STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105783	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solaris Healthcare East Orlando	250 South Chickasaw Trail Orlando, FL 32825

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on interview and record review, the facility failed to notify emergency contacts of changes in condition for 2 of 4 residents reviewed for falls, of a total sample of 5 residents, (#1 and #4). Findings: 1. Review of the medical record revealed resident #1, an [AGE] year-old female, was admitted to the facility on [DATE] with diagnoses including right side sciatica, osteoarthritis, difficulty walking, and generalized muscle weakness. The Admission Record or face sheet contained essential information including resident #1's selected emergency contacts with their associated telephone numbers. The document listed the resident's husband as emergency contact #1 and her daughter was emergency contact #2. Review of the hospital to facility transfer form, dated 5/16/24, revealed resident #1's emergency contact was her husband and his telephone number was the same number transcribed to the facility's Admission Record. Review of the Minimum Data Set (MDS) Admission assessment with assessment reference date (ARD) of 5/22/24 revealed resident #1 had a Brief Interview for Mental Status (BIMS) score of 12 which showed she had moderate cognitive impairment. The MDS assessment indicated resident #1 felt it was very important to have her family involved in discussions regarding her care. The document revealed the resident, her significant other, and her family were active participants in the assessment process. Review of a Nurses Note dated 6/15/24 at 7:50 PM, revealed the Weekend Registered Nurse (RN) Nursing Supervisor conducted a post-fall assessment for resident #1. The note indicated the resident's husband was notified of the fall incident. A Nurses Note dated 6/15/24 at 10:50 PM, revealed the Weekend RN Nursing Supervisor received an order from the physician for x-rays of resident #1's bilateral hips and pelvis. The medical record did not show resident #1's emergency contacts were notified of the new physician order. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/23/24 at 1:22 PM, in a telephone interview, resident #1's daughter stated the facility did not notify the family of her mother's fall on 6/15/24. She explained the resident's husband, emergency contact #1, was made aware of the incident when he visited the facility the following morning, approximately 15 hours after the fall. The resident's daughter stated she informed the facility that nobody called them, and she verified the facility's emergency contact information was correct. She stated she checked family phone records and neither emergency contact received a phone call at the time of the fall or during the overnight shift. Review of the family's phone records from 6/15/24 to 6/16/24 revealed no incoming telephone calls for resident #1's husband and daughter at the time the Weekend Nursing Supervisor indicated she notified the husband, or after she received a new physician order for diagnostic testing. The document showed there were no incoming calls to the resident's emergency contacts during the 7:00 PM to 7:00 AM shift. On 9/23/24 at 2:21 PM, in a telephone interview, the Weekend RN Nursing Supervisor confirmed the facility's protocol was to notify the family after a fall. She explained if she was unable to speak to the family, she would leave a voicemail and inform the nurse on the next shift to follow up. The Weekend RN Nursing Supervisor acknowledged she wrote that she notified the resident's husband but she could not recall details of the conversation. However, she stated she remembered resident #1 had a cell phone and she had verbalized she wanted to call her husband. On 9/24/24 at 10:55 AM, the Administrator, Director of Nursing (DON), and the Director of Quality Management were informed resident #1's family provided phone records that showed they were not notified of her fall. The Administrator reviewed the resident's face sheet and explained there was a home telephone number listed and the nurse might have called that number. The Administrator explained she called the home phone number once and left a message on the answering machine. When informed the home telephone number was listed as a previous phone number, and not an emergency contact number, the Administrator maintained she felt it was appropriate and acceptable to utilize a number provided for resident #1's home. The Director of Quality Management interjected that when the nurses pulled up a resident's information on the electronic medical record, they did not see a printed face sheet with previous addresses and phone numbers. She retrieved resident #1's medical record and validated the spouse and daughter were listed as emergency contacts. The Director of Quality Management stated her expectation was after a fall incident, nurses would call the emergency contacts in the order noted in the medical record. She explained if the resident's first emergency contact was not available, the nurse should attempt to notify the second contact. On 9/24/24 at 11:40 AM, the Admissions Coordinator stated the facility always received residents' emergency contact information with the referral from the hospital, prior to admission. She stated to her knowledge, emergency contacts would be called in the order selected by the resident. She said, We start calling the numbers from the top down. Number 1, then number 2, as many as they have listed. 2. Review of the medical record revealed resident #4, a [AGE] year-old male, was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included fractures of the right humerus and left radius, right hip osteoarthritis, chronic gout, and generalized muscle weakness. The Admission Record or face sheet contained essential information including resident #4's selected emergency contacts with their associated telephone numbers. The document listed the resident's nephews as emergency contacts #1 and #2. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the hospital to facility transfer form, dated 7/31/24, revealed resident #4's emergency contacts were his nephews, whose telephone numbers were transcribed accurately onto the facility's Admission Record. Review of the MDS Admission assessment with ARD of 7/18/24 revealed resident #4 had a BIMS score of 15 which indicated he was cognitively intact. The MDS assessment showed resident #4 felt it was very important to have his family involved in discussions regarding his care. The document revealed the resident was an active participant in the assessment process. Review of a Nurses Note dated 9/22/24 at 5:00 PM revealed resident #4 lost his balance as he walked in his room and fell to the floor. A Change in Condition Evaluation note dated 9/22/24 revealed resident #4's assigned nurse, the Sea Breeze unit's Licensed Practical Nurse (LPN) Unit Manager (UM) documented she notified the resident's physician and his nephew, emergency contact #1, of the fall. The document indicated she notified the resident's nephew on 9/22/24 at 6:00 PM. On 9/23/24 at 10:34 AM, the Sea Breeze LPN UM confirmed resident #4 fell on Sunday, 9/22/24. She explained even though he was not injured, notification of the physician and chosen emergency contact was required. On 9/23/24 at 1:03 PM, in a telephone interview, resident #4's nephew confirmed he was his uncle's health care surrogate and first emergency contact in the event of an accident. He stated he was made aware that his uncle fell yesterday when the facility called this morning, between 8:00 AM and 10:00 AM. He verified he had no voicemail messages from the facility yesterday. On 9/23/24 at 1:36 PM, the DON was informed although resident #4's Change in Condition Evaluation form indicated the Sea Breeze LPN UM notified his nephew of the fall on 9/22/24 at 6:00 PM, the nephew stated he was not notified until the following morning, approximately 14 hours after the incident. On 9/23/24 at 1:41 PM, the Sea Breeze LPN UM explained she called resident #4's nephew yesterday, but he did not answer. She confirmed she did not attempt to call the other listed emergency contact. When asked if she left a voicemail, the LPN UM said, I did not leave a voicemail. I don't know why I didn't leave a voicemail. I don't have an answer. I just don't know. She acknowledged proper notification was therefore not made at the time of the fall. The LPN UM stated her expectation as a UM was nurses would attempt to notify the first emergency contact, and if there was no response, then contact the second person listed. She explained if nurses were unable to contact the family, that information should be documented in the medical record. On 9/23/24 at 1:44 PM, the DON validated the Sea Breeze LPN UM should have left a voicemail message for the nephew since he was emergency contact #1. She indicated the LPN UM could have told the oncoming night shift nurse to attempt notification again. Review of the facility's policy and procedures for Change in a Resident's Condition or Status, revised on 1/25/23, revealed the facility would promptly notify the resident, the attending physician, and the representative of changes in the resident's medical condition or status. The policy indicated the Nursing Supervisor would notify the resident's family or representative when the resident was involved in an accident or incident that resulted in injury.