STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105987	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hunters Creek Nursing and Rehab Center	14155 Town Loop Blvd Orlando, FL 32837

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 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** 36489 Based on interview, and record review, the facility failed to ensure a Minimum Data Set (MDS) assessment accurately reflected a skin condition related to an acquired pressure injury for 1 of 4 residents reviewed for pressure injuries, of a total sample of 9 residents, (#1). Findings: Review of the medical record revealed resident #1, an [AGE] year-old female, was admitted to the facility on [DATE] for short-term rehabilitation. Her diagnoses included gastrointestinal hemorrhage, posthemorrhagic anemia, and generalized muscle weakness. The Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form dated 6/27/24 indicated resident #1 was at risk for developing pressure injuries, and on discharge from the hospital, she had no pressure injuries, skin lesions, or wounds. Review of the Admission Data Set, dated 6/27/24, revealed resident #1's skin color was normal and her skin integrity was clear, with no conditions present. The linked Admission Note, dated 6/27/24, revealed a body assessment showed a small, white intact area on her sacrum and another white intact area on her left buttock. Review of a Post-Admission Skin Check dated 7/01/24 revealed the facility's Wound Nurse assessed resident #1 and she noted, Skin Clear, no condition present. A Weekly Skin Check dated 7/03/24 revealed resident #1 had a head-to-toe skin check which showed no skin impairments. Review of the MDS Admission assessment with assessment reference date of 7/04/24 revealed resident #1 was admitted to the facility from an acute care hospital on 6/27/24. Contrary to the hospital transfer form and the facility's admission assessment, Section M - Skin Conditions indicated the resident was admitted with two known pressure injuries that were unstageable due to the coverage of the wound bed by slough and/or eschar. The document revealed the pressure injuries were unhealed. The MDS assessment indicated that during the 7-day look back period, she received pressure injury care and had ointments applied to areas other than her feet. Section Z - Assessment Administration indicated Section M of the MDS assessment was completed by the Lead MDS Coordinator. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105987	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hunters Creek Nursing and Rehab Center	14155 Town Loop Blvd Orlando, FL 32837

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The National Pressure Injury Advisory Panel (NPIAP) defines a pressure injury or pressure ulcer as localized damage to the skin and underlying soft tissue usually over a bony prominence. The injury is caused by prolonged pressure and can present as either intact skin or an open ulcer, usually at the site of bony prominences such as heels, hips, sacrum, and coccyx or tailbone. According to NPIAP, an unstageable pressure injury is defined as obscured full-thickness skin and tissue loss in which the extent of the tissue damage is not visible due to the presence of slough and/or eschar, types of dead tissue. Once the slough or eschar is removed, a stage 3 or stage 4 pressure injury will be revealed (retrieved on 11/26/24 from www.https://cdn.ymaws.com/npiap.com/resource/resmgr/NPIAP-Staging-Poster.pdf). Review of resident #1's Medication Review Report revealed an admission order dated 6/27/24 for weekly skin checks every Wednesday during the day shift. The document showed no physician orders for ointments, wound care, or treatments during the look back period as noted in the MDS Admission assessment. On 11/12/24 at 1:46 PM, the Lead MDS Coordinator stated she obtained necessary information to complete MDS assessments from different sources including discussions in daily morning clinical meeting, review of the medical record, wound physician notes, documentation from the hospital, admission nurses' notes, and staff interviews. The Lead MDS Coordinator stated nursing staff informed her resident #1 had white areas on her bottom on admission, but her skin was intact as the areas were not open. The Lead MDS Coordinator was prompted to review resident #1's medical record and she validated the Post-Admission Skin Check done by the Wound Nurse on 7/01/24 and the Weekly Skin Check done on 7/03/24 indicated her skin was intact. She confirmed there was no nursing documentation of pressure injuries or other concerns, and no physician orders for wound care during the 7-day look back period. The Lead MDS Coordinator explained she possibly assumed that the white areas noted by the admission nurse were slough. On 11/13/24 at 9:50 AM, the Wound Nurse stated she evaluated resident #1's skin four days after admission and noted no skin concerns. She confirmed resident #1 acquired a stage 4 pressure injury in the facility. The Wound Nurse validated the MDS Admission assessment that showed the resident was admitted with two unstageable pressure injuries was inaccurate. On 11/13/24 at 2:19 PM, the Director of Nursing (DON) validated documentation in resident #1's medical record indicated on admission to the facility, she had two small white areas on her buttocks and sacrum, but no open areas. She acknowledged nursing staff, including the Wound Nurse, who evaluated the resident's skin after admission noted no skin impairments during the timeframe associated with the MDS Admission assessment. The DON explained all newly admitted residents' charts were reviewed by the interdisciplinary team, which included the Lead MDS Coordinator, and a pressure injury identified on admission would have been noted and discussed at that time. She stated during the State Survey Agency's current investigation, she discovered the Lead MDS Coordinator assumed resident #1 had pressure injuries based on documentation of small white areas on her skin. The DON stated the Lead MDS Coordinator should have reached out to her for clarification to ensure the MDS assessment was accurate. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105987	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hunters Creek Nursing and Rehab Center	14155 Town Loop Blvd Orlando, FL 32837

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure for the Resident Assessment Instrument (RAI) Process, reviewed August 2023 revealed the RAI was used to provide staff with ongoing assessment information necessary for the development and modification of care plans that reflected appropriate, person-centered care and services for all residents. The policy indicated the MDS was the foundation of the comprehensive assessment and addressed essential screening, and clinical, and functional elements. The document revealed MDS assessment data would be obtained by observation of and communication with residents whenever possible and/or discussions with licensed and non-licensed staff, physicians, family member, and consultants. The procedure revealed each member of the interdisciplinary team would review the entire MDS assessment for accuracy before it was signed of as completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105987	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hunters Creek Nursing and Rehab Center	14155 Town Loop Blvd Orlando, FL 32837

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on interview, and record review, the facility failed to develop, implement, and update an appropriate baseline care plan to mitigate risk factors for skin impairment, and failed to incorporate person-centered interventions to promote healing for an acquired pressure injury for 1 of 4 residents reviewed for pressure injuries, of a total sample of 9 residents, (#1). Findings: Review of the medical record revealed resident #1, an [AGE] year-old female, was admitted to the facility on [DATE] for short-term rehabilitation. Her diagnoses included gastrointestinal hemorrhage, posthemorrhagic anemia, and generalized muscle weakness. Resident #1 was transferred to the hospital for evaluation of a wound on 7/11/24. The Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form dated 6/27/24 indicated resident #1 was hospitalized for a gastrointestinal bleed and anemia. The document revealed she was alert, oriented, and followed instructions, and was at risk for pressure ulcers. The form showed on discharge from the hospital, resident #1 had no pressure injuries, other skin lesions, or wounds. Review of the facility's Admission data set dated [DATE] revealed the Admission Nurse noted resident #1's skin integrity was clear with no conditions present. The linked Admission Note dated 6/27/24 revealed a full body assessment showed a small, white intact area on her sacrum and another white intact area on her left buttock. A Progress Note date 7/06/24 at 12:00 PM revealed resident #1's assigned nurse, Licensed Practical Nurse (LPN) A, received a message from the resident's daughter via another nurse on the unit regarding a request to evaluate her mother's skin. LPN A noted resident #1 was in a therapy session at the time, and when she returned to the unit, she declined a skin evaluation and stated she preferred to wait until her daughter returned. The progress note indicated LPN A instructed the oncoming evening shift nurse to follow up. Review of subsequent Progress Notes for 7/06/24 to 7/07/24 revealed no follow-up nursing notes to indicate either the evening or night shift nurses attempted to evaluate the resident's skin after her daughter returned to the facility. Review of a Change in Condition Evaluation note dated 7/07/24 at 2:43 PM, written by the Captiva/Key [NAME] Unit Manager, revealed resident #1 had a new skin area on her sacrum that measured 7.5 centimeters (cm) x 4.0 cm x 2.5 cm. The document indicated the physician was notified of the wound and ordered a referral to the Wound Physician. Review of an Initial Wound Evaluation & Management Summary note dated 7/09/24 revealed the Wound Physician assessed resident #1 and determined she had a full thickness stage 4 pressure injury on her sacrum that measured 12 cm x 10 cm with the depth not measurable due to the presence of nonviable tissue and necrosis. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105987	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hunters Creek Nursing and Rehab Center	14155 Town Loop Blvd Orlando, FL 32837

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #1's medical record showed a baseline care plan for risk for skin impairment was initiated on 6/27/24. The document indicated the resident was admitted with wounds to her left buttock and sacrum, which was inconsistent with the admission nursing skin evaluation. The care plan goal was to minimize complications related to skin impairment. An intervention dated 6/27/24 instructed Certified Nursing Assistants to turn and reposition the resident with care rounds and as needed. The care plan focus was not updated on 7/07/24 when the newly identified wound was assessed and reported to the physician. On 7/11/24, the day resident #1 was transferred to the hospital for evaluation of her wound, the document was updated to show she had a stage 4 pressure injury on her sacrum. However, the baseline care plan goal and interventions were not changed to reflect the necessary care and services to prevent worsening and promote healing of the pressure injury. The only active care plan approach remained to turn and reposition the resident with care rounds and as needed. On 11/14/24 at 10:48 AM, the Lead Minimum Data Set (MDS) Coordinator reviewed resident #1's baseline care plans and confirmed on admission, there was only one intervention developed related to the prevention of skin impairment, and that was to turn and reposition her during rounds and as needed. The Lead MDS Coordinator validated she updated the baseline care plan with five additional interventions on 7/12/24, the day after resident #1 was transferred to the hospital. She explained all members of the interdisciplinary team were responsible for updating care plans. She acknowledged the assigned nurses, the Unit Manager, and/or the Wound Nurse could have added appropriate interventions at any time. The Lead MDS Coordinator recalled someone told her resident #1 was noncompliant with approaches to promote skin integrity and she developed a care plan for behavior related to resisting care. She confirmed the resident's reported behaviors were not identified before the wound was discovered. The Lead MDS Coordinator verified it was essential for baseline care plans to be complete, accurate, and updated on an ongoing basis to properly meet residents' care needs. Review of the MDS Admission assessment with assessment reference date of 7/04/24 revealed resident #1 had clear speech and no comprehension issues. Her Brief Interview for Mental Status score was 15/15 which indicated she was cognitively intact. The MDS assessment revealed resident #1 had no behavioral symptoms and did not reject evaluation or care that was necessary to achieve her goals for health and well-being. Review of resident #1's medical record showed no pattern of refusal of care in Progress Notes for June and July 2024. There was no documentation of attempts by nursing staff to educate resident #1 and/or her daughters regarding interventions to promote skin integrity such as the need to limit the time she spent seated on her scooter, prior to 7/09/24. Review of a Care Plan Meeting note dated 7/11/24 revealed resident #1's daughters attended via telephone. The note indicated the resident had a stage 4 pressure injury and she was at risk for wound deterioration due to noncompliance with repositioning, offloading of the wound, and skin assessments. The note read, . daughter acknowledges wound prior to admission.Daughter is aware of the risk of further deterioration [related to] resident's noncompliance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105987	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hunters Creek Nursing and Rehab Center	14155 Town Loop Blvd Orlando, FL 32837

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 2:27 PM, and 11/14/24 at 8:07 AM, in telephone interviews, resident #1's daughter emphasized her mother had no wounds on her body prior to admission to the facility. When the Care Plan Meeting note was read to the daughter, she expressed shock, and stated she never had a conversation with the facility regarding her mother having wounds prior to admission. The daughter said, If the facility felt my mother came there with a wound, why weren't they treating it? She stated at no time was she informed of the severity of the wound or that her mother refused to comply with necessary interventions. She explained she visited her mother twice daily, and stated staff never mentioned any concerns related to adherence to the plan of care or development of appropriate approaches to promote wound healing. On 11/14/24 at 12:48 PM, the Director of Nursing (DON) was made aware of concerns related to the accuracy and appropriateness of resident #1's baseline care plans. After review of the behavior care plan and nursing progress notes, the DON acknowledged there was no documentation to support the alleged refusals of skin assessments, only that resident #1 asked for her daughter to be present on one occasion. When informed the resident's skin impairment care plan had only one intervention and was not updated after her pressure injury was discovered, the DON indicated the care plan in the medical record had several interventions related to promoting skin integrity and wound healing. She was informed those interventions were initiated on 7/12/24, the day after resident #1 was transferred to the hospital. She verified resident #1's baseline care plans did not reflect the facility's expected processes. Review of the facility's policy and procedure for Baseline Plan of Care, revised August 2023, revealed the facility would develop and implement a baseline care plan that included necessary instructions to provide effective, person-centered care. The document indicated the purpose of the baseline care plan was to promote communication between staff and prevent adverse events likely to occur soon after admission. The policy revealed any member of the interdisciplinary team could update the baseline care plan and nurses were expected to consider areas including functional status, health maintenance, and risk factors for pressure injuries.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105987	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hunters Creek Nursing and Rehab Center	14155 Town Loop Blvd Orlando, FL 32837

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on interview, and record review, the facility failed to provide appropriate care and services, consistent with professional standards of practice, to adequately evaluate skin integrity and promptly intervene to prevent the development and worsening of a pressure injury for 1 of 4 residents reviewed for pressure injuries, of a total sample of 9 residents, (#1). The facility's failure to identify early stages of skin breakdown, promptly initiate wound care and treatment, and develop nursing interventions to promote wound healing resulted in actual physical and psychosocial harm for resident #1. The resident's skin was intact on admission to the facility and within 12 days, she was diagnosed with a stage 4, full-thickness skin loss pressure injury. Two days later, resident #1 was transferred to the hospital for signs of a possible wound infection. She required a surgical wound debridement procedure and was discharged home from the hospital with a wound vacuum machine. Resident #1 became homebound, experienced a decline in her overall physical status due to decreased mobility, and suffered depression related to ongoing wound treatments and the inability to participate in her preferred social and religious pastimes. Findings: Review of the medical record revealed resident #1, an [AGE] year-old female, was admitted to the facility on [DATE]. Her diagnoses included gastrointestinal hemorrhage, posthemorrhagic anemia, and generalized muscle weakness. Resident #1 was transferred to the hospital on 7/11/24. The Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form dated 6/27/24 indicated resident #1 was hospitalized for a gastrointestinal bleed and anemia. The document revealed she was alert, oriented, and followed instructions, and was at risk for pressure ulcers. The form showed on discharge from the hospital, resident #1 had no pressure injuries, other skin lesions, or wounds. Review of the facility's Admission data set dated [DATE] revealed the Admission Nurse noted resident #1's skin color was normal for her ethnic group, her skin temperature warm and dry, and her skin integrity was clear with no conditions present. The associated Admission Note dated 6/27/24 revealed the resident was alert and oriented and able to make her needs known. The note indicated a body assessment showed a small, white intact area on her sacrum and another white intact area on her left buttock. Review of a Post-Admission Skin Check dated 7/01/24 revealed the facility's Wound Nurse assessed resident #1 and noted. Skin Clear, no condition present. The document indicated the Wound Nurse utilized the Braden Scale, a tool used to predict the risk of developing pressure injuries, to evaluate resident #1 and obtained a score of 16 which indicated a mild risk for pressure ulcer development. A Weekly Skin Check dated 7/03/24 revealed resident #1 had a head-to-toe skin check which showed no skin impairments. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105987	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hunters Creek Nursing and Rehab Center	14155 Town Loop Blvd Orlando, FL 32837

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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) Admission assessment with assessment reference date of 7/04/24 revealed resident #1 had clear speech and no comprehension issues. Her Brief Interview for Mental Status score was 15/15 which indicated she was cognitively intact. The MDS assessment revealed resident #1 had no behavioral symptoms and did not reject evaluation or care that was necessary to achieve her goals for health and well-being. Review of a Nursing Progress Note date 7/06/24 at 12:00 PM, revealed resident #1's assigned nurse, Licensed Practical Nurse (LPN) A, received a message from the resident's daughter via another nurse on the unit regarding a request to evaluate her mother's skin. LPN A noted resident #1 was in a therapy session at the time, and when she returned to the unit, she declined a skin evaluation and stated she preferred to wait until her daughter returned. The Progress Note indicated LPN A instructed the oncoming evening shift nurse to follow up. Review of the facility's Visitor Sign In-and-Out Log for 7/06/24 showed resident #1's daughter returned to the facility that afternoon and remained there from 3:30 PM to 7:15 PM. However, review of resident #1's medical record showed no evidence of follow up by nurses on 7/06/24 related to conducting a skin evaluation, notifying the physician, obtaining physician orders, or implementing appropriate preventative interventions. Review of a Change in Condition Evaluation note dated 7/07/24 at 2:43 PM, written by the Captiva/Key [NAME] Unit Manager (UM), revealed resident #1 had a new skin area on her sacrum that measured 7.5 centimeters (cm) x 4.0 cm x 2.5 cm. The document indicated the physician was notified of the wound and ordered a referral to the Wound Physician. Review of the Medication Review Report revealed a wound treatment order, dated 7/07/24, to clean resident #1's buttocks and wound area with normal saline solution, apply zinc oxide ointment, and cover with a dry gauze dressing every shift. Zinc oxide is a mineral ointment that is applied to the skin to treat minor skin irritations such as diaper rash, minor burns, or severely chapped skin (retrieved on 11/26/24 from https://www.drugs.com/mtm/zinc-oxide-topical.html). Review of a Skin Impairment Observation note dated 7/08/24 revealed the Wound Nurse evaluated resident #1 and identified a pressure ulcer on her sacrum that measured 8.5 cm x 3.5 cm x 2.5 cm and had a moderate amount of slightly bloody drainage. She noted normal surrounding tissue, no tunneling or undermining, and fully granulating, or healthy tissue. The document indicated the Wound Nurse changed the wound treatment. Review of resident #1's Medication Review Report revealed the new wound treatment order, dated 7/08/24, instructed nurses to cleanse the sacral wound with normal saline, apply calcium alginate, and cover it with a dry bordered gauze dressing once daily and as needed. Calcium alginate dressings are prescribed for wounds with moderate to heavy drainage such as pressure injuries and infected wounds (retrieved on 11/26/24 from www.woundsource.com/product-category/dressings/alginates#). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105987	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hunters Creek Nursing and Rehab Center	14155 Town Loop Blvd Orlando, FL 32837

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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of an Initial Wound Evaluation & Management Summary note dated 7/09/24 revealed the Wound Physician assessed resident #1 and determined she had a full thickness stage 4 pressure injury on her sacrum, of duration greater than three days. The wound measured 12 cm x 10 and the depth was not measurable due to presence of nonviable tissue and necrosis. The Wound Physician noted on one side of the wound, the tissue under the wound's edge was eroded to create a 3 cm pocket or area of undermining. The wound had a moderate amount of slightly bloody drainage. Sixty percent of the wound was comprised of thick adherent devitalized necrotic tissue and slough and the Wound Physician performed a surgical excisional debridement procedure. The document revealed the area surrounding the wound was a maroon/purple color, indicative of a deep tissue injury. The note read, The best medical estimate of the time required for this wound to heal with continued physician evaluation and intervention is 376 days. The National Pressure Injury Advisory Panel (NPIAP) defines a pressure injury or pressure ulcer as localized damage to the skin and underlying soft tissue usually over a bony prominence. The injury is caused by prolonged pressure and can present as either intact skin or an open ulcer, usually at the site of bony prominences such as heels, hips, sacrum, and coccyx or tailbone. According to NPIAP, a stage 3 pressure injury shows full-thickness skin loss with visible fat and/or granulation tissue. Slough and eschar (types of dead tissue) may be present but does not obscure the depth of tissue loss. A stage 4 pressure injury involves full-thickness loss of skin and tissue that leaves muscle or bone exposed. A deep tissue pressure injury (DTI) is a persistent non-blanchable deep red, maroon or purple discoloration or a blood-filled blister that is covered with intact or non-intact skin (retrieved on 11/26/24 from www.https://cdn.ymaws.com/npiap.com/resource/resmgr/NPIAP-Staging-Poster.pdf). Review of the medical record showed the Wound Physician revised resident #1's treatment order on 7/09/24 to cleanse her sacrum with normal saline, pat dry, and apply Calcium Alginate and Santyl, and cover with a gauze island border once daily and as needed. Santyl is a topical debriding agent that promotes wound healing by removing dead skin tissue (retrieved on 11/26/24 from www.drugs.com/mtm/santyl.html). Review of resident #1's medical record showed a care plan for risk for skin impairment was initiated on 6/27/24. The goal was to minimize the resident's risk for skin impairment. The only intervention instructed Certified Nursing Assistants (CNAs) to turn and reposition the resident with care rounds and as needed. The care plan focus was updated on 7/11/24 to show resident #1 had a stage 4 pressure injury to her sacrum, but there were no additional interventions developed. Review of a Progress Note dated 7/11/24 revealed resident #1 exhibited signs of a wound infection and the physician ordered her to be sent to the hospital Emergency Department (ED) for evaluation of her wound. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105987	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hunters Creek Nursing and Rehab Center	14155 Town Loop Blvd Orlando, FL 32837

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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of resident #1's hospital record revealed a General Surgery Consult Note dated 7/11/24 at 10:48 PM. The document indicated the resident was transferred to the hospital from a skilled nursing center via emergency medical services for evaluation of a sacral ulcer. On arrival at the hospital, her white blood cell count was elevated, indicative of an infective process, and she was started on three antibiotic medications. The surgeon's assessment of resident #1's wound showed it was a stage 4 pressure injury of 20 cm in diameter with purulent drainage, that goes to the bone. A Wound Consult Note dated 7/12/24 revealed a specialist physician assessed resident #1 and determined her sacral wound had exposed connective tissue, palpable bone in the center, and undermining. The note indicated the resident was scheduled for surgery the following day for operative debridement, with placement of a wound vacuum soon afterwards. An Infectious Disease Consult Note dated 7/13/24 revealed the physician revised resident #1's antibiotic regimen to treat the wound which he noted had necrotic skin, palpable bone, profuse drainage, and a foul odor. The hospital record revealed resident #1 was discharged home from the hospital on 7/19/24 with Home Health Care services for management of a 6-week course of intravenous antibiotics and a wound vacuum machine. On 11/12/24 at 9:34 AM, in a telephone interview, resident #1's daughter stated her mother was admitted to the facility at the end of June 2024 for short-term rehabilitation. She explained she expected her mother to obtain the benefits of physical and occupational therapy services while in the facility, and then return home. The resident's daughter stated prior to hospitalization for a bleeding ulcer, her mother was able to transfer herself from her bed to a wheelchair, use a walker, and complete self-care activities with minimal assistance. The resident's daughter stated her mother previously used an electric scooter and a wheelchair accessible van to attend church and participate in family activities. She explained she initially visited her mother in the facility early in the mornings to assist her to get out of bed, complete personal care, and get dressed so she was ready for the first therapy session. The daughter stated after a few days, facility staff instructed her to stop performing those tasks as therapists needed to incorporate them into her mother's therapy sessions. She explained she complied and started visiting later in the day when her mother was dressed, therefore she no longer saw her skin during care. Resident #1's daughter recalled on Saturday 7/06/24, she arrived in her mother's room and saw that she was not yet out of bed and ready for therapy. She offered to get her dressed and during care noted an open area on her mother's bottom. She stated the wound was approximately 3 to 4 centimeters long and had a small amount of drainage. The resident's daughter stated her mother's assigned nurse was not on the unit at that moment, but she informed the other nurse of the skin issue and also asked her to ensure the Wound Nurse was notified. She stated she never saw the wound again as it was always covered with a dressing, and when she asked, she was told the Wound Physician would continue seeing her mother weekly. Resident #1's daughter stated she was surprised when facility staff contacted her on 7/11/24 to inform her that her mother would be transferred to the hospital for evaluation of the wound. She recalled on arrival in the Emergency Department she was horrified when she saw her mother's wound as it was significantly larger and extended almost down to the bone. She said, I did not know it had worsened. I had no idea it had gotten so bad. The resident's daughter stated her mother was hospitalized for surgical debridement of the wound and had a vacuum machine placed to help with healing. She stated her mother was discharged home from the hospital and now required home health nursing services and physician home visits. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105987	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hunters Creek Nursing and Rehab Center	14155 Town Loop Blvd Orlando, FL 32837

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 0686 Level of Harm - Actual harm Residents Affected - Few	On 11/12/24 at 2:40 PM, LPN B confirmed she completed a weekly head-to-toe skin check for resident #1 on 7/03/24. She recalled the daughter was present during the evaluation and the resident had no open areas or any other type of skin impairment on her body on that date. LPN B explained a few days later, the resident's daughter approached her and asked her to let the assigned nurse know that her mother had an open area on her bottom. LPN B stated when LPN A returned to the unit, she relayed the message and told LPN A to evaluate resident #1's skin issue. On 11/12/24 at 3:44 PM, in a telephone interview, LPN A recalled she completed resident #1's full body skin evaluation on admission. She verified the resident's skin was intact and she had no open areas on her buttocks or sacrum. LPN A explained that if the newly admitted resident had any skin breakdown, she would have discussed it with the attending physician when she called to review and verify her admission orders. She stated in addition to the initial skin evaluation, the facility had a Wound Nurse who conducted a thorough skin assessment soon after admission. On 11/13/24 at 9:50 AM, the Wound Nurse confirmed she completed resident #1's post-admission skin assessment on 7/01/24, four days after she was admitted to the facility. She validated the resident's skin was intact on that date. The Wound Nurse stated she re-evaluated resident #1 on 7/08/24, when the Captiva/Key [NAME] UM informed her there was a wound on the resident's bottom. She recalled resident #1 was alert, oriented, and cooperative during the procedure. The Wound Nurse explained she implemented a new treatment as the zinc oxide ointment was not appropriate for a wound of that depth. She stated the following day, the Wound Physician assessed the wound, diagnosed it as a stage 4 pressure ulcer, revised the treatment order, and made recommendations . On 11/13/24 at 10:19 AM, CNA C stated she usually rounded with the Wound Nurse to assist with turning and positioning residents during skin evaluations and wound care. She recalled she was with the Wound Nurse on 7/01/24 for resident #1's post-admission assessment and validated the resident's skin was intact. CNA C stated she accompanied the Wound Nurse about a week later and was shocked to see the wound that had developed. On 11/13/24 at 11:35 AM, CNA D stated she was sometimes assigned to care for resident #1. She recalled she once changed the resident's brief and noted redness but no open areas. CNA D stated she did not report the redness to a nurse, and a few days later she saw that the resident had a big wound. On 11/13/24 at 2:19 PM, the Director of Nursing (DON) acknowledged resident #1's hospital transfer form, facility admission skin evaluation, and the Wound Nurse's post-admission skin evaluation showed she had no open areas or pressure ulcers. The DON explained the wound developed, deteriorated quickly, and resident #1 was sent to the hospital for a possible wound infection. On 11/13/24 at 3:10 PM, in a telephone interview, CNA E stated she regularly cared for resident #1, often with assistance from her daughter(s). She explained the resident was incontinent of bowel but would immediately ask for help when she needed to be changed. CNA E stated even when the resident's family provided care, she observed her skin every shift. She stated to her knowledge, resident #1's skin was intact on admission, and she was not aware of any skin breakdown until informed by the resident's daughter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105987	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hunters Creek Nursing and Rehab Center	14155 Town Loop Blvd Orlando, FL 32837

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 0686 Level of Harm - Actual harm Residents Affected - Few	On 11/14/24 at 8:07 AM, in a telephone interview, resident #1's daughter stated staff never discussed any risk factors for pressure ulcers or interventions to prevent skin breakdown prior to the development of her mother's wound. The resident's daughter stated she believed staff did not observe her mother's skin thoroughly or often enough to identify the skin concern in its early stage as the facility was not aware of the open area until she brought it to the nurse's attention. She explained if she had been told how severe the wound was, she would have discussed interventions with her mother including returning to bed for intervals during the day. Resident #1's daughter confirmed her mother still suffered from the both the physical and psychosocial impacts of the wound she acquired in the facility over five months ago. The daughter stated her mother now needed a full body mechanical lift for transfers between her bed, wheelchair, and recliner as she was no longer able to stand. She explained her mother used to enjoy going in person to church three days weekly for social and service activities, and also enjoyed shopping outings with her daughters, but since her return home with the wound vacuum she has not been able to sit up for long enough to go anywhere. Resident #1's daughter explained the pressure wound significantly decreased her mother's quality of life and she was eventually prescribed antidepressant medication. Review of the facility's policy and procedure for Pressure Ulcer & Skin Care, revised August 2023, revealed a resident who was admitted to the facility without pressure injuries would not develop them, and a resident who developed pressure injuries would receive necessary care and services to promote wound healing. The procedures indicated licensed nurses were responsible for skin evaluations on admission and weekly thereafter. The interdisciplinary team would review resident assessment data to determine necessary care and collaborate with the physician to obtain and implement treatment orders that were appropriate for the resident and the type of wound. Review of the Center Facility Assessment, revised 10/18/24, revealed the facility was able to provide general care and services related to skin integrity, specifically pressure injury prevention and care.