

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  06/10/2025
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)
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, and record review, the facility failed to provide appropriate care and services to a long-term resident with a suprapubic catheter (SPC) after hospitalization for 1 of 3 residents reviewed for urinary catheters, of a total sample of 4 residents, (#2).</p> <p>Findings:</p> <p>Review of the medical record revealed resident #2 was initially admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included quadriplegia (paralysis that affects all limbs and body from the neck down), traumatic brain injury, and neuromuscular dysfunction of the bladder.</p> <p>Review of the annual Minimum Data Set assessment with Assessment Reference Date of 4/11/25 revealed resident #2 was in a persistent vegetative state. The assessment indicated he had an indwelling catheter.</p> <p>A suprapubic catheter is a surgically implanted device that helps to drain urine from your bladder through your abdomen. It is important to keep the area around the suprapubic catheter clean, to flush the catheter regularly to prevent clots and if placed long term, to change the catheter at least every four weeks, (retrieved on 6/23/25 from www.mycllevelandclinic.org).</p> <p>Review of the Florida Agency for Health Care Administration 5000-3008 Medical Certification for Medicaid Long-Term Care Services and Patient Transfer (3008) Form dated 5/01/25 revealed resident #2's primary diagnosis was sepsis. The document indicated the resident had a suprapubic catheter inserted on 4/18/25.</p> <p>Review of the 3008 Form from a previous hospitalization, dated 3/12/25 revealed resident #2's suprapubic catheter was inserted on 3/07/25.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of resident #2's hospital urology consultation note dated 4/20/25 indicated, His urologic history is significant for complicated recurrent UTIs (urinary tract infections), left obstructive uropathy, bilateral nephrolithiasis, atrophic right kidney, hematuria, and SPC (suprapubic catheter). Patient has had numerous interventions by urology group. Patient recently underwent cystoscopy, left ureteroscopy, laser lithotripsy, ureteral stent exchange, and suprapubic catheter exchange on 4/18/25 for left renal calculi. The note revealed resident #2 presented to the hospital from the facility, with fevers and rapid heart rate. The urologist detailed that the initial laboratory workup showed abnormalities with white blood cells (high), and the urinalysis showed blood and white blood cells in the urine.</p> <p>Review of resident #2's hospital urology consultation note dated 4/21/25 read, Patient now admitted with urine for catheter related UTI and sepsis.</p> <p>Review of a Care Plan focus initiated on 5/02/25 read, The resident has suprapubic catheter: Neurogenic bladder with obstruction right and left nephrostomy tube. The interventions directed the nurses to change the catheter as needed for blockage or leakage; to irrigate as ordered and as needed; and to provide catheter care.</p> <p>On 6/10/25 at 11:20 AM, during a telephone interview, resident #2's sister mentioned the suprapubic catheter was supposed to be changed monthly by the nursing staff in the facility. She explained the catheter had been changed twice at the hospital in recent months. Resident #2's sister continued, she was misinformed and thought the urologist appointment scheduled for 6/03/25 was a virtual visit. She indicated it was not until 6/03/25 when she received a call from the urologist office explaining the visit was in person so she told them he required transfer by stretcher and was told the office could not accommodate it. She indicated the last time she spoke with the nurse at the facility they were trying to obtain orders to change the suprapubic catheter. She indicated the urologist in the hospital gave her verbal instructions when he was discharged from the hospital that the catheter needed daily flushes and monthly changes. She stated she mentioned the discharge instructions to a nurse in the facility but couldn't recall who. She said she assumed those instructions were included in the discharge paperwork or documented in her brother's medical record. Resident #2's sister said she had a care plan meeting with the Unit Manager (UM) last week who informed her there was no orders for changing the suprapubic catheter. She said, she guessed it wasn't ordered because she received a call today asking for clarification of this information.</p> <p>On 6/10/25 at 10:01 AM, the East Wing Unit Manager UM explained they had a care plan meeting on 6/03/25 with resident #2's sister. She indicated during the meeting she learned resident #2 had a follow up appointment with the urologist but the sister had canceled the appointment because she thought it was a virtual one. The UM indicated the care and monthly suprapubic catheter changes were discussed during the meeting. She stated she obtained orders from the primary care provider and entered them in the medical record. The UM stated the batch order did not include the catheter change. She indicated they reached out to urology for clarification. In a subsequent interview on 6/10/25 at 1:43 PM, the UM reiterated resident #2's sister wanted to make sure the facility had orders in place for flushes and a suprapubic catheter change.</p> <p>Review of the After Visit Summary from 4/20/25 - 5/01/25 listed an appointment with urology on 6/03/25.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of resident #2's order summary at the start of survey on 6/09/25 revealed physician orders including to drain and record suprapubic catheter output every shift for monitoring, dated 5/02/25; check suprapubic catheter tubing for kinks and flow of urine, secure tubing to prevent pulling out/trauma every shift for surveillance, dated 6/03/25; and irrigate suprapubic urinary catheter with 60 cc (milliliter) of normal saline for blockage or sluggish output, dated 6/03/25. There were no orders to change the suprapubic catheter itself.</p> <p>Review of Progress Notes for May and June 2025 did not reveal evidence of contact with the urologist or the primary care provider to clarify when the suprapubic catheter needed to be changed.</p> <p>Review of the discontinued physician orders revealed a physician order dated 11/11/24 to change the suprapubic catheter every evening shift every 30 days. The order was discontinued on 3/04/25, when resident #2 was sent to the hospital, it was not restarted or reordered when he returned.</p> <p>Review of the Treatment Administration Record from November 2024 to June 2025 revealed the suprapubic catheter was changed at the facility on 11/11/24, 12/11/24, 1/10/25, 2/08/25 and 2/27/25. Review of the medical record showed the suprapubic catheter was changed in the hospital on 3/07/25 and 4/18/25. There was no evidence of a physician order to change the suprapubic catheter after he returned from the hospital on 5/01/25.</p> <p>On 6/10/25 at 11:38 AM, Registered Nurse (RN) A explained he looked at the hospital orders and the packet received when residents were readmitted . He shared there were batch orders for catheters. RN A stated he knew resident #2's suprapubic catheter was changed monthly, and they needed to check it every shift to ensure it was worked properly. He recalled he readmitted resident #2 but could not recall if batch orders were entered. He stated he was aware the UM reviewed the orders and hospital paperwork the day after the readmission to ensure everything was all right. He stated no one mentioned anything was missing or asked any questions after resident #2's readmission. He indicated he did not recall noticing the order for care or to change the suprapubic catheter was missing or finding out when the next change would be. He stated it was important to ensure the suprapubic catheter was patent to avoid or decrease chances of urinary retention and UTIs. He mentioned the use of urinary catheters itself, could lead to UTI's which resident #2 had a history of.</p> <p>On 6/10/25 at 12:54 PM, RN B stated she was familiar with resident #2's care. She indicated she flushed the suprapubic catheter daily with 60 cc of normal saline to ensure it flowed well and it was patent. She stated she assessed the site and the tubing. She mentioned the Certified Nurses Assistants emptied the bag and reported the urine output to the nurses. She shared she had never changed resident #2's suprapubic catheter. She indicated when he returned from the hospital, there were no specific instructions for flushes, which she had been doing before, but she thought they were no longer required because of the stents placed during his hospital stay. She had flushed the suprapubic catheter before but since she did not see specific instructions or orders she had not flushed the suprapubic catheter any of the 19 times she was assigned to resident #2 in May 2025. She confirmed she did not ask the physician for orders for this care. RN B stated the physician visited resident #2 multiple times, he placed orders for labs, and she thought if it was necessary he would have entered the order.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/10/25 at 2:18 PM, The [NAME] Wing UM explained hospital documents for admissions and readmissions were reviewed, including medications, treatments, and compared with the orders entered in the medical record. She indicated they also ensured there was a care plan in place. She stated resident #2's orders should have included flushes and an assessment of the site. The UM or nurses would have been responsible to ensure the care / irrigation or flushes orders were in place, anyone who looked in the chart would be responsible. She indicated the suprapubic catheter change was when soiled, there was leakage or blockage. She stated she did not recall talking to resident #2's sister after he returned from the hospital on 5/01/25. The UM looked in resident #2's medical record and confirmed there were no orders entered for suprapubic catheter care or changes upon readmission from the hospital. She shared there were only orders to drain and record the output and to irrigate every 8 hours as needed and both orders were entered in May. She validated resident #2 had a history of UTIs. She shared when she was in the East Wing, nurses did not ask her about suprapubic catheter changes or flushes. She shared halfway through May she switched wings, and she missed it too.</p> <p>Review of the facility's undated policy titled Suprapubic Catheter Care indicated any care should be documented in the resident record, as indicated.</p>