

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  01/14/2025
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)
<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35339</p> <p>Based on interview, and record review, the facility failed to notify and update the hospice provider regarding a fall for 1 of 1 resident reviewed for notification of change, out of a total sample of 5 residents, (#1).</p> <p>Findings:</p> <p>Resident #1 was admitted to the facility on [DATE] for respite care. His diagnoses included dementia, Neurocognitive disorder, depressive disorder, and insomnia. Resident #1 was discharged home from the facility on 10/10/24.</p> <p>Review of resident #1's medical record revealed a late entry nursing progress note as well as a Situation Background Assessment and Recommendation (SBAR) note dated 10/08/24 at 4:15 AM. The notes showed resident #1 was found on the floor next to his bed, the facility Nurse Practitioner was notified on 10/08/24, and the document revealed the responsible party was not yet known, therefore not notified at that time. There was no documentation to show facility nurses contacted resident #1's hospice provider regarding the fall.</p> <p>On 1/13/25 at 12:32 PM, Registered Nurse (RN) A stated if a resident was on hospice services the facility process was to notify the physician, the representative, and the hospice service as a fall was a change in condition.</p> <p>On 1/14/25 at 12:28 PM, the interim Director of Nursing (DON) stated if a resident had a change in condition such as fall, then nursing was responsible for notifying the responsible party, the physician, and the contracted hospice.</p> <p>On 1/14/25 at 12:45 PM, the interim DON placed a telephone call to resident #1's hospice service. The Hospice Team Manager stated by phone that resident #1's wife called them on 10/10/24 at 10:21 AM, to report that her husband had a fall in the facility a few days before. The Hospice Team Manager stated the facility did not call or notify the hospice of resident #1's fall, instead it was his wife.</p> <p>On 1/14/25 at 12:50 PM, the interim DON validated there was no documentation in resident #1's medical record to show that resident #1's hospice service was notified of his change in condition regarding his fall on 10/08/24.</p> <p>(continued on next page)</p>

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

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

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  01/14/2025
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)
<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy and procedure, Change in Condition revised 4/04/23, revealed a purpose to communicate changes in condition, regarding notification about changes in conditions as required.</p> <p>The policy Hospice Services with a revision date of 3/10/23 showed the facility will have an agreement with Hospice that includes the communication process for care of the resident including any changes in condition.</p>