

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

Printed: 10/31/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105754	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Conway Lakes Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 Curry Ford Road Orlando, FL 32812	
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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131 Based on interview, and record review, the facility failed to obtain admission physician orders for immediate care of a surgical site for 1 of 2 residents reviewed for surgical site admission orders, of a total sample of 20 residents, (#7). Findings: Resident #7, a [AGE] year-old-male was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included displaced fracture of the right calcaneous, end stage renal disease, chronic obstructive pulmonary disease, and hemiplegia and hemiparesis following cerebrovascular disease affecting unspecified side. Review of the resident's hospital records revealed an Open reduction and internal fixation (ORIF) of the resident's right ankle was performed on 7/31/24. ORIF .a type of surgery that is used to repair broken bones that need to be put back together .only needed for severe fractures, (retrieved on 9/03/2024 from webmd.com). The resident's Admission Note dated 8/02/24 revealed the resident had a splint. Review of the resident's physician orders revealed no admission order(s) for care of the resident's right ankle, or for any follow up visit with Orthopedic physician. Review of the Communication with physician note dated 8/03/24 at 6:32 PM, revealed the Patient presented with large amounts of serosanguinous drainage from his surgical site. Site is covered by a soft splint and ACE bandage patient is status post right ankle fixation due to a closed fracture he sustained after a fall. On-call surgeon was contacted who then contacted main surgeon . Per MD if conditions worsen send out patient via emergency. A Physician Progress note dated 8/05/24 at 7:20 AM, revealed this was an initial visit by the physician, and read, RN notified me pt (patient) had oozing from RLE's (Right Lower Extremity) wound over the weekend which she re-dressed . Today's impression: Acute and in need of urgent evaluation .Hgb (Hemoglobin) 5.3 this morning. A progress note on 8/05/24 revealed resident #7 was hospitalized for a critical lab. (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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hospital records documented by Inpatient Medicine dated 8/06/24 read, Recent right ankle surgery transferred from [rehabilitation] for low hemoglobin and ongoing right ankle incision site bleeding. [Orthopedics] consulted . Staple placed for minimal bleeding from surgical incision, covered with soft dressing, and splint reapplied. Resident #7 was readmitted to the facility on [DATE], and documentation in the resident's electronic records on 8/12/24 read, Per resident, leave RLE (right lower extremity) surgical site clean and intact till seen by surgeon. There was no documentation to indicate this was clarified with Orthopedics, when the resident was to be seen by the surgeon, and there was no directive regarding the removal of the staple placed in the hospital on 8/06/24. On 8/20/24 at 2:25 PM, resident #7 was sitting in his wheelchair in the facility's courtyard. An Ace wrap/bandage was noted to his RLE, extending from his toes up to his knee. The resident said after he was admitted to the facility on [DATE], his right foot was bleeding, and he was transferred to the hospital where he spent a week. He stated he was readmitted to the facility three weeks ago, and nothing had been done about his right leg dressing, nor had he seen the surgeon since his readmission. On 8/21/24 at 10:47 AM, and at 12:38 PM, in interviews with the East Wing Registered Nurse/ Unit Manager (RN/UM), and the Regional Nurse Consultant (RNC), the RN/UM recalled resident #7 was transferred from the [NAME] Wing to the East Wing on 8/15/24. She explained that normally residents came to the facility with instructions regarding their care on their discharge paperwork, which would be entered into the electronic medical record (EMR) by the admission nurse. She stated she called the Orthopedic Office on 8/15/24, but no appointment was available that week, and she was told the office would contact the facility. She verbalized she was still waiting on a response from the office. The RN/UM stated she was not aware the resident had a staple in his surgical incision as documented in the hospital records. She reviewed the resident's discharge papers, and stated the discharge papers addressed medication, but did not address care/ instruction for the surgical site to resident #7's right lower extremity. The RN/UM acknowledged there were no orders in place for continuity of care for the resident's surgical site, and said if a resident was admitted without orders, the expectation was that the physician would be notified, and orders obtained. The RNC said the expectation was that physician orders would be clarified and obtained as needed/identified for a new admission. On 8/21/24 at 12:43 PM, the resident's clinical records were reviewed with the Director of Nursing (DON). The findings regarding no physician orders for care of the resident's surgical site, or for removal of the staple placed in the hospital were discussed. The DON stated the expectation was for the facility to obtain orders for continuity of care. On 8/21/24 at 2:09 PM, the [NAME] Wing Licensed Practical Nurse/UM (LPN/UM) stated that when resident #7 was first admitted to the facility, they had issues with his dialysis transportation, and she did not recall obtaining orders for monitoring of the surgical site to his RLE. She explained, that if a resident was admitted to the facility with no orders, the staff who completed the admission, should obtain orders. The LPN/UM stated she had the resident on her unit twice, and both times, it was a two days turn around, and the focus was on his dialysis. She said hospital discharge instructions had no mention of the surgical site to the resident's right lower extremity, and acknowledged she should have called for admission orders pertaining to the resident's surgical site. (continued on next page)		

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility did not have a policy regarding Admission orders but indicated nurses should follow the facility's Admission Completion Check Off List Mandatory Forms. Instructions listed on the document directed staff that, All shifts are responsible for follow up and completion of admission paperwork. Tasks listed on the document for completion included, Admit/Re-admit orders verified with practitioner: Verification of orders documented on the POS (Physician Order Sheet) and discharge orders received from the hospital Treatment orders for all skin areas/wounds noted upon admission Telephone orders written for any clarifications not noted on discharge orders and/or 3008. The 3008 Is a Medicaid form for folks looking for long-term care services, (retrieved on 9/03/24 from elderneedslaw.com).		

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131 Based on interview, and record review, the facility failed to ensure necessary care and services were provided to promote healing and prevent infection of a facility acquired pressure ulcer for 1 of 2 cognitively impaired residents reviewed for pressure ulcer management, of a total sample of 20 residents, (#1). The facility's failure to ensure timely and adequate care and treatments for pressure injury and infection resulted in actual harm for a cognitively impaired resident at risk for development of pressure wounds. Resident #1 subsequently was transferred to a higher level of care with an admitting hospital diagnosis of sepsis with hypotension, and sacral wound. Resident #1 was placed on Hospice services on [DATE] and expired four days later on [DATE]. Findings: Resident #1, a [AGE] year-old-male was admitted to the facility on [DATE]. His diagnoses included type II diabetes mellitus, vascular dementia, Parkinson's disease, atrial fibrillation, and atherosclerotic heart disease. Resident #1 was transferred to the hospital on [DATE]. The resident's quarterly Minimum Data Set (MDS) assessment, with Assessment Reference Date (ARD) of [DATE], revealed the resident was rarely/never understood. The assessment noted the resident had functional limitation in range of motion to both sides of his upper and lower extremities, he required substantial/maximal assistance for toileting hygiene, and mobility, and was dependent on staff assistance for personal hygiene and transfer. The assessment noted the resident was at risk for pressure ulcer, but had no unhealed pressure ulcer. Review of the Order Summary Report revealed resident #1 had physician orders dated [DATE] for Nutrashield cream 1% to be applied to bilateral buttocks every shift daily and as needed. On [DATE] the wound care order was, cleanse with normal saline (NS), pat dry and apply calcium alginate to wound bed, cover with border gauze every day shift. An order on [DATE] was for Sulfamethoxazole-Trimethoprim , d+[DATE] milligram (mg) every 12 hours for wound infection, start date was [DATE], with an end date of [DATE]. Another physician's order dated [DATE] was for Acetic acid to be applied to the coccyx every day shift, and directed the wound should be cleanse with NS, pat dry, apply skin prep to peri-wound, pack with Acetic acid-soaked gauze and cover with bordered gauze until healed, and as needed. Nutrashield cream, is used to treat and prevent diaper rash and other minor skin irritations .It works by forming a barrier on the skin to protect it from irritants/moisture, (retrieved on [DATE] from webmd.com). Calcium alginate dressings are wound dressings made from seaweed used to treat a moderate to heavily draining wound, (retrieved on [DATE] from wound pros.com). Sulfamethoxazole-Trimethoprim is .is a combination of two antibiotics used to treat a wide variety of bacterial infections, (retrieved on [DATE] from webmd.com). (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Acetic acid, also known as vinegar, is a topical agent that can be used to treat wounds because it kills microorganisms and promotes healing, (retrieved on [DATE] from dermatologytimes.com). A Weekly skin observation dated [DATE] read, new area of skin irregularities: coccyx- pressure ulcer- stage 3 . Nurse on duty and CNA (Certified Nursing Assistant) getting resident up for the day . As resident was rolled to one side, a dressing with drainage was observed. Resident open wound has been cleansed with normal saline, calcium alginate and border gauze applied. A Change in Condition & Transfer form with effective date of [DATE] revealed a new area of skin impairment located on the resident's coccyx was identified, and the physician, and the resident's representative were notified. Documentation indicated the area was cleansed with normal saline, and calcium alginate with border gauze was applied. Review of the Skin & Wound Evaluation document with effective date of [DATE] revealed an impairment to the resident's coccyx, was in-house acquired on [DATE], and was described as Moisture Associated Skin Damage (MASD) measuring 9.0 x 6.9 centimeters (cm) with light serosanguineous drainage, with no odor noted after cleaning, and no infection present. Serosanguineous fluid is a combination of serous fluid and blood. It's usually a light pink to red color . and isn't a concern in normal amounts, (retrieved on [DATE] from my.clevelandclinic.org.) A review of the wound care provider's, Evaluation and Management Report dated [DATE], revealed a consultation was done for a chief complaint of open wound, and also revealed the coccyx wound was in-house acquired, and classified as MASD, measuring 9.8 x 6.9 x 0.1 cm, and the treatment was calcium alginate, covered with bordered gauze daily. Documentation read, wound coccyx: New moisture associated skin damage. The wound care provider's Evaluation and Management Report dated [DATE], revealed the resident's coccyx wound was now classified as an unstageable pressure wound, and measured 8 x 5.6 x 0.4 cm with 20 % necrotic tissue, and purulent green drainage with moderate odor. The treatment was changed to Acetic acid moistened gauze covered with bordered gauze. Documentation read, Wound etiology has been changed from MASD to pressure because there is now an open wound. Tissue depth changed because there is necrotic tissue in the wound bed. Wound stage has been changed from N/A to Unstageable for the reason the depth of the wound is unable to be measured due to the necrotic tissue in the wound bed. Due to the peri-wound erythema, purulent drainage and foul odor, will update treatment and start oral antibiotics . Plan: Sulfamethoxazole- trimethoprim ,d+[DATE] mg PO (by mouth) Q 12 hours for 10 days for wound infection. Necrosis is the death of body tissue. It occurs when too little blood flows to the tissue . Necrosis cannot be reversed, (retrieved on [DATE] from medlineplus.gov). Purulent drainage is a sign of infection The fluid may also have an unpleasant smell, (retrieved on [DATE] from webmd.com.). (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the Skin & Wound Evaluation document with effective date of [DATE] addressed the coccyx wound, however, the date the wound was acquired was now documented as [DATE]. Measurements were 8.0 x 5.6 cm with 10% epithelial tissue, and 90% slough. Documentation indicated there was no evidence of infection, and the wound had moderate, serous drainage with no odor noted after cleansing. The Goal of Care selected read, Slow to Heal: wound healing is slow or stalled but stable, little/no deterioration. The treatment was Acetic acid-soaked gauze, and improving was selected for wound progress. Documentation by the wound care provider, and by nursing staff in the Skin & Wound Evaluation completed on the same date [DATE], contained conflicting information regarding the appearance, and odor of the wound. Nursing documented the wound had serous drainage with no evidence of infection, odor, and indicated the wound was improving. However, the wound care provider documented the wound had purulent drainage, foul odor, and was, Not improved. A Quality of Care Note documented by the East Wing Unit Manager dated [DATE], read, Resident was seen by Wound MD on [DATE]. Resident has area to left leg, right leg and coccyx . Coccyx is treated with acetic acid-soaked gauze and bordered gauze . Resident will be started on Bactrim DS (double strength) for 10 days for wound infection. Three days later, a Change in Condition & Transfer form with effective date of [DATE] read, Identified on [DATE] 12:00 AM . Pt has a necrotic wound on the sacrum with a foul odor . Family requested IV (intravenous) ABX (antibiotic) rather than PO (by mouth) ABX. Provider was notified . 911 was called and pt(patient) was transferred to (name of hospital). On [DATE] at 1:10 PM, the Registered Nurse (RN) East Wing Unit Manager (UM) stated a skin issue to resident #1's coccyx was identified on [DATE], was classified as MASD, and treated with calcium alginate. The UM recalled the resident was first seen by the wound care provider two days later on [DATE] with no change in the treatment. She recalled a week later on [DATE] the resident was seen by the wound care provider again, the treatment was changed to Acetic acid, and Bactrim DS was started for a wound infection. The UM explained that on [DATE], the wound was still smelling, and the facility's Supervisor suggested the resident could be started on IV antibiotic, but the family wanted the resident to be sent to the hospital. On [DATE] at 1:23 PM, Licensed Practical Nurse (LPN) B stated she recalled the resident, he had contracted bilateral lower extremities but was able to use his upper extremities. LPN B stated resident #1 had a wound to his sacrum, and she did wound care as ordered by the physician. She recalled there was drainage to the wound, but no odor, and the resident was on an antibiotic when she cared for him. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 9:56 AM, the Director of Nursing (DON) stated the primary nurse did daily wound care for the residents, and explained she would think if there was anything different from the prior day, the change would be documented by nursing staff and reported. She stated weekly wound rounds were conducted with the Wound Care Provider, and included the DON, and UMs. The DON explained that during the weekly wound round, the progress of wounds was discussed with the Wound Care Provider, and any changes, or recommendations would be implemented as indicated. Resident #1's clinical records were reviewed with the DON, who acknowledged no documentation could be identified regarding daily wound care, apart from signatures on the Treatment Administration Record (TAR). She acknowledged there was no documentation identified regarding any changes in the wound characteristics, nor was there any documentation by nurses to indicate any communication was made with the Wound Care Provider between [DATE] and [DATE] when the Wound Care Physician noted the wound now had 20 % necrotic tissue and purulent, malodorous green drainage. On [DATE] at 11:14 AM, LPN A stated she has worked at the facility on an as needed basis since [DATE] and floated to the different wings as needed. LPN A stated she recalled resident #1 was very contracted, with fragile skin, and a pressure wound on his buttock. The LPN recalled resident #1's wound was tunneling when she worked with him on [DATE], the day before the Wound Provider noted the changes in the wound. She recalled the CNA had washed and cleaned the resident, and the dressing to his buttock had been removed due to soilage. LPN A remembered she asked the resident's assigned CNA, When did this happen? She confirmed she did not document a note about the change in resident #1's wound condition nor contact the physician but explained that the wound care order simply popped up on the TAR to be signed off. Review of the resident's TAR for the period [DATE] through [DATE] revealed the signature of LPN A on [DATE], [DATE], [DATE], and [DATE] which indicated she provided wound care for the resident on those dates. There was no documentation by the LPN, describing the tunneling of wound, or other change in the resident's wound. On [DATE] at 11:41 AM, the resident's clinical records were reviewed with the East Wing UM. She acknowledged there was no previous wound care order in place for the resident prior to [DATE]. She said the physician order on [DATE] was for Nutrashield cream, but there was no order or documentation regarding any open area to the resident's coccyx prior to the weekly skin evaluation dated [DATE]. She confirmed the nurse applied calcium alginate, and a physician order for the treatment was entered on [DATE]. The East Wing UM stated she was not aware of drainage from the resident's wound prior to [DATE]. She recalled that when she rounded with the wound care provider on [DATE], the resident had an open area, and the wound drainage was, malodorous. She stated the Advance Practice Registered Nurse (APRN)) changed the dressing to Acetic acid and started the antibiotic Bactrim. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 12:10 PM, in a second interview with the DON, she stated the open area to the resident's coccyx was identified on [DATE] and was addressed appropriately by the nurse. She said the treatment in place on [DATE] was calcium alginate, and a physician's order entered in the resident's medical records on [DATE] was for calcium alginate. However, the DON confirmed the order did not specify where the calcium alginate was to be applied. When asked about the progress of the wound from [DATE] through [DATE], the DON stated there was no documentation by nursing regarding drainage, or odor of the wound, prior to the documentation on [DATE]. The DON again verbalized the facility's process was if there were a change in condition, the expectation was staff would complete a change in condition form, notify the physician, the DON, and the respective UM. She verbalized that a change in condition was not completed regarding the resident's wound since [DATE] when the nurse initially identified the open area to the resident's coccyx. On [DATE] at 5:14 PM, LPN D stated she worked on the 3 PM to 11 PM shift and recalled having resident #1 in her assignment. The resident's TAR for the period [DATE] through [DATE] was reviewed with the LPN, and she acknowledged her signature on orders completed on [DATE]. LPN D stated resident #1's wound was on his lower back, above the buttocks. She described the area as stable, with no drainage, and no odor. LPN D recalled that at the time she did the dressing on [DATE], it was stable, but looked as if, someone took some skin and peeled it off, which indicated the skin was, denuded. On [DATE] at 5:43 PM, a telephone interview was conducted with the wound care providers, APRN H, and APRN G, with the DON present in the conference room. APRN H recalled she was consulted regarding the resident's wound on [DATE]. She stated he had a left leg traumatic wound, right leg traumatic wound, and MASD to his coccyx at that time. APRN H said the coccyx wound measured 9.8 x 6.9 x 0.1 cm, with 100 % dermal tissue, and treatment was calcium alginate with silicone border gauze daily. She recalled she next saw the resident on [DATE] and changed the etiology of the coccyx wound from MASD to unstageable pressure ulcer. She said the resident now had an open wound, with necrotic tissue in the wound bed, peri-wound erythema (redness), with green, purulent, malodorous drainage; a change from [DATE]. She indicated she changed the treatment to fill the wound with Acetic acid moistened gauze, and cover with silicone daily, and started the resident on an oral antibiotic for the infection, but did not obtain/order a wound culture. APRN G said they typically do not obtain culture of a wound with 100% slough, they would recommend debridement first, and once they got healthy tissue, they could culture it to identify what antibiotic the wound would be sensitive to. She stated a broad-spectrum antibiotic along with topical treatment would be recommended for the resident. APRN G stated the green drainage from the resident's coccyx wound indicated a Pseudomonas infection and the Bactrim ordered covered this type of gram-negative bacteria. When asked what could have caused the worsening of the resident's coccyx wound, APRN H stated that given the patient's immobility, and his comorbidity, there were multiple factors that could have caused the worsening of his wound. APRN H stated that between visits to the resident, if there were any status change with the wound, the facility could contact her to get an order change based on the progression or change in the wound. When asked if the facility notified her of any change in the status of resident #1's wound between her visit on [DATE] and [DATE], APRN H stated the East Wing UM had notified her of a change in the resident's wound between her weekly assessments. However, she could not recall the specific date the communication happened, or the details of the change that was reported. When asked what actions were taken after she was notified of the change in status of the resident's wound, APRN H said she believed they kept the dressing the same. APRN G stated if she was made aware by nursing staff of a change in the status of a wound, she would inquire about the details of the change and get, something else on board to address it. The DON stated she did not believe facility staff contacted APRN H between her visits, since she recalled seeing the drainage from the resident's wound on [DATE] during the wound round. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 11:14 AM, in a second interview with APRN H and APRN G who were at the facility for wound rounds, APRN H stated she miss-spoke during the telephone interview on [DATE]. She stated she was not contacted by the East Wing UM as she previously shared and was not aware of the change in the condition of the resident's wound prior to [DATE] during her wound rounds. She reiterated that if there was any change in a wound status between her visits, the expectation was for staff to notify her. On [DATE] at 12:17 PM, LPN C recalled she was the resident's primary nurse on [DATE] on the East Wing, and she completed a change in condition for the decline of resident #1's coccyx wound. LPN C stated she did not work on the East Wing often, and recalled the resident had a wound to his coccyx, and the last time she provided wound care for him, the wound to his coccyx was circular. The resident's Change in Condition form with effective date [DATE] was reviewed with the LPN. She confirmed the form was completed by her, and said she recalled one day she could not recall the specific day, the resident's CNA called her to say that when she provided morning care, resident #1's dressing had fallen off. LPN C remembered when she went to apply a new dressing, the wound had an odor. She explained she completed the change in condition and obtained an order for an antibiotic from the physician. On [DATE] at 1:36 PM, in a telephone interview, CNA E stated she usually worked on the 7 AM to 3 PM shift and resident #1 was in her assignment. She recalled resident #1 had an open area to his coccyx, and had assisted the nurse during wound care. CNA E could not recall any odor or drainage from resident #1's pressure wound, but said she had an allergy. Review of the receiving Hospital's Emergency Department (ED) Provider notes dated [DATE] revealed the resident's pressure wound as, weeping, with redness, and bleeding. The Emergency Department Attending/Resident Note dated [DATE] indicated the resident presented at the ED for evaluation of sacral wound and read, Wound on left side, being seen by wound care at (Skilled Nursing Facility name) progressed since [DATE]rd. The Physical exam conducted showed a stage IV sacral wound with, exposure of the coccyx bone tunneling underneath the skin ranging about 6 cm. Surrounding skin necrosis. Diagnoses listed on the document included hypotension, sepsis with hypotension, and wound of sacral region. The facility's policy Skin Integrity with copyright date of 2008 indicated the purpose of the policy was, To provide consistent assessment and evaluation, monitoring, documentation, and implementation of therapeutic interventions to heal and maintain skin integrity . To promote the prevention of pressure ulcer/injury development; To promote the healing of existing pressure ulcers/injuries (including prevention of infection to the extent possible). Review of the Facility Assessment, last reviewed [DATE], revealed the services provided were based on resident need and included, pressure injury prevention and care . wound care management.		

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NAME OF PROVIDER OR SUPPLIER Conway Lakes Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 Curry Ford Road Orlando, FL 32812	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40892 Based on observation, interview, and record review, the facility failed to maintain proper infection control practices to prevent the potential of dangerous bacteria from spreading between residents during use of shared vital sign equipment during blood pressure monitoring on 2 of 2 Wings. Findings: 1. Resident #16 was admitted to the facility on [DATE] with diagnoses including dementia, non-ST elevation myocardial infarction, and age-related physical debility. On 8/21/24 at 3:50 PM, Certified Nursing Assistant (CNA) K, entered resident #16's room with the wheeled portable vital signs monitor to measure her blood pressure. Resident #17 was admitted to the facility on [DATE] with diagnoses including pneumonia, congestive heart failure, and chronic obstructive pulmonary disorder. On 8/21/24 at 3:55 PM, CNA K was observed as she walked to the next bed where resident #17 lay in the same room, measured her blood pressure, but did not clean the reusable equipment between the two residents. On 8/21/24 at 4:01 PM, CNA K stated, I clean the vital sign machine when I come on shift, then when I am done checking all of my resident's vitals. On 8/21/24 at 5:35 PM, the [NAME] Unit Manager stated CNAs were supposed to clean the blood pressure equipment between each resident. They use the Caviwipes to clean the vital sign machine. She state the CNAs were trained upon hire and annually on the cleaning of equipment. A review of the facility's infection control manual read, Ensure that reusable equipment is not used for the care of another resident until it has been cleaned . 32131 2. On 8/21/24 at 3:28 PM, CNA I was observed doing vital signs for residents, utilizing the vital signs machine which had a blood pressure cuff, thermometer, and pulse oximetry monitor. CNA I obtained the vital signs for resident #18, then proceeded to obtain the vital signs for resident #19. The CNA did not clean/disinfect the equipment between the residents. On exit from the room, the CNA entered a room across from residents #18 and #19's room to obtain the vital signs for the residents in that room. When asked if she cleaned the equipment between residents, the CNA said she cleaned the equipment with Premium Adult Washcloths, that was kept in the basket attached to the vital sign equipment. Cleaning of the equipment was not observed prior to the surveyor's interview. On 8/21/24 at 3:58 PM, CNA J stated the vital sign machine was normally cleaned with bleach wipes between residents, if not she used the Premium Adult washcloths. CNA J, then went to a vital sign machine located in the hallway and indicated the wipes used. It was noted to be the Premium Adult washcloths. (continued on next page)		

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/21/24 at 4:02 PM, the Assistant Director of Nursing (ADON)/ Infection Preventionist stated Sani-cloth wipes were to be used to clean/disinfect the vital sign machine, and not the Premium adult washcloths. The ADON/Infection Preventionist explained the equipment should be clean/disinfected between each resident, and when CNAs had completed their vital signs for the residents assigned to them, the equipment was to be cleaned with Sani-cloth wipes, and a label indicating the equipment was cleaned/disinfected should be placed. The facility's policy, Isolation- Two Tier Transmission Based Precautions- Standard Precautions with copyright date of 2013 read, Ensure that reusable equipment is not used for the care of another resident until it has been cleaned and disinfected appropriately.		