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	03/13/2025

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** 28892 Based on observations, interviews, and record review, the facility failed to provide toenail care for one (Resident #33) of four residents reviewed for Activities of Daily Living (ADLs), from a total survey sample of 41 residents. Resident #33's toenails extended approximately one half inch beyond the nailbed and were jagged. The findings include: An observation made on 03/10/25 at 1:43 PM, revealed that Resident #33's toenails extended approximately one half inch beyond the nail bed and were jagged on both feet. (Photographic evidence obtained) An interview was attempted with the resident, but he did not respond. On 03/11/25 at 10:44 AM, Resident #33's toenails were observed and were in the same condition as the previous day's ovservation. They extended approximately one half inch beyond the nail bed and were jagged on both feet. (Photographic evidence obtained) An interview was again attempted with the resident, but he did not respond. During an interview with Certified Nursing Assistant (CNA) B on 03/13/25 at 11:37 AM, she reported that she had been employed by the facility since July 2024 and was familiar with Resident #33 and his care needs. She stated the resident was dependent for ADLs and further explained that she considered toenails extending a half inch beyond the nailbed as too long and that they should be trimmed. She said that while she provided residents' ADL care, she made observations of their personal hygiene needs. If, during provision of care, she discovered a resident had long toenails, she would ask the resident for permission to trim the nails. She would then check the electronic medical record (EMR) to determine whether facility staff were permitted to trim the resident's toenails. If the resident was able to have their nails trimmed by staff, she would use nail clippers, which were located in the clean supply room near the nurses' station. After trimming the nails, she would document it in the task tab of the EMR. When asked if she saw Resident #33's toenails, she stated she did not look at his toes when she recently changed his brief and hospital gown. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105570	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Indigo Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 595 N Williamson Blvd Daytona Beach, FL 32114	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Licensed Practical Nurse (LPN) C on 03/13/25 at 12:00 PM, she stated she had been employed by the facility for three months and was familiar with Resident #33 and his care needs. She stated she considered excessive toenail length as any growth beyond the nail bed. She said that long nails could result in snagging and scratching hazards. She stated while administering medication, if she noticed a resident had long toenails, she would ask the resident for permission to arrange for their toenails to be trimmed. She would then ask Social Services to place the resident on the list for podiatry. She stated even if a resident was not diabetic, facility staff were not permitted to trim toenails. She reported that she did not notice Resident #33's toenail length while recently administering his medication. On 03/13/25 at 12:11 PM, CNA B was accompanied to Resident #33's room to observe his toenails. She verified that his toenails were too long and could be a scratching hazard. During an interview with the Assistant Director of Social Services on 03/13/25 at 1:50 PM, she stated the nurse unit managers notified her when a resident needed to be added to the list for a podiatrist visit. Her process to arrange podiatrist visits for residents included sending an email to the podiatrist's office, and receiving confirmation of when the podiatrist would come to the facility to see the residents. After checking her records, she stated no requests were noted for trimming Resident #33's toenails, and the last time he was seen by the podiatrist was for a routine foot care visit on 05/23/24. A review of Resident #33's medical record revealed an admitted [DATE] and diagnoses including metabolic encephalopathy, diabetes mellitus, diabetic retinopathy, traumatic subdural hemorrhage, other cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, aphasia (language disorder affecting a person's ability to communicate) following cerebral infarction, diabetic polyneuropathy, tinea unguium (fungal infection of the nails), age-related cataracts bilaterally, altered mental status, contracture of left elbow, contracture of left hand, and epilepsy. A review of the Minimum Data Set (MDS) assessment for Resident #33, dated 01/17/25, revealed no brief interview of mental status (BIMS) score. The resident had no hallucinations or delusions; no verbal or physical behavioral symptoms directed toward others; and did not exhibit wandering or refusal of care. The resident had impairment on one side of the upper and lower extremities. The resident was assessed as dependent in all selfcare ADLs and received enteral nutrition. All mobility was assessed as either dependent or not applicable. A review of the resident's care plan revealed a focus area for Physical Functioning Deficit related to mobility impairment and range of motion limitations. The care plan goal documented that the resident would receive passive range of motion to the left elbow, left wrist and left hand up to seven days a week through next review. Resident will tolerate left hand and elbow splints up to seven days a week through next review. The resident will maintain his current level of physical functioning and have no complications through next review date. Initiation date was 05/10/22 and revision was 11/19/24. The target date of the care plan was documented as 01/17/25. Interventions included nail care as needed. Initiation date was 08/09/22 and revision was 11/09/22. Interventions also included personal hygiene, dependent with assistance of one. Initiation date was 08/09/22 and revision was 08/23/24. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy for Activities of Daily Living (ADLs) (implemented: 01/01/2022; date reviewed/revised (blank); reviewed/revised by: (blank) revealed: Policy: . Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care . Policy Explanation and Compliance Guidelines: 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene . 5. The facility will maintain individual objectives of the care plan and periodic review and evaluation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28892 Based on observations, interviews, and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as was possible; and that each resident received adequate supervision to prevent accidents for one (Resident #7) of three residents reviewed for accidents, from a total survey sample of 41 residents. Resident #7 was discovered keeping smoking materials on self. The findings include: On 03/10/25 at 9:55 AM, an observation was made of Resident #7 holding a cigarette lighter while seated in his wheelchair on the elevator going to the first floor. On 03/13/25 at 10:29 AM, Resident #7 was observed in his room and was interviewed. He reported that he was a smoker and smoked during the 8:00 AM, 10:00 AM, 1:00 PM and 3:00 PM smoking breaks. He further reported that he kept his cigarette lighter in the dresser next to his bed. He became agitated and yelled that the facility could just take his lighter and take it all away. During an interview with the Assistant Director of Nursing (ADON) on 03/13/25 at 10:50 AM, the ADON explained that Resident #7 had been a cigarette smoker for a long time and often asked visitors to borrow a lighter. He would never return it and would then pocket the lighter. The ADON stated the resident often arrived to smoke breaks and produced a lighter from his pocket to light his cigarette. Facility staff continually found the resident with lighters and took them away for safe storage. The ADON further explained that the resident had been informed that he could not keep lighters on himself or in his room, as it posed a safety hazard, yet the resident continued to produce lighters during smoke breaks. During an interview with Certified Nursing Assistant (CNA) D on 03/13/25 at 11:27 AM, she reported she had been employed by the facility since April 2023 and was assigned as the smoking attendant. She explained that the Staffing Coordinator trained her on the facility's smoking policy. She stated safety precautions included only issuing residents one cigarette at a time during smoke breaks. Residents were permitted to smoke two cigarettes during the 15-minute break but they were not permitted to use lighters. She was responsible for lighting cigarettes. Facility staff kept resident lighters and cigarettes in individual plastic bags labeled with the residents' names. The bags containing resident cigarettes and lighters were stored in a bin at the receptionist area. She further explained that safety precautions included smoking bibs for residents assessed as a risk, and oxygen tanks were not permitted in the smoking area. At the end of each smoke break, she emptied ashtrays with cigarette butts in a designated red metal bin, which was not accessible to residents. She reported that if she were to see a resident produce a cigarette or lighter, she would inform the Director of Social Services. If the resident refused or was noncompliant with smoke break rules, she would inform the ADON or DON. She said she did not see Resident #7 with a cigarette lighter. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the ADON at 2:30 PM on 03/13/25, she explained that she had spoken to Resident #7 numerous times about not using lighters and that they posed a safety risk to the resident. She stated she had reviewed the resident smoking agreement with the resident several times, and the resident continued to be noncompliant with the facility's smoking policy. A review of Resident #7's medical record revealed that he was admitted to the facility on [DATE] with diagnoses including dementia with other behavioral disturbance, vascular dementia with psychotic disturbance and agitation, age-related bilateral cataracts, repeated falls, major depressive disorder, other specified persistent mood disorders, and paranoid schizophrenia. A review of the Minimum Data Set (MDS) assessment dated [DATE], revealed that Resident #7 had a brief interview for mental status (BIMS) score of 7 out of 15 possible points, indicating severe cognitive impairment. Verbal behavior directed toward others occurred 4-6 days during the look-back period. The resident had no impairment in upper or lower extremity mobility; used a walker, and was independent in all self-care and mobility. He received antidepressant, antiplatelet and anticonvulsant medications. A review of Resident #7's care plan revealed a focus area for At Risk for Smoking-Related Injury related to: smokes independently during designated times under supervision of facility staff per agreed upon policy. He will keep his own smoking material and does not always adhere to smoking policy. Date focus initiated: 08/29/22. The care plan goal documented the resident was to maintain independence safely while smoking during designated times under supervision of facility staff per agreed upon policy through next review. Date goal initiated: 08/29/22; revision date: 11/29/24; target date: 02/26/25. Care plan interventions included: document any episodes of non-compliance with smoking policy. Date initiated: 02/28/23. Explain to resident danger of non-compliance, including risk for facility fire. Date initiated: 02/28/23. Observe patient for unsafe smoking behaviors or attempts to obtain smoking material from outside sources. Immediately inform facility management. Date initiated: 08/29/22. Patient not to have cigarettes or smoking material on person. Date initiated: 12/03/22. Storage of smoking materials per Living Center policy. Date initiated: 08/29/22. A review of the progress notes for Resident #7 revealed no documented evidence of incidents related to smoking or possession of smoking material. A review of the facility's smoking list confirmed that Resident #7 did smoke. A review of smoke break assignment sheet revealed that staff were assigned to supervise residents during smoke breaks at 8:00 AM, 10:00 AM, 1:00 PM, 3:30 PM, 6:00 PM and 8:00 PM. It further documented that each department manager would be responsible for making sure the smoke breaks were assigned. Smoking materials could be picked up at the reception desk in the front lobby. A review of the resident smoking agreement, signed by Resident #7 on 01/03/25, and witnessed and signed by facility staff revealed: 1. Smoking times. 2. All smoking materials will be maintained by nursing staff . 11. If you do not abide by the smoking policy (e.g. smoking materials are provided directly to the resident . the plan of care may be revised to include additional safety measures. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Attachment D, titled Tobacco-Restrictive Policy Acknowledgement, revealed that it was the policy of the facility to discourage any smoking in the facility. However, we are also understanding of the fact that as a skilled nursing and rehabilitation facility, some of our residents may choose to smoke . Purpose . to reduce the risk of fire. Procedure: Every resident who smokes will be assessed for safety . Staff will dispense the resident's cigarettes, light the cigarette, and stay with the resident until the cigarette is properly extinguished . For qualified residents, cigarettes, lighters and any other smoking materials will be kept at the nurses' station .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45153 Based on observation, interview, record review, and policy and procedure review, the facility failed to ensure ensure that one (Resident #137) of 39 residents receiving respiratory care, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Resident #137 was not receiving oxygen at the ordered flow rate. The findings include: On 03/10/25 at 1:51 PM, Resident #137 was observed lying in bed receiving oxygen via nasal cannula (NC). The oxygen concentrator located next to the head of her bed had a flow rate setting of 3.25-3.50 Liters per minute (L/min). (Photographic evidence obtained) On 03/13/25 at 12:50 PM, while checking the resident's oxygen flow rate, Licensed Practical Nurse (LPN) K verified that Resident #137's oxygen flow rate setting was currently set at 4 L/min, but the oxygen order was for a flow rate of 2 L/min. She stated nurses provided ongoing monitoring of the resident's oxygen therapy. Nursing was responsible for ensuring that the resident was receiving the correct oxygen flow rate per the physician's order. Correct oxygen settings were identified by checking the resident's chart on the computer. Nursing staff on the night shift were responsible for changing the resident's oxygen tubing and concentrator. Correct settings were communicated from one staff person to another through shift reports. Resident #137 would remove her nasal cannula but did not change her own flow rate settings. When Resident #137 refused oxygen therapy, nursing staff ensured her oxygen was at saturation level; she would comply when provided with an explanation of why the oxygen was needed. On 03/13/25 at 4:52 PM, the Director of Nursing confirmed that correct oxygen settings were identified by reviewing the physician's orders. A review of Resident #137's medical record revealed the following active orders: Oxygen at 2 L/min via NC as needed for oxygen saturation below 92% every shift. Place NC or mask in bag when not in use (3/11/2025). No oxygen order was located in the medical record prior to 3/11/25 when the resident was observed receiving oxygen at 3.25-3.50 L/min. Other orders related to oxygen included: Change oxygen tubing every Thursday night on 7 PM to 7 AM shift every night shift every Thursday (3/11/2025); May remove oxygen for transport and showers every shift (3/12/2025). (Photographic evidence obtained) A review of the resident's medical record revealed an admitted [DATE]. Her diagnoses included: hypertensive heart disease without heart failure; major depressive disorder; insomnia; anxiety disorder; other specified depressive episodes; dementia; and encounter for palliative care. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Quarterly minimum data set (MDS) assessment, dated 02/27/25, revealed that the resident was not identified as requiring oxygen. A review of the active care plan, focus and goals revealed no care plan for oxygen therapy. A review of the Medication Administration Record (MAR) for March 2025 revealed an order for providing oxygen at 2 L/min via nasal cannula as needed for oxygen saturation below 92% every shift. Place NC or mask in bag when not in use. The date ordered by the physician was 3/11/25. (Copy obtained) A review of the facility's policy and procedure titled Medication Administration (dated: 01/01/24), revealed: Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines . 14. Administer medication as ordered in accordance with manufacturer specifications. (Copy obtained)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48947 Based on observations, staff interviews, medical record review, and facility policy and procedure review, the facility failed to ensure that its medication error rate was not 5% or greater. Two medication errors out of 25 opportunities for error, resulted in an error rate of 8 % and involved Residents #45 and #113. The findings include: On 03/12/25 at 12:44 PM, Registered Nurse (RN) L was observed preparing Oxycodone-Acetaminophen 10/325 mg (milligrams), 1 tablet by mouth every 6 hours routinely for Resident #45 in room [ROOM NUMBER]-2. RN L was then accompanied into room [ROOM NUMBER]-1 where Resident #77 was lying in bed. RN L greeted the resident and explained that she was going to administer pain medication the resident had requested. The nurse asked Resident #77 what her pain level was and at that point, was asked to hold the medication and step outside of the resident's room. RN L was asked if she had chosen the right patient, medication, dose, time, and frequency. RN L was accompanied back to the medication cart to review Resident #45's Narcotic Reconciliation Sheet and current MAR (medication administration record). RN L acknowledged that she almost medicated the wrong resident. On 03/13/25 at 8:37 AM, Licensed Practical Nurse (LPN) M was observed preparing medication to administer to Resident #113. Among the medications pulled for administration was Docusate Sodium 100 mg. After LPN M prepared the medications she intended to administer, she was asked if she intended to administer the medications that she had prepared. She confirmed that she was going to administer them. She was asked to recheck the over-the-counter medication bottles that she poured from against the resident's MAR (medication administration record). LPN M acknowledged that the resident did not have an order for Docusate Sodium. The resident had an order for Senna 8.6 mg by mouth daily. LPN M acknowledged that she almost administered medication that had not been ordered for Resident #113. A review of the facility's policy and procedure for Medication Administration (implemented: 01/01/2024), revealed: Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and compliance guidelines: 3. Identify resident by photos in the MAR (medication administration record) 10. Review MAR to identify medication to be administered 11. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 45153 Based on kitchen food service observations, staff interviews, record 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's kitchen, by failing to log proper temperatures for the dish machine and chemical sanitization for the 3-compartment sink, and clean food buildup stuck on the back handle and under the safety guard of the mixer. Food handling and sanitation is 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 03/10/25 at 11:07 AM. During the tour, a review of the dish machine temperature logs for January, February, and March 2025, revealed a wash temperature of 140 degrees Fahrenheit (F) and a rinse temperature of 145 degrees F, consistently. Further, a review of the 3-compartment sink, Pot/Pan temperature logs for January (29th, 30th, and 31st), February, and March 2025 revealed chemical sanitation at 190 ppm (parts per million), consistently. Dietary Aide J explained ware washing of the 3-compartment sink and stated the ppm should be 190 followed by 400. Dietary Aide J completed another sanitization test and stated the ppm reading was 200 - 400, and again at 400 - 500. When asked if he had been provided with training on ware washing at the 3-compartment sink, he replied that his last training was four years ago. [NAME] L explained ware washing of the 3-compartment sink and stated, Dishes are air dried and sanitation should be above 150. (Copy obtained) A follow-up tour of the kitchen was conducted on 03/12/25 at 11:30 AM. During the tour, the mixer located next to the oven had brownish-colored food buildup stuck on the back handle and under the safety guard of the mixer. On 3/13/25 at 10:33 AM, the same observations were made again of the mixer located next to the oven with brownish colored food buildup stuck on the back handle and under the safety guard of the mixer. (Photographic evidence obtained) An interview was conducted on 03/13/25 at 10:40 AM with Dietary Aide F. She reported that Dietary Aide staff rotated using the dish machine. She had been assigned to the dish machine for about one month. She was usually assigned to prep, work the tray line, and take resident meal orders using the tablet. Dietary Aide F reported that the dish machine was a high-temperature machine and the wash temperature should reach 104 degrees. Sanitation strips were used to test the dish machine's sanitation. The pot staff were responsible for washing dishes in the 3-compartment sink. She was not sure about the chemical sanitation or what was prepared using the mixer. She stated the mixer had not been used. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview was conducted on 03/13/25 at 11:02 AM with [NAME] H. She stated Dietary Aides were responsible for use of the dish machine. The dish machine was a low-temperature machine and the temperature should be greater than 120 degrees. The pot washer was responsible for use of the 3-compartment sink. When asked how staff tested for proper chemical sanitation and where that was logged, she replied, Dip the strip in water but she was not sure of the ppm. When asked what was prepared using the mixer, she replied, Nothing, it has not been used since I started one year ago. [NAME] H stated she received training on the dish machine and 3-compartment sink a couple of months ago in January 2025. An interview was conducted on 03/13/25 at 11:08 AM with Dietary Aide I. She stated Dietary Aides rotated working the dish machine. The dish machine was a low-temperature machine with temperatures ranging from 120-140 degrees. Chemical sanitation using test strips should read 50 ppm. The pot washer was responsible for use of the 3-compartment sink. When asked how staff tested for proper chemical sanitation, she replied, Test strips and the ppm should be 50. When asked who was responsible for logging the temperatures on the log, she replied, Whoever is the dish washer. I logged this morning because I was the dish washer. When asked what was prepared using the mixer, she replied, cakes and cookies. She had not seen the mixer used since her employment at the facility, over approximately one month's time. Dietary Aide I stated she recently received training on the dish machine and 3-compartment sink. An interview was conducted on 03/13/25 at 11:16 AM with Dietary Aide J. He reported that Dietary Aides were responsible for the use of the dish machine. Dietary Aide J was not sure what the proper temperature should be to show that the machine was working accurately. He stated he was responsible for washing pots and pans in the 3-compartment sink. He stated he tested sanitation using the test strip and the ppm should be 200. Dietary Aide J was also responsible for cleaning the mixer. He stated meat loaf was prepared last Friday using the mixer. His last training on the dish machine and 3-compartment sink was two years ago. During an interview with the Certified Dietary Manager (CDM) on 03/13/25 at 11:23 AM, the CDM confirmed that the Dietary Aides were responsible for use of the dish machine. When asked how staff tested for sanitation of the dish machine and what the proper ppm was, the CDM replied, Staff should run the dishwasher until it gets up to temperature and test using a test strip. The ppm should be 50. The pot washer is responsible for use of the 3-compartment sink. Use a test strip to determine proper chemical sanitation by dipping the strip in the sanitation sink to compare the strip to the card; it should read 200 ppm. The CDM confirmed sanitation for ware washing was 200 ppm and sanitation for the dish machine was 50 ppm. The cook is responsible for cleaning the mixer after each use. She confirmed the mixer is not a piece of equipment Dietary use on a regular basis; it was last used about one year ago. The CDM provided a copy of the kitchen and equipment cleaning schedule but stated she did not currently have a tracking method to show duties completed. (copy obtained) A review of the facility's policy and procedure titled Procedures for Cleaning Equipment Sanitation (undated), revealed: Procedure for cleaning food mixer. Immediately after use; 1. As soon as the food has been emptied from the mixer, disconnect the electric power; 2. Remove the bowl and beaters to the dishwasher; run through the wash and rinse cycle and air dry; 3. Wash the base of the unit with warm detergent solution; rinse and air dry. Be sure to wash splash-up areas. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105570	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Indigo Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's policy and procedure titled 3-Compartment Sink (dated 3/1/23), revealed: Food and nutrition services staff must be trained to properly utilize the 3-compartment sink to manually wash, rinse, and sanitize food equipment, dishes, utensils, and removable parts from equipment. Compliance Guidelines: pre-scrape all dishes before proceeding . c. utilizing the Hydrion tester dip a 1-inch piece of the strip in the sanitized water. Compare the color of the strip to the chart in the case. The sanitizer level should be 200 ppm. Record the ppm and initials on the pot and pan log provided. A review fo the facility's policy and procedure titled Low-Temp Conveyor Dish Machine (dated 3/1/23), revealed: Food and nutrition staff must be trained to properly utilize the Low-Temp Conveyor Dish Machine to wash, rinse, and sanitize food equipment, dishes, utensils, and removable parts from equipment. Compliance Guidelines: Pre-scrape all dishes before proceeding . 2. Close the dish machine door and allow the machine to run a complete cycle. Do this a minimum of 2 times to ensure the water is getting hot . 3a. Check machine's temperature gauge is operating while it is running in both the wash and rinse cycles; wash temp of min 120-150 max, rinse temp of min 120-150 max; record the temp on the dish log provided; do not move to the next step if these criteria were not met. Notify Dietary Director, Dietitian, or Kitchen Manager immediately for next step. 4. After the cycle completes test the sanitizer ppm level utilizing a chlorine test strip. 4a. touch the strip to the surface of the plate and compare to ppm chart on the bottle; approved chlorine rate is 50-100 ppm at 120-140 degrees; record the ppm on the dish log provided; do not move to the next step if these criteria were not met. Notify Dietary Director, Dietitian, or Kitchen Manager immediately for next step. (Copy obtained) Reference: FDA Food Code 2022 Page 126. https://www.fda.gov/media/164194/download?attachment (Accessed on 3/14/2025): Chapter 4 Equipment, Utensils, and Linens, 4-6 Cleaning of Equipment and Utensils; 4-601 objective; 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-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. .