DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/13/2020 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-0391
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COM	SURVEY PLETED
		105987	B. WING			02	/27/2020
	ROVIDER OR SUPPLIER CREEK NURSING AND	REHAB CENTER		14	FREET ADDRESS, CITY, STATE, ZIP CODE 1155 TOWN LOOP BLVD RLANDO, FL 32837	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	Rehabilitation Center 42 CFR Part 483 and Long-Term Care Faci	Hunters Creek Nursing And was not in compliance with 488, requirement for lities.					
F 677 SS=D	ADL Care Provided for CFR(s): 483.24(a)(2)	or Dependent Residents	F	677			
	out activities of daily is services to maintain opersonal and oral hyd This REQUIREMENT	ent who is unable to carry iving receives the necessary good nutrition, grooming, and piene; is not met as evidenced					
	failed to provide manner for 1 of 3 res	and record review, the facility care in a timely sidents reviewed for g, (ADL) of a total sample of			Resident #33 received care at approx. 8 am on Resident #33 skin check was comple on and revealed no adverse affects from delay in the care. APRN assessed resident #33 on for	ted	
	Findings:				negative effects from d in care and assessed none present. I	elay	
	with her most Her diagno	affecting right side and			D was educated regarding the timelin of delivery of care. 2. Resident audit conducted by DON/ designee on to identify othe residents requesting care	r	
	revealed the	m data set (MDS) essment reference date e resident's cognition was with a brief interview of score of The for bed let use, and personal			within timely delivery and found no furconcerns. 3. Staff educated by SDC/ designee regarding the importance of answerin calls in a timely manner to meet residneeds. 4. Random weekly audits will be conducted by the DON designee. The results of these audits will be present the monthly OA committee for further	g ent's e	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE /2020

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 nursip homes, the findings stated above are disclosable 90 days, to 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

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 disclossable 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.

Electronically Signed

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CENTERS FOR MEDICARE &	ENTERS FOR MEDICARE & MEDICAID SERVICES CONTROL OF THE SERVICES						
FATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED				
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			A. BUILDI	MG		
		105987	B. WING			02/27/2020
NAME OF PROVIDER OR SUPPLIER HUNTERS CREEK NURSING AND REHAB CENTER				14	REET ADDRESS, CITY, STATE, ZIP CODE 155 TOWN LOOP BLVD RLANDO, FL 32837	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION E DATE
F 677	and at 9:00 / #33 stated that last in and had a mov light to call for assisted call light on, waited for response. She said si hello, hello at 10:00 for some one came into h stated she told staff if and needed for be che member told her to we get someone to assis she was not changed was not changed at about 9: at 5:12 PM, (UM) stated that a president this morning UM stated that a president this morning UM stated that the far monitored the hallway ideo footage could b lights were on, and w call lights. On at 10:22 Director of Nursing (C was started on concern of not being the concern of not being the concern of the protector (Shappened sometime Camera footage for was viewed with the /Footage showed licer entered resident #33 came out of the room	M and at 4:11 PM, resident ght, she was wet ement, and used the call noe. She said she put her rhalf an hour, with no he then started calling out, errown. The resident hat she was covered in anged. She said the staff ait a minute as she would to the resident stated that until this morning on 30 AM. The resident stated that until this morning on 30 AM. The Captiva Unit Manager, evenoe was placed by the regarding the incident. The cility had cameras that is. She further stated that a reviewed to see if call hen staff responded to the AM, the Administrator and ONN) stated that a grievance regarding resident #33's changed in a timely manner.	Fi	677	review and recommendations for three months and as deemed necessary thereafter.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES							
CENTERS FOR MEDICARE &	MEDICAID SERVICES		OMB NO. 0938-039				
ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED				
	105987	B. WING	02/27/2020				

MANUE OF PROVIDER OR SUPPLIER HUNTERS CREEK NURSING AND REHAB CENTER (P4) ID PRETEX TAGE (P4) ID (PROVIDER'S STITE, STATE, ZIP CODE (PA) ID (PROVIDER'S STATE, ZIP CODE (PA) ID (PROVIDER'S STATE, ZIP CODE (PA) ID (PA) ID (PROVIDER'S STATE, ZIP CODE (PA) ID	
HUNTERS CREEK NURSING AND REHAB CENTER (04) ID PRETIX TAGE (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 677 Continued From page 2 resident's room. As per the DON, CNA E stated she asked the resident is the wanted to be changed, and the resident stated she was fine. At 4.46 AM, LPN D went into the resident's room. The DON stated, that LPN D told her risher resident's all light, and when the CNA went into the resident's room. The time when LPN D responded to the resident's room. The resident's call light, and when the CNA went into the resident's room. The DON stated, that LPN D responded to the resident's room. The DON stated, that LPN D responded to the resident's room. The DON stated that the resident's room. The DON stated that the resident's room. The DON stated to the resident's room. The DON stated the resident's room. The room stated the resident's room the room the room the room the room the room	
OKLANDO, FL 32837 OKLANDO, FL 32837 OKLANDO, FL 32837	
PREERY TAG REGULATORY OR ISC IDENTIFYING INFORMATION) F 677 Continued From page 2 resident's room. As per the DON, CNA E stated she asked the resident stated she was fine. At 4.46 AM, LPN D vent into the resident's room. The DON stated, that LPN D told her the resident's call light was on, and the resident asked to be changed. Both the Administrator verified that there was a period of an hour between the time when LPN D responded to the resident's call light, and when the CNA went into the resident's call light, and when the CNA went into the resident's call light, and when the CNA went into the resident's call light, and when the CNA went into the resident's call light, and when the CNA went into the resident's call light, and when the CNA went into the resident's call light, and when the CNA went into the resident's call light, and when the CNA went into the resident's call light and when the CNA went into the resident's call light, and when the CNA went into the resident's call light and when the CNA went into the re	
resident's room. As per the DON, CNA E stated she asked the resident if she wanted to be changed, and the resident stated she was fine. At 4.46 AM, LPN D went into the resident's room. The DON stated, that LPN D told her the resident's call light was on, and the resident asked to be changed. Both the Administrator verified that there was a period of an hour between the time when LPN D responded to the resident's call light, and when the CNA went into the resident's con. The DON said LPN D	(X5) COMPLETION DATE
off. came out of the room, but forgot to tell the CNA. LPN D did not provide care to the resident. The DON stated that the 7AM-3 PM CNA F said the resident was wet when she changed her at approximately 8 AM. On at 11:18 AM, registered nurse (RN) G stated that resident #33 was able to make her needs known, and if the resident told him she was wet, he would expect the resident to be changed within minutes. On at 5:00 PM the DON stated, that when a resident said they were soiled, someone needed to go in and get care done as soon as possible. On at 5:30 PM, LPN D stated that she worked with resident #33 on on the 11PM-7AM shift LPN D stated she answerd the	

she was wet. LPN D said she told the resident she would let the CNA know. LPN D stated resident#33 was very alert and used the call light when she needed something. LPN D stated she saw CNA E go into the resident's room, but she did not see if the CNA changed the resident. LPN

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE COMP	SURVEY
		105987	B. WING	_		02/	27/2020
NAME OF PR	ROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE		
HUNTERS	CREEK NURSING AND	REHAR CENTER		1	14155 TOWN LOOP BLVD		
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F 677	said she did not chan reported that the CNA when she approache stated that she was find the CNA when she approache stated that she was find the control of t	ectation was that the anged immediately. LPN D ge the resident. She A did not inform her that of the resident ne. AM, the Social Services that a green was a gree	F	677			
F 686 SS=D	Treatment/Svcs to Pr CFR(s): 483.25(b)(1)	event/Heal	F	686	3		

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		MEDICAID SERVICES					0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		105987	B. WING			02/	27/2020
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1	4155 TOWN LOOP BLVD		
HUNTERS	CREEK NURSING AND	REHAB CENTER		0	DRŁANDO, FL 32837		
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F 686	§483.25(b) Skin Integ §483.25(b) (T) §483.25(b)(T) Based on the compre resident, the facility m (i) A resident receives professional standard unless the indi demonstrates that the (ii) A resident with necessary treatment. With professional star promote healing, prevene from deve This REQUIREMENT by: Based on interview a failed to implement in healing of a sure resident reviewed for sample of 50 resident Finding Resident #7 was adm and readmit diagnoses included to right in right and The resident's curren read, read	rity hensive assessment of a use ensure that- use ensure that- use ensure that- is care, consistent with is of practice, to prevent loses not develop, vidual's clinical condition y were unavoidable; and receives and services, consistent dards of practice, to rent and prevent loping, is not met as evidenced and record review, the facility terventions to promote for 1 of 1 for	F	686		No	
		cover with dry sed to help the healing of					

and skin

Facility ID: 35960916

...It works by helping to

break up and remove . . . skin and tissue."

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPI IDENTIFICATION NUMBER: A. BUILDING		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
	105987	B. WING		02/27/2020
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	

NAME OF P	ROVIDER OR SUPPLIER			FREET ADDRESS	S. CITY, STATE, ZIP CODE		
				155 TOWN LOC	OP BLVD		
HUNTERS	CREEK NURSING AND	REHAB CENTER		RLANDO, FL	32837		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAC	ROVIDER'S PLAN OF CORRECTION CHI CORRECTIVE ACTION SHOULD E B-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(X5) COMPLETION DATE
F 686	Continued From page (WebMD)	5	F				
	revealed the rarely/never understo dependence on staff living. The resident w frequently The "Rounds' "Resident was seen be	essment reference date at the resident was od, and had total for all activities of daily as assessed as being of and 'f and read, ry care MD (medical					
	3.4 x 2.5 (cer	of the right medial attimeters)recommend					
	"Resident was seen b 0 2.5 x 4.7 x 0.8Debr without any complicat due to resident const healing, not for dribbles" "A is a	f the right medial idement was performed					
	Resident was seen by of the right in Debridement was per	Rounds note read, " y care MD for nedial 4 x 3.8 x1 formedskin irritation n due to heavy wetting."					
	right medial for						

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NAME OF PROVI	DER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HUNTERS CR	EEK NURSING AND	REHAB CENTER		14155 TOWN LOOP BLVD ORLANDO, FL 32837		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERÊNCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686 Co	ontinued From page	6	F 68	36		

not measurable, and the had 25% Debridement was performed to "remove tissue and establish margins of viable tissue recommend , for healing.". Documentation indicated, that "The clinical documentation for this consultation was made available to the referring physician ...also made available to the skilled nursing facility at any time for placement in the skilled nursing facility record " A handwritten note documented on the "

Evaluation & Management Summary" for read, "Recommendation noted for placement of ...,-will reassess ... on next visit. D/W (discuss with) ID (but due to recent we will wait on "

. . . . the . . . measurements were 2.5 x 4.7 x 0.8 cm. The ____ care physician's documentation read, "_____ of the right, medial -improved evidenced by decreased tissue." Recommendations included " , for healing."

measurements were 4 x

is in an inflammatory stage and is unable to progress to a healing phase because of the presence of a biofilm. progress: Deteriorated ... of the right, medial -deteriorated due to contamination." Recommendations included: "2.4.20 recommend , for healing; 2.18.20 recommend, for ... healing."

On measurements were 4.5 x

3.5 x 2 cm. Documentation read, ". of the right, medial Event ID: UO9C11

the

3.8 x1 cm, and documentation read, "This

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CENTERS FOR MEDICARE & I	MEDICAID SERVICES			OMB NO. 0938-039	
TATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
	105987	B. WING		02/27/2020	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS CITY STATE ZIP CODE		

		105987	B. WING			02/27/2020
NAME OF PROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1	4155 TOWN LOOP BLVD	
HUNTERS CREEK NURSING AND REHAB CENTER		REHAB CENTER		(DRLANDO, FL 32837	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(XS) COMPLETION DATE
F 686	-deteriorated of necompliance with necompliance with necompliance with necompliance with the commendations reprevious visit. The Advance register (ARNP) notes for resind the commendation for a healing was an order of the care nurse state of the care nurse stated that resident # and was seen by the care nurse stated that resident # and was seen by the truesday and The care nurse provided from the resphysician (PCP) for the PCP was made at recommendation on evaluation & revealed that the recommendation for a on at 2:25 f (DON) stated the inset discussed with the PCP was made at recommendation on at 2:25 f (DON) stated the inset discussed with the PCP was made at recommendation on at 3:25 f (DON) stated the inset discussed with the PCP was not stated that recommendation on at 3:25 f (DON) stated the inset discussed with the PCP was not stated that residual stated the stated that the recommendation of a stated that residual stated the stated that stated that stated that stated the stated that stated that stated the stated that	due to patient care, "are and a subsequent of the same as the ed nurse practitioner dent #7 dated read, ement without will MD.* No other be identified from the ow up with the care the repeated not subsequent of a didessed. MM and at 9:22 AM, the teet that the resident's was a facility acquired She stated that the lowed by the care id alily were done rise. The care nurse ? was a frequent "wetter" care physician on he recommended a said she must get ident's primary care he insertion of the management summary" care physician made the "Review of the management summary" care physician made the "for healing" and production of Nursing PM in the Director of Nursing PM in the Din the Director of Nursing PM in the Director of Nursing PM in the	FF	686		

DEPARTMENT OF HEALTH AN	D HUMAN SERVICES			FORM APPROVE
CENTERS FOR MEDICARE & I	MEDICAID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
	105987	B. WING		02/27/2020
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	

		105987	B. WING	B. WING		02/27/2020
NAME OF P	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE	
HUNTERS	CREEK NURSING AND	REHAB CENTER		1	14155 TOWN LOOP BLVD	
				L	ORLANDO, FL 32837	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F 686	resident's history of fr	equent	F	68	3	
	resident #7 had uroge , and started the PCP had now decide	stated, that the PCP said and overflow of resident on The d to go with the, and were placed today				
	reviewed with the DO nurse. An order for identified. Both the D nurse verified this and by the care nu was ordered, stated that she though order in the electronic check to see if the ordistated that the	ON and the care diverified that documentation used that				
	was aware of the recommendation for a ARNP stated she spo physician and discuss to insert a	sed the resident 's history of , and that she was hesitant to this history. She stated of at a point that it was it was at the time, onitor the , and her next visit. When asked , the ARNP stated that she was "just a conversation." he , was warranted at a trying to be very NP stated that the 's she decided to go with the The ARNP stated that the				

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		105987	B. WING _		02/27/2020
	CREEK NURSING AND	REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 14155 TOWN LOOP BLVD ORLANDO, FL 32837	•
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION
F 686	(). She adde nurse notified her abo yesterday". On at 3:41 F physician stated, that his recommendation(s has the final decision physician stated that has the final decision physician stated that ARNP tried the final decision stated that he did not about the resident will or or T stated that the erisident will or T stated that the resident will or T stated that the resident patting wet, and he fe helped /contributed to Captiva/Key West unincare nurse. Th notes, physician order ARNP notes were revnurse stated that the /corder for for reusually entered it into record." I don't know have been distracted, but it in." When asker regarding review of the adequate and correct the care nurse followed up. The Capt has the did not go on the followed up. The Capt has the did not go on the followed with the state that the last not go on the followed up. The Capt has the did not go on the followed up. The Capt has the did not go on the followed with the state of the followed up. The Capt has the did not go on the followed up. The Capt has the did not go on the followed up. The Capt has the did not go on the followed up. The Capt has the did not go on the followed up. The Capt has the did not go on the followed up. The Capt has the did not go on the followed up. The Capt has the did not go on the followed up. The Capt has the did not go on the followed up. The Capt has the did not go on the followed up. The Capt has the did not go on the followed up. The Capt has the did not go on the followed up. The Capt has the followed u	ed that the care ut the , "either" "or today" M, the care generally he documented j) in his notes, but the PCP making. The care le was aware that the le was made aware of this . The care physician recall speaking directly in the ARNP on he care physician recall speaking directly in the ARNP on he care physician it's was constantly it that the , would have the healing of the resident's M, an interview was iministrator, the DON, the tmanager, (UM) and the e resident's care s, progress notes, and the tewed. The care RNP gave her a verbal seident #T. She said, she the electronic medical what happened, I could I do not know why I did not a about the facility's process e resident's care to ensure implementation of orders, said she did not know who iva/Key West UM stated	F6	86	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		E CONSTRUCTION	(X3) DATE	
		105987	B. WING _			02/	27/2020
NAME OF PR	ROVIDER OR SUPPLIER	•		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
интепе	CREEK NURSING AND	DEMAR CENTER		1	4155 TOWN LOOP BLVD		
HUNTERS	CREEK NUKSING AND	REHAB CENTER		C	DRLANDO, FL 32837		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 686	on the care n. regarding the resident stated that the the ARNP about the rit was a verbal discus and it was not documentation provided assessment. When a between the PCP/AR and the facility, the faboth the ARNP, and it thought the resident vower as rever on The Administrator state for the physician/ARN saw residents. On at 5:44 f (MD) stated that he with care for rithat the care for that the care for that the care for the thing the same factor of the physician of the provided in the virtual factor of the provided in the virtual factor of the provided in the virtual factor of the virtual	ne stated that she depended use to keep her informed it's care. The DON care physician spoke with resident's on	F	686			
F 695	that the resident was was never or	ician, and the ARNP believed on , when in fact the dered. The MD stated, that nunication open, but there vernent. , Care and Suctioning	Fé	395			

Facility ID: 35960916

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		105987	B. WING _			02/27/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	
			- 1	14155 TOWN LOOP BLVD		
HUNTERS	CREEK NURSING AND	REHAB CENTER		ORLANDO, FL 32837		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	TION SHOULD BI THE APPROPRIA	
F 695	Continued From page	e 11	F 6	95		
	The facility must ensi needs car care and suc care, consistent with practice, the compret care plan, the resider and 483.65 of this su This REQUIREMENT by: Based on observatio review, the facility fail at the prescri order for 2 of 4 reside care of a total sample #56). Findings: 1. Review of resident revealed he was adm with diagnoss (loss of ability to unde (irreg (CR)) assessment of a carely/never understo of care, was totally de daily living (ADL), use nobility, was always had	nd suctioning. rer that a resident who e, including clinoling, is provided such professional standards of tensive person-centered tist goals and preferences, tipart. is not met as evidenced n, interview and record ed to provide () bed rate as per physician's rist reviewed for of 50 residents, (#100, #100's medical record titted to the facility on se including aphasia perstand or express speech), ular heartbeat), and).		1. Resident #100 corrected by rursing mans of notification. Resident #56 flow corrected by rursing unit time of notification. 2. Facility audit conducted DON/designee on residents flow rate at the prescribed rate per 3. Licensed nursing staff e SDC/designee to appropriensure residents flow rate. 4. Random weekly audits conducted by DON/design of these audits will be presmothly QA committee for and recommendations for and as deemed necessary	ager at the tir rate was nanager at the by to review a e was deliver physician ore ducated by ducated by ately verify a ate is at the will be nee. The resi sented at the further reviet three months	ne ill ed ed nnd utts

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/13/2020

DEL ARTIMENT OF FILM	.111740	D HOMMIN SERVICES			FOI	RM APPROVED
CENTERS FOR MEDICA	RE&	MEDICAID SERVICES			OMB N	IO. 0938-0391
STATEMENT OF DEFICIENCIES UND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	INSTRUCTION		TE SURVEY MPLETED
		105987	B. WING		0	2/27/2020
NAME OF PROVIDER OR SUPPL	IER		STRE	EET ADDRESS, CITY, STATE, ZIP CO	DDE	
HUNTERS CREEK NURSIN	G AND	DELIAD CENTED	1415	5 TOWN LOOP BLVD		
HOW END CREEK NORDIN	G AND	REMAD CENTER	ORL	ANDO, FL 32837		
PREFIX (EACH DE	FICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
for dependent relevant relevan	dent ## ted to bation nd whe nervent via te)." resider a admir PM co conduct at 10: 55 PM, tich was bedsi 54 PM, tich was bedsi 55 PM, tich was bedsi 65	00's care plan revised on Focus read, "	F 695			

was assigned to resident #100 for the past 3 days

PRINTED: 04/13/2020 DEDARTMENT OF HEALTH AND HISMAN CEDWICES

105987	B. WING	02/27/2020
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIF ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X3) DATE SURVEY COMPLETED
CENTERS FOR MEDICARE & MEDICAID SERVICES		OMB NO. 0938-039
DEPARTMENT OF HEALTH AND HUMAN SERVICES		FORM APPROVE

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14155 TOWN LOOP BLVD HUNTERS CREEK NURSING AND REHAB CENTER ORLANDO, FL 32837 SUMMARY STATEMENT OF DEFICIENCIES. PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 695 | Continued From page 13 F 695 and had checked his . , , . during her morning rounds. The DON asked LPN A to demonstrate how she was reading the . , . . concentrator setting. LPN A's demonstration revealed that she stood up and looked down at the concentrator flow rate which did not show an accurate reading. LPN A added that she was responsible for connecting resident #100's ,, to the portable , ... when he went to LPN A stated that she did not realize that the resident was only getting 2 LPM when she stood to read the flow rate or from the portable tank on Nurse or ..., Care Practitioner performs this procedure...Check physician's order...turn the unit on the desired flow rate, and assess equipment for proper functioning..." 2. Resident #56 was initially admitted to the facility on ... with diagnoses that included , and () tubing was on the right side of the bed, and the ... concentrator flow rate was set at 3.5 liters per minute (LPM). at 4:09 PM, resident #56's On was set at 3.5 LPM. at 10:14 AM and 4:12 PM, resident On

		ID HUMAN SERVICES				FORM APPROVED
		MEDICAID SERVICES				OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	IPLE CONSTRUCTION	_	(X3) DATE SURVEY COMPLETED
		105987	B. WING			02/27/2020
NAME OF PR	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY	, STATE, ZIP CODE	
MINTERS	CREEK NURSING AND	DEMAR CENTED		14155 TOWN LOOP BL	VD	
HUNTERS	CREEK NURSING AND	REMAD CENTER		ORLANDO, FL 3283	7	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COF	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD E RENCED TO THE APPROPRI DEFICIENCY)	
F 695	Continued From page #56 was resting in be	e 14 ed with closed. The	F			
	concentration LPM.	n flow rate remained at 3.5				
	order dated	cal record noted a physician that read, " via via physic 2, every shift for "				
	(RN), said that she ha #56, and was replacing RN C stated that she	had just adjusted the _ ct amount of 2 LPN as				
	(DON) and reviewed resident #5 and acknowledged th	PM, the Director of Nursing B() B() Side, physician orders for at the physician orders were 3.5 LPM as noted during				
		ents quarterly Minimum Data ent dated and , documented that he				***************************************
	every shift and as ne	terventions to administer nd to check rate of flow eded.				***************************************
F 759 SS=D	Free of Medication E CFR(s): 483.45(f)(1)	rror Rts 5 Pront or More	F	759		
	§483.45(f) Medication The facility must ensi					

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE	
		105987	B. WING			02/	27/2020
NAME OF P	ROVIDER OR SUPPLIER		_	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	CREEK NURSING AND	DELLA D. GENTED		1.	4155 TOWN LOOP BLVD		
HUNTERS	CREEK NURSING AND	REHAB CENTER		c	ORLANDO, FL 32837		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 759	percent or greater; This REQUIREMENT by: Based on observatio review, the facility fail errors for 1 of 6 residual administration observe errors in 30 opportuni the 4 nurses observe of 10%. Findings: During a medication o on at 9:30 AM (LPN) A said, she just which proceeded to prepare medications. She pia (mg) tablet, D3 1000-unit resident's other oral in administering the me surveyor both counte She then proceeded medications to the ret Review of the medica revealed her most rec was on Her c read: ta one time a day for ((diastolic	ion error rates are not 5 is not met as evidenced n, interview, and record ed to prevent medication ants sampled for medication atton, (#27). There were 3 ties on 1 of 2 units by 1 of d, for a medication error rate administration observation d, licensed practical nurse tchecked resident #27's was . She then the resident's scheduled ced . 10 milligram	F	759	1. Medication variance report for resid #27 was completed on #27 was evaluated by physician and stated no adverse effects from medica error. LPN A was re-educated on medication administration by SDC at the signed or for survey. 2. Facility audit conducted by DON' designee on to review reside orders were administered as ordered. Other concerns were identified. 3. Licensed nursing staff educated by SDC/ designee on medication administration. 4. Random weekly audits will be conducted by the DON' designee. The results of these audits will be presented the monthly AQ committee for further review and recommendations for three months and as deemed necessary thereafter.	dent tion ne nt's No d at	

, hold for below 100 or

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/13/2020 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES					NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		ATE SURVEY OMPLETED
		105987	B. WING_				02/27/2020
	ROVIDER OR SUPPLIER CREEK NURSING AND	REHAB CENTER		14	TREET ADDRESS, CITY, STATE, ZIP CODE 4155 TOWN LOOP BLVD PRLANDO, FL 32837		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	ĸ	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 759	tablets po one time a On at 2:45 Pl conducted with LPN J hysician orders rege the medications beca she did not follow ph parameters to hold fo then read the physicia D3 which ind to get total of 2000 ur she though that she I the pill cup. Surveyor 11 and if she had give the pill count should I On at 2:52 Pl (DON) said that LPN count to eliminate err medications (when resident #27's I Review of the facility dated read, complete and accura physician medicationfor each resid administration of drea safePhysician Orde safePhysician Orde	blet 1000 units, give 2 day for (2000 units). M a follow up interview was A. After reading the rding resident #27's LPN A sald, she gave use the was high and sician orders regarding r DBP less than 60. She an order regarding the sician orders regarding r DBP less than 60. She an order regarding the and put 2 1000-unit tablets in then verified pill count was and put 2 1000-unit tablets in then verified pill count was an 2 tablets of D3 ave been 12. M, the Director of Nursing A should have done a pill ors and should have held and) DBP was less than 60. Medication Pass Guidelines Purpose: To assure the most te implementation of orders and to optimize drug tent by providing for is in an accurate, rs- medication are si nan accurate, rs- medication are	F	759			

		No. Co.			PRINTED: 04/13/2020 FORM APPROVE
STATEMENT	or Health Care Adminis OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		35960916	B. WING		02/27/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
HUNTERS	CREEK NURSING AND	REHAB CENTER	OWN LOOP BLV O, FL 32837	'D	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
N 000			N 000		
N 054 SS=D	All physician orders n prescribed, and if not	ollow Physician Orders	N 054		
	Based on observation review, the facility fail, at the preson orders for 2 of 4 resid, care (#10 administer medication physician for 1 of 6 remedication administra of 50 residents. Findings: 1. Review of resident revealed he was adminiment to the substitution of the substitution of the substitution of the substitution administration of the substitution administration of the substitution administration administra	bed rate as per physician's ents reviewed for , #50 and failed to is as ordered by the sidents sampled for altion, (#27) of a total sample #100's medical record		1. Medication variance report for resise #27 was completed on Res #27 was evaluated by physician and stated no adverse effects from mediceror. LPN A was re-educated on medication administration by SDC at time of survey. Residents #100 and # flow rate was corrected by runtif manager at the time of ontification continuits and the properties of the prope	ation the 56's rising 1. ant's
	(irreg	ular heartbeat), and .).		administration and appropriately verification residents' prescribed flow rate 4. Random weekly audits will be conducted by the DON/ designee. The	

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE Electronically Signed /20

): 04/13/2020 1 APPROVE
		tration (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING:		(X3) DATE SURVEY COMPLETED	
		35960916	B. WING		02/2	7/2020
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA			
HUNTERS	CREEK NURSING AND	REHAB CENTER	VN LOOP BLV , FL 32837	D		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S HAN OF CORPECTION LEGAL DEFICIENCY MUST BE PRECEDED BY FULL PREFIX GRAH ORGANICATION TAG CROSS-REFERENCED TO THE APPROPRIATE OF CROSS-REFERENCED TO THE APPROPRIATE O		BE	(X5) COMPLETE DATE		
N 054	rarely/never understoot of care, was totally de daily living (ADL), use mobility, was always had breathing when lying in the search of the daily living when lying in dependent related to for dependent related to restore the subsorption. Intervent humidified via (liters per minute)." Review of the residen read to admiring the search of the resident of the search o	ated revealed he was od, no behaviors or rejection pendent and required of staff with activities of d a wheelchair or walker for of and or trouble with all in bed and received of scare plan revised on Focus read," John Staff with activities of d awheelchair or walker for of and or trouble with all in bed and received on Focus read," John Staff with a scare plan revised on Focus read," John Staff with a scare plan revised on Focus read," John Staff with a scare plan revised on Focus read, " John Staff with a scare plan revised on single plan revised plan	N 054	results of these audits will be present the monthly QA committee for further review and recommendations for thre months and as deemed necessary thereafter.		
	at 12:25 PM,	resident #100 was in				

is at 2 LPM." B left the room and returned AHCA Form 3020-0001

___, and had portable ____ tank set at 2 LPM via NC. On at 9:25 AM and 2:20 PM, NC was on resident and connected to the concentrator at beside which was set at 2 LPM. On _____ at 2:40 PM, ___, ___ ()
B went into resident #100's room, kneeled down and checked the concentrator. B said, "it

STATE FORM 6550 UO9C11 If continuation sheet 2 of 16

PRINTED: 04/13/2020 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B MING 35960916 02/27/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14155 TOWN LOOP BLVD HUNTERS CREEK NURSING AND REHAB CENTER ORLANDO, FL 32837 (X433D) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 054 Continued From page 2 N 054 within 2 minutes and stated, "the physician order for , is 3 LPM." B stated that nursing staff were responsible to ensure the resident's ... was set at the prescribed rate. at 3:02 PM, the Director of Nursing (DON), Administrator and Licensed Practical Nurse (LPN) A were interviewed. LPN A said she was assigned to resident #100 for the past 3 days and had checked his __ during her morning rounds. The DON asked LPN A to demonstrate how she was reading the __ concentrator setting, LPN A's demonstration revealed that she stood up and looked down at the concentrator flow rate which did not show an accurate reading. LPN A added that she was responsible for connecting resident #100's . , ... to the portable , when he went to , . LPN A stated that she did not realize that the resident was only getting 2 LPM when she stood to read the flow rate or from the portable ... tank on 2. Resident #56 was initially admitted to the facility on with diagnoses that included ded , and at 10:27 AM, resident #56's , , () tubing was on the right side of

LPM.

the bed, and the concentrator flow rate was set at 3.5 liters per minute (LPM).

On at 10:14 AM and 4:12 PM, resident #56 was resting in bed with ___ closed. The concentration flow rate remained at 3.5

A review of the medical record noted a physician

was set at 3.5 LPM.

at 4:09 PM, resident #56's

Agency for Health Care Adminis	tration				D: 04/13/2020 MAPPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	35960916	B. WING		02/2	27/2020
NAME OF PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STAT	E, ZIP CODE		
HUNTERS CREEK NURSING AND	REHAB CENTER	WN LOOP BLVD			
PREFIX (EACH DEFICIENCY	ORLANDO, SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	TION SHOULD BE THE APPROPRIATE	
N 054 Continued From page	3	N 054			
specify (PM, Registered Nurse C d provided care to resident g the machine tubing. had just adjusted the t amount of 2 LPN as sician. PM, the Director of Nursing B () 6's, physician orders for at the physician orders were 3.5 LPM as noted during nts quarterly Minimum Data nt dated and documented that he documented that he dost administer d to check rate of flow				

AHCA Form 3020-0001

STATE FORM 690 UO9C11 If continuation sheet 4 of 16

which was She then proceeded to prepare the resident's scheduled medications. She placed 10 milligram (mg) tablet, 50 mg tablet and D3 1000-unit tablet into a pill cup with the resident's other oral medications. Prior to administering the medications, the nurse and surveyor both counted total of 11 pills in the cup. She then proceeded to administer the

P Agency for Health Care Administration							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			John EE IED	
		35960916	B. WING		02/2	7/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE			
UINTED	S CREEK NURSING AND	14155 TO	NN LOOP BLVI	D			
HUNTERS	CREEK NURSING AND	ORLANDO	D, FL 32837	,			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	CTION SHOULD BE COMPLE THE APPROPRIATE DATE		
N 054	Continued From page	4	N 054				
	medications to the re-	sident who was in her room.					
	revealed her most rec was on Her c read: Her c read: ((diastolic times a day for DBP below 60. D3 ta tablets po one time a On at 2.45 Pt conducted with LPN / physician orders rega and the medications beas she did not follow phy parameters to hold for then read the physician D3 which indi- to get total of 2000 ur she though that she l	tablet 50 mg PO two hold for below 100 or below 100 or below 100 or belot 1000 units, give 2 day for (2000 units). W a follow up interview was 3. After reading the reding resident #27's , LPN A said, she gave use the was high and siscian orders regarding r DBP less than 60. She an order regarding the cated that resident #27 was its and the nurse said that ad put 2 1000-unit tablets in then verified pill count was an 2 tablets of D3					

complete and accurate implementation of AHCA Form 3020-0001

dated

STATE FORM 699 UO9C11 If continuation sheet 5 of 16

On at 2:52 PM, the Director of Nursing (DON) said that LPN A should have done a pill count to eliminate errors and should have held medications (and) when resident #27's DBP was less than 60.

Review of the facility Medication Pass Guidelines

read, "Purpose: To assure the most

PRINTED: 04/13/2020 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B MING 35960916 02/27/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14155 TOWN LOOP BLVD HUNTERS CREEK NURSING AND REHAB CENTER ORLANDO, FL 32837 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 054 Continued From page 5 N 054 physician medication orders and to optimize drug , , for each resident by providing for administration of drugs in an accurate, safe...Physician Orders- medication are administered in accordance with written orders of the attending physician..." Class III N 201 400.022(1)(I), FS Right to Adequate and N 201 SS=D | Appropriate Health Care The right to receive adequate and appropriate health care and protective and support services. including social services; mental health services. if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on observation, interview and record Physician order regarding review, the facility failed to implement for healing were obtained on for resident #7. interventions to promote the healing of a

Finding

ARNP discontinued the order for

resident #33 on

designee on

noted

on Skin check completed for

skin concerns from delay in receiving ...

care consults within the last 2 weeks and to identify any other residents with

concerns for call light response in a timely

manner. No further discrepancies were

and skin check was clear and intact. 2. Facility audit conducted by DON/

to review

to observe for

for 1 of 1 resident reviewed for

care in a timely manner for 1 of 3

. (#7), and failed to provide

residents reviewed for activities of daily living (ADL) (#33), of a total sample of 50 residents.

1. Resident #7 was admitted to the facility on

and readmitted on

diagnoses included 's

Agency fo	or Health Care Adminis	tration				: 04/13/2020 APPROVED
AND PLAN OF CORRECTION (X1) PROVIDERSUPPLIERCLIA AND PLAN OF CORRECTION (X1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		35960916	B. WING		02/2	7/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE		
HUNTERS	CREEK NURSING AND	REHAB CENTER	VN LOOP BLV	D		
			, FL 32837			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
N 201	Continued From page	6	N 201			
	night right and resident's current read, medial every normal dry and is a "product u and skin break up and remove (WebMD) The quarterly minimu assessment with assement with assement with assement understo understo	Jay shift, cleanse with , apply , follow by , follow by , follow by cover with dry , seed to help the healing oflt works by helping to skin and tissue." In data set (MDS) sessment reference date at the resident was odd, and had total for all activities of daily		Nursing staff educated by SDC/ designee to review and address care consult recommendations and th importance of answering calls in a tim manner and ensure resident's needs : met. Random weekly audits will be conducted by the DON/designee. The results of these audits will be present the monthly OA committee for further review and recommendations for three months and deemed necessary there:	ely are ed at	
	The "Rounds' "Resident was seen be doctor) for 3.4 x 2.5 (cer constant moisture to go on the constant was seen be seen	of the right medial timeters)recommend or of the right medial timeters)recommend or of the right medial timeters)recommend or of the right medial				

AHCA Form 3020-0001

without any complications ...recommend due to resident constant moisture to promote healing ..., notified MD orders was given ..., for dribbles."

"A _____ is a thin, sterile tube inserted into the ______ to drain ____." (eMedicineHealth)

STATE FORM 699 UO9C11 If continuation sheet 7 of 16

PRINTED: 04/13/2020 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B WING 35960916 02/27/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14155 TOWN LOOP BLVD HUNTERS CREEK NURSING AND REHAB CENTER ORLANDO, FL 32837 SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 201 Continued From page 7 N 201 On the Rounds note read, " Resident was seen by care MD for . of the right medial 4 x 3.8 x1 ... Debridement was performed...skin irritation superficial breakdown due to heavy wetting." Evaluation & The resident's " Management Summary" dated "She has an (due to necrosis) of the right medial for at least 2 days duration." Measurements were, 3.4 cm (centimeter) x 2.5 x not measurable, and the had 25% Debridement was performed to "remove tissue and establish margins of viable tissue recommend . . , for . . . healing.". Documentation indicated, that "The clinical documentation for this consultation was made available to the referring physician ...also made available to the skilled nursing facility at any time for placement in the skilled nursing facility record." A handwritten note documented on the "

AHCA Form 3020-0001

Evaluation & Management Summary" for read, "Recommendation noted for placement of ___,-will reassess on next visit. D/W (discuss with) ID (but due to recent we will wait on ...

x 4.7 x 0.8 cm. The ___ care physician's

the right, medial -- improved evidenced by decreased tissue." Recommendations included " . . , for . . . healing." On ... the ... measurements were 4 x 3.8 x1 cm, and documentation read. "This is in an inflammatory stage and is unable to progress to a healing phase because of the

measurements were 2.5

the

documentation read. "

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recommendation on . . Review of the

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at 8:59 AM and at 9:22 AM, the care nurse stated that the resident's to her was a facility acquired and was She stated that the resident was being followed by the physician weekly, and daily were done by the care nurse. The

stated that resident #7 was a frequent "wetter" and was seen by the care physician on Tuesday and he recommended a care nurse said she must get approval from the resident's primary care physician (PCP) for the insertion of the ,, and the PCP was made aware of the

care nurse

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at 3:14 PM the ARNP stated that she

at the time.

., and

was aware of the ... care physician's recommendation for a for resident #7. The ARNP stated she spoke to the . . . care physician and discussed the resident 's history of . , , and that she was hesitant to insert a due to this history. She stated that the was not at a point that it was going to be an issue. It was

and she decided to monitor the

assess the on her next visit. When asked

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getting wet, and he felt that the would have helped /contributed to the healing of the resident's at 4:52 PM, an interview was conducted with the Administrator, the DON, the Captiva/Key West unit manager. (UM) and the care nurse. The resident's ... care notes, physician orders, progress notes, and the ARNP notes were reviewed. The nurse stated that the ARNP gave her a verbal for resident #7. She said, she usually entered it into the electronic medical record. "I don't know what happened, I could have been distracted, I do not know why I did not

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The Administrator stated that the expectation was for the physician/ARNP to document when they

would not have

, when in fact the

On at 5:44 PM, the Medical Director (MD) stated that he was aware of the concern with ... care for resident #7. He was aware care physician recommended a , ..., and the ARNP did not was not in

had any effect on the , and there were no guidelines for the use of The MD stated that would control episode of , but not the volume. He stated the resident would still need the same care. The MD was informed that both the ... care physician, and the ARNP believed

favor. The MD stated that

that the resident was on

saw residents.

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resident this morning regarding the incident. The

call light on, waited for half an hour, with no response. She said she then started calling out, "hello, hello." After 10 minutes of calling out, someone came into her room. The resident stated she told staff that she was covered in and needed to be changed. She said the staff member told her to wait a minute as she would get someone to assist. The resident stated that she was not changed until this morning on at about 9:30 AM.

at 5:12 PM, the Captiva Unit Manager. (UM) stated that a grievance was placed by the

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On

asked to be changed. Both the Administrator verified that there was a period of an hour between the time when LPN D responded to the resident's call light, and when the CNA went into the resident's room. The DON said LPN D reported that she turned the resident's call light off, came out of the room, but forgot to tell the CNA. LPN D did not provide the resident. The DON stated that the 7AM-3 PM CNA F said the resident was wet when she changed her at approximately 8 AM.

at 11:18 AM, registered nurse (RN) G stated that resident #33 was able to make her needs known, and if the resident told him she

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be right

On

Administrator stated that

at 9:10 AM, the Social Services Director (SSD) stated that a grievance was started on resident #33 on

, turned off the call light, but did not come The resident reported she got changed by another CNA at 9AM. The SSD stated resident #33 was alert, oriented x 2 and able to make her needs known.

at 10:54 AM, the DON and

not provided to resident #33 in a timely manner.

resident #33 stated she was "soaking wet" and had put her call light on around 3 AM on She added that a staff came in, said she would

. She said

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