STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105315	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Augustine Health and Rehabilitation Center	51 Sunrise Blvd Saint Augustine, FL 32084

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38804 Based on observations and interviews, the facility failed to provide its residents with a safe, clean, comfortable, and homelike environment, directly affecting residents in five (Rooms 118, 121, 124, 126, and 132) of 66 resident rooms. Failure to maintain a safe, clean comfortable environment could result in accidents, the spread of infection, and a negative impact to residents' psychosocial well-being. The findings include: During an initial tour of the facility on 9/9/2024 from 9:30 AM through 12:00 PM, the following environmental concerns in resident areas were observed: Heavily stained privacy curtains and window curtains, holes in window curtains, uncomfortable temperatures, and bug carcasses in the following resident rooms: Rooms 121, 118, 124, 126, and 132. (Photographic evidence obtained for all) During an interview on 9/9/2024 at 11:36 AM with Resident #9, she stated the air conditioning (AC) in her room had been broken for about a month. She further stated she and her roommate had both notified staff of their concerns regarding the AC unit. The roommate interjected during the interview stating she had night sweats and one of the facility's certified nursing assistants (CNAs) had provided her with a personal fan. A small blue fan was observed on the resident's overbed table. The roommate's face was light red in color with small beads of perspiration noted during the interview. Her hair was limp and damp. Resident #9 stated a CNA told her she would also bring her a fan. She stated she also perspired badly during the night. She further stated the CNA had not brought her the fan as of this date. The AC window unit displayed a temperature of 61 degrees Fahrenheit (F); however, the air could not be felt throughout the residents' room. While looking at the AC unit, the window curtains were observed with holes permitting the sun to come through. They were also heavily stained. A black hair clip was holding the curtains together. The residents' privacy curtains were also heavily stained. (Photographic evidence obtained for all) During an interview on 9/9/2024 at 12:54 PM with Resident #82, she stated she had resided in the facility for two years. The resident's bathroom light was flickering. The resident stated she had asked Maintenance to repair it. She further stated they had changed the bulb several times; however, the problem persisted. She said the flickering light bothered her. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/9/2027 at 2:46 PM with Resident #27, he stated he had concerns about pests. He saw them in his room alongside the window and in the bathroom. A dead roach was observed in resident's bath tub, and the resident's room had an overall unkempt appearance. The bedside table was soiled, the floors were dingy, and no personal items were observed. During an interview on 9/10/2024 at 11:22 AM with Resident #20, he stated his toilet had been broken for two days. He further stated he had an order for a laxative and had to go down the hall to use another restroom. The resident's toilet tank cover had been removed from the back of the toilet and was placed across the toilet bowl. Dirty water was observed in the toilet bowl. (Photographic evidence obtained) During another tour of the facility on 9/10/2024 at 11:57 AM, a personal refrigerator was observed in a room occupied by Residents #3 and #59. Both residents were non-verbal. The floor in front of the refrigerator was heavily stained. Upon opening the refrigerator, a live roach was observed crawling on the bottom shelf. At 12:01 PM, Resident #82 again stated she had informed Maintenance that the [electrical] ballast was broken and it wasn't the lightbulb. She stated she also sent the receptionist a text asking her to notify Maintenance about the flickering bathroom light. An interview was conducted with the Housekeeping Supervisor on 9/12/2024 at 11:30 AM. She stated the housekeeping department was responsible for cleaning the privacy curtains and the maintenance department was responsible for the window curtains. She stated the privacy curtains were taken down to be cleaned monthly and as needed. We take down the privacy curtains. She stated the housekeepers were responsible for reporting soiled linens. Every room was cleaned every day. A tour of the facility was conducted with the Housekeeping Supervisor and the Director of Maintenance at this time. The rooms where the environmental concerns were observed were toured. The Housekeeping Supervisor stated the housekeepers were responsible for catching that. She further stated the torn curtains were caused by the handles used to open the windows. They would all be replaced eventually. During this tour, in room [ROOM NUMBER], where a roach had previously been observed crawling in the resident's refrigerator, a roach was now observed crawling on the floor near the refrigerator. The Housekeeping Supervisor stepped on the roach. A second roach was observed crawling on the side of the resident's refridgerator. It was killed. The Housekeeping Supervisor and Director of Maintenance were directed to the small, empty roach eggs that were between the refrigerator and the wall. The Housekeeping Supervisor said she would notify the Administrator of the observation. An interview was conducted with the Director of Maintenance on 9/12/2024 at 12:13 PM. He acknowledged the flickering light in Resident #82's bathroom. He stated he had changed the bulb a couple of times. He observed the light was still flickering on the day of this interview. He stated he believed the [electrical] ballast needed to be replaced again. During an interview with the DON on 9/12/2024 at 11:15 AM, she confirmed that the facility had no established policies and procedures to address the environmental concerns identified during the survey.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42442 Based on observations, interviews, and record reviews, the facility failed to ensure that two residents (#29 and #55) with limited range of motion (ROM) received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. There were three residents reviewed for limited range of motion in a total survey sample of 35 residents. The findings include: 1. During the initial tour on 09/09/24 at 10:00 AM, Resident #29 was observed in her room seated in her wheelchair. She had left-sided weakness. Her left foot was dorsiflexed (upward bending and contracting) and crossed over her right foot. When she was asked if she had any concerns, she used a communication board with alphabet letters on her bedside table and spelled out, It she would like the mess cleaned up. She pointed across the room next to her TV. A splint was located under a heap of belongings there. When asked if she used the splint, she shook her head no. (Photographic evidence obtained) She was asked if anyone assisted her with range of motion and again, she shook her head no. During another observation on 09/09/24 at 11:00 AM, Resident #29 was in her room leaning forward with her head on the bedside table. She did not have a splint on her hand or foot. On 09/11/24 at 12:47 PM, Resident #29 was observed in her room having lunch. The heap of clothing, including the splint, had been removed. The resident did not have a splint on either of her upper or lower extremities. A review of the medical record revealed that Resident #29 was admitted to the facility on [DATE] with diagnoses including hemiplegia - left non-dominant side, cerebral infarction, chronic pain, carpal tunnel syndrome, aphasia, and tarsal tunnel syndrome. A review of the physician's orders, dated 8/23/24, revealed that the resident was an overnight get up with directions provided to wash, dress and get the resident up. Hydrocodone- Acetaminophen 7.5 - 325 milligrams (mg) every 6 hours for chronic pain was ordered on 8/1/24. Diclofenac sodium gel 1%, apply 2 grams topically to left deltoid, was ordered two times a day on 7/16/23. Another order dated 8/5/24, indicated that the resident required a sit-to-stand mechanical lift for transfers. There were no orders for a functional maintenance program or range of motion management. (Copies obtained) A review of the resident's care plan, revised on 9/4/24, revealed that the resident required staff assistance with all activities of daily living (ADLs) related to impaired mobility (L) hemiplegia, non-ambulatory. The care plan also noted that the resident had a potential for contractures related to impaired mobility, hemiplegia, and muscle spasms. Interventions included following the current functional maintenance program (FMP) if one had been done. A review of the quarterly Minimum Data Set (MDS) assessment with an assessment reference date of 6/6/24, revealed that the resident had a brief interview for mental status (BIMS) score of 15 out of 15 possible points, indicating intact cognition. She was documented as not receiving any kind of therapy including restorative therapy. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the physical therapy (PT) discharge summary, dated 9/12/23, revealed discharge recommendations for Resident #29 to be discharged to FMP for transfers, and to a certified nursing assistance maintenance program for ankle/foot orthosis (AFO) and sit-to-stand use. (Copy obtained) 2. On 09/09/24 at 1:55 PM, Resident #55 was observed in bed. She had pillows under her knees. She stated she was getting therapy but ran out of time about two weeks ago. She added that she was notified she would be getting bed exercises at least two to three times a week, but she had not seen anyone yet. A review of the medical record revealed that Resident #55 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, long-term use of anticoagulants, contractures at the right knee, left knee, right ankle, and left ankle, pain in left hip, osteoporosis, fracture of unspecified part of neck of left femur, subsequent encounter for closed fracture with routine healing, and periprosthetic left hip joint subsequent encounter. A review of the physician's order dated 2/19/24, revealed that Hydrocodone-Acetaminophen 7.5 - 325 milligrams (mg) every 6 hours for chronic pain was ordered. On 8/8/24, Xtampza extended release (Oxycodone myristate) 13.5 mg every 12 hours for pain was ordered. There were also orders for a FMP. (Copies obtained) A review of the quarterly Minimum Data Set (MDS) assessment with an assessment reference date of 8/6/24, revealed that the resident had a brief interview for mental status (BIMS) score of 14 out of 15 points, indicating intact cognition. The resident was documented as having received three days of physical therapy totalling 90 minutes during the 7-day look-back period. No restorative nursing or any other therapy was documented. A review of the physical therapy (PT) discharge summary, dated 8/13/24, revealed recommendations for the resident to be discharged to a restorative nursing program for active range of motion (AROM) to both lower extremities (BLE) as well as a splint and brace program. The summary also indicated that the splint and brace program was established for bilateral (both knees) knee extension orthotic for three hours per day for three to five days per week. The goal was to decrease further contractures of the ankle/knees. (Copy obtained) In an interview on 09/12/24 at 1:22 PM, Certified Nursing Assistant (CNA)/Restorative Aide I stated when a resident was added to the program, the unit manager notifed them. She added that the therapy department also provided a referral with what the restorative aide should be working on and provided education as needed. When asked about Resident #55, CNA I stated the resident was on a FMP for transfers and training the resident on sit-to-stand mechanical lift use; however, the resident was refusing and her legs were buckling so the program was discontinued. When asked about the ankle/foot orthosis (AFO), CNA I stated the resident got up early in the morning and the CNAs assigned to her were responsible for putting on the AFO. She was then asked if Resident #55 was on a FMP program. She replied, As far a I know, she is still in the program for ROM. When asked how often the resident was receiving the exercises, CNA I reviewed the FMP weekly schedule and stated,Mondays, Thursdays and Saturdays. (Copy of schedule obtained) When asked if the sessions were documented, she said the restorative aide should document in the electronic charting system after every session. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/12/24 at 11:23 PM with Licensed Practical Nurse (LPN)/Unit Manager J, she was asked how she was informed of residents' progress on the FMP. She stated the restorative aides should document. She mentioned that when residents had more than a week of refusals, the interdisciplinary team reviewed the reasons for refusal and provided education to the resident. If the resident continued to refuse, the program was discontinued and the therapy department was notified. She was asked to review the FMP for Residents #29 and #55. She confirmed that she could find no documentation verifying that either resident was on the FMP. On 09/12/24 at 3:14 PM, the Director of Rehabilitation (DOR) was asked to explain the discharge recommendations on the PT discharge summaries for Residents #29 and #55. She stated Resident #29 required AFO and the task should be completed by a CNA. She stated the resident was on FMP for transfers and sit-to-stand. She continued to explain that Resident #55 was on a FMP for range of motion. When asked if she had been notified of any refusals, she replied no. She added that normally, if the resident refused the program, nursing should discontinue the program and assess the resident if PT screening was warranted. In a 09/12/24 interview at 3:44 PM, the Director of Nursing (DON) stated Resident #29 was not on a FMP due to refusal, and Resident #55 was on a FMP for ROM. When asked for the documentation for both residents including the documentation of refusals, the DON confirmed there was no documentation and stated she would initiate training right away. A review of the facility's policy and procure titled Restorative Services (Effective October 1, 2010), revealed that the policy's purpose was to ensure that residents received necessary rehabilitative services as determined by comprehensive reviews and care plans, to prevent avoidable physical and mental deterioration, and to assist them in obtaining or maintaining their highest practicable level of functional and psychosocial well-being. The policy further indicated that a comprehensive review should be completed on admission, quarterly, with any MDS (minimum data set assessment) and with a significant change in the residents condition. A comprehensive review included interviews with staff, residents, and family/significant others, along with reviewing and communicating with other members of the interdisciplinary team. Quarterly, significant change and MDS assessment, and restorative reviews should include: A review of the physician orders A review of the FMP to ensure it was still meeting the resident's needs and if not, obtain a physician's order for a therapy evaluation. A review of the the FMP's daily documentation, and Review and update the plan of care as needed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50968 Based on observation, interview, and record review, the facility failed to 1) Label drugs and biologicals in accordance with currently accepted professional principles, and 2) Ensure medications were not used past the expiration date for four (Residents #45, #3, #8, and #90) of 35 residents in the total survey sample. Failure to ensure medications are labeled appropriately and are not expired, pose a risk to resident health due to potentially reduced efficacy and contamination. The findings include: During medication administration observation on 09/10/24 at 10:40 AM, Licensed Professional Nurse (LPN) G was observed preparing a Novolog (insulin) FlexPen (a multi-dose injection pen designed to be used multiple times by the same receiver) for Resident #45. She read the label, placed a new needle on top of the FlexPen, primed the needle, set the correct ordered dose to be administered, and provided it for inspection. Reading the label revealed an opened date of 7/19/24 and an expired date of 8/16/24. When LPN G was asked to look at the expired date, she acknowledged that the FlexPen was past the expiration. She then asked if it was still okay to give. All insulin stored in LPN G's medication cart was reviewed and revealed the following: Two additional single-user, multi-dose prescriptions of insulin were past their expired date for Residents #3 and #8 (expired on 8/27/24 and 8/14/24 respectively). One insulin for Resident #90 had no opened or expired date. (Photographic evidence obtained) A review of the physician's order dated 8/6/23 for Resident #45 revealed Novolog (insulin aspart) per sliding scale before meals. A review of the August and September 2024 medication administration records (MARs) for Resident #45 indicated that the medication was administered daily beyond 8/16/24. A review of the physician's order dated 3/10/24 for Resident #3, revealed Levemir 100 units/milliliters, inject 12 units at bedtime. A review of the August and September 2024 MARs for Resident #3 revealed that the medication was administered daily beyond 8/27/24. A review of the physician's orders for Resident #8 revealed no current orders for Novolog or any other type of insulin. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a 09/11/24 interview with the Director of Nursing (DON) and the Nurse Manager for the unit LPN G was currently working on (LPN J) at 3:08 PM, they confirmed that Resident #8 did not have current orders for Novolog or any other type of insulin, but that he did back in July of 2024. They stated the current procedure for ensuring the removal of discontinued and/or expired medications in the medication carts was to have the nurse in charge of the medication cart at the time the medication is discontinued remove that medication from the cart. Nurses should be looking at the expiration dates and removing medications when they expired. Additionally, the nurse managers checked the medication carts weekly, on the weekend, for medications that had been discontinued and/or expired and removed them from the carts. A review of the facility's policy and procedure titled Storage and Expiration Dating of Medication and Biologicals (revised 08/01/24), revealed the following: General storage procedures: 10. The facility should ensure that medication and biologicals that :1) have an expired dated on the label ;2) have been retained longer than recommended by manufacture or supplier guideline; or 3) have been contaminated or deteriorated , are stored separate from other medications until destroyed or returned to the pharmacy or supplier. 11. Once any medication or biological package is opened, facility should follow manufacturer/supplier guideline with respect to expiration dates for opened medication. Facility staff should record the date opened on the primary medication container (i.e vial, bottle, inhaler) when the medication has a shortened expiration date once opened or opened 11.1 Facility staff may record the calculated expiration date based on date on the primary medication container. 11.2 mediations with the manufacturer's expiration date expressed in month and year will expire on the last day of the month. 11.3 If a multi-dose vial of the injectable medication has been opened or accessed (e.g., needle punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45153 Based on kitchen food service observations, staff interviews, and facility policy and procedure review, the facility failed to follow proper sanitation and food handling practices to prevent the outbreak of foodborne illness with the potential to affect all residents who consumed foods from the facility's kitchen, by failing to seal and date mark open food products in the walk-in refrigerator, and discard food products on or before the expiration date. Food handling and sanitation is important in health care settings serving nursing home residents. Unsafe food handling practices represent a potential source of pathogen exposure. The findings include: A tour of the kitchen was conducted on [DATE] at 10:14 AM. During the tour, no date markings were observed on one open box of tomatoes, one bin of potatoes, or one open bag of onions in the walk-in refrigerator. The dry storage room had one open bag of wrapped potato chips with no date marking and nine thickened lemon-flavored water containers with expiration dates of [DATE]. On [DATE] at 11:36 AM, the Certified Dietary Manager (CDM) was notified that nine expired thickened lemon-flavored water containers were sitting on the shelf in the dry storage room. (Photographic evidence obtained) On [DATE] at 10:00 AM, nine expired thickened lemon-flavored water containers were observed still sitting on the shelf in the dry storage room. A follow-up tour of the kitchen was conducted on [DATE] at 11:05 AM. No date marking was observed on one open bag of onions or one open box of tomatoes in the walk-in refrigerator. The dry storage room had one thickened lemon-flavored water container with an expiration date of [DATE] sitting on the shelf. During the same tour, three expired thickened lemon-flavored water containers and one bottle of grape juice with no date marking were observed and discarded from the south unit nourishment room refrigerator. (Photographic evidence obtained) An interview was conducted on [DATE] at 1:40 PM with Dietary Aide/Cook A who reported that second shift dietary aides were responsible for stocking the dry storage room. The CDM and the cooks stocked the refrigerator and freezer. When asked to explain the facility's policy regarding date marking food products, Dietary Aide/Cook A stated any food received had to be labeled and dated. When food was opened, used, and placed back in the refrigerator or freezer, the food was placed in a safe container or saran wrapped, labeled with the date made or opened, and discarded after three days. The CDM was notified of any expired food that needed to be discarded. An interview was conducted on [DATE] at 1:45 PM with [NAME] B who reported that dietary aides were responsible for stocking the dry storage room. The morning shift dietary aides were responsible for stocking the refrigerator and freezer. When asked to explain the facility's policy regarding date marking food products, [NAME] B stated food products were labeled with the date delivered. Opened food was dated with the date opened or used. Expired food was discarded. Opened refrigerated food was discarded after three days. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the CDM on [DATE] at 1:53 PM. She reported that evening staff were responsible for stocking the dry storage room. When asked to explain the facility's policy regarding date marking food products, the CDM confirmed all open food was dated and discarded after three days. When a food item was opened, used, and placed back in the refrigerator or freezer, the food item was wrapped, labeled with the date opened, and discarded after three days. A review of the facility's policy and procedure titled Food Receipt and Storage (dated [DATE]), revealed the Purpose: Foods should be received and stored properly to prevent foodborne illness . e. New items should be placed on the back of shelves with labels in view, with older items pulled to the front of the shelves for use. The First In First Out (FIFO) system should be used to rotate stock routinely. k. Open food items should be covered, labeled, and dated; open dry goods should be kept in tightly sealed containers. (Copy obtained) Reference: FDA Food Code 2022. https://www.fda.gov/media/164194/download (Accessed on [DATE]) Annex 5. Conducting Risk-Based Inspections Annex 5 - C. Intervention Strategies for Achieving Long-term Compliance. 4. Establish First-In-First-Out (FIFO) Procedures. Page 31. https://www.fda.gov/media/164194/download (Accessed on [DATE]): Product rotation is important for both quality and safety reasons. First-In-First Out (FIFO) means that the first batch of product prepared and placed in storage should be the first one sold or used. Date marking foods as required by the Food Code facilitates the use of a FIFO procedure in refrigerated, ready-to-eat, TCS foods. The FIFO concept limits the potential for pathogen growth, encourages product rotation, and documents compliance with time/temperature requirements.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38804 Based on observations and interviews, the facility failed to develop and implement a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This failure directly impacted residents in four (Rooms 108, 120, 121, and 126) of 66 resident rooms with the potential to impact every resident with a personal refrigerator. The findings include: During an initial tour of the facility on [DATE] from 9:30 AM through 12:00 PM, resident areas/rooms were observed: Multiple residents had personal refrigerators in their rooms. There were no temperature logs and expired food was located in the following rooms: Rooms 108, 120, 121, and 126. (Photographic evidence obtained for all) On [DATE] at 11:57 AM, a personal refrigerator was observed in a room occupied by Residents #3 and #59. Both residents were non-verbal. Upon opening the refrigerator, a live roach was observed crawling on the bottom shelf. An interview was conducted on [DATE] at 2:10 PM with Licensed Practical Nurse (LPN) J. She stated the overnight nurses were responsible for checking the residents' refrigerators. She further stated there were temperature log books kept at the nursing station. A tour of the North Wing was conducted with LPN J. The refrigerators in rooms 108, 120, 121, and 126 were observed. LPN J confirmed that there were expired food items in the refrigerators. When asked about the missing thermometers (rooms [ROOM NUMBERS]), she stated she was not sure why they were missing. She was shown the opened, unlabeled and expired items. She stated family members also brought food in without staff knowing. She was asked who should have been monitoring. She again stated it was the responsibility of the overnight nurses. She was asked to read the temperature in the refridgerator in room [ROOM NUMBER]. She stated it read 47 degrees F. She was asked what it should read. She stated she didn't know and she would have to check. She was shown the expired food items. She removed those items and discarded them. She was shown several open and undated/unlabeled items in the refrigerators in rooms [ROOM NUMBERS]. She stated these residents bought food items themselves. Again, she was asked who was responsible for making sure opened items were dated and labeled. She stated it was the responsibility of the overnight nurses. She was asked to provide the temperature logs for the residents' refrigerators. She retrieved a binder labeled N. Wing Temp Log. She stated this wasn't the correct information. At 2:22 PM, she left to find what she said she believed was the correct information. She returned stating she didn't find it. She retrieved another binder from the shelf labeled N. Wing Temp Log. Again, she said this was not the correct information. She stated the information was not current. Both binders were reviewed. The first binder contained information from 2022. The second binder contained information for February 2024. LPN J stated she wasn't able to locate anything more current, and she would have to consult with nursing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105315	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Augustine Health and Rehabilitation Center	51 Sunrise Blvd Saint Augustine, FL 32084

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 3:53 PM, the Director of Nursing (DON) was asked to provide a list of residents who had personal refrigerators in their rooms. She stated there was no list. An interview was conducted with the DON on [DATE] at 11:15 AM. She stated the facility did not have a policy for personal resident refrigerators. She stated the upkeep of the refrigerators was generally the responsibility of the nightshift staff. She added that the housekeepers would go in and do any deep cleaning required. She confirmed that LPN J was unable to locate any current temperature logs. She stated it wasn't something the facility had a structure or policy on and confirmed there were no recent logs. She stated they had discussed the concerns and determined there was some room for improvement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105315	A. Building B. Wing	09/12/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 42442 Based on observations, record reviews, and staff interviews, the facility failed to maintain an infection prevention and control program designed to help prevent the transmission of communicable diseases and infections, by failing to perform appropriate hand hygiene during medication administration for two (Residents #13 and #33) of eight residents observed for medication administration from a total survey sample of 35 residents. The findings include: During another observation of medication administration on 9/11/24 at 1:10 PM, LPN H was observed preparing medication for Resident #13 at the nurses' station. LPN H reviewed the physician's orders and obtained two tablets of Buspirone 10 mg (milligrams), Clonazepam 0.5 mg, and Oxycodone-Acetaminophen 10-325 mg. She did not perform hand hygiene before popping medications into a medication cup. She then handed the medication cup with the medication to Resident #13 who was seated on his Rollator walker at the nurses' station. After the resident took the medication, LPN H discarded the cup in the trash but did not perform hand hygiene. She then pushed the medication cart to Resident #33. She reviewed the physician's orders and obtained acetaminophen (Tylenol) 325 mg for pain. She did not perform hand hygiene before popping two tablets into a medication cup and handing the medication to the resident. In an interview in 9/11/24 at 1:30 PM, LPN H was asked about hand hygiene during medication administration. She said, I knew I was forgetting something. A review of the facility's policy and procedure titled General Dose Preparation and Medication Administration (Revised 4/30/24), revealed that prior to preparing or administering medications, authorized and competent facility staff should follow infection control policy. Appropriate hand hygiene should be performed before and after direct resident contact.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105315	A. Building B. Wing	09/12/2024

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45153 Based on kitchen food service observations, staff interviews, and facility policy and procedure review, the facility failed to ensure essential kitchen equipment was in safe operating condition, by failing to maintain the inspection of the kitchen exhaust system to prevent excessive grease build-up. This could potentially endanger staff, residents and any other building occupants due to the risk for fire. The findings include: A kitchen tour was conducted on [DATE] at 11:05 AM. The kitchen hood located above the cook area had an inspection date that was expired. The documented date of inspection should have occurred between , d+[DATE] and ,d+[DATE]. (Photographic evidence obtained) In an interview with the Certified Dietary Manager (CDM) on [DATE] at 1:53 PM, she reported that the exhaust hood was inspected every three months, and the Maintenance Department was responsible for contacting the vendor. During an interview with the Director of Maintenance on [DATE] at 2:23 PM, he stated he did not notice that the inspection was expired. The vendor came automatically every three months and he was not aware that they had not been to the facility to complete the inspection. On [DATE] at 3:36 PM, the CDM reported that broken equipment was reported to the Maintenance Department. She was not aware that the exhaust hood inspection was due; usually the vendor came automatically. A review of the facility's policy and procedure titled Safety Principles (dated [DATE]) revealed: Purpose: To prevent injury to food service employees through exposure to heat, cold, chemicals and other workplace hazards. (Copy Obtained)