STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105570	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Indigo Manor	595 N Williamson Blvd Daytona Beach, FL 32114

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and policy and procedure review, the facility failed to provide fingernail care for one (Resident #3) of five residents reviewed for Activities of Daily Living (ADLs), from a total survey sample of 7 residents. The finding include:On 02/17/26 at 10:49 AM, Resident #3 was observed sitting in a wheelchair adjacent to the south unit nurse's station. Several of the resident's fingernails of both hands were observed as jagged and extended approximately 1/2 inch beyond the nail bed. When the resident was asked about his nails, he stated he did not like his nails so long but could not remember if he asked the facility staff to trim his fingernails. (Photographic evidence obtained)A review of Resident #3's medical record revealed he was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), unspecified, type II diabetes mellitus without complications, pseudobulbar affect, chronic kidney disease, stage 2 (mild), and dementia in other diseases classified elsewhere.A review of the quarterly minimum data set (MDS) assessment, dated 10/1/25, revealed the resident had a brief interview for mental status (BIMS) score of 07/15, indicating severe cognitive impairment. No psychosis or behaviors were indicated. A review of his functional status revealed he required extensive to dependent assist with activities of daily living (ADLs). A review of Resident #3's most recent care plan revealed he was care planned for ADL self-care performance deficit related to impaired cognition and functional mobility. The care plan goal noted that the resident will participate in care as able and be clean and well-groomed through next review. Care plan interventions included assisting the resident with ADL care daily including showers, transfers, incontinent care, dressing, bathing, toileting, hygiene, dining; reapproach if care is refused. The resident requires nail care as needed.personal hygiene and is dependent upon staff. The care plan did not contain information related to the resident rejecting care. On 02/17/26 at 11:42 AM, an interview was conducted with Certified Nursing Assistant (CNA) E. After observing Resident #3's fingernails, she confirmed the resident's fingernails were too long and they should have been trimmed. She further explained that resident fingernails are usually trimmed during shower days while fingernails are soft.On 02/17/26 at 12:14 PM, an interview was conducted with Licensed Practical Nurse (LPN) F. After observing Resident #3's fingernails, she confirmed that the resident's fingernails were much too long. She explained that she was familiar with the resident's care needs, which included ADL assistance. She stated that she administered medications to Resident #3 this morning but did not notice the resident's fingernails were excessively long. She further explained that the CNAs usually trim resident fingernails on shower days when the fingernails are softer and easier to trim. On 02/17/26 at 1:12 PM, a second observation was made of Resident #3's resident's fingernails. Both hands were observed as jagged and extended approximately 1/2 inch beyond the nail bed. (Photographic evidence obtained)On 02/17/26 at 1:24 PM, an interview was conducted with Licensed Practical Nurse (LPN) I/Unit manager, who explained that CNAs and nurses are permitted to file resident (continued on next page)

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

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fingernails.On 02/17/26 at 2:22 PM, an interview was conducted with the Assistant Director of Nursing (ADON), who explained the process to trim resident fingernails. Nurses and CNAs are permitted to trim nails, but if the resident is diabetic, a nurse must trim the resident's fingernails. CNAs are instructed to document shower assistance on a shower sheet, which is kept in a binder at the nurse's station. There is an area on the shower sheet for CNAs to note whether a resident needs to have toenails trimmed, and the CNA must circle the body diagram noting fingernails need attention. A review of shower sheets for Resident #3 lacked documentation showing the resident required attention to his fingernails. A review of Activities of Daily Living (ADL), Supporting Policy (undated) revealed the following: Residents are provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.5. Appropriate care and services are provided for residents who are unable to carry out ADLs independently, and with the consent of the resident, and in accordance with the plan of care, including appropriate support and assistance with: a) hygiene (bathing, dressing, grooming and oral care). (Photographic evidence obtained)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on kitchen food service observations, staff interviews, facility document review, and facility policy and procedure review, the facility failed to follow proper sanitation and food handling practices to prevent the outbreak of foodborne illness, with the potential to affect all residents who consumed foods from the facility, by failing to maintain sanitary conditions in the cooking area, with significant accumulation of grease buildup, food debris and residue, and heavy soilage on both floor surfaces and equipment. Food handling and sanitation are important in health care settings serving nursing home residents. Unsafe food handling practices represent a potential source of pathogen exposure.The findings include:A tour of the kitchen was conducted on 2/17/26 at 10:15 am. During the tour the following unsanitary conditions were observed: food residue on equipment and cookware, grease buildup, accumulated debris, and grime on the kitchen floor in and around the cooking area. (Photographic evidence obtained)A follow-up tour of the kitchen was conducted on 2/17/26 at 3:27 pm. The same observations were made of food residue on equipment and cookware, grease buildup, accumulated debris, and grime on the kitchen floor in and around the cooking area. (Photographic evidence obtained)On 2/17/26 at 12:10 pm, an interview was conducted with Employee J, dietary aide, who reported dietary aides and cooks are responsible for stocking the dry storeroom. Employee J confirmed the facility policy around date marking food and discarding after 3 days and explained that the cooks are responsible for cleaning the kitchen and food service equipment daily or after each use. The dietary aides are responsible for cleaning the microwave and ice machine in the nourishment rooms.On 2/17/2026 at 1:47 pm, Employee B, Certified Dietary Manager (CDM) reported the cooks were responsible for cleaning the cook area. The CDM stated her goal is to schedule a deep cleaning by the end of this month; the last kitchen deep cleaning was completed in January 2025. The cleaning schedule includes a list of daily cleaning assignments and assigned deep cleaning. Deep cleaning consists of cleaning bins, cooler racks, wiping walls, and inside and out of seals. She also stated the CDM was responsible for ensuring cleaning was completed daily in the kitchen.On 2/17/26 at 3:38 pm, Employee C, dietary aide, reported the cook was responsible for cleaning their area. The Pot staff clean their area. Dietary aides clean all other areas which include the tray line, scrape carts, clean belt, and mop floor. Cleaning is completed daily. At the start of her shift, duties consist of prep; cleaning; organizing; wipe out refrigerator; scrape/empty food carts; sanitize, rinse, and dry food carts. The same cleaning routine is completed after dinner.On 2/17/26 at 3:52 pm, Employee D, cook, reported the scheduled cook was responsible for cleaning the cook area but all staff should participate and do not. When this happens, he informs the CDM. He stated he was aware that cleaning should be completed daily. A review of the facility's policy and procedure entitled Food Safety/Sanitation, dated: 3/1/2020 revealed Policy: Cleaning and Sanitation of dining and food service areas: The food and nutrition services staff will maintain the cleanliness and sanitation of the dining and food service area through compliance with a written, comprehensive cleaning schedule. (Copy obtained)Reference: FDA Food Code 2022, https://www.fda.gov/media/184685/download?attachment reviewed 2/23/2026, Chapter 4. Equipment, Utensils, and Linens. 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. 4-6 Cleaning of Equipment and Utensils, 4-601 Objective, Equipment Food-Contact Surfaces and Utensils. (A) Equipment Food Contact Surfaces and Utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and facility policy review, the facility failed to ensure one (Resident #7) of five sampled residents' room were maintained in a safe, functional, sanitary, and comfortable environment by leaving disposable razors unattended on the resident's bedside table. The findings include:On 02/17/26 at 11:13 AM, two unused disposable razors were observed on Resident #7's bedside table. When asked about the razors, the resident reported that a certified nursing assistant (CNA) brought the razors into his room and abruptly left before providing shaving assistance. He couldn't remember the name of the CNA or whether the incident occurred during the daytime or nighttime shift.A review of Resident #7's medical record revealed he was admitted to the facility on [DATE] with diagnoses including muscle wasting and atrophy, muscle weakness, type II diabetes, chronic obstructive pulmonary disease (COPD), peripheral vascular disease, unspecified, chronic systolic (congestive) heart failure, and major depressive disorder.Further record review revealed that Resident #7 is alert and oriented to person, place and time. He communicates verbally, with clear speech and is able to understand others and be understood by others. On 02/17/26 at 12:33 PM, Registered Nurse (RN) G was observed removing two disposable razors from Resident #7's room. She said that the razors did not appear to be facility disposable razors and thought that perhaps a family member brought the disposable razor to the resident's room. She explained that residents are not permitted to keep disposable razors in their room and CNAs should remove razors after providing shaving assistance. On 02/17/26 at 12:53 PM, an interview was conducted with CNA H, who is assigned to Resident #7 and is familiar with his care needs. She explained that she provided care to the resident in his room this morning and did not notice disposable razors on the resident's bedside table. She further explained that residents are not permitted to have disposable razors unattended in their room. If she had seen the razors in his room, she would have removed the razors and reported it to her nurse. On 02/17/26 at 5:20 PM, an interview was conducted with the DON. She reported that razors are not permitted in resident rooms, as anyone could potentially wander into the resident's room and injure themselves. She has informed CNA staff that after providing shaving assistance, they must immediately remove the razor from the resident's room and dispose of the razor in a sharp's container. She makes attempts to educate residents and their families to inform facility staff when they bring personal items to resident's rooms. Facility staff conduct quarterly cleaning of resident rooms and ask families to help remove unnecessary items from resident rooms and inform them of items brought into the facility which were not listed on resident inventory sheets. CNAs have been instructed to immediately inform her if they observe items such as disposable razors in a resident's room. A review of the facility's policy titled, Needlesticks and Cuts, Revision Date: August 2013, documented All personnel must follow our facility's established procedures to help prevent injuries caused by needlesticks, sharp blades, broken glass, or other sharp instruments or devices, and to report all such incidents that occur. (Photographic evidence obtained)