

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 05/16/2024
NAME OF PROVIDER OR SUPPLIER Conway Lakes Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 Curry Ford Road Orlando, FL 32812	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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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** 45646 Based on interview, and record review, the facility failed to develop a comprehensive person-centered care plan to meet the resident's medical, nursing, mental and psychosocial needs for 2 of 3 residents reviewed for comprehensive care plans out of a total sample of 40 residents, (#33 and #99). Findings: 1. Resident #33 was admitted to the facility on [DATE] with diagnoses including dementia, and depression. Review of the Minimum Data Set (MDS) admission assessment with assessment reference date (ARD) of 3/05/24 revealed resident #33 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated he had moderate cognitive impairment. He reported feeling down, depressed or hopeless 2-6 days a week. The assessment indicated the resident sometimes experienced social isolation. Review of resident #33's electronic medical record (EMR) revealed progress notes by resident's physician, psychiatric and psychological services. The notes indicated the resident had diagnoses of post-traumatic stress disorder (PTSD) and history of inpatient psychiatric treatment for combat exposure with PTSD as well as ongoing outpatient treatment for the same. A psychotherapy progress note dated 3/13/24 indicated resident #33 experienced symptoms of depression and anxiety as well as audio/visual hallucinations and mild paranoia. Review of resident #33's EMR, revealed a comprehensive person-centered care plan was not developed to address trauma informed care related to his diagnosis of PTSD. On 5/13/24 at 12:51 PM, resident #33 was observed seated in his wheelchair in his room with his daughter at his side. Resident #33's daughter reported she was upset because she found her dad crying. She noted he had episodes of crying. Resident #33 spoke about having served in 3 wars during his time in the military. On 5/16/24 at 10:47 AM, the Social Services Director (SSD) stated she was aware resident #33 served in the military but was not aware he had PTSD. She acknowledged she did not read the psychological services notes that were included into the EMR. The SSD reviewed resident #33's EMR and confirmed a care plan was not developed to address trauma informed care. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 105754	Facility ID: 105754 If continuation sheet Page 1 of 7

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #99 was admitted to the facility on [DATE] with diagnoses including unspecified dementia, hypertensive chronic kidney disease stage 2, chronic obstructive pulmonary disease and benign prostatic hyperplasia with lower urinary tract symptoms. Review of the MDS quarterly assessment with assessment reference date of 4/05/24 revealed resident #99 had a BIMS score of 09 out of 15 which indicated he had moderate cognitive impairment. His active diagnoses included dementia, anxiety and depression (other than bipolar). The assessment indicated resident #99 did not exhibit any behaviors. Review of physician orders revealed active orders for Quetiapine Fumarate (Seroquel) for behaviors secondary to dementia and Buspirone HCl (Buspar) for dementia with behaviors. Review of resident #99's EMR, revealed a comprehensive person-centered care plan was not developed to address his cognitive impairment, dementia care or behaviors. On 5/16/24 at 10:11 AM, the SSD stated she was not aware resident #99 was prescribed antipsychotic, antianxiety and antidepressant medications. She reviewed the EMR and acknowledged a care plan was not developed to address cognition, dementia or behaviors. The SSD was unaware of what behaviors resident #99 exhibited prior to the medication being prescribed. On 5/16/24 at 12:32 PM, the Director of Nursing (DON) reviewed the medical record for resident #33. She verified a care plan was not in place to address resident #33's PTSD. The DON stated resident #33 received psychological services for counseling. She acknowledged if no one was reading the notes and a care plan was not developed then there was no coordination of services. The DON reviewed the medical record for resident #99 and verified a care plan was not developed to address his cognition and dementia care. She was not aware of what behaviors resident #99 exhibited prior to being prescribed psychoactive medications and could not locate any documentation regarding his behaviors. The DON acknowledged staff should have obtained the necessary information and care plans developed to address each of the identified areas.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50401 Based on observation, interview, and record review, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice regarding non-pressure related skin wounds, specifically, treating a wound without a physician order, and not documenting treatment for 1 of 1 resident reviewed for non pressure wounds out of a total sample of 40 residents, (#17). Findings: Resident #17 was admitted to the facility on [DATE] with the diagnoses of Rhabdomyolysis, Major Depressive Disorder, recurrent, moderate venous insufficiency (chronic) (peripheral), Type 2 Diabetes Mellitus without complications, and Bipolar Disorder. She was hospitalized on [DATE] due to an unwitnessed fall. Review of the Minimum Data Set (MDS) assessment dated [DATE], noted the resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15 that indicated severe cognition impairment. On 05/13/24 at 9:08 AM , the resident was observed resting in bed with the head of bed elevated. There was a discolored area to her lower left leg with an undated gauze dressing on her left shin. On 05/13/24 at 1:33 PM, the resident was observed sitting in a chair. The undated gauze dressing remained on the lower left leg. On 05/14/24 at 12:39 PM , the resident was observed sitting at a table in the dining room. The undated gauze dressing remained on the lower left leg. On 05/15/24 at 1:29 PM, the resident still had the undated bandage on her left leg. Licensed Practical Nurse (LPN) D stated she did not know why the resident had the gauze dressing and was not aware of any treatment orders to the left lower leg. She said she would take the resident to her room and see what was under the dressing. On 05/15/24 at 3:02 PM, LPN D explained there was a very small scab which started bleeding when she took the dressing off. She did not explain how the resident sustained the scab or why the dressing was not dated. On 05/15/24 at 3:08 PM, the Director of Nursing reported that LPN D was the first staff member to make note in the resident's chart regarding skin care in the weekly skin check note dated 5/08/24. The DON added that LPN D did not remember applying a dressing or seeing the dressing on the resident's left lower leg. Review of a nursing progress note dated 4/30/24 indicated the resident's weekly skin check was completed with no prior and no new areas of skin impairment. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 5/06/24 indicated the resident was found on the floor by her chair. The note indicated the resident was found lying on her back, screaming out in pain to her right hip and leg area. There were no abrasions, erythema, bleeding, or obvious signs of injury and the resident was transferred to the hospital's emergency department for evaluation. A progress note dated 5/07/24 at 2:45 AM, showed the resident returned from the hospital with no injuries identified. Another progress noted dated 5/08/24, completed by LPN D, indicated the resident's weekly skin check was completed. It noted, prior areas of skin impairment included skin tears and there were no new areas of skin impairment noted on completion of skin check. On 05/15/24 at 1:33 PM, the DON stated she did not know how the resident sustained the scab to the left lower leg or who had applied the gauze dressing. The DON explained it was facility policy and procedure, that if a resident needed a wound dressing, the nurse would obtain an order from the Physician. She added that if a resident needed wound dressing right away, the nurse would apply the dressing then contact the physician for an order including any treatment orders.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35086 Based on observation, interview, and record review, the facility failed to provide intravenous (IV) care and services according to standards of practice for 2 of 2 residents reviewed for IV care, out of 40 total sampled residents, (#321, #182). Findings: 1. Resident #321 was admitted to the facility from an acute care hospital on 5/3/24 with diagnoses including osteomyelitis (infection of the bone) metatarsal stump, right foot infection, revision of transmetatarsal resection of 5 digits right foot on 5/1/24, diabetes, and peripheral vascular disease. Review of the AHCA (Agency for Healthcare Administration) Form 5000-3008 dated 5/2/24 showed he had a peripherally inserted central catheter (PICC) line inserted at the hospital on 5/2/24. A PICC line is a thin, flexible tube that is inserted into a vein in the upper arm and guided (threaded) into a large vein above the right side of the heart called the superior vena cava. It is used to give intravenous fluids, blood transfusions, chemotherapy, and other drugs. Retrieved on 5/17/24 at 12:31 PM from (https://www.cancer.gov). On 5/13/24 at 9:40 AM, resident #321 was observed lying in bed in his room. He had a PICC noted in his right upper arm with clear dressing dated 5/2/24. There was an empty bag of IV antibiotics (Ceftazidime Avibactam) hanging from the IV pole. The resident who was alert and oriented said he was getting the medication for infection in his foot and the dressing had not been changed since they put it in at the hospital on 5/2/24. Review of resident #321's medical record revealed physician orders dated 5/3/24 until 5/23/24 for IV (intravenous) Ceftazidime Avibactam 2.5 grams (GM) every 8 hours for Enterobacter (gram negative bacteria). An order dated 5/4/24 noted to flush PICC with normal saline 10 ml (milliliters) prior to and post administration of IV medication. An order dated 5/3/24 was for nursing staff to monitor IV insertion site every shift for pain, redness, and warmth. There was also a physician order dated 5/11/24 to change dressing and measure PICC line length every week and prn (as needed). Review of the medical record did not show any evidence the PICC line IV dressing had been changed at the facility from the time the resident was admitted on [DATE] to the present dated of 5/13/24. The nurses were giving IV medication every 8 hours and failed to identify the dressing should have been changed by 5/9/24. (continued on next page)		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/24 at 10:05 AM, Licensed Practical Nurse (LPN) A said she was resident #321's assigned nurse today as well as last week on the day shift. LPN A was not aware the dressing on resident 321's right arm PICC was dated 5/2/24. LPN A said she had not looked at the dressing date today or last week. LPN A went into the resident room and acknowledged the IV dressing was dated 5/2/24. The LPN said the standard of practice was to change IV dressings weekly and the resident's PICC line dressing should have been changed on 5/9/24, 4 days ago. She acknowledged she had administered IV antibiotics and had flushed the PICC line and did not think to look at the IV dressing date. LPN A added that any of the nurses that administered the resident's IV antibiotics every 8 hours on 3 shifts should have noticed his IV dressing needed to be changed, obtained appropriate physician orders, and changed the dressing sooner. On 5/14/24 at 4:15 PM, the Director of Nursing (DON) explained the admission nurse should have entered the appropriate batch orders for PICC line care which included dressing changes, monitoring site, changing cap and flushes. The DON added that nurses had documented they monitored the IV site every shift but failed to identify the dressing was due to be changed per their policy. The DON verified the standard of nursing practice was to change a clear IV dressing every 7 days and sooner if loose or soiled. Review of the facility policy and procedure revised July 2011 for Catheter Insertion and Care of Central Venous Catheter Dressing Changes read, Central venous catheter dressings will be changed at specific intervals, or when needed, to prevent catheter related infections Change transparent semi-permeable membrane [TSM] dressings every 5-7 days and PRN 40892 2. Review of resident #182's medical record revealed she was admitted to the facility on [DATE] from an acute care hospital with diagnoses including closed displaced comminuted fracture of the shaft of the right femur, hyponatremia, and acute kidney injury. On 5/13/24 at 9:52 AM, resident #182 was observed lying in bed in her room. She had a peripheral IV line inserted into her right upper arm with a dressing dated 5/8/24. She was unaware of the last time someone had changed her dressing. A peripheral IV is a thin, flexible tube. It's used to deliver treatments into a vein for different health conditions (www.myleavelandclinic.org). On 5/14/24 at 8:47 AM, LPN B, who was responsible for resident #182's care, was in her room and observed the peripheral line tip exposed and transparent film dressing that was loose and not secure on the right upper arm dated 5/8/24. LPN B stated the dressing should be changed every 3 days and sooner if soiled or loose. On 5/14/24 at 8:54 AM, the [NAME] Wing Unit Manager confirmed the IV dressing was dated 5/8/24. The [NAME] Wing Unit Manager stated the resident was getting fluids related to abnormal labs. She noted the protocol was to change the IV dressing weekly. A review of the physician orders revealed an order dated 5/8/24 that read, IVF (IV fluids) please place now. There were no physician orders to monitor or flush the IV or to change the IV dressing. (continued on next page)		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 4:14 PM, the DON stated batch orders for IV fluid should have been entered by the nurse who obtained the IV order. The DON added those orders included monitoring, dressing changes, and flushes. The nurses should have noticed the IV dressing and obtained orders for a dressing change. The policy is to change every 72 to 96 hours or immediately if the clear film dressing is coming off or lifting up. The facility's policy for Catheter Insertion and Care, revised on 12/2013, reads, Change the dressing at the time of catheter site rotation (every 72 to 96 hours) or immediately upon observing that the integrity of the dressing has been compromised.		