

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

Printed: 07/18/2026
Form Approved OMB
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 01/08/2026
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 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 observation, interview, and record review, the facility failed to provide care and services in accordance with professional standards of practice related to knee immobilizer application, the physician order, and failed to create a comprehensive care plan for 1 of 1 resident reviewed for limited range of motion, of a total sample of 43 residents, (#180). Findings: Resident #180 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's dementia, osteoporosis, history of falls, hip and left knee fractures, and status post left total knee arthroplasty (knee replacement surgery). Review of the quarterly Minimum Data Set assessment dated [DATE], revealed resident #180 had a Brief Interview for Mental Status score of 5 out of 15, which meant she had severely impaired memory. The assessment indicated resident #180 had limited range of motion to her arms and her left leg. The MDS documented she used a wheelchair for mobility and was dependent on staff for toileting, personal hygiene, lower body dressing, and mobility. On 1/05/26 at 10:49 AM, resident #180 was in her room, sitting in her wheelchair. She had a left knee immobilizer in place with a folded pillowcase stuffed under the immobilizer. The resident was unable to say why she had the immobilizer or why the pillowcase was there. Review of current physician orders for resident #180 showed no telephone order or other active order in the electronic medical record for the left knee immobilizer. Review of resident #180's care plan, with a most recent review date of 1/06/26, revealed no interventions related to application of a knee immobilizer or use of a pillowcase for resident comfort. On 1/07/26 at 1:30 PM, Certified Nursing Assistant (CNA) A stated this was the first time she worked with resident #180 and was not aware how often to apply or remove the immobilizer or why the pillowcase was there. CNA A said she was educated on application of immobilizers in the past and said she put the pillowcase in the immobilizer because it was previously there when she removed the immobilizer to give the resident a shower. On 1/07/26 at 1:25 PM, Licensed Practical Nurse (LPN) B said this was the first time she was assigned to resident #180 and was aware of the immobilizer but was not aware of the frequency or removal of the immobilizer. LPN B confirmed in the electronic medical record there was no physician order for the immobilizer, but there should be. The LPN stated therapists checked the orders and applied or removed the immobilizer. Upon entering resident #180's room with LPN B at approximately 1:30 PM, the nurse noted the immobilizer had not been applied correctly by CNA A who had just showered her. On 1/07/26 at 2:08 PM, LPN C said she was assigned to resident #180 over the past three days. She explained residents usually were admitted with physician orders from the hospital. LPN C reviewed resident #180's medical records and confirmed there were no orders for the immobilizer. She again said therapists checked the orders and applied or removed the immobilizer. On 1/08/25 at 11:18 AM, the Physical Therapy Assistant (PTA) said he worked with resident #180 daily and was aware she had an immobilizer. The PTA said he saw the folded pillowcase inside the immobilizer and did not remove it because the resident had complained of discomfort in the past. On 1/08/25 at 11:10 AM, the Director of Rehabilitation Services (DOR) said therapists reviewed physician orders on their electronic program. She explained their process was to review the hospital discharge records including physician orders and assistive devices or equipment used by the residents. After reviewing hospital records, the DOR stated their (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	EMR generated an order for the therapists. The DOR said the therapists would reapply any device if they were not applied correctly. The director explained in regard to the pillowcase inside the resident's immobilizer, My expectation would be for therapists to remove anything placed inside an immobilizer and inform a nurse. On 1/08/26 at 11:52 AM, the Director of Nursing (DON) said she was aware there was no physician order for resident #180's immobilizer. The DON confirmed her expectation was for a physician order to first be obtained by a nurse for use of any device or devices such as an immobilizer. The facility's policy titled, Medication and Treatment Orders, revised July 2016 indicated medications/treatments shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications/treatments in this state. The policy, further detailed verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date and the time of the order.		