STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105776	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Port Orange Nursing and Rehab Center	5600 Victoria Gardens Blvd Port Orange, FL 32127

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. Based on interviews and record review, the facility failed to ensure the residents' right to be free from neglect by failing to implement sufficient safeguards and supervision to prevent one (Resident #1) of four residents reviewed for Activities of Daily Living (ADL) care from an avoidable fall with a subsequent right hip fracture. The facility failed to ensure that staff implemented care plan interventions specifying two-person assistance with ADLs for Resident #1. On January 10, 2026, Resident #1's ADL care was provided by one Certified Nursing Assistant (CNA) rather than by two CNAs as indicated in the resident's care plan. The resident fell out of bed during ADL care and sustained a right hip fracture.Any resident requiring two-person staff assistance was at risk. There were 20 residents who required two-person assistance with ADL care at the time of the survey.The facility's failure created a situation that caused a serious injury to Resident #1 and resulted in the determination of Immediate Jeopardy on February 6, 2026. The findings of Immediate Jeopardy were determined to have been corrected as of January 16, 2026.The findings include: Cross reference F0689 A review of Resident #1's Situation, Background, Assessment and Recommendation (SBAR) summary note, dated 01/10/26 at 8:41 AM, revealed that the resident had a fall. Recommendations included: STAT (immediately) right hip x-ray and continue with neurology status check. A review of the 01/10/26 radiology report revealed, mildly displaced right femoral neck fracture with femoral shaft impaction. A review of the 01/10/26 hospital emergency department note revealed, While being transferred, patient was dropped by staff as per EMS (emergency medical services). Patient did land on her right hip. Patient does take Eliquis for atrial fibrillation, no known head injury. She is complaining or 4-10 pain to the right hip. Conclusion: Mildly displaced and angulated acute sub-capital fracture of the right femoral neck. A review of Resident #1's active care plan, revised on 10/16/25, revealed that the resident had an ADL Self-Care Performance Deficit related to atrial fibrillation (AFIB – rapid, irregular heartbeat), hypertension (HTN – high blood pressure), overactive bladder, a history of breast cancer, dementia, anemia, and end-stage disease process. The care plan noted that the resident required assistance as follows: Bed Mobility: Substantial/maximal assistance of two. Transfers: Dependent/Total Mechanical Lift/two-person/medium pad. The care plan indicated that the resident was at risk for a fall or a fall-related injury due to impaired mobility and decreased safety awareness. Interventions included: Bariatric mattress, bed in lowest position, bolsters to bed, left side mobility bar, and cue for safety awareness. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105776	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Port Orange Nursing and Rehab Center	5600 Victoria Gardens Blvd Port Orange, FL 32127

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	A review of the CNA task list from 12/10/25 through 01/10/26 revealed that the resident received one-person ADL assistance on 21 of the 31 days reviewed. A telephone interview was conducted with CNA B on 02/05/26 at 1:52 PM. She stated 01/10/26 was her first day of work and she was being coached by CNA A that day. When she and CNA A entered Resident #1's room to provide care at approximately 5:15 AM, CNA A asked her to care for resident in bed B while CNA A cared Resident #1. CNA B pulled the privacy curtain in order to provide care to the resident in bed B. As she was providing care, she stated she heard a thud and then CNA A yelled, Oh shit, she is on the floor. When CNA B looked out from behind the curtain, she saw CNA A running toward Resident #1's bed from the doorway of the room. Resident #1 was on her back kind of toward her right side with her head toward the top of the bed. The bed was in the high position. Resident #1 was complaining of right hip pain. CNA A called for the nurse and the nurse came to evaluate Resident #1. CNA A stated she had gone to get the nurse to perform wound care to the resident because her dressing was soiled and she left the resident propped on her side in the bed. When asked if they had reviewed the Kardex prior to entering the room, CNA B stated, no. She added that she was not aware of how to access the Kardex either since this was her first day. She said that after the incident she received training. She further stated the resident was obese and required two people for transfers and bed mobility. In a joint interview with the Director of Nursing (DON) and the Administrator on 02/05/26 at 4:20 PM, the DON stated the staff were expected to review the residents' Care Plans and Kardex's (summary form used by clinical staff to reference crucial resident information at a glance) prior to providing care. She further stated staff should also conduct change-of-shift rounds to communicate with one another about residents' care needs. Once the care was provided, it should be documented electronically in the residents' records. When the DON was asked about Resident #1's fall on 01/10/26, the DON explained that she received a call from the unit manager indicating that she had been notified by the assigned nurse that the resident had a fall from bed and was complaining of head and leg pain. The unit manager stated the CNA was providing care by herself. The DON was informed that Hospice and the attending physician had already been notified and a new order was obtained for a STAT (immediate) x-ray and neuro checks. The resident's son had also been notified. At approximately 9:17 AM on 01/10/26, the resident's son called the facility and asked that Resident #1 be sent to the hospital for an evaluation. In the afternoon the same day, the hospital nurse confirmed that the resident had a right hip fracture. The resident's family elected not to move forward with surgery as the resident was on palliative care. She passed away a week later. The DON and the Administrator initiated an investigation. The DON stated she interviewed CNA A over the phone. CNA A confirmed that she provided care for Resident #1 by herself. She also confirmed that she had not reviewed the Care Plan/Kardex before providing care. She was suspended pending the outcome of the investigation. On 01/12/26 around 7:30 AM, the DON asked CNA A to come to the facility. The CNA conducted a reenactment of how the incident occurred, revealing that Resident #1 was on her right side holding the mobility bar. The resident's bed was waist high. CNA A walked to the door to ask the assigned nurse to conduct a dressing change because the resident's dressing was soiled. CNA A left the bed waist high with Resident #1 positioned on her side. As CNA A was walking back to the resident from the doorway, the resident's left leg was bending, and the weight of it pulled the resident over the side of the bed to the floor. She landed on her back and rolled to her left side. The resident complained of hitting her head and CNA A yelled for help. During their investigation, the DON and the Administrator stated they identified a systemic issue; CNAs were not documenting the care provided per the care plan. After the 01/10/26 incident, the facility initiated a performance improvement Plan (PIP) on proper positioning during care, wound care and (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Port Orange Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5600 Victoria Gardens Blvd Port Orange, FL 32127	

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	repositioning residents. One of the systemic changes was to conduct a random audit three times a week to ensure residents who required two-person assistance with ADLs received care per the care plan and documentation was completed accordingly. A review of the CNA Job Description revealed essential duties and responsibilities including: Provides personal care and services such as: a) Assisting with activities of daily living (turning and positioning, toileting and elimination, assistive devices, safety and cleanliness, bathing and grooming, feeding, maintaining mobility, nutrition and hydration, reporting abnormal signs and symptoms, data gathering, patient socialization and reality orientation, end-of-life care cardiopulmonary resuscitation and emergency care, postmortem care, residents' rights, documentation of nursing-assistant services. and other tasks that a CNA may perform.) b) Obtains and records vital signs and weight as assigned. c) Accurately documents all care as required by company policy and in compliance with state and federal regulations. Contributes to the resident assessment and care plan. Makes routine rounds on each assigned resident and patient in accordance with established procedures. A review of the facility's policy and procedure titled Abuse and Neglect Prohibition (revised 8/2023), revealed: Policy: Resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion, exploitation and misappropriation of property. Definition: Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. The facility's immediate actions to remove the Immediate Jeopardy included: The CNA involved with the incident was suspended on 01/10/26 and terminated on 01/12/26. The CNA was reported to the board of nursing on 01/13/26. An ad hoc QAPI (Quality Assurance and Performance Improvement) committee meeting was held on 01/10/26 with the Administrator, Director of Nursing (DON), and Medical Director to review the incident and plan to be implemented. On 01/10/26, Neglect education was initiated and completed verbally by the Staff Development Coordinator (SDC) and Unit Managers (UMs) for licensed nurses and certified nursing assistants related to proper positioning of residents in bed when providing routine care, wound care and repositioning of (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	residents in bed with an emphasis on abuse and neglect. 100% of signatures were obtained prior to the staff's first shift on 01/16/26. Assessments were completed by 01/14/26 by the DON, UMs, MDS (Minimum Data Set) Coordinator, SDC, IPCO (Infection Preventionist), and Rehabilitation Director of residents to determine which residents required assistance with ADL care while in bed, proper positioning during care and the number of persons required to assist during care while in bed. Competencies were initiated on 01/10/26 by the DON, UMs, IPCO and SDC of licensed nurses and certified nursing assistants in providing ADL care and repositioning of residents during ADL care while in bed. Competed 100% by 01/16/26. A second ad hoc QAPI meeting was conducted on 01/12/26 with root cause analysis and discussion. It was determined that no other residents were affected by the deficient practice. The root cause analysis was completed on 01/12/26. The root cause was identified as CNA A's failure to follow Resident #1's plan of care. A third ad hoc QAPI meeting was conducted on 01/15/26 to ensure all components of the QAA(Quality Assessment and Assurance)/QAPI of this incident were addressed and were in substantial compliance as of 01/16/26. The monitoring procedure to ensure that the removal plan was effective and remained corrected/in compliance with the regulatory requirements included: To remain in compliance and under the direction of the Administrator, beginning 01/16/26: Initiated monitoring on 01/16/26 by the NHA (Nursing Home Administrator), DON, UMs, IPCO, SDC, 3-11 Supervisor, and Weekend Supervisor for CNA documentation to ensure it matched the Kardex, that the appropriate number of staff were visualized providing care, and interviews were conducted with the residents, if possible, to ascertain the appropriate number of staff was used to provide care. All newly hired licensed staff and certified nursing assistants to receive education on the process of reviewing the Kardex prior to providing care and using the appropriate number of staff for bed mobility. Verification of the facility's removal plan was completed by the survey team on 02/05/26 and 02/06/26. Interviews were conducted with twelve clinical staff members, who worked across all shifts, as well as facility management, including the Administrator, Director of Nursing, Unit Managers, MDS Coordinators and Rehabilitation Director. Interviews revealed that staff were able to state they had been trained and were knowledgeable about facility policies and procedures regarding care plans, use of the Kardex, the definition of neglect, and the required number of staff to care for individual residents. Tours of the facility indicated that safe resident transfers and bed mobility assistance, using appropriate equipment and number of staff to assist, were in place. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of in-service documentation revealed that 100% of staff had acknowledged education and training related to neglect, resident supervision, resident assistance needs and following care plans/Kardex's. Based on verification of the facility's Immediate Jeopardy removal plan, the immediate jeopardy was determined to have been corrected as of 01/16/26.

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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	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 interviews and record review, the facility failed implement sufficient safeguards and supervision to prevent one (Resident #1) of four residents reviewed for Activities of Daily Living (ADL) care from an avoidable fall with a subsequent right hip fracture. The facility failed to ensure that staff implemented care plan interventions specifying two-person assistance with ADLs for Resident #1. On January 10, 2026, Resident #1's ADL care was provided by one Certified Nursing Assistant (CNA) rather than by two CNAs as indicated in the resident's care plan. The resident fell out of bed during ADL care and sustained a right hip fracture.Any resident requiring two-person staff assistance was at risk. There were 20 residents who required two-person assistance with ADL care at the time of the survey.The facility's failure created a situation that caused a serious injury to Resident #1 and resulted in the determination of Immediate Jeopardy on February 6, 2026. The Immediate Jeopardy was determined to have been corrected as of January 16, 2026.The findings include: Cross reference F600 A review of Resident #1's medical record revealed an admission date of 09/01/22 with a re-entry on 04/19/23 and subsequent discharge on [DATE]. The resident's diagnoses included cerebrovascular disease (condition that impairs blood flow to the brain, restricting necessary oxygen and nutrients), stage IV sacral pressure ulcer (a severe wound that exposes muscle, tendon or bone), malignant neoplasm of the breast (cancer), palliative care (specialized care for people living with a serious illness, focused on relieving symptoms, pain, and stress), chronic pain syndrome, and atrial fibrillation (AFIB – rapid, irregular heartbeat). A review of Resident #1's Situation, Background, Assessment and Recommendation (SBAR) summary note, dated 01/10/26 at 8:41 AM, revealed that the resident had a fall. Recommendations included: STAT (immediately) right hip x-ray and continue with neurology status check. A progress note dated 01/10/26 at 9:35 AM indicated that the writer spoke with Resident #1 in her room about being transferred to the emergency room (ER) for an evaluation per her son's request. The resident was noted as initially upset about being transferred out of facility, but after a discussion, she agreed to go. Her X-rays were not completed in the facility due to her being transferred to the ER. A review of the 01/10/26 radiology report revealed, mildly displaced right femoral neck fracture with femoral shaft impaction. A nursing progress note dated 1/10/26 at 1:45 PM, revealed that the writer was notified by the ER nurse that the resident had a positive hip fracture. A review of the 01/10/26 hospital emergency department note revealed, While being transferred, patient was dropped by staff as per EMS (emergency medical services). Patient did land on her right hip. Patient does take Eliquis for atrial fibrillation, no known head injury. She is complaining or 4-10 pain to the right hip. Conclusion: Mildly displaced and angulated acute sub-capital fracture of the right femoral neck. A review of Resident #1's active care plan, revised on 10/16/25, revealed that the resident had an (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	ADL Self-Care Performance Deficit related to atrial fibrillation (AFIB – rapid, irregular heartbeat), hypertension (HTN – high blood pressure), overactive bladder, a history of breast cancer, dementia, anemia, and end-stage disease process. The care plan noted that the resident required assistance as follows: Bed Mobility: Substantial/maximal assistance of two. Transfers: Dependent/Total Mechanical Lift/two-person/medium pad. The care plan indicated that the resident was at risk for a fall or a fall-related injury due to impaired mobility and decreased safety awareness. Interventions included: Bariatric mattress, bed in lowest position, bolsters to bed, left side mobility bar, and cue for safety awareness. A review of the CNA task list from 12/10/25 through 01/10/26 revealed that the resident received one-person ADL assistance on 21 of the 31 days reviewed. A review of Resident #1's annual Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 01/06/26, revealed that Resident #1 had a brief interview for mental status (BIMS) score of 14 out 15 possible points, indicating intact cognition. She was noted as dependent with toileting hygiene, bed mobility and transfers. A telephone interview was conducted with CNA B on 02/05/26 at 1:52 PM. She stated 01/10/26 was her first day of work and she was being coached by CNA A that day. When she and CNA A entered Resident #1's room to provide care at approximately 5:15 AM, CNA A asked her to care for resident in bed B while CNA A cared Resident #1. CNA B pulled the privacy curtain in order to provide care to the resident in bed B. As she was providing care, she stated she heard a thud and then CNA A yelled, Oh shit, she is on the floor. When CNA B looked out from behind the curtain, she saw CNA A running toward Resident #1's bed from the doorway of the room. Resident #1 was on her back kind of toward her right side with her head toward the top of the bed. The bed was in the high position. Resident #1 was complaining of right hip pain. CNA A called for the nurse and the nurse came to evaluate Resident #1. CNA A stated she had gone to get the nurse to perform wound care to the resident because her dressing was soiled and she left the resident propped on her side in the bed. When asked if they had reviewed the Kardex prior to entering the room, CNA B stated, no. She added that she was not aware of how to access the Kardex either since this was her first day. She said that after the incident she received training. She further stated the resident was obese and required two people for transfers and bed mobility. A telephone interview was conducted on 02/05/26 at 2:41 PM with Licensed Practical Nurse (LPN) C, who stated she had been employed by the facility for about four years. She further stated she had a permanent assignment unless there was a call out. She confirmed that she was familiar with Resident #1 as she was regularly part of her assignment. She described her as alert and oriented with episodes of confusion. The resident was totally dependent for care by two staff members. LPN C stated she was assigned to Resident #1 on 01/10/26, the date of Resident #1's fall with subsequent hip fracture. She stated at approximately 5:30 AM, CNA A peeked her head out of the resident's door and asked LPN C to get a wound dressing because the resident's current dressing was soiled. As LPN C was getting the dressing, she heard CNA A yell that the resident was on the floor. She immediately ran to the room; the bed was raised. Resident #1 was lying on the floor between the beds. She was on her right side then rolled to her back. Her head was close to the wall, and her hands were on her head. She complained of head pain and stated she hit her head. LPN C assessed the resident (no injuries noted) and assisted her back in bed with the help of three staff and a mechanical lift (Hoyer). Shortly after getting back in bed, the resident complained of pain in her right hip at 10/10 (worst possible pain). The physician and hospice were notified. (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	Review of the facility's policy and procedure titled Comprehensive Person-Centered Care Plan (revised 8/2023), revealed: The center will develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following: 1. The services that are to be provided to attain or maintain the resident's highest practicable physical mental, and psychosocial well-being as required are provided to the resident to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The facility's immediate actions to remove the Immediate Jeopardy included: The CNA involved with the incident was suspended on 01/10/26 and terminated on 01/12/26. The CNA was reported to the board of nursing on 01/13/26. An ad hoc QAPI (Quality Assurance and Performance Improvement) committee meeting was held on 01/10/26 with the Administrator, Director of Nursing (DON), and Medical Director to review the incident and plan to be implemented. On 01/10/26, Neglect education was initiated and completed verbally by the Staff Development Coordinator (SDC) and Unit Managers (UMs) for licensed nurses and certified nursing assistants related to proper positioning of residents in bed when providing routine care, wound care and repositioning of residents in bed with an emphasis on abuse and neglect. 100% of signatures were obtained prior to the staff's first shift on 01/16/26. Assessments were completed by 01/14/26 by the DON, UMs, MDS (Minimum Data Set) Coordinator, SDC, IPCO (Infection Preventionist), and Rehabilitation Director of residents to determine which residents required assistance with ADL care while in bed, proper positioning during care and the number of people required to assist during care while in bed. A comparison was completed by 01/14/26 by the DON, Ums, MDS Coordinator, SDC, IPCO, and Rehabilitation Director to ensure all residents' care plans and Kardex's accurately reflected the residents' bed mobility needs and the number of staff required to assist the resident. Competencies were initiated on 01/10/26 by the DON, UMs, IPCO and SDC of licensed nurses and certified nursing assistants in providing ADL care and repositioning of residents during ADL care while in bed. Competed 100% by 01/16/26. A second ad hoc QAPI meeting was conducted on 01/12/26 with root cause analysis and discussion. It was determined that no other residents were affected by the deficient practice. The root cause analysis was completed on 01/12/26. The root cause was identified as CNA A's failure to follow Resident #1's plan of care. A third ad hoc QAPI meeting was conducted on 01/15/26 to ensure all components of the QAA(Quality Assessment and Assurance)/QAPI of this incident were addressed and were in substantial compliance as (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	of 01/16/26. The monitoring procedure to ensure that the removal plan was effective and remained corrected/in compliance with the regulatory requirements included: To remain in compliance and under the direction of the Administrator, beginning 01/16/26: Initiated monitoring on 01/16/26 by the NHA (Nursing Home Administrator), DON, UMs, IPCO, SDC, 3-11 Supervisor, and Weekend Supervisor for CNA documentation to ensure it matched the Kardex, that the appropriate number of staff were visualized providing care, and interviews were conducted with the residents, if possible, to ascertain the appropriate number of staff was used to provide care. All newly hired licensed staff and certified nursing assistants to receive education on the process of reviewing the Kardex prior to providing care and using the appropriate number of staff for bed mobility. Verification of the facility's removal plan was completed by the survey team on 02/05/26 and 02/06/26. Interviews were conducted with twelve clinical staff members, who worked across all shifts, as well as facility management, including the Administrator, Director of Nursing, Unit Managers, MDS Coordinators and Rehabilitation Director. Interviews revealed that staff were able to state they had been trained and were knowledgeable about facility policies and procedures regarding care plans, use of the Kardex, required supervision of residents and the required number of staff to care for individual residents. Tours of the facility indicated that safe resident transfers and bed mobility assistance, using appropriate equipment and number of staff to assist, were in place. A review of in-service documentation revealed that 100% of staff had acknowledged education and training related to resident supervision, resident assistance needs and following care plans/Kardex's. Based on verification of the facility's Immediate Jeopardy removal plan, the immediate jeopardy was determined to have been corrected as of 01/16/26.