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	08/30/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on observation, interview, and record review, the facility failed to treat residents who required assistance with meals in a dignified and respectful manner for 1 of 1 residents reviewed for dignity, of a total sample of 49 residents, (#42). Findings: Review of resident #42's medical record documented she was readmitted to the facility on [DATE] with diagnoses of dysphagia (difficulty swallowing), aphasia (comprehension and communication disorder), stroke, and contracture of right hand. Review of the Quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date of 6/02/24 revealed resident #42's Brief Interview for Mental Status was not obtained because she was rarely or never understood. The MDS showed she was dependent of staff for most Activities of Daily Living. Review of the Follow Up Question Report for August 2024 revealed resident #42 was dependent for eating. On 8/26/24 at 8:43 AM, Certified Nursing Assistant (CNA) K stated resident #42 was not interviewable and she was, a feeder. On 8/27/24 at 4:50 PM, CNA H explained this was her first time caring for resident #42. She shared resident #42 did not talk and said, She is a feeder too. When asked why she referred to resident #42 as a feeder she stated that was the term they used. On 8/29/24 at 3:40 PM, CNA J stated although she had not been assigned to resident #42, she knew whoever was assigned to her had to assist her to eat because she was, a feeder. On 8/29/24 at 11:49 AM, the Keys Unit Manager (UM) stated CNAs should refer to residents who needed assistance to eat, as dependent diners. She indicated it was not appropriate to refer to the residents as feeders. She said it was, not politically correct and was a dignity issue. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105430	A. Building B. Wing	08/30/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/30/24 at 10:00 AM, the Director of Nursing (DON) stated residents who required assistance with meals were called dependent diners, not feeders. Later at 12:28 PM, the DON explained a checklist was used to validate CNAs competencies for tasks such as eating and swallowing. She stated they also reviewed the facility's Resident Rights policy with the CNAs. During the exit conference on 8/30/24 at approximately 4:10 PM, the Resident Council President stated she had heard the CNAs refer to some residents as feeders before which she had brought to staff attention. She indicated this was, demeaning and demoralizing. Review of the CNA's job description revealed CNAs were to provide, Care in a manner that protects and promotes Resident Rights, dignity, self-determination and active participation . Refers to residents by proper names unless residents request otherwise. Avoids use of all pet names . Review of the facility's policy and procedure titled Resident Rights dated 4/01/22 revealed a purpose to preserve every resident's right to a dignified existence. The document indicated it was the facility's policy to, . treat each resident with respect and dignity and care for reach resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.

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	08/30/2024

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 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** 50875 Based on observation and interview the facility failed to provide a sanitary, comfortable and homelike interior for one out of 10 residents reviewed for environment, of a total sample of 42, (#126). Findings: Resident #126 was admitted to the facility on [DATE] with diagnoses which included left leg above the knee amputation, other abnormalities of gait and mobility and the need for assistance with personal care. On 8/26/24 at 8:53 AM, resident #126 was observed in his room, alert and oriented, sitting up in his wheelchair eating breakfast. He indicated the bedside commode next to his table had not been emptied for two days. When he lifted the lid of the commode, there was a foul odor and a large amount of feces and urine were observed. He explained he asked the staff that morning during breakfast service to empty it but was told it was not their job. On 8/26/24 at 1:30 PM, observation of the bedside commode in resident #126's room revealed it remained dirty with a foul odor in the room and still had not been emptied. A few minutes later, outside the resident's room, Certified Nursing Assistant (CNA) B, stated she had not been asked by resident #126 to empty his bedside commode. She stated that resident #126 used the bathroom and not the bedside commode. The next day, on 8/27/24 at 10:19 AM, resident # 126 was again observed sitting in his wheelchair in his room with assigned CNA A present. The bedside commode was in the same place beside his bedside table and the odor of old feces and urine continued to be present in the room. CNA A opened the bedside commode and verified it was dirty with old feces and urine. CNA A stated she was not aware of the commode being full and said the resident did not tell her it needed to be emptied. CNA A explained she had noticed the odor in the room, but thought the odor came from the resident after he soiled himself, so she took him to the shower room. On 8/27/24 at 4:33 PM, assigned Licensed Practical Nurse (LPN) D, confirmed she was aware of resident #126's dirty bedside commode and had directed the CNA yesterday to empty it. She stated she did not realize the CNA yesterday had not emptied it. She indicated she also asked the assigned CNA the present morning to empty the commode because resident #126 again mentioned it had not been emptied for two days. LPN D confirmed it was part of the CNA's responsibility to empty the commode. On 8/30/24 at 9:12 AM, the Director of Nursing stated it was the responsibility of any staff to check and empty the commodes and urinals. She continued, it was not acceptable for resident #126 to have a dirty commode for such a long time without it neither being checked nor emptied. The undated facility's Job Description for CNAs under the section of Specified Duties indicated CNAs were responsible for maintaining a safe, clean, orderly and pleasant physical environment throughout the facility. The duties described CNAs were to assist in keeping a clean, orderly area, and were involved in cleaning equipment. (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	08/30/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy and guidelines for implementation on Resident Rights- Safe/Clean/Comfortable Homelike Environment dated April 1st, 2022, stated it was the policy of the facility to provide a safe, clean comfortable homelike environment in such a manner to acknowledge and respect resident rights.

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	08/30/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on interview, and record review, the facility failed to ensure the Minimum Data Set (MDS) assessments were accurate for eating assistance for 1 of 3 residents reviewed for nutrition, of a total sample of 49 residents, (#42). Findings: Cross Reference F550 Review of resident #42's medical record revealed she was readmitted to the facility on [DATE] with diagnoses of dysphagia (difficulty swallowing), aphasia (comprehension and communication disorder), stroke, and contracture of right hand. On 8/27/24 at 5:26 PM, resident #42 was observed in bed, wearing a splint on her right arm and her both of her hands were contracted. Review of the Quarterly MDS assessment with Assessment Reference Date (ARD) of 6/02/24 revealed resident #42's Brief Interview for Mental Status was not obtained because she was rarely or never understood. The MDS incorrectly showed she needed partial/moderate assistance for eating. Review of the previous Quarterly MDS assessment with ARD dated 3/02/24 also showed resident #42 needed partial/moderate assistance for eating. Review of the Certified Nursing Assistant (CNA) Kardex dated 8/30/24 revealed for eating, resident required extensive assistance by one staff for participation to eat. Review of the Follow Up Question Report from 5/26/24 to 6/02/24 in which CNA responses were recorded for Activities of Daily Living (ADL) abilities revealed resident #42 was dependent on staff for eating 16 of 19 times, (with three responses recorded as not applicable or refused). Review of the Follow Up Question Report from 2/25/24 to 3/02/24 in which CNA responses were recorded for ADL abilities revealed resident #42 was dependent on staff for eating on 6 out of the 7 days. CNAs documented 8 times out of the 13 documented responses that resident #42 was dependent on staff or needed maximum assistance from staff to eat, (with six responses recorded as not applicable). Resident #42 had a Care Plan for ADL Self Care Performance Deficit dated 10/23/23. Interventions included for eating resident required extensive staff assistance from one staff for participation to eat. An additional Care Plan for Risk for Malnutrition dated 10/25/23 included an intervention for staff to, Provide adequate supervision/assistance as indicated with meals, supplements and snacks. (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	08/30/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/30/24 at 10:51 AM, the MDS Lead explained she verified the medical record and conducted interviews with staff and residents to complete the MDS assessments. She indicated section GG was completed in collaboration with therapy and nursing. She validated resident #42's Quarterly assessments for March and June 2024 showed the resident required partial/moderate assistance for eating. She indicated she could not tell when the change from partial to dependent occurred as the information was collected during the lookback period through review of documentation and interviews. She mentioned any MDS coded incorrectly would require revision. She stated accuracy of the MDS assessment was important so staff could take proper care of the resident. She indicated they used the Resident Assessment Instrument (RAI) as their guide to complete the MDS assessment. Review of the Resident Assessment Instrument instructions for Section GG read, Code 03, Partial/moderate assistance: if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. Code 01, Dependent: if the helper does ALL of the effort. Resident does none of the effort to complete the activity; or the assistance of two or more helpers is required for the resident to complete the activity. Review of the facility's policy and procedure titled Resident assessment dated [DATE] read, The facility will conduct an initial and periodic comprehensive, accurate assessment of a resident's functional capacity which will include needs, strengths, goals, life history and preferences utilizing the RAI. It also included, The assessments will be conducted by individuals with the knowledge to complete an accurate assessment of relevant care areas and knowledgeable about the resident's status, physical, mental and psychological needs, strengths and areas of decline.

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	08/30/2024

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48878 Based on interview, and record review, the facility failed to ensure completion and accuracy of Level I Preadmission Screening and Resident Reviews (PASARRs) on admission, and/or failed to make referrals for newly evident or possible mental disorders, to evaluate the need for specialized mental health services or alternate placement for 3 of 6 residents reviewed for PASARR, of a total sample of 49 residents, (#90, #134, and #22). for 3 of 3 residents reviewed for PASARRs, out of a total sample of 47 residents, Findings: 1. Review of the medical record revealed resident #90 was originally admitted to the facility on [DATE] from the hospital, with a most recent readmission on 8/16/24. Her diagnoses included bipolar disorder, anxiety, major depressive disorder and psychoactive substance abuse with onset date of 6/29/23. Resident #90's 5-day Minimum Data Set (MDS) with an assessment reference date of 7/05/24 revealed the resident had a diagnosis of anxiety, depression, and bipolar disorder. The MDS assessment noted the resident was taking antianxiety and antidepressant medications. Review of resident #90's medical record revealed a care plan which indicated the resident was at risk for alteration in mood secondary to bipolar disorder, anxiety, and tended to have emotional outburst at times. The care plan also indicated the resident received antidepressants for depression. Review of the State of Florida Agency for Health Care Administration Preadmission Screening and Resident Review Level I screen dated 6/26/23 and signed by the admitting hospital Social Worker, Section I for decision making listed mental illness or suspected mental illness as Bipolar disorder and Substance abuse, but did not include diagnoses of anxiety and major depressive disorder. Section II of the decision making (Other Indications) did not indicate any functional limitations in major life activities such as interpersonal functioning, which would help to trigger additional screening for a Level II PASARR. On 8/28/24 at 11:20 AM, the Social Service Director stated she and the Director of Nursing (DON) were responsible to ensure the residents' Level I and Level II PASARRs were accurate and submitted timely. She also stated residents were to have Level I PASARRs submitted prior to admission, if a resident was diagnosed with a new mental illness diagnosis, or if there was a change in condition. The Social Service Director viewed resident #90's Level I PASARR dated 6/26/23 and verified the diagnoses listed were bipolar and substance abuse. The Social Service Director confirmed the resident had an additional diagnosis of anxiety disorder and major depressive disorder on 6/29/23 which was not included on the 6/26/23 Level I PASARR. She acknowledged a new Level I PASARR should have been submitted with the new diagnosis listed. (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	08/30/2024

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/28/24 at 3:40 PM, the DON stated she had been working at the facility for one year. She conveyed it was the Social Service Director's responsibility to oversee the PASARR process and make sure the facility was compliant. She specified when the Social Service Director was absent, it would be the DONs responsibility to ensure the PASARRs were accurate and submitted timely. She also stated a Level I PASARR was required prior to admission or when there was a new diagnosis. The DON verified resident #90 had a Level I PASARR submitted on 6/26/23 with bipolar and substance abuse diagnosis listed. She confirmed the resident had a new anxiety and major depressive disorder diagnosis on 6/29/23 but a new Level I PASARR was not submitted. The DON reiterated a new Level I should have been submitted but did not know why it was missed. 51023 2. Resident #134's medical record revealed he was admitted to the facility on [DATE] with diagnoses of severe protein-calorie malnutrition, muscle weakness, delusional disorders, psychotic disorder with delusions due to known physiological condition, dementia without behaviors, adult failure to thrive, and myocardial infarction type 2. The resident's PASARR form dated 6/09/23 was completed prior to admission to the facility. The form incorrectly indicated no diagnosis listed under Section IA Mental Illness or suspected Mental Illness. Under Section II, a secondary diagnosis of Dementia was listed. A Psychiatry evaluation note dated 7/03/23 revealed the resident had a diagnosis of delusional disorder, psychotic disorder, and dementia. Review of resident #134's physician medication orders revealed the resident was ordered Buspirone Hydrochloride (HCl) 5 milligrams (MG) for anxiety with a start date of 8/07/24, Seroquel 200 MG for psychotic disorder with delusions with a start date of 5/29/24, Depakote sprinkles 375 MG for mood disorder with a start date of 3/18/24 and ABH GEL 1 milliliter (0.5 MG Ativan / 25 MG Benadryl/ 0.5 MG Haldol) every 8 hours for agitation with a start date of 1/16/24. Review of resident #134's care plan dated 7/02/24 revealed focuses included history of refusing medications and activities of daily living care related to dementia/delusions, and being verbally and physically abusive to staff related to psychosis and cognitive status. Another focus listed that the resident was observed playing with feces, not easily redirected, hallucinations, anxious behaviors, naked, restless and easily agitated. He again was noted to be fighting staff and striking at staff when re-directed. Review of resident medical record revealed no updates had been made to the PASARR form to include these mental illnesses. 49840 3. Resident #22 was admitted to the facility on [DATE] with diagnoses that included dementia, anxiety, and convulsions. After admission the resident was newly diagnosed with psychotic disorder, major depression, and schizoaffective disorder Review of resident #22's Level I PASARR Screen dated 6/26/15, revealed no mental or intellectual diagnosis were indicated. There were no other PASARRs completed after admission. (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	08/30/2024

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MDS Quarterly assessment dated [DATE], revealed resident #22 had a Brief Interview for Mental Status score of 14 out of 15 which indicated she was cognitively intact. The assessment showed she did not show any moods or behaviors in the look back period but was actively taking antidepressants. Her active diagnoses included dementia, anxiety disorder, depression, psychotic disorder, and schizophrenia. Review of resident #22's order summary report dated 8/28/24, revealed she was took Donepezil for dementia, and Escitalopram to treat anxiety disorder and depression. The Medical record for resident #22 revealed she actively received psychiatric services once per week to treat anxiety and insomnia. A psychiatric note dated 8/13/24 revealed a recommendation for resident #22 to continue on Escitalopram for anxiety. Resident #22 had a care plan revised on 8/09/23 with a focus on her behavior of fixating on other resident's care, removing her dressings, removing her oxygen, and refusing medications as well as care. The goal of this care plan, with revision date 7/10/24, was for resident to show less behaviors. Interventions included behavior monitoring, medication administration, and psychiatric consult. She also had a care plan initiated on 5/08/23 to monitor antidepressant medication use. On 8/28/24 at 9:46 AM, the Social Service Director acknowledged the Level I PASARR for resident #22 was incorrect because she was admitted to the facility with several mental health diagnoses and other diagnoses were added later. She stated a PASARR audit had been initiated on 7/31/24 to identify and correct all PASARRs in the facility. The goal was to correct the PASARRs and then submit them for review. However, she said she went on medical leave after completing the audit and could not continue with the next step which would have been to submit them for review. She stated that the DON was the only other person qualified to complete and submit PASARRs in her absence. The Social Service Director revealed she had a conversation with the Regional Nurse Consultant about PASARRs still not being submitted. There was an active Performance Improvement Plan (PIP) for PASARRs that was presented to the Quality Assurance and Performance Improvement (QAPI) committee, but they had yet to meet to discuss the issue. On 8/28/24 at 9:54 AM, the Regional Nurse Consultant acknowledged she was aware of the delay with correcting and submitting PASARRs. She stated she was working with the Social Service Director to get them completed as soon as possible. She explained that the PIP for PASARRs was ineffective because there were no target dates for completion of the tasks identified in the plan and delegation of tasks should have been done when the Social Service Director was on medical leave to prevent delays. The facility PASARR policy dated 4/01/22 revealed it was the facility's policy to assure that all residents admitted to the facility receive a Pre-Admission Screening and Resident Review, in accordance with State and Federal Regulations. Furthermore, the facility must refer all level I and II residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon significant change in status assessment.

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	08/30/2024

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48878 Based on interview and record review, the facility failed to request a Preadmission Screening and Resident Review (PASARR) level I and level II evaluations for 2 of 6 residents reviewed for PASARR,of a total sample of 49 residents, (#100, and #93). Findings: 1. Review of the medical record revealed resident #100 was admitted to the facility on [DATE] from the hospital. Her diagnoses included psychosis and major depressive disorder. Resident #100's Quarterly Minimum Data Set (MDS) with an assessment reference date of 8/02/24 revealed the resident had diagnoses of depression and psychotic disorder. The Quarterly assessment also noted the resident had severely impaired cognitive skills for daily decision making. Review of resident #100's medical record revealed her care plan noted the resident had alteration in thought processes related to psychosis and major depressive disorder. On 8/28/24 at 11:13 AM, the Social Service Director accessed resident #100's Level I PASARR dated 7/30/21, (prior to admission), in the medical record and confirmed it noted a Level II evaluation was required because there was a diagnosis or suspicion of a serious mental illness. The Social Service Director acknowledged she could not locate the Level II PASARR and did not know if one was submitted. She also acknowledged the resident should have had the Level II PASARR prior to admission and did not know why there was not one submitted. On 8/28/24 at 3:17 PM, Director of Nursing (DON) stated she had been working at the facility for 1 year. She conveyed it was the Social Service Director's responsibility to oversee the PASARR process and make sure the facility was compliant. She specified when the Social Service Director was absent, it would be the DONs responsibility to ensure the PASARRs were accurate and submitted timely. She acknowledged a Level I PASARR was required prior to admission and a Level II be submitted when triggered. She confirmed resident #100's Level I PASARR dated 7/30/21 prior to admission triggered a Level II evaluation to be submitted. The DON conveyed she was unable to locate it or know if she had one submitted. She reiterated the Level II should have been submitted in July 2021 prior to the resident being admitted to the facility and was unsure how it was missed. Review of resident #100's PASARR re-submitted on 8/28/24 after it was brought to the Social Service Director's attention noted a Level II evaluation was required because there was a diagnosis or suspicion of a serious mental illness. 2. Review of the medical record revealed resident #93 was admitted to the facility on [DATE] from the hospital. His diagnosis included severe dementia with agitation, bipolar disorder, depressive episodes, anxiety disorder, psychosis, and insomnia. (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	08/30/2024

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #93's Quarterly MDS with an assessment reference date of 6/14/24 revealed the resident had a diagnosis of anxiety disorder, bipolar, psychotic disorder, and schizophrenia. The Quarterly MDS noted the resident received antipsychotic, antianxiety, and antidepressant medications. The Quarterly MDS assessment also noted the resident scored 3 out of 15 on the Brief Interview for Mental Status that indicated he had severe cognitive impairment. Review of resident #93's medical record revealed his care plan noted the resident had cognitive impairment related to schizophrenia, bipolar, general anxiety disorder, and major depressive disorder. On 8/28/24 at 11:30 AM, the Social Service Director stated it was her and the DONs responsibility to ensure the residents' Level I and Level II PASARRs were accurate and submitted timely. She also stated residents were to have Level I PASARRs submitted prior to admission, if a resident was diagnosed with a new mental illness, or if there was a change in condition. The Social Service Director confirmed resident #93 was admitted on [DATE] but was uncertain if a Level I PASARR was submitted prior to admission since she was unable to locate it. She acknowledged the resident's diagnoses included anxiety disorder, bipolar disorder, depressive disorder, insomnia, psychosis, and severe dementia agitation. She also acknowledged a Level I PASARR should have been submitted prior to admission to the facility. On 8/28/24 at 3:25 PM, the DON stated it was the Social Service Director's responsibility to oversee the PASARR process and make sure the facility was compliant with the regulations. She specified when the Social Service Director was absent, it would be the DONs responsibility to ensure that PASARRs were accurate and submitted timely. She also confirmed a Level I PASARR was required prior to admission. She confirmed resident #93 was admitted to the facility on [DATE] and was unable to determine if a Level I PASARR was submitted prior to admission. She acknowledged the Level I should have been submitted prior to admission and was unsure why it was not completed. Facility policy dated 4/01/22 read, It is the facility's policy to assure that all residents admitted to the facility receive a Pre-Admission Screening and Resident Review, in accordance with State and Federal Regulations.

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	08/30/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on interview and record review, the facility failed to develop a comprehensive person-centered care plan for a resident with diabetes for 1 of 5 residents reviewed for high-risk medications, of a total of 49 residents, (#571). Findings: Review of resident #571's medical record revealed she was readmitted to the facility on [DATE] with diagnoses of type 2 diabetes mellitus, lupus, and congestive heart failure. Review of resident #571's Admission Minimum Data Set (MDS) assessment with Assessment Reference Date of 8/04/24 revealed a Brief Interview for Mental Status score of 15 out of 15, which indicated intact cognition. The assessment showed resident #571 received insulin injections. Review of resident #571's physician orders dated 8/20/24 showed medication orders dated the same day for Steglatro 5 milligrams (mg) daily, 24 units of Insulin Glargine two times a day and 10 units of Insulin Lispro with meals for diabetes. Review of resident #571's medical record revealed a comprehensive care plan for diabetes was not developed for the resident after the completion of the admission MDS assessment. On 8/30/24 at 10:51 AM, the MDS Lead explained her responsibilities included to oversee the MDS assessments and development of care plans. Later at 1:41 PM, the MDS Lead indicated the comprehensive care plan included medications and diagnoses. She stated resident #571 had been, in and out of the hospital, since she was admitted to the facility, therefore, a full care plan was not done. She validated a care plan for diabetes was not developed until 8/28/24 and indicated a full care plan should had been developed when the admission MDS assessment was completed. She explained the care plan painted the picture of the resident's needs. She said, It should have been done but it was missed. Review of the facility's policy and procedure titled Resident assessment dated [DATE] read, The results of the assessment will be used to develop, review and revise the resident's comprehensive care plan.

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	08/30/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50875 Based on observation, interview, and record review, the facility failed to provide appropriate care consistent with professional standards of practice, and treatment to promote healing of a sacral pressure ulcer (PU) for 1 of 4 residents reviewed for pressure ulcers, of a total sample of 42 residents, (#42). Findings: Resident #42 was readmitted to the facility on [DATE] with a diagnosis of dysphagia (trouble swallowing) following unspecified cerebrovascular disease, end stage renal disease, need for assistance with personal care, aphasia (difficulty speaking), and unspecified protein-calorie malnutrition. Review of the Minimum Data Set quarterly assessment, with Assessment Reference Date 6/02/24 revealed resident # 42's Brief Mental Status score was 3 out of 15 which indicated severe cognitive impairment. The assessment indicated she had no behaviors or refusal of care and was dependent on staff to roll from left to right. Further review of the assessment showed resident #42 required substantial assistance for personal hygiene; was at risk for developing pressure ulcers, but did not have any pressure ulcers or injuries, or other skin problems at the time of the assessment. On 8/27/24 at 4:22 PM, resident #42 was observed lying on a low air loss mattress with her eyes opened. She did not respond to questions. Review of the Weekly Skin Observations dated 7/06/24 to 8/16/24 showed resident # 42 had no skin issues. On 8/23/24 the Weekly Skin Observation revealed resident #42 had a dialysis port on her right upper chest and an opened area on her buttocks. Review of a change in condition note for 8/23/24 (a late entry dated 8/27/24) revealed, The symptom, sign, change I called about is the following: Left buttocks skin impairment; open area noted. This change started 08/23/2024. Review of the Wound Physician progress note dated 8/23/24 revealed a sacral PU that measured 6 x 3 x 0.3 centimeters (cm) with necrotic adipose (fat tissue) exposed, scant amount of serous drainage, with no odor. The wound bed contained 26-50 % epitheliazation (new layer of skin cells). necrosis 20%, epithelial 30%, dermis 50%. Wound orders included Xeroform, and cover with border dressing every day, as needed. Recommendations included a low-air-loss mattress, float heels, and apply pressure ulcer precautions. Review of the Treatment Administration Record for the month of August 2024 revealed wound treatment per the Wound Physician's orders commenced 8/27/24, three days after the wound was initially found. The physician's order was started on 8/27/24, three days after the Wound Physician's consultation on 8/23/24 with wound orders, which read, Wound #1 Sacral, Cleanse wound Normal Saline Solution. Apply Xeroform, cover with border dressing. (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	08/30/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per the medical record, a care plan for resident #42's skin/wound was also not initiated until 8/27/24 for the pressure ulcer to her sacrum. A Stage 3 pressure ulcer is a Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss, (Retrieved on 9/06/24 from the CMS Appendix PP Manual). On 8/29/24 at 11:49 AM, the [NAME] Unit Manager (UM), stated the facility had a Wound Care Nurse whose sole task was wound care. Once they were notified, about wound care orders, the UM said she assumed they were handled by the Wound Care Nurse whom she said recently resigned. The UM was unsure of when she last checked resident # 42's bottom and had not seen any skin impairments. The UM validated there was no documentation after she saw resident #42's bottom. She recalled she had learned sometime before Friday 8/23/24, the Wound Care Physician needed to see resident #42 but could not recall how she learned of it. The UM stated she saw two residents on [NAME] Unit with the Wound Care Physician on Friday 8/23/24 and one of them was resident #42. She stated the Wound Care Physician debrided resident #42's wound and, placed a pressure gauze or something, then he covered the wound. The UM explained the Wound Care Physician would have given orders later with his consult note however, she found out later that the Wound Care Physician had left the note somewhere on the nurses' station desk. She confirmed the physician orders for resident #42 wound care were not entered or started until 8/27/24, three days after the wound was found and the Wound Physician consulted on the resident's wound. The UM stated it was fair to say resident #42 had not received wound care for a few days and she validated the physician orders were not followed. On 8/30/24 at 11:51 AM, RN L, the former Wound Care Nurse, stated via telephone, she did not recall if she had seen resident #42 or if she had any skin breakdown. Review of Policy and Procedures, Skin Integrity, dated 7/05/23 revealed the objective was to decrease the prevalence and incidence of residents who developed pressure injuries and provide a guideline for optimal care to promote healing to residents with all identified alterations in skin integrity.

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	08/30/2024

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49840 Based on observation, interview, and record review, the facility failed to provide appropriate care for a resident on tube feedings in relation to feeding rate and time for 1 of 1 resident reviewed for tube feedings, of a total sample of 49, (#48). Findings: Resident #48 was readmitted to the facility on [DATE] from an acute care hospital with diagnoses that included metabolic encephalopathy, diabetes mellitus type II, moderate protein-calorie malnutrition, anemia in chronic kidney disease, dysphagia, and vascular dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed resident #48 was severely cognitively impaired and was dependent on staff for all care. Resident #48 had diagnoses listed for aphasia (lost or impaired speech), malnutrition, and gastrostomy status. Services received included feeding tube care and wound care for a stage 3 pressure ulcer. The assessment also indicated he received hospice services. Review of resident #48's order summary report dated 8/28/24 revealed an order for nothing by mouth (NPO) as of 8/07/24. He also had a tube feeding order for Glucerna 1.2 kilocalorie (kcal) to be given daily via percutaneous endoscopic gastrostomy (PEG) tube and feeding pump at a continuous rate of 75 milliliters (ml)/ an hour (hr) for 20 hours. The tube feeding was to be turned off at 10:00 AM and turned back on at 2:00 PM daily. A PEG tube is a tube that allows you to receive nutrition through your stomach if you have difficulty swallowing or can't get enough nutrition by mouth, (retrieved on 9/10/24 from www.clevelandclinic.org). On 8/27/24 at 9:55 AM, resident #48 was in bed with eyes closed and head of bed elevated. He was connected to a feeding pump that was actively running and the feeding bag was labeled Glucerna 1.2 kcal at 75 ml/hr. There was 900 ml out of 1000 ml still left in the bag and the pump was running at a rate of 60 ml/hr. On 8/27/24 at 4:40 PM, resident #48 was in bed with eyes closed and tube feeding turned off. Licensed Practical Nurse (LPN D), stated the tube feeding for resident #48 had been stopped later than 10:00 AM due to staff being busy. She said he was supposed to have a 4-hour break after 20 hours of continuous feeding, so she had a timer going to start the next feeding. LPN D said the facility allowed for medications to be administered 1 hour before or 1 hour later than scheduled to accommodate delays in administration. She acknowledged the feeding was late because it had been stopped at 11:30 AM and it was now 4:20 PM (more than two hours past the scheduled restart time). When questioned about the rate at which the feeding was running, LPN D confirmed the resident had an order to run the feeding at a rate of 75 ml/hr. (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	08/30/2024

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #48's medical record revealed a Mini Nutritional Assessment was completed by the Regional Dietician (RD) on 8/14/24 which recommended continuing Glucerna 1.2 kcal via feeding pump at a rate of 75 ml/hr continuously for 20 hours. Resident #48 had a care plan initiated on 8/09/24 that addressed feedings and skin integrity. Interventions included administer feedings via gastric tube as ordered and encourage good nutrition and hydration to promote healthier skin. On 8/28/24 at 3:17 PM, resident #48's tube feeding was still running at rate of 60 ml/hr. LPN D was asked why the resident's tube feeding was running at 60 ml/hr instead of the physician ordered rate. She stated when she hung the feeding bag, she turned on the machine and that was the rate that was preset. She acknowledged when a resident received an order for tube feeding, the nurse was responsible for hanging the feeding and setting the rate on the feeding pump. LPN D explained for resident #48 she was not the original nurse who received the order so she did not set up the pump. She said she hung the feeding, then turned on the machine but did not verify the rate. LPN D confirmed she had received education on tube feeding care from the facility. On 8/28/24 at 5:23 PM, LPN I, stated she cared for another resident with tube feeding orders. She stated she did not always compare the rate on the feeding pump with the physician order because she knew the resident's orders very well. On 8/28/24 at 5:29 PM, the LPN Unit Manager (UM) for the Keys unit, confirmed resident #48 had physician orders for tube feeding to run at a rate of 75 ml/hr starting at 2:00 PM and ending at 10:00 AM the following day. She said nurses could stop and start the feeding up to 1 hour before or 1 hour after if they were busy, but if there was a longer delay they would need to document the reason and contact the physician. The UM stated it was the nurses' responsibility to verify the order in the medical record, and set the rate on the feeding pumps per the physician order. On 8/28/24 at 5:51 PM, the Director of Nursing (DON) said the expectation was for nurses to follow physician orders when administering enteral (tube) feedings. All nurses received competencies on tube feeding when they were hired. She further explained if the nurse had to delay the feeding for any reason, they should document in the medical record and call the physician. On 8/29/24 at 11:04 AM, the Registered Dietitian explained if a resident was on the incorrect rate for a prolonged period it could cause unintentional weight loss, a calorie deficit, and poor wound healing. The expectation was for nurses to follow the physician orders. Review of the facility's Enteral Feeding policy dated 1/01/22, revealed the licensed nurse was responsible to assure patency of the feeding tube, administration of nutritional products and medications per physician's orders, assessment of the tube and skin site, and documentation of the enteral feeding process. The purpose of this policy was to ensure the safe and effective administration of enteral formulas and medications.

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	08/30/2024

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39943 Based on interview, and record review, the facility failed to ensure the manufacturer's specifications regarding the preparation and administration of an over-the-counter medication was followed to ensure accurate and safe administration of medication for 1 of 1 residents reviewed for dialysis, of a total sample of 49 residents, (#18). Findings: Resident #18 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included pulmonary edema, acute and chronic respiratory failure, lupus, end stage renal disease, congestive heart failure, hypertension, dependence on renal dialysis. Review of resident #18's physician orders revealed an order for Diclofenac Sodium External Gel 1 % (Topical) dated 7/26/24. The order indicated the nurse was to apply to neck topically four times a day for pain. Diclofenac is a Nonsteroidal anti-inflammatory drug (NSAID), people who use NSAIDS such as topical Diclofenac may have a higher risk of having a heart attack or stroke than people who do not use these medications. These events happen without warning and may cause death. You should always use the dosing card to measure out the correct dose of Diclofenac. For the upper body area use 2 grams, (retrieved from www.mayoclinic.org on 8/30/24). Monitor renal function in patients with renal impairment. Avoid use of Diclofenac Sodium gel in paitents with advanced renal disease, (retrieved from www.drugs.com on 9/11/24). On 8/29/24 at 5:29 PM, Licensed Practical Nurse (LPN) M stated resident #18 received Diclofenac topical gel for pain. When asked how she administered the medication to the resident she replied, I squeeze some into a plastic medication cup to take to her room. When asked how much she put in the cup she said about a fourth of the cup. She confirmed she was not aware the medication required a dose in grams and it should be measured prior to use. On 8/29/24 at 5:56 PM, LPN G explained if she was going to administer Diclofenac topical gel, she would remove the tube and squeeze some gel into a little medication cup and take it to the resident's room. When asked if she knew the medication had dosing instructions for upper and lower body parts, she confirmed she was not aware of that and did not know it should be measured before it was put on the resident. On 8/30/24 at 9:03 AM, the Director of Nursing stated Diclofenac topical gel had a dosing stick for nurses to measure the dose of medication. She explained if the dose was not included in the order, pharmacy would usually let us know. She stated the order should have a specific dose to administer. She said, It can't be 2-4 grams because a nurse could not make the determination of how much to apply. The dose should be clarified by the nurse when it is not included in the order. (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	08/30/2024

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/30/24 at 9:32 AM, the Consultant Pharmacist stated, typically the order would have a dose specified, and it would have an amount in grams. If we were dispensing the medication, we would send a fax to the facility to clarify that dose. She explained Diclofenac gel was an over the counter medication so the pharmacy did not supply it to the facility, instead it was in the facility stock. The Pharmacist explained a fax should have been sent to the facility for clarification of the dose, but she explained she could do not confirm whether this process was done. She confirmed if the resident who received the Diclofenac topical gel received dialysis and the dose was not measured, the resident could be at risk for increased side effects of the medication because their kidneys were already compromised. The facility policy, Physician Medication Orders dated 4/01/22 indicated orders for medication must include the name and strength of the drug, quantity or specific duration of therapy, and the dosage and frequency of administration.

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	08/30/2024

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 45646 Based on interview, and record review, the facility failed to ensure the Quality Assessment & Assurance (QAA) / Quality Assurance and Performance Improvement (QAPI) committee conducted performance improvement activities to ensure prior improvement measures were sustained. Findings: Review of the policy and procedure, Quality Assurance and Performance Improvement (QAPI) dated 6/01/21, revealed the facility would take actions aimed at performance improvement and would measure the success of those actions and track performance to ensure that improvements were realized and sustained. The facility had deficiencies cited at F641 for accuracy of assessments and F693 for concerns with tube feeding per physician orders and standards of care during the previous recertification survey conducted 10/17/22 through 10/20/22. During this survey, the facility was found to be in noncompliance with F641 and F693. As a result of these repeat deficiencies, it was identified there was insufficient auditing and oversight to prevent the citation. On 8/30/24 at 2:20 PM, the Administrator stated the facility had a QAPI committee that met monthly. He explained the committee reviewed several areas which included reportable incidents, clinical metrics, care issues, grievances and survey activity to include deficiencies cited. He stated when an issue was identified, the QAPI committee would create a performance improvement plan to address the concern to bring it back into compliance. Concerns from the current survey were reviewed with the Administrator. He acknowledged there were repeat citations from the previous recertification survey and stated, The process failed.

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	08/30/2024

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51023 Based on observation, interview, and record review, the facility failed to ensure residents were able to call for staff assistance through a call bell system for 2 of 2 residents reviewed for call bells, of a total sample of 49 residents, (#71 and #95). On 8/26/24 at 8:59 AM, residents #71 and #95 were observed in their shared room, each lying in their own bed, each, awake and alert. Resident #71 was asked if staff responded in a timely manner when he activated his call bell, and the resident responded, I don't even have a call bell. At that moment, resident #71's roommate, resident #95 stated, Neither do I. Upon observation, both residents' call bells were noted to be attached by a hook to the wall behind the head of their beds, which was out of reach for both residents. Resident #71 was asked what would he do if he needed help, he replied, Yell, I guess. A few minutes later assigned Registered Nurse (RN) E was asked to come to the room. She confirmed the call bells were attached to the walls out of reach of both residents. RN E stated there was no reason the residents should not have their call bells in reach. The nurse then unhooked the call bell from the wall and handed the call bells to each resident. Review of #71's medical record revealed he was admitted on [DATE] with diagnoses including type 2 diabetes mellitus with neuropathy, morbid obesity, repeated falls, dementia, muscle weakness and anxiety disorder. The resident's mobility status revealed he was dependent on staff to roll side to side, as well as a two person assist with a mechanical lift for transfers. Review of #95's medical record revealed the resident was admitted on [DATE] with diagnoses including chronic kidney disease stage 3, cognitive communication deficit, type 2 diabetes, orthostatic hypotension and muscle weakness. The resident's mobility status revealed he needed supervision to roll side to side, as well as a minimum assist of one person with transfers. Review of the facility's call bell policy dated 4/01/22 titled, Call Bells revealed that, . all residents are to have access to call bells at all times, even if it is generally believed that the resident is unable to use it. Staff are expected to be as vigilant as possible in keeping the call bell within reach of the residents. The call system must be accessible to the residents while in their bed.