

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106024	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/04/2024
NAME OF PROVIDER OR SUPPLIER  Solaris Healthcare College Park		STREET ADDRESS, CITY, STATE, ZIP CODE  730 Courtland Street Orlando, FL 32804	

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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51023</p> <p>Based on interview, and record review, the facility failed to protect the resident's right to be free from abuse and neglect by not ensuring staff followed resident #1's care plan for safe transfers for 1 of 6 residents reviewed for transfers with a mechanical lift, out of a total sample of 6 residents, (#1).</p> <p>On 11/07/24 at approximately 9:00 AM, the facility failed to prevent serious injury of a physically impaired resident during a transfer from bed to wheelchair. Two CNAs failed to follow resident #1's care plan which required the resident to be transferred using a mechanical lift with assistance of two staff. The two CNAs transferred the resident from his bed by manually lifting the resident and pivoting him to the wheelchair. The resident complained of extreme pain to his right leg shortly after the transfer. An X-ray of resident #1's leg indicated a right distal femur fracture. The resident was transferred to the hospital, and it was determined he was not a candidate for needed surgery due to his advanced age. The resident was prescribed pain medications, and a leg brace with follow up orthopedic appointments. The facility failed to ensure nursing staff followed resident #1's plan of care for safe transfers.</p> <p>The failure to ensure staff transferred residents according to their transfer status and care plan contributed to the injury of resident #1 and placed him and all other residents who needed mechanical lifts for transfer at risk for serious impairment, and/or death. This failure resulted in Immediate Jeopardy starting on 11/07/24. The Immediate Jeopardy was determined to be removed on 11/09/24 after verification of the immediate actions implemented by the facility. The Immediate Jeopardy was determined to be past noncompliance as of 11/21/24 after verification of the facility's corrective actions.</p> <p>Findings:</p> <p>Cross reference F689</p> <p>Resident #1 was admitted to the facility on [DATE], with diagnoses that included Alzheimer's disease, chronic lung disease, depression, dementia, heart failure and adult failure to thrive.</p> <p>Review of the resident's care plan revised 11/20/24 revealed a focus of Activities of Daily Living self-care. The resident had an intervention for a mechanical lift with assistance of two staff for transfers initiated on 11/01/21.</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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of resident #1's Quarterly Minimum Data Set assessment dated [DATE] revealed the resident has a Brief Interview for Mental Status score of 15/15 which indicated he was cognitively intact. The mobility section revealed that the resident had bilateral lower extremity impairment and was dependent on staff for all care. It was noted that due to his medical conditions and/or safety concerns resident sit to stand, perform a transfer to the toilet or walk 10 feet were not attempted.</p> <p>Review of resident #1's lift and transfer assessment dated [DATE] determined the resident required a two person transfer using a mechanical lift. He was determined to be non-weight bearing.</p> <p>On 12/03/24 at 11:08 AM, the Director of Rehabilitation revealed that on 9/10/24 resident #1 was evaluated by therapy and it was determined he needed a mechanical lift for transfers due to the resident's physical ability, choice, and safety concerns. The Director of Rehabilitation said typically, a resident who had physical limitation and refused to get out of bed or sit up to the edge of bed would be a candidate for mechanical lift as opposed to physical assistance from two staff.</p> <p>A witness statement from Certified Nursing Assistant (CNA) A from the morning of 11/07/24 at approximately 8:30 AM, revealed resident #1 was assisted to get ready for his urology appointment with a pick up time of 9:30 AM. She documented that around 9:00 AM she asked Registered Nurse (RN) E how resident #1 transferred. RN E told her she was not sure and for her to ask a different CNA. CNA A indicated she asked CNA D how the resident transferred and was told that he needed a mechanical lift. CNA A documented she could not find a mechanical lift and asked CNA B to instead transfer the resident into his wheelchair manually as a two person assist without the use of the mechanical lift since, he wasn't that big.' CNA A said she placed the lift pad onto resident #1's wheelchair then they positioned the wheelchair close to the bed. The CNAs then positioned the resident to a sitting position on the side of the bed. CNA A said she and CNA B stood on either side of the resident and grabbed underneath his arms and the back of his pants then pivoted the resident and seated him in his wheelchair.</p> <p>On 12/02/24 at 2:57 PM, CNA C revealed when she went to transport resident #1 to the front lobby on 11/07/24, she noticed he was sweating. The CNA indicated she informed RN E who assessed him and gave him some medication before his appointment. The CNA described once she and resident #1 were in the transport van, he complained that his right leg hurt and asked if it could be repositioned. She recalled resident #1 pointed towards his knee and said, Those girls roughed me up and my leg is hurting really bad. Once they arrived at the appointment, around 11:15 AM, CNA C called the facility and asked to speak with the East Wing Unit Manager (UM) and reported what had happened. The UM told her not to move resident #1's leg anymore because he would be evaluated once he came back to the facility. The CNA recalled resident #1 continued to complain of pain while at the appointment and on the way back. She explained resident #1 told her that the other CNAs sat him up in bed, put the sling pad on the wheelchair, then threw him into the wheelchair instead of using the mechanical lift. He told her they were rough with him. She said she reported the allegations to the UM.</p> <p>The timeline provided by the facility indicated resident #1 returned from his appointment at 12:00 PM on 11/07/24 and was assisted into his bed by mechanical lift.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 12/04/24 at 9:40 AM, the Medical Director revealed he was notified of the incident soon after it occurred. He said that resident #1 was assessed after his return to the facility. The Medical Director recalled resident #1's right leg noted to be edematous and painful to the touch, so he ordered a STAT X-ray of the right hip and knee as well as the muscle relaxed medication. He said interventions in the care plans were to help the residents achieve their best level of health. He explained that in order for that to happen the interventions and care plans needed to be followed by staff.</p> <p>The Medication Administration Record for November 2024 indicated resident #1 received Tylenol 650 milligrams (mg) at 12:16 PM on 11/07/24, which was noted to be effective. A progress note dated 11/07/24 revealed the X-ray of the right hip and knee was completed and per the Medical Director he reviewed the results and ordered for the resident to be sent to the emergency room for evaluation at 7:15 PM. Resident #1 returned to the facility from the hospital on 11/08/24 at 1:45 AM, with a diagnosis of an acute impacted distal femur centered in the metadiaphyseal area and osteopenia. He returned with new orders for a knee immobilizer and to follow up with orthopedics on 11/08/24.</p> <p>An orthopedic consult from 11/08/24 revealed it was decided by the Orthopedist that resident #1 would undergo conservative treatment due to the fact that the fracture was not complete and due to his advanced aged. A knee immobilizer was ordered to protect the area as well as orders for him to be completely non-weight bearing on the right leg. The consult indicated the right leg needed to be extremely carefully supported when transported and a follow up X-ray and consult was requested.</p> <p>On 12/02/24 at 2:10 PM, in a telephone interview CNA A recalled she was told by the nurse resident #1 had to be up for a medical appointment about 30 minutes prior to his pick up time. She explained she did not look in the CNA Kardex to check how resident #1 was supposed to transfer before she actually transferred him, but said she instead asked another CNA who told her he needed a mechanical lift to transfer. She said she asked the other CNA to assist her to get resident #1 up without the lift because she, wanted to hurry up and get him in the chair. CNA A recalled she had cared for resident #1 in the past but had never had to transfer him previously, and said she knew how to check the transfer status on the Kardex but did not do that as she only ever used it for documenting.</p> <p>The Facility's Abuse and Neglect policy dated 1/24/23 revealed the facility was committed to protecting the physical and emotional well-being of every resident. The policy indicated that any form of mistreatment for any resident including abuse, neglect and injuries of unknown origin were strictly prohibited. The document described that all allegations were to be investigated and immediately reported per state and federal regulations. Neglect was defined as the failure of the facility, or its employees to provide goods and services to a resident that were necessary to avoid physical harm, mental anguish, or emotional distress.</p> <p>The Immediate Jeopardy removal plan was verified by the survey team and included the following:</p> <ul style="list-style-type: none"> <li>- On 11/07/24, resident #1 was immediately assessed, X-ray completed and pain medication given. He was sent to emergency room .</li> <li>- On 11/07/24, CNAs A and B were removed from service immediately on 11/07/24 and interviewed about the transfer.</li> <li>- On 11/07/24, residents' Plan of Care( POC)/Kardex reviewed on 11/07/24 prior to receiving care from Nursing Staff.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- On 11/07/24, education of staff begun on all shifts regarding the importance of following residents' POC of transfer status and where to obtain transfer status from Kardex.</li> <li>- On 11/07/24, 70 day shift staff, 20 evening shift staff, 11 night shift staff provided education that included post test of reporting of any allegation of abuse/ neglect/ exploitation (ANE), who to report to in facility i.e., abuse coordinator, DON, or supervisor and correlation to failure to provide care as outlined in Plan of Care.</li> <li>- On 11/7/24 a group discussion with CNAs to ask what their barriers may or may not be to following POC and the importance of communicating those barriers immediately to their supervisor</li> <li>- On 11/07/24 all residents were reviewed on 11/07/24 to ensure POC accuracy for transfer</li> <li>- On 11/07/24, interviews were conducted with 9 residents on the CNA's assignment to verify that staff are consistently following care planned transfer status.</li> <li>- On 11/07/24, interviews were conducted with 41 interviewable residents regarding abuse and neglect to determine any other concerns.</li> <li>- On 11/07/24, any staff member not present were educated prior to starting their shift.</li> <li>- On 11/07/24, an Ad Hoc Quality Assurance and Performance Improvement (QAPI) Meeting held and attended by Administrator, Director of Nursing, Medical Director and Interdisciplinary team to review incident and investigation.</li> <li>- On 11/08/24, 13 Clinical Nursing Staff on 7AM-3 PM shift, 8 Clinical Nursing on 3 PM-11 PM shift, and 5 Clinical Nursing Staff on 11 PM-7AM shift provided education regarding the importance of following residents' plan of care of transfer status and where to obtain transfer status from Kardex.</li> <li>- On 11/08/24, another Ad Hoc QAPI meeting with Administrator, Director of Nursing, Medical Director, Company President, Chief Nursing Officer, Regional Plant Operations Director and Interdisciplinary team to review incident and investigation.</li> <li>- On 11/09/24, 8 Clinical Nursing Staff on 7 AM-3 PM shift, 6 Clinical Nursing Staff on 3 PM-11 PM shift, and 4 Clinical Nursing staff on 11 PM -7 AM shift provided education regarding the importance of following residents' plan of care of transfer status and where to obtain transfer status from Kardex. Any Clinical Nursing staff member not present received education prior to their shift. Education was continued regarding education of reporting of any allegation of abuse/ neglect/ exploitation, who to report to in facility i.e., abuse coordinator, DON, or supervisor and correlation to failure to provide care as outlined in Plan of Care.</li> <li>- On 11/09/24, an Ad Hoc QAPI meeting attended by Regional Director of Operations, Quality Management Specialist, Nursing Home Administrator and Director of Nursing. Discussion completed to include needed re-education regarding where to find transfer status on the Kardex, ANE continued education review of assignments on 11/8/24, review of current status of lifts/batteries. Review of monthly lift inspections- review of interviews and re-enactments.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>- On 11/09/24, education was continued with staff regarding education of reporting of any allegation of abuse/ neglect/ exploitation, who to report to in facility i.e., abuse coordinator, DON, or supervisor and correlation to failure to provide care as outlined in Plan of Care. 22 additional staff were provided education.</p> <p>- On 11/09/24, Nurse Leadership completed quality monitoring , on all three shifts, to include verbal review and/or return demonstration to ensure following residents' plan of care of transfer status and where to obtain transfer status from Kardex.</p> <p>The facility presented additional information of corrective actions which was verified by the survey team and included the following:</p> <p>-On 11/10/24, audits/observations completed of resident transfers, where to obtain transfer status, how many staff needed to transfer - completed on all three shifts.</p> <p>-On 11/10/24, daily room rounds completed with guardian angel rounds- regarding abuse and neglect, observations made regarding transfers.</p> <p>-On 11/10/24, Ad Hoc QAPI meeting held included review of education completed, and individual phone calls continued regarding mandatory education needed- staff to sign education and post test prior to working.</p> <p>-On 11/11/24, audits/observations completed of resident transfers, where to obtain transfer status, how many staff needed to transfer, completed on all three shifts.</p> <p>-On 11/11/24, daily room rounds completed with guardian angel rounds-completed with guardian angel rounds- regarding abuse and neglect, observations made regarding transfers.</p> <p>-On 11/11/24, Ad Hoc QAPI meeting held-review of education completed, continued individual phone calls continue regarding mandatory education needed- staff to sign education and post test prior to working, discussed need to review Facility Assessment.</p> <p>-On 11/12/24, continued audits/observations completed of resident transfers, where to obtain transfer status, how many staff needed to transfer, completed on all three shifts. Daily room rounds completed with guardian angel rounds- regarding abuse and neglect, observations made regarding transfers.</p> <p>-On 11/12/24, Ad Hoc QAPI meeting held-review of education completed, continued individual phone calls continue regarding mandatory education needed- staff to sign education and post test prior to working.</p> <p>-On 11/13/24, Ad Hoc QAPI meeting held-review of education completed, continued individual phone calls continue regarding mandatory education needed- staff to sign education and post test prior to working.</p> <p>-Daily room rounds completed with guardian angel rounds- regarding abuse and neglect, observations made regarding transfers, continued through 11/19/24.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-On 11/19/24, 100% of Nursing staff was trained regarding resident transfer status, where to obtain information on the Kardex, and regarding Abuse and Neglect to include post test- (1 employee out of the country and 1 on family medical leave).</p> <p>-On 11/20/24, monthly QAPI meeting held-Facility Assessment reviewed, education, audits, post test reviewed- IDT has determined compliance. DON/designee will continue to complete random audits/observations of resident transfers to evaluate ongoing compliance. DON/designee will continue to complete random audits/interviews of staff to validate staff can articulate abuse/neglect reporting process. These findings will be submitted to the Quality Assurance/Performance Improvement until determined by QAPI members to no longer be needed.</p> <p>Review of the in-service attendance sheets noted staff participated in education on the topics listed above and confirmed by interview with staff on 12/02/24 through 12/04/24. Interviews were conducted with 12 staff members across different shifts including 7 licensed nurses, and 5 CNAs who verbalized their understanding of the education provided.</p> <p>The resident sample was expanded to include five additional residents identified as requiring a mechanical lift for transfers. Observations, interviews, and record reviews revealed no concerns related to for residents #2, #3, #4, #5, and #6.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51023</p> <p>Based on interview, and record review, the facility failed to provide adequate supervision and a safe environment to prevent accidents for 1 of 6 residents reviewed for transfers with a mechanical lift, out of a total sample of 6 residents, (#1).</p> <p>On 11/07/24 at approximately 9:00 AM, the facility failed to prevent serious injury of a physically impaired resident during a transfer from bed to wheelchair. Two CNAs failed to follow resident #1's care plan which required the resident to be transferred using a mechanical lift with assistance of two staff. The two CNAs transferred the resident from his bed by manually lifting the resident and pivoting him to the wheelchair. The resident complained of extreme pain to his right leg shortly after the transfer. An X-ray of resident #1's leg indicated a right distal femur fracture. The resident was transferred to the hospital, and it was determined he was not a candidate for needed surgery due to his advanced age. The resident was prescribed pain medications, and a leg brace with follow up orthopedic appointments. The facility failed to ensure nursing staff followed resident #1's plan of care for safe transfers.</p> <p>The failure to ensure staff transferred residents according to their transfer status and care plan contributed to the injury, and subsequent disability and pain of resident #1 and placed him and all other residents who needed mechanical lifts for transfer at risk for serious impairment, and/or death. This failure resulted in Immediate Jeopardy starting on 11/07/24. The Immediate Jeopardy was determined to be removed on 11/09/24 after verification of the immediate actions implemented by the facility. The Immediate Jeopardy was determined to be past noncompliance as of 11/21/24 after verification of the facility's corrective actions.</p> <p>Findings:</p> <p>Cross reference F600</p> <p>Resident #1 was admitted to the facility on [DATE], with diagnoses that included Alzheimer's disease, chronic lung disease, depression, dementia, heart failure and adult failure to thrive.</p> <p>Review of resident #1's care plan with revision date 11/20/24 revealed a focus of activities of daily living self-care. The resident had an intervention for use of a mechanical lift with assistance of two staff for transfers initiated on 11/01/21.</p> <p>Review of resident Quarterly Minimum Data Set assessment dated [DATE] revealed the resident has a Brief Interview for Mental Status score of 15/15 indicating he was cognitively intact. The mobility section revealed that the resident had bilateral lower extremity impairment and was dependent on staff for all care. The assessment noted that due to his medical conditions and/or safety concerns resident sit to stand, perform a transfer to the toilet or walk 10 feet was not attempted.</p> <p>Review of resident #1's lift and transfer assessment dated [DATE] determined the resident required a two-person transfer using a mechanical lift. The assessment determined resident #1 was non-weight bearing.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 12/02/24 at 2:57 PM, Certified Nursing Assistant (CNA) C explained on 11/07/24 when she went to transport resident #1 in his wheelchair to the front lobby to escort him to a medical appointment, she noticed he was sweating. The CNA indicated she informed his assigned Registered Nurse (RN) E who assessed him and gave him some medication before his appointment. The CNA described once she and resident #1 were in the transport van, he complained that his right leg hurt and asked if it could be repositioned. She recalled resident #1 pointed towards his knee and said, Those girls roughed me up and my leg is hurting really bad. Once they arrived at the appointment, around 11:15 AM, CNA C called the facility and asked to speak with the East Wing Unit Manager (UM) and reported what resident #1 had told her. The UM told her not to move resident #1's leg anymore because he needed to be evaluated once he came back to the facility. The CNA remembered resident #1 continued to complain of pain while at the appointment and on the way back. She explained resident #1 told her that the CNAs sat him up in bed, put the sling pad on the wheelchair, then threw him into the wheelchair instead of using the mechanical lift. He told her they were rough with him. She said she reported the allegations to the UM.</p> <p>A witness statement from CNA A dated 11/07/24 revealed that on the morning of 11/07/24 at approximately 8:30 AM, resident #1 was assisted by CNA A to get ready for his urology appointment with a pick up time of 9:30 AM. CNA A noted that around 9:00 AM she asked RN E how resident #1 transferred. RN E told her she was not sure and for her to ask a different CNA. CNA A indicated she asked CNA D how the resident transferred and was told that he needed a mechanical lift. CNA A documented she could not find a mechanical lift and asked CNA B to instead transfer the resident into his wheelchair manually as a two person assist without the use of the mechanical lift since, he wasn't that big.' CNA A said she placed the lift pad onto resident #1's wheelchair then they positioned the wheelchair close to the bed. The CNAs then positioned the resident to a sitting position on the side of the bed. CNA A said she and CNA B stood on either side of the resident and grabbed underneath his arms and the back of his pants then pivoted the resident and seated him in his wheelchair.</p> <p>On 12/02/24 at 2:10 PM, in a telephone interview, CNA A recalled she was told by the nurse resident #1 had to be up for a medical appointment about 30 minutes prior to his pick up time. She explained she did not look in the CNA Kardex to check how resident #1 was supposed to transfer before she actually transferred him, but said she instead asked another CNA who told her he needed a mechanical lift to transfer. She said she asked the other CNA to assist her to get resident #1 up without the lift because she, wanted to hurry up and get him in the chair. CNA A recalled she had cared for resident #1 in the past but had never had to transfer him previously, and said she knew how to check the transfer status on the Kardex but did not do that as she only ever used it for documenting.</p> <p>On 12/03/24 at 11:08 AM, the Director of Rehabilitation revealed that on 9/10/24 resident #1 was evaluated by therapy and it was determined he needed a mechanical lift for transfers due to the resident's physical ability, choice, and safety concerns. The Director of Rehabilitation said typically, a resident who had physical limitation and refused to get out of bed or sit up to the edge of bed would be a candidate for mechanical lift as opposed to physical assistance from two staff.</p> <p>The timeline provided by the facility indicated resident #1 returned from his appointment at 12:00 PM on 11/07/24 and was assisted into his bed by mechanical lift.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 12/04/24 at 9:40 AM, the Medical Director revealed he was notified of the incident soon after it occurred. He said that resident #1 was assessed after his return to the facility. The Medical Director recalled resident #1's right leg noted to be edematous and painful to the touch, so he ordered a STAT X-ray of the right hip and knee as well as the muscle relaxed medication. He said interventions in the care plans were to help the residents achieve their best level of health. He explained that in order for that to happen the interventions and care plans needed to be followed by staff.</p> <p>The Medication Administration Record for November 2024 indicated resident #1 received Tylenol 650 milligrams (mg) at 12:16 PM on 11/07/24, which was noted to be effective. A progress note dated 11/07/24 revealed the X-ray of the right hip and knee was completed and per the Medical Director he reviewed the results and ordered for the resident to be sent to the emergency room for evaluation at 7:15 PM. Resident #1 returned to the facility from the hospital on 11/08/24 at 1:45 AM, with a diagnosis of an acute impacted distal femur centered in the meta-diaphyseal area and osteopenia. He also returned with new orders for a knee immobilizer and to follow up with orthopedics on 11/08/24.</p> <p>An orthopedic consult from 11/08/24 revealed it was decided by the Orthopedist that resident #1 would undergo conservative treatment due to the fact that the fracture was not complete and due to his advanced aged. A knee immobilizer was ordered to protect the area as well as orders for him to be completely non-weight bearing on the right leg. The consultation indicated the right leg needed to be extremely carefully supported when transported and a follow up X-ray and consult was requested.</p> <p>On 12/03/24 at 1:13 PM, the Risk Manager reviewed the facility's timeline of events for the day of the incident, 11/07/24. She revealed she was informed by the Director Of Nursing (DON) on 11/07/24 at around 11:30 AM that resident #1 had complained of pain to his leg and they suspected it was an injury because the CNAs did not use the Hoyer lift for the transfer as he was care planned. The Risk Manager explained at the time of the incident there were five mechanical lifts and 2 sit to stand lifts in working condition at the facility that were being used daily. The Risk Manager said that the resident was interviewed, and his story correlated with what the CNAs reported. She explained she was notified around 6:00 PM on 11/07/24 that the X-ray showed the resident had sustained an injury to his right leg. She said the Medical Director was notified of the findings, and an order was given to send him to the hospital. She stated that after the incident the staff members involved in the incident were immediately removed from their assignments to prevent injury to other residents. Then the investigation started which included interviewing the staff involved, the resident, and other witnesses as well as notifying law enforcement and senior care services. She said they accepted the case and came to the facility on [DATE]. She explained law enforcement concluded there were no criminal charges for the CNAs. The Risk Manager confirmed the root cause for the incident was that the CNA made a bad decision even though she had the tools and means to give the right care, but chose not to do the right thing when not following the care plan for the transfer of resident #1.</p> <p>The facility's policy titled, Positioning and Moving with most current revision of 1/05/23 revealed that the purpose of the procedure was to help lift residents using a manual lifting device. The policy described that the facility used appropriate techniques and devices to lift and move residents in order to protect the safety and well-being of staff and residents, and to promote quality care. The document indicated that in order to prepare for a transfer staff were required to review the resident's care plan to assess for any special needs of the resident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106024	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/04/2024
NAME OF PROVIDER OR SUPPLIER  Solaris Healthcare College Park		STREET ADDRESS, CITY, STATE, ZIP CODE  730 Courtland Street Orlando, FL 32804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the Facility Assessment Policy dated 9/18/17 revealed that the purpose of the assessment was to determine what resources were necessary to care for residents competently during both day-to-day operations and emergencies. The Facility Assessment assessed and updated on 8/04/24 and 11/14/24 revealed that they offered services and care for those individuals with mobility issues and history of falls. The facility assessment described a specialization for fall with injury prevention which included transfers. The assessment described that facility staff received training on topics including transfers, and using mechanical lifts.</p> <p>The Immediate Jeopardy removal plan was verified by the survey team and included the following:</p> <ul style="list-style-type: none"> <li>- On 11/07/24, resident #1 was immediately assessed, X-ray completed and pain medication given. He was sent to emergency room .</li> <li>- On 11/07/24, CNAs A and B were removed from service immediately on 11/07/24 and interviewed about the transfer.</li> <li>- On 11/07/24, all residents' POC/Kardex reviewed on 11/07/24 prior to receiving care from Nursing Staff.</li> <li>- On 11/07/24, education of staff begun on all shifts regarding the importance of following residents' plan of care (POC) of transfer status and where to obtain transfer status from Kardex, including post test.</li> <li>- On 11/7/24, a group discussion with CNAs to ask what their barriers may or may not be to following POC and the importance of communicating those barriers immediately to their supervisor</li> <li>- On 11/07/24, all residents were reviewed on 11/07/24 to ensure POC accuracy for transfer</li> <li>- On 11/07/24, interviews were conducted with 9 residents on the CNA's assignment to verify that staff are consistently following care planned transfer status.</li> <li>- On 11/07/24, interviews were conducted with 41 interviewable residents regarding abuse and neglect to determine any other concerns.</li> <li>- On 11/07/24, any staff member not present were educated prior to starting their shift.</li> <li>- On 11/07/24, an Ad Hoc Quality Assurance and Performance Improvement (QAPI) Meeting held and attended by Administrator, Director of Nursing, Medical Director and Interdisciplinary team to review incident and investigation.</li> <li>- On 11/08/24, 13 Clinical Nursing Staff on 7 AM-3 PM shift, 8 Clinical Nursing on 3 PM-11 PM shift, and 5 Clinical Nursing Staff on 11 PM-7 AM shift provided education regarding the importance of following residents' plan of care of transfer status and where to obtain transfer status from Kardex.</li> <li>- On 11/08/24, Nurse Leadership completed quality monitoring on 11/8/24 , on all 3 shifts, to include verbal review and/or return demonstration</li> </ul> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>- On 11/08/24, an Ad Hoc QAPI meeting with Administrator, Director of Nursing, Medical Director, Company President, Chief Nursing Officer, Regional Plant Operations Director and Interdisciplinary team (IDT). Discussion completed to include needed re-education regarding where to find transfer status on the Kardex, review of current status of lifts/batteries. Review of monthly lift inspections- review of interviews and re-enactments. Reviewed plan for the weekend to ensure that staff continue to be educated prior to working. Text blast sent regarding mandatory education needed.</p> <p>- On 11/09/24, 8 Clinical Nursing Staff provided education that included testing and/or return demonstration as well during their shift of 7 AM-3 PM , 6 Clinical Nursing Staff provided education that included testing and/or return demonstration during their shift of 3 PM-11 PM, 4 Clinical Nursing staff provided education that included testing and/or return demonstration during their shift of 11 PM-7 AM regarding the importance of following residents' plan of care of transfer status and where to obtain transfer status from Kardex. Any Clinical Nursing staff member not present received education prior to their shift.</p> <p>- On 11/09/24, an Ad Hoc QAPI meeting attended by Regional Director of Operations, Quality Management Specialist, Nursing Home Administrator and Director of Nursing. Discussion completed to include needed re-education regarding where to find transfer status on the Kardex, education review of assignments on 11/08/24, review of current status of lifts/batteries. Review of monthly lift inspections- review of interviews and re-enactments.</p> <p>- On 11/09/24, Nurse Leadership completed quality monitoring , on all three shifts, to include verbal review and/or return demonstration to ensure following residents' plan of care of transfer status and where to obtain transfer status from Kardex.</p> <p>The facility presented additional information of corrective actions which were verified by the survey team and included the following:</p> <p>-On 11/10/24, audits/observations completed of resident transfers, where to obtain transfer status, how many staff needed to transfer - completed on all three shifts.</p> <p>-On 11/10/24, daily room rounds completed with guardian angel rounds- observations made regarding transfers.</p> <p>-On 11/10/24, Ad Hoc QAPI meeting held included review of education completed, and individual phone calls continued regarding mandatory education needed- staff to sign education and post test prior to working.</p> <p>-On 11/11/24, audits/observations completed of resident transfers, where to obtain transfer status, how many staff needed to transfer, completed on all three shifts.</p> <p>-On 11/11/24, daily room rounds completed with guardian angel rounds- observations made regarding transfers.</p> <p>-On 11/11/24, Ad Hoc QAPI meeting held-review of education completed, continued individual phone calls continue regarding mandatory education needed- staff to sign education and post test prior to working, discussed need to review Facility Assessment.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-On 11/12/24, continued audits/observations completed of resident transfers, where to obtain transfer status, how many staff needed to transfer, completed on all three shifts. Daily room rounds completed with guardian angel rounds- observations made regarding transfers.</p> <p>-On 11/12/24, Ad Hoc QAPI meeting held-review of education completed, continued individual phone calls continue regarding mandatory education needed- staff to sign education and post test prior to working.</p> <p>-On 11/13/24, Ad Hoc QAPI meeting held-review of education completed, continued individual phone calls continue regarding mandatory education needed- staff to sign education and post test prior to working.</p> <p>-Daily room rounds completed with guardian angel rounds- observations made regarding transfers continued through 11/19/24.</p> <p>-On 11/19/24, 100% of Nursing staff was trained regarding resident transfer status, where to obtain information on the Kardex- (1 employee out of the country and 1 on family medical leave).</p> <p>-On 11/20/24, Monthly QAPI meeting held-Facility Assessment reviewed, education, audits, post test reviewed- IDT has determined compliance. DON/designee will continue to complete random audits/observations of resident transfers to evaluate ongoing compliance- These findings will be submitted to the Quality Assurance/Performance Improvement until determined by QAPI members to no longer be needed.</p> <p>Review of the in-service attendance sheets noted staff participated in education on the topics listed above and confirmed by interview with staff on 12/02/24 through 12/04/24. Interviews were conducted with 12 staff members across different shifts including 7 licensed nurses, and 5 CNAs who verbalized their understanding of the education provided.</p> <p>The resident sample was expanded to include five additional residents identified as requiring a mechanical lift for transfers. Observations, interviews, and record reviews revealed no concerns related to for residents #2, #3, #4, #5, and #6.</p>		