STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bedrock Rehabilitation and Nursing Center at Winte	1700 Monroe Ave Maitland, FL 32751

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 0552

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that residents are fully informed and understand their health status, care and treatments.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 51234

Based on record review, and interview, the facility failed to notify a resident's Power of Attorney (POA) of changes in condition for 1 of 3 residents reviewed for change in condition, of a total sample of 5, (#1).

Findings:

Review of resident #1's medical record revealed their responsible party/durable POA was family member #1.

Review of resident #1's Quarterly Minimum Data Set Assessment (MDS) dated [DATE] and Annual MDS dated [DATE] indicated she rarely/never understood regarding communication and a mental status examination should not be conducted. One of her diagnoses included unspecified dementia with unspecified severity.

Review of resident #1's medical record revealed a nursing note dated 3/17/24 that the resident had a skin tear to the right forearm. There was no documentation about what caused this injury. There was no description of the size of the wound, nor its placement on the forearm.

A nursing note dated 3/18/24 revealed a physician was made aware of the skin tear and treatment orders were obtained for the right forearm skin tear noted in the 3/17/24 nursing note.

On 10/22/24 at 11:19 AM, the Director of Nursing (DON) reviewed resident #1's nursing note dated 3/17/24 that indicated a skin tear to her right forearm. She verified there was no documentation that resident #1's POA was notified of this injury. She said she did not know why the POA was not notified.

Review of resident #1's medical record revealed a nursing note dated 4/13/24 which indicated resident #1 had bruises to the forehead and side of left eye. There was no documentation about what caused these injuries. There was no documentation with a description of the injury including the approximate size, shape, coloration of the bruising nor more detailed placement of location. It was documented the physician was notified. There was no mention the POA was notified.

On 10/22/24 at 11:11 AM, the Assistant Administrator verified there was no documentation that resident #1's bruising to the forehead and side of left eye injuries from 4/13/24 were reported to her POA.

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2024
NAME OF PROVIDER OR SUPPLIER: Bedrock Rehabilitation and Nursing Center at Winte		STREET ADDRESS, CITY, STATE, ZIP CODE: 1700 Monroe Ave Maitland, FL 32751	

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #1's record revealed a nursing note dated 5/09/24 that resident #1 was observed coughing, the physician was contacted, and new orders were received for a chest x-ray, 2 views. On 10/22/24 at 11:00 AM, the DON verified that there was no documentation that the POA was notified for this change in condition of resident #1 coughing as noted in the 5/09/24 nursing note nor notification of the follow-up order for a chest x-ray. Review of resident #1's medical record revealed a note dated 5/28/24 that resident #1's psychotropic medications were discussed among nursing staff and the psychiatric providers. There was a physician's order to change her Trazadone (antidepressant medication) to 50 milligrams (mg). Review of resident #1's treatment administration record indicated that 100 mg of Trazadone HCl was administered on 5/27/24 and the dose was decreased to 50 mg of Trazadone HCl, which was administered beginning on 5/28/24. On 10/22/24 at 10:49 AM, the DON verified there was no documentation that resident #1's POA had been notified of the Trazadone dosage decrease. Review of resident #1's record revealed a nursing note dated 7/11/24 that resident #1 had itchy skin due to little pink dots on back, buttocks, and front areas. The physician was notified and new orders were obtained for Permethrin External Liquid 1% (an insecticide). There was no mention resident #1's POA was notified. On 10/22/2024 at 10:48 AM, the DON verified it was not documented that resident #1's POA was notified of this change to using Permethrin External Liquid 1% medication for resident #1's rash. Review of the facility's change in condition policy, dated 4/01/22 included content in the procedure section that the facility would consult the resident's physician and if known, notify the resident's legal representative or an interested family member when there was an acute illness or a significant change in the resident's physical, mental or psychosocial status or a need to alter treatment significantly. Review of the facility's policy and guidelines for Abuse, dated 4/1/22 included content that injuries of unknown origin must be immediately investigated to rule out abuse and indicated Social Service staff or designee should keep in frequent contact with the resident and/or resident representative.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2024
NAME OF PROVIDER OR SUPPLIER Bedrock Rehabilitation and Nursing Center at Winte		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 Monroe Ave Maitland, FL 32751	

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51234 Based on record review, and interview, the facility failed to follow their policy and family member request to thoroughly investigate injuries of unknown origin for 2 of 3 residents reviewed for injuries of unknown origin, of a total sample of 5, (#1 and #4). Findings: 1. Review of resident #1's Quarterly Minimum Data Set (MDS) dated [DATE] and Annual MDS dated [DATE] indicated she rarely/never understood regarding communication and a mental status exam should not be conducted. One of her diagnoses included unspecified dementia, with unspecified severity. Review of resident #1's medical record revealed a nursing note dated 3/17/24 that the resident has a skin tear to the right forearm. There was no documentation about what caused this injury. There was no description of the size of the wound, nor its placement on the forearm. On 10/22/2024 at 11:19 AM, the Director of Nursing (DON) reviewed resident #1's nursing note dated 3/17/24 that indicated a skin tear to right forearm. She verified that there was no documentation about how this injury occurred and there was no documentation of an investigation about how it occurred. On 10/22/2024 at 11:30 AM, the Administrator stated that he did not recall this situation regarding a skin tear documented in the 3/17/24 nursing note. He does not have any additional investigation documentation, and this injury of unknown origin was not reported to the State Agency,nor other required entities. Review of resident #1's medical record revealed a nursing note dated 4/13/24 which indicated resident #1 had bruises to the forehead and the side of her left eye. There was no documentation about what caused these injuries. There was no documentation about the approximate size, shape, coloration of the bruising nor more detailed placement of location. It was documented the physician was notified. On 10/22/2024 at 11:11 AM, the Assistant Administrator verified there was no documentation how resident #1's bruising to the forehead and side of left eye injuries occurred, and no documentation an investigation was performed to understand what caused resident #1's injuries of unknown origin observed by nursing staff on 4/13/24. The Assistant Administrator described resident #1 as combative toward staff who offered care in August of 2024 and received care planning at that time regarding such behavior. She confirmed there was no such documentation of any such behavior occurring on 4/13/24 when the bruising to the forehead and the side of left eye was noted in her record. She verified there was no witness to this injury when it occurred, and was unable to say how these injuries occurred. She verified there was no reporting about this injury to State Agency, nor other required entities. Review of resident #1's medical record revealed a nursing note dated 5/21/24 which indicated resident #1 had a skin tear to the right elbow. It described the resident moved her upper extremities frequently and hit the wall. There was no documentation about the size of the skin tear. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bedrock Rehabilitation and Nursing Center at Winte	1700 Monroe Ave Maitland, FL 32751

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #1's medical record revealed a nursing note dated 5/26/24 that resident #1's family was concerned about the origin of the injury on her right elbow which was noted in the 5/21/24 nursing note. The facility described the wound as a tear and the family member was concerned it was instead a cut. The family requested an investigation about the origin of the injury, last week, but they had not been provided a follow-up response. On 10/22/24 at 11:06 AM, the Administrator and Assistant Administrator verified they were never notified by any staff that resident #1's family was concerned about the causation of the injury to resident #1's right elbow. They verified there was no witness to this injury and no follow-up investigation was documented about the injury to understand its causation or to implement interventions. They verified the injury was not reported to the State agency nor to other required entities. Review of resident #1's medical record revealed a nursing note dated 7/30/24 which indicated resident #1 had a skin tear to her right lower leg. There was no documentation about what caused this injury. There was no description of the size of the wound, nor its placement on the lower leg. On 10/22/24 at 10:35 AM, the Assistant Administrator verified there was no documentation about what caused the injury to resident #1's right lower leg which was observed 07/30/24, and said there was no additional documentation of an investigation having been done to understand what caused resident #1's injury. She verified the injury was not reported to the State Agency for possible abuse or neglect or to any other required entities. 2. Resident #4 was admitted to the facility on [DATE]. Her Quarterly MDS assessment dated [DATE] revealed she had a Brief Interview for Mental Status score of 2 out of 15 which indicated severe cognitive impairment. Review of resident #4's medical record revealed a nursing note dated 7/04/24 in which a nurse observed purplish, red internal bruising on resident #4's right and left hands and right lateral forearm. On 10/22/24 at 4:18 PM, the Assistant Administrator reviewed the investigation about bruising on resident #4's hands and right lateral forearm that was observed by the nurse on 7/04/24. No witnesses had noted when the injuries occurred. She explained they were believed to have been caused by blood draws for specimen collection that were done on 6/29/24. She said the blood draw company was contacted, but it did not have documentation of how many blood draws were attempted. Although the number of attempted blood draws was not verified by the blood draw company the Assistant Administrator verified there was no additional investigation, such as interviewing staff from various shifts or assessing other residents' skin who have severe cognitive impairment, to understand how the injuries occurred. She verified the injuries were not reported to the State Agency or other required entities for possible abuse or neglect. In a telephone interview on 10/23/24 at 1:34 PM, the blood lab draw Assistant Operations Manager verified there was no record of how many times a blood draw was attempted on resident #4, nor what site or sites on her body the specimen was collected from on 6/29/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2024
NAME OF PROVIDER OR SUPPLIER Bedrock Rehabilitation and Nursing Center at Winte		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 Monroe Ave Maitland, FL 32751	

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record revealed a Licensed Nurse Weekly Skin Observation dated 9/01/24 which indicated there were no skin issues. A nursing note dated 9/02/24 indicated the resident's family member observed bruising on the resident. The nurse indicated that on assessment a purplish bruise was noted on top of her right hand, the top of her left hand, the right wrist and left lower arm. There was no documentation about what caused these injuries, but the nurse documented the physician and Risk Manager were notified. On 10/23/24 at 9:13 AM, the Assistant Administrator confirmed the facility was aware resident #4's daughter had concerns that Certified Nursing Assistant (CNA) B abused her mother and the CNA was suspended while the facility investigated. The Assistant Administrator verified that as part of the facility's investigation regarding the abuse allegations from 9/02/24 the facility did not assess the skin of other severely cognitively impaired residents who were not able to self report but were provided care by the same staff to investigate if there were other injuries of unknown origin which could exist. Review of the facility's policy and guidelines for implementation, abuse policy, dated 4/01/22 included content regarding injuries of unknown origin. The document revealed it was the policy of the facility that reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source.) were promptly and thoroughly investigated. Additionally, it noted that investigation of injuries of unknown origin or suspicious injuries must be immediately investigated to rule out abuse. The policy included examples of injuries, and remarked they were not limited to, bruising of the face, bruises of unusual size, multiple unexplained bruises, and/or bruising in an area not typically vulnerable to trauma.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bedrock Rehabilitation and Nursing Center at Winte	1700 Monroe Ave Maitland, FL 32751

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 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 51234

Based on record review, and interview, the facility failed to report injuries of unknown origin in a timely manner per regulations for 2 of 3 residents reviewed for injuries of unknown origin, of a total sample of 5 residents, (#1 and #4).

Findings:

1. Resident #4 was admitted to the facility on [DATE]. Her Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she had a Brief Interview for Mental Status score of 2 out of 15, which indicated severe cognitive impairment.

Review of resident #4's medical record revealed a nursing note dated 9/02/24 by Registered Nurse (RN) A that the resident's family member observed bruising on the resident. The nurse indicated that upon assessment a purplish bruise was noted on top of the right hand, top of left hand, right wrist and left lower arm. There was no documentation about what caused these injuries, but the nurse documented she reported the concerns to the physician and the Risk Manager.

In interviews on 10/22/24 at 4:36 PM, and on 10/23/24 at 9:14 AM, with the Administrator and the Assistant Administrator, the Assistant Administrator confirmed the facility was aware resident #4's daughter had concerns that Certified Nursing Assistant (CNA) B abused her mother and the CNA was suspended while the facility investigated. She acknowledged the facility did report the allegations but verified there was an over 24-hour delay in reporting to the State agency, and other entities per the regulations regarding the bruising injuries of unknown origin documented on the nursing note by RN A dated 9/02/24. The Administrator said he did not know why he didn't know about the bruising injuries earlier. He said the Director of Nursing (DON), at the time of the survey, now a former employee, was the Risk Manager at the time.

Review of resident #4's medical record revealed a nursing note dated 7/04/24 in which the nurse observed purplish, red bruising on resident #4's right and left hands and right forearm. There was no documentation about what caused the injuries.

On 10/22/24 at 4:18 PM, the Assistant Administrator reviewed the investigation about the bruising on resident #4's hands and right forearm that was observed by the nurse on 7/04/24. She acknowledged no witnesses were noted when the injury occurred. She explained it was believed to have been caused by blood draws for specimen collection that was done on 6/29/24. She said the blood draw company was contacted, but it did not have documentation of how many blood draws were attempted. Although the number of attempted blood draws by the blood draw company was not verified by the facility, the Assistant Administrator verified no additional investigation, such as interviewing staff from various shifts or assessing other residents' skin who had severe cognitive impairment, to understand how the injuries might have occurred was completed. There was no documentation that the facility notified the State agency nor other entities of the injuries of unknown origin or possible abuse/neglect.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2024
NAME OF PROVIDER OR SUPPLIER: Bedrock Rehabilitation and Nursing Center at Winte		STREET ADDRESS, CITY, STATE, ZIP CODE: 1700 Monroe Ave Maitland, FL 32751	

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 10/23/24 at 1:34 PM, the blood lab draw Assistant Operations Manager verified there was no record of how many times a blood draw was attempted on resident #4, nor what from what site or sites on resident #4's body the specimen was collected from on 6/29/24. 2. Resident #1 was most recently admitted to the facility on [DATE] and discharged on [DATE]. Review of resident #1's Quarterly MDS assessment dated [DATE] and Annual MDS dated [DATE] indicated she rarely/never understood regarding communication and a mental status exam should not be conducted. One of her diagnoses included unspecified dementia, with unspecified severity. Review of resident #1's medical record revealed a nursing note dated 3/17/24 noting the resident had a skin tear to the right forearm. There was no documentation about what caused this injury. There was no description of the size of the wound, nor its placement on the forearm. A nursing note dated 3/18/24 revealed the skin tear was reported to the physician and treatment orders were given. On 10/22/24 at 11:19 AM, the Director of Nursing (DON) reviewed resident #1's nursing note dated 3/17/24 which indicated she had a skin tear to her right forearm. She verified there was no documentation about how the injury occurred nor was there documentation of an investigation about how it occurred. On 10/22/24 at 11:30 AM, the Administrator stated he did not recall the situation regarding resident #1's skin tear as documented in the 3/17/24 nursing note. The Administrator confirmed the facility did not have any additional investigation documentation and he confirmed the incident was not reported to to the appropriate entities or state agency for possible abuse or neglect. Review of resident #1's medical record revealed a nursing note dated 4/13/24 which indicated resident #1 had bruises to the forehead and the side of her left eye. There was no documentation about what caused these injuries. There was no documentation about the approximate size, shape, coloration of the bruising nor more detailed placement of location. It was documented the physician was notified. On 10/22/2024 at 11:11 AM, the Assistant Administrator verified there was no documentation how resident #1's bruising to the forehead and side of left eye injuries occurred, and no documentation an investigation was performed to understand what caused resident #1's injuries of unknown origin observed by nursing staff on 4/13/24. The Assistant Administrator described resident #1 as combative toward staff who offered care in August of 2024 and received care planning at that time regarding such behavior. She confirmed there was no such documentation of any such behaviors occurring on 4/13/24 when the bruising to the forehead and the side of left eye was noted in her record. She verified there was no witness to this injury when it occurred, and she was unable to say how these injuries occurred. She verified there was no reporting about this injury to the State Agency, nor other required entities. Review of resident #1's record revealed a nursing note dated 5/21/24 which indicated that resident #1 had a skin tear to the right elbow. It described the resident moved her upper extremities frequently and hit the wall. There was no documentation about the size of the skin tear noted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105430	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bedrock Rehabilitation and Nursing Center at Winte	1700 Monroe Ave Maitland, FL 32751

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #1's medical record revealed a nursing note dated 5/26/24 that resident #1's family was concerned about the origin of the injury on her right elbow which was also noted in the 5/21/24 nursing note. The nursing staff described the injury as a tear and the Power of Attorney (POA) was concerned it was more like a cut. The document indicated the POA requested an investigation to the Unit Manager about the origin of the injury, last week, but had not received a follow-up response. On 10/22/24 at 11:06 AM, the Administrator and Assistant Administrator verified they were not notified by any staff that resident #1's family was concerned about the causation of the injury on resident #1's right elbow. They verified there was no witness to this injury and no follow-up investigation was documented about this injury to understand its causation. They confirmed that this injury was not reported to the State agency or other required entities for possible abuse or neglect. Review of resident #1's record revealed a nursing note dated 7/30/24 that resident #1 had a skin tear to her right lower leg. There was no documentation about what caused this injury. There was no description of the size of the wound, nor its placement on the lower leg. On 10/22/24 at 10:35 AM, the Assistant Administrator verified there was no documentation about what caused the injury to resident #1's right lower leg which was observed 7/30/24, and said there was no additional documentation of an investigation or subsequent reporting for possible abuse or neglect having been done to understand what caused resident #1's injury. Review of the facility's abuse policy, dated 04/01/22 included content regarding injuries of unknown origin. In the reporting and response portion of the policy it indicated abuse allegations including (abuse, neglect, exploitation, or mistreatment, including injuries of unknown source.) were reported per Federal and State law. The facility would ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source. were reported immediately, but not later than two hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to other officials. in accordance with State law through established procedures. It stated the Administrator or designee would make an initial (immediate or within 24 hours) report to the State Agency. A follow-up investigation would be submitted to the State Agency within five (5) days. The Administrator/ Designee would notify the agency for Adult Protective Services, the Statewide Abuse Hotline, would utilize the State agency Nursing Home Reporting System for Immediate and 5 day reports, and would utilize the State agency Reporting System to submit the 15-day Adverse Report.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2024
NAME OF PROVIDER OR SUPPLIER: Bedrock Rehabilitation and Nursing Center at Winte		STREET ADDRESS, CITY, STATE, ZIP CODE: 1700 Monroe Ave Maitland, FL 32751	

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51234 Based on record review, and interview, the facility failed to remove an indwelling urinary (foley) catheter and collect a urine specimen in a timely manner which led to a delay in treatment for 1 of 2 residents reviewed for urinary catheters, of a total sample of 5 residents, (#1). Findings: Review of resident #1's Annual Minimum Data Set assessment dated [DATE] indicated she rarely/never understood regarding communication and a mental status exam should not be conducted. Her diagnoses included unspecified dementia, with unspecified severity. Review of resident #1's record revealed a nursing note dated 7/30/24 at 2:55 PM, that resident #1 was straight catheterized for urine with 600 cubic centimeters (cc) output due to no urine output. The physician was notified, and orders were received that day for a urinalysis with a culture and sensitivity and to place an indwelling foley catheter for three days pending the urinalysis results. Review of resident #1's medical record revealed a nursing note dated the next day on 7/31/24 at 8:08 AM, that a foley catheter had been placed. The note did not mention that a urine sample for urinalysis was collected. Resident #1 had a care plan for risk for urinary tract infection (UTI) and complications of indwelling foley catheter related to retention initiated on 7/31/24. The goal was for the risk for UTI and complications to be minimized with the use of current interventions through the next review. Interventions included check for catheter patency every shift and as needed and labs as ordered dated 7/31/24. Review of resident #1's Treatment Administration Record (TAR) revealed an order for foley catheter check for patency every shift and change as needed with a start date of 7/31/24 and was discontinued on 8/10/24. The order did not contain the direction for the removal of the catheter after three days as documented in a verbal order from the physician on 7/30/24. Also the TAR documentation showed there were two shifts the patency check was missing, one on 08/04/24 and again on 08/07/24, from the start of the order on 7/31/24 until the first shift of 8/10/24 when the catheter was discontinued. Review of resident #1's medical record revealed a nursing note dated 8/05/24 that the foley catheter had been removed, five days after it was inserted. This note conflicted with documentation by nurses on the TAR which on six shifts nurses documented they checked the patency of the foley catheter even though the nurse documented it was removed on 8/05/24. Nurses on 8/09/24 did not document the patency check on the TAR and instead documented 9- other/see Progress notes. Review of resident #1's medical record revealed a urinalysis lab report with a collection date of 8/05/24 at 6:45 AM, with results reported on 8/07/24, six days after the verbal order was initially received as noted by the nurse on 7/30/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bedrock Rehabilitation and Nursing Center at Winte	1700 Monroe Ave Maitland, FL 32751

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #1's record revealed a physician's note dated 8/08/24 that the urine culture and sensitivity had been received, a urinary tract infection was diagnosed , and an antibiotic which the bacteria was sensitive to was ordered, nine days after the original order date for a urine analysis with culture and sensitivity. On 10/22/24 at 10:33 AM, the Director of Nursing (DON) acknowledged the urine collection for resident #1's urinalysis was not done until 8/05/24. She stated resident #1 should have been straight catheterized again on 7/31/24 in the morning for specimen collection for the urinalysis and culture and sensitivity, as it had not been collected on 7/30/24. The DON was unable to explain why it had not been done with the insertion of the foley catheter, nor why the order for the foley catheter did not specify it was for three days per the verbal order of the physician. She confirmed there was a delayed collection for the urinalysis and verified the foley catheter was in longer than three days. She verified the late urinalysis collection caused the ordered treatment (antibiotics) to be delayed.