

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 08/27/2025
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)		
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on the kitchen food service observations, staff interviews, and a review of facility records and policies and procedures, the facility failed to maintain dietary equipment in safe and sanitary condition to prevent the outbreak of foodborne illness, with the potential to affect any resident who consumed ice from the facility's kitchen, by failing to maintain and clean the ice machine to prevent contamination/biological growth. Food safety and sanitation are important in health care settings serving nursing home residents. Kitchen equipment shall be maintained and kept free of waterborne microorganisms to avoid a potential source of pathogen exposure. The findings include: During a follow up visit to the kitchen on 08/26/2025 at 11:20 AM, the ice machine located outside the kitchen's main door's ice diverter was covered with a slimy, pink substance. The 2025 ice machine cleaning log hanging on the side of the ice machine documented cleaning on 08/24/2025. (Photographic evidence obtained) During this follow up visit, the Regional Food Service Director verified with his personal cell phone a document showing that the ice machine was cleaned by Maintenance on 07/31/2025. He stated the ice machine would be shut down, all ice removed and cleaned today. (Photographic evidence obtained). On 08/27/2025 at 8:29 AM, Dietary Aide A was asked who was responsible for cleaning the ice machine and how often. She replied, At one time we were told it was Maintenance, then they said it was Dietary. We were told last that it was Maintenance's responsibility. Dietary is currently cleaning the outside, and inside edges around the open area of the door one time per week. On 08/27/2025 at 8:42 AM, [NAME] B was asked who was responsible for cleaning the ice machine and how often. She replied, As far as I know it's Maintenance; I don't know their cleaning schedule. Dietary does not clean it at all. On 08/27/2025 at 9:03 AM, the Certified Dietary Manager was asked who was responsible for cleaning the ice machine and how often. She replied, The kitchen staff. It's an ongoing issue with Dietary and Maintenance. We wipe down the outside and run the scoop through the dish machine every week. On 08/27/2025 at 9:49 AM, the Maintenance Director was asked who was responsible for cleaning the ice machine and how often. He replied, Dietary and Maintenance. Maintenance cleans the ice machine quarterly. The top and bottom of the ice machine including the fan, condenser, the tray and diverter area is cleaned. A review of the facility's Work History Report, Direct Supply TELS (electronic maintenance program) indicated: Task Description: Ice machines/ice bins: Verify ice machine and ice cart scoops and scoop bins are cleaned and sanitized; marked done on-time by the Maintenance Director on 7/21/2025. A review of the facility's policy and procedure titled Ice Machines and Ice Storage Chest (revised 01/2012), revealed: Policy Statement: Ice machines and ice storage/distribution containers will be used and maintained to assure a safe and sanitary supply of ice . 3. Our facility has established procedures for cleaning and disinfecting ice machines and storage chests which adhere to the manufacturer's instructions. The infection Preventionist (or designee) maintains a copy of these procedures. A review of the facility's policy and procedure titled Ice Machine and Ice Storage Chests (revised 8/27/2025), revealed: Policy: Ice machine and ice storage chest/containers must be maintained in a safe and sanitary condition . 3. The ice machine will be cleaned monthly per manufacturers' recommendation and as needed by Maintenance. 4. The Dietitian will check the ice machine for cleanliness monthly during facility visits and will report need for additional cleaning to the Administrator. (Copies obtained)		

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, and a review of the facility's policy and procedure for Falls and other facility documentation, the facility failed to implement a comprehensive person-centered care plan for one (Resident #10) of 27 residents whose care plans were reviewed for falls. Fall mats were ordered for Resident #10 but were not in place, which could result in fall injuries. The findings include: On 8/24/25 at 11:30 a.m., Resident #10 was observed lying in a high bed with an air mattress and 1/4 side rails. The resident was asked if he had fallen and he replied yes. He reported several falls and having gone to the hospital after one fall. He could not remember the date, only that the fall was recent. On 8/25/25 at 9:30 a.m., the facility's matrix was reviewed. The matrix revealed that the resident had fallen with a major injury. On 8/25/25 at 2:30 p.m., Resident #10 was observed lying in bed. No fall mats were at bedside. His room and bathroom were checked, but there were no fall mats in his room. He reported that he did not need the mats when he was asked about them. The bed was in high position. A record review revealed that the resident had episodes of confusion. On 8/26/25 at 9:00 a.m., Resident #10 was observed lying in bed watching TV and eating his breakfast. Fall mats were not observed at bedside. His bed was in high position. On 8/27/25 at 9:30 a.m., the resident was observed in bed with his eyes closed. The bed was in high position, and no fall mats were observed. On 8/27/25 at 11:00 a.m., Resident #10 was observed in bed watching TV. The bed was in high position, and no fall mats were observed. A review of Resident #10's medical record revealed that he had a re-entry on 7/18/25 with an initial admission on [DATE]. His diagnoses included osteomyelitis of the ankle and foot, chronic obstructive pulmonary disease (COPD), mild protein calorie malnutrition, and anemia. The five-day Minimum Data Set (MDS) assessment dated [DATE] revealed a prior fall and that the resident needed substantial, maximum assistance with toileting, partial, moderate assistance with bed mobility, and for transfers, he required substantial maximal assistance. Resident #10 had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 possible points, indicating moderate cognitive impairment. A review of the Care Plan dated 7/10/25 revealed that the resident was at risk for falls and had a history of falls. Interventions included that the bed be in low position (initiated 7/23/25) and fall mats (two) beside the bed (initiated 7/11/25). (Copy obtained) The medical record documented a fall on 7/11/25 with a small abrasion under the left knee where the resident slid out of his wheelchair, and on 7/16/25, he was found lying prone on the side of the bed. Resident #10 hit his head and suffered skin tears to his right elbow and was transferred to the hospital. An interview was conducted with Registered Nurse (RN) E on 8/27/25 at 11:00 a.m. who said she had worked in the facility for two years. She reported that the resident had a fall and was sent to the (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hospital last month. He returned to the facility. When she was asked what interventions were used for fall prevention, she reviewed the resident's care plan and reported that he had a low bed and fall mats at bedside. RN E was accompanied to Resident #10's room. After entering the room, RN E confirmed that the resident had no fall mats, and his bed was not low. She started lowering the bed and told the resident she was going to get him some fall mats. An interview was conducted on 8/27/25 at 11:32 a.m. with the Assistant Director of Nursing (ADON). She reported that the resident had a fall on 7/11/25 where he slid out of his wheelchair trying to reach the call light. The Unit Manager arrived and reported that the resident suffered a small abrasion under his left knee and a Dycem cushion to the wheelchair was implemented on 7/16/25. The Unit Manager/Licensed Practical Nurse (LPN) also reported that two fall mats at bedside were added to the care plan on 7/11/25. The ADON reported that on 7/16/25 the resident was transported to the hospital due to oa change in condition. He had fallen and stated his head hurt. He had slid out of bed. The fall risk evaluation revealed a high risk for falls (12) on 7/18/25. The Unit Manager confirmed that there were no fall mats at bedside. She went to get some. She stated the resident had fall mats, but his room was deep cleaned, and the mats were removed. The Unit Manager confirmed that there had been no fall mats in room since 8/24/25. A review of the facility's policy and procedure titled Falls (dated April 2022) revealed: It is the policy of this center to determine fall risk, provide interventions to prevent/reduce falls, and update interventions as needed to prevent and/or reduce falls and injury. 1.Fall risk screen within 24 hours of admission, quarterly and PRN (as needed). 2.Care plan in place for fall reduction. 3.Update the plan of care. (Copy obtained) A review of the facility's Performance Improvement Plans (PIPs) revealed that Falls was one of seven PIPs in in place for this facility. It had a start date of 8/25/25, one day after the survey began on 8/24/25. The Falls PIP was implemented due to notification of family, no timely interventions and documentation. Resident #10 did have a Fall care plan documented but did not have his fall mats or low bed implemented. The concern was not following the care plan.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and a review of the facility's policies and procedures, the facility failed to ensure treatment and care were provided in accordance with professional standards of practice and the comprehensive person-centered care plan for one (Resident #28) of 27 residents in the survey sample whose care plans were reviewed. Resident #28, with a Brief Interview for Mental Status (BIMS) score indicating intact cognition, stated he was not receiving his medications as ordered, and a review of his medical record for August 2025 revealed that on numerous dates, five medications were not signed off by nursing as having been administered. Failure to administer medications as ordered by the physician has the potential to cause a negative outcome to the resident's physical, mental, or psychosocial health and well-being. The findings include: On 08/24/2025 at 1:33 PM, Resident #28 stated he believed some of his medications were missed. He stated they were sometimes late or not provided at all. Resident #28 could not identify a particular medication that was late or missed. A review of the resident's active physician's orders revealed: Ferrous Sulfate oral tablet 325 (65 Fe (iron) mg, give 1 tablet by mouth in the morning for anemia (08/07/2025) Plavix oral tablet 75 mg (Clopidogrel Bisulfate), give 1 tablet by mouth at bedtime for antiplatelet (06/13/2025) Vitamin C oral tablet (Ascorbic Acid), give 500 mg by mouth in the morning for iron absorption (08/07/2025) Risperidone oral tablet 2 mg, give 1 tablet by mouth every morning and at bedtime for schizophrenia (06/13/2025) Amlactin Daily External Lotion 12% (Lactic Acid (Ammonium Lactate), apply to bilateral (both) feet topically every morning and at bedtime for dry skin. Wash feet with soap and water before applying lotion (07/20/2025) A review of Resident #28's August 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed missing documentation used to verify that the following medications were administered: Ferrous Sulfate oral tablet 325 (65 Fe) mg for anemia was missing signatures on 8/10/2025 and 8/13/2025 verifying that the medication was administered. Plavix oral tablet 75 mg for antiplatelet was missing a signature on 8/9/2025 verifying that the medication was administered. Vitamin C oral tablet (Ascorbic Acid) for iron absorption was missing signatures on 8/10/2025 and 8/13/2025 verifying that the medication was administered. Risperidone Oral Tablet 2 mg for schizophrenia was missing a signature on 8/9/2025 verifying that the medication was administered. Amlactin Daily External Lotion 12 % (Lactic Acid (Ammonium Lactate) was missing signatures on 8/9/2025 and 8/12/2025 verifying that the medication was administered. (Copy obtained) Further review of the medical record revealed that Resident #28 was admitted to the facility on [DATE]. Primary diagnoses included, but were not limited to, Parkinson's disease without dyskinesia, anemia, dementia in other diseases classified elsewhere with other behavioral disturbance; schizoaffective disorder - bipolar type, persistent mood disorder; dementia with psychotic disturbance. A review of the 5-day minimum data set (MDS) assessment dated [DATE] revealed that the resident was receiving antipsychotic and antiplatelet medications. He had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 possible points, indicating intact cognition. A review of the resident's Care Plan, dated 07/01/2025, revealed impaired cognitive function/or impaired thought processes related to dementia; at risk for adverse reaction related to Doxycycline, Seroquel allergies; use of psychotropic medications related to schizophrenia; antiplatelet therapy related to history of cerebral infarction; Parkinson's disease, anemia, dementia, and risk for alteration in skin integrity related to Parkinson's disease, wasting syndrome and malnutrition. Interventions included administration of medications as ordered by the physician. Monitor/document for side effects and effectiveness; monitor weight/weight changes; administer medications as ordered by the physician; monitor for side effects and effectiveness every shift; provide and serve supplements as ordered: see current orders; and keep skin clean and dry, use lotion on dry skin. (Copies obtained) On 08/27/2025 at 10:20 AM, Certified Nursing Assistant (CNA) G was asked if the resident had complained about not receiving his medications at all or receiving his (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications late. CNA G replied, no. On 08/27/2025 at 10:29 AM, Licensed Practical Nurse (LPN) H was asked if the resident complained about not receiving his medications at all or receiving his medications late. LPN H replied, No, I give it to him on time. LPN H was asked about the following medications that were missing the documentation to verify that they were administered: Ferrous Sulfate oral tablet 325 (65 Fe) mg for anemia missing signatures on 8/10/2025 and 8/13/2025. She replied, I'm not sure what happened. It was 5:00 AM medication in the morning. I was not at the facility. Plavix oral tablet 75 mg for antiplatelet, missing a signature on 8/9/2025. She replied, That's night shift. Vitamin C oral tablet (Ascorbic Acid) for iron absorption, missing signatures on 8/10/2025 and 8/13/2025. She replied, That's an AM medication. I'm not sure. Risperidone oral tablet 2 mg for schizophrenia, missing a signature on 8/9/2025. She replied, Night shift. Amlactin Daily External Lotion 12 % (Lactic Acid (Ammonium Lactate), missing signatures on 8/9/2025 and 8/12/2025 to verify that the medication was administered. She replied, Night shift. On 08/27/2025 at 11:52 AM, the Assistant Director of Nursing (ADON) was asked to verify that the following medications, missing signatures on the MAR to verify administration, were provided: Ferrous Sulfate oral tablet 325 (65 Fe) mg for anemia, missing signatures on 8/10/2025 and 8/13/2025; Plavix oral tablet 75 mg for antiplatelet, missing a signature on 8/9/2025; Vitamin C oral tablet (Ascorbic Acid) for iron absorption, missing signatures on 8/10/2025 and 8/13/2025; Risperidone oral tablet 2 mg for schizophrenia, missing a signature on 8/9/2025; and Amlactin Daily External Lotion 12 % (Lactic Acid (Ammonium Lactate), missing signatures on 8/9/2025 and 8/12/2025. She confirmed that these medications were not documented as having been administered on the dates noted above. A review of the facility's policy and procedure titled Administration of Drugs (dated 04/2022), revealed: Policy: Drugs will be administered in a timely manner and as prescribed by the resident's attending physician or the Center's Medical Director. Policy Interpretation and Implementation . 2. Drugs must be administered in accordance with the written orders of the attending physician. 3. All current drugs and dosage schedules must be recorded on the resident's Electronic Medication Administration Record (eMAR). 4. Topical drugs used in treatments should be recorded on the resident's treatment record . 9. The nurse administering the drug must record such information on the resident's eMAR before administering the next resident's drug. 10. The nurse administering the drugs must electronically sign the resident's eMAR . 12. Should a drug be withheld, refused, or given other than at the scheduled time, the nurse should give the appropriate chart code inside the eMAR that states the reason for not administering that particular drug. 13. The nurse should enter an explanatory note in the progress notes for the eMAR when drugs are withheld, refused, or given other than at scheduled times. The physician should be notified of drugs that are withheld and/or repeated refusal of drugs. (Copy obtained)		

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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** Based on interviews, record review, and a review of the facility's policies and procedures, the facility failed to ensure residents' medical records were complete and accurately documented, in accordance with accepted professional standards and practices, for one (Resident #28) of a total survey sample of 27 residents whose records were reviewed. Resident #28, with a Brief Interview for Mental Status (BIMS) score indicating intact cognition, stated he was not receiving his medications as ordered, and a review of his medical record for August 2025 revealed that on numerous dates, five medications were not signed off by nursing as having been administered. The resident's record must reflect the care and services provided to the resident. The findings include: On 08/24/2025 at 1:33 PM, Resident #28 stated he believed some of his medications were missed. He stated they were sometimes late or not provided at all. Resident #28 could not identify a particular medication that was late or missed. A review of the resident's active physician's orders revealed: Ferrous Sulfate oral tablet 325 (65 Fe (iron) mg, give 1 tablet by mouth in the morning for anemia (08/07/2025) Plavix oral tablet 75 mg (Clopidogrel Bisulfate), give 1 tablet by mouth at bedtime for antiplatelet (06/13/2025) Vitamin C oral tablet (Ascorbic Acid), give 500 mg by mouth in the morning for iron absorption (08/07/2025) Risperidone oral tablet 2 mg, give 1 tablet by mouth every morning and at bedtime for schizophrenia (06/13/2025) Amlactin Daily External Lotion 12% (Lactic Acid (Ammonium Lactate), apply to bilateral (both) feet topically every morning and at bedtime for dry skin. Wash feet with soap and water before applying lotion (07/20/2025) A review of Resident #28's August 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed missing documentation used to verify that the following medications were administered: Ferrous Sulfate oral tablet 325 (65 Fe) mg for anemia was missing signatures on 8/10/2025 and 8/13/2025 verifying that the medication was administered. Plavix oral tablet 75 mg for antiplatelet was missing a signature on 8/9/2025 verifying that the medication was administered. Vitamin C oral tablet (Ascorbic Acid) for iron absorption was missing signatures on 8/10/2025 and 8/13/2025 verifying that the medication was administered. Risperidone Oral Tablet 2 mg for schizophrenia was missing a signature on 8/9/2025 verifying that the medication was administered. Amlactin Daily External Lotion 12 % (Lactic Acid (Ammonium Lactate) was missing signatures on 8/9/2025 and 8/12/2025 verifying that the medication was administered. (Copy obtained) A review of the 5-day minimum data set (MDS) assessment dated [DATE] revealed that the resident was receiving antipsychotic and antiplatelet medications. He had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 possible points, indicating intact cognition. On 08/27/2025 at 10:29 AM, Licensed Practical Nurse (LPN) H was asked if the resident complained about not receiving his medications at all or receiving his medications late. LPN H replied, No, I give it to him on time. LPN H was asked about the following medications that were missing the documentation to verify that they were administered: Ferrous Sulfate oral tablet 325 (65 Fe) mg for anemia missing signatures on 8/10/2025 and 8/13/2025. She replied, I'm not sure what happened. It was 5:00 AM medication in the morning. I was not at the facility. Plavix oral tablet 75 mg for antiplatelet, missing a signature on 8/9/2025. She replied, That's night shift. Vitamin C oral tablet (Ascorbic Acid) for iron absorption, missing signatures on 8/10/2025 and 8/13/2025. She replied, That's an AM medication. I'm not sure. Risperidone oral tablet 2 mg for schizophrenia, missing a signature on 8/9/2025. She replied, Night shift. Amlactin Daily External Lotion 12 % (Lactic Acid (Ammonium Lactate), missing signatures on 8/9/2025 and 8/12/2025 to verify that the medication was administered. She replied, Night shift. On 08/27/2025 at 11:52 AM, the Assistant Director of Nursing (ADON) was asked to verify that the following medications, missing signatures on the MAR to verify administration, were provided: Ferrous Sulfate oral tablet 325 (65 Fe) mg for anemia, missing signatures on 8/10/2025 and 8/13/2025; Plavix oral tablet 75 mg for antiplatelet, missing a signature (continued on next page)		

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