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	09/11/2025

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview, and record review, the facility failed to ensure referrals to the appropriate state designated authority for Preadmission Screening and Resident Review (PASARR) Level II evaluation and determination were made for two of three residents reviewed for PASARR, of a total sample of 25 residents, (#11, and #80). Findings:1.Record review of resident #11's most recent Level I PASARR, dated 2/08/24, revealed resident #11 was assessed as having, No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASARR evaluation not required. A review of the Facility Resident Matrix dated 9/08/25 indicated resident #11 had a diagnosis and/or was being treated for PTSD (Post Traumatic Stress Disorder); [Resident #11 name].On 9/10/25 at 11:50 AM, the Director of Nursing (DON) stated the facility did not have documentation that indicated resident #11's Level I PASRR had been revised to show the diagnosis of PTSD, nor was a Level II PASARR screening initiated.2. Record review revealed resident #80 had a Level I PASARR completed on 5/16/22. Further review revealed a diagnosis of bipolar disorder was made on 11/20/24, and a diagnosis of major depressive was initiated on 5/14/25. Resident #80 had a care plan for bipolar disorder related to potential for behavior problems, such as calling out, r/t Bipolar Date Initiated: 03/13/2025 There was no evidence in the medical record of a Level II PASARR evaluation after the new diagnoses were made. On 9/10/25 at 12:35 PM, the DON confirmed a Level II PASARR should have been completed for both residents, #11 and #80, due to the new diagnoses they received.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medications were securely stored in one of two residential halls in the facility, (100s hall, resident #7). Findings:Review of resident #7's medical record revealed diagnoses that included sepsis, bacteremia, urinary tract infection, type II diabetes, and need for assistance with personal care. Review of active physician orders revealed no orders related to self-administration of medications. Review of the Minimum Data Set assessment revealed resident #7 had severely impaired cognition. On 9/09/25 at 9:49 AM, resident #7 was in his room in bed. Two pills were observed on the bedside table. Resident #7 explained why the nurse had left the pills on the table, saying, that's my medicine they left me to take. (Photo evidence obtained) On 9/10/25 at 8:00 AM, the Unit Manager (UM) confirmed resident #7's medications shouldn't have been left at bedside by the nurse. The Unit Manager verified a self-administration order was needed otherwise the nurse should not leave medications with residents to take on their own.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food was safely stored and/or discarded in the areas of the main reach-in coolers, the pot/pan sink sanitizing solution was at the correct concentration and failed to ensure food preparation surfaces were not cross-contaminated during production in accordance with professional standards for food service safety. Findings:1.On 9/08/25 at 9:36 AM, an initial walk-through tour of the kitchen was conducted with the Dietary Manager (DM). In the reach-in cooler a white plastic container had a label that read: Turkey Prepared date 7/07/25, Use by 7/10/25. The DM confirmed the date on the label of the white plastic container read, Turkey Prepared date 7/07/25 Use by 7/10/25 and should have been discarded almost two months prior. (Photo evidence obtained) 2. On 9/08/25 at approximately 9:45 AM, the sanitizing solution in pot/pan sink was tested and was <100 parts per million (ppm). The sanitizing solution concentration should have been 150 - 200 ppm along with the contact time per the manufacturer's instructions. Th DM confirmed the sanitizing solution was not at the proper ppm in order to safely sanitize any kitchen items that were washed and sanitized there. 3. On 9/09/25 at approximately 12:10 PM, the lunch tray line was served in the dining room kitchenette. The cook used a wiping cloth to wipe excess food off of plates and placed the dirty cloth on the counter and not in a cleaning or sanitizing solution. 4. On 9/09/25 at 12:30 PM, the lunch tray line was served in the main kitchen. The cook used a wiping cloth and placed the dirty cloth on the counter and not in a cleaning or sanitizing solution. A few minutes later at 12:35 PM, the DM confirmed she observed the cook place the dirty wiping cloth on the counter after use. The DM stated the wiping cloths should have been placed in the sanitizing solution after use to prevent potential cross contamination. The facility's undated policy entitled, Dietary Guidelines Manual, Subject Cleaning Cloths indicated, cleaning cloths were to be kept in a container of clean sanitizing solution between uses.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview the facility failed to maintain infection control practices by not keeping the urine collection bag and the tubing off the floor and away from unsanitary surfaces for one of one resident reviewed for urinary catheters, of a total sample of 25 residents, (#7).Findings:On 9/08/25 at 10:51 AM, resident #7's catheter bag was found to be clipped to a trash can located at the side of his bed. The base of the urine collection bag was resting on the floor. (Photo evidence obtained)On 9/08/25 at 12:38 PM, resident #7's catheter bag was lying flat on the floor of his room.On 9/09/25 at 10:15 AM, the catheter bag was again clipped to the trash can with the base of the collection bag lying on the floor. On 9/10/25 at 9:17 AM, in resident #7's room, the Director of Nursing (DON) confirmed resident #7's urinary catheter bag clipped to the trash can. A few minutes later the DON stated she was the Infection Prevention Nurse and verified it was not appropriate for the urinary collection catheter bag to be attached to the trash can. She confirmed the catheter urine collection bag should not be on the floor to prevent infection.