STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105754	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conway Lakes Health & Rehabilitation Center	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 - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to thoroughly investigate and report an allegation of neglect and an injury of unknow origin resulting in serious bodily injury to the Agency for Healthcare Administration (AHCA). The facility failed to report the allegation to AHCA within the federally required 2-hour timeframe, and the 5-day investigation report lacked sufficient detail, as required under federal regulation, for 1 of 1 resident reviewed for neglect, of a total sample of 8 residents, (#1).Findings:Resident #1 was originally admitted to the facility on [DATE] and readmitted from an acute care hospital on 4/09/24. Her most recent diagnoses included speech and language deficits after a stroke, reduced mobility, history of falling, muscle weakness, fracture of upper end of right humerus, and osteoarthritis.Review of the Minimum Data Set Quarterly assessment with Assessment Reference Date 3/09/25 revealed resident #1's was nonverbal, and cognitively impaired with bilateral upper extremity impairments. The assessment indicated she was dependent on staff for all care and mobility. Review of resident #1's progress notes revealed she was found on 6/01/25 with unexplained bruising, swelling, and guarding of the right upper arm (RUA). Later that evening, X-rays confirmed a fracture of the proximal humerus. The resident was transferred to the hospital, where significant bruising was noted to the RUA, the fracture of the proximal humerus was confirmed and concern for possible elder abuse was documented by hospital staff. In a telephone interview on 6/29/25 at 1:16 PM, Certified Nursing Assistant (CNA) A stated she had worked in the facility for 10 months and was assigned to resident #1 on 6/01/25 during the 7:00 AM to 3:00 PM shift. She reported CNA B assisted her with transferring resident #1 to her wheelchair at approximately 9:00 AM. CNA A stated resident #1 ate breakfast and spent the remainder of the day in the day room. She denied observing any bruising or signs of pain during her shift. She shared later that day she received a call from a supervisor who inquired about swelling and bruising noted on resident #1's right arm by the next shift's CNA. She stated she consistently used two staff to transfer resident #1, who was dependent and unable to assist with transfers. CNA A indicated she always sought assistance for transfers due to resident #1's weight and contractures. She expressed concern that CNA B denied helping with the transfer of resident #1 on 6/01/25 and confirmed she demonstrated her transfer technique to management the day after the incident. On 6/29/25 at 2:16 PM, with translation assistance from CNA H, CNA B explained that on 6/01/25 she asked CNA A for equipment between 7:00 AM and 7:30 AM and later returned it during her break around 2:00 PM. CNA B denied assisting CNA A with any transfers that day. She stated she could not recall how transfers were conducted when she previously trained with CNA A. In a telephone interview on 6/29/25 at 3:19 PM, resident #1's son stated his mother was nonverbal and physically unable to inflict injury on herself. He expressed concern about the lack of clear information from the facility regarding the incident on 6/01/25. He reported the facility later informed the family that resident #1 was mishandled during a transfer and that the employee involved was terminated. He expressed skepticism with the facility's explanation, citing the hospital's suspicion of potential abuse. Resident #1's son emphasized his mother had always previously required a two-person assist, but staff were observed performing single-person transfers, despite repeated complaints from the family. On 6/29/25 at 3:59 PM, CNA C recounted resident #1 required total assistance and prior to the incident, was transferred by one person using a gait belt. She indicated she observed a purple bruise on resident #1's RUA while changing her clothes on 6/01/25. She shared she immediately informed the nurse who was unaware of the injury. CNA C stated resident #1 was nonverbal and guarded the injured arm during care. She described resident #1's upper extremities as contracted and difficult to assess for pain unless physical signs were present. She stated after the nurses assessed resident #1, she transferred her back to bed with caution. CNA C indicated a few days after the incident, she was called into the DON's office and gave a verbal report of what she had observed. She recalled receiving an in-service training on transfers but was not required to demonstrate how she actually performed them. A gait belt is a device used by caregivers to help stabilize and guide a patient who walks but is not steady on their feet. The belts help enable safe functional mobility and reduce patient falls as well as patient and staff injuries. Staff should know when and how to use the gait belt as an important part of safe patient handling, (retrieved on 7/16/25 from www.medline.com). On 6/29/25 at 5:02 PM, Registered Nurse (RN) D recounted she was the nurse assigned to resident #1 on 6/01/25 and was informed of the bruising by CNA C. She indicated she observed a large purple bruise extending from the resident's right shoulder to her elbow. RN D confirmed there were no prior

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop, implement, and revise a person-centered, comprehensive care plan to address communication needs for 1 of 4 residents reviewed for care planning, of a total sample of 8 residents, (#1).Findings: Cross Reference F689 Review of the medical record revealed resident #1 was originally admitted to the facility on [DATE] and readmitted on [DATE] from an acute care hospital. Her most recent diagnoses included stroke with residual speech and language deficits, impaired mobility, right humerus fracture, type 2 diabetes, and osteoarthritis. Review of the Minimum Data Set (MDS) signification change in condition assessment with Assessment Reference Date (ARD) of 6/10/25 revealed resident #1's preferred language was Spanish. Resident #1 had bilateral upper extremities impairment and was dependent on staff for all Activities of Daily Living, mobility and transfers. The MDS quarterly assessment with ARD of 3/09/25 showed resident #1's preferred language was Spanish. In a telephone interview on 6/29/25 at 3:19 PM, resident #1's son stated after his mother suffered two strokes, she could no longer speak but she only spoke Spanish. He explained he posted a note with reminders for staff which included she only understood Spanish. On 7/01/25 at 8:03 AM, resident #1's son described how his mother became frightened and withdrawn due to her inability to understand staff. He shared he contacted the facility leadership about his concerns and provided a copy of an email he sent to the former Director of Nursing (DON) dated 9/10/23 stating, in part, . Between her weight and her immobility, we know she is not easy to maneuver. Especially if they are not speaking Spanish to her, she will not understand a word they are saying. A review of an undated sign observed posted in resident #1's room on 6/30/25 at 11:20 AM read: Reminders: -NOT ABLE TO SPEAK -ONLY UNDERSTANDS SPANISH . Review of resident #1's care plan for communication problems related to weak or absent voice, language barrier, and impaired cognition, revised on 12/13/24, did not reflect the resident's preferred language or outline individualized communication strategies for addressing the language barrier. Review of the Kardex (Certified Nursing Assistant care plan) revealed a Communication section which read, Use task segmentation to support short term deficits. Break tasks into one step at a time. The document did not reference resident #1's language preference. On 6/29/25 at 3:59 PM Certified Nursing Assistant (CNA) C stated she explained what she would be doing with resident #1 in English, even though the resident only Speaks Spanish. On 7/01/25 at 12:18 PM, CNA G indicated resident #1 understood some English, but she only knew a few words in Spanish. CNA G stated resident #1 was totally dependent and could not do anything for herself.On 7/02/25 at 11:56 AM, the East Wing Unit Manager (UM) acknowledged the sign posted in resident #1's room, which included the resident only understood Spanish. She explained the facility could not always accommodate language preferences. She mentioned no formal Spanish-speaking staff assignments were in place for resident #1. She then shared they had some nursing or therapy staff who spoke Spanish and staff could ask one of them to translate when needed. She validated resident's preferred language should be included in the care plan but was unsure if resident #1's reflected it. She stated every nurse had the ability to update the care plan if needed. On 6/30/25 at 1:30 PM, the MDS Coordinator stated the care plan should be person-centered and reflect a clear picture of the resident's status across all disciplines. She explained her role in updating care plans during clinical meetings. On 7/02/25 at 10:43, the MDS Coordinator validated the resident's primary language should have been included in the care plan so staff would know. She stated she did not recall if this was discussed during any of the care plan meetings she attended. Review of the Facility assessment dated [DATE] showed the facility identified the presence of Hispanic residents and that care would be directed as culturally appropriate. The assessment also referred to the use of a Cultural Competency and the goal of ensuring staff could meet the cultural and linguistic needs of residents.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a Certified Nursing Assistant (CNA) followed facility protocol when transferring a physically and cognitively impaired vulnerable resident from bed to wheelchair; and failed to ensure staff transferred residents safely for 1 of 4 resident reviewed for accidents, of a total sample of 8 residents, (#1). On 6/01/25 at approximately 10:40 AM, resident #1, vulnerable and dependent on staff for all Activities of Daily Living (ADLs), mobility and transfers, sustained a displaced fracture of the right humerus when the 7:00 AM to 3:00 PM shift CNA transferred the resident by herself without the use of a gait belt. After CNA A transferred resident #1 from her bed to the wheelchair she transported her to the dayroom. Hours later, when resident #1 was taken back to her room by the next shift CNA, she noticed a bruise on the resident's right upper arm (RUA) and notified the nurse. Resident #1 was assessed by her assigned Registered Nurse (RN) and via telehealth by a medical provider who ordered a STAT (immediately) X-ray of the right shoulder. At approximately 8:00 PM, an X-ray revealed an acute displaced proximal humerus fracture. Resident #1 was transferred to the hospital for evaluation, where it was determined surgical repair was not recommended due to comorbidities and age. Findings:Cross Reference F726Resident #1, a [AGE] year-old female, was originally admitted to the facility on [DATE] and readmitted from an acute care hospital on 4/09/24. Her most recent diagnoses included speech and language deficits after a stroke, reduced mobility, history of falling, muscle weakness, fracture of upper end of right humerus (upper arm bone), type 2 diabetes, and osteoarthritis.Review of the Minimum Data Set (MDS) quarterly assessment with Assessment Reference Date 3/09/25 revealed resident #1's Brief Interview for Mental Status was not obtained because the resident was rarely or never understood. Instead, a Staff Assessment for Mental Status was conducted, and short and long-term memory were selected. The MDS assessment indicated resident #1 had severely impaired cognitive skills for daily decision making. The MDS assessment noted no behavioral issues or rejection of care during the lookback period. Resident #1 had bilateral upper extremity impairment and no lower extremity impairment. She was dependent on staff for all ADLs, mobility, transfers and locomotion on and off the unit. A sit-to-stand test was Not attempted due to medical condition or safety concerns.Review of resident #1's care plan for ADL self-care performance deficit related to generalized weakness, impaired mobility, impaired cognition, revised on 12/13/24, revealed resident #1 required the assistance of one staff for transfers until 6/02/25. An intervention dated 5/16/23 directed staff to report changes in ADL self-performance to the nurse.Resident #1 had a care plan for risk for falls related to confusion, impaired mobility, and incontinence. Another care plan was for communication problems related to weak or absent voice, language barrier, and impaired cognition; both revised on 12/13/24.Review of the Nursing Quarterly Evaluation dated 4/21/25 revealed resident #1 was always disoriented to person, place, and time. The evaluation indicated resident #1 had a balance problem while standing/sitting/walking and required the use of a wheelchair. Review of resident #1's medical record revealed a progress note by the on-call provider on 6/01/25 at 5:12 PM, which detailed, Nurse notified clinician that new bruising was noted to the patient's RUA, and she is guarding with touch and attempted movement. She is nonverbal so unable to verbalize any possible injuries. Per the nurse, there are no recent documented falls. She is a total care patient. Will obtain STAT (immediate) X-rays of right shoulder and humerus. The note revealed a physical exam per nurse and video observation showed skin bruising to RUA, guarding right shoulder with touch and range of motion (ROM), and pain in RUA. Review of a progress note dated 6/01/25 at 5:38 PM, by Licensed Practical Nurse (LPN) E indicated, she was called into the resident's room by the evening shift CNA after she found right shoulder bruising, and left bloodshot eye was also noted. The nurse documented that the patient was noted to be grimacing and guarding upon movement of the extremity. She noted the physician was notified, and a STAT X-ray was ordered.Review of a progress noted by the on-call provider on 6/01/2025 at 8:29 PM, revealed the Xray showed a visible fracture at the upper end of the humerus. The note detailed that due to the location of the fracture and possible dislocation the resident would be sent to the hospital emergency department (ED) for orthopedic evaluation.Review of resident #1's Change in Condition & Transfer form dated 6/01/25 at 9:58 PM, revealed the change of condition was an abnormal X-ray finding which occurred on 6/01/25 at 7:45 PM which resulted in a transfer to an acute care hospital. The narrative summary identified that at 7:00 PM the evening shift CNA notified the nurse of bruising on the right shoulder. In conflict with the nurse's progress note from 5:38 PM, the form indicated resident #1 did not show signs of

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the appropriate level of transfer assistance for a cognitively and physically impaired vulnerable resident and failed to ensure nursing staff demonstrated competency in all aspects of the transfer process. The facility failed to validate staff retained education provided and monitor Certified Nursing Assistants (CNAs) for adherence to facility transfer processes for 1 of 4 resident reviewed for accidents, of a total sample of 8 residents, (#1). On 6/01/25 at approximately 10:40 AM, resident #1, vulnerable and dependent on staff for all Activities of Daily Living (ADLs), mobility and transfers, sustained a displaced fracture of the right humerus when the 7 AM to 3 PM shift CNA transferred the resident by herself without the use of a gait belt. After CNA A transferred resident #1 from her bed to the wheelchair, she spent approximately six hours in the dayroom. Resident #1 was taken back to her room by the 3 to 11 PM shift CNA, who noticed a bruise on the right upper arm (RUA) and notified the nurse. Resident #1 was assessed by her assigned Registered Nurse (RN) and via telehealth by a medical provider who ordered a STAT (immediately) X-ray of the right shoulder. At approximately 8:00 PM, an X-ray revealed an acute displaced proximal humerus fracture. Resident #1 was transferred to the hospital for evaluation. The hospital determined surgical repair was not recommended due to comorbidities and age. Findings:Cross Reference F689Review of the medical record revealed resident #1, a [AGE] year-old female, was originally admitted to the facility on [DATE] and readmitted from an acute care hospital on 4/09/24. Her most recent diagnoses included speech and language deficits after a stroke, reduced mobility, history of falling, muscle weakness, fracture of upper end of right humerus, and osteoarthritis. Review of the Minimum Data Set (MDS) quarterly assessment with Assessment Reference Date of 3/09/25 revealed resident #1 had severely impaired cognitive skills for daily decision making. Resident #1 had bilateral upper extremity impairment and no lower extremity impairment. She was dependent on staff for all Activities of Daily Living, mobility and transfers. Review of resident #1's care plan for ADL self-care performance deficit related to generalized weakness, impaired mobility, impaired cognition, revised on 12/13/24, revealed resident #1 required the assistance of one staff for transfers until 6/02/25, when it was revised to the assistance of two. An intervention dated 5/16/23 directed staff to report changes in ADL self-performance to the nurse. Resident #1 had care plans for risk for falls related to confusion, impaired mobility, and incontinence and for communication problems related to weak or absent voice, language barrier, and impaired cognition. Both care plans were revised on 12/13/24. Review of resident #1's medical record revealed a progress note by the on-call provider on 6/01/25 at 5:12 PM, which detailed, Nurse notified clinician that new bruising was noted to the patient's RUA, and she is guarding with touch and attempted movement. She is nonverbal so unable to verbalize any possible injuries. Per the nurse, there are no recent documented falls. She is a total care patient. Will obtain STAT X-rays of right shoulder and humerus. 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A Change in Condition & Transfer form dated 6/01/25 at 9:58 PM, revealed the change of condition was an abnormal X-ray finding which occurred on 6/01/25 at 7:45 PM which resulted in a transfer to an acute care hospital. The narrative summary identified that at 7:00 PM the evening shift CNA notified the nurse of bruising on the right shoulder. In conflict with the nurse's progress note from 5:38 PM, the form indicated resident #1 did not show signs of pain. Review of an Emergency Department Provider Note dated 6/01/25 revealed, Emergency Medical Services (EMS) reported resident #1 was found to have bruising of the right arm and an X-ray showed a proximal humerus fracture. EMS noted there was no reported falls or trauma at the facility. The ED provider note included, Significant bruising noted to the right upper arm. X-rays confirmed proximal humerus fracture. In a telephone interview on 6/29/25 at 1:16 PM, CNA A explained she held this position for about 10 months which was her first as a

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview, and record review, the facility failed to ensure effective implementation of policies, including thorough monitoring of previously identified areas of concern and adequate tracking of performance to verify improvement measures were realized and sustained. Findings: Review of the facility's policy titled QAPI (Quality Assurance and Performance Improvement)/Risk Management Program, dated 2017, read, The purpose of QAPI is to take a proactive approach to continual improvement of the care is given to residents, . The policy also referenced the QAPI Guiding Principles, stating, . QAPI focuses on systems and processes in order to examine and improve care or services in areas that are identified through the performance improvement plan (PIP) teams, as needing attention and setting priorities for action based on the information gathered. Data is obtained through the QAPI process from caregivers, residents, healthcare practitioners, families and others in the community, in order to systematically clarify areas of concentration focusing on root cause to determine proper interventions for improvement and to prevent future events and promote sustained improvement.The facility was previously cited for deficiencies under F689 and F610 on the complaint survey of 2/01/25. During the current survey, repeat deficiencies under F689 and F610 were again identified, indicating prior corrective actions were not adequately monitored or sustained. This demonstrated a lack of sufficient auditing and oversight in addressing the cited concerns.During an interview conducted on 7/02/25 at 6:16 PM, with the Nursing Home Administrator (NHA) and Director of Nursing (DON), the NHA reported that upon assuming his role as Administrator, the facility had recently submitted a Plan of Correction for deficiencies cited under F689 and F610, which included two Immediate Jeopardy situations. The NHA stated audits were conducted and environmental modifications were implemented as required. He explained the facility received significant support from corporate leadership since that time. He acknowledged they were unaware of issues related to residents' transfers. The DON shared regional leadership was involved in reviewing all reports prior to submission to the State Survey Agency. The NHA added although efforts were being made to address the concerns, the process remained a work in progress, and there was still need for cultural change and continued improvement in QAPI practices.