STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105518	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winter Garden Rehabilitation and Nursing Center	12751 W Colonial Drive Winter Garden, FL 34787

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to include pressure and surgical wounds as part of Comprehensive Resident Centered Care Plans, for 2 of 3 residents reviewed for wound care, (#1 and #3), of a total sample of 4 residents.Findings:1. Review of the medical record revealed resident #1, a [AGE] year-old female was admitted to the facility on [DATE] from another nursing home and re-admitted from an acute care hospital on [DATE]. The resident's diagnoses included fracture of right femur (hip), dementia, muscle weakness, and pressure ulcer of left lower back. On 11/04/25, the resident was discharged to the hospital for failed surgical repair of the right hip.The most recent Comprehensive admission Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 9/07/25 indicated resident #1 had one unhealed stage 2 pressure ulcer that was present upon admission. The Discharge Return Anticipated MDS Assessment with an ARD of 11/04/25 incorrectly documented the resident had one unhealed stage 2 pressure ulcer that was not present upon admission/entry or reentry during the look-back period.Review of resident #1's most recent Care Plan Report did not include a focus for pressure or surgical wounds.In a joint interview with the Director of Nursing (DON) and the Traveler MDS Nurse by telephone, the Care Plan Report was reviewed on 2/03/26 at 2:50 PM. The current Comprehensive Care Plan did not include a pressure wound, a surgical wound focus nor contained a goal with interventions. The MDS Traveler acknowledged she completed the Comprehensive admission MDS Assessment of 9/07/25 and recalled a decision to address pressure wounds in the care plan. The MDS Traveler said she was unable to locate a pressure wound care plan in the most recent record which should have been included in the Comprehensive Care Plan. The DON checked the medical record and said she was not aware resident #1's wounds were missing and conveyed they should have been in resident #1's Comprehensive Care Plan. 2. Review of the medical record revealed resident #3, a [AGE] year-old female was admitted to the facility from another nursing home on 9/13/18 and re-admitted from an acute care hospital on 1/16/23. The resident's diagnoses included metabolic encephalopathy (brain dysfunction), type 2 diabetes mellitus, malnutrition, anemia, dementia, and contractures of right and left knees. On 1/23/26, a diagnosis of pressure ulcer of sacral region, stage 3 was added by the Wound Care Physician's Assistant (PA).The Wound Care PA's progress note dated 1/23/26 documented resident #3 had a recurrent stage 3 pressure wound.Review of the most recent Quarterly MDS Assessment with an ARD of 12/31/25 noted an unhealed pressure ulcer was present that was not present on admission/entry or reentry during the look-back period.Review of the January 2025 Treatment Administration Record (TAR) revealed on 1/24/26, physician's orders were implemented for sacrum wound care treatment.Review of the current Care Plan Report on 2/02/25 noted the Comprehensive Care Plan did not include a focus for resident #3's pressure ulcer. In a joint interview with the DON and Nursing Home Administrator on 2/04/26 at 11:55 AM, the DON explained that resident #3's pressure ulcer care plan was added the previous day after the surveyor brought the missing care plan focus (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for resident #1's wound to their attention. She acknowledged resident #3's pressure ulcer care plan was found to be missing and said, corrections were made.Review of the facility's standards and guidelines dated February 2024 titled Comprehensive MDS Assessment and Care Plan outlined the facility developed and implemented comprehensive person-centered care plans for each resident that included measurable objectives and timeframes to meet a resident's medical and nursing needs identified in the comprehensive assessment.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to implement revised wound specialist physician's orders for a stage 3 pressure injury for 1 of 3 residents reviewed for pressure wounds, of a total sample of 4 residents, (#1).According to the Centers for Medicare & Medicaid Services (CMS), stage 3 pressure ulcers are described as full thickness tissue loss without bone, tendon, or muscle exposure. Stage 4 pressure ulcers include full thickness tissue loss with exposed bone, tendon, or muscle, (retrieved from cms.gov on [DATE]).Findings: Review of the medical record revealed resident #1, a [AGE] year-old female was admitted to the facility on [DATE] from another nursing home and re-admitted from an acute care hospital on [DATE] after hip fracture surgery. The resident's diagnoses included fracture of right femur (hip), dementia, muscle weakness, and pressure ulcer of left lower back, stage 2. On [DATE], the Wound Care Specialist Physician's Assistant (PA) assessed the resident's pressure wound as a stage 3. A week later on [DATE], the back wound was documented as worsened with exposed bone now diagnosed at stage 4. On [DATE], the resident was discharged to the hospital for another surgery due to faulty hardware from her hip replacement. She was diagnosed and treated for a Methicillin-Resistant Staphylococcus Aureus (MRSA infection) in the wound and bacteremia (blood infection). Resident #1 died at the hospital on [DATE]. The most recent Comprehensive admission Minimum Data Set (MDS) Assessment with Assessment Reference Date (ARD) of [DATE] indicated resident #1 had one unhealed stage 2 pressure ulcer that was present upon admission. The Discharge Return Anticipated MDS Assessment with ARD of [DATE] indicated the resident had one unhealed stage 2 pressure ulcer that was not present upon admission/entry or reentry during the look-back period. Review of resident #1's most recent Care Plan Report did not include a pressure wound. The Wound Care Specialist PA's progress notes dated [DATE] noted treatment for a deteriorating stage 3 pressure wound which measured as 1.5 cubic centimeters (cm) long by 0.7 cm wide, and 0.1 cm deep on the left lower back with treatment orders for Normal Saline, pat dry, apply Collagen and Honey Gel to wound bed, cover with border gauze daily and as needed. Honey hydrogels are highly effective for wound healing and include antimicrobial, anti-inflammatory, and anti-eschar effects which has shown promise in accelerating tissue regeneration and preservation of wound healing mechanisms to facilitate skin tissue recovery, (retrieved from pmc.ncbi.nih.gov on [DATE]). The Wound Care Nurse's Weekly Wound Evaluation dated [DATE] noted current treatment that read, collagen. A week later the Wound Care PA's Progress Note Details for [DATE] noted clinical goals to promote epithelial (outer layer of skin) wound edge advancement. The note revealed the physician's orders were revised and read, cleanse wound with Normal Saline - pat dry, apply Santyl nickel thick to wound bed, then apply ca (Calcium) alginate dressings and cover border gauze, daily and prn (as needed). A professional clinical review dated [DATE], indicated patients treated with Collagenase Santyl ointment showed its use underscored the clinical benefits of early treatment with accelerated wound repair and improved closure rates. Key findings included that more than 85% of wounds treated with Santyl achieved healthy granulation tissue that covered at least two-thirds of the wound area within two weeks of initiation, (retrieved from beckershospitalreview.com on [DATE]). Calcium alginate dressing is a highly absorbent wound dressing made from alginate, a natural polymer with primary components of calcium and sodium alginate fibers. The fibers form a gel when they come into contact with wound exudate, creating a moist healing environment, (retrieved from thewoundpros.com on [DATE]). Review of the Wound Care Nurse's Weekly Wound Evaluation dated [DATE] and signed [DATE] revealed she documented a decline and noted an n/a (not applicable) under other interventions. The Wound Care nurse's notes contained no mention of the Primary Care Physician's (PCP) orders to override the Wound (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Specialist PA's revised treatment orders given the same day. Review of the Wound Care PA's Progress Note Details for wound treatment dated [DATE], noted resident #1's pressure wound showed further deterioration with bone exposure and increased size, now staged at level 4. The PA noted the wound was further complicated by multiple coexisting medical conditions alongside the primary diagnosis. Orders for continued treatment was noted for Santyl and Calcium Alginate with Xeroform over the exposed bone. Imaging was requested to rule out suspected osteomyelitis (bone infection), and it was noted that the facility's medical team (PCPs) followed the resident's other medical conditions. In one week, the wound had increased in size from 2 cm long by 2 cm wide by 1 cm deep with 4 square cm of area and 4 cm in volume, to 5.5 cm long by 4 cm wide by 2 cm deep with 22 square cm area and 44 cm of volume prior to debridement (surgical removal of dead tissue). Xeroform gauze helps reduce the risk of infection and promotes the body's natural healing process. Xeroform's ability to keep a wound hydrated is one of its key features. Hydration plays a critical role in the wound healing process. By creating a moist environment, it promotes cell growth, reduces pain, and accelerates the overall healing process. Unlike traditional gauze that can cause wounds to dry out, Xeroform maintains the wound bed in an optimal state for healing by minimizing scab formation and avoiding tissue damage during dressing changes, (retrieved from specialtywoundcare.com on [DATE]). The Wound Care Nurse's Weekly Wound Evaluation dated [DATE] documented resident #1's wound with decline and noted n/a for other interventions. The current treatment orders read, xeroform, Santyl, calcium alginate. The document was completed on [DATE], two weeks after the evaluation date. Review of resident #1's physician's orders showed the pressure wound care treatment orders started on [DATE] to cleanse with Normal Saline, pat dry, apply barrier cream to peri-wound (around wound) followed by Collagen to wound bed, cover with border gauze dressing. The Treatment Administration Records (TARs) for October and [DATE] documented the same treatment was provided from [DATE] to [DATE] when the resident was discharged to the hospital. None of the Wound Care Specialist PA's revised orders since [DATE] were implemented. On [DATE] at 10:13 AM, the Wound Care Nurse confirmed she was a Licensed Practical Nurse (LPN) who had been in her role for approximately two years. She explained her normal practice was to receive verbal orders from the Wound Care Specialist PA during his assessments, and to transcribe them from his progress notes provided to her within a day of his visit. She said she was expected to enter her notes into the medical record within 24 hours. She said it was important to enter treatment orders timely so they could be carried out. The next day on [DATE] at 9:57 AM in a joint interview with the Director of Nursing (DON), the Wound Care Nurse relayed that she recalled in [DATE] months prior, even though she received orders from the Wound Care PA for a deteriorating pressure wound, she received verbal orders from resident #1's PCP to override the Wound Care Specialist's treatment order revisions and to leave the previous orders unchanged however, she had not documented that anywhere, nor did she recall informing the Wound Care Specialist PA. The nurse said she could not explain why there were no progress notes or treatment notes for the verbal orders she recalled. She said she was aware resident #1's Weekly Wound Evaluation note of [DATE] was entered on [DATE], two weeks late. The LPN stated, I got a little behind. In an interview on [DATE] at 11:12 AM, the DON checked resident #1's medical record and found wound treatment orders signed by the PCP on [DATE] after the resident was re-admitted from the hospital. The DON checked the record further and acknowledged the Wound Specialist PA's revised orders were not entered by the Wound Care Nurse and stated she did not know why the revisions were never implemented. She agreed that the PA's recommendation for an Xray to rule out suspected osteomyelitis was never ordered or entered and said she could not explain why the Xray and treatment orders were missed. In a telephone interview on [DATE] at 10:40 AM, the Wound Care Specialist PA (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	explained he gave verbal orders to the nurse during assessment and treatment and printed a copy of the notes for transcription and implementation at the end of assessment rounds, the same day. He said he relied upon the nurse to enter and implement the orders. He said he revised treatments when there was no improvement or deterioration. The PA further explained that it was normal practice for the nurse to remove the dressing exposing the wound prior to his assessment, which prevented him from knowing what type of dressing was there and he was unable to recall any of his orders overridden by the PCP. On [DATE] at 1:53 PM, resident #1's daughter recalled in [DATE], her mother fell at the facility, was hospitalized for hip surgery, and she returned to the facility from the hospital. She said she was horrified to learn from the hospital nurse that when the resident arrived at the hospital, staff found a severe, large, infected spinal wound with exposed bone. She said treatment for the infection was going to require 6 weeks of intravenous antibiotics and a special infusion catheter. She recalled one week prior to her mother's re-hospitalization on [DATE], the facility's Wound Care Nurse contacted her and reported the wound's size was 2 cm. She explained while hospitalized her mother looked terrible, rapidly declined, suffered, and she was unable to communicate with her. On [DATE] at 1:17 PM, the Medical Director said he relied on the Wound Care Specialist for pressure wound care and treatments and took into consideration what worked and if it did, it was continued. He explained that when resident #1 returned to the facility from the hospital in [DATE] after hip surgery, the Wound Care Specialist resumed the pressure wound care. He said an Xray for suspected osteomyelitis recommended by the Wound Care PA was not ordered because an Xray could not detect osteomyelitis, the resident was scheduled to see the orthopedic surgeon within the next week, and since that was a bone issue, it was deferred to that provider for evaluation. Review of the orthopedic surgeon's office progress note dated [DATE] showed the resident's reason for visit was for post-operative evaluation of hip surgery that required re-hospitalization for failed repair. The note did not address a notification, consultation, or evaluation of suspected osteomyelitis in exposed bone of the pressure wound. Resident #1's PCP follow up progress notes for [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] did not address assessments, evaluations or problems about pressure wounds or care. The diagnoses listed were for the resident's medical conditions other than pressure wounds. Resident #1 was admitted to the hospital on [DATE]. The hospital records showed during hospitalization, she required intravenous antibiotic medications to treat an infected mid-back pressure wound, bacteremia due to MRSA, and sepsis (body immune dysregulation response to infection). The resident later died on [DATE] at 5:01 AM. A letter from the facility's Medical Director and resident #1's PCP dated [DATE], after the survey ended read, seeing that the previous treatment worked well, an order was given to continue with the previous treatment. Review of the facility's standards and guidelines titled Physician's Orders dated [DATE] outlined procedures that physician's orders should be followed as prescribed, and if not followed, this should be recorded in the resident's medical record during that shift. The physician should be notified, and verbal orders may be received by licensed personnel and transcribed by the authorized person receiving the order and recorded in the resident's medical record. Review of the facility's standards and guidelines titled Prevention of Skin Impairments/Pressure Injury dated [DATE] noted prevention included that the plan of care should include revised interventions as indicated by the resident's condition.