

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105967	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/07/2025
NAME OF PROVIDER OR SUPPLIER  Lake Bennet Center for Rehabilitation & Healing		STREET ADDRESS, CITY, STATE, ZIP CODE  1091 Kelton Ave Ocoee, FL 34761	

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 0755  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.  (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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, and record review, the facility failed to administer blood pressure medication according to physician ordered parameters for 1 of 5 residents reviewed for unnecessary medications, of a total sample of 39 residents, (#63). Findings: Review of the medical record revealed resident #63 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hypertension, heart valve insufficiency, and hyperlipidemia. Review of the Minimum Data Set quarterly assessment with assessment reference date of 7/29/25 revealed resident 63 had an active diagnosis of hypertension. Review of the Order Summary Report for August 2025 revealed resident #63 had a physician order dated 7/21/25 for Metoprolol Tartrate 12.5 milligrams to be given two times a day for beta-blocker. The order included parameters to hold the medication if resident #63's heart rate was less than 55 beats per minute or her Systolic Blood Pressure (SBP) was less than 120. Metoprolol is a beta-blocker medication used to treat hypertension (high blood pressure). Metoprolol affects the heart and circulation (blood flow through arteries and veins) by relaxing the blood vessels which helps to lower blood pressure and may cause very slow heartbeats (retrieved on 8/08/25 from www.drugs.com). Review of the Medication Administration Record (MAR) for July 2025 and August 2025 revealed nine nurses administered Metoprolol Tartrate to resident #63 outside of specified parameter, 10 times over a 30-day period. Documentation showed resident #63 received this medication on nine days although her SBP was less than the 120 indicated in the order parameters. The medication was administered on 7/06/25 with an SBP of 114, on 7/07/25 with an SBP of 112, on 7/08/25 with an SBP of 118, twice on 7/25/25 with an SBP of 116, on 7/27/25 with an SBP of 115, on 8/01/25 with an SBP of 112, on 8/02/25 with an SBP of 110, on 8/04/25 with an SBP of 107 and on 8/05/25 with an SBP of 118. Review of Progress Notes for July 2025 and August 2025 revealed no associated documentation for the above dates to explain why the Metoprolol was given outside of the physician ordered parameter. On 8/06/25 at 2:38 PM, Licensed Practical Nurse (LPN) C reviewed resident #63's MAR and confirmed she administered Metoprolol on 7/08/25 when it should have been held due to a low SBP. She acknowledged the medication was used to treat high blood pressure and giving it out of parameters could cause the resident's blood pressure to drop too low. On 8/06/25 at 2:46 PM, Registered Nurse (RN) B verified she gave resident #63 Metoprolol on 7/07/25 when it should have been held. She stated the parameters were set because the medication lowers blood pressure but you would not want it to drop too much. She explained she administered the medication outside the order parameters in error. On 8/07/25 at 10:38 AM, LPN D reviewed resident #63's MAR and acknowledged she administer Metoprolol outside of parameters on 7/25/25 and 8/01/25. LPN D stated it was in error. She explained Metoprolol does not always have a parameter set. But if there is one, it should be followed as prescribed. On 8/06/25 at 2:53 PM, the Director of Nursing (DON) - [NAME], RN/DON - verified medication was a blood pressure/cardiac medication. Used to lower blood pressure. Sometimes has parameters, but not always. Should follow the physician order. Expectation is nurses should follow physician orders. Medications should be given reviewed resident #63's MAR and confirmed that doses of Metoprolol were not held according to parameters. She confirmed the medication should have been held as it could further lower blood pressure. The DON explained Metoprolol sometimes has parameters set by a physician but not always. She stated nurses were expected to follow physician orders and only administer medications as prescribed. The facility's policy and procedure for Administering Medication revised April 2019 indicated medications were to be administered in accordance with prescriber orders including any required time frame. The policy included guidelines to check/verify vital signs, if necessary, for each resident prior to administering medications.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to ensure dishes were washed at the appropriate temperature, with regard to the dish machine's data plate and manufacturer's instructions. Findings: On 08/04/2025 at 9:57 AM, during kitchen tour observation, Dietary Aide J was observed putting a dish rack containing dishes into the dish machine while [NAME] L removed items from the dish machine area and placed them with other eating items in the kitchen. The temperature dial on the dish machine showed temperature to be 110 degrees Fahrenheit (F). On 8/04/2025 at 10:03 AM, the Certified Dietary Manager (CDM) stated the dish machine was a low temperature machine and should wash at 120 degrees F or higher. She verified the temperature gauge registered at 110 degrees F and not 120 degrees F as noted on the data plate on the machine. She stated a repairman had been there the previous Friday and machine read 120 degrees F at that time. The CDM ran a rack through the machine again and the temperature gauge did not move past 110 degrees F. Dietary Aide J stated she began washing dishes at 9:00 AM that morning. The CDM did not tell the staff to pull the dishes and did not tell them to rewash the dishes that had already gone through the machine. On 8/04/2025 at 11:25 AM, [NAME] L, Dietary Aide J and Dietary Aide K were observed on tray line. No dishes were observed in the wash area. The dish machine was not running. The temperature gauge on top of the machine showed a water temperature of 90 degrees F. The dietary staff began meal service and were observed preparing trays and placed them on a delivery cart. After four trays were placed on the racks, staff were asked where the prepared meal trays were going to be delivered. Dietary Aide J stated the meals on the cart were for restorative dining. Staff acknowledged the dishes that were removed from the dish machine earlier in the morning were now mixed in with the other dishes. On 8/04/2025 at 11:35 AM, the CDM came from the other side of the kitchen. She was unaware the previous dishes were mixed in with clean dishes and had not been pulled out of service and re-washed. The CDM instructed the staff to re-plate the meals and serve them on disposable dishware. She stated she spoke to the Maintenance Director once she was made aware of the low dish machine temperature. On 8/04/2025 at 11:35 AM, the Maintenance Director verified he spoke with the CDM earlier and checked the hot water supply. He reported one of the screens needed to be cleaned. He stated the water temperature came back up to the appropriate level once the screen was cleaned. The Food and Drug Administration 2022 Food Code notes in section 4-501.15A, that a ware washing machine and its auxiliary components should be operated in accordance with the machine's data plate and other manufacturer's instructions.</p>		