

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Winter Garden Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50929</p> <p>Based on observation, interview, and record review, the facility failed to conduct a medication self-administration assessment to ensure safety for 1 of 1 resident reviewed for self-administration of medications, of a total sample of 39 residents, (#93).</p> <p>Findings:</p> <p>Resident #93 was admitted to the facility on [DATE] with diagnoses including heart failure, hyperlipidemia, hypertension, and prostate cancer.</p> <p>On 2/03/25 at 10:10 AM, resident #93 had a tube of drug store brand Multipurpose Antibiotic ointment, on the bedside table. Resident #93 stated he used it for a rash on his right ear and applied it himself a few times a day. Resident #93 picked up the tube and asked that the facility not be told of the tube of ointment as he feared they would take it away from him.</p> <p>On 2/04/25 at 10:30 AM, resident #93's bedside table was observed with Registered Nurse (RN) B, a primary care nurse. The RN reported the resident was not supposed to have medications at bedside and explained she had to ask the physician to put an order in for self-administration of medications. The RN clarified that resident #93 may not keep a box of the ointment at the bedside. Resident #93 explained to RN B that he used the ointment for a painful rash on his right ear. He stated he received powder and a cream before for the rash but they didn't work. RN B stated the medication was discontinued, and she needed to remove the ointment. She explained she would get a self-administration order from the physician and keep the medication in the cart. The RN confirmed that medications could not be kept at bedside. Resident #93 stated he had the medication for a week and nobody noticed. The RN responded, I didn't notice.</p> <p>On 2/04/25 at 11:26 AM, a review of resident #93's physician orders revealed no order for self-administration of medications. A review of the medical record revealed no care plan for self-administration of medications. The annual Minimum Data Set (MDS) assessment with assessment reference date 11/01/24, revealed a Brief Interview of Mental Status score of 15/15 that indicated the resident have any cognitive impairment. The assessment revealed the resident required minimal or touch assistance for dressing and personal hygiene, and was independent for eating, bed mobility, and toilet use.</p> <p>On 2/05/25 at 11:00 AM, the Director of Nursing (DON) confirmed the facility policy on self-administration of medication. The DON validated residents should not have medications at bedside unless they have an evaluation and a physician's order for self-administration of medication.</p> <p>(continued on next page)</p>		

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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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/07/25 at 11:53 AM, a review of the facility's 190301 Welcome Packet revealed Prescription medication and over the counter medication may not be brought into the facility. These items include antibiotic tablets, aspirin, laxatives, and arthritis creams. Please send these items home with your family. Our nursing staff may administer medications dispensed from our pharmacy that have been ordered by a facility physician only, unless otherwise approved by administration. Includes locked boxes/drawers for residents and a policy for self-administration of medication with approval by Physician.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>14730</p> <p>Based on interview, and record review, the facility failed to ensure the care plan for activities of daily living (ADL) self-care deficit was revised to accurately reflect the interventions for toileting for 1 of 2 residents reviewed for bowel and bladder incontinence, of a total sample of 39 residents, (#89).</p> <p>Findings:</p> <p>The most recent Annual Minimum Data Set (MDS) assessment for resident #89 was completed on 12/06/24. The Bladder and Bowel Incontinence section indicated the resident was not on a bladder or bowel toileting program and was always incontinent (no episodes of continent voiding or bowel movements). A comparison with the Quarterly MDS completed on 9/06/24 revealed the Bladder and Bowel incontinence section assessment had the same findings.</p> <p>The care plan for resident #89 for ADL self-care deficit for toileting was revised on 12/20/24 with a target date of 3/05/25. The goal was, the resident will maintain and/or improve ADL functioning through next review date. The interventions for toileting indicated the resident needed, extensive assistance of one or two staff to stand and transfer on and off the commode or bedpan.</p> <p>On 2/06/25 at 1:30 PM, resident #89's assigned Licensed Practical Nurse (LPN) C stated the resident did not get out of bed to use the commode and did not use a bedpan. She stated the resident was incontinent. On 2/06/25 at 1:45 PM, the resident's Certified Nursing Assistant (CNA) B also confirmed resident #89 did not get out of bed to use a commode and did not use a bedpan.</p> <p>The MDS assessment completed on 12/06/24 and the Care Plan revised on 12/20/24 were reviewed with the MDS Care Plan Coordinator on 2/07/25 at 10:24 AM. The MDS Coordinator confirmed the care plan had not been revised to accurately reflect the interventions for toileting.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13252</p> <p>Based on observation, interview, and record review, the facility failed to provide activities of daily living (ADLs) related grooming/personal hygiene for 1 out of 5 residents sampled for ADLs, of a total sample of 39 residents, (#88).</p> <p>Finding:</p> <p>Resident #88 was a non-geriatric age resident who was admitted to the facility on [DATE]. Her diagnoses included Huntington's disease, respiratory failure, neuromuscular dysfunction, and dementia.</p> <p>On Tuesday, 2/04/25, at 3:15 PM, resident #88 was in bed and her legs were unshaven. Resident #88 stated she could make her needs known but had poor memory. She stated she couldn't get out of bed by herself due to her condition. She acknowledged she would like her legs to be shaved but could not recall the last time staff had shaved them.</p> <p>Resident #88's Quarterly Minimum Data Set assessment dated [DATE] indicated she required substantial/maximal assistance with bathing and personal hygiene. Review of resident #88's care plan initiated on 7/15/23 and revised on 2/02/24 noted she was dependent on staff for bathing, but there were no approaches that included shaving her legs. Review of the shower schedule revealed staff showered resident #88 on Tuesdays and Fridays on the 3:00 PM to 11:00 PM shift.</p> <p>On 2/07/25 at 11:08 AM, resident #88 was in bed and her legs were still unshaven. Resident #88 spoke about her dementia and memory loss. She believed she had a shower but could not recall if she had asked the staff to shave her legs. The resident indicated it would be a good idea to put the intervention for shaving her legs on her care plan so staff would know she preferred them to be shaved without her having to ask them to do it.</p> <p>On 2/07/25 at 2:32 PM, resident #88's care plan, kardex and ADL care were discussed with the Care Plan staff and the Social Worker (SW). The Care Plan staff confirmed the intervention for staff to shave the resident's legs were not on either the care plan or the kardex. A short time later at 2:40 PM, the resident was in bed and told the SW her legs were, as hairy as her ex-husband. Upon leaving the resident's room the SW acknowledged resident #88's hairy legs had more than a week's growth. The SW did not want to speculate how long it had been since the resident had her legs shaved.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51234</p> <p>Based on observation, interview, and record review, the facility failed to address an alteration in a resident's skin integrity in a timely manner, for 1 of 4 residents reviewed for skin conditions, of a total sample of 39 sampled residents, (#2).</p> <p>Findings:</p> <p>Review of resident #2's medical record revealed an initial admitted [DATE]. The resident's diagnoses included cerebral infarction (stroke), chronic kidney disease (unspecified), and cervicalgia (neck pain).</p> <p>Resident #2's Annual Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 12/15, which indicated mild cognitive impairment.</p> <p>Resident #2's medical record revealed a physician's order dated 6/26/24 for Calamine external lotion with directions to apply to rash on arms topically every eight hours as needed for itching.</p> <p>Review of the resident's weekly skin checks dated 1/11/25 and 1/17/25 indicated scratch marks to legs, right arm and right chest, with order for Calamine lotion for itching. The skin check on 1/25/25 indicated resident #2 had a rash on both arms and treatment was in place.</p> <p>Review of resident #2's Treatment Administration Record revealed Calamine external lotion had not been applied to resident #2 in January 2025 nor for February 2025.</p> <p>On 2/07/25 at 3:12 PM, after consent from resident #2, Certified Nursing Assistant (CNA) A observed multiple scabbed and open areas of skin on resident #2's front chest area and the front of his legs. CNA A stated resident #2's skin had scabbing and some open areas for approximately a month from scratching.</p> <p>On 2/07/25 at 3:25 PM, after consent from resident #2, the Director of Nursing (DON) and East Unit Manager observed resident #2's skin and verified he had multiple scabbed areas with several open wounds on his front upper chest above the waistline to under his neck, along the front of his arms, and on the front of his legs from the upper thigh to the front of the calf areas.</p> <p>On 2/07/25 at 6:10 PM, the DON verified that skin checks completed on 1/11/25, 1/17/25 and 1/25/25 indicated resident #2 had problems with his skin. The DON verified that no additional treatment such as applying the Calamine external lotion in January nor February 2025 had been performed nor was the physician notified of the scratch marks noted on the skin checks in January 2025. She acknowledged the condition of resident #2's skin she observed earlier warranted the nurse to complete a significant change in condition note as well as scheduling a dermatology consult for the next day.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>13252</p> <p>Based on observation, record review, and interview, the facility failed to determine if potentially hazardous foods were at a safe cold holding temperature prior to distribution.</p> <p>Findings:</p> <p>On 2/07/25 at 11:30 AM, during observation of the lunch trayline, the facility cook initiated taking temperatures of the hot food items on the steam table. At 11:45 AM, the cook stated she had completed taking all of the food holding temperatures and the Certified Dietary Manager (CDM) instructed the staff to start the lunch trayline. There was a small table across from the steam table which had beverages including milk, a potentially hazardous food.</p> <p>Review of the facility's food holding temperature log for February 2025 revealed the cold holding temperature for the milk had not been obtained. Shortly after 11:45 AM, as staff began plating food, the cook acknowledged she had not taken the temperature of the milk. The CDM stated the holding temperature of the milk should have had been taken before the start of the trayline but did not offer any reason as to why it was not done. The cook and the CDM confirmed the cold holding temperature of potentially hazardous foods was required to be at or below 41 degrees Fahrenheit.</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>14730</p> <p>Based on interview, and record review, the administration failed to ensure safe water temperatures from 2 of 2 boiler rooms that supplied hot water to all resident areas were adequately monitored and failed to oversee environmental services to ensure resident room repairs were conducted routinely.</p> <p>Findings:</p> <p>On 2/03/25 at 3:15 PM, during an interview with resident #62, she stated the bath water the Certified Nursing Assistant (CNA) brought to her bedside that day from the bathroom was too hot and the CNA had to make it cooler. She could not recall the CNA's name. At 3:25 PM, the hot water from the faucet in the bathroom was felt for temperature, but the water was too hot to hold a hand under the water for more than a few seconds. Later at 5:00 PM, the Maintenance Director was asked to take water temperatures in bathrooms for resident #50 and resident #62. At 5:10 PM, the Maintenance Director arrived with an infrared thermometer and a digital probe thermometer. The Maintenance Director turned on the hot water and after approximately 15 seconds, put the probe under the running hot water in the bathroom of resident #50. The water temperature was 151.7 degrees Fahrenheit (F), (photographic evidence obtained). The water temperature in the bathroom for resident #62 was checked at 5:13 PM, and it was 149.1 F, (photographic evidence obtained). The Maintenance Director also used the infrared thermometer at that time and acknowledged the temperature read 20 degrees less than the probe thermometer. At that time the Maintenance Director confirmed the water was too hot.</p> <p>In an interview with the Administrator on 2/03/25 at 6:30 PM, he acknowledged the water temperatures obtained on earlier at 5:10 PM, and 5:13 PM, were not safe for resident's use. The water temperatures in two resident bathrooms were 151.7 F and 149.1 F respectively. He explained the acceptable temperature was 115 F.</p> <p>A review of the Performance Evaluation for the Maintenance Director dated 12/11/24 indicated the Maintenance Director needed to anticipate safety measures.</p> <p>On 2/03/25 at 6:46 PM, the Administrator stated he was not aware the Maintenance Director adjusted the mixing valve that provided the hot water to the resident rooms. He also stated he was not aware the Maintenance Director used an infrared thermometer to check water temperatures. The Administrator acknowledged he did not have knowledge of the Maintenance Director's actions on any given day and he was not aware of any training the Maintenance Director received or did not receive. The Administrator confirmed the Maintenance Director reported directly to the Administrator. The Administrator did not provide documentation of how he monitored the Maintenance Director's performance or how the Maintenance Director's anticipated safety measures were evaluated.</p> <p>Review of the job description, undated, for the Director of Environmental Services (Maintenance Director), revealed the Maintenance Director reported directly to the Administrator.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the job description for the Administrator dated 8/15/19 revealed the Overview: The Administrator administers, directs, and coordinates all functions of the facility to assure that the highest degree of quality of care is provided to the patients. The Responsibilities section included but was not limited to:</p> <p>Interview, hire, orient, train, supervise, and evaluate staff.</p> <p>Maintain safe working and living environment.</p> <p>Operate the facility in accordance with Citadel Care Center policies and federal, state, and local regulations.</p> <p>The Administrator did not acknowledge the job description for Administrator for [name of facility corporation], the job description did not include the correct facility name. The job description's Supervisory Responsibilities indicated the Administrator position oversaw all departments within the facility.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51234</p> <p>Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed regarding safe medication administration for 1 of 7 residents sampled for medication administration, of a total sample of 39 residents, (#51).</p> <p>Findings:</p> <p>Resident #51 was admitted to the facility on [DATE]. Her diagnoses included type 2 diabetes mellitus with hyperglycemia.</p> <p>Resident #51 had a physician's order dated 9/24/24 for Humalog Kwikpen Subcutaneous solution pen injector 100U (units)/ml (milliliter) (insulin Lisro) inject subcutaneously before meals and at bedtime per sliding scale for type 2 diabetes mellitus with hyperglycemia. Inject as per sliding scale: if 150-200=1 U, 201-250=2U; 251-300=3U; 301-350= 4U; 351-400= 5U; 401-500= 6 units greater than 500, call physician.</p> <p>Review of the facility provided manufacturer's instructions for use of the Humalog KwikPen insulin injection, revised on 7/20/23, revealed in preparing the pen section step 1 included to wipe the rubber seal with an alcohol swab before inserting the needle into the pen.</p> <p>On 2/3/25 at 11:37 AM, Registered Nurse (RN) A used a small plastic tray to carry resident #51's finger stick blood glucose monitoring supplies from the top of the medication cart to resident #51's room. RN A placed the tray on resident #51's bedside table. Upon completing resident #51's blood glucose check, he carried the tray out of resident #51's room and placed it back on top of his medication cart. He did not disinfect the tray prior to placing it on his medication cart. After he returned to his cart, RN A did not use an alcohol prep pad to clean the hub of the Humalog KwikPen injection device before attaching the disposable needle. RN A confirmed he should have cleaned the tray after removing it from the resident's room because it could have been contaminated which would then transfer any germs to the top of his medication cart. RN A stated he forgot to disinfect the rubber seal of the insulin pen prior to attaching the needle.</p> <p>On 2/03/25 at approximately 11:40 AM, the Director of Nursing (DON) acknowledged RN A did not disinfect the tray he used to carry blood glucose monitoring supplies into resident #51's room before setting it down on his medication cart and he did not clean the hub of the Humalog KwikPen injection device with alcohol before attaching the disposable needle. She verified it was best practice to disinfect the tray after it had made contact with the surface in the resident's room so as not to potentially contaminate the top of the medication cart. The DON stated nurses received education regarding disinfecting the Humalog Kwikpen rubber seal prior to attaching a needle and said RN A should have done that.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14730</p> <p>Based on observation, interview, and record review, the facility failed to maintain a safe environment to protect residents, staff, and the public from potential burns to skin by not monitoring the hot water temperatures for water supplied to all resident rooms from 2 of 2 sets of hot water tanks; failed to maintain walls in a resident room in a sanitary manner, (#62); failed to repair the wall after a water leak under the sink, (#97); and failed to maintain the area around a wall unit air conditioner, leaving open space to the outside, (#97).</p> <p>Findings:</p> <p>1. On 2/03/25 at 3:15 PM, resident #62 stated the bath water the certified nursing assistant (CNA) brought to her bedside that day from the bathroom was too hot and the CNA had to make it cooler. At 3:25 PM, the hot water faucet in the bathroom was turned on and tested by feel. The water was too hot to hold a hand under it for more than a few seconds.</p> <p>On 02/03/25 at 5:10 PM, the Maintenance Director tested the water temperatures in resident #50's and resident #62's bathrooms. The Maintenance Director arrived to the first room with an infrared thermometer and a digital probe thermometer. The Maintenance Director turned on hot water and after approximately 15 seconds, put the probe under the running hot water in the bathroom of resident #50. The water temperature on the digital probe indicated 151.7 degrees Fahrenheit (F), (photographic evidence obtained). The hot water temperature in the bathroom for resident #62 was checked a few minutes later at 5:13 PM, and the thermometer reading was 149.1 degrees F, (photographic evidence obtained). The Maintenance Director used the infrared thermometer at that time to measure the temperature of the water and acknowledged the temperature read 20 degrees F less than the probe thermometer. At that time the Maintenance Director confirmed the water from the resident's faucets was too hot.</p> <p>The time required for a third degree burn to occur at those temperatures is 2 seconds, (Studies of thermal injuries - see below):</p> <p>Time and Temperature Relationship to Serious Burns</p> <p>Water temperature Time required for a third degree burn to occur</p> <p>155 F (Fahrenheit)/68 C (Celsius) 1 second</p> <p>148 F/64 C 2 seconds</p> <p>140 F/60 C 5 seconds</p> <p>133 F/56 C 15 seconds</p> <p>127 F/52 C 1 minute</p> <p>124 F/51 C 3 minutes</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>120F/48 C 5 minutes</p> <p>100 F/37 C Safe temperatures for bathing</p> <p>Reference: [NAME], A.R., Herriques, F.C. Jr. Studies of thermal injuries: II The relative importance of time and surface temperature in the causation of cutaneous burns. Am J Pathol 1947; 23:695-720.</p> <p>On 2/03/25 at 5:15 P, the Maintenance Director stated he checked water temperatures in a few rooms of the facility every day on Monday through Friday. He explained routine temperature checks were not conducted on Saturdays and Sundays. The Maintenance Director added he did not check water temperatures that day, Monday 2/03/25, and did not recall what the water temperatures were on the previous Friday.</p> <p>On 2/03/25 at 5:30 PM, two hot water tanks were located in the [NAME] boiler room. The Maintenance Director revealed he adjusted the mixing valve on Friday 1/31/25 to provide hotter water after a resident told him the water was too cold. The Maintenance Director was unable to say who complained about water being too cold and could not provide documentation of any complaint of cold water from that day. The Maintenance Director stated he did not document the temperatures from Friday before the adjustment or afterwards. The Maintenance explained he turned the mixing valve to allow more hot water, but acknowledged the only way to know how it affected the resident areas was to actually take the temperature in the resident's bathrooms. At 5:44 PM, he adjusted the mixing valve and said he turned it to allow more cold water to bring the water temperature down in the resident rooms. The Maintenance Director stated he was not trained on how to adjust the equipment that delivered hot water to the building and may have turned it too far so that it raised the water temperature in resident rooms to an unsafe temperature. The Maintenance Director said the [NAME] water tanks provided hot water to the middle hall and [NAME] wing (rooms 150 to 188). He acknowledged the temperature gauge for the water heaters was broken and did not show the current temperature in the water tanks, (photographic evidence obtained). The Maintenance Director acknowledged he had not been trained on the process for taking water temperatures and had not been aware the infrared thermometer was not appropriate for taking water temperatures. The Maintenance Director stated he had used the infrared thermometer to take water temperatures for the past two weeks, (photographic evidence of the infrared thermometer obtained). The Maintenance Director stated no one else in the facility monitored water temperatures in his absence or at any other time.</p> <p>Review of the undated user manual for the infrared thermometer indicated the laser grip thermometer could only measure surface temperature and could not accurately measure internal temperature.</p> <p>On 2/03/25 at 6:46 PM, the Administrator stated he was not aware the Maintenance Director adjusted the mixing valve that provided the hot water to the resident rooms. He added he was not aware the Maintenance Director had used an infrared thermometer to check water temperatures.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Winter Garden Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/03/25 at 7:05 PM, the Maintenance Director revealed he had also adjusted the mixing valve for the other boiler room that supplied hot water to the rest of the resident rooms (100-148) on 1/31/25. The Maintenance Director then conducted a random check of water temperatures in the affected areas. The probe thermometer that the Maintenance Director used for temperatures at 5:10 PM, no longer functioned and he did not have another working thermometer to take water temperatures. A digital probe thermometer was retrieved from the kitchen and was calibrated in an ice bath. At 7:15 PM, the water temperature in the bathroom sink in room [ROOM NUMBER] was 125.1 F. The water temperature in room [ROOM NUMBER] at 7:22 PM was 125.4 F.</p> <p>On 2/03/25 at 6:30 PM, the Administrator acknowledged the water temperatures in resident rooms were not safe. He said acceptable temperature was 115 degrees F.</p> <p>A review of the maintenance Log Book documentation on 02/04/25 for the dates 1/04/25, 1/10/25, 1/17/25, 1/24/25, and 1/31/25, revealed steps for water temperature checks: Test and log the hot water temperatures. The Log Book text suggested the user review the training video that accompanied the task. The steps were listed as follows:</p> <p>The dial thermometer is accurate to 1 to 2 degrees F - however it is not a precision instrument and should be calibrated on a regular basis.</p> <p>Let the hot water run for 3 to 5 minutes.</p> <p>Insert the stem into the stream of running water so that the sensor is fully immersed .</p> <p>After the temperature of the water is taken, hold your hand under the running water about the same time to assess how the water feels on your skin.</p> <p>The Log Book documentation included:</p> <ol style="list-style-type: none"> 1. For burn prevention, federal guidelines advise that you keep domestic water temperatures below 120 degrees Fahrenheit although this temperature can still cause burns if exposure reaches five minutes. 2. Test temperature in shower areas. 3. Test temperature at the mixing valve. 4. Check resident rooms at the end of each wing on a rotating basis or per facility policy. 5. Common area bathrooms, public bathrooms and any other areas having sinks should be checked and recorded as well. <p>The Maintenance Director was unavailable for interview from 2/04/25 through 2/07/25.</p> <p>A review of the electronic report for Water Temps from the two weeks the Maintenance Director reported using the infrared thermometer revealed temperatures were logged to range from 110.2 F to 114.7 degrees F.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/05/25 at 10:59 AM, the [NAME] wing Unit Manager, said no there had been no recent reports of hot water issues. She explained that staff had three ways to report maintenance issues: via a paper Maintenance Work Order, verbally to the Maintenance Director, or electronically.</p> <p>The Administrator was asked for the policy and procedure for monitoring water temperatures. He provided the Standards and Guidelines: Water Temperatures for Environmental Services, issued April 2021 and revised on January 2024. The document listed a Standard: The facility utilized water heaters (with control valves) to maintain water temperatures between 105 and 115 F in resident care areas. The Procedure listed as follows:</p> <ol style="list-style-type: none"> 1. Maintenance was responsible for performing periodic tap water temperature checks and should record results of the water temperatures as indicated. 2. Any temperature found out of compliance would be adjusted, the water in the area with the out of compliance temperatures would be temporarily turned off until temperatures were returned to normal. 3. Water temperatures were controlled through the use of temperature control valves (mixing valves) with the temperatures set at or slightly below 115 F. 4. Any malfunction of the system relating to not being able to control the water temperature, would cause the system to be taken offline it had been repaired. <p>The job description for the Director of Environmental Services (Maintenance Director) signed on 5/21/24 listed responsibilities including but not limited to:</p> <ul style="list-style-type: none"> Ensure that staff provided a safe environment for the facility and its residents. Develop maintenance procedures and schedules. Directs the maintenance and operations of various facility systems to ensure uninterrupted service - Covered systems may include .water. Oversees necessary repairs and maintenance in rooms and common areas including refurbishment for move-ins. <p>2. On 2/03/25 at 3:15 PM, the wall behind the headboard in resident #62's room was damaged with deep scratches exposing the drywall. The affected area was approximately the same size as the headboard.</p> <p>On 02/07/25 at 6:03 PM, the Administrator presented a schedule for room renovations that extended into 2026 as part of the plans for regular repairs for wall damages in resident's rooms. He was unable to discuss or produce a schedule or plan for routine repairs in resident rooms. The Administrator stated the Maintenance Director was responsible for resident room repairs. The Administrator located a schedule for paint touchups in resident rooms, but it did not include a time frame or dates of when the repairs would occur. The Administrator stated repairs could be reported to the Maintenance Director in daily meetings. The Administrator did not have evidence of any room repairs that had been addressed or scheduled.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Maintenance Work History report for the past three months, November 2024, December 2024, and January 2025 listed all categories for routine maintenance tasks, but the report did not include a regular schedule to address resident room repairs.</p> <p>51234</p> <p>2. Review of resident #97's medical record revealed an admitted [DATE]. Her quarterly Minimum Data Set, dated dated [DATE] included a Brief Interview for Mental Status Score of 15 out of 15 that indicated her cognition was intact.</p> <p>On 2/3/25 at 10:40 AM, resident #97 said she had roaches in her bathroom, especially in her bathroom cabinet. She said she used her bathroom daily for toileting and used the sink daily. On observation, the bathroom vanity had 2 brown insects approximately several millimeters (mm) in length that moved on the interior of vanity cabinet door. A numerous amount of black approximately 1 mm circumference round bits noted on the cabinet's interior and at top of cabinet door. See photos. Within the cabinet near the sink's drain pipe there appeared to be a wet area with bubbled cabinet material noted to surface of cabinet's bottom. See photos. Along the north wall outside of the vanity there was bubbled paint. Resident #97 said she was concerned that her air conditioner was not flush with the wall. Observations showed tissue in thickness and size pieces pressed between the air conditioner panel and wall along its top and side. See photos.</p> <p>On 2/3/25 at 11:25 AM, resident #97 said she had not told staff about the roaches she saw in the bathroom because it would not do any good.</p> <p>On 2/4/25 at 8:35 AM, the Visiting Maintenance Director of a sister facility observed and verified that resident #97's vanity area had black 1 mm circumference round bits noted on the cabinet's interior. He would not say what he thought those black round bits were. He noted 1 brown insect several millimeters in length moving on the interior of the vanity cabinet. He used his finger to verify that liquid was under the sink's drain pipe on the cabinet's bottom surface and there was bubbled cabinet material in the wet area. He said the bubbled paint along the north wall adjacent to the vanity could have occurred from wicking along the wall from the liquid under the sink. He said the damage was so extensive it would warrant removal of the vanity. The Visiting Maintenance Director viewed the air conditioner wall unit and removed the tissue-like material from the edges between the unit and the wall. The outdoors was viewed when the tissue was removed. He noted black bits approximately 1 mm in circumference on the floor near the air conditioner wall unit as well as along the wall, behind the bed of resident #97's roommate. He said caulking would be needed around the air conditioner.</p>		