

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105839	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/23/2025
NAME OF PROVIDER OR SUPPLIER Terrace of Kissimmee, The		STREET ADDRESS, CITY, STATE, ZIP CODE 221 Park Place Blvd Kissimmee, FL 34741	

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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>(continued on next page)</p>

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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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the Minimum Data Set (MDS) assessments accurately reflected health conditions for 1 of 3 residents reviewed for falls, of a total sample of 12 residents, (#2). Findings: Review of resident #2's medical record revealed she was originally admitted to the facility on [DATE] and readmitted from an acute care hospital on [DATE]. Her diagnoses included seizures, disorders of bone density and structure, anxiety, muscle weakness, and dementia with mood disturbance. Review of resident #2's medical record revealed an Event Report dated 11/18/25 that documented a fall that resulted in bleeding from the nose and a skin tear above the right eyebrow. Review of the Observation Detail List Report dated 11/18/25 revealed resident #2 was transferred to the hospital due to the fall. Review of Section J - Health Conditions of resident #2's Discharge Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 11/18/25 revealed she had one fall with no injury since her Admission/Entry or Reentry of Prior Assessment. Review of the hospital History and Physical form dated 11/19/25 revealed that upon evaluation of resident #2 at the hospital she was found to have a subdural hematoma (a type of bleeding near the brain that can occur after a head injury) with midline shift. The note mentioned resident #2 had a laceration/abrasion over the nasal bridge, dried blood in the nares, and facial abrasions. Results of a Computed Tomography scan revealed comminuted (broken apart or in pieces) nasal bone fractures and possible nondisplaced fracture of the nasal septum. A right frontal scalp hematoma with soft tissue gas was also identified. A right femoral neck (hip) fracture was also documented. On 12/23/25 at 6:21 PM, the MDS Coordinator confirmed the hospital documentation was reviewed upon resident #2's return to the facility. She validated the discharge MDS assessment with an ARD of 11/18/25 showing one fall with no injury was incorrect. She stated that despite the incorrect entry, she could not make a correction to the MDS assessment until the next assessment was completed, possibly at the next 90-day assessment, where the fracture/major injury would be captured. She stated she used the Resident Assessment Instrument (RAI) Manual as her guide. On 12/23/25 at 6:49 PM, the Director of Nursing (DON) stated she did not think the fracture would be captured on the discharge MDS assessment with an ARD of 11/18/25 because it was completed before they learned resident #2 sustained fractures due to the fall. She validated the discharge MDS assessment was inaccurate because resident #2's injury was documented in the medical record and injury should have been selected instead of no injury. On 12/23/25 at 7:08 PM, in a telephone interview, the Regional MDS Nurse validated the discharge MDS assessment with an ARD of 11/18/25 was incorrect and should have been coded as one fall with minor injury. She stated they completed 5-day MDS assessments for some residents upon return from the hospital and confirmed that was not the case for resident #2. She reviewed the RAI Manual and stated that based on the rationale, the MDS assessment needed to be modified to reflect the fracture. Review of the facility's policy and procedure titled Resident Assessments, revised October 2023, read, All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information. Information in the MDS assessment will consistently reflect information in the progress notes, plans of care, and resident observations/interviews.</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to communicate with the hospice provider when a change in condition was identified to ensure collaboration on the provision of necessary care and services for 1 of 1 resident reviewed for hospice services, of a total sample of 12 residents, (#2). Findings: Review of resident #2's medical record revealed she was originally admitted to the facility on [DATE] and readmitted from an acute care hospital on [DATE]. Her diagnoses included seizures, disorders of bone density and structure, anxiety, muscle weakness, and dementia with mood disturbance. Review of resident #2's Progress Notes revealed a nursing note dated 8/15/25 and a Social Services note dated 8/17/25, detailing the resident returned to the facility from the hospital on hospice services. Review of resident #2's comprehensive care plan revealed a hospice care plan initiated on 8/18/25 and revised on 11/24/25. The care plan included an approach that directed nursing staff to observe the resident daily for pain medication effectiveness, nausea/vomiting, appetite, ability to move, and ability to communicate needs, and to notify the nurse, physician, and hospice provider of any noted changes. Review of resident #2's medical record revealed an Event Report dated 11/18/25 that documented a fall that resulted in bleeding from the nose and a skin tear above the right eyebrow. Review of the Observation Detail List Report dated 11/18/25 revealed resident #2 was transferred to the hospital due to the fall. Review of the Resident Incident Report form dated 11/18/25 revealed the immediate actions taken after resident #2's fall were to apply pressure to the nose and notify the physician and the family. The form did not document that hospice was notified. Review of a nursing Progress Note dated 11/18/25 at 10:31 PM, read, Resident fell off the bed at 10:10 P.M. According to CNA (Certified Nursing Assistant) report, resident was in bed when she noticed that resident rolled over the side rails and fell. Resident hit her nose on the floor. Resident was bleeding from the nose. RN (Registered Nurse) applied pressure to the affected area to stop the bleeding until 911 got to the facility. [Emergency Contact name] was notified of the fall. Risk manager [name] and MD (physician) [last name] were also notified. The note indicated the resident was transported to the hospital by paramedics. Review of the medical record revealed no documentation that the hospice provider was contacted regarding resident #2's change in condition, fall, or transfer to the hospital on [DATE]. On 12/23/25 at 1:17 PM, in a telephone interview, the Hospice Team Manager stated there was no record the facility notified hospice of resident #2's fall or hospital transfer. She indicated hospice expected to be notified of any change in a hospice resident's condition. On 12/23/25 at 6:49 PM, the Director of Nursing (DON) stated the hospice provider should have been informed of resident #2's fall and transfer to the hospital and that such notification should have been documented in the medical record. She indicated she was not the DON at the time of the incident and was not aware hospice had not been notified. Review of the Nursing Facility Services Agreement dated 1/01/19 between the hospice provider and the facility revealed, Nursing Facility shall notify Hospice when the Hospice Patient experiences a change of condition and shall notify the Hospice Patient's attending physician and family of significant change in condition. The agreement further detailed the nursing facility shall immediately notify hospice if a significant change in a hospice patient's physical, mental, or emotional status occurs including the need to transfer a hospice patient from the nursing facility.</p>		