was not aware she needed to be seated when assisting a resident with dining. She then brought a chair from across the room to the resident's bedside to continue with the meal. A short time later at 12:48 PM, CNA E stated she knew she was supposed to sit in a chair while she assisted resident #206 with her meal, but acknowledged she did not do it today. She explained it was a dignity issue and staff should not be standing over the residents but instead at their eye level to make them feel comfortable and not rushed. On 6/19/25 at 1:52 PM, the Assistant Director of Nursing (ADON)/ Staff Development Nurse stated the CNA's were trained on the importance of sitting when assisting residents with meals. She added if a chair were not available in the room, she would expect the staff member to get one. The facility's policy entitled Dining Program, dated June 2024, indicated nursing staff were to assist residents in need of assistance during mealtimes.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide an opportunity to participate in the development and implementation of a person-centered plan of care for 1 of 2 residents reviewed for care planning, of a total sample of 103 residents, (#327). Findings: Review of the medical record revealed resident #327 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses soft tissue disorders, shortness of breath, and myositis (a rare autoimmune condition characterized by muscle inflammation with symptoms that often include muscle pain and soreness, fatigue, trouble swallowing, and difficulty breathing). Review of the Minimum Data Set (MDS) annual assessment with Assessment Reference Date of 5/02/25 revealed resident #249 had a Brief Interview for Mental Status score of 15 out of 15 which indicated she was cognitively intact. The MDS assessment indicated the resident did not exhibit behavioral symptoms or reject evaluation or care that was necessary to achieve her goals for health and well-being. On 6/16/25 at 11:35 AM, resident #327 stated she had not been invited to participate in care plan meetings. On 6/19/25 at 10:24 AM, the Clinical Reimbursement Director explained the care plan meetings were set approximately a week after the MDS assessment was completed. She indicated invitation letters were sent on Fridays by the receptionist. She explained the invitation letter included the date, but the time was left open to accommodate the availability of the resident or resident representative. She indicated previous care plan meetings for resident #327 were held on 11/14/24 and 2/13/25. She stated the resident was invited but she declined to attend those meetings. She explained an invitation was to be sent on 5/02/25 but the same day resident #327 was transferred to the hospital. She shared the invitation on 5/02/25 showed the meeting was to be held on 5/15/25 but the receptionist returned the invitation with D/C written on it because the resident was not in the facility. Later at 2:46 PM, the Clinical Reimbursement Director confirmed resident #327 actually returned to the facility on 5/08/25, but because the invitation was marked D/C, the May meeting was not held. She said, It was unfortunate because she did return to the facility. Review of the facility Policy & Procedure titled Care Plan - Interdisciplinary Plan of Care from Interim to Meeting dated February 2024 revealed the intent to assist residents or their representative, to participate in and understand the assessment and care planning process . holding care planning meetings at the time of day when a resident is functioning best, . (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Resident Handbook dated January 2017 read, Your Plan of Care . We take pride in developing a complete plan of care with each resident, to meet the individual's medical, nutritional, and personal needs. Within a few days after you arrive, we will meet with you to gather specific info that will help our staff develop rehabilitation goals for your POC. You and your family (with your permission) are encouraged to attend this planning meeting and give input into your quarterly care planning conference. The staff will review the complete plan of care with you and your family on a regular basis.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Resident #332 was admitted on [DATE] for dysphagia (trouble swallowing), sepsis, severe protein-calorie malnutrition, and hypertensive heart disease. The quarterly MDS dated [DATE] indicated resident #332 had a BIMS score of 15/15, which reflected no cognitive impairment. On 6/16/25 at 9:47 AM, three medications including a container of Naproxen, 220 milligram (mg) tablets, a tube of triple antibiotic gel, and a tube of Muscle Rub, were on the resident's bedside table. The resident stated he had these medications in his room since he was admitted and took them for pain as needed. At 9:54 AM, the A wing UM verified the medications on the resident's bedside table. She removed the medications and told the resident the facility would need to administer the medications to him per the physician's orders. Review of physician orders revealed there was no order permitting resident to self-administer any medications. Review of the resident's care plan revealed there was no indication he had been assessed for self-administering of medication. On 6/17/25 at 10:34 AM, the Executive Director of Nursing acknowledged the residents should not self administer medications without an assessment and physician orders. She confirmed residents should have an assessment completed and the care plan should be updated if a resident was to self administer medications. The facility's Policy and Procedure on Medication Administration Self administration by Resident dated November 2017 indicated, Residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team had determined that the practice would be safe and the medications are appropriate and safe for self-administration. Based on observation, interview, and record review, the facility failed to assess residents for self-Adminsitration of medication for 2 of 2 residents reviewed for self-administration, of a total sample of 103 residents, (#71, & #332). Findings: 1. Resident #71 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included other specified disorders of the muscle, type 2 diabetes mellitus, severe sepsis, and chronic obstructive pulmonary disease with acute exacerbation. Review of the Minimum Data Set (MDS) quarterly assessment with assessment reference date (ARD) of 3/19/25 revealed resident #38 had a Brief Interview for Mental Status (BIMS) Score of 15 out of 15, which indicated he was cognitively intact. A review of resident #71' s electronic medical record did not indicate he was assessed to self-administer medications. There were not any physician's orders nor was there a care plan for the self-administration of medications. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/17/25 at 9:28 AM, resident #71 entered his room, on his nightstand, there was a medicine cup filled with pills. Resident #71 said that nurse gave the cup of pills to him but he was worried the nurse would be in trouble. A few minutes later, assigned Registered Nurse (RN) L who was outside the room in the hallway, said the care plan or the Medication Administration Record (MAR) would have record of whether a resident was assessed for self administration of medication. She was not sure if resident #71 was assessed or able to self administer his medications. RN L explained there was a list of residents who could self-administer their medications, but said she did not have the list as she was only helping out. She acknowledged she should not have left resident #71 with the medication to self-administer on his own and said she took responsibility. On 6/17/25 at 10:06 AM, in a joint interview with the Staff Development Coordinator and the C Wing Unit Manager (UM), the UM explained it was a safety issue for residents to self-administer medications without an assessment to do so. She acknowledged resident #71 needed a self-administration assessment and a physician's order before he could self administer medications. The Staff Development Coordinator confirmed the assessment needed to be completed and resident #71 had not had an assessment completed. Neither the UM nor the Staff Development Coordinator could provide the list of residents who self-administered medications which RN L spoke about earlier.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure prompt efforts were made to resolve grievances for 1 of 20 sampled residents regarding choices, of a total sample of 103 residents, (#120). Findings: Review of resident #120's medical record revealed an admission date of 1/01/24. His diagnoses included quadriplegia (paralysis to all four limbs), contracture of muscle multiple sites, and abnormal posture. Review of resident #120's Quarterly Minimum Data Set, dated [DATE] indicated his cognitive function was intact. On 6/16/25 at 4:33 PM, resident #120 said that he thought his care concerns were not being addressed by staff. He said he had previously made a complaint about long call bell response, for several hours of delay, but it had not been resolved. Review of the Grievance/Concern report dated 4/30/25 detailed two concerns for resident #120. The first concern was about dietary, the next concern detailed resident #120 said it was hard for him to find help from Certified Nursing Assistants and long call bell response times. Dietary department staff was noted as the individual designated to act on this grievance. On 6/19/25 at 8:14 AM, resident #120's Grievance/Concern report dated 4/30/25, was concurrently reviewed with the Social Services Director. He verified that since two topic areas of concerns were expressed by resident #120 they should have been investigated as two separate grievances. He verified there was only documentation that the one grievance involving dietary concerns had been addressed with resident #120. The Social Services Director said it seemed the other concern regarding the long call bell wait time had not been investigated, but should have. The Social Services Director acknowledged it was not clear from the initial report when the long call bell wait times occurred and there was no further clarification completed by staff regarding the questions. Review of the facility's policy and procedure titled, Grievance/Concern Management with an effective date of 2024 indicated it was the Social Services representative/Grievance Official in collaboration with the Nursing Home Administrator who was responsible for assigning the concern to the appropriate department for investigation. The policy revealed that Social Service staff would monitor and document the resident's satisfaction upon completion of the investigation and summary of findings/conclusion.

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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** 2. Resident #56 was a long-term care resident who admitted to the facility on [DATE]. Review of the level I PASARR dated 9/20/13, noted section 1A was blank and did not include any diagnoses of potential mental illness or intellectual disability. Review of the resident's current diagnoses included dementia, epilepsy, depression, anxiety and psychotic disorder. Record review revealed during a session with the Psychologist on 4/28/25, the resident was noted with a depressed mood and expressed feelings of being overwhelmed. There was not any evidence in the medical record that the level I PASARR had been updated. On 6/19/25 the Social Service Director was ask to provide a copy of the resident's level I PASARR. On 6/20/25 at 1:35 PM, the Social Service Director provided the requested copy of the PASARR dated 9/20/13 and a copy of a new PASARR which was updated on 6/19/25. He could not explain why the resident's PASARR had not been updated prior to 6/19/25. The Facilty's Policy and Procedure dated February 2021 indicated, During the admission process, Business Development will communicate with the facility regarding prospective admissions. A level I PASARR will be provided prior to admission to the Skilled Nursing Facility (SNF). The facility administration will confirm that a Level I review has been completed prior to transfer to the SNF setting. Based on interview, and record review, the facility failed to request a Preadmission Screening and Resident Review (PASARR) level I and level II evaluation after a new major mental disorder diagnosis for 2 of 5 residents reviewed for PASARR, of a total sample of 103 residents, (#16, & #56). Findings: 1. Review of the medical record revealed resident #16 was initially admitted to the facility on [DATE] and re-admitted on [DATE] from an acute care hospital. Some of her diagnoses included adjustment disorder with mixed anxiety and depressed mood, anxiety disorder, bipolar disorder, disorganized schizophrenia, catatonic schizophrenia, unspecified dementia and weakness. Resident #16's Minimum Data Set (MDS) quarterly assessment with an assessment reference date of 5/09/25 revealed the resident scored 12/15 on the Brief Interview for Mental Status which indicated she had mild cognitive impairment. The assessment revealed resident #16 felt depressed, had no behaviors nor rejection of care and had diagnoses of anxiety disorder, bipolar disorder and schizophrenia listed as active diagnoses. Review of the Plan of Care revealed that resident #16 had behaviors with the potential to demonstrate verbally abusive behaviors related to mental or emotional illness; was often combative during Activities of Daily Living (ADL) care often striking staff; declined care and skin assessments at times; and would appear catatonic or non-responsive. The care plan also addressed the use of psychotropic medications to manage schizophrenia, anxiety, depression, bipolar disorder and insomnia. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/16/25 at 4:48 PM, resident #16 was observed sitting in the dining area of the C wing among other residents. At times resident #16 would scream out while using foul language and said, I'll be calm today. On 6/18/25 at 10:50 AM, a review of the Level I PASARR revealed the new major mental illness disorders were not listed on the document dated 2/08/23. The only one of her diagnosis listed was bipolar disorder. On 6/18/25 at 11:32 AM, assigned Certified Nursing Assistant (CNA) M explained resident #16 could be verbally abusive to staff and other residents when having a bad day. She said the resident could be easily redirected or calmed down after speaking with her brother or offered a diversion. On 6/18/25 at 6:07 PM, the Social Services Director said he was responsible for updating the PASARR forms when a resident had a new mental health diagnosis. He was made aware of resident #16's new diagnoses of schizophrenia and adjustment disorder, which he acknowledged the resident should have been re-screened after the new diagnoses were added. The Social Services Director explained that during the Interdisciplinary Team (IDT) meetings, the team would talk about what diagnoses needed to be on the PASARR form and would request the Level II screening, but was not aware of this one.

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	105728	A. Building B. Wing	06/20/2025

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to request a Preadmission Screening and Resident Review (PASARR) level I and level II evaluation for 2 of 5 residents reviewed for PASARR, of a total sample of 103 residents, (#70, and #123). Findings: 1. Resident #123 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included vascular dementia, major depressive disorder, adjustment disorder, congestive heart failure, cerebral infarction, and acute respiratory failure with hypoxia. Review of resident #123's Minimum Data Set (MDS) quarterly assessment with an assessment reference date of 4/04/25 revealed the resident was cognitively impaired and listed depression as a psychiatric diagnosis. A review of the electronic medical record revealed a PASARR dated 1/12/23 and no diagnoses were listed in Section 1 A. On 6/19/25 at 1:45 PM, the Social Services Director stated he was responsible for PASARRs. He acknowledged that no diagnoses were listed in section 1 A of resident #123's PASARR and said, guess I missed that one, I will work on it. He continued to explain that the Admissions department looked at the PASARR from the admission packet from the hospital, but he was responsible for ensuring that they were accurate upon admission. The Social Services Director confirmed the level I PASARR was incorrect, therefore the resident's screening was inaccurate, and required a new one. 2. Resident #70 was admitted to the facility on [DATE]. His diagnoses included schizoaffective disorder, bipolar type; anxiety disorder unspecified; major depressive disorder, recurrent, unspecified; and a personal history of other mental and behavioral disorders. Review of resident #70's medical record revealed a level I PASARR signed by the facility's Social Services Director on 4/02/24. The PASARR screening indicated that resident #70 had anxiety disorder, schizoaffective disorder, depressive disorder, and multiple diagnoses related to alcohol abuse. The responses regarding the level I PASARR indicated that a level II PASRR evaluation should be completed. On 6/17/25 at 4:06 PM, the Social Services Director reviewed the level I PASARR which he had electronically signed on 4/02/24 and he verified a level II PASARR evaluation was required, but had no documentation of its completion. He conveyed he had nothing to show regarding the level II screening including that he attempted to follow-up with the contractor completing the screening. The Social Services Director said he would need to resubmit a request for a Level II PASARR for resident #70, which he had not done yet.

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	105728	A. Building B. Wing	06/20/2025

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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 a resident centered activities program to meet the needs of residents who required 1:1 in room activities for 5 of 6 residents reviewed for in room activities, of a total sample of 103 residents, (#152, #174, #345, #349, & #359). Findings: The following residents resided on the locked unit and were observed daily for five days, from 6/16/25-6/20/25, between the hours of 8:15 AM to 9:30 AM, and 11:30 AM to 4:30 PM. During those times no activities for the residents were observed. 1. Resident #152 was admitted to the facility on [DATE] with diagnoses to include dementia, mood disorder, repeated falls. Resident #152's activity care plan indicated, resident requires staff assistance with involvement of activities related to behavioral symptoms that may affect participation. Cognitive deficits .requires staff visits for supplies and assistance with partaking in passive activities in his room, initiated on 2/11/25). The goal was for staff visits completed one to two times per week to offer assistance with active leisure involvement in activities of past interest as tolerated, initiated on 2/11/25. Interventions included in-room activities (reading, staff visits, watching TV. Preferred time afternoons) initiated on 2/11/25. Review of the activity documentation for individual activity and activity participation for the month of June 2025 revealed no documentation of individual activities for resident #152. Resident #152 was not observed taking part in any activity during the survey from 6/16/25 to 6/20/25. Review of the record revealed resident had no documented in-room activities in the past 30 days. 2. Resident #174 was admitted to the facility on [DATE], with diagnoses including encephalopathy (brain disorder), schizophrenia, adjustment disorder, and repeated falls. Resident #174's activity care plan indicated, resident requires staff assistance with involvement of activities related to behavioral symptoms that may affect participation. Cognitive deficits .does not stay for the entire activity, states some enjoyment with watching television, initiated on 12/10/24. The goal was for resident #174 to receive staff visits one to two times per week for participation in activities of interest and sensory stimulation attempts through next review, initiated on 12/10/24. Interventions included in-room reading, television, socializing, and music, initiated on 12/10/24. Review of the activity documentation for individual activity and activity participation for the month of June 2025 revealed no documentation of individual activities. Resident #174 was not observed taking part in any activity during the survey from 6/16/25 to 6/20/25. (continued on next page)

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	105728	A. Building B. Wing	06/20/2025

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #345 was admitted to the facility on [DATE] with diagnoses including dementia, encephalopathy, and difficulty walking. The resident's activity care plan detailed, he is capable of pursuing his own activities, is capable of attending activities but prefers to stay in room .Resident's son stated his dad enjoys watching television and listening to music, initiated on 2/20/25. The goal was for resident #345 to receive staff visits one to two times per week to offer assistance in active leisure pursuits and ensure leisure satisfaction until next review, initiated on 2/20/25. Interventions included preference for in-room television, socializing and music, initiated on 2/20/25. Review of the record revealed resident had no documented in-room activities in the past 30 days. Resident #345 was not observed taking part in any activity during the survey from 6/16/25 to 6/20/25. 4. Resident #359 was admitted to the facility on [DATE] with diagnoses that included vascular dementia, encephalopathy, and cerebral infarction. Resident #359's activity care plan indicated the resident required staff assistance with involvement of activities related to behavioral symptoms that may affect participation. Prefers to stay in room, initiated on 4/22/25. The goal was resident #359 would receive staff visits one to two times per week to offer assistance with partaking in activities of past interest as tolerated, initiated on 4/22/25. Interventions included resident prefers in-room reading, television, socializing and music, initiated 4/29/25. The resident had one documented in-room activity in the past 30 days, on 5/26/25. Resident #359 was not observed taking part in any activity during the survey from 6/16/25 to 6/20/25. 5. Resident #349 was admitted to the facility on [DATE] with diagnoses to include respiratory failure, stroke, encephalopathy, tracheostomy (a surgical hole in the throat for breathing) status, and gastrostomy (feeding tube) status. Resident #349's activity care plan detailed, the resident required staff assistance with the involvement of activities related to requires physical assistance to and from activities. Unable to complete interview for daily and activity preference. Requires 1:1 visit for sensory stimulation, initiated 2/23/25. The goal was resident #349 would receive a 1:1 visit for sensory stimulation one to two times per week until next review, initiated 2/23/25. Interventions included resident would benefit from in-room television and music, would benefit from passive/active room activity, preferred activities are television, music, animals, and sitting outside, initiated 2/23/25. Resident #349 had not been seen involved in any activity during the time period from 6/16/25 to 6/20/25. Her television was on only one day of the five. On 6/19/25 at 9:21 AM, the Activity Director stated she provided activities daily in the locked unit beginning at 9:30 AM. She stated she provided different activities throughout the day and in-room activities were performed one to two times per week and documented in the activity task on the computer. The Activity Director was not able to explain why the locked unit staff were not seen participating in activities with residents #152, #174, #345, #349, and #359 throughout the day during the week of the survey.

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	06/20/2025

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to timely provide coordination of care for diagnostic imaging/laboratory services and a specialty gastrointestinal (GI) consult for 2 of 2 residents reviewed for coordination of care, (#159 and #22); and failed to obtain physician's wound treatment orders and complete weekly wound measurement assessments for 1 of 5 residents reviewed for non- pressure skin condition concerns, (#120), of a total of 103 sampled residents. Findings: 1. Review of resident #159's medical record revealed an admission date of 5/23/22. Her diagnoses included volvulus (twisting intestines) and abdominal distension-gaseous. Review of resident #159's Quarterly Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status of 13/15, which indicated her cognitive function was intact. On 6/16/25 at 1:34 PM, both resident #159's family member and resident #159 said the size of the resident's abdominal area had increased over time since she had been at the facility. They stated they did not know why. Review of resident #159's medical record revealed a gastrointestinal specialty progress note dated 6/11/25 which indicated resident #159 had a distended abdomen and it was recommended she have a computerized tomography (CT) scan of her abdomen and pelvis to rule out an obstruction. On 6/18/25 at 3:55 PM, the A Wing Unit Manager (UM) stated she obtained a physician's order that day to schedule the recommended CT scan for resident #159. The Um could not explain why it took a week to coordinate with resident #159's physician regarding the GI specialist's recommendation for a follow-up CT scan appointment. 2. Resident #22 was admitted to the facility on [DATE]. His diagnoses included malignant brain cancer, difficulty swallowing, and abnormal weight loss. Review of resident #22's Quarterly MDS assessment dated [DATE] indicated his cognitive function was intact. Review of resident #22's documented eating history from 5/22/25 to 6/18/25 revealed on 20 out of 28 days resident #22 refused a meal or multiple meals; or had 25% or less intake of a meal. Review of resident #22's documented weight history revealed on 6/11/25 he weighed 188.4 pounds (lbs) and on 5/18/25 he weighed 203.8 lbs. This was a 7.37% decrease in less than 30 days. In 45 days his weight decreased 14.08%. On 4/04/25 he weighed 237.2 lbs and a month and a half later on 5/18/25 he weighed 203.8 lbs. (continued on next page)

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	105728	A. Building B. Wing	06/20/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #22's physician's orders revealed an order to test his stool for occult blood on 4/14/25 with an end date of 4/17/25. The status indicated it was completed. Two days later there was another order to test stool for occult blood on 4/16/25 with an end date of 4/18/25 and the status indicated it was completed. 30 days later, there was again an order to test the stool for occult blood, on 5/23/25 with an end date of 6/08/25. On the same day, 6/08/25, there was a physician's order to test stool for occult blood started on 6/08/25 with an end date of 6/18/25. Resident #22's physician's orders dated 6/12/25 indicated a stool specimen had been collected and was awaiting lab testing. Five days later on 6/17/25, it was noted that a stool specimen had been collected and was awaiting lab testing. Review of resident #22's physician's orders revealed an order for a GI consult dated 4/14/25 with an end date of 6/08/25. On 6/08/25 another physician's order occurred for a GI consult which indicated to discontinue the order when it had been completed; the order appeared as active. On 6/19/25 at 8:57 AM, resident #22's physician's orders from 4/25 to the current date were reviewed with the A Wing UM. She verified there were no results from a fecal occult blood test. She confirmed there was no documentation that a GI consult was made for resident #22, 66 days after it had been ordered by the physician on 4/14/25 and reordered on 6/08/25. The UM could not explain why the consult had not been completed yet. On 6/19/25 at 10:20 AM, resident #22's laboratory results were reviewed with the Advanced Practice Registered Nurse (APRN) W. She said she could not find results for an occult blood stool from April 2025 to present. APRN W thought the resident had one occult blood stool sample result; however, she could not find documentation of it. She said it would be good to have the results of the occult blood stool sample because resident #22 had weight loss, and considered he possibly had an internal mass. APRN W conveyed she did not recall contacting the GI specialty group associated with the facility to request a consultation. On 6/19/25 at 11:23 AM, the Executive Director of Nursing (DON) reviewed resident #22's physician orders for a GI consult from 4/14/25 to 6/08/25 and then the active order from 6/08/25 to present. She was unsure if resident #22 had the ordered GI consult. She acknowledged it should take over two months for a GI consult to be completed. No additional documentation for a completed GI consult for resident #22 was provided by the survey's end. On 6/19/25 at 11:59 AM, APRN X, the GI consult specialist for the facility, said he did not recall having provided a consultation for resident #22. 3. Resident #120 was admitted to the facility on [DATE]. His diagnoses included quadriplegia (paralysis), contracture of muscle multiple sites, and abnormal posture. Review of resident #120's Quarterly MDS assessment dated [DATE] indicated his cognitive function was intact. Review of resident #120's skin evaluations revealed he had an abrasion on his right gluteal area which was measured on 5/20/25, 6/04/25, and 6/19/25. There was no documentation for two weeks from 5/25/25 to 5/31/25 and from 6/08/25 to 6/14/25 in which there was no documentation of his wound measurement during these time frames. Review of the medical record revealed there were no physician's orders regarding the care for this wound area. (continued on next page)

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	06/20/2025

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #120's skin evaluation of an abrasion on his left ischial tuberosity documented measurements on 4/30/25, 5/20/20, 6/04/25, and 6/19/25, which revealed two concurrent weeks and two additional weeks that the wound had not been measured within this time frame. Resident #120 had physician orders dated 4/29/25 regarding the left ischial tuberosity to cleanse wound with normal saline, apply Xeroform and cover with dry dressing every night shift. Review of resident #120's skin evaluation of an abrasion on his penis documented measurements on 4/25/25, 5/20/25, 6/04/25, and 6/19/25, which revealed two concurrent weeks and two additional weeks that had no documentation the wound was measured. Review of resident #120's care plan revealed he had a risk for skin integrity with a care plan initiation date of 4/17/23 and a revision date of 5/19/25. One of the interventions dated 4/17/23 was to monitor and document the size and treatments of skin concerns, to report failure to heal and maceration to the doctor. On 6/19/25 at 7:20 AM, Registered Nurse (RN) BB stated the wound care she did for resident #120 during her night shift was to apply a barrier cream to his wounds. She described the wounds on the right gluteus and penis. She could not provide the name of the barrier cream she used, nor could she locate the tube of the cream she used, nor show a sample from the stock of creams of the variety she used for his wounds. On 6/20/25 at 7:55 AM, resident #120's wound orders were reviewed with the A Wing Unit Manager (UM) who verified there were no physician orders for wound treatment regarding the abrasion on his right gluteus. She confirmed the wound should have physician's orders as documentation revealed it had been present since 5/20/25. The A Wing UM verified the physician's treatment orders regarding the left ischial tuberosity were not followed by Registered Nurse BB as she did not indicate she had covered the left ischial tuberosity with a Xeroform dressing. She said she thought the physician's order should be changed. On 6/20/25 at 9:43 AM, the Executive DON confirmed that wounds including lacerations, abrasions, and pressure ulcers should be measured weekly. She said she did not know why weekly measuring was not done for resident #120 regarding his wounds. On 6/20/25 at 9:49 AM, resident #120's right gluteal abrasion, left ischial tuberosity abrasion, and penis abrasion wound measurements were reviewed by the First Floor DON. She stated the wounds should be measured weekly and acknowledged in the case of resident #120's wounds that had not been followed. The First Floor DON verified no refusals from resident #120 were documented regarding taking wound measurements since April 2025 up to the present time. She acknowledged it was the facility's responsibility to obtain weekly wound measurements even if resident #120 was not available in bed when she and the Unit Managers rounded to measure wounds. She explained the value in taking wound measurements was to document any change over time to assess if the wound was improving or declining in regards to healing.

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	06/20/2025

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services related to management and application of orthotic devices to prevent worsening of contractures and promote skin integrity for 1 of 1 residents reviewed for limited range of motion (ROM) and reduced mobility, of a total sample of 103 residents, (#249). Findings: Review of the medical record revealed resident #249 was admitted to the facility on [DATE] with diagnoses including stroke with left side weakness and paralysis, type 2 diabetes, and cataracts. Review of the Minimum Data Set (MDS) annual assessment with Assessment Reference Date of 3/09/25 revealed resident #249 had a Brief Interview for Mental Status score of 15 out of 15 which indicated she was cognitively intact. The MDS assessment indicated the resident did not exhibit behavioral symptoms or reject evaluation or care that was necessary to achieve her goals for health and well-being. The MDS assessment revealed resident #249 had functional limitation in range of motion due to impairment of upper and lower extremities on one side. Resident #249 required substantial assistance for bathing and required partial/moderate assistance from staff with oral hygiene, toileting hygiene, dressing, and personal hygiene. The MDS assessment revealed the resident did not receive ROM services or assistance with splints or braces. Review of resident #249's physician orders revealed an order dated 6/03/25 which read, Splint: Apply palm guard split (sp) goal wear time up to 3 hrs (hours) every day shift. Additional orders dated 3/11/23 indicated restorative nursing as needed and physical therapy / occupational therapy / speech therapy to evaluate & treat as needed. A previous order for splinting program dated 6/14/24 was discontinued on 6/03/25 and instructed nurses to don the palm guard splint with a goal wear time up to three hours. Review of resident #249's Care Plan Report revealed a focus for ROM - at risk or actual limitation in ROM as evidenced by requires splinting applications initiated on 6/05/25. Another focus included Activities of Daily Living (ADL), initiated on 3/11/23 - resident has an ADL self-care performance deficit related to left side weakness . decreased mobility . hemiplegia affecting left non-dominant side, right arm contracture, insomnia, need for assistance with personal care, lack of coordination. Review of resident #249's Kardex (Care Plan used by Certified Nursing Assistants (CNAs)) showed a restorative section which read, Assistance with splint or brace apply palm guard splint goal wear time is 3 hours. (continued on next page)

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	105728	A. Building B. Wing	06/20/2025

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/17/25 at 8:34 AM, resident #249 was sitting up in bed, her left hand was contracted, and no splint was noted. She stated she had a splint, but her sister took it home to be washed because it was smelly. She shared she was unsure who could wash it in the facility. She indicated she did not use rolled towels or anything on the contracted hand and she was not receiving restorative nursing services. She shared when she had the splint, there were times she had to apply the splint by herself, and it was difficult and painful. Resident #249 mentioned when she wore the splint, it protected her from touching the blanket and feeling pain. She shared when she saw her former Occupational Therapist walking by the hallway, she would call her to assist applying the splint. She indicated she wore the splint and removed it herself. Later on 6/18/25 at 4:36 PM, resident #249 was seen near the receptionist area on the first floor not wearing a splint. On 6/18/25 at 2:02 PM, CNA N stated she had not seen any braces or boots in resident #249's room. She shared resident #249 used to work with therapy but she believed it stopped due to insurance. She indicated the resident had mentioned she would like to work with therapy again. CNA N stated she had not seen resident #249 wearing a splint and the resident had never mentioned a splint to her. Review of resident #249's Treatment Administration Record (TAR) for June 2025 revealed nurses signed off the splinting tasks as completed every day. Review of resident #249's Documentation Survey Report revealed a task initiated on 6/03/25 that read, NURSING REHAB: Assistance with splint or brace apply palm guard splint goal wear time is 3 hours. The report showed CNAs documented not applicable (NA) 16 times out of 18 days. Two days were left blank. Review of resident #249's Progress Notes from May to June 2025 did not reveal documentation of any refusal to wear splints. On 6/19/25 at 1:13 PM, the H-Wing Unit Manager (UM) said it was debatable who was responsible to apply the splint daily. She explained therapy staff handled the information she entered under physician orders for residents who needed splints. She validated nurses were to follow physician orders. She shared they did not have a Restorative Nursing Program (RNP) at the facility. The UM stated resident #249 used her splint whenever she wanted to use it. The UM mentioned a care plan for refusal was just created on 6/16/25 but could not provide evidence in the medical record for the refusals. She recalled therapy donned resident #249's splint occasionally and notified the nurse so the nurse could document it. On 6/19/25 at 1:37 PM, Registered Nurse (RN) O validated she documented resident #249 had the splint on. RN O accompanied surveyor to resident #249's room. RN O confirmed the resident was not wearing her splint. Resident #249 repeated her sister took her splint last week to wash it. After leaving resident #249's room, RN O stated she was not aware the resident's sister took the splint to be washed. RN O validated she documented the splint was applied to the resident twice this week without confirming resident was in fact wearing it. She stated she should have not documented it completed because she did not actually see if the splint was on or not. (continued on next page)

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	105728	A. Building B. Wing	06/20/2025

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Orlando Health and Rehabilitation Center	830 West 29th Street Orlando, FL 32805

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/19/25 at 3:01 PM, the Rehabilitation Director indicated resident #249 was not currently on therapy caseload. She shared Occupational Therapy (OT) last worked with resident #249 in October 2024. She shared resident #249 was in the RNP for splinting. She explained once therapy discharged a resident with a splint, the program was given to nursing. She mentioned therapy met with RNP at the beginning to show how to don and doff the splint. She stated therapy gave nursing the recommendation for RNP but nursing ran the program. She indicated the RNP was different for each unit. She stated if a resident did not tolerate the splint or refused to use it, nursing informed therapy but she was not aware of any issues with resident #249. On 6/19/25 at 4:18 PM, the Executive Director of Nursing (DON) stated they did not have a Restorative Nurse. She explained the CNAs were responsible for performing the ROM exercises or donning the splints on residents. The DON indicated the splinting showed on the CNAs tasks and the TAR for nurses to perform it. She indicated this was not changed in the year she had worked in the facility. She shared CNAs received training by therapy to handle splints. She recapped CNAs were responsible for splints and the nurse who signed it off was responsible for ensuring the task was completed. Review of resident #249's Therapy Referral form dated 5/22/24 revealed a referral was made to OT and Physical Therapy. It read, left hand contracture wants to be able to toilet herself. Review of resident #249's OT Therapist Progress & Discharge summary dated [DATE] revealed resident improved in orthotic management tolerance using the palm guard to improve joint integrity. Review of resident #249's Therapy Recommendations for Restorative Program form dated 6/20/24 included goals to maintain ability to move upper extremity and wear splint for up to three hours. Review of resident #249's Splinting Program Form with a start date of 6/21/24 read, Gently position left digits in extension and don palm guard. The form was signed by the OT, Charge Nurse and a CNA. Review of resident #249's Nursing Quarterly and PRN (as needed) Data Collection form dated 3/22/25 included the resident was alert and oriented; and cooperative with care and treatment. The question, Does the resident use any splints, braces or orthoses? was answered, Yes. It read, Splinting Program. [NAME] palm guard split (sp) goal wear time up to 3 hrs. Review of the Certified Nursing Assistant (CNA) Job Description dated 7/01/19 revealed the CNA worked under the supervision and guidance of a licensed nurse (RN or License Practical Nurse). The form read, Performs restorative and rehabilitative procedures as instructed.

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	105728	A. Building B. Wing	06/20/2025

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Orlando Health and Rehabilitation Center	830 West 29th Street Orlando, FL 32805

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, interview, and record review the facilty failed to provide care and services for a Peripherally Inserted Central Catheter (PICC) intravenous (IV) line for 1 of 1 residents reviewed for central line catheters, of a total sample of 103 residents, (#922). Findings: Resident #922 admitted to the facility from the hospital on 6/10/25. Her diagnoses included type 2 diabetes, heart failure, abdominal hernia, epilepsy and ventricular tachycardia (fast heartbeat). The hospital transfer form did not indicate the resident had an IV line. Staff noted in a progress note dated 6/10/25, the resident had an IV line that was located in the resident's right arm. On 6/16/25 at 2:59 PM, the resident was observed in the therapy gym and said the facilty did not use her PICC line. She conveyed she did not receive antibiotics through the line nor did the facility staff flush it. The PICC dressing had a date of 6/07/25, before she was admitted to the facility, which meant the dressing had not been changed since she had been at the facility. A PICC line is a thin, flexible tube inserted into an upper arm vein and guided into the large vein on the right side of the heart. It is used for intravenous delivery of antibiotics or chemotherapy drugs. The most common complication of a PICC line is infection which can lead to sepsis, shock, and death. The reported patient mortality rate was between 12% and 25% for central line related blood stream infections, Care for the PICC includes, checking the site for redness or bleeding, changing the dressing at least weekly and flushing the IV regularly, (retrieved from www.ncbi.nlm.nih.gov on 7/06/25). Review of the Electronic Medication Administration Record (EMAR) noted a physician order to remove the midline on or about 6/15/25. The EMAR indicated this order was checked off as completed that the PICC line had been removed. Review of the EMAR also noted there was no physician orders for dressing changes, saline flushes, or assessment of the PICC site. On 6/16/25 at 3:03 PM, Registered Nurse A (RN) confirmed resident #922's PICC line dressing was dated 6/07/25. The nurse added resident #922 did not receive any medication via the PICC line and confirmed she did not flush it. RN A did not provide any information as to how the facilty maintained the patency of resident #922's PICC, nor what was done to assess the PICC site for signs of infection, swelling, redness or other symptoms. RN A said IV line dressings were supposed to be changed every 7 days, but did not offer any other steps nurses took to assess, and maintain the central IV line. On 6/19/25 at 3:26 PM, the Executive DON acknowledged the admitting nurse did not put in the batch orders into the computer for the PICC. She was also aware that another nurse checked off the physician's order as completed even though the PICC had not been removed. The DON explained the facility's chart audits for new admissions, confirmed resident #922's medical chart had not been audited and the resident did not have orders for the PICC line dressing change, flushes, or site assessment.

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	06/20/2025

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 6. Resident #349 was admitted to the facility on [DATE] with diagnoses to include respiratory failure with hypoxia (low O2), pulmonary embolism (clot in lung), encephalopathy (brain disorder), and tracheostomy status. Review of the Medication Review Report (physician orders) revealed the following orders: Tracheostomy size 6 Shiley, tracheostomy care daily and as needed. Clean the inner cannula and replace. Maintain Ambu bag at bedside and replacement tracheostomy of equal size and one size down at bedside every shift for preventative measure, dated 3/13/25. On 8/18/25 at 5:55 PM, resident #349 was in bed; at bedside there was no Ambu bag, and no size 5 or 6 replacement tracheostomy set seen. On 6/18/25 at 5:57 PM, Licensed Practical Nurse (LPN) J verified the Ambu bag and replacement tracheostomy required to be at the bedside for resident #349 was not present. She was unable to say why the equipment was not at the bedside as ordered. At that time, the G Wing UM confirmed the equipment was not available at resident #349's bedside. Resident #349's tracheostomy care plan dated 2/14/25, revealed an intervention to maintain Ambu bag and replacement tracheostomy at bedside per order. 7. Resident #315 was admitted to the facility on [DATE] with diagnoses to include chronic pulmonary insufficiency, encephalopathy, compression of the brain, pulmonary embolism, and tracheostomy status. A physician order dated 4/27/25, revealed maintain Ambu bag at bedside and replacement tracheostomy of equal size and one size down maintained at bedside every shift for preventative measure for respiratory failure requiring a tracheostomy. The tracheostomy care plan dated 7/12/24, revealed an intervention to maintain the Ambu bag and replacement tracheostomy at bedside per order. On 6/18/25 at 6:30 PM, resident #315 was in bed; at bedside there was an Ambu bag and a size 6 tracheostomy inner cannula. There were no smaller sized replacement tracheostomy inner and outer cannula at bedside as ordered. On 6/18/25 at 6:32 PM, the D Wing UM confirmed the emergency equipment was not at bedside but was unsure why it was not at the bedside. 8. Resident #300 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include acute respiratory failure with hypoxia, heart failure, encephalopathy, and tracheostomy status. A physician order dated 3/14/25 indicated maintain Ambu bag at bedside and replacement tracheostomy of equal size and one size down at bedside every shift for preventative measure. (continued on next page)

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	06/20/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Tracheostomy Care Plan dated 6/07/24 and revised on 3/14/25, revealed an intervention to Maintain Ambu bag and replacement trach at bedside per order. On 6/18/25 at 6:12 PM, there were no replacement tracheostomy cannulas as per order at resident #300's bedside. On 6/18/25 at 6:15 PM, the D Wing UM acknowledged the replacement tracheostomies were not in the emergency bag. She stated her DON told her to get them from the Central Supply Room earlier that morning, but when she went to Central Supply, no one was there. The D Wing UM did not respond to why she didn't try to get them later in the day when someone in Central Supply was available. On 6/19/25 at 1:00 PM, the Director of Central Supply stated she had a difficult time getting size 5 Shiley tracheostomy cannulas. She stated they were frequently on back order and currently did not have any in her Central Supply room. She was not sure when they would be available. On 6/19/25 at 2:00 PM, the Respiratory Therapist (RT) stated she assessed all of the respiratory residents weekly, usually on Tuesday or Thursday. She explained she changed all the tracheostomies monthly and checked all the emergency supplies weekly. The RT was unable to say why most of the residents with tracheostomies did not have all of the ordered emergency equipment available at the time of the survey. 10. Review of the medical record revealed resident #327 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including soft tissue disorders, shortness of breath (SOB), and myositis (a rare autoimmune condition characterized by muscle inflammation with symptoms that often include muscle pain and soreness, fatigue, trouble swallowing, and difficulty breathing). Review of the MDS annual assessment with Assessment Reference Date of 5/02/25 revealed resident #327 had a BIMS score of 15/15 which indicated she was cognitively intact. The MDS assessment indicated the resident did not exhibit behavioral symptoms or reject evaluation or care that was necessary to achieve her goals for health and well-being. The MDS assessment revealed resident #327 had SOB with exertion, when sitting at rest and when lying flat. The assessment noted the resident relied on a manual wheelchair for mobility and received O2 therapy. Review of the Florida Agency for Health Care Administration 5000-3008 Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form signed by the hospital's physician on 5/08/25 revealed resident #327 used a BiPAP at night. A bilevel positive airway pressure (BiPAP) machine uses pressure to push air into the lungs, and it is commonly used for people with obstructive sleep apnea. Depending on the settings, it opens the upper airways leading to and increasing the flow into the lungs, improving the level of oxygen in the blood. Breathing difficulties during sleep could impact a person's quality of life. (Retrieved from www.healthline.com on 6/24/25). Review of resident #327's care plan for altered respiratory status for difficulty breathing related to SOB, initiated on 5/10/25, revealed a goal to maintain a normal breathing pattern. The interventions instructed the nurses to apply a BiPAP at bedtime, with settings 12/8. It read, BIPAP as ordered. (continued on next page)

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	06/20/2025

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #327's physician orders revealed the following orders: *Apply BiPAP at bedtime (QHS): Settings 12/8 at bedtime for SOB- chronic respiratory insufficiency secondary to muscle contact provider if unable to apply - dated 6/06/25 * Change BiPAP O2 adapter monthly, and as needed (PRN), when O2 filter is changed - dated 5/09/25 * Change BiPAP O2 tubing weekly and PRN - dated 5/09/25 * Fill BiPAP humidifier chamber with distilled or sterile water QHS - dated 5/09/25 * Empty and Rinse BiPAP humidifier chamber every morning (Q AM) and allow to dry every day shift - dated 5/10/25 * Wash BiPAP mask with warm soapy water and wipe dry weekly - dated 5/09/25 * Empty and Rinse BiPAP humidifier chamber Q AM and allow to dry every day shift - dated 5/09/25 Review of resident #327's Progress Notes revealed the following entries: * 6/12/25 - A call was made to the respiratory equipment company to follow up on the resident's BIPAP ordered on Monday, June 9. The representative stated the physician order needed to include the settings. * 5/03/25 - A follow up call was placed to the hospital. Resident was admitted and the nurse reported resident #327 was placed on a BiPAP. * 5/02/25 - Resident experienced respiratory distress and the physician ordered a transfer to the hospital. Review of a physician's Progress Note at the hospital dated 5/07/25 mentioned resident #327 would require the use of BiPAP at night and as needed and an attempt to arrange an Average Volume-Assured Pressure Support (AVAPS) machine upon discharge. (An AVAPS is a type of noninvasive positive pressure ventilation that provides consistent ventilation support for patients with chronic respiratory conditions). The plan noted, Will need to utilize BIPAP at her facility due to facility ventilator constraints. On 6/16/25 at 11:39 AM, resident #327 shared she was supposed to have a BiPAP approximately two months ago. She indicated she went to an outside pulmonologist appointment on 6/04/25 and he again wrote a prescription for the BiPAP. She stated she received the BiPAP this past weekend. She mentioned no one knew how to set it up at night and they were waiting for her pulmonologist appointment this week to ask about it. She shared she had been experiencing SOB, tightness on her chest, a cold, and recently had pneumonia in the past few weeks. On 6/19/25 at 8:06 AM, resident #327 stated she had not used the BiPAP yet, but she saw the pulmonologist that morning and was told the respiratory equipment company needed to adjust the setting. On 6/19/25 at 2:16 PM, the Respiratory Therapist (RT) stated she did not recall seeing or receiving any information regarding a BiPAP order for resident #327. (continued on next page)

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	105728	A. Building B. Wing	06/20/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/19/25 at 5:40 PM, the H-Wing UM stated when resident #327 returned from the hospital the discharge documents were reviewed. She indicated admissions handled the orders from the hospital when a resident needed oxygen, BiPAP, or anything else they would need when admitted to the facility. The UM reviewed the 3008 form dated 5/08/25 and confirmed a BiPAP was listed under treatment devices. She indicated admissions or the nurse needed to follow up on getting the BiPAP. She stated the Nurse Practitioner entered an order for the BiPAP in resident #327's medical record on 6/06/25. She mentioned she did not know where that order needed to be sent or who was responsible for getting it done. On 6/19/25 at 6:02 PM, Registered Nurse (RN) P stated resident #327 had an order for the use of a BiPAP when she needed it. She shared she offered resident #327 the BiPAP at night but she refused or had used it for a couple of hours but removed it. When asked if she documented the refusals or resident #327's limited use of the BiPAP, RN P stated she did not recall if she did. She explained she asked the Nurse Practitioner about the BiPAP when resident #327 returned from the hospital, and she mentioned she would order the machine. She recalled she saw the BiPAP in resident #327's room but the resident had not used it. When asked why she documented care to the BiPAP in May and June, prior to the BiPAP's delivery, she indicated she was told she had to click it because nothing could stay red. She explained if the assigned tasks were not marked complete in the medical record, they turned yellow then red. She repeated, I clicked it because I saw the order. She stated she could not recall exactly when she saw the BiPAP in the room, but thought it was approximately two weeks ago. RN P said, If (the task) stays red, I get a call to return and document. She stated she was told nothing could stay red, so I click it off, so it goes away. RN P did not respond when asked if she clicked the tasks off even if the treatment was not performed. Review of the Treatment Administration record (TAR) for the months of May and June 2025 showed RN P signed off the order which read, Fill BiPAP humidifier chamber with distilled or sterile water QHS. at bedtime . dated 5/09/25 as completed 12 times in May 2025, (5/12, 5/13, 5/14, 5/16, 5/17, 5/20, 5/21, 5/22, 5/26, 5/27, 5/28, and 5/31) and 12 times in June 2025 (6/1, 6/3, 6/4, 6/5, 6/9, 6/10, 6/11, 6/14, 6/15, 6/17, 6/18, and 6/19). There was no evidence in the medical record of resident #327's refusal to use the BiPAP. On 6/19/25 at 6:35 PM, RN Q indicated the BiPAP was delivered on 6/12/25 during her shift. RN Q recalled resident #327 was in therapy when the delivery occurred, and when she returned to her room she was informed of the BiPAP delivery she started clapping because she had been waiting a while for it. RN Q stated she was unsure why it took so long for her to get a BiPAP as she was new to the facility. She indicated she filled the humidifier chamber with sterile water that night and gave report to the male nurse from the oncoming shift. She shared resident #327 did not have the BiPAP mask on Monday or today when she started her shift at 7:00 AM. (continued on next page)

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	06/20/2025

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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	06/20/2025

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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	06/20/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A tracheostomy (also called a tracheotomy) is an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs. After creating the tracheostomy opening in the neck, surgeons insert a tube through it to provide an airway and to remove secretions from the lungs. The person with a tracheotomy breathes through the tracheostomy tube (trach tube) rather than through the nose and mouth, (retrieved on 6/27/25 from www.hopkinsmedicine.org). A Shiley size refers to the specific size of Shiley tracheostomy tube used. On 6/16/25 at 4:25 PM, resident #171 was observed in her bed, the O2 tubing, tracheostomy mask, and suction canister were not labeled. The tubing between the suction canister to the suction machine was not labeled with a date of the last change. On 6/17/25 at 4:43 PM, resident #171's was observed in bed, the O2 tubing, tracheostomy mask, and suction canister were not labeled with the date of the last change, and contained approximately 600 milliliters (ml) of bodily fluid. The tubing between the suction canister to the suction machine was not labeled with a date of change. On 6/18/25 at 8:41 AM, resident #171's O2 tubing, tracheostomy mask, suction canister was not labeled with change date and contained approximately 600 ml of fluid, and the tubing between the suction canister to the suction machine were not labeled with a date of change. On 6/18/25 at 4:16 PM, the A Wing Unit Manager (UM) verified resident #171's respiratory related equipment including the tracheostomy mask; the O2 tubing; the suction canister, containing approximately 600 ml of fluid; the tubing between the suction canister and suction machine were not dated with their date of change as they should have been. Upon review of the emergency tracheostomy supplies kept in a bag at resident #171's beside there was not a tracheostomy kit, containing an inner and outer cannula, size 5, one size down from resident #171's present size 6, as ordered by the physician. She said she was told by the facility's Central Supply Director there were no size 5 cannulas available on 6/16/25. On 6/18/25 at 4:24 PM, the First Floor Director of Nursing (DON) verified the facility did not have any size 5 tracheostomy cannulas. She said she had spoken with the Central Supply Director on 6/17/25 about this issue. The First Floor DON said she did not know how long the facility had not had size 5 tracheostomy cannulas. The First Floor DON went to the B Wing and obtained a tracheostomy inner cannula size 4. The Director of Central Supply said she had not ordered size 5 tracheostomy cannulas in almost one and a half years she had been in her role at the facility. The First Floor DON provided the smaller size 4 inner cannula to the A Wing UM and told her to put it at resident #171's bedside. On 6/18/25 at 4:46 PM, the A Wing UM recognized the DON only provided her with only a size 4 tracheostomy inner cannula, only moments earlier. She then requested of the First Floor DON and the Central Supply Director that resident #171 receive a size 4 inner and outer cannula set for emergency use to maintain resident #171's airway if her present tracheostomy set experienced an emergency. The UM of A Wing said she did not know for how long resident #171 had not had an tracheostomy set, with inner and outer cannula, in a size smaller than size 6 at her bedside. (continued on next page)

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	06/20/2025

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of resident #158's medical record revealed an admission date of 1/14/25. Review of resident #158's physician orders dated 1/27/25 included a Shiley size 6 tracheostomy, and a physician order dated 1/29/25 to maintain a replacement tracheostomy of equal size and one a size down at his bedside. On 6/18/25 at 5:03 PM, the A Wing UM observed the contents of resident #158's emergency tracheostomy supplies. There was no size 6 tracheostomy set, including the inner and outer cannulas, in the supplies but there was a smaller size 4 tracheostomy set, not the size 5 tracheostomy set as ordered by the physician. 3. Review of resident #356's medical record revealed an admission date of 4/28/25. His physician orders dated 4/28/25 included a Shiley size 6 tracheostomy, and to maintain a replacement tracheostomy of equal size and one size down at his bedside. On 6/18/25 at 7:12 PM, the B Wing UM reviewed the contents of resident #356's emergency tracheostomy supplies. There was a size 6 with only the inner cannula and a size 4 with only the inner cannula in the supplies, the outer cannulas were not present, and there were no size 5 cannulas as directed by physician order. The B Wing UM said she did not think the supplies were lacking in his emergency tracheostomy supplies, even though there was no size 6 outer cannula nor a set of size 5 inner and outer cannulas as specified in the physician orders. 4. Review of resident #79's medical record revealed an admission date of 5/11/25. His physician orders dated 5/11/25 included a Shiley size 6 tracheostomy, and to maintain a replacement tracheostomy of equal size and one size down at his bedside. On 6/18/25 at 7:15 PM, the B Wing UM reviewed the contents of resident #79's emergency tracheostomy supplies. She verified there was a size 4 inner cannula, but no outer cannula for the size 4, and there was no size 5 tracheostomy set, inner and outer cannulas, as directed by physician order. 5. Review of resident #336 medical record revealed an admission date of 5/30/25. Her physician orders dated 6/2/25 included that she had a Shiley size 6 tracheostomy, and she had a physician order dated 5/30/25 to maintain a replacement tracheostomy of equal size and one size down at her bedside. On 6/18/25 at 7:18 PM, the B Wing UM reviewed the contents of resident #336's emergency tracheostomy supplies. She verified there was a size 4 inner cannula, but no outer cannula for the size 4, and there was no size 5 tracheostomy set, with inner and outer cannulas as directed by physician order. The UM was unsure if the resident needed an outer cannula as well as the inner cannula in the emergency supplies. The B Wing UM confirmed the three residents that had been observed with tracheostomies on the B Wing, residents #356, #79, and #336, should have cannulas of the same size and a size that was smaller. On 6/18/25 at 6:55 PM, the Administrator and the Executive Director of Nursing verified the facility nurses should follow physicians' orders regarding what tracheostomy cannula sizes should be kept at residents' bedsides in the case of an emergency. The Executive DON verified that both outer and inner cannulas comprised the tracheostomy sets, were needed at the beside in case of an emergency for residents who employed that style, not an inner cannula alone.

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	105728	A. Building B. Wing	06/20/2025

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to address a resident's pain timely for 1 of 2 residents reviewed for pain, of a total sample of 103 residents, (#250). Findings: Resident #250 was admitted to the facility on [DATE]. His diagnoses included unspecified polyneuropathy, fusion of the spine thoracic region, fusion of the spine lumbar region, pain in right foot, unspecified fracture of the sacrum sequelae, unspecified fracture of the right and left acetabulum sequelae, unspecified fracture of the the shaft of the right tibia, unspecified fracture of the right and left calcaneous (heel bones), and displaced fracture of the fourth metatarsal bone right foot sequelae. Review of resident #250's annual Minimum Data Set assessment dated [DATE] revealed he had no cognitive deficiencies. Resident #250 had a physician order dated 4/14/24 for the pain medication Lyrica (Pregabalin) 100 milligrams (mg) to be administered every eight hours. On 6/16/25 at 5:19 PM, resident #250 stated he currently was in pain. He described his pain as a nine or a ten out of ten, on the numerical pain rating scale with 10 as the highest value. The resident said his left leg was the most painful area, although both legs had burning pain. He said his pain was so terrible he could not sleep much the previous night because the pain kept him awake. He said the facility had not provided him his Lyrica, a pain medication, during the weekend because the pharmacy had not sent it. He said an alternative or additional pain medication was not offered when the ordered medication had not been available. Review of resident #250's medical record revealed a nursing progress note dated 6/15/25 at 1:45 PM, that nursing was waiting for the pharmacy to deliver the Pregabalin. Later, on 6/15/25 at 10:22 PM, another nursing progress note documented that nursing was waiting for the pharmacy to deliver the Pregabalin. On 6/16/25 at 6:17 PM, resident #250's June 2025 medication administration record (MAR) was reviewed with Registered Nurse (RN) S. She explained she did not administer Pregabalin to resident #250 on 6/16/25 although according to the MAR in the scheduled 6:00 AM administration area for 6/16/25 she had. She said the nursing staff was still waiting to receive the medication from the pharmacy. RN R and the A Wing Unit Manager (UM) who were present, RN R said she was resident #250's assigned nurse on 6/15/25 on the 3:00 PM to 11:00 PM shift. RN R verified that resident #250 had not received his Pregabalin pain medication since the morning of 6/15/25 at approximately 6:00 AM, which was approximately 36 hours ago and included four missed doses. They did not say why they had not called the physician to notify of the missing doses of Pregalbin pain medication or to ask for an alternate medication for resident #250's pain. On 6/18/25 at 10:53 AM, the A Wing UM stated her expectation was that when only several doses were left of a medication a nurse should reorder the medication from the pharmacy so that there was no break in receiving it. The medication should be available to administer according to the physician orders and confirmed this was the situation for resident #250 regarding his pain medication.

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	105728	A. Building B. Wing	06/20/2025

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who experienced trauma received trauma-informed care for 1 of 4 residents reviewed for behavioral-emotional concerns, of a total sample of 103 residents, (#251). Findings: Resident #251 was admitted to the facility on [DATE] with diagnoses including heart failure, adjustment disorder with other symptoms, claustrophobia, atrial fibrillation and chronic kidney disease. Diagnoses of post-traumatic stress disorder (PTSD), personal history of physical and sexual abuse in childhood and insomnia due to other mental disorder were added with an onset date of 10/15/24. Review of the Minimum Data Set (MDS) quarterly assessment with assessment reference date (ARD) of 4/02/25 revealed resident #251 had a Brief Interview for Mental Status score of 14/15 which indicated she was cognitively intact. The document revealed resident #251 had an active diagnosis of PTSD and received anti-depressant medications. Review of prior MDS quarterly assessment with ARD of 1/03/25 revealed resident #251 had an active diagnosis of PTSD and received anti-depressant medications. Review of resident #251's Electronic Medical Record (EMR) revealed a care plan for behaviors related to accusations and confabulation about staff and residents, refusal of care, verbally aggressive toward staff which included racial slurs. The EMR did not contain a post trauma care plan. The EMR contained a Psychosocial History and Assessment - V 5 dated 12/30/24 which indicated resident #251 had never been diagnosed with PTSD, had a life altering event or life changing event. A second Psychosocial History and Assessment - V 5 dated 3/30/25 also indicated resident #251 had never been diagnosed with PTSD, had a life altering event or life changing event. Review of psychiatric progress notes revealed resident #251 was seen on 10/14/24. The Psychiatric Advanced Registered Nurse Practitioner (ARNP) noted resident #251 reported continued insomnia with delayed sleep onset and frequent sleep interruptions due to nightmares. Resident #251 recounted significant trauma history of childhood sexual, physical, and verbal abuse. The resident reported witnessing several traumatic events during childhood and abuse during her first marriage. The encounter note indicated resident #251 experienced nightmares, flashbacks and hypervigilance which were worse at night. The resident reported significant emotional distress when triggered by smells or details reminiscent of the traumatic event, had deep shame and difficulty trusting others. On 6/17/25 at 8:45 AM, resident #251 was observed reclined in bed with the door closed and lights off. During interview, resident reported she had PTSD from an incident which occurred when she was a child. Resident #251 stated her mother was not faithful to her father and saw other men behind his back. She recalled one night she was sexually abused by a man her mother was seeing and that her mother was present and aware of the incident. Resident #251 stated the man and his friend had given her peanut butter cups that night prior to the event and she remembered they wore a particular type of cologne. She explained men like the men from that event still made her nervous. She said she hated those candies and the smell of that cologne to this day. Resident #251 acknowledged she received psychological and psychiatric services which were helpful, but was unaware of any other actions the facility staff took to prevent her from being retraumatized. (continued on next page)

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	105728	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/25 at 12:35 PM, the second floor Director of Nursing (DON) and D Wing Unit Manager (UM) were observed at the nursing station. Both stated they were familiar with resident #251 and were aware she had PTSD. The D Wing UM stated she made sure no male Certified Nursing Assistants cared for the resident but could not provide documentation of where nurses were made aware of this intervention to ensure it happened when the UM was not there. The second floor DON and D Wing UM acknowledged neither were aware of all her triggers and verified there was no written communication to staff about the PTSD. In a meeting with the Social Services department on 6/18/25 at 11:49 AM, the the second floor Social Services staff stated she was familiar with resident #251. She explained resident #251 exhibited some behavior problems but was unaware she suffered from PTSD. The second floor Social Services staff stated resident #251 usually preferred to speak with the Social Services Director. The Social Services Director stated he was aware resident #251 had PTSD but was not aware of the specifics of the trauma. The Social Services Director and second floor Social Services staff reviewed the EMR, verified the inaccuracy of the psychosocial assessments and acknowledged that a care plan was not developed or implemented to address trauma informed care. The Social Services Director stated resident #3251 received psychological services He acknowledged that while the psychologist may address the trauma, the staff should be aware of issues and triggers to avoid retraumatizing the resident. On 6/18/25 at 12:39 PM, the Executive Nursing Home Administrator (NHA) was informed of resident #251's PTSD diagnosis and the details relayed by resident #251 regarding the traumatic event. The Executive NHA stated her expectation was that a trauma informed care plan should be developed for any resident identified with PTSD in order to avoid retraumatizing the resident. Review of the facility's policy and procedure for Trauma Informed Care effective June 2025 revealed the purpose of the policy was to ensure that residents who were trauma survivors received culturally sensitive, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. The policy and procedure indicated that the Social Services department would attempt to establish a rapport and conduct further psychosocial assessment of the residents' mental or psychosocial adjustment difficulty and/or post-traumatic stress disorder (PTSD) and develop a comprehensive person-centered care plan that addresses specific triggers and appropriate interventions.

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	105728	A. Building B. Wing	06/20/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to act upon the pharmacist medication recommendations made for one of five residents reviewed for pharmacist recommendations, of a total sample of 103 residents, (#256). Findings: Resident #256 was admitted on [DATE] with the diagnoses of encephalopathy (brain dysfunction), type II diabetes mellitus, history of liver transplant, sepsis, atrial fibrillation, and acute kidney failure. Review of the medical record revealed physician orders included Procrit injection solution 10000 units/milliliter (Epoetin Alfa), one application subcutaneously (under the skin), once a day every Wednesday for prophylaxis until 08/06/25. On 5/23/25, the pharmacist recommended to change the route of administration of the Procrit from intramuscular to subcutaneous and to hold the dose of Procrit for hemoglobin of 10 or more. The physician responded he was in agreement with the recommendation, and that the changes were made to the orders. Upon review of the current physician orders, it was noted the route of administration for the Procrit was changed per the recommendation, but no change was made to address holding the Procrit for a hemoglobin of 10 or more. On 6/19/25 at 4:30 PM, the Executive Director of Nursing (DON) explained she was responsible to ensure the pharmacy recommendations were addressed. She confirmed when doing so, she missed the recommendation to hold the Procrit if the hemoglobin was 10 or more. On 6/20/25 at 2:28 PM, the DON stated it was important to address the pharmacy recommendations accurately to ensure the residents received appropriate and quality care. She added, they didn't want the residents to go back to the hospital if not needed, and oversight of medication orders by the pharmacist was good for the physicians as well, so they had another set of eyes reviewing the residents. The facility's policy entitled Medication Monitoring: Medication Review and Reporting, dated 2007, indicated the purpose of the medication review was to promote positive outcomes and minimize adverse consequences and potential risks associated with medication. The policy detailed, the pharmacist reviewed the medication regimen and medical chart of each resident at least monthly and made recommendations based on findings of irregularities. The nursing care center followed up on the recommendations to ensure appropriate action had been taken within 30 calendar days.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 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 5 residents observed during the medication administration task, of a total sample of 103 residents, (#1). Findings: On 6/17/25 at 10:30 AM, during an observation of medication administration for resident #1, Registered Nurse (RN) B placed two Levetiracetam tablets, 750 milligrams (mg) each in a medication cup. Review of the medication card read, give 1250 mgs. RN B took the medications to the bedside and just before she administered the medication to resident #1, the nurse was asked to bring the cup of medications to the cart. RN B was asked to open her computer and read the order for Levetiracetam. She confirmed the order indicated 1250 mg of Levetiracetam was ordered. RN B verified two 750 mg tablets were in the medication cup she was about to administer to resident #1. RN B then took one of the tablets from the cup and stated she was going to cut it in half. RN B then read the medication card for the Levetiracetam which detailed instructions for administration, to give one 750 mg and one 500 mg tablet to equal the 1250 mg. Levetiracetam (Keppra) is a medicine to help control certain types of seizures. Take only as directed by the physician, do not take more of it than your physician ordered. Don't change the dosage without checking first with the physician, (retrieved on 7/07/25 from www.mayoclinic.org). Review of the physician order dated 5/23/25 detailed, Levetiracetam oral tablet give 1250 mg every 12 hours for seizures. On 6/17/25 at 12:16 PM, the G Wing Unit Manager stated his expectation was for the nurses to ensure the correct dosage of medication was given as ordered by the physician. On 6/17/25 at 12:27 PM, the Executive Director of Nursing stated her expectation was for all nurses to give the dosage of medication as it was ordered by the physician. She stated she would expect the nurse to know how to calculate a dose for medication. Review of the Medication Administration General Guidelines, dated 9/18, indicated, medications are administered in accordance with the written orders of the prescriber. Verify medication is correct three times before administering the medication. The document described, verify when pulling the medication package from medication cart, when the dose was prepared, and again before the dose was administered.

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	105728	A. Building B. Wing	06/20/2025

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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, interview, and record review, the facility failed to follow the menus for portion sizes. The non-compliance found had the potential to affect 263 residents, out of a total resident population of 350 residents that ate meals at the facility. Findings: On 6/18/25 at 12:02 PM, [NAME] F was observed preparing croissant sandwiches with two slices of pre-sliced ham and one of pre-sliced cheese. The Certified Dietary Manager (CDM) weighed these protein sources and found the sandwiches were being prepared with less than half of the three ounce (oz) portion required per the menu and recipe. The CDM provided [NAME] F with the written recipe and had him remake the sandwiches using the correct amount of the protein. On 6/19/25 at 2:21 PM, the CDM stated [NAME] F didn't check the sandwich recipe because he had made these sandwiches in the past and felt he could go by memory. She stated it was important for the cooks to follow the recipes including portion sizes, to ensure all resident's received adequate nutrition and especially when calculating the intake of residents who had difficulty maintaining their nutritional status. On 6/19/25 at 3:16 PM, [NAME] F confirmed he didn't check the recipe for the sandwiches yesterday because he had made these sandwiches before and could remember the recipe called for two slices of ham and one slice of cheese. He stated he didn't realize the pre-sliced ham and cheese did not weigh what the recipe called for and should have made sure they weighed one ounce per slice per the recipe. The facility's policy entitled Standardized Recipes, dated June 2024, indicated standardized recipes were utilized to ensure items prepared were consistent and provided consistent amounts of nutrients per portion. It added, the Food Service Manager was responsible to monitor and check the cooks' use of recipes.

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	105728	A. Building B. Wing	06/20/2025

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to honor food preferences and accommodate residents who required alternate meal times due to appointments/procedures/treatments for 1 of 1 residents reviewed for renal dialysis, of a total sample of 103 residents, (#358). Findings: Resident #358 was admitted to the facility on [DATE] with diagnoses of need for assistance with personal care, type II diabetes mellitus with polyneuropathy, depression, anxiety, heart failure, and end stage renal disease with renal dialysis. The admission Minimum Data Set assessment dated [DATE] indicated the resident had no cognitive impairment. On 6/17/25 at 8:50 AM, resident #358 stated she had a concern about her nutrition. She stated she had already spoken to two dietitians, telling them she didn't want any bread with her meals, but she still received it. She said she asked them to replace her bread with a small salad at lunch and dinner, but often didn't get the salads. She stated she has diabetes and at home her blood sugars were close to 100, but since she has was at the facility, her sugars were often over 200. On 6/18/25 at 12:45 PM, resident #358's lunch meal ticket indicated she was supposed to receive a small salad with ranch dressing and no bread. The salad and dressing were not on her meal tray but she did receive a dinner roll. On 6/18/25 at 6:13 PM, resident #358's dinner tray was on her bedside table while the resident was out of the building for dialysis treatment. Certified Nursing Assistant (CNA) C stated she left the tray at the resident's bedside when it arrived on the unit, at approximately 5:00 PM, and added the resident would eat it when she returned from dialysis, around 7:30 PM, two and a half hours later. The CNA explained she routinely did this on the days the resident went to dialysis, then reheated the food for the resident if she requested. The resident's dinner meal ticket indicated a tossed salad and no bread, but also indicated one and a half ham and cheese croissant sandwiches. The tray did not contain the tossed salad but received one and a half croissant sandwiches as the meal ticket detailed. Resident #358's daughter who was in her room, said when her mom arrived back from dialysis, she would be upset, and added it was way too much bread for her mom. (continued on next page)

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	105728	A. Building B. Wing	06/20/2025

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/25 at 6:21 PM, Registered Nurse (RN) D stated the resident was never back from dialysis by the time she left from her shift at 7:00 PM. She stated she was not aware the CNA left the resident's meal at the bedside. A few minutes later, the resident's daughter stated her mom's dinner tray was always left sitting at bedside when she returned from dialysis and was not offered anything else. The daughter added, soon after her mom was admitted to the facility, the staff told her they were not able to warm up any food and expected her mom to eat her meal cold, but after she pushed back, the staff agreed to warm up her mom's meals. At 6:34 PM, RN D explained the procedure was to keep the meal tray out of the room as no food was to be left in a resident's room if they were out of the facility, whether it was warm or cold food. At 6:38 PM, the A wing Unit Manager reiterated the procedure for providing meals to a resident was to bring the tray to the resident when they were ready to consume it and not leave it at their bedside unattended. She added, meals should be left in the cart if the resident was not in their room because it was important to ensure the resident received the correct meal and that could not be accomplished if a tray was left in the room unattended. On 6/18/25 at 6:43 PM, the Certified Dietary Manager (CDM), Registered Dietitian and the Assistant Food Service Manager stated the resident did speak with a Dietitian and the CDM to request salads and no bread. The Assistant Food Service Manager verified that information was printed on the resident's meal tickets via the electronic tray card system. They confirmed if a resident was out of the facility during mealtimes, the meal should be returned to the kitchen, and thrown away, and the facility should offer them a meal when they return. They added, there was hot food still available at 7:30 PM, which they could provide to the resident, if that was their preference. The CDM, dietitian and Food Service Manager could not explain why resident #358 did not receive the salads on her meal trays as indicated on her meal tickets, but said work was needed to improve their system to ensure food preferences were honored. The facility's policy entitled, Dining Program, dated June 2024, indicated the facility promoted quality meal service to allow residents to have a dignified and pleasurable dining experience and attractive meals were served at appropriate temperatures. The policy's Meal Tray Pass checklist indicated the meal ticket was read to ensure accuracy and the meal trays were properly prepared for residents who could feed themselves. The facility's policy entitled, Electronic Tray Card System dated June 2024, indicated the facility was to ensure the correct diet order, food preferences and food allergies are honored at meal delivery times. The policy indicated the tray tickets were to be referred to during the service of each meal, but this meal /tray checking system does not appear to be adequate to prevent and catch errors on meal trays based on this resident's experience and the tray observations.

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	105728	A. Building B. Wing	06/20/2025

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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. 6. On 6/18/25 at 11:15 AM, kitchen staff prepared for the lunch meal and set up of the tray line. At 11:20 AM, there was Dietary Aide ZZ was in the preparation area near an upright refrigerator. He donned his facial hair restraint incorrectly, so that his mustache was exposed. He remained silent when he asked about the correct way to wear a facial hair restraint. Dietary Aide YY was seen washing dishes at the three compartment sink and had donned his facial hair restraint incorrectly, as well. His beard was sticking out and the facial hair restraint was under his chin. Approximately 3-4 minutes later, Dietary Aide XX was assisting with the lunch tray line set up. He was wearing gloves and adjusted his facial hair restraint, touching his face and underneath his nose. Dietary Aide XX then reached for a bin of individually wrapped bread, without performing hand hygiene before donning a new pair of gloves. At that time, the Assistant Dietary Manager confirmed when staff touched their face they needed to re-wash their hands and change gloves. At 11:38 AM, the lunch tray line commenced and staff started plating meals. The Registered Dietician noted the hot food holding temperatures on a piece of paper, however there were not any potentially hazardous cold food holding temperatures. She and the 2nd floor Administrator said the cold food temperatures were taken earlier. The 2nd floor Administrator removed a half pint of milk that was in a bin covered with ice, and the temperature was 44 degrees Fahrenheit (F). They acknowledged potentially hazardous foods such as milk needed to be at a holding temperature of 41 degrees F or below. 7. On 6/18/25 at 2:04 PM, pantry #1 on the H Wing was observed. In the cupboard there were two half pint sized cartons of milk. The cartons of milk were at room temperature. The H Wing Unit Manager felt the milk cartons with his hands and confirmed they were not cold. She could not explain why the cartons of milk were in the cupboard and not in the refrigerator to be maintained at the correct temperature. Based on observation, interview, and record review, the facility failed to store, hold, and serve foods to prevent the potential of foodborne illness; failed to ensure staff donned facial hair restraints; failed to provide 71 ordered resident nourishment/snacks for all six units one afternoon; failed to air-dry dishes; failed to label, date, and discard outdated resident foods brought in from outside sources; and failed to provide evidence the dish machine attained the required temperature over the past three and a half months. These items had the potential to affect all 350 residents who ate their meals at the facility. Findings: 1. On 6/16/25 at 7:40 AM, during the initial kitchen tour with the Certified Dietary Manager (CDM), in the main walk-in refrigerator, two cases raw chicken dated 6/12/25 (5 days prior) were noted. There were also three additional raw meat products without any date as to when received or pulled from the freezer to thaw: one package of raw mechanical soft separated turkey, one case of raw pork, and one sleeve of raw ground sausage. In addition, in the walk-in freezer, there was a 1/3 pan of frozen meat; dated 6/23, but not labeled as to what it was. The CDM stated whoever put the meat into the refrigerator was responsible for labeling the date it was put there, which was not done in this case. She added, it was important to date the items so they could keep track of how long food items were kept to make sure they were being utilized within a safe time period, so they did not give the residents any food borne illnesses. (continued on next page)

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	105728	A. Building B. Wing	06/20/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's policy entitled Storage, dated June 2024, indicated foods delivered were to have the delivery date written on them. In addition, it detailed prepared items were to be labeled with the product name, preparation date, and use by date. The policy included a Cold Food Storage Chart which indicated raw poultry was to be used within 1-2 days, raw pork within 3-5 days, and raw sausage within 1-2 days. 2. In walk-in refrigerator #1, twelve one-gallon plastic bags filled with labeled individual nourishments (sandwiches, milks, puddings, crackers, etc.), were dated 6/14/25, for resident units A, H, C, G, B, and D . The CDM confirmed these resident snacks were not delivered to the units or distributed to the residents on that afternoon as evidenced by them still being in the refrigerator. She added it was important for snacks to be delivered because it honored the residents' preferences for snacks and because the individual snacks were often needed to help maintain the residents' nutritional status. The facility's policy entitled Nourishment/Snacks, dated June 2024, indicated snacks would be available for residents on request, as a nutrition intervention per dietitian recommendations or by physician orders. The policy continued, individualized evening snacks would be prepared, labeled and dated by the Food and Nutrition Department, and delivered to the nursing units by 7:00 PM. It added, perishable snacks would be distributed as scheduled by the Nursing Department. 3. On 6/18/24 at 11:03 AM, during the follow-up kitchen visit, a cart holding bases used to keep plates of food warm was observed with three bases squeezed into the holder meant for one base, which did not allow space for them to air dry. When the bases were removed from the rack, the sides were touching each other and were still wet. There were approximately 20 additional bases stacked on the side of the tray line on top of each other and were also wet. The Assistant Food Service Manager verified the bases were still wet and said this was wet nesting. She explained it was important to air dry dishes and equipment used for dining because if not, the moist environment could allow germs to grow and could cause illness for those who used them. On 6/19/25 at 2:46 PM, a large cart holding bases was again observed with three bases squeezed into the holder meant for one base which did not allow space for them to air dry. The 2nd floor Assistant Administrator confirmed the findings. On 6/20/25 at 1:20 PM, the CDM and 2nd floor Assistant Administrator acknowledged the facility needed to eliminate the wet-nesting situation. The facility's policy entitled Cleaning and Sanitizing, dated June 2025, indicated cooking utensils and equipment should be allowed to air dry. 4. On 6/19/25 at 9:02 AM, on the A wing, a meal dated 6/12/25 (eight days prior) was noted and thrown away by the Assistance Director of Nursing (ADON)/ Infection Control/ Staff Development nurse who stated it was important to throw away outdated items in a timely manner, so a resident did not eat them and get sick. On 6/19/25 at 9:17 AM, on the G wing, four resident yogurts dated 5/02/25 were noted. Two had an expiration date of 5/09/25 and two had an expiration date of 5/21/25. The G wing Unit Manager (UM) threw them away along with an undated box with leftover pizza. He stated, whoever put the food in the refrigerator was supposed to date it, so the residents didn't get sick from it. The Unit Manager added, he did rounds daily to find and get rid of outdated foods as did the kitchen manager but could not explain why the outdated items had been missed. (continued on next page)

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	105728	A. Building B. Wing	06/20/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/19/25 at 9:37 AM, on the B wing, a resident's bag of cheese sticks was without a date, another package with the resident's name had no item name or date, and a resident's package with the date of 6/18, without a resident or item name was noted. The B wing UM verified the findings and stated she checked the refrigerator daily. She acknowledge she didn't check it today as she thought the dietitian checked it. She added, it was important to ensure items brought to the facility for the resident's consumption were labeled and dated for resident's safety as residents could get sick from old food. The UM conveyed, whoever put the food into the refrigerator was responsible to label the food with the name of resident, the item name, and date. She stated she was unsure of the policy for how long resident food could be kept. The facility's policy entitled, Nourishment Rooms/ Pantries, dated June 2024, indicated residents may store personal food items in the refrigerator or freezers when labeled with the resident's name, room number and date the item was placed there. The policy added, items would be discarded after 72 hours of storage if perishable, and 30 days, if non-perishable, or per the expiration date. The document indicated the Food and Nutrition Services and the Nursing departments would inspect food items daily to ensure the guidelines were met and would discard any expired foods. 5. On 6/19/25 at 2:46 PM, the dish machine temperature logs for June 2025 were reviewed with the wash temperatures consistently being recorded at 120 degrees Fahrenheit (F) and the rinse temperatures consistently being recorded at 165 degrees F. In addition, the sanitizer concentration was consistently recorded at 50 parts per million (ppm). The log did not indicate what the minimum temperature should be to ensure the dishes were cleaned and sanitized. The log did not indicate any interventions made by management when the temperatures were not adequate for the high temperature machine. In addition, the logs for March, April and May 2025 indicated similar information. At that time the CDM verified the findings and stated it was her responsibility to check the logs, to make sure the staff were taking and recording the information correctly and to ensure the dish machine worked properly. She said she was sure the dish machine worked properly, and was running at an adequate temperature. The 2nd floor Assistant Administrator was present and stated the dish machine was equipped to run as a low temperature machine if the mechanisms for maintaining its high temperatures ever failed. He acknowledged, the feature was not used over the past several months and therefore the temperature logs were not accurate. He agreed with the CDM that staff education was needed to rectify the inaccurate temperature logs. The facility's policy entitled Cleaning and Sanitizing, dated June 2025, indicated the temperatures needed for a high temperature dish machine were 165 degrees F for the wash and 180 degrees F for the final rinse. In addition, the policy described the chemical sanitizer was not used for high temperature dish machines.

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	105728	A. Building B. Wing	06/20/2025

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

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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 observation, interview, and record review, the facility failed to demonstrate sustained performance improvement with respect to identified Quality Deficiencies and ensure the deficiencies were not repeated. Findings: Review of the facility's last recertification survey from 3/03/24 to 3/08/24 revealed opportunities for improvement, due to non-compliance in the regulatory requirements for Resident Rights, Resident Assessment, Quality of Life, Quality of Care, Dietary and Infection Control. Current concerns identified during the recertification survey revealed continued concerns, leading to repeated non-compliance in the areas of Resident Rights (F550, F553, F554, and F585); Resident Assessments, (F644, and F645); Quality of Care, (F684, F688, and F695); Dietary, (F803, and F812); Quality Assessment Performance Improvement (QAPI), and Infection Control. On 6/20/25 at 12:20 PM, the Food Services Manager (FSM) and the 2nd Floor Administrator were interviewed about actions taken as part of the facility's QAPI committee. They were informed of the concerns that had risen from this years recertification survey, 6/16/25 to 6/20/25, which were Menus/Food to meet resident needs and Kitchen/Pantry sanitation as it related to the storing, and serving of food. They spoke about the dietary staff's cultural and language barriers with the Hispanic and Creole speaking staff. When it was pointed out that native English staff person was in violation of the incorrect donning of facial hair restraints, the staff could not say why the continued non-compliance occurred. The FSM and Administrator spoke about educating the staff but could not provide details of how the QAPI Committee had proactively approached continuous improvements in the Dietary Department to maintain compliance to the regulations as required. On 6/20/25 at 1:07 PM, the Activities Director stated she attended the monthly QAPI Committee meetings, along with the other department heads. She said she was aware of the previous concerns with activities which were cited on the previous years recertification survey. She stated there were no current QAPI projects for activities and could not say how QAPI ensured the improvements made in the past were sustained. The Activities Director explained that during the monthly QAPI meetings she reported the Resident Council activity, Calendar programs and her audits of the 1:1 visits for in room activities with room bound/self isolating residents. However, she did not provide any insight as to why there were repeated, current concerns for activities this year for residents #152, #174, #345, #349, and #359, identified for not having 1:1 in room activities, as noted in the residents' plans of care. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/20/25 at 1:35 PM, the Social Worker (SW) indicated that he was the only one from his department who attended the monthly QAPI meetings. He said he was aware of the Resident Assessment issue from last year which was related to Preadmission Resident screening assessments. He said to ensure there were not any repeated deficiencies related to the Preadmission screening assessments, a Performance Improvement Plan (PIP) was implemented after last years recertification survey. The SW did not say what was done to ensure the performance improvement was sustained and added there were not any current PIPs for his department. He explained after last year's revisit survey, he was the only person who reviewed the preadmission screening assessments for 390 residents. The SW conveyed he had not asked for help .but said the team was aware. He was not able to explain why residents #16, #56, #70, and #123 had current concerns identified with issues for Level I and/ or Level II preadmission screenings when these issues were identified and cited during last year's recertification survey. The SW provided no insight as to the QAPI committee's commitment to prevent the repeated non-compliance. On 6/20/25 at 2:38 PM, the Administrator and Director of Nursing (DON) in a joint interview, explained all department heads and the Medical Director attended the monthly QAPI meetings. They said each department discussed audits they were working on and the QAPI team detmined if the audits needed to be extended/continued for monitoring. The Administrator and DON conveyed they were not present for last year's recertification survey, but they were familiar with the survey results. They explained that staff placed a focus on the Abuse/Neglect and Risk Management issues. The Administrator and DON addressed the current issues for Peripherally Inserted Central Catheters (PICC) line, and compared resident #922's issues and whether they differed from last year's identified harm issue for PICC's. They explained resident #922's PICC line was identified on the nursing assessment but the nurse failed to put in batch orders to ensure care and services were provided. The Administrator and DON acknowledged the non-compliance were for the same concerns with nursing care and the service was not provided for the PICC. They did not give any detail as to how QAPI ensured what each department and nursing as a whole, was doing to prevent repeated deficiencies,especially concerns with Quality of Care issues. This facility continues to have concerns/repeated non-compliance in the areas of Resident Rights (F550, F553, F554, F585), Resident Assessment (F644, F645), Quality of Care (F684, F688, F695), Dietary (F803, F812), QAPI and Infection control. This facility continues to have concerns/repeated non-compliance in the areas of Resident Rights (F550, F553, F554, F585), Resident Assessment (F644, F645), Quality of Care (F684, F688, F695), Dietary (F803, F812), QAPI and Infection control. Based on the findings of repeated regulatory non-compliance, and on the interview with the Department Head and the Leadership Team; it was found the facility was reactive to concerns, versus being proactive in their approach to Quality Improvement.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. Resident #99 was admitted to the facility on [DATE] with diagnoses of dementia, disorder of the brain, aphasia (inability to speak) and schizophrenia. The annual Minimum Data Set (MDS) dated [DATE] indicated the Brief Interview for Mental Status (BIMS) evaluation was not conducted as resident #99 was rarely or never understood and her cognitive abilities were severely impaired. The Care Plan indicated resident #99 was totally dependent on staff for eating and most other Activities of Daily Living (ADL's). 4. Resident #206 was admitted on [DATE] with diagnoses of disorders of muscle, type II diabetes mellitus with polyneuropathy, heart failure, chronic obstructive pulmonary disease, end stage renal disease, and dysphagia (trouble swallowing). Her annual MDS dated [DATE] indicated the BIMS evaluation was not completed as the resident was rarely or never understood and her cognitive abilities were severely impaired. Her Care Plan indicated she was totally dependent on staff for eating and most other ADL's. On 6/17/25 at 12:17 PM, the lunch meal trays were seen on the bedside tables of residents #206 and #99, who shared a room. Physical Therapist (PT) I was working with resident #99 on stretches/exercises in her bed. At 12:25 PM, Certified Nursing Assistant (CNA) E entered the room to assist resident #206 with her lunch, but did not provide hand hygiene to the resident first. At approximately 12:30 PM, PT I finished providing therapy services to resident #99 and began assisting her with her lunch meal. PT I did not remove the gloves she wore while assisting the resident with physical therapy and did not perform hand hygiene for herself or resident #99 prior to assisting with the resident with her meal. She fed the resident while wearing same gloves she had on when was exercising with the resident. At 12:43 PM, PT I confirmed she didn't perform hand hygiene between providing physical therapy and feeding the resident because she 'just kind of jumped in and didn't think about it.' She added, since the meal was sitting there, she didn't want to leave the resident without helping her eat. PT I said she usually did not provide meal assistance to residents. At 12:48 PM, CNA E stated she was aware she was supposed to wash the residents hands before and after meals but she made a mistake today and didn't do it. She explained offering hand hygiene to residents was important because the resident could touch the food during the meal. On 6/19/25 at 2:08 PM, the facility's Assistant Director of Nursing (ADON)/ Infection Control/ Staff Development nurse stated her expectations for nursing staff when going to assist a resident with their meal was to explain the task, sit in a chair and assist with the meal. She said staff need to wash their hands prior to getting the meal tray and then after the meal also. She added, in the dining rooms, residents were provided with hand wipes prior to meals and wipes were available for after the meals too. She stated it was common sense for a staff member to remove their gloves and wash their hands after providing physical therapy to a resident. The ADON added, it was important to wash the residents' hands before they ate to keep them clean in case they reached for the food and also for general hygiene periodically during the day. She confirmed the resident may get a bed bath in the morning, but still need hand washing later in the day, so it was good practice to do so before lunch and dinner. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/19/25 at 3:30 PM, the Director of Physical Therapy stated it was her expectation for PTs to wash their hands before and after providing physical therapy to a resident. She said therapists should wear gloves when they sanitized equipment and wash their hands after. She stated typically, Speech and Occupational Therapy staff would assist a resident with a meal, and PTs were generally not trained to assist residents with meals. The Director stated it was important to provide hand hygiene to a resident before assisting them with a meal, so the utensils and food didn't get contaminated. The facility's policy entitled, Personal Hygiene, dated June 2025, indicated hands were to be washed after contact with a resident. The facility's policy entitled Dining Program, dated June 2024, indicated nursing staff were to assist residents with hand hygiene as needed prior to meals. Based on observation, interview, and record review, facility staff failed to use personal protective equipment for residents who were identified as needing enhanced barrier precautions for 2 of 8 residents reviewed for skin condition (#159, #120) and failed ensure hand hygiene prior to meals for 2 of 18 residents observed during dining, in a total sample of 103 residents. Findings: 1. Review of resident #159's medical record revealed an admission date of 5/23/22. Review of a progress note dated 6/07/25 revealed the resident had a wound on her sacrum. An active physician order dated 6/12/25 indicated to apply a dressing to the intergluteal fold every night daily. On 6/16/25 at 1:34 PM, an enhanced barrier precautions sign was observed on the exterior door to resident #159's room. The sign indicated that providers and staff must wear gowns and gloves for high contact resident care activities such as providing hygiene or changing briefs. On 6/19/25 at 7:45 AM, Certified Nursing Assistant (CNA) U and CNA V were observed in resident #159's room as they provided pericare/hygiene care without donning gowns for resident #159. Afterwards, CNA U and CNA V reviewed the Enhanced Barrier Precaution sign outside of the room and verified the care they had just provided to resident #159 was indicated on the list of when to don gowns. Both CNAs looked at the supply holder near the room and could not find gowns to don at that time. They both explained they forgot to don gowns before starting care, but acknowledged they should have worn them. 2. Review of resident #120's medical record revealed an admission date of 1/01/24. Review of his physician orders revealed active wound treatment orders dated 5/15/25 for his elbow, 4/28/25 for his left lower gluteus, and 4/25/25 for his penis. On 6/19/25 at 3:27 PM, the A Wing Unit Manager (UM) observed as CNA Z and CNA AA transferred resident #120 from his electric wheelchair to his bed and provided hygiene care without gowns on. She verified that resident #120 had wounds and both CNAs should have been wearing gowns during these activities. The facility's policy and procedure with an effective date of April 2024 indicated that enhanced barrier precautions should be used when the resident has a wound even if the resident is not known to be infected or colonized with a multi-drug resistant organism. This policy stated that a gown and gloves should be used during high contact resident activities.