

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105307	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER Parkview Rehabilitation Center at Winter Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2075 Loch Lomond Drive Winter Park, FL 32792	
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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50875 Based on observation, interview, and record review, the facility failed to provide intravenous (IV) care and services according to standards of practice and the plan of care for 1 of 1 residents reviewed for IV care, of a total sample of 40 residents, (#510). Findings: Resident #510 was readmitted to the facility on [DATE] from an acute care hospital with diagnoses of acute respiratory failure, pleural effusion, pneumonia, and multiple sclerosis. Review of hospital records from her admission on 1/25/25 revealed she had a midline (IV) line in her right upper arm for administration of IV antibiotics. Resident #510's physician orders indicated she received two grams (gm) Ceftriaxone sodium solution daily beginning on 1/27/25 that was to continue until 2/21/25. A midline catheter is put into a vein by the bend in the elbow or the upper arm .midline catheter may allow you to receive long-term intravenous medicine or treatments, (retrieved on 2/14/25 from www.drugs.com). On 2/03/25 at 10:31 AM, resident #510 was alert and oriented, sitting up in her bed. She had a midline IV with a transparent dressing on her right upper arm. The dressing was dated 1/25/25 and the resident explained she got the IV when she was recently hospitalized . The Registered Nurse (RN) A was outside of the resident's room at that time. She entered the room and explained she was the Evening Supervisor. She confirmed the date on resident #510's midline IV dressing and acknowledged the dressing had not been changed in nine days. RN A explained the facility policy was for IV dressings to be changed at least every seven days or more if needed, and confirmed the dressing should have been changed. RN A explained IV dressing changes were important to prevent infection. and said the dressing should be changed immediately. On 2/03/25 at 1:30 PM, resident #510's assigned RN B confirmed that IV dressing changes should be at least every seven days. She acknowledged that resident #510's midline IV dressing should have been changed on 2/01/25 and explained dressing changes were important care in preventing infections and complications in IV lines. (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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #510's medical record revealed no documentation of IV site assessment, nor documentation of midline IV dressing changes from 1/25/25 to 1/31/25 on the Treatment Administration Record. Review of the medical record revealed no physician orders for IV site assessment or midline IV dressing changes. Review of resident #510's care plan revealed a focus for IV therapy related to Pneumonia Infection was initiated on 1/25/25. The care plan did not include interventions to assess the IV site. On 2/05/25 at 1:05 PM, Licensed Practical Nurse (LPN) C said she had worked at the facility for more than twenty years. She explained for residents with IV lines, their IV should be assessed for patency; for signs and symptoms of infection at insertion site; and nurses should change the transparent dressing every seven days and as needed to prevent infection or complications. On 2/05/25 at 3:21 PM, RN D, the Infection Preventionist explained for newly admitted residents with an IV line, nurses had twenty-four hours to change the dressing if needed and enter the appropriate orders for dressing changes every week and as needed. The Infection Preventionist stated the insertion site should be assessed for signs and symptoms of infection every shift. On 2/05/25 at 3:36 PM, the Director of Nursing (DON) explained the facility's protocol regarding IV dressing changes was that the dressing be changed every week, the site monitored for signs and symptoms of infection and that it was the responsibility of the assigned nurse to complete dressing changes. The DON acknowledged resident #510's IV dressing had not been changed as required and said that the expectation was for it to have been changed per protocol to prevent infection. On 2/5/25 at 3:50 PM, the Assistant Director of Nursing (ADON) said, nurses should monitor IVs every day, change the dressing every week and assess to prevent infection. She confirmed resident #510's midline dressing had not been changed per protocol and said, it should have been changed. On 2/6/25 at 10:02 AM, the Nursing Home Administrator stated even though he was not clinical he hoped the facility's protocol for IVs was followed. The facility's Policy and Procedures-Midline Catheter Dressing Change and Infection Prevention and Control Plan, revised on June 2024 indicated Sterile Dressing Change using Transparent dressing is performed upon admission and if transparent dressing is dated clean dry and intact, the admission dressing change may be omitted and scheduled for 7 days from the date on the dressing label. Review of the facility's Infection Control Policy revised June 2024 revealed, An Infection Prevention and Control Program (IPCP) [was] established and maintained to provide a safe sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Section 11-Prevention of Infection part d described, Important facets of infection prevention include instituting measures to avoid complications and educating staff and ensuring that they adhere to proper techniques and procedures.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50401 Based on interview, and record review, the facility failed to assess the resident's condition and monitor and document for complications after dialysis treatments for one of three residents reviewed for dialysis, of a total sample of 40 residents, (#82). Findings: Resident #82 was admitted to the facility on [DATE] with diagnoses that included End Stage Renal Disease with dependence on renal dialysis. Review of the physician order summary for February 2025 revealed an order for hemodialysis on Tuesday, Thursday, and Saturday via a left upper arm fistula. Review of the medical record on 2/05/25 revealed no post-dialysis documentation of nursing Progress Notes from Thursday 1/30/25, Saturday, 2/01/25 or Tuesday, 2/04/25 to indicate post-dialysis nursing care or assessment was completed. On 2/05/25 at 5:37 PM, the Director of Nursing (DON) stated the facility completed the resident information with blood pressure on the top of the Dialysis Communication Form prior to the resident going for dialysis. She explained the dialysis center was supposed to fill out their section of the form but often did not. The DON continued that the staff nurse assessed and monitored the resident's condition when they returned from dialysis. They documented the resident returned then took their blood pressure. She added that the medical records staff checked the resident's Dialysis notebook the following day and followed up with the dialysis center to get any information regarding the resident's dialysis treatment. The DON indicated she or whoever she designated, the Infection Control nurse or the Staff Development Coordinator would also follow up with medical records to ensure they got the information from the dialysis center. The Infection Control nurse was present and acknowledged she had never been involved in the process of ensuring the information from the dialysis center was received. The Regional Nurse stated medical records did not check the resident's dialysis book daily and recommended an interview with the Medical Records Coordinator. On 2/05/25 at 6:05 PM, the Medical Records Coordinator stated last November the facility switched from more frequent record gathering to requesting information from the dialysis center on their resident's dialysis treatment monthly. She added, on Monday, 2/03/25, she requested dialysis records for all the facility residents who received dialysis from December 2024 and January 2025. The Medical Records Coordinator explained there had been a glitch in the system and the facility had not received December's records yet. (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/06/25 at 2:13 PM, in an interview with the DON and the Regional Nurse B, the DON stated she would expect the nurse assigned to the dialysis resident's unit to document at a minimum, the resident returned from dialysis. The Regional Nurse added the DON should expect the resident's nurse to include the resident's vital signs as well and the DON agreed. They confirmed the documentation by the nurse should include if the resident was stable or not. The DON verified resident #82's scheduled days for dialysis were Tuesday, Thursday and Saturdays and confirmed there were no post-dialysis documentation of nursing Progress Notes from the recent dates of Thursday, 1/30/25, Saturday, 2/01/25 or Tuesday, 2/04/25. They acknowledged without the documentation there was no way to know if the resident received dialysis treatments on those days, their status or monitoring of their condition upon their return. The DON and Regional Nurse tried to locate the information in the resident #82's medical record but were unable to locate it. The Regional Nurse phoned the dialysis center to confirm resident #82 had received dialysis treatments on 1/30/25, 2/01/25, and 2/04/25. The DON and Regional Nurse agreed nursing staff needed to document when a resident went to dialysis, returned from dialysis, and that they were monitored for infection, bleeding at the dressing site and vital signs when the resident returned from dialysis. On 2/06/25 at 3:45 PM, the Regional Nurse stated the facility did not have a policy regarding batch orders for residents receiving dialysis treatments. The facility's policy entitled Dialysis dated June 2024 indicated its purpose was to monitor and care for hemodialysis residents in the skilled nursing center, and that the resident was to be monitored for bleeding, post-dialysis treatment. The policy detailed the resident was to be monitored for signs of dyspnea (trouble breathing), rales (crackles or high pitched lung sounds), jugular venous distention (bulging of neck veins) and occasional peripheral edema (swelling of extremities).		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46665 Based on observation, interview, and record review, the facility failed to ensure menu choices were met for 1 of 2 resident reviewed for food, of a total sample of 40 residents, (#99). Findings: Review of the medical record revealed resident #99, a [AGE] year old female was admitted to the facility on [DATE] from an acute care hospital. The resident's diagnoses included chronic heart failure, hypertension, type 2 diabetes mellitus with chronic kidney disease, Alzheimer's Disease, need for assistance with personal care, and moderate protein-calorie malnutrition. The Minimum Data Set Quarterly Assessment with an Assessment Reference Date of 1/08/25 noted during the look-back periods, resident #99 scored 0 out of 15 on the Brief Interview for Mental Status which indicated she was severely cognitively impaired. The assessment showed resident #99 required a therapeutic diet, and staff assistance to complete Activities of Daily Living (ADLs) including eating. The Order Summary Report showed resident #99 had active physician's orders that included, Multivitamins-Minerals once daily for nutritional supplement, protein drinks twice daily, Consistent Carbohydrate (CCHO) diet with fortified foods, fingerstick blood glucose monitoring as needed for diabetes mellitus, and encourage extra liquids to prevent/reduce the risk of infection for rehydration. The Comprehensive Care Plan included focuses for person-centered care, impaired communication and thought processes related to dementia, risk for pressure wounds related to incontinence, diabetes mellitus with a goal to have decreased disease process complications with an intervention to monitor nutritional status and appetite. Other care plans included dependence on staff to complete all activities and ADLs, risk for decreased nutritional status and dehydration related to protein-calorie malnutrition, diabetes mellitus, therapeutic diet, and low body mass index (BMI) with interventions to monitor diet tolerance and intake, supplements, and to provide food preferences and substitutions. On 2/04/25 at 10:42 AM, resident #99's daughter said she completed handwritten menu choice forms a week in advance, but the facility didn't provide what was requested. She explained they often brought sandwiches and cranberry juice that her mother didn't like, and staff just left them on the bedside table. An undated, unwrapped sandwich and a 4-ounce individual cranberry juice was observed on the resident's bedside table. Resident #99's daughter explained she was concerned because her mother didn't eat well, especially if she or her father weren't there for encouragement. She said she gave up asking staff for substitutions, and she brought snacks for her mother from home. The Kardex for Certified Nursing Assistants (CNA) noted staff were to assist resident #99 with meals, encourage fluids, and monitor her diet tolerance. On 2/06/25 at 12:22 PM, CNA I said the facility had cranberry juice and apple juice for residents. She explained resident #99 required staff assistance for her meals and the kitchen had her menu preferences that were provided on the meal tray. (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/06/25 at 11:33 AM, the Certified Dietary Manager (CDM) explained she was newly hired and it was her fourth day on the job. She described the process for providing residents' menu choices was done via a handwritten form, and preferences were entered into the computer system. On 2/06/25 at 12:52 PM, resident #99 was observed sitting in a wheelchair in her room with her daughter. CNA I brought in the resident's lunch tray that included spaghetti covered with marinara tomato sauce. The lunch menu ticket included with the tray dated 2/06/25 read, (Fortified Food) Item(s) not specified, NO PREFERENCES, and a handwritten note that read, no tomato beside the item listed as spaghetti marinara. Resident #99's daughter said she completed menu selections a week in advance with notes. She checked the ticket and said she had written the note for no tomato sauce. Resident #99's daughter explained the resident didn't like any gravy or sauces, but her requests were always ignored. A short time later on 2/06/25 at 1:43 PM, the resident's daughter said she tried to remove the sauce because her mother wouldn't eat the spaghetti and barely ate from the other items on her tray. Two 64-ounce bottles of apple juice and strawberry juice were observed on the resident's dresser. The resident's daughter said she brought them in because staff only gave her mother cranberry juice that she wouldn't drink. The Nutrition Quarterly Note dated 1/03/25 included a plan of care update that read, . BMI : 22.5 indicates underweight . Nutritional interventions in place to promote PO [by mouth] intake . Preferences obtained and honored .will have PO intake greater than 50% at meals . On 2/06/25 at 1:43 PM, the CDM checked resident #99's lunch ticket and confirmed there was an advance request for no tomato/marinara sauce. She said the kitchen could and should have omitted the sauce, and explained the facility kept apple juice on hand. The CDM acknowledged all resident menu choices should be verified and updated to ensure they were honored. She explained she did not have computer access yet and could not verify how the previous CDM managed resident's menu preferences. The CDM stated it was important to provide correct menu choices for residents with items they liked to ensure they ate well. On 2/06/25 at 3:56 PM, the Nursing Home Administrator said the CDM reported to him, and he expected the Dietary Department to meet with residents and/or family representatives to obtain menu choices and update them regularly. He said the facility was working on the process with the new CDM to ensure accuracy. On 2/06/25 at 3:15 PM, Regional Nurse B said the facility did not have a written policy and procedure for how staff obtained resident menu preferences and choices. Review of the Facility assessment dated [DATE] noted all residents' dietary preferences were met daily per diet order and resident preferences.		