

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105974	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Life Care Center of Orlando		STREET ADDRESS, CITY, STATE, ZIP CODE 3211 Rouse Road Orlando, FL 32817	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure food service items were handled with accepted food-handling practices for meals served from the main kitchen. Findings: During tray line observation on 12/17/25 at 11:20 AM, Dietary [NAME] A dropped the thermometer used to take temperature of food items. He gave it to the Certified Dietary Manger (CDM), removed his gloves and obtained a new thermometer. Dietary [NAME] A placed a glove on his right hand, wiped the new thermometer probe with an alcohol pad and continued taking food temperatures. After cleaning the thermometer probe between food items, Dietary [NAME] A touched the metal probe as he turned to take the temperature of the cream corn. Dietary [NAME] A was stopped by surveyor just before he inserted the thermometer probe into the cream corn and made aware of the contaminated thermometer. Dietary [NAME] A stopped and turned to clean the thermometer again before continuing. After food temperatures were taken and tray line began, Dietary Aide B was observed in front of the steam table preparing trays for meal service. She was noted to lick her fingers twice as she thumbed through the tray tickets. The tray tickets she touched after licking her thumb were placed on resident meal trays. On 12/18/25 at 10:11 AM, the CDM reported the identified facility staff were made aware of their actions during tray line observation. He acknowledged the errors and that staff should have been more aware of their actions. Review of the facility's Safe Food Handling policy revised 4/30/25 instructed staff to wash their hands before handling clean equipment and utensils; after touching their hair or mouth and before donning gloves to initiate a task that involves working with food. The document indicated the food thermometer probe should be sanitized with an alcohol wipe before each use.		

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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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services, consistent with professional standards of practice, to ensure medication administration for 1 resident reviewed for intravenous medications, out of a total sample of 25 residents, (#4). Findings:Review of the medical record revealed resident #4 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, type 2 diabetes, sepsis due to E. Coli, stage 3 chronic kidney disease, acute prostatitis, adult failure to thrive and prostate abscess.Review of the Order Summary Report revealed resident #4 had physician orders dated 11/19/25 for Piperacillin Sodium-Tazobactam Sodium Intravenous Solution Reconstituted 4.5 GM intravenously every 8 hours for urosepsis and prostatitis.A prostate abscess is a localized collection of purulent fluid (discharge from a wound which often indicates infection) within the prostate, often forming as a complication of acute prostatitis. A prostatic abscess can cause severe urosepsis or a urinary tract infection that spreads to the bloodstream, which can result in serious complications including death. (retrieved on 12/19/25 https://www.ncbi.nlm.nih.gov/sites/books/NBK551663/)Review of resident #4's medical record revealed he had a care plan for intravenous (IV) antibiotic therapy related to urosepsis, initiated on 11/25/25. The interventions instructed nurses to administer antibiotic medications as ordered by the physician.Review of electronic Medication Administration Record (eMAR) revealed the following:On 11/20/25 at 10:00 PM, the MAR was noted to be 'blank' and no documentation of the medication being administered.On 11/21/25 at 6:00 AM, the MAR was noted to be 'blank' and no documentation of the medication being administered.On 11/25/25 at 6:00 AM, the MAR was noted to be 'blank' and no documentation of the medication being administered.On 11/25/25 at 2:00 PM, the MAR was noted to be 'blank' and no documentation of the medication being administered.On 11/27/25 at 10:00 PM, the MAR was noted to be 'blank' and no documentation of the medication being administered.On 11/28/25 at 10:00 PM, the MAR was noted to be 'blank' and no documentation of the medication being administered.On 12/1/25 at 6:00 AM, the MAR was noted to be 'blank' and no documentation of the medication being administered.On 12/2/25 at 6:00 AM, the MAR was noted to be 'blank' and no documentation of the medication being administered.On 12/4/25 at 6:00 AM, the MAR was noted to be 'blank' and no documentation of the medication being administered.On 12/9/25 at 6:00 AM, the MAR was noted to be 'blank' and no documentation of the medication being administered. On 12/18/25 at 10:10 AM, the Director of Nursing (DON) revealed that the facility reopened at the end of October, and she had started in this position at the beginning of December. She acknowledged resident #4's eMAR does not reflect the intravenous medication was administered. The DON said at this facility only Registered Nurses (RN) may administer IV medications unless a Licensed Practical Nurse is IV certified. She stated she assumed the RN administered the medication and 'forgot' to document the medication was administered. She acknowledged the IV medication administration could not be verified for resident #4. Review of the facility policy titled Administration of Medications reviewed 2/13/23 reads that the facility will ensure medications are administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms.		