

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105287	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Jacksonville Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2061 Hyde Park Rd Jacksonville, FL 32210	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30905</p> <p>Based on observations, interviews, record review, and facility policy and procedure review, the facility failed to notify the physician for one (Resident #128) in a total sample of 43 residents, after she choked during the lunch meal she consumed in her room.</p> <p>The findings include:</p> <p>On 04/14/2024 at 12:56 PM, Resident #128 was observed seated in a wheelchair next to the bed of one of her roommates. She got up from the wheelchair and walked with an unsteady gait and spastic movements of her hands across the room to her bed. She ran into her tray table and sat down on her bed that was positioned in the lowest position. The right side of the bed was against the wall and a floor mat was observed next to the bed. She stood up from her bed and bumped into her tray table again, then dropped down on her bed. She stood up again and ran into her tray table. She walked in and out of the room with an unsteady gait and uncoordinated, spastic movements of her limbs. A staff member delivered the resident's meal tray, set it on her tray table, and told the resident it had been left in her room. Resident #128 came back into the room, took the meal tray, and placed it on the mattress at the foot of her bed. She then sat with her legs crossed in front of her and began eating her meal. She took three large bites of the hotdog on a bun on her plate. She then got up off the bed, holding the hotdog, and started walking around her room bumping into things. She appeared to be choking. Her roommate engaged the call light, the assigned nurse, Licensed Practical Nurse (LPN) F, entered the room a few seconds later and performed the Heimlich maneuver on Resident #128. The resident coughed up three large bites of hotdog and bun. The nurse asked the resident if she could speak to ensure she had cleared her airway. The resident stated she was okay. Resident #128 then went over and sat on her bed. She did not continue to eat right away but did not appear to be in further distress. After a few minutes, she got up and walked out of the room.</p> <p>On 04/15/2024 at 10:20 AM, Resident #128 was observed lying on her bed, face down, with her face turned toward the wall. Her eyes were closed and she did not appear to be in any distress.</p> <p>On 04/15/2024 at 3:05 PM, a review of the resident's progress notes, revealed a note dated 04/14/2024 at 3:03 PM, which read: Resident experienced difficulty swallowing today at noontime. She was eating a hotdog and was unable to swallow it properly. (Photographic evidence obtained) There was no indication in the medical record that the physician or the resident's family/representative were notified of the incident.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/15/2024 at 3:07 PM, a review of the active physician's orders revealed no order for a Speech Therapy (ST) screening or evaluation. (Copy obtained)</p> <p>On 04/15/2024 at 3:10 PM, a review of the resident's active care plan, dated 03/14/2024, revealed no care plan was in place related to swallowing difficulties. (Copy obtained)</p> <p>On 04/16/2024 at 4:26 PM during an interview with Speech Therapist (ST) E, he stated he had never screened or evaluated Resident #128. He had not been asked to evaluate her. He was not aware of an incident involving her choking.</p> <p>A review of the medical record revealed that Resident #128 was admitted on [DATE]. Her diagnoses included Huntington's disease, unspecified dementia - severe with psychotic disturbance, major depression, and dementia in other diseases classified elsewhere - mild with agitation.</p> <p>On 04/17/2024 at 10:18 AM, an interview was conducted with Resident #128 in her room. She stated she remembered choking on 04/14/2024. She stated, I put too much food in my mouth.</p> <p>On 04/17/2024 at 11:01 AM during an interview with LPN F, she stated she had been through the facility's orientation process but she did not know all of the facility's policies. She stated the protocol for notifying the physician was to contact the physician when there was something major happening with a resident. When Resident #128 choked on 04/14/2024, she stated she asked other nurses if she should contact the physician. She spoke with the Assistant Director of Nursing (ADON), the Director of Nursing (DON) and the Unit Manager (UM). She was told by the ADON that she (ADON) would contact the physician and the therapy department in order to have the resident evaluated. She stated, I think she (Resident #128) needs to be evaluated for a swallowing disorder. She confirmed that the physician should be notified but that she had not done it.</p> <p>On 04/17/2024 at 4:29 PM, a review of the active physician's orders revealed no new order for a Speech Therapy evaluation or screening since the date of the choking episode on 04/14/2024.</p> <p>A review of the Annual Minimum Data Set (MDS) assessment, dated 03/15/2024, revealed that Resident #128 had a Brief Interview for Mental Status (BIMS) score score of 00 out of 15 possible points, indicating severe cognitive impairment. She had no signs or symptoms of a swallowing disorder. She ate by mouth only. She had no dental problems. She did not receive any special treatments or skilled therapy.</p> <p>On 04/18/2024 at 10:20 AM, the resident's primary care physician was contacted via telephone. The physician stated she had not been contacted regarding Resident #128's choking incident on 04/14/2024. She stated her Advance Practice Nurse Practitioner (APRN) may have been notified.</p> <p>On 04/18/2024 at 10:25 AM during an interview with the DON, he stated he was not aware of Resident #128's choking incident on Sunday, 04/14/2024.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/18/2024 at 11:07 AM during an interview with the ADON she shook her head and stated, I have not heard of any incident with [Resident #128]. She was asked to confirm with APRN G whether he was contacted regarding the choking incident on 04/14/2024. The ADON called APRN G and when he answered the telephone, the ADON put him on speaker. He confirmed that he was following Resident #128. Without being asked, he stated he had not been contacted by the facility regarding a choking incident for Resident #128. He confirmed that the primary care physician had spoken with him this morning to determine whether he had been contacted regarding the choking incident. He stated, If the nurse had to use the Heimlich maneuver to clear the airway for the resident, it was a pretty intensive intervention. I would expect the staff to contact me immediately after that happened. He confirmed that it was not uncommon for residents who had a diagnosis of Huntington's disease to develop swallowing difficulty as part of the progression of the disease, and he would have ordered a Speech Therapy evaluation for the resident had he been informed.</p> <p>A review of the resident's progress notes revealed a note dated 04/18/2024 at 11:57 AM, which read: Resident was observed choking on her lunch. Heimlich maneuver was performed on the resident to clear what was blocking resident's airway. Airway was cleared. NP (Nurse Practitioner) notified and [resident's spouse] was notified. No new orders. (Copy obtained)</p> <p>A review of the facility's policy and procedure titled Change in a Resident's Condition or Status (Notification of Change), revealed:</p> <p>The Center shall promptly notify the resident, his or her attending physician, and representative of change in the resident's condition/status. 1. The Center designee will notify the resident's attending physician when: f. Deemed necessary or appropriate in the best interest of the resident. (Copy obtained)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28892</p> <p>Based on observations, interviews, record review, and facility policy review, the facility failed to ensure that one (Resident #116) of 43 sampled residents received necessary services to maintain good grooming, by failing to ensure his fingernails were trimmed/clipped.</p> <p>The findings include:</p> <p>On 04/17/24 at 10:51 AM, an observation of Resident #116 revealed that all of his fingernails on both hands were dark yellow and elongated. They extended approximately 1/4 inch beyond the tip of each finger. The resident reported that he did not like his fingernails so long.</p> <p>On 04/17/24 at 11:43 AM, another visit was made to Resident #116's room and photographs were taken, with his permission, of both hands, which remained in the same condition as they were on 04/17/24 at 10:51 AM.</p> <p>A review of the medical record revealed that he was admitted to the facility on [DATE] with diagnoses including monoplegia of upper limb following unspecified cerebrovascular disease affecting left dominant side, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, hyperlipemia, pain, and hypertension.</p> <p>A review of the Minimum Data Set (MDS) assessment, dated 02/29/24, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 possible points, indicating intact cognition. He was documented with a range of motion (ROM) impairment on one side and required assistance with personal hygiene.</p> <p>A review of the care plan, initiated on 02/19/24, revealed a focus area noting the resident had an Activities of Daily Living (ADL) Deficit in self-care performance due to fatigue and impaired balance. The care plan goal included that the resident's needs would be met. Interventions included the provision of personal hygiene with partial to moderate assistance.</p> <p>On 04/18/24 at 11:15 AM, an interview was conducted with Certified Nursing Assistant (CNA) C, who reported that he had been employed with the facility part-time for three weeks. He explained that either he, or the Activities Director, whoever noticed excessive long fingernails first, would either clip or file a resident's fingernails. He explained that he was not certain where he would document the assistance of clipping or filing a resident's fingernails. He further explained that whenever providing ADL care, he completed a body visual check for cleanliness and fingernail length. When he was asked whether he noticed Resident #116's fingernails, he stated, Today I noticed his fingernails were long, and I was planning to file or clip them after I finished my charting. CNA C further explained that yesterday was his first day assigned to provide services for this resident. He expressed that he received ADL care training during his orientation three weeks ago. The employee verified that CNAs should be looking at the condition of the resident, including length of nails while providing care to residents.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/18/24 at 11:24 AM, an interview was conducted with Registered Nurse (RN) D, who reported that she had been employed with the facility for one and a half years. She explained that CNAs and nurses clipped and filed residents' fingernails. She further explained that while providing medication administration services, nurses should be taking notice if a resident's fingernails are excessively long. If she were to observe a resident with long fingernails, she would ask permission from the resident to trim the fingernails and obtain fingernail clippers from central supply. She would then glove up and trim the resident's fingernails. After trimming a resident's fingernails, she would document it in a progress note in the facility's electronic medical record. When she was asked about the condition of Resident #116's fingernails, she stated, [Resident's name] requires care in ADLs. I noticed the resident's nails were long this morning while administering medications. She explained that she had been working in the C hall (where Resident #116 resides) for a while, and that today was the first time she noticed the resident's fingernails were excessively long. She reported that she received ADL training during orientation.</p> <p>A review of the facility's policy and procedure titled Activities of Daily Living (ADLs) Maintain Abilities (Undated0, revealed that the intent of the policy was to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs in order to achieve and or assist the resident in attaining the highest physical abilities. 3. The facility will provide care and services for the following activities of daily living a) Hygiene-bathing, dressing, grooming, and oral care. 4. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming .</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>28892</p> <p>Based on observations, interviews and document review, the facility failed to store and prepare food in accordance with professional standards for food service safety, by failing to ensure kitchen equipment was clean and opened food was labeled, dated and sealed for 162 residents who received food from the facility's kitchen.</p> <p>The findings include:</p> <p>On 04/14/24 between 11:28 AM and 11:39 AM, the following items were observed in the kitchen's dry storage area: An open, undated and unsealed bag of potato chips, opened, undated penne pasta noodles, and opened, undated, unsealed Classic [NAME] Quick Grits mix. (Photographic evidence obtained)</p> <p>On 04/14/24 at 11:15 AM, two bags of opened, undated wheat bread were observed in the kitchen prep area. (Photographic evidence obtained)</p> <p>On 04/14/24 at 11:42 AM, the cook top and three sides of the kitchen's stove were observed covered with food debris, grease and grime. The interior of two ovens under the stove were also covered with food debris, grease and grime. (Photographic evidence obtained)</p> <p>On 04/14/24 at 11:46 AM, a cleaning schedule dated 04/12/24, was observed taped to a wall in the kitchen and noted an employee was assigned to deep clean the oven and stoves in the cook area that day. (Photographic evidence obtained)</p> <p>On 04/14/24 between 11:49 AM and 11:54 AM, the following items were observed in the kitchen's walk-in refrigerator: An unsealed, dated (4/12/24 prep date) canister of battered fish; a canister of opened, canned pineapple without a label or date; an open and undated bag of shredded lettuce; an unsealed, undated opened bag of iceberg lettuce heads; an undated, opened bag of chopped green peppers, and an opened and unsealed bag of chicken thighs. (Photographic evidence obtained)</p> <p>On 04/14/24 at 12:08 PM, an opened, unsealed bag of frozen biscuits was observed in a reach-in freezer in the kitchen. (Photographic evidence obtained)</p> <p>On 04/15/24 at 9:06 AM, a second observation was made of the kitchen's cooktop and three sides of the stove, which were covered with food debris, grease and grime, as well as the interior of two ovens under the stove that were covered with food debris, grease and grime. (Photographic evidence obtained)</p> <p>On 04/15/24 at 9:53 AM, a second observation was made in the kitchen of an unsealed bag of chicken thighs and an unsealed, undated opened bag of iceberg lettuce heads in the walk- in refrigerator. A second observation was made of an open, undated bag of penne pasta in the dry storage area. (Photographic evidence obtained)</p> <p>On 04/15/24 at 9:59 AM, a second observation was made of an open, unsealed bag of frozen biscuits in the kitchen's reach-in freezer. (Photographic evidence obtained)</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>On 04/15/24 at 10:02 AM, an open, unsealed bag of tortillas was observed in the kitchen's walk-in refrigerator. (Photographic evidence obtained)</p> <p>On 04/18/24 at 10:40 AM, an interview was conducted with the Certified Dietary Manager (CDM). She stated she had been employed with the facility for eleven months. She explained the process to ensure that kitchen area cleanliness was maintained included both she and the kitchen supervisor checking the daily cleaning schedule. The CDM created a bi-weekly cleaning schedule, and the supervisor created a daily cleaning schedule. The CDM and kitchen supervisor made daily sweeps of the kitchen to determine what needed to be cleaned. A cleaning schedule was created and hung on the window in the main area of the kitchen. Staff were trained to check the cleaning schedule at the beginning of each shift. The CDM and supervisor checked daily to ensure kitchen staff had completed and signed off on their assigned cleaning tasks. She further explained that the dietician made a thorough assessment of the kitchen area and created a monthly sanitization report for items needing cleaning. The CDM reported that opened, perishable food was only good for three days in the walk in refrigerator. Employees should place opened food in a closed container or wrapped in plastic, labeled and dated. The same process should be used for opened, non-perishable food stored in the dry storage area.</p> <p>On 04/18/24 at 10:52 AM, the CDM verified the condition of the stove and ovens layered with food, grease and grime. She explained they had a floor technician who pressure washed once a month, which included cleaning the inside and outside of the stove and ovens. She further explained that the stove and ovens should be cleaned on a regular basis outside of the monthly pressure washing.</p> <p>A review of the facility's protocol (Undated) related to opened food, revealed the requirement to label food not stored in original containers, mark dates after opening or preparation.</p> <p>The facility's policy titled Leftovers (Dated April 2022), revealed: It is the dietary department's goal to maximize food usage in order to avoid waste. To this end, certain leftover foods are reused with restrictions. 5. Cover, label and date all containers with the date that the food was first prepared or thawed.</p> <p>A review of the facility's policy titled Cleaning and Sanitation of Food Service Area (Undated), revealed: The food service staff will maintain the sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule. 5. Staff will be held accountable for cleaning assignments.</p> <p>A review of the facility's cleaning protocol (Undated), documented how to clean the inside of an oven.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32159</p> <p>Based on observations, interviews, and a review of the policy and procedure for Maintenance Services, the facility failed to ensure the floors on hallways A, B and C as well as one (room [ROOM NUMBER]) of 53 rooms were safe and without accident hazards. Staff, residents, and visitors were at risk for falls due to the raised floor boards and a missing area of floor board in the aforementioned areas of the facility.</p> <p>The findings include:</p> <p>On 4/14/24 at 11:45 a.m., hallway A, Unit 1 was observed with raised floor boards in multiple areas which presented a tripping hazard. There is also a hole in one of the floor boards entering the hallway. room [ROOM NUMBER] had multiple floor boards which had separated from other boards leaving spaces open which were a tripping hazard. (Photographic evidence obtained)</p> <p>On 4/14/24 at 1:33 p.m., a family member reported that the floors in the hallways and the floor in room [ROOM NUMBER] were tripping hazards; she had tripped twice. She reported the flooring was raised in the room and hallways, and it had been reported to management but nothing had been done about it.</p> <p>An interview was conducted with the Director of Plant Operations on 4/18/24 at 10:15 a.m. He was accompanied on a tour of the hallways on Units 1 and 2. He confirmed the hole in the flooring at the beginning of the Unit 1 hallway. He toured the unit and confirmed the concerns in the A, B, and C hallways with A being the worst. Multiple floor boards were raised on that hallway. He reported the old glue was loosening up and raising the boards causing bubbles. In room [ROOM NUMBER], he confirmed the floor boards were separating, and there were spaces between the floor boards. He confirmed that the raised floor boards were a tripping hazard.</p> <p>The Environmental Performance Improvement Plan was reviewed which started on 3/21/24. The EPIP focused on the age of the building, housekeeping, and work orders being completed timely. Housekeeping was retrained and staff were retrained on placing work orders. A review of the Angel rounds for the past week noted no acknowledgment of the floors being a trip hazard or any concerns about the flooring. Most comments concerned the floors being soiled. Nothing reviewed addressed holes in the flooring or raised flooring causing a tripping hazard.</p> <p>The Maintenance Service Policy and Procedure (Dated April 2022) was reviewed. Under Section 2, following functions performed by maintenance: Maintaining the building in good repair and free from hazards.</p>		