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	12/13/2024

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35339 Based on interview, and record review, the facility failed to ensure baseline care plan summaries were reviewed with or a copy provided to the resident and/or the resident representative for 2 of 4 residents reviewed for baseline care plan, of a total sample of 10 residents, (#1, and #2). Findings: 1. Resident #1's electronic medical record (EMR) revealed the resident was admitted on [DATE] with diagnoses of cerebral infarction (stroke), hemiplegia, type 2 diabetes, speech and language deficits, abnormal posture, need for assistance with activities of daily living (ADLs). He resided in the facility for 10 days and was discharged on [DATE]. On 12/12/24 at 2:57 PM, Registered Nurse (RN) C stated the care plan was initiated upon admission, then Minimum Data Set (MDS) nurses completed the comprehensive care plan. She stated that resident #1 did not receive a baseline care plan from the nurse on admission and there were other people who had to sign off on it as well, as part of a team effort. RN C explained the resident was supposed to get a copy of the baseline care plan once it was finished. On 12/12/24 at 3:51 PM, Licensed Practical Nurse (LPN) B stated nurses completed the baseline care plans in the computer. She explained she thought the MDS nurse reviewed the care plans with residents and then gave them a copy once they were completed. On 12/13/24 at 12:26 PM, and 1:12 PM, the Director of Nursing (DON) stated the nurse who held the key was expected to do the initial admission assessment, and the nursing baseline care plan. She explained the care plan should be signed by the resident, family or representative, and a copy given to them. The DON conveyed the baseline care plan stayed with the admission packet and was placed with the admission paperwork for the clinical team to review in the morning. She stated the clinical team reviewed the packets in the morning for accuracy and completeness. Resident #1's EMR was reviewed with the DON which revealed there was no baseline care plan present for resident #1. The DON confirmed there was no baseline care plan scanned into the computer record for resident #1. On 12/13/24 at 5:15 PM, the Lead MDS Coordinator, stated nursing was responsible for the residents' baseline care plans, and it was a team effort to complete it. (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/13/24 at 5:20 PM, the DON provided a paper copy of resident #1's baseline care plan. The document revealed an admitted [DATE] with baseline care plan dated 10/29/24. The care plan included a summary of goals, interventions, physician orders, services, and treatments. Further review showed on page six under the section, Date reviewed with resident/representative, the line was blank with no date for review, signature, or provided copy of the baseline care plan summaries to the resident or the resident's representative. Review of resident #1's EMR revealed no documentation that the resident or the representative refused to review or sign the baseline care plan summary. 2. Resident #2's EMR showed the resident was admitted to the facility on [DATE], with a previous admission on 8/22/24. Diagnoses included subsequent fall with fracture, cognitive communication deficit, dementia, depressive disorder, and need for assistance with ADLs. Resident #2 resided in the facility for 26 days and was discharged on [DATE]. Review of the EMR for resident #2 revealed there was no baseline care plan summary for the admitted [DATE] and the medical record did not reveal documentation of a copy of the baseline care plan provided to the resident or the representative or their refusal to review and sign the baseline care plan summary. On 12/13/24 at 5:30 PM, the DON provided a copy of the baseline care plan summary for resident #2. The form presented by the DON was dated for the previous admission of 8/22/24, and page 6, the signature page for date reviewed with the resident or representative was not included. The DON stated nurses were responsible for the baseline care plans, and she was unsure if any audits or education had been completely recently regarding care plans. Review of the facility's Baseline Care Plan, Comprehensive Care Plan and Ongoing Care Plan Updates dated 4/1/22 showed the facility would provide the resident and their representative with a summary of the baseline care plan when requested and a written summary must be provided to the resident or representative by completion of the comprehensive care plan.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35339 Based on interview, and record review, the facility failed to maintain complete, accurate, and readily accessible medical records for 2 of 2 residents reviewed for medical record review,of a total sample of 10 residents, (#1, and #2). Findings: 1. Resident #1 was admitted to the facilty on 10/28/24 with diagnoses of hypertension, muscle weakness, cerebral infarction (stroke), hemiplegia, cognitive and social or emotional deficit, and type 2 diabetes. Resident #1 remained in the facility for 10 days and was discharged on [DATE] Review of resident #1's medical record revealed resident #1's Admission Agreement paperwork was missing from the medical record and the baseline care plan for the admitted [DATE] had date discrepancies regarding the discharge plans section and incomplete documentation regarding no date or signature for review with the resident or representative for the baseline care plan summary. On 12/13/24 at 1:40 PM, the Director of Community Relations stated there was no scanned copy of the Admission Agreement in the computer for resident #1. On 12/13/24 at 1:44 PM, the Admissions Director stated she was unable to locate the signed admission agreement in the computer or in the record. She said, Don't know what happened there. On 12/13/24 at 4:20 PM, the Admissions Director explained the admission packet was, a part of the electronic medical record. She stated the main thing was getting the packet signed. She stated the timeframe for getting the admission packet paperwork completed, signed and into the medical record was 24-48 hours or longer if you have to contact the family for a signature if the resident was unable to sign. She stated it was important because it was the agreement between the resident and the facility for the services provided. The Admission Director confirmed she was responsible for the Admission Agreement and explained the packed contained information so the residents knew their rights and the protocols for the facility. On 12/13/24 at 5:20 PM, the Director of Nursing (DON) provided a copy of the resident baseline care plan which reflected an admitted [DATE], and a completion date of 10/29/24 with a staff signature. Discrepancies were noted on page 4 of the baseline care plan, which showed no date, and under the section for Discharge Plans, showed a location for transfer to another skilled facility with home health care. Review of a progress note by the Assistant Administrator dated 11/05/24 at 10:41 AM, revealed, Patient and family requested to transfer . Referral sent. A progress note by the Assistant Administrator dated 11/06/24 at 1:41 PM, showed she confirmed resident #1's transfer to the skilled nursing facility. Comparison of the progress notes dated 11/05/24 at 10:41 AM, and 11/06/24 at 1:41 PM, conflict with date of completion on the baseline care plan of 10/29/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/13/24 at 5:30 PM, the DON acknowledged that the copy of the baseline care plan summary was incomplete and stated nursing was responsible for baseline care plans. 2. Resident #2 was admitted to the facility on [DATE] with a previous admission on 8/22/24. She had diagnoses of fractured nasal bones, contusions-scalp, subsequent falls, chronic obstructive pulmonary disease, disorders of the brain, depressive disorder and hypertension. She resided in the facility for 26 days and was discharged on [DATE]. Record review showed resident #2's admission of 10/18/24 base line care plan summary was missing from the electronic record. On 12/13/24 at 1:08 PM, the DON reviewed resident #2's medical record and confirmed there were no scanned documents for the baseline care plan. On 12/13/24 at 5:30 PM, the DON provided a paper copy of the baseline care plan that showed the previous admitted [DATE], that was missing page 6 which contained the baseline care plan summary completion date, the date reviewed with resident or representative and staff signature. The DON stated this was all she could find. Review of the EMR did not reveal documentation of the resident or the representative refusing to review or sign the baseline care plan summary for 10/18/24 admission. Review of the Resident Rights Policy dated 4/01/22 revealed the purpose was to ensure the preservation for resident's right to a dignified existence, and communication with access to services inside and outside of the facility. Review of the facility Admission Agreement indicated the agreement contained the entire understanding between the facility and the resident and/or representative. The facility accepted the application for admission subject to the resident or representative executing consent for admission, and medical treatment. The resident and/or representative acknowledged that they had been fully informed, and signed their signature to indicate they executed the agreement on the date and year written. The Admission Policy dated 9/26/22, revised 5/15/23 showed the facility would provide admissions according to State and Federal regulations and no potential or current resident would be requested or required to waive their rights. Review of the signed job description dated 12/22/22 for Admission Director reflected advising residents and /or families of admission requirements as established by the facility, ensures proper completion, signing and distribution of paperwork, and ensure residents and families received the highest quality of service.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35339 Based on observation, interview, and record review, the facility failed to ensure residents were provided necessary maintenance services to maintain a comfortable, homelike environment regarding functional television (TV) channels with audio, channel programming, and availability of remote controls for 4 rooms on the 100 unit, 6 rooms on the 200 unit and 1 room on the 300 unit, out of a total of 27 sampled rooms reviewed, (Rooms 111-B, 112-B, 114-A, 128-A, 128-B, 204-A, 207-A, 215-A, 215-B, 219-A, 219-B, 223-A, 230-A, 230-B, 301-A, and 301-B). Findings: 1. On 12/12/24 at 3:24 PM, during a tour of the 200-nursing unit, resident #3 in room [ROOM NUMBER]-A was laying in bed with the TV remote in his hand. He stated the TV channels were fuzzy and to make it worse it only got a handful of channels. He said he, reported it 2 times within the last week and a half. One maintenance guy came in and said it was the mount on the wall that holds the TV that was causing the problem something about the coax cable. He explained he repaired things, and knew that was not the issue. He said he informed the maintenance person and said, No one has come back since then to follow up or fix the issue. He stated when his roommate's television was on, it did not have any channels showing. Review of the work order report created on 11/13/24 for TV being fuzzy, and some channels not working had a status of completed on 12/11/24. A work order created on 11/22/24 for the resident having difficulty with his TV also had a status of completed on 12/11/24. Observations on 12/12/24 and 12/13/24 showed the TV channels continued to be fuzzy. On 12/12/24 at 3:31 PM, Licensed Practical Nurse (LPN) A stated she was aware that the TV for the A bed was not clear, and it had been verbally reported maintenance one day last week. On 12/12/24 at 3:39 PM, the Maintenance Director stated he was responsible for facility maintenance. He received work orders verbally, and on the computer, he checked the maintenance books on the units daily, and then took care of it. On 12/13/24 at 2:48 PM, the Maintenance Director stated we replace whatever TV was broken, or static coax cables, and explained they couldn't replace anything in the walls. He said they would have to contract out to a cable company for those repairs. He stated, they had not had to contract anything out to the cable company recently, within the last six months. On 12/13/24 at 3:25 PM, resident #3 in room [ROOM NUMBER]-A stated yesterday (12/12/24) confirmed they changed the TV and gave him a new TV. He stated the TV still had fuzzy channels, and now his remote control worked both his and his roommate's TV. He stated he could turn both TV's on, and off, as well as change the channels on both TV's. He stated he didn't get some TV channels. The Maintenance Director confirmed resident #3's TV channels were not clear, and his remote control did turn on, and off, and changed the channels on his TV. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 12/12/24 at 3:27 PM, resident #4 in room [ROOM NUMBER]-B was observed laying in bed. He stated the TV didn't work when you turned it on. He proceeded to attempt to turn on his TV by pushing the button on the remote control to change the channels. The TV display showed a guide listing for the channels, however when he attempted to select several channels there were no visual images displayed for any of the channels selected, and there was no sound. 3. On 12/13/24 at 2:57 PM, A walk-through was conducted with the Maintenance Director, and the Administrator to inspect reported and completed TV and/or remote-control work orders. In room [ROOM NUMBER]-B the Maintenance Director confirmed there was only 1 remote control in the room to operate both residents' TVs. 4. On 12/13/24 at 3:06 PM, observations of room [ROOM NUMBER]-B with the Maintenance Director revealed the TV channels were fuzzy, and unclear for both TVs. There was only one remote control in the room for both residents. Closer observation showed a crossover of the one remote control, as it turned both TVs on, off, and changed channels. 5. On 12/13/24 at 3:08 PM, in room [ROOM NUMBER]-A the TV check by the Maintenance Director showed the picture on the TV channels was not clear. 6. On 12/13/24 at 3:10 PM, a TV check for room [ROOM NUMBER] revealed resident #6 in 128-B in bed watching TV. She stated her roommate did not have a remote control for her TV. The Maintenance Director searched and was not able to locate the remote control for the A bed. He validated there was no remote control for room [ROOM NUMBER]-A's television. Resident #6 stated her TV was currently playing on the antenna only. She stated it was the only way to see the channels clearly. She explained her husband worked with the cable company and he fixed her TV because all of her channels were fuzzy. She stated some channels did not even show up and she could not get any of the higher channels on the TV. Resident #6 then proceeded to switch her TV from antenna mode to the facility cable which revealed all channels were fuzzy as well as missed channels on the TV channel selection. She confirmed she had previously reported this concern to the facility. 7. On 12/13/24 at 3:15 PM, resident #7 in 204-A, stated the TV was loud, and the volume and TV channels were not responsive with the remote control. He stated it was not synced and it woke up his roommate with the loud volume. The Maintenance Director checked his TV and stated it was an issue with the guide setting. 8. On 12/13/24 at 3:17 PM, resident #8 in 207-A stated the TV did not pick up some of the channels. The Maintenance Director stated the TV needed to be reprogrammed. Further review of the facility work order report revealed there was a work order created on 10/24/24 for reprogramming resident #8's TV. The status showed completed on 11/06/24, however, the TV required frequent reprogramming. 9. On 12/13/24 at 3:23 PM, the Maintenance Director revealed the remote control for room [ROOM NUMBER]-A would turn on and off the TV for 215-B. Observation revealed neither TV had pictures displayed on the channels. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. On 12/13/24 at 3:34 PM, in room [ROOM NUMBER]-A, resident #9 stated the remote control did not work properly. He stated if he turned on his TV with his remote control it would turn on both TVs in the room, his TV and the roommate's TV. The Maintenance Director confirmed both TVs in the room could be turned on and off from resident #9's remote control. 11. On 12/13/24 at 3:38 PM, the TV check with the Maintenance Director revealed both beds 230-A and 230-B's TV channels were unclear, the images were fuzzy as displayed on the TVs, and the remote controls turned on both A and B bed's TVs. 12. On 12/13/24 at 3:34 PM, in room [ROOM NUMBER]-A resident #10 stated when it rained all the channels went out and you couldn't see any channels on the TV. He stated when he turned on his TV it also turned on his roommate's TV and that woke him up. He said, I asked for a computer TV and they stated they can't do that because they would have to re-wire everything. The Maintenance Director confirmed 301-B had no remote control for the TV. On 12/13/24 at 3:45 PM, Maintenance Director confirmed it was not homelike, and not normal for TVs to be fuzzy, and not showing pictures on the channels. He stated each resident should have their own remote control. He said, The remote control for one resident's TV should not turn on or off the TV for the roommate. He stated he had not done any audits on the functionality of the TVs display of pictures, availability of channels, or checked to make sure each resident had their own remote control which operated their individual TV in the rooms. On 12/13/24 at 3:56 PM, the Administrator stated the TVs should work better, should not be fuzzy or have channels that the residents couldn't get. Review of the facility Work Order policy dated 4/01/22 showed that work orders should be completed in order to establish maintenance service and were addressed. Review of the Resident Rights Policy dated 4/01/22 revealed the purpose was to ensure the preservation of the resident's right to a dignified existence, with access to services inside and outside of the facility. The policy detailed that each resident had the right to a safe, clean comfortable, homelike environment with maintenance services to maintain a comfortable interior.