

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: 105589	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Coquina Center		STREET ADDRESS, CITY, STATE, ZIP CODE 170 N Center Street 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure that three (Residents #1, #8 and #20) of three residents reviewed for dignity were able to exercise their right to dignity. Staff referred to Residents #1 and #8 as feeders, and were observed standing over Residents #1, #8 and #20 while assisting them with their meals. The findings include: 1. On 2/23/26 at 12:10 PM, Certified Nursing Assistant (CNA) I was observed in Resident #1's room assisting her with her lunch meal. Resident #1 was lying in bed while CNA I stood over her feeding her food from her lunch tray. This observation lasted five minutes. During an interview with CNA I at the time of the observation, she was asked if Resident #1 normally required assistance with her meal. CNA I stated the resident was a feeder but that she did not usually feed the residents and was not sure if the resident normally required assistance. On 2/25/26 at 12:00 PM, CNA F was observed in Resident #1's room assisting her with her lunch meal. Resident #1 was lying in bed while CNA F stood over her feeding her food from her lunch tray. This observation lasted 5 minutes. During an interview with CNA F at the time of the observation, she was asked if she received training related to assisting residents with their meals. She stated she received annual training in this area. She further stated she stood when feeding a resident in their room at bedside, and she sat when feeding residents in the dining room. A review of Resident #1's medical record revealed a quarterly Minimum Data Set (MDS) assessment conducted on 12/26/25 with a Brief Interview for Mental Status (BIMS) score of 6 out of 15 possible points, indicating severe cognitive impairment. The resident's medical diagnoses included dementia and anorexia. 2. On 2/24/26 at 10:05 AM during an interview with Licensed Practical Nurse (LPN) H, she stated she had removed Resident #8's breakfast tray from her room. She was asked if the resident had eaten any of her breakfast. She replied, yes, the CNA told her the resident ate a few bites of her breakfast and drank some juice. She was asked if the resident required assistance with eating her meals. She replied, Yes, she is an assisted feeder. A record review for Resident #8 revealed a quarterly MDS assessment dated [DATE] with a BIMS score of 5 out of 15 possible points, indicating severe cognitive impairment. The resident's diagnoses included congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). 3. On 2/24/26 at 1:15 PM, CNA G was observed in Resident #20's room assisting her with her lunch meal. Resident #20 was lying in bed while CNA G stood over her feeding her food from her lunch tray. This observation lasted seven minutes.		

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for one (Resident #128) of two residents reviewed for transfer/discharge. The findings include: A record review for Resident #128 revealed that the resident had been emergently transferred on 1/8/26. A nursing note dated 1/9/26 at 7:30 AM revealed: Upon coming onto my shift at 11pm, I received in report from the 3-11 nurse that (Resident #128's physician) had come to the facility and initiated customer to being (emergently transferred) related to aggressive behaviors toward staff. Police officer was already on site and EVAC (emergency medical transportation) arrived at approx 11:10 in which I helped assist the medics transfer resident onto the stretcher. Per police officer, customer was being transferred to (local) hospital. During an interview with the Director of Nursing (DON) on 2/25/26 at 12:58 PM, she was asked if Resident #128 had been transferred or discharged on 1/8/26. She stated the police (emergently transferred) her, not the facility. She was asked if the resident was in the facility and under the care of the facility when she was emergently transferred. She replied, Yes, I will get you the documentation we have to review. I was told because the police emergently transferred the resident, it doesn't fall under the facility. The DON returned 20 minutes later and stated, I called (local police) but they said they don't have a record of an (emergent transfer). I called (Resident #128's physician) and he said he completed the paperwork and handed it to the (local police). She was transferred by (emergency medical transport), not by police. She was status-post fracture, and the police transport would not have been appropriate. During an interview with the Administrator on 2/25/26 at 1:30 PM, she was asked if the local Ombudsman's office was notified of Resident #128's transfer on 1/8/26 along with the reason for the transfer. The Administrator replied, Yes, we have the faxed report to show they were notified on 2/10/26. A discharge report, which included Resident #128's discharge on [DATE], was reviewed. The report showed the resident was transferred to a local acute care hospital. The report did not show the reason for the transfer. The Administrator was asked if she had any information verifying that the local Ombudsman's office was notified of the reason for Resident #128's transfer/discharge. She provided a copy of a Nursing Home Transfer and Discharge Notice for Resident #128, dated 1/8/26. This report revealed: Reason for Discharge or Transfer: Your needs cannot be met in this facility. Brief explanation to support this action: [NAME] Act [The discharge form identified the brief explanation as [NAME] Act, indicating an involuntary emergency psychiatric evaluation for safety concerns.] The Administrator was asked if this report was sent to the Ombudsman's office. She replied, No. She was asked if she could confirm whether the reason for discharge was sent to the Ombudsman's office. She replied, No, the reason for transfer was not sent. On 2/26/26 at 9:30 AM during an interview with the Ombudsman, she was asked if her office was made aware of Resident #128's transfer on 1/8/26. She replied Yes, we have their monthly transfer/discharge report for January, and I see Resident #128 was transferred to (local hospital) on January 8th. She was asked if the facility reported to her office that this resident was sent out as an involuntary emergency psychiatric evaluation. She replied, No, we were not aware of that. I have explained several times both in person and on the phone to that facility's Administrator and Social Worker that whatever notice they send to the resident and/or family, they need to send to us, too, and they should be letting us know if any resident is sent out for an involuntary emergency psychiatric evaluation. During a follow-up interview with the Administrator on 2/26/26 at 9:50 AM, she was asked if she could confirm who was notified that Resident #128 was sent out for an involuntary emergency psychiatric evaluation on 1/8/26. She stated (resident's physician) was notified by the Unit Manager. She was asked if she could confirm whether the Ombudsman's office was notified not just of the transfer to an acute care facility, but of the reason for the resident's transfer. She replied, I believe they were sent (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the transfer/discharge notice which stated that on it. I'll need to confirm with Social Services. She returned a few minutes later and stated the transfer form was not sent to the Ombudsman's office. We send a monthly discharge report. We didn't notify the Ombudsman's office that the transfer was due to an involuntary emergency psychiatric evaluation. On 2/26/26 at 10:27 AM during an interview with Resident #128's physician, he was asked if he recalled sending Resident #128 out for an involuntary emergency psychiatric evaluation. He replied, Yes, that did happen. It was in January of this year. It was at night. I recall the facility calling and I could hear her screaming in the background. The facility had called me to say she was out of control, hitting staff, throwing things, yelling. I could hear her in the background. I came into the facility and asked her why she was acting this way. She just kept screaming and yelling and trying to throw things. Basically, she wasn't getting what she wanted. I decided to send her for an involuntary emergency psychiatric evaluation for her safety and the staff and other residents' safety. I filled out the paperwork and told staff to stay with her until she was transferred. I wasn't there when she was actually transferred. A review of the facility's policy titled Transfers and Discharges (effective 5/2020, revised 2/2024), revealed: Standard: The facility will develop and implement an effective discharge process that focuses on the residents' discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care. Procedure: 4. A copy of the transfer notice will be sent to the Office of the State Long-Term Care Ombudsman.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and interviews, the facility failed to review the accuracy and completion of the Preadmission Screening and Resident Review (PASRR) forms for two (Residents #70 and #44) of two residents reviewed for PASRR completion. Failure to ensure the accuracy/completion of the residents' PASRRs placed the residents at risk for not receiving needed services. The findings include: 1. A review of Resident #70's medical record revealed an admission date of 7/29/24 with diagnoses including brief psychotic disorder, major depressive disorder (MDD) - recurrent, insomnia, and signs/symptoms involving cognitive functions and awareness. An active physician's order dated 1/7/25 revealed Escitalopram Oxalate (antidepressant) Tablet 10 mg (milligrams) - Give 1 tablet by mouth one time a day related to major depressive disorder. A review of the active care plan (revised 11/12/25) revealed that the resident was at risk and/or had actual impaired cognitive function/impaired thought processes related to a diagnosis of brief psychotic disorder, unspecified signs and symptoms involving cognitive function and awareness, and a Brief Interview for Mental Status (BIMS) score of 00 out of 15 possible points, indicating severe cognitive impairment. A review of a psychiatric progress note dated 2/20/26 revealed that the reason for referral/chief complaint was follow up for mood, anxiety, adjustment and psychotic symptoms. The resident's psychiatric history was noted as MDD, dementia, mood disorder, psychosis and insomnia. A review of the resident's PASRR Level I, dated 7/23/24 section 1, revealed that the PASRR screening decision making was not completed. 2. A review of Resident #44's medical record revealed an admission date of 3/13/25 and diagnoses including encephalopathy, mental disorder, delusional disorders, dementia with unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, brief psychotic disorder, anxiety disorder, major depressive disorder - recurrent, moderate adjustment disorder with mixed anxiety and depressed mood. A review of the active care plan (revised 7/3/25), revealed that the resident had a history of exhibiting the following behaviors: History of non-compliance with smoking policy, non-compliance with medical care, refuses medications, history of calling 911, verbally aggressive/yelling out at staff. Hoarding cups. The care plan further noted that the resident was at risk and/or had actual impaired cognitive function/impaired thought processes related to acute encephalopathy, dementia, altered mental status (AMS), confusion, delusions, cerebral ischemia, parenchymal volume loss, memory and cognitive deficits, unspecified psychiatric disorder, adjustment disorder with mixed anxiety and depressed mood. A review of the resident's PASRR Level 1, dated 2/18/26 - Section 1, revealed that the PASRR screening decision making was not completed. Section II: Other indications for PASRR screen decision making. Question #2. Does the individual typically have or may have had at least one of the following characteristics on a continuing or intermittent basis? Interpersonal functioning: The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, fear of strangers, avoidance of interpersonal relationships, social isolation, or has been dismissed from employment. This was answered Yes. Section III: PASRR Screen Provisional admission or Hospital Discharge Exemption was noted as not a provisional Admission. Therefore, Level II PASRR should have been completed. In an interview with the Minimum Data Set (MDS) Coordinator on 2/25/26 at 2:34 PM, she stated the Social Services Director (SSD) and she reviewed PASRRs for new admissions during the clinical meetings. If any discrepancy was noted, the Admissions Department requested a new PASRR from the discharging facility or they completed a new PASRR at the facility. The MDS Coordinator stated current residents were reviewed quarterly for any new diagnoses to ensure that a new PASRR was not required. When she was asked to review Residents #70 and #44' PASRRs, she confirmed that the PASRRs were incomplete. She stated she would check the medical record for any additional copies. She said, I'm sure we reviewed them. During a follow-up interview with the MDS Coordinator on 2/26/26 at 1:25 PM, she confirmed that the PASRRs for Residents #70 and #44 were incomplete and there were no additional PASRRs found in (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical records. She added that she was conducting a whole house audit of all residents' PASRRs for accuracy.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interviews and record review, the facility failed to check gastric residual volume (GRV) for one (Resident #52) of three residents reviewed for enteral nutrition. Failure to check for gastric residual volume can result in accidental inhalation of food/liquid into the airway and lungs instead of the esophagus, which can lead to choking, lung infections and/or breathing difficulty. The findings include: A review of Resident #52's medical record revealed an admission date of 12/2/25 with diagnoses including quadriplegia (paralysis resulting in partial or total loss of function in all four limbs and the torso), protein-calorie malnutrition, gastrostomy (feeding tube) status, metabolic encephalopathy (brain dysfunction causing symptoms like confusion, delirium, tremors and/or seizures), expressive language disorder (difficulty expressing thoughts, ideas and feelings despite having normal comprehension). A review of the resident's active physician's orders revealed: Enteral Tube: Flush tube with 60 ml (milliliters) of water every 1 hour while feeding in progress. Total 1026 ml - ordered 2/25/26 Jevity 1.5 (enteral nutrition formula designed for tube feeding) at the rate of 75 ml per hour for 18 hours a day until the total volume (1350mL) is infused; 60 ml water auto flush every 1 hour while feeding in progress; Start feeding at 4:00 pm - ordered 2/25/26 NPO (Nothing by mouth) diet, NPO texture, NPO consistency - ordered 12/2/25 Enteral Tube: Check residual every shift. If greater than 60 ml, hold feeding for one hour. If residual remains greater than 60 ml, continue to hold feeding and notify physician. A review of the resident's active care plan (revised 1/13/26), revealed that the resident was at risk for Alteration in Nutrition/Hydration related NPO, g-tube (feeding tube) status, and risk for malnutrition. The care plan further noted that the resident required tube feeding related to multiple strokes. Interventions included following physician's orders regarding the nutrition orders and flushes. Check for tube placement and gastric contents/residual volume and record. Notify MD (physician) as indicated. A review of the Nutritional Note dated 2/25/26 revealed that the resident was tolerating her enteral nutrition and g-tube feedings. Recommendations included increasing formula as follows: Jevity 1.5 via pump at 75 ml/hour (milliliters per hour) x 18 hours. 60 ml water every 1 hour while feeding in progress (1026 mL H₂O); start pump at 4 pm and finish (pump off) at 10 am or when 1350 ml formula is infused. On 2/25/26 at 3:56 pm, Licensed Practical Nurse (LPN) E was observed administering nutrition via a g-tube (feeding tube) to the resident. The nurse donned a gown and gloves after performing hand hygiene. She hung a bottle of Jevity 1.5, ran the tubing through the pump and primed the tube. She flushed the resident's g-tube with 60 ml of water and connected the tube with the enteral nutrition to the resident's g-tube. LPN E turned on the pump which was preset to 75 ml/hour. She did not review the physician's orders first. She doffed her gown and gloves and performed hand hygiene. When she was asked about checking for gastric residual, she said, Oh, I forgot; you got me on that one. She stated she should have checked the residual prior to connecting the feeding. On 2/26/26 at 12:25 pm during an interview, the Director of Nursing (DON) stated LPN E notified her of the enteral feeding concern that occurred with Resident #52. The DON confirmed that nursing staff should review the physician's orders prior to administering medication or enteral nutrition to ensure that they were administered appropriately as ordered.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infections, by repeatedly failing to ensure that one (Resident #1) of one resident who was reviewed for urinary catheter care, had a urinary catheter bag that was kept off the floor. Failure to ensure a urinary catheter bag remains off the floor can result in a catheter-associated urinary tract infection. The findings include: On 2/23/2026 at 12:10 PM, Resident #1 was observed lying in bed. Her urinary catheter bag was observed on the door side of her bed and was observed to be resting on the floor. (Photographic evidence obtained) On 2/24/2026 at 9:58 AM, Resident #1 was observed lying in her bed. Her urinary catheter bag was observed on the door side of her bed and was observed to be resting on the floor. (Photographic evidence obtained) On 2/24/2026 at 12:40 PM, Resident #1 was observed lying in her bed. Her urinary catheter bag was observed on the door side of her bed and was observed to be resting on the floor. On 2/26/2026 at 5:20 AM during an interview with Certified Nursing Assistant (CNA) J, she confirmed that she was caring for Resident #1. She confirmed that she provided urinary catheter care for the resident. When she was asked what that care involved, she stated, I make sure there are no kinks in the tubing, I empty the bag and I let the nurse know how much was in the bag. She was asked about the positioning of the urinary catheter bag. She stated, I make sure the tubing is straight. She was asked if the urinary drainage bag should be resting on the floor. She replied, No, it can't touch the floor. On 2/26/2026 at 5:30 AM, Resident #1 was observed lying in her bed. Her urinary catheter bag was observed on the door side of her bed and was observed to be resting on the floor. (Photographic evidence obtained) On 2/26/2026 at 5:35 AM, during an interview with CNA J, she was asked to observe Resident #1's urinary catheter bag. During the observation, she was asked to confirm whether or not the urinary catheter bag was resting on the floor. She stated, Yes, I see it's on the floor. Sometimes when the beds are in low position like her's is, the bags will touch the floor. A review for Resident #1's medical record revealed diagnoses including encounter for fitting and adjusting or urinary device. A review of the resident's active physician's orders revealed an order dated 12/30/25: Indwelling Urinary Catheter: Encourage and assist resident to use/apply catheter tube securing device as tolerated, may change, replace, and change position as needed. A review of the person-centered care plan revealed a Focus Area indicating that Resident #1 was At Risk for Urinary Tract Infection related to incontinence, indwelling urinary catheter. Resident has a risk for injury/infection related to presence of catheter. Goal: Resident will remain free from signs/symptoms of urinary tract infection through the next (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review date. Interventions: Position catheter bag and tubing so that it promotes dignity and drainage. A review of Resident #1's quarterly Minimum Data Set (MDS) assessment, dated 12/26/25, revealed a Brief Interview for Mental Status (BIMS) score of 6 out of 15 possible points, indicating severe cognitive impairment. A review of the facility's policy titled Catheter Care & Quality of Care (effective 10/2020, revised 1/2024) revealed: Standard: The facility will maintain infection control guidelines related to catheter use and catheter care to minimize catheter associated infections. Procedure: 3. Ensure the drainage spigot is not touching the floor, the tubing is free of kinks, the catheter is kept at an appropriate level to promote urine flow, and dignity is maintained.		