STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105586	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak View Health and Rehabilitation Center	833 Kingsley Ave Orange Park, FL 32073

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 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 observations, interviews, record review, and facility policy and procedure review, the facility failed to ensure that residents who needed respiratory care received such care (oxygen therapy) as ordered for two (Resident #31 and #86) of three residents reviewed for oxygen use, from a total of 23 residents receiving oxygen. Both residents were observed receiving oxygen at a flow rate of 1.5 Liters per minute over several days. Each resident was ordered oxygen at a flow rate of 2.0 Liters per minute.

The findings include:

1. On 02/24/25 at 12:28 PM, Resident #31 was observed in bed receiving oxygen via a nasal cannula. The oxygen concentrator, located next to the wall at the head of his bed and out of his reach, was set with a flow rate of 1.5 L/min. (Liters per minute). (Photographic evidence obtained)

On 02/25/25 at 10:08 AM, Resident #31 was observed lying in bed. His nasal cannula was not in place. The oxygen flow rate setting on the concentrator was 1.5 L/min. (Photographic evidence obtained) Resident #31 stated he did not know where his call light was. It was attached to the sheet above the right side of his head. He was given his call light, and he pushed the button for staff assistance. Certified Nursing Assistant (CNA) F answered the call light and saw that the resident's nasal cannula was not in place. CNA F told the resident, You chewed it again. This is the second time today that [the resident] has chewed the cannula. He does that sometimes. CNA F took the nasal cannula from the bed and removed it from the concentrator, stating it would be replaced.

On 02/25/25 at 10:27 AM, Resident #31 was observed receiving oxygen via a nasal cannula with his oxygen concentrator flow rate set at 1.5 L/min. (Photographic evidence obtained)

A review of Resident #31's active physician's orders revealed:

Oxygen at 2 liters/min via nasal cannula. Humidification: yes (9/12/2024)

A review of Resident #31's medical record revealed an admitted [DATE]. The resident's diagnoses included acute and chronic respiratory failure with hypoxia.

A review of the resident's Quarterly MDS (minimum data set) assessment, dated 02/13/25, revealed that the resident was receiving hospice care, required oxygen therapy, and had a Brief Interview for Mental Status (BIMS) score of 5 out of 15 possible points, indicating severe cognitive impairment.

(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: 105586	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER: Oak View Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 833 Kingsley Ave, Orange Park, FL 32073	

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's care plan revealed a focus area for oxygen therapy related to signs/symptoms of poor oxygen absorption. Interventions included administration of medications as ordered by the physician and observe/document side effects and effectiveness. The resident's Medication Administration Record (MAR) for February 2025 was initialed by nursing as having administered oxygen at 2 L/min via nasal cannula, as ordered by the physician. (Copy obtained) 2. On 02/25/25 at 10:38 AM, Resident #86 was observed lying in bed receiving oxygen via a nasal cannula. He stated he had no concerns. When he was asked if he knew his prescribed oxygen flow rate, he did not respond. The oxygen concentrator located next to the head of his bed was set at 1.5 L/min. (Photographic evidence obtained) On 02/26/25 at 8:34 AM, Resident #86 was observed lying in bed receiving oxygen via a nasal cannula. The oxygen setting on his concentrator was set at 1.5 L/min. (Photographic evidence obtained) On 02/26/25 at 8:39 AM, Resident #31 was observed lying in bed receiving oxygen via a nasal cannula. The oxygen setting on his concentrator was set at 1.5 L/min. (Photographic evidence obtained) A review of Resident #86's active physician's orders revealed: Oxygen 2 L/min via nasal cannula. Humidification: yes; every shift (12/20/2024) A review of Resident #86's medical record revealed a readmission on 12/20/24 with an initial admitted [DATE]. His diagnoses included: COPD (chronic obstructive pulmonary disease) and shortness of breath. A review of the resident's Quarterly MDS (minimum data set) assessment, dated 02/04/25, revealed that he required oxygen therapy and had a Brief Interview for Mental Status (BIMS) score of 7 out of 15 possible points, indicating severe cognitive impairment. A review of the resident's care plan revealed a focus area for oxygen therapy related to ineffective gas exchange, COPD, and asthma. Interventions included administration of medications as ordered by the physician; observe/document side effects and effectiveness, and oxygen therapy per MD (physician) order. On 02/26/25 at 2:57 PM, Licensed Practical Nurse (LPN) D looked at the flow rate setting on Resident #86's oxygen concentrator, confirmed that the concentrator was set to 1.5 L/min, and stated the oxygen order was for 2 L/min. She further stated the nurses provided ongoing monitoring of the residents' oxygen therapy. Nursing was responsible for ensuring that the residents were receiving the correct oxygen flow rate per the orders. Correct oxygen settings were identified by checking the physicians' orders. Nursing staff on the night shift were responsible for changing the residents' oxygen tubing and concentrator. Correct settings were communicated from one nurse to another during shift change reports. LPN D stated Resident #86 habitually took off his nasal cannula. On 02/26/25 at 3:00 PM, LPN D verified that Resident #31's oxygen concentrator flow rate was set at 1.5 L/min. She stated when on shift, she checked Resident #31's oxygen frequently because he took his nasal cannula off all the time. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/26/25 at 3:42 PM, the Director of Nursing confirmed that correct oxygen settings were identified by checking the physicians' orders. A review of the facility's policy and procedure titled Oxygen Administration (revised: 05/04/22), revealed: Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Policy Explanation and Compliance Guidelines: 1. Oxygen is administered under orders of a physician, except in the case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control . 12. Staff shall notify the physician of any changes in the resident's condition, including changes in vital signs, oxygen concentration, or evidence of complications associated with the use of oxygen. (copy obtained)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	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, 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 date fresh fruit and vegetable products stored in open bins in the walk-in refrigerator. 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 02/24/25 at 10:13 AM. During the tour, no date markings and/or labels were observed on open bins filled with fresh fruit and vegetables stored in the walk-in refrigerator. One bin of onions, one bin of zucchini, one bin of tomatoes, one bin of green bell peppers, and one bin of cucumbers were observed. Another observation was made on 2/26/25 at 11:21 AM. During this time, new observations were made of no date markings on one open bin of apples and one open bin of oranges. (Photographic evidence obtained) An interview was conducted on 02/26/25 at 11:50 AM with Dietary Aide A who reported that she was responsible for date marking only the milk and juice products using the FIFO (first in first out) method. Dietary Aide/Cook B was responsible for date marking the other food items in the walk-in refrigerator. An interview on 02/26/25 at 11:52 AM with Dietary Aide/Cook B revealed that every Wednesday he stocked the refrigerator, freezer, and paper goods. He confirmed that he was responsible for date marking food items including fresh fruit and vegetables that were placed in the refrigerator. An interview was conducted with the Dietary Manager on 02/26/25 at 12:07 PM. She confirmed that Dietary Aide/Cook B was responsible for labeling and dating food received from the delivery truck and placed in the walk-in refrigerator. The Dietary Manager was accompanied to the walk-in refrigerator and confirmed that the fruits and vegetables stored in bins were not dated. She stated fruits and vegetables were ordered monthly. If any were old when the new stock was delivered, they were discarded. A review of the facility's policy and procedure titled Food Safety Requirements (dated 2024), revealed: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Policy: It is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state and local authorities. Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety. Policy Explanation and Compliance Guidelines: . 3. Facility staff shall inspect all food, food products, and beverages for safe transport and quality upon delivery/receipt and ensure timely and proper storage . c. Refrigerated Storage - Foods that require refrigeration shall be refrigerated immediately upon receipt or placed in the freezer, whichever is applicable. Practices to maintain safe refrigerated storage include: . iv. labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable)/discarded. (Copy obtained) Reference: FDA Food Code 2022. https://www.fda.gov/media/164194/download?attachment (Accessed on 02/27/2024) Annex 5. Conducting Risk-Based Inspections Annex 5 - 31 . 4. Establish First-In-First-Out (FIFO) Procedures: Product rotation is important for both quality and safety reasons. First-In-First Out (FIFO) means that the first batch of product prepared and placed in storage should be the first one sold or used. Date marking foods as required by the Food Code facilitates the use of a FIFO procedure in refrigerated, ready-to-eat, TCS foods. The FIFO concept limits the potential for pathogen growth, encourages product rotation, and documents compliance with time/temperature requirements.