

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: 106130	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Orlando Health Center for Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 Hempel Avenue 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on interview, and record review, the facility failed to report an allegation of neglect to the State Agency, (#1) and failed to report timely an allegation of neglect, (#3), for 2 of 2 residents reviewed for abuse, of a total sample of 7 residents. Findings: 1. Review of resident #1's medical record revealed she was admitted to the facility on [DATE] and readmitted on [DATE] from an acute care hospital. She had diagnoses of dementia, fracture of neck of left femur, wedge compression fracture of the first lumbar vertebra, unsteadiness in her feet, and aftercare joint replacement surgery. Review of resident #1's Minimum Data Set (MDS) quarterly assessment with Assessment Reference Date (ARD) of 2/28/24 revealed a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated she was cognitively impaired. The MDS assessment noted no rejection of evaluation or care necessary to obtain goals for her health and well-being. The MDS showed resident #1 required supervision or touching assistance to roll left and right, sit to lying, and lying to sitting on side of bed. She required partial/moderate assistance for chair/bed-to-chair transfer and toilet transfer. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Agency for Health Care Administration (AHCA) Nursing Home Adverse Incident Report submitted on 12/01/23 revealed the following information: resident #1 was observed sitting on the floor in the dining area on 11/18/23 at approximately 5:30 PM and was assisted up by two Certified Nursing Assistants (CNAs). The report noted the assigned nurse was close by and witnessed staff assist the resident. The CNAs and the nurse acknowledged the event as the resident's common behavior with no follow up documentation or assessment done by the assigned nurse. At approximately 9:00 PM on the same day, resident #1's assigned CNA went to check on her and found her lying on her left side on the floor in her room. The report indicated the nurse was notified and resident #1 was assisted back to bed by two CNAs. The nurse and CNAs didn't think the resident fell but purposely laid on the floor, and viewed the incident as the resident's known behavior. No follow-up documentation was found in the resident's medical record. Incidents were not reported during the change of shift at 11:00 PM to the following shift. At approximately 4:00 AM on 11/19/23 during care, resident #1, Was making sounds like pain, but the CNA was unsure because resident #1 had similar known behaviors when she wanted to be left alone. On 11/19/23 at approximately 12:00 PM, the CNA notified the nurse resident #1 was crying out when she attempted to assist her with care. The nurse evaluated the resident and observed a yellowish discoloration to her left hip. She noted resident #1 had pain and notified the physician. An x-ray of the left knee, hip and femur were ordered, and the results revealed she suffered a fracture of the left femur. The resident was transferred to the hospital and underwent left hip replacement surgery. The Analysis of the Incident Section listed: Failure to follow the protocol for falls, resulted in inadequate assessment of resident; lack of appropriate interventions that could have minimized the risk of fall with major injury; failure to follow protocol for change of condition, resulted in not notifying the physician for orders and competency regarding documentation. On 5/02/24 at 5:05 PM, the Risk Manager explained the nurse's statement indicated the resident's gait was off and the resident was found again on the floor but there was no subsequent documentation or follow up in the medical record. The Risk Manager stated the nurse did not follow the fall protocol. The Administrator and Risk Manager explained the incident was an unwitnessed fall which they did not consider neglect even though the nurse did not follow the proper fall protocol including assessment, notification, and documentation. 2. Review of resident #3's medical record revealed he was admitted to the facility on [DATE] with diagnoses including syncope and collapse, dementia, type 2 diabetes, and fall. Review of resident #3's MDS quarterly assessment with ARD of 11/01/23 revealed a BIMS score of 99, which indicated he was unable to complete the interview. Review of the medical record revealed resident #1 had a care plan for elopement risk/wanderer related to history of attempts to leave the facility unattended, and impaired safety awareness initiated on 5/19/23. The goal was the resident's safety would be maintained. Resident #3 also had a care plan for risk for falls and injuries from falls related to unsteadiness at times, impaired cognition, history of syncope and collapse initiated on 5/10/23. Review of AHCA's Nursing Homes Federal Reporting submitted on 11/29/23 revealed an allegation of neglect related to resident #3 occurred on 11/27/23 at 9:30 AM. The report indicated resident #3 was sent to a medical appointment via transport without an escort. The Department of Children and Families (DCF) was notified on 11/29/23. The Administrator and Director of Nursing (DON) reported it was standard practice to send an escort with the resident to appointments unless family or guardian was in attendance. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/02/24 at approximately 5:30 PM, the Administrator explained he was contacted by the former DON at approximately 6:40 PM on 11/27/23, and told resident #3 had not returned from his cardiac appointment that the morning. The Administrator stated he went to the doctor's office and found resident #3 at approximately 7:15 PM sitting in the main lobby by himself. He stated he spoke with the physician's office the following day and learned the appointment was supposed to be a telehealth visit. He explained when resident #3 arrived at the appointment, they tried to accommodate him for a later appointment time. He indicated transport came to pick him up, but he was not ready since he was still waiting to be seen by the physician. He stated transport arrived a second time, but the resident was being seen at the time by the provider and they left. He explained after resident #3 was seen by the physician, the physician's office tried to call the facility to inform them resident #3 was ready for pick up but the face sheet used at the time had only the facility name, not their address or phone number. He stated the physician's office searched the facility online but called a different facility with a similar name and were told there was no one by resident #3's name. The Administrator acknowledged resident #3 spent over 9 hours without supervision, food, or medications until he was picked up and could have gotten lost or into an accident. Later at 6:56 PM, the Administrator stated he could not say why the facility did not file a report with AHCA within 24 hours as required. On 5/02/24 at approximately 5:40 PM, the Risk Manager stated she was unable to determine when the immediate report to AHCA was filed. Later at 6:58 PM, she stated she could not recall why the facility did not report timely. On 5/02/24 at 6:48 PM, the DON stated she was the Abuse Coordinator but was not working in the facility when resident #3's incident occurred. She explained an allegation of abuse must be reported within 2 hours to AHCA, DCF and law enforcement. She stated an allegation of neglect without injury was to be reported within 24 hours. The DON stated neglect was the failure to provide goods and services needed for the safety and well-being of a resident. Review of the facility Abuse Prevention Program policy and procedure not dated read, All reports of resident abuse, neglect exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. The procedure included notification to the designated agencies in accordance with state law. It read, All alleged violations involving abuse, neglect exploitation or mistreatment, including and/or injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse that result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (Including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. The policy mentioned the Administrator had the overall responsibility for the coordination and implementation of the facility's abuse prevention program policies and procedures.		