

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105458	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Ormond Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  103 Clyde Morris Blvd Ormond Beach, FL 32174	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41837</p> <p>Based on observations, interviews, and record reviews, the facility failed to treat residents in a dignified manner while providing care and services for 3 of 22 sampled residents (Residents #15, #38, and #247).</p> <p>The findings include:</p> <p>1. A review of Resident #15's medical record revealed that the resident was originally admitted to the facility on [DATE] with a diagnosis of acute respiratory failure with hypoxia.</p> <p>A review of the resident's Minimum Data Set (MDS) assessment, dated 03/15/24, revealed in Section C a Brief Interview for Mental Status (BIMS) score of 3 out of 15 possible points, indicating severe cognitive impairment.</p> <p>On 05/20/24 at 9:29 AM, an observation was made of Licensed Practical Nurse (LPN) J administering medications in the hallway to Resident #15, who was located next to the medication cart outside of room [ROOM NUMBER].</p> <p>During an interview with LPN J on 05/23/24 at 11:30 AM, she stated she had worked at the facility for three years. When asked if medications were administered to the residents in the hallway, she said, You're not supposed to administer meds in the hallway.</p> <p>2. A review of Resident #38's medical record revealed that the resident was admitted to the facility on [DATE] with a diagnosis of displaced fracture of lateral end of left clavicle subsequent encounter for fracture with routine healing.</p> <p>A review of the resident's MDS assessment, dated 05/07/23, revealed in Section C a BIMS score of 10/15, indicating moderate cognitive impairment.</p> <p>On 05/20/24 at 9:43 AM, an observation was made of RN M administering medications in the hallway to Resident #38, who was located next to the medication cart outside of room [ROOM NUMBER].</p> <p>3. A review of Resident #247's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including sepsis and abscess of liver.</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
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the resident's MDS assessment, dated 05/02/24, revealed in Section C a BIMS score of 12/15, indicating moderate cognitive impairment.</p> <p>On 05/20/24 at 2:25 PM, an observation was made of RN I gathering supplies outside of Resident #247's room. She went into the room. RN I was observed changing the dressing on Resident # 247's abdomen. She removed the old dressing, cleaned around the entry site of the abdominal drain, applied gauze, placed four pieces of paper tape around the gauze, applied a fifth piece of paper tape over the dressing and said, Now I will sign and date it. RN I then proceeded to write on the dressing located on the resident with a marker to sign and date the abdominal dressing.</p> <p>During an interview with RN I on 05/23/24 at 12:05 PM, she stated she had worked at the facility almost one year. When asked how the nurses were expected sign and date a dressing, she said, You should sign and date a piece of tape and then apply it to the resident after the wound care is completed. When asked if medications were ever administered in the hallway, she said, No, we do not do that. The medications are given in the resident's room.</p> <p>A review of the facility's policy titled Dignity (dated 08/22/22) revealed in part: Treat each resident with respect and dignity with regards to the following:</p> <p>Personal Care</p> <p>During medication and treatment opportunities</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39026</p> <p>Based on observation, interviews, policy and record review, the facility failed to provide showers per resident preference for 1 of 3 residents sampled for shower choices (Resident #146).</p> <p>The findings included:</p> <p>On 05/20/24 at 11:17 AM, Resident #146 was interviewed. She stated she was not given a choice of the number of showers she could receive. She was told that her shower days were Wednesdays and Saturdays on the 3-11 shift. She was not given a preference of whether she wanted a morning or evening shower, or if she wanted to have a shower more than twice a week. She said she would like more showers but was not given that option.</p> <p>A review of Resident #146's medical record revealed that she was admitted to the facility on [DATE] with diagnoses including congestive heart failure, Type 2 diabetes, and hypertension. Her Brief Interview for Mental Status (BIMS) score was 15 out of 15 possible points on the Resident Interview &amp; Staff Assessment, dated 05/16/24. This indicated the resident was cognitively intact.</p> <p>A review of bathing preferences in the task section of the electronic health record (EHR), revealed that the resident was given one shower on 05/18/24. On 05/23/24 at 2:00 PM, during an interview with the Director of Nursing, she was asked if there was any other documentation that would show that the resident had received showers, and she replied that all documentation was electronic and the certified nursing assistants (CNAs) charted showers in the task section of the EHR.</p> <p>A review of the facility's policy titled Activities of Daily Living (ADLS)/Maintain Abilities (dated 8/2022), revealed: Residents have the right to choose their schedules, consistent with their interests, assessments, and care plans. This includes, but is not limited to, choices about the schedules that are important to the resident, such as waking, eating, bathing, and going to bed at night.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41837</p> <p>Based on observations, interviews, and record review, the facility failed to maintain a safe, sanitary, and homelike environment for two (one across from room [ROOM NUMBER] and the other across from room [ROOM NUMBER]) of two shower rooms and 5 of 38 resident rooms, affecting Residents #12, #146, #248, #247, and #197.</p> <p>The findings include:</p> <p>On 05/20/24 at 9:45 AM, an observation was made in Resident #12's room of the wall behind the bed with peeling paint, and the light fixture on the wall behind the head of the bed with one of three light bulbs not working.</p> <p>On 05/20/24 at 10:00 AM, an observation was made in Resident #146's room of walls and baseboards with peeling paint, and the light fixture on the wall behind the head of the bed with two of three light bulbs not working.</p> <p>On 05/20/24 at 10:16 AM an observation was made in Resident #248's room of the wall behind the head of the bed with mismatched paint, and the light fixture on wall behind the head of the bed with one of three light bulbs not working.</p> <p>On 05/20/24 at 1:30 PM, an observation was made in Resident #247's room of the light fixture on wall behind the head of the bed with one of three light bulbs not working.</p> <p>On 05/20/24 at 9:56 AM, an observation was made in Resident #197's room of the floor around and behind the resident's bed with debris and disposable food packaging.</p> <p>On 05/21/24 at 10:20 AM, an observation was made in the shower room (central bath) located across from room [ROOM NUMBER]. The shower had loose tiles on the floor below the shower head, and there was black biological growth on the shower floor between the tiles and where the tiles met the wall in the shower.</p> <p>On 05/21/24 at 10:25 AM, an observation was made in the shower room (central bath) located across from room [ROOM NUMBER]. The shower room had an overwhelming odor of urine; there was a hair brush in the sink; a used brief in a plastic bag on the floor next to the sink; and personal belongings and towels in a plastic bag on the shower floor. Black biological growth was observed on the tile on the shower floor, between the floor tiles, and along the wall/floor. The fluorescent light fixture between the shower and the toilet was not working, and the lock to the shower room/central bath did not lock.</p> <p>During an interview with Resident #197 on 05/20/24 at 9:56 AM, she stated she was admitted to the facility a few weeks ago. She said she told staff multiple times about the dirt and debris around the room and behind the bed, but nothing had been done thus far.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Director of Housekeeping (DOH) on 05/21/24 at 10:30 AM, he stated he had worked at the facility for five years. He acknowledged that the shower room smelled of urine and had dirty items on the floor and in the sink. He also acknowledged that the flourescent light fixture was not working and that he would contact maintenance to repair the light and look at the door lock.</p> <p>During an interview with the DOH and with the Director of Maintenance (DOM) on 05/23/24 at 9:20 AM while doing an environmental facility tour, the DOM stated he had worked at the facility a little over a year. He stated they were ordering light bulbs that had a lower wattage, so they were not so bright if the resident did not like the lights to be so bright. The DOH and DOM said they were working together on repairing walls and painting as residents were discharged from their rooms. The DOH said they would work with nursing to ensure that when residents got out of bed, they could move the beds away from the wall to clean behind the bed. The DOM said they made room rounds daily to ensure equipment and the environment was maintained. The DOH and DOM stated they were working on getting the shower floors cleaned.</p> <p>A review of the facility's policy titled Environmental Services (dated 08/2022) revealed in part:</p> <ol style="list-style-type: none"> <li>1. The facility will maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner.</li> <li>2. The facility will provide a safe, clean, comfortable, and homelike environment, which allows the resident to use his or her personal belongings to the extent possible.</li> <li>3. The facility will provide:             <ol style="list-style-type: none"> <li>a. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</li> <li>d. Adequate and comfortable lighting levels in all areas.</li> </ol> </li> </ol>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41837</p> <p>Based on interviews and record reviews, the facility failed to 1) Implement a smoking care plan for two (Residents #7 and #28) of 22 sampled residents, and 2) Implement an Enhanced Barrier Precaution (EBP) care plan for one (Resident #247) of 22 sampled residents.</p> <p>The findings include:</p> <p>1. Record review for Resident #7 revealed the resident was admitted to the facility on [DATE] with diagnoses that included Synovitis and Tenosynovitis and Generalized Anxiety Disorder.</p> <p>Review of the Minimum Data Set (MDS) for Resident #7 dated 03/18/24 revealed in Section C a Brief Interview of Mental Status (BIMS) score of 15 indicating a cognitive response.</p> <p>Review of the Smoking Evaluation for Resident #7 dated 05/22/24 documented in Section AA, Is resident a smoker - yes.</p> <p>Review of the Care Plan for Resident #7 dated 05/22/24 with a focus on the resident smokes when signed out off of the property. The goal was for the resident to continue to be a safe smoker throughout next review date. The interventions included: Encourage good oral hygiene. Instruct resident about smoking risks and hazards and about smoking cessation aids that are available. Resident educated on properly storing smoking materials. Smoking evaluation completed as needed.</p> <p>During an interview conducted on 05/22/24 at 1:50 PM with Resident #7 who was asked if he smokes, he said yes, he signs himself out and goes to the facility next door. When asked what he smokes, he said cigarettes. When asked where are the cigarettes and lighter kept, he said they are hidden in his closet. When asked is the closet was locked, he said no. When asked how long he has been smoking at the facility, he said it was for months.</p> <p>2. Record review for Resident #28 revealed the resident was admitted to facility on 12/29/23 with diagnoses that included: Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation, Major Depressive Disorder, and Tobacco Use.</p> <p>Review of the MDS for Resident #28 dated 04/04/24 revealed in Section C a BIMS score of 15 indicating a cognitive response.</p> <p>Review of the Smoking Evaluation for Resident #28 dated 5/22/24 documented in Section AA, Is resident a smoker - yes.</p> <p>Review of the care plan for Resident #28 dated 05/22/24 with a focus on the resident smokes while off of property. The goal was for resident to remain a safe smoker while off of property through the next review date. The interventions included: Complete smoking evaluation as needed. Educate resident regarding smoking risks and hazards and about smoking cessation aids that are available. Encourage good oral hygiene. Resident educated on proper storage of smoking materials.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/20/24 at 9:18 AM during the facility entrance conference with the Administrator, when asked if they have any residents who smoke, she stated this is a non-smoking facility.</p> <p>During an interview conducted on 05/22/24 at 1:20 PM with Resident #28 who was asked if he smokes, the resident said yes, but he signs himself out of the facility to smoke on the property next door. When asked what he smokes, he said cigarettes, it helps calm his nerves. When asked how long he has been smoking, he said since before he came here. When asked where the cigarettes and lighter are kept, he refused to answer and stated, I don't want to talk to you, if you have any more questions, you can talk to my lawyer.</p> <p>During an interview conducted on 05/22/24 at 1:40 PM with the Administrator, who was asked if they have any residents who smoke, she said yes, 2, they sign themselves out of the facility and go to the Assisted Living Facility's property next door to smoke. She added they are both alert and oriented and all that. The Administrator said we are a smoke free facility, so residents are not allowed to smoke on our property. The Administrator said she sees the residents smoking on the other property but has no idea who holds their cigarettes or lighters.</p> <p>During an interview conducted on 05/22/24 at 1:57 PM with the Director of Nursing (DON) who stated they are a non-smoking facility they have 1 resident who admits to smoking but they have never seen cigarettes or lighter on the resident or in the resident's room. They have another resident they suspect smokes, because the resident sometimes smells like cigarettes, but the resident denies he smokes. The DON said they are a non-smoking facility, and residents have the right to sign themselves out of the facility to smoke off the property. When asked about who keeps the cigarettes and lighters, she said they do not keep the items. When asked if residents were evaluated for safe smoking, she said no, because they are a non-smoking facility.</p> <p>During an interview conducted on 05/22/24 at 2:20 PM with the Administrator who stated the smoking policy in the Admission Packet was incorrect and provided the new smoking policy.</p> <p>3. Record review for Resident #247 revealed the resident was admitted to the facility on [DATE] with diagnoses that included Sepsis and Abscess of Liver.</p> <p>Review of the MDS for Resident #247 dated 05/02/24 revealed in Section C a BIMS score of 12 indicating moderate cognitive impairment.</p> <p>Review of the Care Plan for Resident #247 dated 4/29/24 with a focus on the resident is on ABT (Antibiotic) IV (Intravenous) Medications related to infection via PICC (Peripherally Inserted Central Catheter) line to LUE (Left upper extremity). The goal was for the resident to not have any complications related to IV Therapy through the review date. The intervention included EBP when providing care per facility protocol was created/added to the care plan on 05/20/24.</p> <p>Review of the Care Plan for Resident #247 dated 05/02/24 with a focus on the resident has liver abscess infection w/ drain in place. The goal was for the resident to be free from s/sx of liver complications, including infection, abnormal or unexplained bleeding, malnutrition, anemia, cognitive decline, or mental status changes by review date. The intervention included EBP when providing care per facility protocol created/added to the care plan on 5/20/224.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Care Plan for Resident #247 dated 05/09/24 with a focus on the resident has actual impairment to skin integrity to coccyx. The goal was for the resident to be free from injury through the review date. The interventions included: Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Group 2 mattress for wound healing on coccyx. Roho cushion to wheelchair. Ensure cushion in place when resident using wheelchair. There was no intervention for EBP when providing care per facility protocol.</p> <p>Review of the facility's policy titled Care Plan - Comprehensive dated January 2023 included in part: A Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychological needs shall be developed for each resident. An Interdisciplinary Team in coordination with the resident, his/her family or representative develops and maintains a Comprehensive Care Plan for each resident. The Comprehensive Care Plan has been designed to: Incorporate identified problem areas, incorporate risk factors associated with identified problems. The resident's Comprehensive Care Plan is developed within seven (7) days of the completion of the resident assessment or within twenty-one (21) days after the resident's admission, whichever occurs first. Care plans are revised as changes in the resident's condition dictate. Reviews are made at least quarterly.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837</b></p> <p>Based on interviews and record reviews the facility failed to identify a pressure ulcer on admission for 1 of 1 residents sampled for pressure ulcers (Resident #247).</p> <p>The findings included:</p> <p>Review of the facility's policy titled: Pressure Injury Protocol dated 02/17/18 included the following in part: All residents will be assessed for their risk of developing pressure injury using a standardized and approved assessment tool upon admission and periodically throughout their stay. Residents with an existing pressure injury and those with a history of pressure injury fall into the category of High Risk for development of further pressure injuries. An appropriate interdisciplinary plan of care will be developed within 72 hours of admission to reduce the risk of pressure injury and aid in the prevention of new pressure injuries.</p> <p>Record review for Resident #247 revealed the resident was admitted to the facility on [DATE] with diagnoses included: Other Gram-Negative Sepsis and Abscess of Liver.</p> <p>Review of the Minimum Data Set for Resident #247 dated 05/02/24 revealed in Section C a Brief Interview of Mental Status score of 12 indicating moderate cognitive impairment. Documented in Section M was the following: Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device? The answer documented to this question was no. Is this resident at risk of developing pressure ulcers/injuries? The answer documented to this question was yes. Does this resident have one or more unhealed pressure ulcers/injuries? The answer documented to this question was no.</p> <p>Review of the Physician's Orders for Resident #247 revealed an order dated 05/07/24 for Wound care Consult two times a day for Evaluation and Treatment of Coccyx area.</p> <p>Review of the Physician's Order for Resident #247 revealed an order dated 05/09/24 to cleanse coccyx with NS (Normal Saline) and pat dry. Apply honey, collagen, and calcium alginate. Cover with dry dressing, one time a day for wound care.</p> <p>Review of NSG (Nursing) Admission/Readmission for Resident #247 dated 04/27/24 under Skin Alterations Present pressure ulcers was not documented.</p> <p>Review of the Admission/readmission summary for Resident #247 dated 04/27/24 documented Skin alterations noted on admission/readmission (if present):Abdomen - Surgical Incision: Width - Stage Unstageable, Left knee (front) - Other (specify): scab: Right knee (front), Other (specify): scab.</p> <p>The Acute Visit authored by the Nurse Practitioner for Resident #247 dated 05/07/24 documented resident was seen, 05/07/2024, per nurse request for a possible stage II pressure injury on his coccyx area. Noted stage II pressure injury on coccyx area. Skin pink and warm to the touch. Assessment and Plan: Pressure ulcer of coccyx , unstageable *: Zinc Oxide External Ointment 10% - Applied topically to coccyx two times a day. Advised patient to lay on his side to relieve pressure.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Weekly Skin Integrity review for Resident #247 dated 05/02/24 documented under current skin condition included:</p> <p>Left knee (front)-scab/ redness.</p> <p>Right knee (front)- redness</p> <p>Right iliac crest (front)-drain</p> <p>Left antecubital-iv site</p> <p>Right buttock-red/dry</p> <p>The Weekly Skin Integrity review for resident #247 dated 05/09/24 documented under current skin condition: Sacrum-open area</p> <p>Review of the Care Plan for Resident # 247 with an initiated date of 4/27/24 with a focus on the resident has potential/actual impairment to skin integrity was revised on 05/09/24 to the resident has potential/actual impairment to skin integrity to coccyx. The goal was for the resident to be free from injury through the review date. The interventions included: Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Group 2 mattress for wound healing on coccyx. Roho cushion to wheelchair. Ensure cushion in place when resident using wheelchair. There was no intervention for EBP when providing care per facility protocol.</p> <p>During an interview conducted on 05/22/24 at 2:00 PM with the Director of Nursing (DON) who was asked if the facility had any residents with acquired pressure ulcers, she said no. When asked about Resident #247, the DON said the resident was admitted with several wounds. The DON acknowledged there was no documentation of a coccyx or sacral wound on admission. The DON also acknowledged the documentation for the coccyx pressure ulcer was identified after the resident was admitted to the facility.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41837</p> <p>Based on interviews and record reviews the facility failed to identify and evaluate residents who smoke for 2 out of 55 residents who were identified for smoking (Residents #7 and #28).</p> <p>The findings included:</p> <p>Review of the facility's policy titled Free of Accident Hazards/Supervision/Devices dated 08/2022 included in part: It is the policy of this facility to ensure it provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes Identifying hazard(s) and risk(s), evaluating and analyzing hazard(s) and risk(s), implementing interventions to reduce hazard(s) and risk(s), and monitoring for effectiveness and modifying interventions when necessary.</p> <p>Review of the facility's policy titled: Smoke Free Facility Policy with no date included in part: The facility shall establish and maintain a smoke-free environment, inclusive of all tobacco products and electronic cigarettes (E-Cigarettes). Procedure:</p> <ol style="list-style-type: none"> <li>1. A non-smoking policy shall be enforced for all staff and residents.</li> <li>4. Upon admission, the resident's smoking history will be taken and the facility smoking policy shall be explained to the resident. If needed, a resident centered care plan is to be put in place by the interdisciplinary team.</li> <li>1. Record review for Resident #7 revealed the resident was admitted to the facility on [DATE] with diagnoses that included Synovitis and Tenosynovitis and Generalized Anxiety Disorder.</li> </ol> <p>Review of the Minimum Data Set (MDS) for Resident #7 dated 03/18/24 revealed in Section C a Brief Interview of Mental Status (BIMS) score of 15 indicating a cognitive response.</p> <p>Record review for Resident #7 revealed no Nursing Admission/Readmission for the resident.</p> <p>Review of the Admission/Readmission Summary for Resident #7 dated 12/08/23 included: Has recently quit smoking in the past 0-6 months.</p> <p>Review of the Smoking Evaluation for Resident #7 dated 05/22/24 is documented in Section AA, Is resident a smoker - yes.</p> <p>Review of the Care Plan for Resident #7 dated 05/22/24 with a focus on the resident smokes when signed out off of the property. The goal was for the resident to continue to be a safe smoker throughout next review date. The interventions included: Encourage good oral hygiene. Instruct resident about smoking risks and hazards and about smoking cessation aids that are available. Resident educated on properly storing smoking materials. Smoking evaluation completed as needed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview conducted on 05/22/24 at 1:50 PM with Resident #7 who was asked if he smokes, he said yes, he signs himself out and goes to the facility next door. When asked what he smokes, he said cigarettes. When asked where are the cigarettes and lighter kept, he said they are hidden in his closet. When asked if the closet was locked, he said no. When asked how long he has been smoking at the facility, he said he has been for months.</p> <p>2. Record review for Resident #28 was admitted to facility on 12/29/23 with diagnoses that included: Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation, Major Depressive Disorder, and Tobacco Use.</p> <p>Review of the MDS for Resident #28 dated 04/04/24 revealed in Section C BIMS 15 indicating a cognitive response.</p> <p>Review of the Nursing Admission/Readmission for Resident #28 dated 12/29/23 documented under Section Smoke/Smoking Eval: Is resident a smoker - no.</p> <p>Review of the Smoking Evaluation for Resident #28 dated 5/22/24 is documented in Section AA, Is resident a smoker - yes.</p> <p>Review of the care plan for Resident #28 dated 05/22/24 with a focus on the resident smokes while off of property. The goal was for resident to remain a safe smoker while off of property through the next review date. The interventions included: Complete smoking evaluation as needed. Educate resident regarding smoking risks and hazards and about smoking cessation aids that are available. Encourage good oral hygiene. Resident educated on proper storage of smoking materials.</p> <p>On 05/20/24 at 9:18 AM during the facility entrance conference with the Administrator, when asked if they have any residents who smoke, she stated this is a non-smoking facility.</p> <p>During an interview conducted on 05/22/24 at 1:20 PM with Resident #28 who was asked if he smokes, the resident said yes, but he signs himself out to smoke on the property for the Assisted Living Facility next door. When asked what he smokes, he said cigarettes, it helps calm his nerves. When asked how long he has been smoking at the facility, he said since he has been here it helps calm his nerves. When asked where the cigarettes are kept, he refused to answer. When asked if he had a lighter for the cigarettes, he said I don't want to talk to you, if you have any questions, you can talk to my lawyer.</p> <p>During an interview conducted on 05/22/24 at 1:40 PM with the Administrator, who was asked if they have any residents who smoke, she said yes, 2, they sign themselves out of the facility and go to the Assisted Living Facility's property next door to smoke. She added they are both alert and oriented and all that. The Administrator said we are a smoke free facility, so residents are not allowed to smoke on our property. The Administrator said she sees the residents smoking on the other property but has no idea who holds their cigarettes or lighters.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview conducted on 05/22/24 at 1:57 PM with the Director of Nursing (DON) who stated they are a non-smoking facility they have 1 resident who admits to smoking but they have never seen cigarettes or lighter on the resident or in the resident's room. They have another resident they suspect smokes, because the resident sometimes smells like cigarettes, but the resident denies he smokes. The DON said they are a non-smoking facility, and residents have the right to sign themselves out of the facility to smoke off the property. When asked about who keeps the cigarettes and lighters, she said they do not keep the items. When asked if residents were evaluated for safe smoking, she said no, because they are a non-smoking facility.</p> <p>During an interview conducted on 05/22/24 at 2:20 PM with the Administrator who stated the smoking policy in the Admission Packet was incorrect and provided the new smoking policy.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39026</p> <p>Based on observation, interviews, record review and policy review, the facility failed to provide an anchor for catheter tubing for 1 of 1 resident observed for catheter care (Resident #25).</p> <p>The findings included:</p> <p>The policy of the facility titled Catheter Care, Urinary dated April 2022 revealed Key Procedural Points . Check to see that the catheter remains secured with a leg strap, if applicable, to reduce friction and movement at the insertion site. and Steps in the procedure Secure catheter utilizing a leg band, if applicable.</p> <p>Resident #25 was admitted to the facility on [DATE] with diagnoses that included Unspecified fracture of second thoracic vertebra, Hypertension, and Neuromuscular dysfunction of the bladder. Her Brief Interview for Mental Status (BIMS) score was 15 on the quarterly Minimum Data Set with an assessment reference date of 03/29/24. This indicated the resident was cognitively intact.</p> <p>A review of the physician's orders for catheter care for Resident #25 revealed an order for Urinary Catheter: Change Catheter Anchor and urine bag every night shift every Sun for urine catheter.</p> <p>On 05/23/24 at 1:40 PM Foley catheter care was observed on Resident #25 with Staff H, a certified nursing assistant (CNA). Staff H cleansed the perineal area around the tubing on the Foley catheter and cleansed the tubing with soap and water. She dried the tubing with a towel. During the observation of catheter care, there was no anchor for the tubing either before the care was done or after. An interview was conducted with Staff H immediately after catheter care was completed asking if she had an anchor for the catheter. Staff H stated that she did not have an anchor.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153</b></p> <p>Based on observations, interviews, and record reviews, the facility failed to identify a significant weight loss and provide nutritional interventions in a timely manner for 2 of 5 residents reviewed for nutrition (Resident #10 and Resident #199).</p> <p>The findings included:</p> <p>A review of the facility ' s policy titled Weighing and Weight at-risk protocol dated April 2022, showed the following: Complete all weights with re-weights on the following parameters: 0-175 pounds-variances of 4 pounds for loss or gain. Nursing and Dietitian to review weights for significant weight loss and at-risk weight loss and determining variances with re-weights as noted above. Interventions in place: notify the Dietitian of newly identified significant weight loss, review the needs for fortified foods, diet liberalization, frequent foods that the Resident likes, and frequent meals or snacks. It further showed that intakes should be reviewed at a minimum weekly, and the narrative documentation should include areas identified and measures put in place to show interventions.</p> <p>1. Resident #10 was admitted to the facility on [DATE] with diagnoses of Dysphagia, Sepsis, and Muscle Weakness. The Order Summary Report revealed the following orders: health shake three times a day, dated 04/21/24 (seven days after Resident #10 ' s admission); night snack at bedtime, dated 05/02/24; and a diet order for a mechanically chopped diet with nectar thick consistency, dated 04/14/24.</p> <p>A review of Resident #10 ' s weights showed the following: a weight of 118 pounds on 04/14/24, a weight of 102 pounds on 04/18/24, a weight of 98.1 pounds on 05/02/24, a weight of 99.4 pounds on 05/09/24 and a weight of 101 pounds on 05/16/24. This showed a 13.5% severe weight loss from 04/14/24 to 04/18.24 and a severe 16.86% weight loss from 04/14/24 to 05/02/24.</p> <p>In an observation conducted on 05/22/24 at 8:59 AM, Resident #10 finished her breakfast meal. She ate some of her French toast but did not touch any of her ham, hot cereal, or house shake.</p> <p>In an observation conducted on 05/22/24 at 12:00 PM, the lunch tray was brought into Resident #10 ' s room and was set up for her. The tray was filled with ground turkey, mashed sweet potato, and ground vegetables. At 12:17 PM, the Resident ate 20% of her lunch meal but did not drink any of her house shakes.</p> <p>The Initial Nutrition Evaluation dated 04/18/24 showed the following: Resident #10 ' s admission weight was noted at 118 pounds which matched the hospital admission weight that was recorded on admission. Resident #10 ' s Usual Body Weight was noted at 125 pounds, and her meal intake was noted between 26% to 75% of her meals. No other nutritional assessment or notes were completed after 04/18/24 addressing the severe weight loss for Resident #10.</p> <p>The Certified Nursing Assistants' documentation of meal intake revealed that from 04/14/24 to 05/21/24, Resident #10 consumed 100 meals between 40.6% and 64%.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Minimum Data Set (MDS) dated [DATE] revealed that Resident #10 has a Brief Interview of Mental Status (BIMS) score of 05, which is severely cognitively impaired. The Care Plan, which was initiated on 04/29/24, showed that Resident #10 was at risk for dehydration, suboptimal intake, and malnutrition. A registered dietitian will evaluate and make recommendations as needed.</p> <p>In an interview conducted on 05/21/24 at 3:45 PM with the facility 's Registered Dietitian, she stated that 5% weight loss in less than a month is considered severe. There is a Weight Exception log that she runs to identify any weight changes with gains or losses that are triggered in the parameters that are in the electronic system. She runs the report once a week and will follow up to address the weight loss and reassess the nutritional needs. When asked if she noticed the severe weight loss that Resident #10 had from 04/14/24 to 04/18/24, she said no. When asked if she knew that Resident #10 had a significant weight loss, she said, I do not see it in my notes. She further said it was not on her list for residents with severe weight loss who needed to be seen.</p> <p>2. A record review showed that Resident #199 was admitted to the facility on [DATE] with diagnoses of severe protein-calorie malnutrition, muscle weakness, and respiratory failure.</p> <p>In an observation conducted on 05/20/24 at 12:03 PM, the staff brought the lunch tray into Resident #199's room. The observation continued at 12:15 PM, which showed that Resident #199 did not eat anything on his lunch tray. In this observation, Resident #199 said, I am in pain and have nausea.</p> <p>In an observation conducted on 05/20/24 at 12:35 PM, Resident #199 did not touch any food on his lunch tray. During this observation, Resident #199 asked the Surveyor if they could take his lunch tray out of the room.</p> <p>In an observation conducted on 05/21/24 at 8:50 AM, Resident #199 was noted in his room with a breakfast tray of only 10% consumed. In this observation, Resident #199 was asked how his appetite was, and he said, I have no appetite. He further stated that his stomach was hurting and he was not feeling well. When asked by Surveyor if he knew his current body weight, he said that the last time they took his weight was in the hospital. Resident #199 stated that his weight used to be 170 pounds.</p> <p>A review of the weight log showed the following weights recorded: 161 pounds on 05/04/25 and 149.8 pounds on 05/07/24. This shows a 6.9% severe weight loss from 05/04/24 to 05/07/24.</p> <p>The Initial Nutrition assessment dated [DATE] revealed Resident #199's Usual Body Range of 175 pounds. Resident #199 meets the criteria for malnutrition diagnosis and muscle wasting. It further showed that Resident #199 eats between 51% to 100% of meals and that his son brings Ensure, a Nutritional Supplement. Further review did not show any additional nutritional assessment or notes addressing the severe weight loss from 05/04/24 to 05/07/24 and poor intake of meals.</p> <p>A review of the Minimum Data Set (MDS) dated [DATE] revealed a BIMS score of 15, which is cognitively intact. The nutrition care plan dated 05/05/24 revealed that Resident #199 will maintain adequate nutritional status by not having significant weight loss and consuming at least 50% of meals daily through the review date.</p> <p>In an interview conducted on 05/23/24 at 9:50 AM with Staff C, Certified Nursing Assistant, she stated that Resident #199 has not been eating very well this week and has only consumed between 0-25% of his meals. She further said that she told the Nurse about Resident #199's poor meal intake.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview conducted on 05/23/24 at 11:53 AM with the facility's Registered Dietitian, she stated that there is an overall clinical dashboard that will show the list of Residents with poor intake of meals and the percentage intake of meals. This dashboard is linked to the CNA's documentation of the daily intake of meals. She will then follow up with the residents and get more information regarding any medication changes, speak to the residents, refer to her first initial nutritional assessment, and provide the necessary dietary interventions. When asked if she knew that Resident #199 was not eating well, she said no and stated, He did not show up on the clinical dashboard for her to see She then said, It is still not showing up on my dashboard today.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40153</p> <p>Based on observations, interviews, and record review, the facility failed to ensure that each Resident received care and services for the provision of hemodialysis consistent with professional standards of practice for two of the two residents reviewed for Dialysis (Resident #196 and Resident #201).</p> <p>The findings included:</p> <p>A review of the facility policy titled Dialysis dated 04/2022 revealed that A communication process must be established between the nursing home and the dialysis facility to be used 24 hours a day. The care of the Resident receiving dialysis services must reflect ongoing communication, coordination, and collaboration between the nursing home and the dialysis staff. The communication process should include how the communication will occur, who is responsible for communicating, and where the communication and responses will be documented in the medical record.</p> <p>1. Resident #196 was admitted to the facility on [DATE] with a diagnosis of end-stage renal disease and dependence on renal dialysis. A review of orders showed the following: Sevelamer tablet 800 milligrams to be given every morning and at bedtime with meals dated 05/03/24. Dialysis every Monday, Wednesday, and Friday, which was dated 05/06/24.</p> <p>The Minimum Data Set (MDS) dated [DATE] revealed that Resident #196 had a Brief Interview of Mental Status (BIMS) score of 08, which indicated moderate cognitive impairment.</p> <p>In an interview conducted on 05/20/2024 at 3:30 PM with Resident #196's wife, she stated that he was not back from the dialysis center and that he was picked up at 9:00 AM this morning. She is concerned that the medication Sevelamer is not given with the meals as needed and that this morning, the nurse tried to give Resident #196 his dosage of Sevelamer on his way out to the transportation car outside the facility. She further said that she has complained about the medication not being given with the meals, but nothing has been done about it.</p> <p>The care plan initiated on 05/06/24 included communicating with the dialysis center regarding medication, diet, and lab results and coordinating residents' care with the dialysis center.</p> <p>A review of the dialysis binder located in the nurse's station did not show any dialysis communication sheets between the facility and the dialysis center for Resident #196 since his admission to the facility on [DATE].</p> <p>In an interview conducted on 05/21/24 at 11:50 AM with Staff B, Licensed Practical Nurse, she stated that the communication sheets are usually in the dialysis binder located in the unit. When asked why the dialysis communication sheets were missing for Resident #196, she said that she needed to know. She further stated they are sent with the Resident when he goes to dialysis treatments. The dialysis center always needs to remember to send the dialysis sheets back with the Resident and that she must call the dialysis center to request the forms. When asked by Surveyor if she had any of the communication sheets for Resident #196 for the last few weeks, she said no.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a phone interview conducted on 05/23/24 at 12:12 PM, the facility's Pharmacist stated that the medication Sevelamer helps control the level of phosphate in patients on dialysis. It is better absorbed with meals, so it is preferred to be given with meals.</p> <p>2. A chart review revealed that Resident #201 was admitted to the facility on [DATE] with diagnoses of end-stage renal disease and dependence on renal dialysis. A review of the Physician's orders showed an order for Sevelamer 800 milligrams to give two tablets with meals, which was dated 05/17/24.</p> <p>In an interview conducted on 05/21/24 at 9:00 AM with Resident #201, he stated that he only started dialysis for the first time about two weeks ago, and yesterday was the first time he went to an outpatient dialysis center from the facility. He further said that he only came back to the facility around 8:30 PM last night and that his dinner plate was waiting for him in his room when he came back from dialysis. When asked by the Surveyor if the medication (Sevelamer) was given with his dinner, he did not know.</p> <p>The care plan dated 05/20/24 revealed the following: communicate with the dialysis center regarding medication, diet, and lab results and coordinate the resident's care with the dialysis center.</p> <p>A review of the dialysis communication binder located in the nurse's station, did not see any communication sheet for Resident #201.</p> <p>Review of the Medication Administration Record for the month of May 2024 showed that the scheduled medication for Sevelamer was given on 05/20/24 at 8:00 AM and 12:00 PM but was not given at 5:00 PM because Resident #201 was outside the facility at dialysis. Further review revealed that the medication order for Humalog (insulin) 100 units was not given at 5:00 PM as scheduled because Resident #201 was at dialysis.</p> <p>In an interview with the Director of Nursing on 05/22/24 at 10:40 AM, she stated that Sevelamer is to be given with meals. When an order is given with meals, they must hold the medication and schedule it around dialysis times. On admission, the medicines need to be reviewed by the nursing team and addressed immediately by calling the doctor for further direction on working with the scheduled dialysis times. She also expected the nurse to call the doctor and ask them what to do if they needed to administer medication, but the resident was not in the facility.</p> <p>In an interview conducted on 05/23/24 at 4:00 PM, with the facility's Administrator, she was informed of the findings.</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40153</p> <p>Based on observations, interviews, and record review, the facility failed to provide the correct diet order per the physician's orders for one (1) of 5 sampled residents, Resident #200, reviewed for nutrition.</p> <p>The findings included:</p> <p>Record review documented Resident #200 was admitted on [DATE] with diagnoses of protein-calorie malnutrition, Dysphagia, and type 2 Diabetes. The documented Brief Interview of Mental Status (BIMS) score dated 05/17/24 revealed a score of 11, indicating mild to moderate cognitive impairment.</p> <p>In an observation conducted on 05/20/24 at 12:00 PM, Resident #200 was in his room with the lunch meal. The meal ticket on the lunch tray revealed the following: a mechanically ground diet with mechanically ground roasted red potatoes and mechanically ground lemon chicken. The lunch meal on the plate showed mechanically ground chicken and pieces of red potatoes that were about 2 inches long, not mechanically ground. In this observation, Resident #200 stated that he has a poor appetite and only ate about 15% of his lunch meal.</p> <p>In an observation conducted on 05/21/24 at 11:44 AM, Resident #200 was eating his lunch meal. The meal ticket was noted with a mechanically ground diet, with spaghetti noodles and a mechanically ground broccoli floret. The meal tray was observed with pieces of broccoli florets that were chopped and not grounded, about 1 inch in size.</p> <p>Review of the active order summary report dated 05/15/24 revealed a diet order for consistent carbohydrates, chopped texture regular diet; and on 05/22/24, and order for a diet order for consistent carbohydrates, pureed texture.</p> <p>The care plan dated 05/15/24 showed that Resident #200 has the potential for nutritional problems and to provide diet as ordered.</p> <p>In an interview with the Director of Nursing (DON) on 05/22/24 at 12:48 PM, she stated when an order is written for a diet, it is filled out by the nursing staff on a meal slip and then taken into the central kitchen. It is later added to meal tracker that is printed on the meal tickets for the specific resident. When asked as to why the printed meal tickets observed this week for Resident #200 were different than the diet order in the electronic system, she did not know.</p> <p>In an interview conducted on 05/22/24 at 1:20 PM with the facility's Food Service Director (FSD), he stated there are two types of mechanical diets. One is mechanically chopped, and the other type is mechanically ground. When asked about the mechanical ground diet, he stated that the vegetables will be minced like garlic, with a minced texture. The chef will put the veggies on the cutting board and cut the veggies until they are minced size. The FSD stated the nurses would write the diet order on a slip to give to him, and he would input the diet order into the meal tracker, which is what produces the meal ticket. The meal tracker has two options for mechanically altered diets from which he can choose.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Ormond Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  103 Clyde Morris Blvd Ormond Beach, FL 32174	
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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview conducted on 05/22/24 at 1:46 PM with the facility's Speech Language Pathologist (SLP), she stated that Resident #200 was admitted to the facility on a mechanical chopped diet consistency. He was eating about 25% of his meals and needed help loading up the utensils with food items to eat. According to the SLP, the resident only ate about 5-6 bites of his food and stated that he was not hungry. When she tried giving him a yogurt, he said that he liked the consistency and texture of the yogurt. When she tried trials of a purred diet, the resident was able to independently feed himself and consume much more of the food on his own. Resident #200 liked the purred texture and asked the SLP to downgrade the diet to a puree texture. When asked about the two types of mechanical diets, the SLP was unaware that two types of options could be placed in the electronic system.</p> <p>In an interview conducted on 05/23/24 at 3:45 PM with the facility's Administrator, she was told of the findings and the importance of providing the correct diet order for Resident #200.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>40153</p> <p>Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 2 of 2 observations conducted in the central kitchen.</p> <p>The findings included:</p> <p>Review of the facility's policy, titled, Sanitation, dated November 2017, revealed the following: All kitchens, kitchen areas, and dining areas shall be kept clean, free from litter and rubbish, and protected from rodents, roaches, flies, and other insects. All utensils, counters, shelves, and equipment shall be kept clean and maintained in good repair and shall be free from breaks, corrosion, open seams, cracks, and chipped areas. Kitchen waste not disposed of by mechanical means shall be kept in clean, leak-proof, nonabsorbent, tightly closed containers and disposed of daily.</p> <p>1. In a tour of the central kitchen on 05/20/24 at 8:55 AM, accompanied by the facility's Food Service Director (FSD), the following were noted:</p> <ul style="list-style-type: none"> <li>a. The floor around the kitchen and behind the stove area was noted dirty with pieces of scattered debris.</li> <li>b. Opened cardboard boxes were noted on the floor near the three-compartment sinks.</li> <li>c. Two (2) round skillets were coated with a grease-like film with a black/brown coloring.</li> <li>d. A large round dumpster located near the food production area, with exposed garbage and no lid.</li> <li>e. Used dirty paper napkins sitting on top of the plate warmers.</li> <li>f. Three (3) of the three hood lights were not working under the hood.</li> <li>g. Three (3) of the nine (9) fluorescent lights were missing bulbs and were noted to be broken and chipped.</li> <li>h. Two (2) exposed air vents were noted to have black / brown matter around the rims with no lids.</li> <li>i. A round silver bowl was noted sitting on top of a delivery cart with canned peaches. Closer observation showed a round scoop sitting on top of the canned peaches.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>j. The Food Service Director was using a Hydrion Chlorine meter (testing the chlorine concentration) to take the reading on a red bucket that was sitting on top of the kitchen counter. The reading showed a range of 0 out of 500 maximum level. In this observation, the Food Service Director stated that this was not the correct Hydraulic meter that was used to test the chlorine levels and proceeded to look for another Hydrion strip meter. In this observation, Staff D, Dietary Aide, said that the cloth in the red bucket had no cleaning solution but only soap and water. She was in the process of replacing the soap water in the red bucket with the appropriate cleaning solution.</p> <p>k. A dirty fryer basket was noted sitting on dirty cardboard behind the kitchen stove area.</p> <p>l. The walk-in refrigerator had a plastic bag of green bean salad that was not dated.</p> <p>m. The walk-in refrigerator had a plastic bag of raw carrots that was not dated or labeled.</p> <p>n. The walk-in refrigerator had three (3) unidentified food items inside a dish bowl that needed to be labeled and dated.</p> <p>o. The walk-in refrigerator had a box of frozen meat patties that were not sealed and opened to the air.</p> <p>p. The walk-in freezer had three large bags of unidentified frozen food items that needed to be labeled or dated.</p> <p>q. The floor around the dry storage area was noted to be dirty with pieces of scattered debris.</p> <p>r. A dirty, used rag was sitting on the kitchen counter, not in a red bucket with cleaning solution.</p> <p>s. Used, dirty brown paper towels were noted underneath the stove area behind a metal bar.</p> <p>2. A second visit and observation to the main kitchen was conducted on 05/22/24 at 11:30 AM. The following were noted:</p> <p>Using a facility digital thermometer, the Corporate Food Service Manager took the temperature of a cold cottage cheese and ham salad. The ham salad had an internal temperature of 46 degrees Fahrenheit (F) and not the recommended 40 degrees Fahrenheit and below.</p> <p>Using a facility digital thermometer, the Corporate Food Service Manager took the temperature of another cold cottage cheese and ham salad. The ham had an internal temperature of 48.8 degrees Fahrenheit, not the recommended 40 degrees Fahrenheit and below. In this observation, the Corporate Food Service Manager stated that the cold ham and cottage cheese salads were recently taken out of the walk-in refrigerator for the tray line.</p> <p>In an interview conducted on 05/23/24 at 3:30 PM with the facility's Administrator, she was informed of the findings.</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Dispose of garbage and refuse properly.</p> <p>40153</p> <p>Based on observations, interviews, and record review, the facility failed to dispose of refuse in a sanitary manner for two of two observations conducted in the main dumpster area.</p> <p>The findings included:</p> <p>Review of the policy, titled, Garage and Rubbish Disposal, dated April 2022, revealed the following: All garbage and rubbish containing food waste shall be kept in containers. All containers shall be provided with tight-fitting lids or covers, and such containers must be kept covered when stored or not in continuous use. Each container must be thoroughly cleaned at least daily on the inside and outside so as not to contaminate food, equipment, utensils, or food preparation areas. Garbage and rubbish containing food wastes shall be stored to be inaccessible to vermin. Storage areas shall be always kept clean and shall not constitute a nuisance. All garbage and rubbish shall be disposed of daily. Outside dumpsters provided by garbage pick-up services must be kept closed and free of litter around the dumpster area.</p> <p>1. In an observation conducted on 05/20/24 at 8:50 AM in the main dumpster area, the following were noted:</p> <p>a. A large roll-off dumpster was noted with debris, cardboard boxes, soda boxes, furniture, a mattress, and unidentified garbage. The dumpster had no lid and was only secured on three sides. Photograph Evidence Obtained.</p> <p>b. A large, open patio area located near the backdoor to the kitchen was observed with used utensils, food wraps, and debris.</p> <p>c. Four (4) gray round dumpsters were noted with dirty standing water, unidentified trash, and garbage bags. Closer observation showed insects flying over the dumpsters, and a foul odor came from all four dumpsters. Photographic Evidence Obtained.</p> <p>2. In an observation conducted on 05/20/24 at 3:10 PM in the main dumpster area, the following were noted:</p> <p>d. A large roll off dumpster noted with debris, cardboard boxes, soda boxes, furniture, mattress, and unidentified garbage. The large roll off dumpster had no lid and was only secured on 3 sides. Photograph Evidence Obtained.</p> <p>e. A large, open patio area located near the backdoor to the kitchen was observed with used utensils, food wraps, and debris.</p> <p>f. Four (4) gray round dumpsters were noted with dirty standing water, unidentified trash, and garbage bags. Closer observation showed insects flying over the dumpsters with a foul noticeable odor coming from all 4 dumpsters. Photographic Evidence Obtained.</p> <p>(continued on next page)</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview conducted on 05/20/24 at 3:20 PM with the facility's Maintenance Director, he said he oversees the daily cleaning of the dumpster area. He further said that he did not see the large, open patio area near the backdoor to the kitchen with all the utensils, food wraps, and debris.</p> <p>In an interview conducted on 05/23/24 at 3:30 PM with the Administrator, she was informed of the findings.</p>

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<p>F 0826</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide specialized rehabilitative services by qualified personnel, when ordered for a resident by a doctor.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39026</p> <p>Based on observation, interviews, policy and record review, the facility failed to obtain a physician order for Occupational Therapy (OT) prior to commencing OT for 1 of 1 sampled resident reviewed for rehabilitation (Rehab) services, Resident #146.</p> <p>The findings included:</p> <p>The policy of the facility, titled, Physician's Therapy Orders, dated April 2022 documented, Therapy services must be ordered by a licensed physician / licensed nurse practitioner. All therapy services provided to the resident must be ordered in writing by the resident's physician / nurse practitioner.</p> <p>Record review documented Resident #146 was admitted to the facility on [DATE] with diagnoses that included Congestive Heart Failure, Type 2 Diabetes, and Hypertension. On the Resident Interview &amp; Staff assessment dated [DATE], it was documented the resident's Brief Interview for Mental Status (BIMS) score was 15, indicating the resident was cognitively intact. The resident expressed at this time that she thought she should be getting more therapy.</p> <p>On 05/20/24 at 11:17 AM, during the initial pool process, Resident #146 was interviewed.</p> <p>Review of Resident #146's order for therapy revealed an order for skilled PT (physical therapy) intervention 5x week x 4 weeks which was dated 05/17/24. There was no physician order for OT.</p> <p>On 05/22/24 at 1:53 PM, an interview was conducted with Staff E, Occupational Therapist and Director of Therapy. Resident #146's therapy was discussed, and the surveyor asked if Resident #146 was receiving any OT. Staff E stated that the resident started OT on 05/16/24 and has had 4 days of OT so far on 05/16/24, 05/18/24, 05/20/24 and 05/21/24. The surveyor asked where the order was for OT and Staff E reviewed the orders and stated she would have to put in a late entry clarification order because there was no order.</p> <p>On 05/23/24 at 10:00 AM, the physician orders were reviewed for Resident #146. The order for OT was put in on 05/22/24, effective 05/16/24 for OT evaluation and treatment.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39026</p> <p>Based on observation, interviews, policy and record review, the facility failed to ensure accuracy of records for a resident with a PICC (peripherally inserted central catheter) line dressing for 1 of 1 sampled resident sampled for PICC line, Resident #247; and failed to document a resident-to-resident interaction for 2 of 3 sampled residents reviewed for accidents, Resident #26 and #28.</p> <p>The findings included:</p> <p>The facility's policy, titled, Charting and Documentation, revised July 2017 and September 2023, documented, Documentation in the medical record will be objective (not opinionated or speculative), complete, accurate and timely. A late entry must indicate the date and time of the occurrence.</p> <p>1. Record review revealed Resident #26 was admitted to the facility on [DATE] with diagnoses that included Muscular dystrophy, Severe intellectual disabilities, and Cognitive communication deficit. The record documented the Brief Interview for Mental Status (BIMS) score was 15 on the quarterly minimum data set (MDS) dated [DATE], indicating the resident was cognitively intact.</p> <p>Record review documented Resident #28 was admitted to the facility on [DATE] with diagnoses that included Hemiplegia and Hemiparesis following a Cerebral Infarction, Major Depressive Disorder, and Chronic Obstructive Pulmonary Disease. The record documented the BIMS score was 15 on the quarterly MDS dated [DATE], indicating the resident was cognitively intact.</p> <p>On 05/21/24 at 9:42 AM Resident #26 was interviewed. She stated on Sunday, 05/19/24, she was yelled at by Resident #28 because she believed he was giving out the code to the door. She said that she told him that no one is supposed to give out the code then he yelled at her then she yelled back at him. She stated she told Staff F, an admissions coordinator, on Sunday and told Staff G, a psychiatrist too. The surveyor looked for progress notes for Resident #26 and #28 in the electronic health record (EHR) but there was no documentation regarding this interaction.</p> <p>On 05/22/24 at 8:50 AM, an interview was conducted with Staff F, Admissions Coordinator. Staff F was asked if she was aware that there was an argument between Resident #26 and #28 on 05/19/24. She stated she was aware because Resident #26 told her but she was not present at the time of the argument, as she came after this occurred. She stated that she came into work around 10:00 AM and this happened around 8:30 AM. She stated that Resident #26 told her that Resident #28 was screaming at her and told her to go to her room. Staff F stated that Resident #26 is always trying to control Resident #28 and gets upset. She did not say he was trying to push her but he said to go to your room, but she is always trying to get into his business. Staff F was asked why she did not document this interaction and she replied that she might have put notes in the manager on duty book.</p> <p>A telephone call was placed to Staff G, psychiatrist, on 05/22/24 at 9:09 AM. Staff G stated that he was called in to see Resident's #26 and #28 on Monday, 05/20/24 by the Administrator. Staff G stated Resident #26 is not new to him and he has been trying to teach her how to work out conflict. He had not seen Resident #28 prior to Monday and the resident did not want to talk to him about the conflict that happened on 05/19/24.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the Director of Nurses (DON) on 05/22/24 at 9:45 AM. She stated she was in the facility on 05/19/24 but not at the time of the argument. It was reported to her by a nurse on duty at the time. She stated there had been previous arguments between Resident #26 and #28. She tried to talk to Resident #26 on 05/19/24 but the resident brushed her off and did not want to talk about it. She stated she did not document the interaction. She felt this was not an abuse situation because Resident #26 was not bullied or physically abused. There has been friction between the two of them. She stated she called the Administrator.</p> <p>An interview was conducted with the Administrator on 05/22/24 at 9:53 AM. She was told it was a verbal disagreement and Resident #28 told Resident #26 to stay away from him.</p> <p>41837</p> <p>2. Record review for Resident #247 revealed the resident was admitted to the facility on [DATE] with diagnoses that included Other Gram-Negative Sepsis and Abscess of Liver.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #247 dated 05/02/24 revealed in Section C a BIMS score of 12, indicating moderate cognitive impairment.</p> <p>Review of the Physician's Orders for Resident #247 revealed an order dated 05/03/24 to change PICC [Peripherally Inserted Central Catheter] line dressing every evening shift every Friday.</p> <p>On 05/20/24 at 1:44 PM, an observation was made of Resident #247 with the PICC in his left upper arm with a faded date of 05/13/24 on the dressing. Photographic Evidence Obtained.</p> <p>Review of the Treatment Administration Record (TAR) for Resident #247 from 05/03/24 to 05/20/24 revealed the PICC line dressing was documented as completed on 05/03/24, 05/10/24, and 05/17/24. There was no documentation that the PICC line dressing was changed on 05/13/24.</p> <p>An interview was conducted on 05/20/24 at 1:46 PM with Resident #247 who was asked how often staff change the dressing for the PICC in his left arm. He said not every day, they do it every so often. When asked when the last time was the dressing had been changed, he said he did not remember, all the days seem the same.</p> <p>During an interview conducted on 05/22/24 at 2:30 PM with the Director of Nursing (DON) who was asked about PICC line dressing changes, the DON said they are done weekly and PRN (as needed). When asked about Resident #247 she stated the documentation shows the PICC line dressing was changed on 05/03/24, 05/10/24, and 05/17/24. When asked if the dressing was changed on 05/13/24, she acknowledged there was no documentation for Resident #247 of the PICC dressing being changed on 05/13/24.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837</b></p> <p>Based on the observations, interviews, and record review, the facility failed to ensure staff were made aware of residents on Enhance Barrier Precautions (EBP) for 1 of 11 sampled residents on EBP (Resident #247); failed to use appropriate Personal Protective Equipment (PPE) for 1 of 11 sampled residents on EBP (Resident #247); and failed to maintain Contact Isolation Precautions as ordered for 1 of 3 sampled residents on Transmission Based Precautions (TBP) (Resident #199).</p> <p>The findings included:</p> <p>Review of the facility's policy, titled, Enhanced Barrier Precautions [EBP] with a revised date of 03/30/24 included, in part: Multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities. EBP is an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities.</p> <p>Procedure:</p> <ol style="list-style-type: none"> <li>1. EBP is used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing.</li> <li>2. EBP are indicated for residents with any of the following as long as they reside in the facility:             <ol style="list-style-type: none"> <li>b. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with MDRO.</li> <li>c. Wounds generally include chronic wounds, not shorter-lasting wounds such as skin breaks or skin tears covered with an adhesive bandage or similar dressing.</li> <li>d. Chronic wounds include but are not limited to pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers.</li> <li>e. Indwelling medical device examples include central lines, urinary catheters, feeding tubes and tracheostomies.</li> </ol> </li> <li>4. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities:             <ol style="list-style-type: none"> <li>a. Dressing</li> <li>b. Bathing/showering</li> <li>c. Transferring</li> <li>d. Providing hygiene</li> </ol> </li> </ol> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>e. Changing linens</p> <p>f. Changing briefs or assisting with toileting</p> <p>g. Device care or use: central line, urinary catheter, feeding tube, tracheostomy</p> <p>h. Wound care: any skin opening requiring a dressing</p> <p>10. EBP are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device. The facility has discretion on how to communicate to staff which residents require the use of EBP.</p> <p>11. PPE, an alcohol-based hand rub, should be readily accessible to staff. Discretion may be used in the placement of supplies which may include placement near or outside the resident's room.</p> <p>Review of the facility's policy, titled, Isolation Precautions, Categories of with a date of 02/23/23 included, in part:</p> <p>Contact Precautions</p> <p>3. In addition to Standard Precautions, Contact Precautions must be implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaced or patient-care items in the resident's environment.</p> <p>b. Gloves and Hand Hygiene</p> <p>1) In addition to wearing gloves as outlined under Standard Precautions, wear gloves (clean, nonsterile) when entering the room.</p> <p>2) Remove gloves before leaving the room and wash hands or alcohol based use hand rub (ABHR).</p> <p>c. Gown</p> <p>1) In addition to wearing a gown outlined under Standard Precautions, wear a gown (clean, nonsterile) when entering the room if you anticipate that your clothing will have substantial contact with the patient, environmental surfaces, or items in the patient's room, or if the resident is incontinent, has diarrhea an ileostomy, a colostomy, or wound drainage not contained by a dressing.</p> <p>2) Remove the gown before leaving the resident's environment.</p> <p>Isolation Notices</p> <p>When Isolation Precautions are implemented, signage should be placed on the entrance/doorway of the room to indicate the type of precautions that are in place. Use the CDC-approved signs for all 4 types of isolation:</p> <p>a. Contact Precautions: <a href="http://www.cdc.gov/infectioncontrol/pdf/contact-precautions-sign-pdf">www.cdc.gov/infectioncontrol/pdf/contact-precautions-sign-pdf</a></p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Ormond Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  103 Clyde Morris Blvd Ormond Beach, FL 32174	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. Enhanced Barrier Precautions: <a href="http://www.cdc.gov/hai/pdfs/contaminment/enhanced-barrier-precaution-sign-p.pdf">www.cdc.gov/hai/pdfs/contaminment/enhanced-barrier-precaution-sign-p.pdf</a> .</p> <p>Review of Consideration for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities website located at <a href="https://www.cdc.gov/hicpac/media/pdfs/EnhancedBarrierPrecautions-508.pdf">https://www.cdc.gov/hicpac/media/pdfs/EnhancedBarrierPrecautions-508.pdf</a> dated June 2021 included in part:</p> <p>Framework for Applying Enhanced Barrier Precautions in Skilled Nursing Facilities Implementation Approaches</p> <p>Facilities should develop a method to identify residents with wounds or indwelling medical devices, and post clear signage outside of resident rooms indicating the type of PPE required and defining high risk resident care activities.</p> <p>Review of the CDC website for Implementation of PPE Use in Nursing Homes to Prevent Spread of Multi-resistant Organisms (MDROS), dated July 12, 2022, located at <a href="https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html">https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html</a>, included, in part,</p> <p>Under Implementation: When implementing Contact Precautions or Enhanced Barrier Precautions .Post clear signage on the door or wall outside of resident room Make PPE, gowns and gloves, available immediately outside of the resident room.</p> <p>1. Record review for Resident #247 revealed the resident was admitted to the facility on [DATE] with diagnoses that included Other Gram-Negative Sepsis and Abscess of Liver.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #247 dated 05/02/24 revealed in section C a Brief Interview of Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. Documented in Section M was: Does this resident have one or more unhealed pressure ulcers/injuries? - No. Documented in Section O for IV (Intravenous) Medications on admission - yes, while a resident - yes.</p> <p>Review of the Physician's Orders for Resident #247 revealed an order dated 04/27/23 to change PICC (Peripherally Inserted Central Catheter) line dressing every evening shift every Friday was discontinued on 05/20/24.</p> <p>Review of the Physician's Orders for Resident #247 revealed an order dated 04/30/24 to monitor drainage site for any sign or symptoms of infection every shift.</p> <p>Review of the Physician's Orders for Resident #247 revealed an order dated 04/30/24 to drain abdomen drainage bag every shift.</p> <p>Review of the Physician's Order for Resident #247 revealed an order dated 05/09/24 to cleanse coccyx with NS (Normal Saline) and pat dry. Apply honey, collagen, and calcium alginate. Cover with dry dressing. one time a day for wound care.</p> <p>Review of all orders (current and discontinued) for Resident #247 from 04/26/24 to 05/21/22 revealed no order for Enhanced Barrier Precautions.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Care Plan for Resident #247, with an initiated date of 04/29/24 and a focus on the resident is on ABT (Antibiotic) IV (Intravenous) Medications r/t (Related/to) infection via PICC (Peripherally Inserted Central Catheter) line to LUE (Left Upper Extremity), documented the goal was for the resident to not have any complications related to IV Therapy through the review date. Included the intervention, added on 05/20/24, for EBP when providing care per facility protocol (no discipline assigned).</p> <p>During a facility tour conducted on 05/20/24 from 9:30 AM to 10:30 AM, an observation was made of no Enhanced Barrier Precaution signage on any resident room doors. Some resident rooms had Contact Isolation signs and those rooms had Personal Protective Equipment (PPE) carts just outside of the door with the signage.</p> <p>On 05/20/24 at 2:25 PM, an observation was made of Staff I, Registered Nurse (RN), gathering supplies outside of Resident #247's room that had no EBP signage on the door, and no PPE cart at or near the door. Staff I entered the room not wearing gown or gloves. Staff I proceeded to change the dressing to Resident # 247's abdomen only wearing gloves, and no gown. Observation revealed Staff I removed the old dressing, cleaned around the entry site of the abdominal drain, applied gauze, and placed 4 pieces of paper tape around the gauze.</p> <p>An interview was conducted on 05/20/24 at 11:20 AM with the Director of Nursing (DON) who was asked about EBP. The DON said they have some residents who are on EBP. When asked how staff know which residents are on EBP, she said they do not place signs on the door, the resident will have a care plan in place for EBP and it will also be in the tasks portion of the residents electronic medical record (EMR). When asked what residents would need EBP, she said residents with any line added to them, such as PEG (feeding tube), IV (intravenous), Urinary catheter, colostomy, and any wound with a covered dressing. The DON said we follow the CDC (Center for Disease Control) guidelines.</p> <p>An interview was conducted on 05/20/24 at 02:27 PM with Staff I, RN, who stated she has worked at the facility for 1 year and also has her Infection Control Certificate but did not have it with her today. When asked if she is the wound care nurse, she said she does wound care on Wednesdays, all other days she works a medication cart, and is just here today to help out. When asked if she has had any training on Enhanced Barrier Precautions (EBP) she said they have gone over it, yes. When asked if she could describe what EBP is, she said it is for all residents with infections to prevent the infection from spreading. When asked if that is the only criteria for EBP, she said if they have something poking in their skin like a urinary catheter.</p> <p>When asked if Resident #247 is on EBP, she said 'no, he is not'. When asked would residents with wounds, abdominal drains or central lines be on EBP, she said, I see where you are going with this. Staff I said yes, they would be on EBP for those situations. When asked how she knows if a resident is on EBP she said, it is given in report, there would be a sign of the door, and an order in the chart. Staff I acknowledged Resident #247 should be on EBP. Staff I also acknowledged there was no EBP sign on the resident's door and no PPE cart outside of the resident's room.</p> <p>Staff I was asked to check Resident #247's electronic medical record (EMR) and she acknowledged there was no order for EBP but she was able to locate care plans for Resident #247 that included an intervention for EBP dated today 05/20/24.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 05/21/24 at 10:40 AM with Staff L, Certified Nursing Assistant (CNA), who stated he has worked in the facility for [AGE] years and for the past 6 years as a CNA. When asked about Enhanced Barrier Precautions, Staff L stated when the resident first gets here, the resident is placed on EBP. When asked how to know which residents are on EBP, Staff L stated it is given in report, or by the nurse, or there will be a sign on the door or a cart with Personal Protective Equipment [PPE] outside of the residents' room. When asked if a resident is on EBP when and what PPE would be worn, he said a gown and gloves whenever you go into the room. When asked where the PPE is kept for residents on EBP, he said it would be in the cart located just outside of the door. When asked if there is no cart or the cart is empty, where would you get the PPE, he said gloves are always in the rooms, but if you need gowns, you have to go to the shed outside behind the facility.</p> <p>An interview was conducted on 05/22/24 at 2:00 PM with the Director of Nursing (DON) who was asked EBP for Resident #247. She said the staff have been educated on EBP, they do not place signage on the door, and the PPE is located in the resident's rooms in the closet. When asked how staff are aware a resident is on EBP, she stated it is in the care plan and also on the Certified Nursing Assistant (CNA) task.</p> <p>40153</p> <p>2. Record review revealed Resident #199 was admitted to the facility on [DATE] with a diagnosis of severe sepsis. The order summary report revealed an order for contact precautions for ESBL (Extended Spectrum Beta-Lactamase) in the urine, dated 05/05/24. Another order, dated 05/20/24, noted contact isolation with all services to be provided for the room related to contact isolation for infection control.</p> <p>A progress note dated 05/05/24 revealed Resident #199 was on contact precautions for ESBL in the urine. A progress note dated 05/11/24 showed that Resident #199 was with Contact precautions for ESBL in urine. Another progress note dated 05/15/24 documented Resident #199 was on contact precautions for ESBL in urine.</p> <p>In an observation conducted on 05/20/24 at 9:45 AM, Resident #199 was noted in his room with the door open. Further observation did not note any contact isolation sign posted on the door or Personal Protective Equipment (PPE) outside the room door.</p> <p>In an observation conducted on 05/20/24 at 10:20 AM, Resident #199 was noted in his room with no PPE or contact isolation sign on the door. At 11:40 AM, a PPE cart was noted outside the door with no contact isolation sign posted on the door. In this observation, Staff C, CNA, stated that Resident #199 was just placed on contact isolation and that they are taking care of the procedures for isolation. Continued observation at 12:00 PM revealed an isolation sign for contact isolation posted on Resident #199's door.</p> <p>In an interview conducted on 05/23/24 at 9:30 AM with the facility's Director of Nursing (DON), it was reiterated that Resident #199 was placed on contact isolation on 05/05/24. Resident #199 went out the hospital on 05/13/24 for uncontrolled pain and came right back to the facility (05/13/24). He has been on contact isolation since 05/05/24. The DON further emphasized that when a resident is placed on contact isolation, they will place the signage on the door for the type of isolation and place a cart of PPE outside the resident's door. She further said that they follow the Centers for Disease Control and Prevention (CDC) guidelines for contact isolation.</p>		