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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105447	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bedrock Rehabilitation and Nursing Center at West	1851 Elkcam Blvd Deltona, FL 32725

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30969 Based on observations and staff interviews, the facility failed to follow proper sanitation and food handling practices to prevent foodborne illness by failing to ensure: (1) Opened refrigerated foods were labeled and dated; (2) Canned goods received from the vendor and intended for resident consumption were within the manufacturer's expiration date; and (3) Food was prepared and served from a clean, sanitary kitchen. Unsafe food handling and sanitation practices present a potential source of pathogen exposure which could result in foodborne illness. This had the potential to affect all residents who consumed foods from the facility's kitchen. The findings include: During an initial kitchen tour with the Certified Dietary Manager (CDM) on [DATE] at 10:28 AM, the walk-in refrigerator was observed with a large, clear plastic bin containing shredded iceberg lettuce. There was no label or date on the bin. A small cellophane-covered bowl held one half of a cut onion, and a Ziploc baggie contained fresh herbs; however, neither item was labeled or dated. The bread rack in the dry storage room held several loaves of bread that had a manufacturer's date stamp of [DATE]. The hot dog buns manufacturer's date stamp was [DATE]. There was no label to reflect when the baked goods were received by the facility. Inspection of the canned good rack revealed six cans of pineapple tidbits with handwritten dates on each can of [DATE]; however, the manufacturer's expiration date on the cans was [DATE]. (Photographic evidence obtained) The horizontal surface of the table under the food steamer was soiled with debris resembling flour and food crumbs, and the legs of the steamer had build-up resembling lime/scale or rust. Some of the buildup had come off and pooled around the base of the legs. The inside of the drain underneath was coated with wet, black mildew-like matter. The floor tiles in the corner of the kitchen near the walk-in refrigerator were coated with a buildup of a black grimy substance. The drain under the pipes in the corner was surrounded by a wet, black substance that was also built up in large patches on the surface of the drain cover. Similar buildup was seen in the drain under the two-compartment sink. Splatters of dried food and hard water marks were seen on the vertical surfaces of the serving side of the tray-line steam table. The metal cart that housed the juice machine was rusted and soiled. (continued on next page)

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The CDM acknowledged the unlabeled lettuce, onion and herbs in the refrigerator, confirming that each should be dated. She explained that the baked goods were all delivered frozen. She thawed them upon receipt and placed them on the racks for use. She acknowledged that there was no date on the bread or the rack reflecting when the items were received and thawed. The CDM produced an invoice for the last bread delivery, which revealed a delivery date of [DATE], one month ago. The CDM could not locate a delivery slip for the hot dog buns and confirmed that the handwritten date on the pineapple chunks reflected the date they were received and stocked. The CDM also confirmed the manufacturer's date revealed they were all expired upon receipt. She said no one had recognized the products were expired, and had no explanation as to how it was missed. A final walk-through of the kitchen was conducted on [DATE] at 9:40 AM with the CDM. The buildup of drips, debris and crumbs were still evident on the metal table under the food steamer. The floor drain under the steamer was still soiled, and closer inspection revealed the tiles around the drain were loose. Water condensing from the drain was dripping down and pooling under the floor tiles. The exposed side of the ice machine had scale-like drip marks on it, and the juice machine rack was still rusted and soiled. The floor tiles in the corner near the walk-in refrigerator held the same black slimy substance as previously observed. Close inspection of the drain under the 2-compartment sink revealed the same black wet buildup as before. [NAME] sewer flies surrounded and flew in and out of the drain. Drips of dried-on food soiled the vertical surface of the serving side of the tray-line steam table. Food had dripped, pooled and dried on the bottom of the table at the shelf level. The face of the electrical outlet protruding from the floor in front of the the steam table was broken and the housing was coated with a buildup of unknown substance. There was a large piece of white PVC (polyvinyl chloride) pipe next to the outlet that was soiled with brown debris. The CDM explained this pipe was intended to be placed over and cover the floor outlet. (Photographic evidence obtained) The CDM confirmed each of the above findings throughout the tour. She stated housekeeping was responsible for deep-cleaning by pressure washing the kitchen. She had seen this done twice in the last year.

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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** 30969 Based on a review of resident records, resident and resident room observations, and resident and staff interviews, the facility failed to maintain accurate resident records reflective of the care provided for one (Resident #17) of two residents reviewed for wounds, from a total of 34 sampled residents whose records were reviewed. The findings include: A record review for Resident #17 revealed she was admitted to the facility on [DATE]. She had diagnoses including, but not limited to, diabetes mellitus and left foot diabetic ulcer. A Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #17 had a brief interview for mental status (BIMS) score of 13 out of 15 possible points, indicating intact cognition. She was dependent on staff for toileting, dressing and transfers. Resident #17 was care planned on 9/13/24 for compromised skin integrity with an ulcer of the left planter foot. The care plan revealed that she was readmitted status-post graft to the left foot/osteomyelitis (infection of the bone) on 10/25/24. A weekly nursing skin observation, dated 1/25/25 at 2:08 revealed, Sacrum Wound. Left plantar wound, under treatment. Resident #17 had a physician's order dated 12/6/24 for a Multi podus boot (a medical device that suspends or floats the heel and removes pressure from the back of the heel to help heal and prevent ulcers) to left foot when out of bed. She also had an order dated 1/16/25 for wound care to the left planter foot ulcer. Instructions were to clean with normal saline, pat dry, apply collagen sheet to ulcer and cover with a dry dressing. A review of the Treatment Administration Record (TAR) found the multi podus boot for the left foot when out of bed was signed off as having been worn daily on every shift up to 1/28/25. (Photographic evidence obtained) A review of the certified nursing assistant (CNA) task records also reflected that the boot was worn every day. (Photographic evidence obtained) An interview was conducted with Resident #17 on 1/27/25 at 2:19 PM. She stated her heel had been hurting and she had a history of facility-acquired pressure ulcers, but they had resolved. With consent from Resident #17, the affected left heel was observed by the Registered Nurse Specialist surveyor. Resident #17 had a sock on that foot, which was pulled back to reveal an unbandaged wound on the bottom center of her left heel. The wound was approximately quarter-sized in diameter with a deep red wound bed and raised white border. The left foot was swollen. (Photographic evidence obtained) Resident #17 explained that she required assistance with putting her sock on that foot. There was no multi podus boot on her left foot. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #17 was observed daily in the west and front hall throughout the survey between 1/27/25 and 1/30/25. At at no time did she have a multi podus boot on her left foot; she only wore socks. An interview was conducted with CNA A on 1/29/25 at 3:42 PM in Resident #17's room. She was asked where Resident #17's multi podus boot was. CNA A said there was no boot, only a padded footrest. She said she often put a pillow under Resident #17's left foot. Resident #17, also in the room, confirmed there was no multi podus boot. She said there used to be one, but not any more. She did not have one. With consent from Resident #17, a search of the room, including the closet and drawers, revealed no multi podus boot. The wound care doctor (WCD) was interviewed on 1/30/25 at 4:01 PM. He stated Resident #17 had a partial calconectomy (a surgical procedure that removes infected or non-viable tissue from the heel bone) before he took over management of her heel wound. He was not sure if he was the ordering physician for the multi podus boot. When asked if she wore the boot, he stated, in a perfect world, but she has rights. He stated Resident #17 worse than refuses to wear the boot. The WCD stated Resident #17 had hydrocephalus (a build-up of fluid in the cavities deep within the brain) and a decline in executive function. She still, however, made her own decisions. The WCD was advised that CNAs and nurses were documenting that the boot was in place daily; however, she had not been observed wearing the boot during the four-day survey. The WCD replied that Resident #17 was resistant to most offloading interventions; We just cant do the things we used to be able to do twenty years ago. The wound care nurse/licensed practical nurse was interviewed on 1/30/25 at 4:10 PM. He stated he had not seen Resident #17 wearing the multi podus boot; she refused. He had no comment about staff signing that the boot was being worn daily.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 50369 Based on facility record review, staff interview, and facility policy and procedure review, the facility failed to develop and implement a comprehensive water management program for the purpose of reducing the risk of growth and spread of Legionella and other opportunistic pathogens in the facility water system. Residents of nursing homes who may suffer from a weakened immune system, chronic lung disease, or other underlying medical conditions such as immunosuppression, are at risk for Legionnaires' Disease (type of pneumonia) if exposed to Legionella bacteria. This had the potential to affect all residents residing in the facility. Facilities must be able to demonstrate their measures to minimize the risk of Legionella and other opportunistic pathogens in building water systems such as by having a documented water management program that must be based on nationally accepted standards. The program must include an assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread; measures to prevent the growth of opportunistic waterborne pathogens (control measures), and how to monitor them. The findings include: A review of the facility's water management program revealed a copy of the Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings, A Practical Guide to Implementing Industry Standards by the U.S. Department of Health and Human Services Centers for Disease Control (CDC) and Prevention, dated 06/05/2017. Page two contained a guide form to Identify Buildings at Increased Risk. This form was left blank. A review of the CDC tool kit, on pages 3 and 23 revealed, Identified control measures: Things you do in your building water systems to limit growth and spread of Legionella, such as heating, adding disinfectant, or cleaning. Control limits: The maximum value, minimum value, or range of values that are acceptable for the control measures that you are monitoring to reduce the risk for Legionella growth and spread. Control points: Locations in the water systems where a control measure can be applied. Disinfectant: Chemical or physical treatment used to kill germs, such as chlorine, monochloramine, chlorine dioxide, copper-silver ionization, ultraviolet light, or ozone (Photographic evidence obtained) The water management program contained drawings showing water flow throughout the facility, resident room water temperature checks, flushing dates for the water pipes, and pressure relief valve checks. The program did not include control measures for preventing Legionella growth. It did not include points in the system where critical limits of the antigen could be monitored or where control could be applied. There were no physical controls or protocols, such as testing of the water's disinfectant levels and pH, performing visual inspections, or environmental testing for pathogens. There were no acceptable ranges or control measures within the water management plan. The Regional Maintenance Director was interviewed on 01/28/25 at 11:00 AM. He stated they did not do any water or Legionella testing in the facility, as it was not required by the Centers for Disease Control. He then produced a diagram of the water lines for both hot and cold water. The diagram did not identify the areas where Legionella could potentially grow and spread. (Photographic evidence obtained) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the Director of Maintenance on 01/30/25 at 02:30 PM, he confirmed that he had received no training on the water management program, and confirmed that water testing had not been done since he was hired in March 2024. He stated he had no testing kit for the disinfectant levels in the water. A review of the facility's policy and procedure titled Infection Control Prevention and Control Program, section 13, Water Management (effective 02/21/23) revealed: A water management program has been established as part of the overall infection prevention and control program. Control measures and testing protocols are in place to address potential hazards associated with the facility's water systems. The Maintenance Director serves as the leader of the water management program. (Photographic evidence obtained) There were no guidelines within the policy for identifying or testing for Legionella.