

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105402	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2025
NAME OF PROVIDER OR SUPPLIER Bridgeview Center		STREET ADDRESS, CITY, STATE, ZIP CODE 350 S Ridgewood Avenue Ormond Beach, FL 32174	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)		

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

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

TITLE

(X6) DATE

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and facility policy review, the facility failed to ensure that the residents environment remained as free of accident hazards as is possible by failing to 1) assess Resident #7 for smoking safety and 2) failing to supervise Resident #8 during smoking, from a sample of three residents reviewed for smoking, from a total sample of 7 residents who smoked. The findings include: 1. On 8/4/25 at 3:45 pm, Resident #7 was observed smoking in the lobby. He was on oxygen via nasal canula, and his portable oxygen tank was at the back of his wheelchair. The receptionist was observed turning off the oxygen tank and removing the canula from the resident's nose. She then wheeled the resident to the designated smoking area near the lobby but left the oxygen tank at the back of his wheelchair. A clinical record review for Resident #7 indicated he was admitted to the facility on [DATE]. His diagnoses included Chronic Obstructive Pulmonary Disease (COPD), dementia, unspecified severity, with other behavioral disturbance, major depressive disorder, and recurrent, moderate. A review of the admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 5/29/25 for Resident #7 indicated that he had a Brief Interview for Mental Status (BIMS) score of 08 out of 15, indicating moderate cognitive impairment. He exhibited physical and verbal behavioral symptoms directed to other. He also had other behavioral symptoms not directed to others. In an interview on 8/4/25 at 3:50 pm, the Director of Nursing (DON) stated that that the facility was a smoking facility. She stated residents were allowed to smoke any time if they were deemed safe to smoke. She explained that residents were assessed for safe smoking on admission and quarterly. She was then directed to Resident #7 at the smoking area. She said, Oh my he is not supposed to have the oxygen tank, and he knows better. She walked to the resident and retrieved the oxygen tank. There were two other residents at the smoking area. The DON stated Resident #7 had another incident and was educated on safe smoking. He was notified to leave his wheelchair with oxygen at the lobby and walk to the smoking area. She was asked for a copy of the resident's smoking assessment. On 8/4/25 at 4:00 pm, the Regional Nurse consultant (RNC) provided the copy of Resident #7's assessment. He said, I'll be honest, there was a mistake the assessment indicates that the resident was not a smoker. He added that the facility would conduct a full house audit for smoking and initiate a performance improvement plan (PIP) on smoking. Review of the physician orders for Resident #7 dated 5/23/25 revealed the following: Respiratory-Oxygen: Encourage and assist resident to use oxygen at 2 Liters via nasal canula (NC) continuously for COPD. Respiratory-Oxygen Tubing Change: Change oxygen tubing/mask/bag weekly and as needed (PRN). Trazodone HCl Oral Tablet 100 milligrams (MG). Give one tablet by mouth at bedtime or Depression, Insomnia. Risperidone Tablet 0.5 MG- Give 1 tablet by mouth at bedtime for dementia, agitation. Risperidone Tablet 1 MG- Give 1 tablet by mouth in the morning for agitation, dementia. Duloxetine HCl Capsule Delayed Release Particles 30 MG- Give 1 capsule by mouth two times a day for depression. Lorazepam Tablet 0.5 MG- Give 1 mg by mouth three times a day for anxiety. A review of the care plan for Resident #7 initiated on 5/29/25 noted that the resident is at risk and/or have actual impaired cognitive function/impaired thought processes related to BIMS less than or equal 12 and diagnosis of dementia. The resident is at risk for altered respiratory status/difficulty breathing related COPD-Interventions included to Administer OXYGEN as ordered. Monitor O2 saturations as ordered/PRN. Change tubing per MD order and PRN. Notify MD as indicated. Resident #7 was not care planned for smoking. (Copy obtained) A review of the smoking assessment for Resident #7 dated 5/23/25 indicated that the resident did not smoke. (Copy obtained) Review of the interdisciplinary care plan meeting sheet dated 5/26/25 indicated that Resident #7 was educated on not taking oxygen outside to the smoking area due to risk of injury. Resident agreed to leave wheelchair and oxygen in the building. (Copy obtained) A smoking contract/policy was signed by the resident on the same day. 2. A clinical record review for Resident #8 indicated he was admitted to the facility on [DATE] with re-entry on 5/10/25. His diagnoses included Sequelae of Cerebral Infarction, Moderate Protein-Calorie Malnutrition, gastrostomy status, iliotibial band syndrome, low back pain, critical illness myopathy, Vascular Dementia, Mild, With Anxiety, Unspecified Convulsions, Nontraumatic Subdural Hemorrhage, Unspecified and muscle weakness. Review of the physician orders for Resident #8 dated 5/10/25 revealed the following: Risperidone 1 mg by mouth two times a day for paranoia. Levetiracetam (Keppra) 100mg/ml. Give 5 ml via PEG tube every morning and at bedtime for seizure control. Valproic acid oral solution. Give 1000mg via G-tube at bedtime and 250 mg in the morning for mood disorder/ agitation Review of the care plan for</p>		