

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105731	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Commons at Orlando Lutheran Towers		STREET ADDRESS, CITY, STATE, ZIP CODE 210 Lake Avenue Orlando, FL 32801	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from neglect by not identifying an escalation in exit seeking behaviors; not implementing additional actions/interventions to prevent elopement; and not responding appropriately to an emergency exit door alarm to prevent elopement for 1 of 8 residents reviewed for elopement, of a total sample of 8 residents, (#1). These failures contributed to the elopement of resident #1 and placed her at risk of serious injury, impairment, or death. While outside the facility unsupervised, resident #1 fell and sustained a head injury and facial abrasion, leading to hospitalization. There was reasonable likelihood she could have become lost, harmed by strangers or hit by a motor vehicle. On 5/19/26 at approximately 7:30 PM, the facility failed to provide the necessary care and services to prevent a resident with severe cognitive impairment from exiting the facility unsupervised. The facility was unaware of resident #1's whereabouts for approximately two hours, until 9:36 PM, when staff learned resident #1 had been transported to the hospital emergency department. Review of facility information identified seven residents at risk for elopement on the first day of survey. The facility's failure to provide needed care and services contributed to resident #1's elopement and threatened all residents at risk of elopement. These failures resulted in Immediate Jeopardy which started on 5/19/26 and was removed on 5/22/26 after verification of the facility's immediate actions. The scope and severity was decreased to a D, (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy). Substandard Quality of Care was identified at F600 and F689. A partial extended survey was conducted on 6/03/26. Findings: Cross reference F689. Review of the medical record revealed resident #1, an [AGE] year-old female, was admitted to the facility on [DATE]. Her diagnoses included vascular dementia, hemiplegia and hemiparesis, aphasia (difficulty communicating), cardiac arrest, congestive heart failure and atypical atrial flutter. Review of a Progress Note written by the Director of Nursing (DON) on 5/19/26 revealed she received a call at 8:26 PM that evening, informing her resident #1 was missing and an active search had begun throughout all areas of the facility including outside the facility grounds. The noted indicated the search continued both inside and outside the facility and local law enforcement were notified of the missing resident at 8:41 PM. The DON documented the search was expanded to nearby streets in the downtown area where the facility was located. The documentation by the DON noted staff were directed to inquire at local hospitals in hopes to find resident #1. The Progress Note detailed at 9:36 PM the DON was notified by the Admissions Director that the resident was being treated at the Emergency Department of the local downtown hospital. On 6/03/26 at approximately 10:05 AM and continuing through 10:48 AM, video footage from the evening of 5/19/26 was reviewed. In the beginning of the video resident #1 was viewed as she descended the staircase from the second floor. She was seen as she reached the bottom of the staircase, attempted to open the locked door into the first floor unit several times, then she turned towards the exit door, and as she walked out of view of the camera an exterior light was seen as the door opened, and the resident exited the facility. Approximately five minutes after resident #1 was seen leaving the facility on camera, the video (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	footage showed facility security personnel turning off the alarm on the exit door. There was nothing on the video to indicate the security personnel looked outside or around to see if there was any residents who may have opened the door and left the facility. Review of the Minimum Data Set (MDS) 5-Day Medicare assessment with assessment reference date of 5/18/26 revealed resident #1 had short-term and long-term memory problems and severely impaired cognitive skills for daily decision-making. The assessment indicated resident #1 was not evaluated for her ability to go up and down one step, which was not attempted due to her medical conditions and/or safety concerns. On 6/02/26 at 10:29 AM, the Registered Occupational Therapist G clarified that resident #1 was able to walk approximately 125 feet but required hand-held assistance due to poor safety awareness. The electronic medical record (EMR) contained an elopement risk evaluation dated 5/12/26 which indicated resident #1 was at risk for elopement. Review of resident #1's care plan revealed a care plan initiated 5/12/26 which indicated resident #1 was identified as at risk for wandering/elopement and an electronic wander-alert bracelet had been applied on 5/18/26. The care plan contained an intervention to engage in purposeful activities but did not contain any interventions for redirection, increased supervision, or what to do if these behaviors occurred. Review of resident #1's physician orders revealed an order dated 5/12/26 for a psychiatry consultation due to anxiety/restlessness and an order dated 5/18/26 for an electronic wander-alert bracelet to be applied as a safety precaution, as resident had displayed and/or voiced exit-seeking behavior. The EMR contained a progress note entered by the Assistant Director of Nursing (ADON) dated 5/18/26 which indicated resident #1 became very restless after dinner, paced the unit, stated she needed to go home and pushed on exit doors. The note indicated an electronic wander-alert bracelet was in place. A progress note written by the ADON on 5/19/26 revealed resident #1 was agitated, pacing the unit, pushing doors and telling staff to leave her alone. On 6/02/26 at 3:44 PM, Certified Nursing Assistant (CNA) E verified she was working on the unit the evening of 5/19/26. She stated she saw resident #1 in the dining room between 5:30 PM - 6:00 PM. CNA E explained the resident did wander throughout the unit and would go to the emergency exit doors. On 6/02/26 at 3:19 PM, CNA D stated she was on duty the night of the incident but could not recall what assignment she had. She stated she was certain she was not assigned to resident #1. CNA D recalled she heard the emergency exit alarm around 5:30 PM and saw resident #1 approach the emergency exit door again around 6:45 PM. She explained she redirected resident #1 to the dayroom and then returned to work. In a phone interview on 6/01/26 at 2:21 PM, CNA A stated she was assigned to resident #1 on 5/19/26. She recalled the resident was very agitated that evening and was walking constantly throughout the unit. CNA A explained she passed resident #1 several times in the hallway that night with the last occurrence being around 7:25 PM as she was going to provide care to another resident. She stated that resident #1 walked very fast. CNA A clarified she did not know resident #1 was missing until she was notified by Licensed Practical Nurse (LPN) B around 8:00 PM. In a phone interview on 6/02/26 at 12:14 PM, LPN B verified she was assigned to resident #1 at the time of the elopement. She explained her regular shift was 11:00 PM -7:00 AM but she came in early to cover half a shift. LPN B stated she arrived on the unit around 7:00 PM. She recalled observing resident #1 walking down the hallway toward the back of the unit. LPN B explained resident #1 exhibited exit-seeking behavior and would go to the exit doors, push on the release bar and walk away when the alarm sounded. She recalled redirecting resident #1 back to the dayroom at least twice prior to taking over the medication cart at approximately 7:15 PM and then she made her rounds. She stated she was not aware resident #1 was missing until 7:55 PM when she went to take resident #1 her medication. On 6/02/26 at 3:31 PM, Registered Nurse (RN) C confirmed she worked the evening of 5/19/26. She stated she was familiar with resident #1. She explained resident #1 walked constantly and was very active that day. RN C stated resident #1 went to the emergency exit door several times during the shift and set off the alarm multiple times. She recalled last seeing the resident around 7:30 PM in the dayroom. She reported she was not aware resident #1 was missing until LPN B alerted her around 8:00 PM. RN C was unable to explain why resident #1 was (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	not placed on closer supervision or other intervention despite repeatedly going to the exit doors during the shift and setting off alarms after staff redirection. On 6/01/26 at 2:56 PM, the ADON reported she was covering as a floor nurse for half of the 3:00 PM - 11:00 PM shift on 5/19/26 until a relief nurse arrived. She stated resident #1 was active during the shift and was observed walking around the unit in the common areas, dining room and hallways. The ADON reported she turned the medication cart over to LPN B at approximately 7:15 PM and went to her office to complete other tasks. She recalled she left the building around 7:50 PM. The ADON reported she was not aware resident #1 was missing until RN C called her. She recalled she was driving home and turned around to go back to the facility. The ADON explained she called the DON immediately to inform her at 8:26 PM of the elopement. In a follow-up interview on 6/04/26 at 11:26 AM, the ADON stated resident #1 was supposed to be on 30-minute checks. She explained that meant a CNA would be assigned every 30 minutes to kind of follow the resident around. The ADON was unable to provide documentation or to state where documentation was located to show which CNAs were assigned or that the 30-minute checks were completed. On 6/01/26 at 11:25 AM, resident #1's daughter stated the facility did call her on the night her mother eloped. She explained her mother was admitted to the facility after a stroke to get therapy to get stronger. Resident #1's daughter stated she still was not sure how her mother got out of the facility. She recalled her mother had never exhibited this behavior previous to admission at the facility. Resident #1's daughter clarified the facility only told her that her mother was missing, but not where she was or other details of what happened. She stated the hospital chaplain was the person who called to inform her that her mother was in the emergency room. She recalled when she visited her mother that evening, her mother had a bump on her head and a mark on her face. She reported her mother was still hospitalized with medical issues involving her heart. In a joint meeting with the Administrator and DON on 6/02/26 at 3:57 PM, the Administrator stated the facility initiated an investigation and corrective measures immediately following the elopement on 5/19/26. The Administrator explained that the facility held an Ad-HOC Quality Assurance and Performance Improvement (QAPI) meeting on 5/20/26 to review the incident and the outcome of the facility's investigation. The Administrator reported that their investigation showed that resident #1 began exhibiting increased exit seeking behaviors by pacing the unit, pushing on doors and stating she wanted to leave on 5/18/26. She stated an order was obtained for a wander-alert bracelet which was applied to resident #1 on 5/18/26. The Administrator stated staff interviews and statements indicated resident #1 went to the emergency exit doors multiple times on the evening of 5/19/26 and set off the alarms several times, after which staff had to reset them. The Administrator stated the facility believed a staff member must have reset the alarm without checking the staircase or exit doors to see if a resident had gone through those doors; however, they were unable to determine which staff had reset the alarm without checking the staircase. The Administrator stated the facility identified that resident #1 should have been on 15- or 30-minute checks and that staff failed to respond appropriately to the emergency exit-door alarms. The Administrator acknowledged that staff failure to respond to an increase in exit seeking behaviors and alarms enabled resident #1 to exit through the emergency exit door, descend a flight of stairs and ultimately exit the facility unsupervised and without staff knowledge. Review of the policy and procedure for Abuse and Neglect dated March 2018 revealed neglect was defined as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The document listed examples of situations that might constitute or could be construed as neglect, including inappropriate management of problematic behavior. The facility's policy and procedure for Elopement dated October 2014 indicated each resident would receive adequate supervision and assistance to prevent elopement from the facility. Review of corrective measures implemented by the facility revealed the following, which were verified by the survey team at the time of the survey: *On 5/19/26 at approximately 7:30 PM, resident #1 left the facility through an exit door unsupervised and was admitted to the hospital at 8:06 PM via Emergency (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Medical Services. *On 5/19/26 at approximately 8:45 PM, the unit emergency exit door, alarm and keypad were checked by the Supervisor. *On 5/19/26 at approximately 9:00 PM, the DON conducted a full census headcount to ensure all other residents were accounted for. *On 5/19/26 at 9:02 PM, resident representative was notified of the elopement. *On 5/19/26 at approximately 10:00 PM, the Medical Director was notified of resident elopement and transfer to hospital. *On 5/20/26 at approximately 7:30 AM, the Maintenance Supervisor checked the unit emergency exit door alarm and keypad for function with no errors noted. Weekly audits for the function of emergency exit doors, alarms and keypads continued. *On 5/20/2026, the DON, ADON and MDS coordinator reviewed the elopement risk assessment for all residents to ensure accuracy. *On 5/20/2026, the MDS coordinator reevaluated residents with wander guards for elopement risk assessment and care plan for accuracy. *On 5/20/2026, the facility's policy and procedures for elopement and wandering residents were reviewed and with no changes. *On 5/20/26, the DON initiated a review of all new admissions for documentation related to exit seeking behaviors and elopement-risk evaluations. *On 5/20/26, the DON initiated audits for exit-seeking behaviors. *On 5/20/26, additional wander-alert bracelets were put on each unit for ease of access and radios were placed throughout the facility for communication between staff. *On 5/20/26, elopement drills were initiated for all staff on all three shifts. *On 5/20/2026, the Administrator and DON began monitoring for neglect on units relate to exit seeking behaviors during community rounds. *On 5/20/2026, the Interdisciplinary Team (IDT) began to verify accuracy of care plans for residents identified as at risk for wandering/elopement. *On 5/20/2026, an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held which included the Administrator, DON, Medical Director and members of the IDT to discuss the event including wander/elopement alert system, the elopement procedure and emergency exit-door alarms. The committee reviewed the investigation up to that point and implemented immediate actions, including information provided to staff regarding the use of one-on-one supervision if resident behavior was escalating; enhanced supervision for residents with wander/elopement alert bracelets (every 15/30 minutes as needed); and decorative door decals added to emergency exit doors. *From 5/19/26 through 5/21/26, nursing leadership provided education to all staff regarding abuse and neglect, identification of exit seeking behaviors, safety of residents, protecting a resident from exiting the building through the emergency exit doors, and one-on-one supervision for residents with increased exit-seeking behavior.- 37/47 (78.2%) of licensed nurses received education by 5/21/26.- 59/79 (74.6%) of CNAs received education by 5/21/26. - 11/13 (85%) of the therapy department received education by 5/21/26.- 4/4 (100%) of social workers received education by 5/21/26.- 7/7 (100%) of activities staff received education by 5/21/26.- 10/14 (71%) of dietary staff received education by 5/21/26.- 2/2 (100%) of maintenance staff received education by 5/21/26. *By 5/26/26, education was provided to 90% of staff. Any staff who had not received education were not allowed to work until they received the training prior to their work shift.		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate supervision to ensure vulnerable residents did not exit the facility without supervision for 1 of 8 residents reviewed for elopement, of a total sample of 8 residents, (#1). This failure contributed to the elopement of resident #1 and placed her at risk of serious injury, impairment, or death. While outside the facility unsupervised, resident #1 fell and sustained a head injury and facial abrasion. There was reasonable likelihood she could have become lost, been accosted/harmed by strangers or been hit by a motor vehicle while outside the facility unsupervised. On 5/19/26 at approximately 7:30 PM, the facility failed to prevent a resident with severe cognitive impairment from exiting the facility unsupervised. The facility was unaware of resident #1's whereabouts until 9:36 PM, when staff learned that resident #1 had been transported to the hospital emergency room. The facility failed to ensure resident #1 was adequately supervised to ensure vulnerable residents did not exit the facility without staff knowledge. Information provided by the facility identified seven residents at risk for elopement on the first day of survey. The facility's failure to provide adequate supervision resulted in Immediate Jeopardy (IJ) beginning on 5/19/26 and removed on 5/22/26 after verification of immediate actions. The scope and severity of the deficiency decreased to a D, (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy). Substandard Quality of Care was identified at F600 and F689. A partial extended survey was conducted on 6/03/26. Findings: Cross reference F600. Review of the medical record revealed resident #1, an [AGE] year-old female, was admitted to the facility on [DATE]. Her diagnoses included vascular dementia, hemiplegia and hemiparesis, aphasia (trouble communicating), cardiac arrest, congestive heart failure and atypical atrial flutter. Review of the Minimum Data Set (MDS) 5-Day Medicare assessment with assessment reference date of 5/18/26 revealed resident #1 had short-term and long-term memory problems and severely impaired cognitive skills for daily decision-making skills. The assessment indicated resident #1 was not evaluated for her ability to go up and down one step, which was not attempted due to her medical conditions and/or safety concerns. On 6/02/26 at 10:29 AM, Registered Occupational Therapist G clarified that resident #1 was able to walk approximately 125 feet but required hand-held assistance due to her poor safety awareness. The electronic medical record (EMR) contained an elopement risk evaluation assessment dated [DATE] which indicated resident #1 was at risk for elopement. Review of resident #1's care plan revealed a care plan initiated 5/12/26 which indicated resident #1 was identified as at risk for wandering/elopement. The care plan focus indicated an electronic wander-alert bracelet was applied on 5/18/26. Resident #1 also had a care plan initiated 5/12/26 which indicated she was at risk for falls related to her recent hospitalization with declines in strength, balance and activity tolerance. Review of resident #1's physician orders revealed an order dated 5/18/26 for an electronic wander-alert bracelet to be applied as a safety precaution as resident had displayed and/or voiced exit-seeking behavior. The record also contained an order for Apixaban 5 milligrams given twice a day to prevent blood clots. Apixaban is an anticoagulant. It works by decreasing the clotting ability of the blood and helps prevent harmful clots from forming in the blood vessels. A person may bleed and bruise more easily while using this medicine. People who take Apixaban are cautioned to be extra careful to avoid injuries and to stay away from situations where a person could be bruised, cut, or injured, (retrieved from www.mayoclinic.org on 6/10/26). The EMR contained a progress note entered by the Assistant Director of Nursing (ADON) dated 5/18/26 which indicated resident #1 became very restless after dinner, paced the unit, stated she needed to go home and pushed on exit doors. The note indicated an electronic wander-alert bracelet was in place. On 6/02/26 at 3:26 PM, Certified Nursing Assistant (CNA) F confirmed she was on duty at the time resident #1 eloped from the facility but was not on her assignment. She recalled she may have seen resident #1 around dinner time (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	between 5:30 PM - 6:00 PM but was in another resident's room providing care when she was told resident #1 was missing. On 6/02/26 at 3:44 PM, CNA E verified she worked on the unit the evening of 5/19/26. She stated she saw resident #1 in the dining room between 5:30 PM - 6:00 PM. CNA E explained the resident wandered throughout the unit and would go to the emergency exit doors. She stated she was providing care to another resident when she was informed resident #1 could not be located. On 6/02/26 at 3:19 PM, CNA D stated she was on duty the night of the incident but could not recall what assignment she had. She stated she was certain she was not assigned to resident #1. CNA D recalled she heard the emergency exit alarm around 5:30 PM. She stated she observed resident #1 approach the emergency exit door again around 6:45 PM. She explained she redirected resident #1 to the dayroom and then returned to work. CNA D reported she was in the bathroom with another resident when she was notified resident #1 could not be located. In a phone interview on 6/01/26 at 2:21 PM, CNA A stated she was assigned to resident #1 on 5/19/26. She explained the resident was very agitated that evening and was walking constantly throughout the unit. CNA A recalled she passed the resident several times in the hallway with the last occurrence being around 7:25 PM. She stated she went to provide care to another resident at approximately 7:45 PM. CNA A explained that later when she exited the room, Licensed Practical Nurse (LPN) B asked her about resident #1 and informed her the resident could not be located. In a phone interview on 6/02/26 at 12:14 PM, LPN B verified she was assigned to resident #1 at the time of the elopement. She explained that her regular shift was 11:00 PM - 7:00 AM but she came in early to cover half a shift. LPN B stated she arrived on the unit around 7:00 PM. She recalled she observed resident #1 walking down the hallway toward the back of the unit. LPN B explained resident #1 exhibited exit-seeking behavior and would go to the exit doors, push on the release bar and walk away when the alarm sounded. She recalled she redirected resident #1 back to the dayroom at least twice prior to taking over the medication cart at approximately 7:15 PM. LPN B stated she then made her rounds and was informed by the Assistant Director of Nursing (ADON) of a new medication for resident #1. She stated the medication was not in the cart, so she pulled it from the automated medication dispenser at 7:55 PM. LPN B recalled she looked around the unit and could not locate resident #1 to administer the medication. She stated she alerted other staff and a search was initiated but they were unable to locate resident #1. On 6/02/26 at 3:31 PM, Registered Nurse (RN) C confirmed she worked the evening of 5/19/26. She stated she was familiar with resident #1. She explained resident #1 walked constantly and was very active that day. RN C stated resident #1 went to the emergency exit door several times during the shift and set off the alarm multiple times. She recalled last seeing the resident around 7:30 PM in the dayroom. She reported she was later informed that resident #1 was missing. RN C stated she called the ADON, who had already left the building, to report the incident and then paged the code for a missing resident on the overhead system. She was unable to state why resident #1 was not placed on increased supervision or other intervention due to her increased exit seeking activity on that shift. On 6/01/26 at 2:56 PM, the ADON reported she was covering as a floor nurse for half of the 3:00 PM - 11:00 PM shift on 5/19/26 until a relief nurse arrived. She stated resident #1 was active during the shift and was observed walking around the unit in the common areas, dining room and hallways. The ADON reported she turned the medication cart over to LPN B at approximately 7:15 PM and went to her office to complete other tasks. She recalled she left the building around 8:00 PM. The ADON reported RN C called her while she was driving and informed her the facility was unable to locate resident #1. She stated she instructed the nurse to page the overhead code for a missing resident and immediately called the Director of Nursing (DON) to inform her of the incident. The ADON reported she turned around and headed back to the facility to help with the search. In a follow-up interview on 6/04/26 at 11:26 AM, the ADON stated resident #1 had been placed on 30-minute checks. She explained that meant a CNA was assigned to kind of follow the resident around, every 30 minutes. The ADON was unable to provide any documentation of the 30-minute checks, including which CNAs were assigned or that the 30-minute checks were completed. On 6/01/26 at 11:25 AM, resident #1's daughter stated (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the facility did call her on the night her mom eloped. She explained her mother was admitted to the facility after a stroke to get therapy to get stronger. Resident #1's daughter stated she still was not sure how her mother got out of the facility. She recalled her mother had never exhibited this behavior previously. Resident #1's daughter clarified the facility only told her that her mother was missing, and the hospital chaplain was actually who called to inform her that her mother was in the emergency room. She recalled when she visited her mother that evening, her mother had a bump on her head and a mark on her face. She reported that her mother was still in the hospital with medical issues involving her heart. In a meeting with the Administrator and DON on 6/02/26 at 3:57 PM, the Administrator stated the facility initiated an investigation and corrective measures immediately following the elopement on 5/19/26. The Administrator explained the facility held an ad-hoc Quality Assurance and Performance Improvement (QAPI) meeting on 5/20/26 to review the incident and the outcome of the facility's investigation. The Administrator reported their investigation showed that resident #1 exited the facility through the second-floor stairwell from the emergency exit door on the nursing unit and continued down the staircase to the first floor where she exited the facility. The Administrator explained she viewed the video from the stairwell and resident #1 could be seen descending the stairs and exiting the facility. She stated a security officer from the independent living building next door could be seen on video, approximately five minutes later, checking and resetting the door; however, no facility staff could be seen on camera checking the staircase after the alarm. The Administrator stated they were able to determine from staff interviews and statements that alarms had gone off several times that night and staff had to reset them. She clarified the emergency exit-door alarm would continue to sound unless the door was closed and a code was entered to reset the alarm. The Administrator stated the facility believed a staff member reset the alarm without checking the staircase or exit doors to see if a resident had exited through those doors. She explained the facility was unable to determine which staff had reset the alarm without checking the staircase. The Administrator acknowledged staff failure to respond to an alarm appropriately allowed resident #1 to exit through the emergency exit door, descend a flight of stairs and ultimately exit the facility unsupervised and without staff knowledge. On 6/04/26 at 1:07 PM, the Director of Resident Services stated there was an issue with the security cameras back in December 2025. He explained when the new system was initially set up in February 2026, the timestamp was incorrectly entered and was off by three hours which would account for the time difference between the time stamp on the video and actual time resident #1 exited the facility. With this revised information, the survey team reviewed the videos from the evening of 5/19/26 provided by the facility again and were able to see resident #1 as she descended the staircase from the second floor at 7:28 PM and continued to the landing on the first floor. She reached the bottom of the staircase at 7:29 PM and began pulling on the secured emergency exit door that led into the first-floor unit. Resident #1 was noted to pull on the door several times until she noticed a keypad next to the door. At 7:29 PM, she began randomly pushing buttons in an attempt to open the door and continued to pull on the door handle. At 7:30 PM, resident #1 gave up her attempt to enter the secured door, turned back toward the staircase and then turned toward the exit door to the outside of the building. Resident #1 went out of sight on the video as she reached the exit door. Exterior light could be seen on the video as the door opened at 7:30 PM and resident #1 exited facility. Review of the policy and procedure for Elopement dated October 2014 revealed an elopement referred to any incident involving a resident who left the facility suddenly, without telling anyone and/or without the knowledge or consent of the facility and without following the facility policies and procedures for signing out. The document indicated that each resident would be screened to identify residents at risk for elopement and interventions would be implemented that were consistent with the resident's needs, goals, plan of care and current standards of practice to reduce the risk of an elopement. The document clarified the facility would monitor the effectiveness of the interventions and modify them as necessary. On 6/02/26, resident #1's likely elopement route was retraced between her room and the seven level public parking garage where she was picked up by (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105731	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Commons at Orlando Lutheran Towers		STREET ADDRESS, CITY, STATE, ZIP CODE 210 Lake Avenue Orlando, FL 32801	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Emergency Medical Services (EMS) personnel, outside the facility. As she left her room, resident #1 would have turned left outside her door and walked approximately 20 feet until she came to another hallway and turned right. She then walked approximately 34 feet and turned left onto an adjacent hallway. She proceeded down that hallway approximately 131 feet to the emergency exit door at the end of the hallway. Resident #1 pushed on the door exit push bar which released and opened the door after 15 seconds. Resident #1 exited the unit through the emergency exit door without knowledge of the facility staff. Once outside the door, the resident would have been on a concrete landing with a staircase going up to the two upper floors and another staircase going down to the first floor and garage. Resident #1 descended 11 steps to another concrete landing, turned right and descended another staircase containing 11 steps until she reached the bottom landing. There were two doors at the bottom. One led to the first floor of the facility and the other door led to the outside which resident #1 was able to open and exit the facility. Once outside, the actual route the resident took is unknown. To arrive at the area where resident #1 was found she would have continued down the sidewalk, turned left and walked 29.5 feet to the intersection of 2 two-lane brick streets. As the sidewalk to the left was blocked for construction, resident #1 likely crossed the street and walked 45 feet to the other side and turned left on the sidewalk. She walked approximately 299 feet until she reached a sidewalk that led to the parking garage. She likely turned right and continued to walk 18.5 feet to the gate and into the garage. She walked approximately 106 feet into the garage headed toward the opposite exit. Per hospital paperwork, a bystander found resident on the ground, and she was minimally responsive. The bystander called EMS via 911, who transported resident #1 to the hospital. Upon arrival, she was noted to have a cervical collar in place, a hematoma (a closed wound with blood inside) to her right forehead and an abrasion to the right cheek. Along the likely path, the resident would have encountered environmental dangers which included motor vehicles travelling in a busy downtown location, multiple concrete stairs and landings, uneven surfaces on the sidewalk, gravel and cobblestone roads. Historical weather data revealed on 5/19/26, the day of resident #1's elopement, the temperature at 7:53 PM was 81 degrees Fahrenheit with mostly cloudy skies, (retrieved on 5/29/26 from www.wunderground.com). Review of immediate corrective measures implemented by the facility revealed the following, which were verified by the survey team at the time of the survey: *On 5/19/26 at approximately 7:30 PM, resident #1 left the facility through an exit door unsupervised and was admitted to the hospital at 8:06 PM via EMS. *On 5/19/26 at approximately 8:45 PM, the unit emergency exit door, alarm and keypad were checked by the Supervisor. *On 5/19/26 at approximately 9:00 PM, the DON conducted a full census headcount to ensure all other residents were accounted for. *On 5/19/26 at 9:02 PM, the resident representative was notified of the elopement. *On 5/19/26 at approximately 10:00 PM, the Medical Director was notified of the resident's elopement and transfer to hospital. *On 5/20/26 at approximately 7:30 AM, the Maintenance Supervisor checked the unit emergency exit-door alarm and keypad for function with no errors noted. Weekly audits for function of emergency exit-doors, alarms and keypads continued. *On 5/20/2026, the DON, ADON and MDS coordinator reviewed the elopement-risk assessment for all residents to ensure accuracy. *On 5/20/2026, the MDS coordinator reevaluated residents with wander-alert bracelets for elopement-risk assessment and care plan for accuracy. *On 5/20/2026, the facility's policy and procedures for elopement and wandering residents were reviewed and with no changes. *On 5/20/26, the DON initiated a review of all new admissions for elopement-risk evaluations for accuracy to identify residents at risk for elopement and ensure the care plan reflects appropriate actions/interventions. *On 5/20/26, elopement drills were initiated for all staff on all three shifts. *On 5/20/2026, the Administrator and DON began monitoring for exit-seeking behaviors and elopement risk during community rounds and will continue to monitor. *On 5/20/2026, the Interdisciplinary Team (IDT) began to monitor 24-hour reports during morning stand-up for potential risk of exit-seeking behavior. *On 5/20/2026, an ad hoc QAPI meeting was held which included the Administrator, DON, Medical Director and members of the IDT to discuss the event including (continued on next page)		

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	wander/elopement alert system, elopement procedure and emergency exit-door alarms. The committee reviewed the investigation to that point and implemented immediate actions to include information provided to staff regarding the use of one-on-one supervision if resident behavior was escalating; enhanced supervision for residents with wander/elopement alert bracelets (every 15/30 minutes as needed); and decorative door decals added to emergency exit doors. *From 5/19/26 through 5/21/26, nursing leadership provided education to all staff regarding supervision of residents, elopement policy, wandering/exit-seeking behavior, response to new or increased wandering/exit-seeking behavior to include 30- and 15-minute checks, providing one-on-one supervision if resident is going in and out of resident rooms and exit-seeking, response to door alarms, overhead paging for Code Alpha (missing resident) and security radios/radio checks.- 5/5 (100%) of nursing management staff received education by 5/20/26.- 37/47 (78.2%) of licensed nurses received education by 5/21/26.- 59/79 (74.6%) of CNAs received education by 5/21/26. - 11/13 (85%) of the therapy department received education by 5/21/26. - 4/4 (100%) of social workers received education by 5/21/26.- 7/7 (100%) of activities staff received education by 5/21/26.- 10/14 (71%) of dietary staff received education by 5/21/26.- 2/2 (100%) of maintenance staff received education by 5/21/26. *By 5/26/26, education was provided to 90% of staff. Any staff who had not received education were not allowed to work until they received the training prior to their work shift. Interviews were conducted on 6/03/26 and 6/04/26 with 21 staff members representing all shifts (6 Registered Nurses, 1 LPN, 6 CNAs, 1 maintenance staff, 2 housekeepers, 4 dietary staff, 1 therapist). Staff interviews revealed they were knowledgeable of the elopement policy and procedures, appropriate response to alarms and supervision of all residents to include those at risk for elopement. The resident sample was expanded during the survey to include five additional residents who were at risk of elopement. Observations, interviews, and record reviews conducted revealed no concerns related to elopement-risk evaluations, care plans and physician orders for residents #4 through #8. During survey, the survey team validated the education and elopement-drill participation through interviews and sign-in sheets and reviewed the wandering and elopement-risk binders for accuracy.		