

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105987	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Hunters Creek Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were treated with dignity for 4 of 15 dependent diners at the facility, out of a total sample of 32 residents, (#11 and #48).</p> <p>1. Review of resident #11's medical record revealed she was readmitted to the facility on [DATE] with diagnoses including dementia, hemiplegia (one-sided paralysis) and hemiparesis (one-sided weakness) following a stroke affecting her right dominant side, dysphagia (difficulty swallowing), and aphasia (language disorder).</p> <p>Review of resident #11's Minimum Data Set quarterly assessment with Assessment Reference Date of 11/05/24 revealed a Brief Interview for Mental Status was not obtained because she was rarely or never understood. The assessment showed resident #11 was dependent on staff for eating and received a mechanically altered diet.</p> <p>On 12/17/24 at 12:18 PM, resident #11 was lying in bed with her lunch tray on her bedside table. Certified Nursing Assistant (CNA) E was assisting resident's #11 roommate and from across the room stated resident #11 was a feeder and she needed to help her with her lunch.</p> <p>On 12/17/24 at 3:59 PM, CNA E explained resident #11 was a feeder. She validated this was the term used for residents who needed assistance with their meals. CNA E stated she did not recall receiving training on assisting residents with their meals.</p> <p>On 12/18/24 at 9:21 AM, the Administrator stated residents who needed assistance with their meals were not supposed to be called feeders. She explained this was, a dignity issue.</p> <p>Review of the Clinical Competency Checklist for Nurses and CNAs signed by CNA E on 3/16/23 included privacy and dignity.</p> <p>Review of the facility's admission packet revealed a document titled Florida Nursing Home Residents' Rights and Responsibilities dated 12/29/22. The residents were informed the facility would treat them courteously, fairly and with the fullest measure of dignity.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility policy titled Resident Dignity & Personal Privacy dated 4/2024 revealed the purpose was to care for residents in a manner that respects and enhances each resident's dignity, individuality, and right to personal privacy. The document read, Call individuals by their preferred name. If the roommate is in the room, speak in lowered tones, as appropriate, when discussing clinical or private issues with the resident.</p> <p>50401</p> <p>2. On 12/15/24 at 12:41 PM, CNA A was observed near a dining table with three seated residents. Referring to resident #48, CNA A told Registered Nurse (RN) C, the resident was a feeder. RN C replied, Oh, she's a feeder? then walked away with the meal tray and uncovered plate left in front of the resident. Seven minutes later, at 12:48 PM, RN C was observed as she fed resident #48 while standing over her.</p> <p>On 12/15/24 at 1:20 PM, review of the master roster of residents which was used by nursing staff during their shift, the term feeder was observed typed next to the names of several residents which indicated this terminology was commonly used at the facility.</p> <p>On 12/18/24 at 9:23 AM, the Administrator stated the facility policy and procedure for passing meal trays was to sit next to a resident and not stand over them while assisting with their meal. She added the nursing staff was not to set the meal tray next to resident or remove the lid until the nursing staff was ready to sit with and assist that resident.</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192</p> <p>Based on observation, interview, and record review, the facility failed to address a pharmacy recommendation for 1 of 5 residents reviewed for unnecessary medications, out of a total sample of 32 residents, (#75).</p> <p>Findings:</p> <p>Review of resident #75's medical record revealed he was readmitted to the facility on [DATE] with diagnoses including Parkinson's Disease, congestive heart failure, type 2 diabetes, and abnormalities of gait and mobility.</p> <p>Review of resident #75's Minimum Data Set quarterly assessment with Assessment Reference Date of 11/05/24 revealed a Brief Interview for Mental Status score of 15 out of 15 which indicated intact cognition. The assessment showed resident #75 received a scheduled pain medication regimen. He experienced pain occasionally and the intensity was rated 8 on a scale of 0 to 10.</p> <p>Review of the physician orders included an order for Lidocaine External Patch 4% dated 4/28/23. The Lidocaine Patch was to be applied to the right leg topically two times a day for pain.</p> <p>Review of resident #75's Medication Administration Record for December 2024 revealed the Lidocaine Patch was applied twice a day from 12/01/24 to 12/17/24.</p> <p>Review of a Consultation Report issued on 10/17/24 indicated resident #75 received a Lidocaine patch. The pharmacist recommendation read, Please ensure the following administration recommendations are followed: order should include instructions to remove after 12 hours, . , do not exceed 3 patches for up to 12 hours within a 24-hour period, document patch application and removal . The report was signed by the Director of Nursing (DON) on 10/23/24.</p> <p>On 12/18/24 at 12:17 PM, resident #75 stated he did not use the patch to his leg every day but when he did it stayed on and was not removed at night.</p> <p>On 12/18/24 at 12:27 PM, Licensed Practical Nurse (LPN) F stated she applied a Lidocaine patch every day to resident #75's right knee. She recalled a patch was usually on resident #75's knee when she applied a new one in the morning. She explained this was an over-the-counter medication and showed the box for this medication. Later at 12:53 PM, LPN F read the directions included in the Lidocaine patch box. She mentioned it read not to use more than one patch in a 12-hour period. She validated the patch stayed on resident #75 over 12 hours and had not been used as directed.</p> <p>On 12/18/24 at 1:19 PM, the Regional Nurse Consultant stated both the DON and Unit Manager were out that day and she could not answer why the pharmacy recommendation was not addressed.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/18/24 at 2:49 PM, during a telephone interview, the Consultant Pharmacist explained his responsibilities included to conduct a monthly medication regimen review. He stated he would review the previous month's recommendation the subsequent month to ensure completion. He indicated if the recommendation was not addressed, he reprinted the form and sent it to the DON. He shared using the Lidocaine patch for longer than recommended could lead to over-absorption. He concluded his expectation was the facility addressed the recommendations.</p> <p>Review of, Topical Lidocaine for Chronic Pain Treatment published by the National Library of Medicine on 9/29/21 included Practice Guidelines which were regularly published by manufacturers and researchers which included, Topical Lidocaine should be used as directed by health care professionals and according to directions of the manufacturer. (Retrieved from www.ncbi.nlm.nih.gov on 12/20/24).</p> <p>Review of the policy and procedures titled Medication Regimen Review (MRR) revised on 6/01/24 revealed the facility would encourage the physician/prescriber or other responsible parties receiving the MRR and the DON to act upon the recommendations contained in the MRR. The document read, For those issues that require physician/prescriber intervention, facility should encourage physician/prescriber to either accept and act upon the recommendations contained within the MRR or reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected, .</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>50401</p> <p>Based on interview, and record review, the facility failed to ensure staff had the appropriate competencies and skills sets to carry out the functions of food and nutrition service to prevent potential food borne illness for 1 of 3 residents reviewed for food, of a total sample of 32 residents, (#1).</p> <p>Findings:</p> <p>On 12/16/24 at 11:47 AM, resident #1 stated she had diabetes and liked a snack before bed for good blood sugar control. She continued, she often requested a sandwich snack from the nursing staff but had frequently been told there wasn't a sandwich available so now she received an egg or tuna salad sandwich on her dinner tray each night. Resident #1 explained although she received the sandwich on her dinner tray she did not eat it right away but instead usually ate it anywhere from 10:30 PM to 12:30 AM. She added, often the only snacks available were graham crackers which didn't have the necessary protein content for good blood sugar control. She stated her dinner meal usually arrived before 6:00 PM and she tried to wait at least four hours before she ate her nighttime snack.</p> <p>On 12/17/24 at 12:05 PM, the Registered Dietitian (RD) stated the nursing staff had told her resident #1 liked a turkey sandwich for a nighttime snack and she received it when requested from nursing. She added, the Dietary staff kept bulk sandwiches in the nourishment room for residents to request from nursing and they usually left about five to ten sandwiches there per night.</p> <p>On 12/17/24 at 12:21 PM, the Certified Dietary Manager (CDM) provided the meal ticket for resident #1's dinner which included an egg or tuna salad sandwich on each dinner tray in addition to her dinner meal. The CDM stated they added the sandwich for the resident on her dinner tray because she requested it as her preference. He explained he had spoken with this resident frequently and told her she was not to keep the sandwich for the next day but instead should ask for a fresh sandwich. The CDM stated he thought that she requested to get one on her dinner tray because she didn't want to bother the nurses. He stated there was no record of when resident #1 started receiving these sandwiches on her dinner tray but recollected it had been longer than six months. He added that his night cook made sandwiches for all three nourishment rooms which were delivered as a bulk snack for any residents who requested them. The CDM stated if he knew a resident was keeping a sandwich from their dinner tray but not eating it until 10:30 PM, that it would be okay. He acknowledged another alternative would be to send sandwich later to the nourishment room with resident #1's name labeled on it if it was requested and ordered.</p> <p>On 12/17/24 at 1:00 PM, the RD acknowledged the resident's dinner meal ticket showed she received an egg or tuna salad sandwich with her dinner meal every evening to eat as an evening snack after 10:30 PM which had been occurring at least 6 months or longer. The RD responded it was not safe to keep the perishable sandwich in her room unrefrigerated for that amount of time. She said the facility could order a sandwich to be put in the nourishment room each evening with her name and room number on it so she could request it from nursing, which would be a safer alternative.</p> <p>(continued on next page)</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/17/24 at 3:00 PM, Certified Nursing Assistants (CNAs), J and K confirmed resident #1 got a sandwich at night on her dinner tray and ate it before going to bed. They stated she went to bed late, usually between 11 PM and 1 AM, but were not sure what the actual time was that she ate the sandwich as they were working with other residents.</p> <p>On 12/18/24 at 9:00 AM, the CDM stated moving forward the plan for resident #1's evening snack was to put her name on it in the nourishment room refrigerator and instruct the nurses this resident was to get this sandwich when she was ready to eat it for her evening snack. He added he should have asked the resident when she was going to eat the sandwich and going forward he would do this as know he realized that keeping a tuna or egg salad sandwich unrefrigerated for 3 hours was too long.</p> <p>On 12/18/24 at 9:23 AM, the facility's Administrator acknowledged it was the facility's responsibility to ensure residents received food in a manner that was safe for them regardless of any requests to receive a food item in a certain manner. She stated in addition to the dietary staff, the CNA's were also responsible to ensure food safety and to be aware of food left unrefrigerated at the resident's bedside.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50401</p> <p>Based on observation, interview, and record review, the facility failed to ensure food products were stored correctly in the walk-in cooler, and failed to ensure the temperature of hot foods being held was taken before service in accordance with professional food service safety.</p> <p>Findings:</p> <p>1. On 12/15/24 at 11:50 AM, during a tour of the walk-in refrigerator with [NAME] D, a small plastic bag holding approximately 12 turkey slices, dated 12/11 (five days ago) was noted. [NAME] D stated the facility policy was to discard perishable food items three days after they were opened, and she removed it to be discarded. Another plastic bag with approximately 20 slices of sliced ham, dated 12/10 (six days ago) was noted and [NAME] D stated it also should have been discarded after three days and she removed it. An opened and resealed plastic bag of shredded mozzarella cheese dated 12/08 (eight days ago) and an opened bag of goat cheese, resealed in a plastic bag was dated 11/21 (25 days ago) was noted and [NAME] D reiterated these also should have been discarded after three days and she threw the bags away. There were two loaves of Italian bread, resealed in a plastic bag, dated 12/06 (10 days ago) that was hard and stale to the touch and [NAME] D discarded it. [NAME] D explained she assisted the Certified Dietary Manager (CDM) with the management of the kitchen, so she was able to tour the kitchen while the CDM was not present.</p> <p>A few minutes later, both a previously opened plastic jar of mayonnaise and a plastic bottle of Italian salad dressing which was approximately 3/4 empty, had a sticker dated 11/19/24 which indicated the day they were received, but neither had a date to indicate when they had been opened. A tub of opened but undated sour cream was also found. [NAME] D discarded the sour cream and explained these items should have been dated when they were opened.</p> <p>Five packages of unopened (in original sealed plastic bag) turkey slices were noted in a box that had been received 11/26/24 (20 days ago). [NAME] D was not sure how long these could be kept before discarding and stated she would check with the CDM when he arrived. There was a previously opened 1/2 of an unsliced ham in a plastic bag dated 12/02 (13 days ago). [NAME] D confirmed this was outdated and she threw it away. A box contained three 10-pound tubes of raw ground beef were noted. The box had a sticker with a received date of 12/06/24 (nine days ago). [NAME] D confirmed there was not an expiration date and was unsure of how long this item could be kept before discarding.</p> <p>On 12/15/24 at 3:45 PM, the CDM stated the plastic bag holding the turkey slices, dated 12/11 should have been discarded after five days- today. He said the sliced ham, dated 12/10 should have been discarded yesterday. He stated the resealed bag of shredded mozzarella cheese, opened eight days ago, and the bag with the goat cheese opened 24 days ago, should not have been discarded as cheese could be kept longer than sliced meat. He acknowledged not being sure exactly how long it could be held but stated they could be kept awhile. The CDM stated he did not have access to the food labeling and storage policy at that time because an outside company provided their policies, but he could get it by tomorrow.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The CDM stated the mayonnaise and Italian salad dressing needed to be discarded by their use by date but was not able to locate a use by date on the labels of these items in the refrigerator, nor the unopened ones in the dry storage area. The CDM could not show when these undated items were opened nor when they needed to be used or discarded. The CDM stated he was positive the sour cream should have a use by date on it but since it was already discarded, he did not have the container to find that date. He also confirmed the opened loaves of Italian bread from nine days ago should have previously been discarded.</p> <p>The CDM was unsure how long the five packages of unopened (but still sealed) turkey slices, could be kept, but would find out. He stated he was sure the unsliced ham should not have been discarded, but was not sure how long it could be kept and used. The CDM stated the box of raw ground beef had previously been frozen and was probably pulled from the freezer to defrost two days ago but had no label or documentation as to when that occurred. He stated he thought it could be kept in the refrigerator for about seven days after being frozen. The CDM stated they followed the standard policies of all food services operations, and he was aware staff was supposed to date items when they were opened.</p> <p>On 12/18/24 at 9:00 AM, the CDM stated he called his food distributor service to find out how long cheese could be kept after it was opened but had not received a return call. He said the only information he obtained at this point was a document he provided after a general computer search for the shelf life of shredded mozzarella cheese, and how long does crumbled goat cheese last? which is not considered a credible source for food service safety guidelines for vulnerable populations and public food service operations. The CDM stated moving forward the facility would get a policy for how long they were to keep cheese.</p> <p>2. On 12/18/24 at 11:15 AM, a tray of individually portioned insulated bowls of chicken noodle soup was observed, on a shelf above the tray line. At 11:28 AM, after temperatures of all of the food items on the steamtable were taken by [NAME] D, the CDM acknowledged soups were usually portioned into individual bowls when food temperatures were taken, which usually started at 11:15 AM. The bowls of soup usually would be held in individual serving bowls, for approximately 25 minutes, until 11:40 AM, when tray line plating began.</p> <p>At 11:30 AM, the CDM asked [NAME] I to reheat the bowls of soup. At 11:38 AM, tray line started without the soup. At 11:43 AM, [NAME] I set the tray of reheated soup bowls back on the shelf above the tray line (without a heat source) and walked away. A Dietary Aide H, then took a bowl of the soup and placed it on a resident's lunch tray. By request of the surveyor [NAME] I took the temperature of the bowls of reheated soup, at 137 degrees Fahrenheit (F). [NAME] I stated she usually took the temperature of food after reheating it but didn't this time. She stated she was aware that reheated food needed to reach 165 degrees F before serving and removed the bowls of soup to again be reheated. [NAME] D then took a separate steam table pan of cream of chicken soup, which had also been sitting on the counter and not in a heated position on the steamtable, to be reheated. At 11:53 AM, the cream of chicken soup temperature was tested at 156 degrees F. [NAME] D then returned the cream of chicken soup to be reheated again. At 11:58 AM, the cream of chicken soup was found to be at 200 degrees and was carried down to the resident unit to be added to the appropriate resident trays which had already been delivered to the unit.</p> <p>(continued on next page)</p>		

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