| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 106024 | A. Building<br>B. Wing | 07/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Solaris Healthcare College Park | 730 Courtland Street<br>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) |
|---|---|
| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>(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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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to follow its grievance process for 1 of 3 residents reviewed for grievances, of a total sample of 12 residents, (#9).Findings:Review of resident #9's medical record revealed she was originally admitted to the facility on [DATE] and readmitted from an acute care hospital on 7/17/25. Her diagnoses included end- stage renal disease, dependence on renal dialysis, congestive heart failure, chronic obstructive pulmonary disease, and type 2 diabetes.Review of the Minimum Data Set quarterly assessment dated [DATE] revealed resident #9's Brief Interview for Mental Status score of 15 out of 15 indicating intact cognition.Review of a Change in Condition Evaluation dated 7/09/25 revealed resident #9 was hypoxic (low oxygen level). The form documented resident #7's oxygen saturation (SpO2) at 68% on 5 liters per minute (lpm) of oxygen. The nurse documented oxygen delivery rate was decreased to 2 lpm, but resident #9's SpO2 dropped to 43%. The document noted the resident was unable to answer questions appropriately, appeared weak and was found soiled. The form read, 911 was called. Patient was sent out to the hospital. Physician notified. Family member (son) notified. Normal blood oxygen levels are 95-100%, low levels of oxygen saturation (hypoxemia) are cause for concern, (retrieved on 8/06/25 from www.healthline.com). Review of the Grievance Log for July 2025 revealed a grievance was filed by resident #9's son on 7/10/25. The Grievance Form documented the Social Services Director (SSD) received the grievance. The Details of Grievance section read, Please see the attached email from the patient's son [name], regarding his concerns. Review of resident #9's son email dated 7/10/25 sent to the SSD, former Director of Nursing (DON), and the Unit Manager (UM) read in part, I am writing to express serious concerns regarding the management of [resident #9's name]'s acute medical crisis that occurred overnight on July 8 into the early morning of July 9. Specifically, we are alarmed by the apparent breakdown in medical protocols and the lack of communication between staff during this critical period. On the morning of July 9, we received a call from a staff member who identified herself as [resident #9's name] daytime nurse. She reported finding [resident #9's name] in respiratory distress and hypoxic on 5L (liters) oxygen via nasal cannula. When asked for details about the events overnight that led to this change from her baseline of room air, the nurse was unable to provide any information. She repeatedly stated that no handoff had been given by the overnight nurse and that she was focused solely on managing the patient's acute condition and arranging hospital transfer. While we appreciate the day nurse's prompt decision to escalate care and transfer [resident #9's name] to the emergency department, we are left with significant concerns regarding the quality and timeliness of her overnight care - specifically, whether appropriate interventions were initiated in a timely manner and if the transfer was unduly delayed. To date, no one from your facility has reached out to provide clarity of reassurance about this incident. On 7/22/25 at 12:04 PM, the SSD shared she was the Grievance Officer. She explained the grievance process included ensuring grievances were investigated and addressed within five days. She reported when she received a grievance, she determined whether interviews with a resident or family were needed for clarification and assigned to the appropriate department for investigation and resolution. She stated she ensured it was thoroughly investigated and resolved. She indicated all grievances were discussed in morning meetings. The SSD confirmed resident #9's grievance would have been discussed during the morning meeting on 7/11/25. The SSD stated the former DON was not present during that meeting, but the Assistant DON and the UM were. On 7/22/25 at 12:18 PM, the Social Services Assistant and the Administrator (NHA) presented resident #9's grievance form and the attached email from the resident's son. The NHA stated the SSD forwarded the email from resident #9's son to the former DON and NHA on 7/10/25. The NHA first stated both DON and NHA were on vacation at the time the email was sent, then last week, they were both separated from employment at the facility. The NHA shared that this concern was brought to her yesterday, and she contacted the son. The NHA stated the UM wanted clarification from the former DON but had received no response, when asked why the UM did not address the grievance herself in a timely manner. On 7/23/25 at 10:26 AM, during a telephone interview, Registered Nurse (RN) B stated resident #9 had dialysis on Monday, Wednesday and Friday and was usually gone by the time she came in to work those days at 7:00 AM. RN B indicated on Wednesday 7/09/25, she came in approximately 10 to 15 minutes late to work, and she did not receive a complete report from the prior shift. She shared she began her rounds and upon entering resident #9's room, her CNA informed her resident #9 was in distress. She stated she assessed resident #9 and called 911. She indicated when she called resident |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to accurately report allegations of neglect to the Agency for Health Care Administration (AHCA) and conduct a thorough investigation for 2 of 3 residents, of a total sample of 12 residents, (#7 and #8).Findings:1. Review of resident #7's medical record revealed he was originally admitted to the facility on [DATE] and readmitted from an acute care hospital on 4/07/25. Resident #7's diagnoses included hemiplegia (one-sided paralysis) and hemiparesis (one-sided weakness) following a stroke affecting his left non-dominant side, contracture of the left knee, and muscle weakness. Review of the Minimum Data Set (MDS) significant change in status assessment dated [DATE] revealed resident #7's Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated moderate cognitive impairment. The assessment revealed he was dependent on staff for all Activities of Daily Living (ADLs) except for eating, and dependent on staff for mobility and transfers. The MDS indicated resident #7 had a functional range of motion impairment on one side of an upper and lower extremity. The MDS assessment showed he was always incontinent of bladder and bowel. Review of resident #7's care plan for ADL self-care performance deficit related to hemiplegia, limited mobility, wounds, left knee contracture, memory deficit, and muscle weakness was initiated on 12/09/24 and revised on 7/13/25. The care plan noted resident #7 required one-person assistance for dressing, personal hygiene, and toilet hygiene. An intervention of bed mobility indicated the resident was totally dependent on two-person assistance for repositioning and turning in bed. Review of a Change in Condition Evaluation dated 3/24/25 revealed resident #7 was observed on the floor and sent to the emergency room (ER) for treatment and evaluation. The form noted resident #7 was alert with confusion. Review of a progress noted dated 3/24/25 revealed resident #7's assigned nurse was passing medications when he heard the resident yelling that he hit his head. The note described the nurse entered the resident's room at 8:10 PM and saw resident #7 on the right side of his bed on the floor. The progress note included resident #7 was near the air conditioner unit by the window with his head underneath the chair located next to his bed. The nurse documented resident #7 stated he hit his head on the floor, the resident was not moved, he was dry, and the call light was clipped to his bed. The note included the nurse asked resident #7 how he ended up on the side of the bed and the resident responded he had a stroke six months ago and could not really think straight but the sheets made me slip. The nurse's note revealed resident #7 had an abrasion to the right side of his head and was sent to the ER. Review of resident #7's care plan for risk for falls related to deconditioning, gait/balance problems, incontinence, psychoactive drug use, and vision was initiated on 12/09/24. An intervention for a concave pressure-reducing foam mattress was added on 3/26/25. Review of a Change in Condition Evaluation dated 6/25/25 revealed resident #7 fell from his bed, was observed on the floor, and blood was noted as coming from his forehead. He was sent to the ER. Review of a progress note dated 6/25/25 revealed, Resident's CNA (Certified Nursing Assistant) stated to the writer of this note that while changing the resident he turned back on his left side and rolled off the bed. CNA was positioned on the left side of the bed close to the bed B window. While resident was noted on the R.T (right) side of the bed on the floor which is close to the room door. CNA yelled for the nurse to attend to the resident. Resident appeared to have an abrasion or cut noted on his forehead. The writer of this note went to the treatment cart and retrieved an ABD (abdominal) pad to place over the abrasion while 911 was being called. Resident was not moved until 911 arrived at the building. He was placed on the stretcher and taken to [name of hospital]. Resident is out [of] the building at this time. Review of the Five-day Nursing Home Federal Report submitted to AHCA on 6/29/25 revealed an alleged neglect incident for resident #7 on 6/25/25 at 12:40 AM. The AHCA report was completed by the Risk Manager. The report noted resident #7's assigned CNA reported that while changing the resident he turned back on his left side and rolled off the bed. CNA was positioned on the left side of the bed close to the bed B window. CNA yelled for the nurse to attend to the resident. Resident appeared to have an abrasion or cut noted on his forehead. The report included Interviews were completed with alert and oriented residents on that assignment- all of whom expressed satisfaction with the care and the facility. Skin assessments completed with the non interviewable [residents] - no new findings identified. The conclusion read, After a thorough investigation was concluded, but not limited to staff and resident interviews, chart reviews, the facility finds no physical abuse occurred. The findings were not verified. On 7/23/25 at 4:06 PM, the Risk Manager (RM) explained she was responsible for initiating investigations, gathering statements, reporting findings to superiors, contacting the |