

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: 105754	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/01/2025
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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49840 Based on interview, and record review, the facility failed to conduct an accurate and thorough investigation for a potential allegation of neglect related to elopement for 1 of 8 residents reviewed for elopement risk, (#3), and for a fall with major injury for 1 of 3 residents reviewed for falls, (#5), of a total sample of 10 residents. The facility's failure to investigate and determine the root cause of the elopement prevented them from implementing interventions and safeguards to mitigate elopement and prevent other cognitively impaired residents from exiting the facility unsupervised. On 10/29/24 between approximately 5:00 AM and 6:00 AM, resident #3, a cognitively impaired woman who resided in the facility's west wing, exited the facility unbeknownst to staff through the east wing door along the front of the facility. Resident #3 traversed the facility's unevenly paved parking lot and crossed over a 45 mile-per-hour, moderately high trafficked four-lane road in the dark. She was found approximately 30 minutes later by the facility's Night Supervisor, sitting on the ground in front of a gas station convenience store approximately 0.3 miles from the facility, and ultimately returned to the facility. While resident #3 was out of the facility unsupervised, she had a fall as evidenced by her muddy and wet clothing her daughter found. There was a likelihood resident #3 could have been seriously injured, lost or hit by a motor vehicle while outside the supervision of the facility. The facility's failure to complete a thorough investigation, maintain accurate record of investigation findings, and ensure appropriate corrective actions were in place, placed resident #3 and other cognitively impaired residents at a risk of elopement. This failure resulted in Immediate Jeopardy starting on 10/29/24. There were a total of three residents currently at the facility identified as at risk for elopement. Findings: Cross Reference F689 1. Resident #3, a [AGE] year-old female, was admitted to the facility from an acute care hospital for short term rehabilitation after a diagnoses of syncope on 10/27/24. Her diagnoses included syncope with collapse, postural low blood pressure, Parkinson's disease, dementia with agitation, abnormalities of gait and mobility, and cognitive communication deficit. She resided on the west wing of the facility. (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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the 5000-3008 State Agency's Medical Certification for Medicaid Long-Term Care Services and Patient Transfer form, dated 10/26/24, by hospital staff, revealed resident #3 was a fall risk, required a surrogate for decision making, and was alert but disoriented. Review of the Physical Therapy (PT) and Occupational Therapy (OT) evaluation dated 10/28/24, revealed resident #3 required some help with her functional cognition and had impaired safety awareness. Review of a written complaint made to the state agency on 1/13/25 by an anonymous staff member revealed that a male resident eloped out the front door of the facility on 1/09/25, and the facility failed to supervise the resident or intervene when he had exhibited elopement behaviors. The anonymous staff member stated previously a female resident eloped from the facility on the night shift and went all the way up the street. The anonymous staff member indicated that the facility did not do education or drills after these elopements occurred and did not properly report the incidents. On 1/27/25 at 2:19 PM, Registered Nurse (RN) C stated she recalled a female resident who eloped from the facility a few months prior, but she could not recall the resident's name. She remembered the resident got out from the side door and, went to the end of the street. She recounted that staff were alerted and attempted to search for the resident. RN C stated from the video that was seen of the resident after the elopement you could tell the resident had everything planned and she knew what she was doing. RN C stated she did not recall receiving any education or training after the incident, about elopements including preventing elopements or what to do if a resident was to elope. Review of the facility's reportable and adverse incidents log for six months from August 2024 through January 2025 revealed the facility had no documented incidents or reports of neglect related to elopement. On 1/28/25 at 3:35 PM, and at 5:30 PM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) were asked if there were any possible elopements, and they denied there were any residents who had eloped or attempted to elope from the facility. Later at 6:00 PM, the DON returned and stated that after speaking to the Assistant Director of Nursing (ADON) she now recalled a near miss with resident #3, but that she only went to the door and the alarms went off. She explained the resident wanted to, take a stroll so the Night Supervisor walked outside with the resident. The DON said the facility had cameras on the property, but they were antiquated, so video of the incident was not available to view. The DON acknowledged that although she did not consider what happened to be an elopement, after the near miss she interviewed staff regarding the event, reviewed the incident during the Interdisciplinary Team (IDT) meeting, and had maintenance check all the doors. She said they concluded the incident was not an elopement because the resident did not leave the property, and she had been supervised the whole time. (continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/28/25 at 5:08 PM, in a telephone interview Licensed Practical Nurse (LPN) A stated she had worked at the facility over four years and was the Night Supervisor on most nights at the facility. She recalled on 10/29/24 she was assigned to work the medication cart on the west wing on the overnight shift. She remembered on 10/29/24 sometime between the hours of 5:45 AM and 6:00 AM she was passing medications on the west wing and a female resident from that wing was following her around trying to go into other resident's rooms. The Night Supervisor said she did not know the female resident very well as the resident was newly admitted and she herself had just returned from an extended leave. The Night Supervisor explained the woman, (resident #3) appeared lonely and wanted attention but she was busy passing out medications, so she guided her back to her room and asked her to wait for the Certified Nursing Assistant (CNA) to come and change her brief. The Night Supervisor left resident #3 unattended in her room and went to ask a CNA B to assist the resident with incontinence care. The Night Supervisor said she continued passing out medications when sometime later a nurse from the east wing informed her the east wing door had alarmed. The east wing nurse told her she did not see anyone outside, so she closed the door. The Night Supervisor recalled she could not hear the door alarm on the west wing but had staff perform a head count of all residents. The Night Supervisor remembered resident #3 wandering around her medication cart earlier and realized she was unaccounted for, so she started to search for the resident. She stated she went outside to look for resident #3 and when she walked toward the road from the parking lot she saw resident #3 down the road, across the street, walking towards a gas station. The Night Supervisor explained she went back, got her personal vehicle and drove down toward the gas station where resident #3 was sitting on the ground near the door of the closed convenience store. The resident was dressed in a pair of pants, short sleeve shirt, and gripper socks but was not wearing shoes. The Night Supervisor recalled resident #3 was combative and resistant to get in her car to return to the facility so three police officers who were parked nearby assisted her. She explained the police officers spoke with the facility Administrator via the Night Supervisor's personal cell phone to confirm resident #3 resided at the facility before assisting to get the resident into the Supervisor's car. The Night Supervisor confirmed she had attempted to notify the NHA, and DON when she learned of resident #3's elopement from the facility but was initially unable to reach them. She recalled she was able to reach the ADON first and then eventually spoke with the NHA while she was at the gas station prior to returning to the facility. She explained resident #3 was returned to the facility at approximately 7:00 AM. The Night Supervisor said she was instructed by the DON by phone to complete a head-to-toe assessment, place an electronic wander bracelet on resident #3 and place her on one-to-one supervision. The Night Supervisor stated she performed the assessment on resident #3, completed a new elopement risk assessment, placed the electronic wander bracelet and initiated one to one supervision to ensure resident #3 did not attempt to elope again. The Night Supervisor recalled when the DON, NHA, and ADON arrived she watched video captured by cameras at the facility and was able to see resident #3 exiting the facility via the east wing door on the front of the building (photo evidence was received). She recalled they could see resident #3 walk across the parking lot toward the road through an area with low tree branches and finally disappear from the camera's view as she left the property. The Night Supervisor described they watched video that captured the east wing nurse close the door that resident #3 left from without going outside to look for any residents. She said she sent a written statement about what happened that morning via email to the DON and was interviewed about it on the day of the incident. The Night Supervisor recalled she was told by the DON not to document about the incident in the resident's medical record or the facility's internal incident reporting system. (continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of resident #3's medical record revealed the only documentation related to the incident on 10/29/24 was an IDT note entered on 10/30/24 at 12:30 PM, by the DON. The DON documented resident #3, ambulated over to the door pressed on the egress bar and sounded the alarm. She indicated in her documentation that staff, Responded to the resident and redirected her back to her room. She was alert and oriented to person, place, and time and said she just wanted to go for a walk. She said she was not feeling quite herself and this happened when she had a UTI [urinary infection]. Review of laboratory results for resident #3, revealed on 10/30/24 a urine culture that was ordered to rule out urinary infection was negative. Further review of the medical record revealed no orders placed for any antibiotics to treat any urinary infection for resident #3 at that time. In interviews on 1/28/25 at 6:00 PM, and 1/30/25 at 4:10 PM, the DON confirmed she was the Risk Manager at the facility. She said she was aware resident #3 had exited the facility but said she only got to the parking lot not to the gas station. She recalled that on 10/29/24 the ADON received a call from the Night Supervisor to inform him resident #3 had opened the east wing front door which triggered the alarm to go off. She said the Night Supervisor said the resident went out into the parking lot, but she immediately went behind her and brought her back inside. The DON said she viewed the camera footage with the NHA and ADON and confirmed that was what happened. She stated other staff members on duty provided similar statements. The DON said the incident was determined to be a near miss, not an elopement. She recalled she had reviewed resident #3's hospital records which showed she had, some impaired cognition but was not aware the resident had dementia. The DON stated she evaluated the resident's mental status after the incident and she was alert and oriented to person, place, and situation with a Brief Interview for Mental Status (BIMS) score of 8/15. The DON acknowledged a BIMS score of 8/15 indicated impaired cognition and that resident #3 was not alert and oriented to person, place and time. The DON confirmed she handwrote all of the witness statements she collected by interview, and explained the Night Supervisor was the first witness she spoke with. The next day, 1/29/25 at 2:15 PM, the DON gave her definition of an elopement as when a resident got out of the facility without staff knowledge. She added resident #3 did not elope because she was just in the parking lot. She did not explain how as the Risk Manager she thoroughly investigated the incident of 10/29/24 if she was not aware resident #3 left the facility property, was found at a gas station down the street and was later returned by the Night Supervisor to the facility in her car. Review of investigation documents from the event on 10/29/24, provided on 1/30/25, revealed the facility determined resident #3 knew what she was doing, did not have exit-seeking behaviors prior to the incident, was not outside of her determined safe space, and was able to recognize and mitigate any potential safety risks. The investigation consisted of an audit tool for the magnetic locks performed on 10/29/24 by the Maintenance Supervisor for seven magnetic door locks in the facility, Review of the investigation document, Missing Resident Accident Plan completed by the DON and dated 10/29/24 revealed the screamer sounded at 5:55 AM. The document indicated the Night Supervisor was notified at that same time and the search was initiated at that time as well. The DON documented the resident was found and returned to the facility three minutes later between 5:57 AM and 6:00 AM. The Activity section indicated staff, Complete an Incident Report and conduct a thorough Incident investigation, and included for staff to follow facility Incident Report and Investigative Guidelines including appropriate state and federal reporting requirements, was checked off and dated 10/29/24 by the DON. (continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Interview Record for the Night Supervisor was signed and dated 10/29/24 by the DON. The document revealed the reason for interview, Unplanned exit. The content of the interview written by the DON indicated, the Night Supervisor was alerted to the alarm on the east wing by RN P and then she went out the front door and saw the resident in the parking lot. She indicated she returned with the resident to the facility between 5:00 AM and 6:00 AM. The interview form was written in the DON's handwriting and never signed by the Night Supervisor to indicate her acknowledgement of the accuracy of the interview. A total of five interview records included the handwritten content of interview, dated 10/29/24 and signed only by the DON were presented as part of the facility investigation. None of the five interviews documented where resident #3 was actually found or revealed who actually found the door open that resident #3 exited from. The interviews did not reveal any information of when resident #3 was last seen by staff or of any behaviors she may have had before leaving the facility that would be pertinent for prevention of future elopements. The records did not include whether staff heard the alarm, any mention of whether staff went outside to look for a missing resident as soon as the open door was found and included conflicting information about which door alarm sounded. Review of resident #3's hospital records from 10/22/24 until 10/27/24 revealed documentation she experienced hallucinations, decreased awareness of need for safety, and impulsiveness. On 1/30/25 at 9:56 AM, the NHA confirmed she was the facility Abuse Coordinator and was responsible for overseeing day-to-day operations in the facility. She recalled that on 10/29/24 she received a call from the Night Supervisor who told her resident #3 had gotten out the door but was safe. She stated that witness interviews were obtained, and she watched the video of resident #3 leaving the facility. The NHA explained the video was not clear because it was dark outside but saw that when resident #3 opened the east wing door and stepped out into the parking lot, the nurse was right behind her. She stated staff responded very fast, policies and procedures were followed, and all things were handled appropriately. She said the Medical Director was informed of the incident during an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting held on 10/29/24. The NHA said she was not aware that resident #3 had walked to the gas station and it was the first time she had heard this. She said as the Abuse Coordinator she encouraged staff to report any care concerns they had and preferred for staff to overcommunicate. The NHA did not explain if the incident was thoroughly investigated how she and the NHA failed to find out from multiple staff who were aware resident #3 eloped from the facility to a gas station down the street. On 2/01/25 at 11:58 AM, the Medical Director was interviewed by phone, and he stated he was not aware of resident #3's elopement on 10/29/24, only the near miss of a male resident who was immediately returned to the facility in December. He confirmed he had taken part in Ad Hoc QAPI meetings both in October and in December of last year but stated he was shocked and did not know of resident #3's elopement from the facility to the gas station down the road. (continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/30/25 at 4:10 PM, the ADON in an interview with the NHA and DON present, stated that in the early morning hours of 10/29/24, he received a call from the Night Supervisor, who told him resident #3 had exited the facility. He said he directed her to call the NHA and said he did not speak with her again until he arrived at the facility that morning. The ADON recalled after staff interviews, he watched the video and saw resident #3 exit the facility via the east wing door. He recalled she only made it to the parking lot before being brought back inside by the nurse. The ADON stated he was not aware resident #3 had walked to the gas station. He said he spoke with staff that morning to review the incident, which he recounted was a near miss not an elopement because staff always had eyes on the resident, and she was safe. On 1/29/25 at 1:45 PM, Regional [NAME] President #1 stated he was not very familiar with the elopement investigation for resident #3 because he had recently switched regions to help the new Regional [NAME] President #2. Regional [NAME] President #1 stated if he had been at the facility on Monday, 1/27/25, (the day the survey started), he would have told the NHA and DON to provide the elopement investigation to the surveyors. He explained there were different definitions for elopement depending on the facility. He said at some facilities if the resident was in line of sight on the property, then it was not an elopement. He declined to provide the facility's definition of an elopement because he said he no longer served this region and was unable to say why this incident had not been reported by the facility. Regional [NAME] President #1 declined to answer whether he considered a resident walking to the gas station down the street an elopement. On 1/29/25 at 4:12 PM, in a telephone interview with anonymous LPN N stated she wished not to give her name as she feared retaliation and retribution from the facility for speaking about the elopement. LPN N stated she worked the 7:00 AM to 3:00 PM shift on 10/29/24 and was driving to work when she saw resident #3 with the Night Supervisor and police at the [name] gas station at approximately 6:30 AM. She said afterwards resident #3 was assigned a one-to-one sitter and she found it odd for the DON and NHA to say resident #3 did not elope because, they don't put someone on 1:1 just for pushing the bar on the door like the DON documented on her note. She indicated resident #3 was confused and her hospital transfer form indicated she needed a surrogate. She said staff were told by the NHA that this was not an elopement because resident #3 only made it to the parking lot. She was not asked to provide a statement and said staff were concerned that the incident was never reported to the state. She said this was not the first time they had failed to report an incident. She said she found it odd that the Regional [NAME] President of Clinical Services attended the morning staff meeting after the incident and read witness statements to all the department heads which she had never done before. She recalled the statements implied resident #3 never left the facility's parking lot and did not mention how she was found at the gas station. She said everything was odd about the way they [the administration] were acting. LPN N stated staff were asked not to document the incident in the facility's electronic incident reports and investigation system. On 1/29/25 at 4:25 PM, in a second anonymous telephone interview Certified Nursing Assistant (CNA) O stated she did not want to give her name for fear of retribution from the facility. CNA O stated she worked the 7:00 AM to 3:00 PM shift on 10/29/24. CNA O said she witnessed the Night Supervisor and resident #3 with the police at the [name] gas station across the street and down the road from the facility on her way to work that morning. She said she recognized the supervisor and resident #3 as she drove by. CNA O was not asked for a witness statement and said this was not the first incident swept under the rug by administration. (continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/31/25 at 9:22 AM, in a joint interview with the Regional [NAME] Presidents #1 and #2, and the Regional [NAME] President of Clinical Services, the Regional [NAME] President of Clinical Services confirmed they were informed of the elopement on 10/29/24, were involved with the investigation but had not been told the resident was found at the gas station down the road. She said they followed their process to complete the investigation and Regional [NAME] President #1 said, You can't blame us because we only know what we are told. They had previously concluded the incident was a near-miss based on the version of events they were given; however, they said they had now identified trust issues within the facility administration after they reviewed the investigation and spoke with witnesses. Regional [NAME] President #1 expressed they started a new investigation at this time because the information given by the NHA and DON regarding the incident with resident #3 conflicted with what staff said happened. He said the differences in what they had been told by the facility administration and what they had received from staff was, egregious, so per facility policy the NHA and DON had been suspended pending results of the new investigation. Regional [NAME] President #1 stated they now knew the facility had internal issues which needed to be addressed. According to the facility's undated, Resident Elopement Risk Management Guidelines procedure #14 indicated after an elopement an electronic Incident report and Investigation form should be completed as well as facility reporting to appropriate state agencies. Review of the facility's policies and procedures titled Resident Incident Report and Investigation (Florida) [undated], revealed the purpose of the reporting system was to report all incidents including falls, and elopements/unplanned exits that lead to harm or injury to visitor or resident. Incidents must be documented, investigated, and recorded in the Electronic Tracking System. Reports were to be reviewed as an integral part of the Quality Assurance and Performance Improvement (QAPI) process by the QAPI committee to identify, assess, and evaluate, through self-critical analysis, quality and care issues and develop initiatives for the improvement of care and the quality of life for our residents. Procedures included 4.) documentation of the incident including physician and family notification, 5.) A thorough investigation of the incident should be completed by the DON/Risk Manager, and 10.) The facility risk manager was responsible for ensuring the timely and accurate reporting of incidents and noting on the Potential State Reportable/State Reportable Incident Log. The resident sample was expanded to include five additional residents who were identified as elopement risk, fall risk, and/or new admission. 43192 2. Review of the medical record revealed resident #5 was initially admitted to the facility on [DATE] and readmitted on [DATE], 12/17/24, and 1/15/25. Her diagnoses included Alzheimer's disease, dementia, falls, muscle weakness and fracture of shafts of humerus on the right and left arms. (continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Progress Note dated 1/11/25, by the on-call provider a week after the 1/04/25 fall, revealed LPN I now reported finding resident #5 on the floor after her roommate alerted staff. The note read, Prior to the fall, she was calm and had been put to bed. Five minutes after being put to bed, she was found on the floor. Following the fall, she became agitated and restless, which is noted to be an acute change from her baseline. Resident is refusing vital signs or other care. Nursing staff have resident at the nursing station to closely monitor her. No head injury or obvious trauma was noted during assessment. The pain level was documented as 4 on a scale of 0-10. The resident appeared agitated/anxious, cognition at baseline, restless with no apparent injury. The plan included to Continue to monitor for delayed symptoms or changes in condition . Facility does not have Hydroxyzine available for acute agitation. Treatment planned: Diphenhydramine to be administered. Neurological checks to be continued. Monitor for changes in mental status. Family to be contacted regarding update in status/behavior. Consider further evaluation if pharmacological intervention ineffective: UA(urinalysis), C&S (culture and sensitivity). Orders : Please administer Benadryl 1 tab (tablet) PO (by mouth) x1 (one time) now for agitation and restlessness. Notify a clinician of any change in condition. The on-call provider documented this was an audio and video call with LPN I with resident #5 present. Review of a Change of Condition for an unwitnessed fall on 1/11/25 at 10:50 PM, revealed resident #5 had noted cognitive impairment and indicators of hurting a little bit or a pain level of 1-2. The documentation included resident #5's roommate alerted staff of resident's fall. The resident was observed on the floor near her roommate's bed on her left side. The note indicated the resident was assessed, and no injury was noted. Resident #5 refused staff to obtain her vital signs and staff assisted her to a wheelchair. The follow-up section included an order for UA with C&S but there was no mention of neurological checks. Review of a Change in Condition form completed the day after the fall on 1/12/25 revealed an order was received to transfer resident #5 to the hospital. The form included resident #5 was hurting a lot more or a pain level of 7-8. The form detailed the resident had an unwitnessed fall in her room on Saturday during the 3:00 PM - 11:00 PM shift. The resident was complaining of shoulder pain and PRN (as needed) Tylenol was given with no relief. Orders were received to obtain x-ray and once results were received, the new order was to send the resident to the hospital due to shoulder fractures. The resident exhibited/expressed localized bruising, swelling, or pain over joint or bone as a result of the fall. Review of a Progress Note dated 1/12/25 read, Report given that the resident had a fall last night and complained of left shoulder pain immediately after the fall. Overnight, the patient continued to experience pain, which persisted into the morning. The resident reported increased discomfort when moving the left shoulder. [Name of oncall group] was notified and orders were received to do imaging. The results from imaging showed a left shoulder fx (fracture). MD (physician) was notified along with family. Orders were received to send patient to ER (emergency room). A Progress Note completed five days after the fall, dated 1/16/25 revealed an IDT note which read, January 11th at approximately 10:50 PM resident observed on the floor near her roommates bed on her left side. Resident's roommate notified staff that the resident was trying to get to her candy and ended up losing her balance and falling to the floor. Resident denied pain at time of fall, next morning complained of shoulder pain. X-rays performed and noted humorous [sic] fracture and sent to ER. Resident returned 1/15/25 IDT discussed circumstances of fall and recommends reassess upon return, increased observation, therapy to re-eval [re-evaluate]. (continued on next page)		

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

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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 02/01/2025
NAME OF PROVIDER OR SUPPLIER Conway Lakes Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 Curry Ford Road Orlando, FL 32812	
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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the undated Fall Investigation Information sheet, included the following details: *patient was attempting to get candy from roommate. *She was found on the floor on the left side. *Roommate placed call light. Call light was within reach. *Patient was placed in bed 5 minutes prior to fall. *She had socks and house shoes on. *Patient ambulates independently. *Unwitnessed fall, no staff providing care/assist. *She was assisted off the floor with a gait belt. *No injuries identified. *Neuro checks were not initiated. *Physician was notified. N [TRUNCATED]		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49840 Based on interview, and record review, the facility failed to ensure the initial comprehensive assessment was accurately completed and reflective of the resident's mental status for 1 of 2 cognitively impaired residents reviewed for elopement, of total sample of 10 residents, (#3). Findings: Resident #3 was admitted to the facility on [DATE] with diagnoses that included syncope (fainting) with collapse, orthostatic hypotension (postural low blood pressure), Parkinson's disease, dementia with agitation, and cognitive communication deficit. She was admitted for short term rehabilitation and was discharged on [DATE]. Review of resident #3's medical record revealed an admission assessment was completed on 10/27/24 which noted she was alert and oriented to person, place, and situation with no cognitive deficits. An elopement risk assessment completed on the same day noted she was not an elopement risk because she ambulated independently with a walker, did not exhibit wandering or exit-seeking behaviors, and had no memory issues. Hospital records for resident #3 revealed that on 10/22/24 she was evaluated by physical therapy (PT), while at the hospital and the evaluation noted she was experiencing hallucinations, had decreased awareness of the need for safety, and impulsiveness. The 5000-3008 State Agency's Medical Certification for Medicaid Long-Term Care Services and Patient Transfer form, dated 10/26/24 noted resident #3 required a surrogate for decision making, and was alert, but disoriented, and could follow simple instructions. The hospital transfer form indicated resident #3 was a fall risk. Review of PT and Occupational Therapy (OT)'s evaluation and treatment plan dated 10/28/24, revealed resident #3 required some help with her functional cognition and had impaired safety awareness. A care plan initiated on 10/28/24 noted resident #3 had impaired cognitive function or impaired thought process related to her diagnosis of dementia. Interventions included reorienting, cuing, and supervision as needed. On 10/29/24 resident #3 exited the facility via the east wing door and walked to a gas station located across the street, approximately 0.3 miles down the road. She did not have elopement interventions including increased supervision or an electronic wander prevention bracelet in place at the time of the incident. A post-elopement assessment completed on 10/29/24 noted resident #3 was pacing in a limited area, was alert and oriented, with memory intact, and with no desires to leave. Review of the Discharge Minimum Data Set (MDS) assessment dated [DATE] revealed resident #3 had a Brief Interview for Mental Status (BIMS) score of 8/15, which indicated moderate cognitive impairment. The assessment noted she had poor recall and was unable to say what day of the week it was. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/31/25 at 4:29 PM, the MDS Coordinator said that assessments were completed by the Interdisciplinary Team. She stated that baseline care plans were completed based on the admission assessment completed by the nurse, which captured the resident's cognition and behavior and the hospital orders received. The MDS Coordinator explained they looked at hospital records to obtain diagnoses as well as notes related to the resident's condition and behaviors when assessing a resident. On 1/30/25 at 4:10 PM, the Director of Nursing (DON) did not say how resident #3 was alert and oriented to person, place, and time per her documentation if her BIMS score was 8/15 which indicated she was cognitively impaired.		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49840 Based on observation, interview, and record review, the facility failed to appropriately evaluate, monitor, and prevent a cognitively impaired resident from exiting the facility unsupervised, for 1 of 8 residents reviewed for elopement risk, (#3) and failed to develop and implement appropriate interventions that included adequate supervision to prevent a fall with fractures for a cognitively impaired resident for 1 of 3 residents reviewed for falls, (#5), of a total sample of 10 residents. These failures contributed to the elopement of resident #3 and placed her at risk for serious injury, impairment, and/or death. While resident #3 was outside the facility unsupervised for over 30 minutes, she fell and there was likelihood she could have been seriously injured, harmed, become lost, accosted by a stranger, or hit by a vehicle and died . The facility's failure to develop and implement appropriate interventions including increased supervision for a resident with history of repeated falls and cognitive impairment resulting in actual harm for resident #5 who sustained bilateral humerus fractures. On [DATE] between approximately 5:00 AM and 6:00 AM, resident #3, exited the facility without staff knowledge through the east wing door to the front of the facility. Resident #3 traversed the facility's unevenly paved parking lot and crossed over a 45 mile-per-hour, moderately high trafficked four-lane road in the dark. She was found approximately 30 minutes later by the facility's Night Supervisor, sitting on the ground in front of a closed gas station approximately 0.3 miles from the facility. The facility's failure to appropriately identify exit-seeking behaviors, provide adequate supervision for cognitively impaired residents, and ensure a safe environment for all residents, contributed to the elopement of resident #3 and placed all elopement risk residents at risk. This failure resulted in Immediate Jeopardy starting on [DATE]. There were a total of three current residents identified at risk for elopement. Findings: Cross Reference F610 Resident #3, a [AGE] year-old female, was admitted to the facility for short term rehabilitation on [DATE] with diagnoses that included syncope (fainting) with collapse, orthostatic hypotension (postural low blood pressure), Parkinson's disease, dementia with agitation, abnormalities of gait and mobility, and cognitive communication deficit. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #3 was previously admitted to an acute care hospital on [DATE] from an Assisted Living Facility (ALF) where she resided with complaints of recurrent syncope (fainting) related to a past medical history of orthostatic hypotension (postural low blood pressure). Per hospital records from the visit, she was treated with intravenous (IV) fluids and antibiotics for dehydration and urinary tract infection (UTI) that was likely exacerbated by her underlying orthostatic hypotension. She was evaluated by hospital physical therapy (PT), the evaluation noted she experienced hallucinations, decreased awareness of need for safety, and impulsiveness. The evaluation indicated she was able to ambulate 15 feet with minimal assistance using a front-wheel walker but needed rehabilitation services prior to returning to the ALF. Review of the ,d+[DATE] State Agency's Medical Certification for Medicaid Long-Term Care Services and Patient Transfer form, dated [DATE], revealed resident #3 required a surrogate for decision making, was alert, but disoriented, could follow simple instructions and was at risk for falls. Review of resident #3's medical record revealed an admission assessment was completed on [DATE] which documented she was alert and oriented to person, place, and situation with no cognitive deficits. An elopement risk assessment completed the same day noted she was not an elopement risk because she ambulated independently with a walker, did not exhibit wandering or exit seeking behaviors, and had no memory issues. Review of PT and Occupational Therapy's (OT)'s evaluation and treatment plans dated [DATE] revealed resident #3 was able to ambulate up to 150 feet with a four-wheel walker and partial to moderate assistance. The assessment indicated she required some help with her functional cognition, had impaired safety awareness, and was at risk of falls due to her history of syncope and orthostatic hypotension. On [DATE] at 2:19 PM, Registered Nurse (RN) C stated she usually worked on the west wing on the overnight shift from 11:00 PM to 7:00 AM but covered other shifts as needed. She recalled a previous incident when a female resident exited the facility through the east wing door and ended up across the street at a gas station. RN C said it happened during the overnight shift and the Night Supervisor had to drive in her personal vehicle to get the resident. She remembered the east wing door alarm went off which prompted staff to do a head count of all the residents, but was unable to remember the name of the resident or exactly when it occurred. On [DATE] at 10:04 AM, RN D said in a phone interview she had worked at the facility since 2023 but had recently resigned due to differences with administration. She recalled that on [DATE] she worked the 7:00 AM to 3:00 PM shift on the west wing. RN D said she arrived at work that morning around 7:00 AM and was told a female resident from the west wing had exited the facility via the east wing door. She said the resident walked across the street to a gas station down the road before the Night Supervisor found her there. RN D recalled resident #3 was confused but had not been wearing an electronic wander prevention bracelet when she eloped. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 5:08 PM, in a telephone interview Licensed Practical Nurse (LPN) A, confirmed she was the Night Supervisor at the facility on Monday through Friday nights. She expressed she had worked at the facility approximately four years and had just returned from maternity leave when resident #3 eloped from the facility. She recalled that on [DATE] at approximately 5:45 AM she was passing medications on a cart on the west wing and noticed that resident #3 had been following her around attempting to go into other resident rooms. The Night Supervisor stated she redirected the resident back to her room and asked her to wait for the Certified Nursing Assistant (CNA) to come change her brief. The Night Supervisor recalled she left resident #3 unattended while she went to ask a CNA B to assist the resident with toileting. The Night Supervisor stated she continued passing out medications when a short time later a nurse from the east wing alerted her that the east wing exit door had alarmed, but said she did not see anyone outside, so she closed the door. The Night Supervisor said she was unable to hear the door alarm from the west wing but immediately had staff perform a head count of all the residents. She recounted that resident #3 was unaccounted for after the head count, so she went outside to look for her. The Night Supervisor recounted when she went outside to look for resident #3 and approached the road from the parking lot she saw resident #3 walking down the road, across the street, towards a gas station. The Night Supervisor explained she went back, got her personal vehicle and drove down toward the gas station where resident #3 was found sitting on the ground near the door of the closed convenience store. She described the resident was dressed in a pair of pants, short sleeve shirt, and gripper socks but was not wearing shoes. The Night Supervisor recalled resident #3 was combative and resistant to get in her car to return to the facility so three police officers who were parked nearby assisted her. She explained the police officers spoke with the facility Administrator via the Night Supervisor's personal cell phone to confirm resident #3 resided at the facility before assisting to get the resident into the Supervisor's car. The Night Supervisor confirmed she had attempted to notify the Nursing Home Administrator (NHA), and the Director of Nursing (DON) when she first learned of resident #3's elopement from the facility but was initially unable to reach them. She recalled she was able to reach the Assistant Director of Nursing (ADON) first and then eventually spoke with the NHA while she was at the gas station prior to returning to the facility. The Night Supervisor explained resident #3 was returned to the facility at approximately 7:00 AM and she was instructed by the DON by phone to complete a head-to-toe assessment, place an electronic wander prevention bracelet on resident #3 and place her on one-to-one supervision. The Night Supervisor stated she performed the assessment on resident #3, completed a new elopement risk assessment, placed the electronic wander bracelet and initiated one-to-one supervision to ensure resident #3 did not attempt to elope again. The Night Supervisor recalled when the DON, NHA, and ADON arrived they watched video captured by cameras at the facility and was able to see resident #3 exiting the facility via the east wing door on the front of the building (photo evidence was received). She recalled they could see resident #3 walk across the parking lot toward the road through an area with low tree branches and finally disappear from the camera's view as she left the property. The Night Supervisor described they watched video that captured the east wing nurse close the door that resident #3 left from without going outside to look for any residents. She said she sent a written statement about what happened that morning via email to the DON and was interviewed about it on the day of the incident. The Night Supervisor recalled she was told by the DON not to document about the incident in the resident's medical record or the facility's internal incident reporting system. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #3's progress notes dated [DATE] indicated at 1:09 PM, Social Service staff completed a Brief Interview for Mental Status (BIMS) evaluation with a score of 8 out of 15, which indicates moderate cognitive impairment. Review of a skilled nursing note dated [DATE] documented resident #3 was confused, disoriented, had disorganized thinking, and severe cognitive impairment. An Interdisciplinary Team (IDT) note entered on [DATE] at 12:30 PM, by the DON, indicated the resident ambulated over to the door pressed on the egress bar which sounded the alarm. The note detailed that staff responded to the resident and redirected her back to her room. The note continued that resident #3 was alert and oriented to person, place, and time and told staff she just wanted to go for a walk. The DON documented the resident said she was not feeling quite herself and this happened when she had a urinary tract infection (UTI). Resident #3's physician order summary for [DATE] showed that on [DATE] a wander device was placed on the resident's left ankle and a urine culture was ordered to confirm that resident's behaviors were due to a UTI. The lab results, received on [DATE], were negative for UTI. The order summary revealed resident #3 did not receive treatment for an infection while at the facility. Review of resident #3's medical record revealed she had no care plans or interventions for risk for elopement or wandering until initiated on [DATE], the day after she left the facility unsupervised. On [DATE] at 3:35 PM, and at 5:30 PM, the DON and NHA stated they were not aware of any incident that involved elopement of a resident. Later at 6:00 PM, the DON returned and said the ADON reminded her of the near miss incident that occurred on [DATE] involving resident #3. She explained the ADON received a call from the Night Supervisor during the morning hours of [DATE] to report resident #3 had opened the east wing front door and the alarm had gone off. She stated the Night Supervisor told the ADON she was right behind the resident when it happened, and she walked outside with her. The DON said she talked with the Night Supervisor and got her statement but was never told the resident left the property. The DON confirmed they looked at the video but said they only saw the resident get out into the parking lot and brought back in immediately. The DON said she spoke with resident #3 after the event and was told she just wanted to go out for a walk because she was feeling a bit off, like when she previously had a UTI. The DON recounted the resident was alert and oriented to person, place, and situation and knew what she was doing. The DON said resident #3's daughter was informed of the elopement and was told she only exited into the parking lot but was brought in immediately and was safe. The DON said she believed the resident was confused due to a UTI she was being treated for and her daughter agreed so a urine culture was ordered. She said she interviewed staff regarding the incident, reviewed the incident during the morning's IDT meeting, and had maintenance check all the doors. She said they concluded that the incident was not an elopement because the resident did not leave the property, and she was being supervised the whole time. She did not say how she was not aware resident #3 left the facility property and was found later at the gas station down the street by the Night Supervisor, but staff who worked that day were. Review of a physician note dated [DATE] at 1:00 PM, revealed resident #3 was evaluated by the behavioral health physician due to disorganized/confused thinking. The behavioral health physician noted the resident had moderate cognitive impairment. She administered the St. Louis University Mental Status Examination (SLUMS) assessment which showed a score of 16 out of 30. She documented that the SLUMS score may have been lower because the resident was being treated for a UTI. The evaluation noted that staff reported that the resident wandered and was actively exit-seeking. Recommendations were made for psychological services to treat mixed anxiety. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	SLUMS is a screening test for Alzheimer's disease and other kinds of dementia. It is often used for people with early signs of dementia and measures aspects of cognition. A score of 0 to 20 indicated dementia, (retrieved on [DATE] from www.verywellhealth.com). On [DATE] at 4:12 PM, in a telephone interview with anonymous LPN N, she stated she wished not to give her name as she feared retaliation from the facility for speaking about the elopement. LPN N stated she worked the 7:00 AM to 3:00 PM shift on [DATE], and was driving to work when she saw resident #3 with the Night Supervisor and police at the [name] gas station at approximately 6:30 AM. She said afterwards resident #3 was assigned a one-to-one sitter and she found it odd for the DON and NHA to say resident #3 did not elope because, they don't put someone on one-to-one just for pushing the bar on the door like the DON documented on her note. She recalled resident #3 was confused and needed a surrogate. She said staff were told by the NHA that this was not an elopement because resident #3 only made it to the parking lot. She said she found it odd that the Regional [NAME] President of Clinical Services attended the morning staff meeting after the incident and read witness statements to all the department heads which she had never done before. She recalled the statements implied resident #3 never left the facility's parking lot and did not mention how she was found at the gas station. She said everything was odd about the way they [administration] were acting. LPN N stated staff were asked not to document the incident in the facility's electronic incident reports and investigation system. On [DATE] Regional [NAME] President #1 provided the team a binder with the investigation completed on [DATE] for resident #3 which included diagnoses of syncope, Parkinson's disease, orthostatic hypotension, UTI, and a new diagnosis of episodic cognitive/behavioral changes specific to infection. A timeline of events was provided which noted resident #3 was outside for approximately five minutes but was being supervised by staff the entire time. The investigation noted resident #3's daughter was notified of the incident by the DON and both resident and daughter were educated on the Leave of Absence (LOA) process and they expressed understanding. The investigation included checking the alarm doors, the electronic wander prevention bracelet system, interviews with staff involved handwritten by the DON, notification to the Medical Director, an Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting, and a Performance Improvement Plan (PIP) initiated. Regional [NAME] President #1 said administration determined that the incident did not meet the criteria for elopement because the resident was acting in a cognizant manner, including recognizing and mitigating any potential safety risks, was easily able to speak about her actions, had intent to leave, and was not outside of her determined safe space. The investigation documents noted that on the morning of the incident resident #3 was dressed for the day in appropriate clothing and footwear but did not utilize the sign in/out process. On [DATE] at 9:56 AM, the NHA confirmed she viewed camera footage on [DATE] and saw resident #3 exit the facility through the east wing door and heard the alarm. She explained that the resident was seen stepping out the door and a nurse was right behind her but it was dark outside so she could not make out who the nurse was. The NHA recalled that staff responded within two minutes and the resident was not harmed. The NHA said the video was no longer available to view because it had not been saved. She confirmed she spoke with the Night Supervisor by phone regarding the incident and then talked to her in person when she arrived at the facility that morning. The NHA did not say why she did not inquire as to the events as witnessed by the Night Supervisor and was unaware the Night Supervisor found resident #3 at the gas station down the road and brought her back to the facility. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 4:10 PM, in an interview with the ADON, with the NHA and DON present, he confirmed he received a call on [DATE] at approximately 6:00 AM from the Night Supervisor informing him resident #3 had exited the facility through the east wing door to the parking lot but she had been brought inside immediately and was unharmed. He recounted he told LPN A to call the DON and NHA but did not speak with her again until he arrived at the facility at around 7:00 AM. He confirmed he watched the video of the incident with NHA, DON, and the Night Supervisor and saw resident go out into the parking lot. On [DATE] at 4:51 PM, in a telephone interview resident #3's daughter, explained she was the Power of Attorney, and said that her mother lived at an ALF prior to hospitalization because she needed some help with activities of daily living (ADLs). She indicated her mother was anxious while at the facility because she did not want to be there. Resident #3's daughter explained her mother was hospitalized because she had repeated falls due to fainting. She confirmed her mother had dementia and forgot things most of the time, but was able to make her needs known. She recalled she received a phone call from an unknown staff at the facility on [DATE] to inform her that her mother had left the building but was safely returned. Resident #3's daughter said she called the DON, left her a message, and visited the facility but was unable to get in contact with her. She recalled that during her visit a staff member was sitting with her mother at the bedside but did not give any further information on the incident. She said her mother must have fallen when she was outside because she did her mother's laundry that day and noticed her pants and shirt were still wet and muddy. She said her mother was discharged from the facility a short time later on [DATE]. Resident #3's daughter said her mother later expressed that she left the facility and went up the street. She said she was upset when she found out this happened to her mother. On [DATE] at 11:58 AM, in a telephone interview the Medical Director stated he was not aware resident #3 left the facility through an exit door, crossed the road in front of the facility and walked down to the gas station approximately 0.3 miles away without knowledge of facility staff on [DATE]. He confirmed he had taken part in an Ad Hoc QAPI meetings, both in October and in December of 2024, but could not recall any details of resident #3's elopement. He stated if resident #3 was able to elope from the facility to a gas station down the road it was concerning. According to the facility's undated, Resident Elopement Risk Management Guidelines an elopement occurred when a resident, who was not alert/oriented, was found outside the property line of the facility without the knowledge of staff, or when a resident was identified as missing from the facility. The purpose of this guideline was for the facility to provide a safe environment for residents and implement measures to identify residents at risk for elopement, as well as preventative measures to minimize elopement occurrences. The Facility Assessment, with most recent review date of [DATE], revealed the facility was able to care for residents with conditions including UTI, impaired cognition, Parkinson's disease, and dementia. The resident sample was expanded to include six additional residents who were identified as at risk for elopement, falls, and/or new admissions. 43192 (continued on next page)		

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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	
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Review of the medical record revealed resident #5 was initially admitted to the facility on [DATE] and readmitted on [DATE], [DATE], and [DATE]. Her diagnoses included Alzheimer's disease, dementia, falls, need for assistance with personal care, muscle weakness and fracture of shafts of humerus on the right and left arms. Review of the admission Minimum Data Set (MDS) assessment with dated [DATE] revealed resident #5's BIMS score of 0 out of 15, which indicated severe cognitive impairment. No behavioral symptoms or rejection of care necessary to achieve goals for health and well-being were noted. The Preferences for Customary Routine and Activities section noted it was somewhat important for her to have snacks available between meals and very important for her to choose her own bedtime. The MDS showed she required partial/moderate assistance for eating and upper body dressing, substantial/maximal assistance for oral hygiene, shower/baths, lower body dressing and personal hygiene and was dependent on staff for toileting hygiene. The MDS assessment noted resident #5 was independent with rolling from left to right in bed, sit to lying and lying to sitting on the side of bed. She needed partial/moderate assistance to sit to stand, chair/bed-to-chair transfer, toilet transfer and to walk 50 feet with two turns. She used a walker for mobility and was frequently incontinent of bladder and bowel functions. Review of resident #5's Admission/Readmission form dated [DATE] revealed she required staff assistance with ADLs. She ambulated with assistance or assistive device and used a wheelchair. The form showed poor trunk control affected her gait/balance. She had 1 to 2 falls in the last three months and was determined to be a fall risk. Review of a Care Conference Note dated [DATE] read, Patient increased fall risk, improved ambulation status and wandering safety addressed with family, during the care plan meeting. Review of the facility's [DATE] to [DATE] Incident Log revealed resident #5 fell on [DATE], [DATE], and [DATE]. A progress note in the medical record revealed resident #5 also fell on [DATE]. Review of resident #5's medical record revealed the Progress Note entered on [DATE] at 10:53 PM, included the resident had reported a fall in the morning, when she went to the bathroom. The nurse documented bruising and swelling was noted to the right cheek and bruising on the chin. The nurse recorded resident #5 complained of pain to her right shoulder for which she administered Tylenol, with positive result. The physician was notified and ordered a right shoulder x-ray. The note indicated the x-ray technician came to the facility but resident #5 refused the x-ray at that time. The nurse noted the on-call physician and resident #5's daughter were notified, and neuro-check was within normal. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Progress Note by the on call provider dated [DATE] revealed LPN I reported finding resident #5 on the floor after her roommate alerted the staff. The note read, Prior to the fall, she was calm and had been put to bed. Five minutes after being put to bed, she was found on the floor. Following the fall, she became agitated and restless, which is noted to be an acute change from her baseline. Resident is refusing vital signs or other care. Nursing staff have resident at the nursing station to closely monitor her. No head injury or obvious trauma was noted during assessment. The pain level was documented as 4 on a scale of , d+[DATE]. The note included, the resident appeared agitated/anxious, cognition at baseline, restless with no apparent injury. The plan read to, Continue to monitor for delayed symptoms or changes in condition. Facility does not have Hydroxyzine available for acute agitation. Treatment planned: Diphenhydramine to be administered. Neurological checks to be continued. Monitor for changes in mental status. Family to be contacted regarding update in status/behavior. Consider further evaluation if pharmacological intervention ineffective: UA (urinalysis), C&S (culture and sensitivity). Orders : Please administer Benadryl 1 tab (tablet) PO (by mouth) x1 (one time) now for agitation and restlessness. Notify a clinician of any change in condition. The on call provider documented this was an audio and video call with LPN I and resident #5 present. Review of a Change in Condition for an unwitnessed fall on [DATE] at 10:50 PM, revealed resident #5 had noted cognitive impairment and indicators of, hurting a little bit or a pain level of ,d+[DATE]. The documentation included resident #5's roommate alerted staff of resident's fall. The note included the resident was assessed, and no injury was noted. The note revealed resident #5 refused vital signs to be obtained and was assisted to a wheelchair. The follow up section included an order for UA with C&S but there was no mention of neurological checks performed. Review of a Change in Condition form dated [DATE] revealed an order was received to transfer resident #5 to the hospital. The form included resident #5 was hurting a lot more, or a pain level of ,d+[DATE]. The resident had an unwitnessed fall in her room on Saturday during the 3:00 PM-11:00 PM shift. The resident complained of shoulder pain and PRN (as needed) Tylenol was given with no relief. Orders were received to obtain an x-ray and once results were received and reviewed by the physician, a new order to send the resident to the hospital due to shoulder fractures. The form included the resident exhibited/expressed localized bruising, swelling, or pain over joint or bone as a result of the fall. Review of a Progress Note dated [DATE] read, Report given that the resident had a fall last night and complained of left shoulder pain immediately after the fall. Overnight, the patient continued to experience pain, which persisted into the morning. The resident reported increased discomfort when moving the left shoulder. [Name of oncall group] was notified and orders were received to do imaging. The results from imaging showed a left shoulder fx (fracture). MD (physician) was notified along with family. Orders were received to send patient to ER (emergency room). (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of resident #5's Progress Notes with date of service [DATE] showed the on-call Physician Assistant (PA) documented Radiology review: abnormal results. Patient had a fall on the day prior. Initially not noted to have injury. Then was complaining of pain this morning. XR (x-ray) of the pelvis with right hip and bilateral shoulders were imaged. Pictures were sent to me which shows a displaced humeral head fracture. The PA noted resident #5 was distressed due to left shoulder pain, and deformity. The Diagnostic Results revealed an unspecified displaced fracture of surgical neck of left humerus, initial encounter for closed fracture. The condition was listed as worsening and an acute new problem. Patient had a displaced fracture of the humeral head - likely a non-surgical fracture. Patient needed additional evaluation. Will send to the ER for additional care. Orders to transfer to the Emergency Department. A discharge MDS assessment dated [DATE] revealed resident #5 sustained two falls, one with major injury, since she was readmitted on [DATE]. An IDT Progress Note dated [DATE] read, [DATE]th at approximately 10:50 PM resident observed on the floor near her roommate's bed on her left side. Resident's roommate notified staff that the resident was trying to get to her candy and ended up losing her balance and falling to the floor. Resident denied pain at time of fall, next morning complained of shoulder pain. X-rays performed and noted humerus [sic] fracture and sent to ER. Resident returned [DATE] IDT discussed circumstances of fall and recommends reassess upon return, increased observation, therapy to re-eval (re-evaluate). Review of a care plan focus initiated on [DATE] and revised on [DATE] read, The resident is at risk for falls. The Care Plan Goal was for the resident's potential for fall/fall-related injuries to be minimized through the next review date. On [DATE] the following interventions were initiated: Use fall screen to identify risk factors, encourage the resident to use call light for assistance as needed, medication review as needed, educate resident/family/caregiver about safety reminders and what to do if a fall occurs, labs as ordered and notify MD (physician) of abnormal labs, encourage resident to wear appropriate non-skid footwear. Additional interventions added after resident #5 had fallen four times and returned from the hospital on [DATE] after the fracture, included increased observation, therapy to reassess, catheter to decrease unassisted ambulation and fall mats while in bed. Review of an additional Care Plan Focused initiated on [DATE] read, Resident is at risk for abnormal bleeding/bruising because of anticoagulant/antiplatelet usage. Review of the medical record revealed a new fall screen was not conducted after resident #5's falls on [DATE] and [DATE]. Review of the OT Evaluation & Plan of Treatment dated [DATE] revealed resident #5's decision making ability for routine activities was moderately impaired and her safety awareness was impaired. The evaluation showed resident #5 required partial /moderate assistance with eating and upper body (UB) dressing. She needed substantial/maximum assistance with oral hygiene, personal hygiene, shower/bathe, lower body dressing, and putting on/taking off footwear. She was dependent on staff for toileting hygiene. Review of the OT Discharge Summary dated [DATE] showed resident #5 functional skills improved to eating with set up assistance. The form indicated she required supervision or touching assistance for oral hygiene, toileting hygiene, toilet transfer, and upper body dressing. Resident #5 needed partial/moderate assistance with showers, lower body dressing, and putting on/taking off footwear. (continued on next page)		

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the OT Evaluation & Plan of Treatment dated [DATE], after her fall and fracture revealed resident #5 was referred to OT due to exacerbation of impaired balance, impaired UB strength, and deconditioning impacting ADL performance. The Functional Skills Assessment showed resident #5 now required substantial/maximum assistance for eating and was dependent on staff for other ADLs and functional mobility. Review of the PT Evaluation & Plan of Treatment dated [DATE] revealed a Fall Risk Assessment with history of falls and a head laceration injury. The assessment included the patient felt unsteady when standing and walking and worried about falling. The reason for referral included, found on ground with unwitnessed fall. Review of the PT Discharge Summary dat[TRUNCATED]		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49840 Based on interview, and record review, the facility failed to maintain complete and accurate medical records in accordance with professional standards of practice related to missing or omitted information pertaining to an elopement for 2 of 4 residents, (#1, and #3); medications administered and fall prevention interventions for 1 of 4 residents reviewed for falls, (#5); and activities of daily living assessments for 1 of 3 residents reviewed for admission assessments, (#8), of a total sample of 10 residents. Findings: 1. Resident #3 was admitted to the facility on [DATE] with diagnoses that included syncope (fainting) with collapse, orthostatic hypotension (postural low blood pressure), Parkinson's disease, dementia with agitation, and cognitive communication deficit. During the early morning hours of 10/29/24 resident #3 exited the facility unnoticed through the east wing door that faced the front of the facility. She walked across the parking lot and a 4-lane road ending up at a gas station 0.3 miles away. The Night Supervisor found her about 30 minutes later and drove her back to the facility. Review of resident #3's medical record revealed no progress notes or change in condition documentation detailing the elopement by resident #3's nurse or other staff who were present during the incident. An Interdisciplinary Team (IDT) note was entered by the Director of Nursing (DON) on 10/30/24 which read, Resident ambulated over to the door pressed on the egress bar and sounded the alarm. Staff responded to the resident and redirected back to her room. In discussion with resident who is alert and oriented to person, place, and time, she stated she just wanted to go for a walk. She also stated she was not feeling quite herself and this happens when she had a UTI [urinary tract infection]. There was no documentation to show the physician or family had been notified of the incident. In a phone interview with the Night Supervisor on 1/28/25 at 5:08 PM, and on 1/29/25 at 5:00 PM, she recalled she had reported the incident to the DON, the Assistant Director of Nursing (ADON), and the Nursing Home Administrator (NHA) but was told not to document in the resident's record. She stated she completed a head-to-toe assessment with no injuries noted and placed resident #3 on one to one supervision after the incident but did not document the occurrence. She said it was her regular practice to document any changes or incidents in the resident's record but was told not to do so by the administration of the facility. The Night Supervisor stated the DON, NHA, and ADON were the only staff authorized to document incidents in the resident's medical record as an IDT note. Review of resident #3's assessments revealed that on 10/29/24, she was evaluated for elopement risk and found to be at risk, so an electronic wander prevention bracelet was recommended. There were no head-to-toe assessments documented for that day. Review of the facility's reportable and adverse incidents log from 8/2024 through 1/2025 revealed no elopements on 10/29/24. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25 at 4:12 PM, in a telephone interview with anonymous Licensed Practical Nurse (LPN) N, she asked to not give her name as she was afraid of retaliation from the facility. LPN N recounted she had been assigned to resident #3 previously and worked the morning she was found at the gas station by the Night Supervisor. She revealed the DON had asked staff not to document resident #3's elopement in the Electronic Tracking System used by the facility for risk management, and was the computer application used for completing incident reports. LPN N recalled nursing staff were told not to complete a change in condition form as well. On 1/30/25 at 4:10 PM, the DON stated staff were educated to document any changes in condition such as new behaviors, falls, or incidents in the resident's medical record. She confirmed a change in condition should have been documented by nurses to note the new exit-seeking behavior since resident #3 had not exhibited the behaviors prior to exiting the facility. The DON explained since there was so much going on that morning, she entered the IDT note after their morning clinical meeting the next day. 2. Resident #1 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, Parkinson's disease, and metabolic encephalopathy (disturbed brain function). Review of the 5000-3008 State Agency's Medical Certification for Medicaid Long-Term Care Services and Patient Transfer form dated 12/17/24 revealed resident #1 was being treated for a Urinary tract infection (UTI) and altered mental status. The hospital transfer form indicated he was alert, disoriented, but could follow simple instructions and was admitted to the facility for rehabilitation. The Admission Minimum Data Set (MDS) assessment dated [DATE] noted resident #1 had severe cognitive impairment. Review of the Admission Elopement assessment dated [DATE] noted resident #1 was alert, but disoriented, ambulatory with assistance, had no wandering behaviors or desire to leave, and had a dementia diagnosis. The summary of these indicators determined he was not at risk for elopement. A progress note dated 12/27/24 documented by nursing staff read, Alerted by spouse around 15:45 [3:45 PM] that resident packed up and wished to go home. Reporter went into room and spoke with resident and spouse on the need for and importance of getting stronger prior to going home and the implications of unapproved D/C [discharge]. Resident expressed understanding of the implications and changed mind to stay longer. However, a [sic] (electronic wander prevention bracelet) was initiated and resident declined and screamed at the reporter to not put that on him. No exit seeking was noted on resident and resident is calm and compliant at this time. UA (urinalysis) and C&S (culture and sensitivity) to be done tonight as a follow up. Will continue to monitor. On 1/27/24 at 3:30 PM, LPN E confirmed he was assigned to care for resident #1 on 12/27/24. He said he notified the physician of the resident's behaviors and the physician gave orders for labs, but confirmed he did not document that. Review of resident #1's physician orders revealed that on 1/09/25 an electronic wander prevention bracelet had been ordered to be placed on his right ankle for safety. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Elopement Risk assessment dated [DATE], revealed resident #1 was now independent with wheelchair, had prior episodes of elopement or exit-seeking, and had behaviors of packing items which put him at a high risk for elopement. Review of resident #3's medical record revealed no documentation or change in condition by nurses to explain why resident #3 was re-assessed for elopement and now ordered an electronic wander prevention bracelet on 1/09/25. On 1/29/25 at 4:25 PM, in a telephone interview with anonymous Certified Nursing Assistant (CNA) O, she stated she worked the day shift at the facility and recounted resident #1 spoke often of wanting to leave the facility. She recounted resident #1 left the facility during the day shift one day in January but was brought back immediately by the parking attendant who was outside the door. She stated staff were told not to document the incident and expressed this was not the first time they had been told this. On 1/28/25 at 12:12 PM, LPN H in an interview with the DON present, confirmed he was resident #3's nurse 1/09/25. He explained resident #1 was more combative than usual that day and kept trying to leave the facility. LPN H stated he was able to wheel himself around and would often sit in the front lobby waiting for his wife. LPN H explained this was what prompted him to obtain an order for the electronic wander prevention bracelet in order to keep the resident safe. LPN H recalled that he was very busy that day and must have missed documenting what happened. 43192 3. Review of the medical record revealed resident #5 was initially admitted to the facility on [DATE] and readmitted on [DATE], 12/17/24, and 1/15/25. Her diagnoses included Alzheimer's disease, dementia, falls, need for assistance with personal care, muscle weakness and fracture of shafts of humerus on the right and left arms. A discharge MDS assessment dated [DATE] revealed she sustained two falls, one with major injury, since admission. Review of the facility's October 2024 to January 2025 Incident Log revealed resident #5 fell on [DATE], 11/14/24 and 1/11/25. A progress note in the medical record revealed resident #5 also fell on [DATE], which was not indicated on the Incident Log. Review of the Progress Notes or Evaluations did not reveal pertinent details of the fall that occurred the morning of 1/04/25. There was no evidence in the medical record that the Interdisciplinary Team reviewed resident #5's fall on 1/04/25, nor initiated new, individualized fall prevention interventions. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/31/25 at 11:50 AM, LPN J stated she learned resident #5 fell the previous day on the 3:00 PM-11:00 PM shift. She explained that morning resident #5 was very agitated. She indicated she could not recall if pain was mentioned but she recalled something had been given for anxiety. She shared at around 9:00 AM, before she began passing medications, another nurse and herself went to get resident #5, who had been sitting in her wheelchair, and brought her to her room. LPN J stated when the other nurse touched the resident on her shoulders, resident #5 became a little hysterical and they noticed she was in pain. She shared they got her to the room, while the resident kept saying bathroom, so she told her assigned CNA to help her to the bathroom. She recounted the CNA returned and told her the resident did not want to be touched even though she said she needed to use the bathroom. LPN J indicated she contacted the on-call physician to report resident #5 was in pain. She stated she received an order for x-rays, then she administered Tylenol for pain. LPN J said she may have forgotten to document giving resident #5 Tylenol for her pain, but recalled she gave it only once during her 7:00 AM to 3:00 PM shift on 1/12/25. In a telephone interview on 1/31/25 at 6:08 PM, LPN I stated she entered the order she received for Benadryl later than when she received it and said when she documented she forgot to change the time. She explained she gave the Benadryl approximately 15 minutes after resident #5 fell on [DATE]. She recalled she was still at the facility until approximately 1:30 to 2:00 AM that morning. In a telephone interview on 1/31/25 at 7:06 PM, LPN K recalled he took care of resident #5 on 1/11/25. He indicated he was told on shift change report at 11:00 PM resident #5 fell ,d+[DATE] minutes before and was told she had dementia. He mentioned she was placed in the common area to prevent another fall. LPN K stated he offered more than once for resident #5 to go to bed, but she could not express herself clearly, and he assumed she was afraid to be left alone in the room or fall again. He stated he gave her Tylenol, when she complained of some pain after 4:00 AM. He corrected his statement and said he administered Tylenol at the beginning of his shift, and he documented it. He stated he did not recall who gave the Benadryl. Review of resident #5's physician orders revealed an order dated 12/17/24 for Acetaminophen (Tylenol) 325 milligrams (mg), 2 tablets every six hours as needed for pain scale 1-10. An order for Benadryl 25 mg for one time only was entered on 1/12/25. Review of resident #5's Medication Administration Record from 1/01/25 to 1/12/25 showed Tylenol was documented as administered one time on 1/04/24 at 4:45 PM. Benadryl was documented as given on 1/12/25 at 1:25 AM, by LPN K. Review of a Progress Note by the on-call provider dated 1/11/25, revealed after resident #5's fall on 1/11/25 the plan included neurological checks were to be continued. Further review of the medical record revealed no neurological checks documented after the fall on 1/11/25. In a joint interview on 1/31/25 at 12:19 PM, with the Nursing Home Administrator (NHA) and the Director of Nursing (DON), they were asked to provide documentation of neurological checks for residents #5's fall on 1/11/25. The DON confirmed confirmed no interventions were put into place, nor did the IDT team discuss the fall of 1/04/25 until after resident #5 fell again on 1/11/25. By the end of the survey on 2/01/25, the facility was unable to provide documentation of neurological checks performed after the unwitnessed fall on 1/04/25. 51023 (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Resident #8 was admitted to the facility on [DATE] with diagnoses including diverticulitis of intestine without perforation and type 2 diabetes. The Florida Agency for Health Care Administration 5000-3008 Medical Certification for Medicaid Long Term Care Services and Patient Transfer Form dated 1/23/25 revealed the resident was non-ambulatory and required assistance of two people for transfers. The hospital transfer form also revealed she needed assistance with eating and was noted to be disoriented but could follow simple instructions. Review of resident #8's admission assessment on 1/23/25 revealed she needed supervision when rolling left to right, and when going from sitting to laying down. The assessment revealed the areas of personal hygiene, dressing of the upper and lower body, going from lying to sitting on the side of the bed, sitting to standing, transferring on and off the toilet and transferring from the chair to the bed were not assessed and not documented by the nurse. Review of resident #8's GG Functional Abilities and Goals assessment dated [DATE] revealed the sections of the assessment for activities for mobility and self care including personal hygiene, sitting to standing, transferring on and off the toilet and transferring from the chair to the bed were documented as not assessed. Review of resident #8's Certified Nursing Assistant (CNA) Kardex on 1/31/25, revealed the sections of activities of daily living (ADLs) for bed mobility, eating, personal hygiene, dressing, locomotion off unit, locomotion on unit and transferring were not completed and did not specify to staff what level of assistance was required for the resident. On 1/31/25 at 4:42 PM, the Minimum Data Set (MDS) Coordinator revealed the CNA Kardex was used by CNAs to know what type or level of care a resident needed. She indicated that the information for resident care plans and the CNA Kardex could be transmitted automatically from the GG assessment or entered manually by the MDS Coordinator. The MDS Coordinator explained sections of the admission assessment could be automatically transmitted. The MDS Coordinator confirmed that on the CNA Kardex, seven of the activities were not documented by the nurse as assessed nor were they individualized to the resident. She explained she did not manually enter the information such as ADLs that was missing. The MDS Coordinator acknowledged that since the GG assessment activities were not completed and documented as 'not assessed', the CNA Kardex sections had no information regarding how resident #8 needed to be cared for by staff. She confirmed she was not aware the sections of the Kardex were incomplete and had not checked them previously.		

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a Compliance and Ethics Program. 49840 Based on interview, and record review, the facility failed to effectively communicate and implement the standards of its compliance and ethics program to promote ethical conduct, and failed to adequately enforce those requirements to deter violations, ensure the provision of quality care and promote the highest practicable well-being for resident #3 and all residents in the facility. Findings: According to the facility's undated Code of Conduct and Ethics Policy the organization believed in creating a culture of respect, integrity, and compassion. They were committed to providing the highest quality of care and expected each team member to utilize legitimate practices that aligned with their mission and values. Employees were to be educated on the Compliance Program upon hire and must acknowledge the I Pledge acknowledgement agreeing to follow corporate values and report unethical behavior. Honesty, respect and care in performing duties while dealing with residents should be a standard benchmark of employee conduct. Employees were to freely report any violations without fear of retaliation. Review of a written complaint made to the state agency on 1/13/25 by an anonymous staff member revealed that a male resident eloped out the front door of the facility on 1/09/25, and the facility failed to supervise the resident or intervene when he had exhibited elopement behaviors. The anonymous staff member stated previously a female resident eloped from the facility on the night shift and went all the way up the street. The anonymous staff member indicated that the facility did not do education or drills after these elopements occurred and did not properly report the incidents. On 1/27/25 at 2:19 PM, Registered Nurse (RN) C stated she recalled an incident of a female resident who exited the facility through the east wing door and ended up across the street at a gas station. She said it happened during the overnight shift and the overnight supervisor had to drive in her personal vehicle to get the resident. She remembered the east wing door alarm going off which prompted staff to do a head count of all the residents, but was unable to recall the specific date of the incident or name of the resident. On 1/28/25 at 10:04 AM, RN D in a phone interview on 10/29/24, said she arrived to work at around 7:00 AM and was told a female resident from the west wing room had exited the facility via the east wing door. She recounted the resident had walked across the street and to a gas station down the road before the overnight supervisor found her. RN D said resident #3 was confused and was not wearing an electronic wander prevention bracelet . Review of the facility's reportable and adverse incidents log for six months from August 2024 through January 2025 revealed the facility had no documented incidents or reports of neglect related to elopement. On 1/28/25 at 3:35 PM, the Director of Nursing (DON), confirmed she was the Risk Manager. She was informed that staff had expressed information regarding an elopement that occurred the last few months of 2024. She stated she was not aware of any elopements. (continued on next page)		

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/28/25 at 5:08 PM, in a telephone interview Licensed Practical Nurse (LPN A) stated she was the Night Supervisor at the facility Monday through Fridays. The Night Supervisor stated she would truthfully recount the incident that occurred a few months ago because she would, rather lose her job, than lose her license. She confirmed resident #3 had exited the facility and ended up at the gas station down the street. She recounted she had to use her personal vehicle to transport the resident back to the facility. She recalled the resident was unsupervised outside the facility for at least 30 minutes. The Night Supervisor stated she was unable to reach the DON but reported the incident to the Nursing Home Administrator (NHA), and the Assistant Director of Nursing (ADON) at that time. She said later she watched video footage of the elopement with the DON, NHA, and ADON the morning of the incident. The Night Supervisor recalled the video showed resident #3 exiting the facility via the east wing door, walk towards the road through an area with low tree branches, and disappear from the camera's view when she left the facility property. On 1/28/25 at 5:30 PM, the DON and NHA were again asked of any elopements that occurred in the past few months that might have been left out of the reportables and incident logs. They both answered no. The DON and NHA were informed of the Night Supervisor's interview statement regarding resident #3's elopement. Again both the DON and NHA stated they had no knowledge of any incidents. Approximately thirty minutes later, at 6:00 PM, the DON returned and said she had spoken with the ADON who recalled an incident on 10/29/24 that involved resident #3 but said it had been determined to be a near miss. The DON explained resident #3 went to open the east wing door but the alarm went off. She described that the Night Supervisor was immediately behind resident #3 and walked outside with her. The DON said the resident told her she just wanted to go for a stroll. The DON explained they considered the incident a near miss not an elopement. On 1/29/25 at 1:45 PM, Regional [NAME] President #1 stated he was not very familiar with the elopement investigation since he worked in a different region but was here to help the new Regional [NAME] President #2. Regional [NAME] President #1 explained there were different definitions for elopement depending on the facility. He said at some facilities if the resident was in line of sight on the property, then it was not an elopement. He declined to say what the facility's definition of an elopement was because he no longer served this region. On 1/29/25 at 2:15 PM, the DON said an elopement, was when a resident got out of the building without staff knowledge, but she did not consider this incident an elopement because the resident was just in the parking lot. She said she was very confused because the Night Supervisor and other staff told her the resident never left the parking lot. She was asked if she spoke to the Night Supervisor on the phone on 10/29/24 during the elopement and she said she did not speak to her until she arrived at the facility. The DON stated the NHA and ADON were the ones in communication with her during the incident. Review of cell phone records and cell numbers provided by the Night Supervisor revealed that on 10/29/24 she spoke with the ADON, and NHA multiple times after resident #3 had exited the facility, and with the DON later in the morning. The resident was believed to have exited the facility between the hours of 5:45 AM and 6:00 AM. In total between 6:20 AM and 7:10 AM the Night Supervisor's phone record revealed four calls with the ADON for a total call time of 15 minutes. There were also three calls to the NHA between that time, for a total calltime of six minutes. (continued on next page)		

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/29/25 at 4:12 PM, in a telephone interview with anonymous LPN N she asked to not give her name due to fear of retaliation by the facility administration. She revealed she saw resident #3 and the Night Supervisor at the gas station on her way to work at approximately 6:30 AM a few months back. She said many staff felt the NHA and DON were very hush-hush about the elopement, and told staff who did not witness the incident, that the resident only got out to the parking lot. She explained she thought everything was odd about the way they handled the incident because the Regional [NAME] President of Clinical Services came to the morning meeting and read statements that seemed to indicate resident #3 had never left the property or actually eloped. Anonymous LPN N recounted that the Regional [NAME] President of Clinical Services had never done anything like that at a morning meeting in the past. Anonymous LPN N stated staff had been told not to document in the medical record. She reiterated that she and other staff feared retribution if they spoke up now. Anonymous LPN N recounted other incidents had occurred at the facility that were not sufficiently documented and/or the details hidden by the administration. She explained in December a confused male resident (resident #1) had also gotten out of the facility and brought back inside by the parking attendant. Anonymous LPN N stated this was not documented in the medical record or reported. On 1/29/25 at 4:25 PM, day shift Certified Nursing Assistant (CNA) O, in a telephone interview stated she wanted to remain anonymous for fear of retaliation from the Administration. She corroborated the Night Supervisor's recollection of the event and said she witnessed the Night Supervisor at the gas station on her way to work that morning with resident #3. CNA O expressed there had been other incidents that were swept under the rug by the administration. In a second telephone interview on 1/29/24 at 5:00 PM, the Night Supervisor re-confirmed she had been working on the early morning of 10/29/24 when resident #3 opened a door on the east wing of the facility, exited the building into the parking lot and was found down the street at the gas station. She recalled she provided a statement about the incident via email to the DON the day of the event, but the ADON called her later and told her to change her statement. She said the NHA told her to keep the statement, short and sweet and not to overshare. She said she was told not to call the resident's daughter and not to document a change of condition or note about the event. Eventually the DON made the call and wrote an Interdisciplinary Team (IDT) note the next day. The Night Supervisor expressed that now the NHA said she never told her resident #3 had gotten outside or to the gas station. The Night Supervisor disclosed that since she spoke with surveyors by phone on 1/28/25, the NHA had told other staff not to speak to her, and she feared for her job. On 1/30/25 at 9:29 AM, the Maintenance Director stated that on the morning of 10/29/24 he was asked to check the east wing door by administrative staff because a resident had exited the building. He said that he first learned of the elopement during the morning IDT meeting with leadership and they told clinical staff that the resident got out into the parking lot. On 1/30/25 at 9:56 AM, in a joint interview with the DON and the NHA, the NHA confirmed that on 10/29/24 she viewed the camera footage and saw when resident #3 exited the facility via the east wing door into the parking lot. She said she was unable to see when the resident was brought back in by the nurse because it was dark outside. The NHA said she was very impressed with the staff's response time in getting the resident back into the facility. She said that based on staff statements and video they were able to create a timeline of events as follows: *5:55 AM: door alarm sounded East Wing; staff member observed the resident through the door in parking lot. (continued on next page)		

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*5:55 AM- 5:56 AM: resident head count completed. *5:57 AM- 6:00 AM: resident returned inside to room. *6:15 AM- 6:30 AM: DON/NHA notified. The NHA said they informed the Medical Director at that time and felt like they had handled everything appropriately. The DON explained as the Abuse Coordinator she educated staff on reporting care concerns and provided them with her cell phone number because she preferred if they over-communicated. In conflict with statements from staff members, the NHA said she believed in an open-door policy for staff, residents, and families. On 1/30/25 at 4:10 PM, the ADON, DON, and NHA were interviewed jointly. The ADON provided his account of the elopement, which mirrored the description given by the DON and NHA. He said that resident #3 only got out to the parking lot. He recounted he received a call from the Night Supervisor on the morning of 10/29/24 but he told her to call the NHA because he was on his way to work. He said he had no other communication with her until she returned to the facility with the resident. He said staff had been told to document any change in condition such as new behaviors, falls, and accidents. The NHA said she spoke with the Night Supervisor only once over the phone that morning after she had already communicated with the ADON. The DON acknowledged retaliation against employees would hinder relations between the staff and administration because they wanted employees to talk to them. On 1/30/25 at 4:51 PM, in a telephone interview resident #3's daughter stated she never received a call from the facility on 10/29/24 to report the incident with her mother. She said she did not receive the information from the DON per her documentation and had attempted to reach out to the DON herself several times to get more details about what happened. She stated her mother told her sister that she got out of the building and walked to the gas station. On 1/31/25 at 9:22 AM, in a joint interview with Regional [NAME] President #1 and #2, and the Regional [NAME] President of Clinical Services, Regional [NAME] President #1 said their company was built on integrity and doing the right thing all the time. Regional [NAME] President #1 confirmed he was the first regional person to receive a call from the facility when the incident happened. He expressed they had identified trust issues within the facility administration after they reviewed their investigation and spoke with witnesses themselves. Regional [NAME] President #1 stated the difference in what they had been told by the facility administration and what they had learned from staff was, egregious, so per facility policy the NHA and DON had been suspended pending results of the new investigation they had initiated. Regional [NAME] President #1 stated they now knew the facility had internal issues which needed to be addressed. He said, You can't blame us because we only know what we are told. On 1/31/25 at 1:33 PM, the Director of Corporate Compliance stated that in her role she was responsible for oversight of all facilities to ensure compliance with regulations and adherence to legal and ethical standards. She explained that each facility had a compliance officer that would assist with reporting. She said staff received education upon hire, during orientation and were made to sign an I Pledge acknowledgement. She explained that their pledge was a statement for employees saying they would do the right thing and if they saw something that was wrong, they would report it. The Director of Corporate Compliance stated it was unethical, and an omission of truth to tell employees not to document an incident, to ask them to change their statements, or to falsify documentation. (continued on next page)		

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/01/25 at 10:37 AM, Regional [NAME] President #2 stated that they strived to maintain the highest level of ethics. On 2/1/25 at 11:58 AM, in a telephone interview the Medical Director stated he attended the ad hoc Quality Assurance and Performance Improvement meetings held previously regarding elopement. He acknowledged he was aware of the male resident (resident #1) who had elopement behaviors, and was found in the parking lot, commenting, He was brought right back in. The Medical Director was informed resident #3 had left the facility in October 2024, unsupervised and was found across the street approximately 0.3 miles away by the Night Supervisor. He said, He didn't know what we were talking about, and stated he was not aware of resident #3's elopement because he had not been told about it. The Medical Director was informed of staff who stated they were told not to document the details of incidents, told to keep their statements short and sweet, and felt they would face retaliation from administration if they did. He was also informed the NHA and DON did not acknowledge the incidents with residents #1 and #3 had occurred for several days until confronted with staff statements by surveyors. The Medical Director said that should absolutely not be happening with higher ups, and, Every incident needs to be documented, and reported. He continued, Even if they get only part ways out, it needs to be looked into, even if they didn't get out the door. The Medical Director explained that from an ethical standpoint, This could have been handled better, and added that, .he got into the business to take care of the elderly. The Medical Director said, I'm so disgusted, and added he didn't know what to say.		