

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105626	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Chautauqua Springs Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 785 S 2nd Street Defuniak Springs, FL 32435	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>50783</p> <p>Based upon observations, interviews, and record review, the facility failed to promote dignity by not having a privacy cover for a foley catheter bag for 1 of 1 residents observed for dignity (Resident #43).</p> <p>The findings include:</p> <p>On 03/10/25 at 12:00 PM, an observation Resident #43's room was made from the hallway since the room door was opened. A foley catheter bag was observed hanging from the bed railing on the side of the bed facing the doorway. The foley catheter bag did not have a privacy cover and was noted to have approximately 300 ml of urine in the bag. Resident #43 was observed lying in bed with eyes closed, respirations even and unlabored at this time.</p> <p>On 03/10/25 at 03:41 PM, the catheter bag was once again observed from the hallway since the room door was open. No privacy cover was in use. The foley catheter had approximately 700 ml of dark yellow urine present.</p> <p>On 03/11/25 at 09:09 AM, Resident #43's room door was again open and could be observed from the hallway. The foley catheter is observed hanging from the bed rail facing the doorway with no privacy cover noted. Approximately 150 ml of yellow urine observed in the bag.</p> <p>On 03/11/25 at 12:00 PM and 2:40 PM, Resident #43 was observed once again with a Foley catheter bag without a privacy cover hanging from the bed railing with yellow urine noted in the catheter bag. Resident 43 denies pain and discomfort at this time.</p> <p>On 03/12/25 at 09:00 AM, Resident #43 is observed out of bed in the hallway sitting in a wheelchair. His foley catheter is observed without a privacy cover and the catheter tubing dragging against the floor as he maneuvers his wheelchair in the hallway.</p> <p>On 03/13/25 at 08:15 AM, Resident #43 was observed with all his personal belongings with him and a foley catheter observed without a privacy cover hanging from bottom of wheelchair. A staff member assisted Resident #43 to the front lobby and then to being assisted on to a transportation vehicle to go home.</p>

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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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>50447</p> <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observations, interviews and record review, the facility failed to provide specialized care needs for the provision of respiratory care in accordance with professional standards of practice, and the resident's care plan, goals and preferences for 1 of 1 resident sampled. (Resident #73)</p> <p>The findings include:</p> <p>On 3/10/2025, there was respiratory tubing, a mask, and a nebulizer observed on the floor beside Resident #73's bed. The tubing was attached to a machine nebulizer with a sticker dated 2/26/2025. On 3/10/2025 at approximately 1:00 pm, a second observation was made and the respiratory tubing, mask and nebulizer were still on the floor beside Resident #73's bed. On 3/11/2025 approximately 08:30 am, the tubing, mask and nebulizer were in a nightstand drawer beside resident #73 bed. The tubing attach to nebulizer machine still had a sticker with a date of 2/26/2025.</p> <p>On 3/11/2025 approximately 12:00 pm, an interview with Staff D, a Registered Nurse, was performed. He stated that Resident #73 has respiratory treatments as needed and tubing for oxygen and respiratory treatments are changed per orders every Wednesday.</p> <p>On 3/12/2025 a record review of orders for respiratory treatments on 2/12/2025 revealed an order for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 1 inhalation inhale orally every 4 hours as needed for SOB/WHEEZING related to CHRONIC RESPIRATORY FAILURE WITH HYPOXIA (J96.11), Check oxygen saturations every shift and as needed. Per administration records, this medication has not been administered to Resident #73 since the order given on 2/12/2025. The care plan included interventions as follows: Monitor lungs sound every shift and as needed. Document every shift.</p> <p>On 3/13/2025 approximately 8:00 am, interview was performed with Staff C, a Licensed Practical Nurse, about the Albuterol order. Staff C stated this is ordered for residents initially on admission for 10 days. On 2/19/2025, there is documentation that Resident #73 had abnormal breath sounds but no documentation of respiratory treatments were found on that day.</p> <p>On 3/13/2025 at approximately 8:30 am, an interview with the Director of Nursing (DON) was performed. She explained that oxygen tubing and respiratory treatment equipment is changed every Wednesday, but the tubing for Resident #73 has not been changed because he has not had any respiratory treatments since it was ordered. The DON was also made aware that Resident #73 did not receive the Albuterol order on 2/19/25. The DON acknowledged this order should have been given.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50082</p> <p>Based upon observation, interview, and record review, the facility failed to practice infection control procedures concerning glucose monitoring for 1 of 1 residents reviewed for glucose monitoring (Resident #27) and for food handling procedures during 1 of 3 meals observed.</p> <p>The findings include:</p> <p>Glucose monitoring</p> <p>On 03/12/25 at approximately 1:28 PM, an observation was made of Staff D, a Registered Nurse (RN), checking Resident # 27's blood sugar using a glucometer and administering insulin. The RN did not perform hand hygiene before donning gloves to complete the blood glucose check or after doffing gloves, prior to exiting the resident's room and accessing the medication cart. The RN brought the communal tube of meter strips into the residents room but did not disinfect the communal container of meter strips prior to placing it back in the medication cart. The RN was asked if he had received training from the facility on infection control related to glucometer use. The RN replied, No training on infection control, just how to use the glucometer.</p> <p>A review of the facilities policy Obtaining a Fingerstick Glucose Level, dated January 2020, under Infection control protocol and safety, it reads, 2. Maintain clean technique and isolation precautions as indicated. Steps 17-19 of the procedure reads, 17. Remove gloves and discard into designated container. 18. Wash hands. 19. Clean glucose monitor with approved disinfectant before and after each resident. (photographic evidence obtained)</p> <p>50783</p> <p>Food handling</p> <p>On 3/12/25 at 11:30 am, during an observation of the dining room, Staff Member G and Staff Member I, both Certified Nursing Assistants, were observed not sanitizing and/or washing hands in between serving residents seated in the dining room. Staff Member I was observed touching the counter top and drinking cup rims without washing her hands, then serving drinks to the residents. Staff Member G was observed entering the dining room without sanitizing or washing his hands, then proceeded to take clean cups sitting on the counter and dipping them into the pitcher of ice filling multiple cups and setting them on the counter. Staff Member I would take cups filled them with juice or tea and serve residents.</p> <p>When asked about hand hygiene, Staff Members G and I responded that it should take place when entering the dining room and in between each resident. Staff member G stated, I should have washed my hands when I came into the dining room prior to filling cups and assisting with the drinks. Staff member G stated that he should not have done dipped ice from the pitcher without hand hygiene. Staff Member I stated that we should have sanitized or washed our hands in between serving each resident their drinks. Both staff were aware of the sink used to wash hands and sanitizer on wall at entry door and on wall by counter where drinks were being provided.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51224</p> <p>Based on observations, interviews and record reviews, the facility failed to maintain a sanitary environment shower room environment in 1 of 4 shower rooms observed and in the laundry area.</p> <p>The findings include:</p> <p>Shower room</p> <p>On 3/10/25 at approximately 4:51 PM, Shower room [ROOM NUMBER] was observed with the trash can overflowing. There was a variety of opened hygiene products cluttered on the vanity next to a biohazard container. A stack of folded towels was sitting on an over bed table exposed.</p> <p>Observed on 3/13/25 at approximately 1:00 PM, a second observation of Shower room [ROOM NUMBER] was made with the following unsanitary conditions were noted: a dirty towel was laying on the shower bed and another towel was on the floor near the shower chair, a stack of clean towels were placed on top of an over the bed table beside an open pack of briefs, and a variety of used hygiene products were on the vanity. A biohazard container that was a third full was sitting next to the variety of hygiene products. A closet that is in the shower room was open exposing an opened cabinet that contained a variety of hygiene products, cleaning chemicals and roll of toilet paper. A small sink with 3 fingernail clippers were laying by faucet. A pair of rain boots and used gloves were underneath a black mat that was propped up against the wall had fallen over. The trash can was full.</p> <p>On 3/10/25 at approximately 11:45 AM during an interview with Staff J, a Licensed Practical Nurse (LPN), verified that the shower room is used all day for showers and incontinence care for residents.</p> <p>50783</p> <p>Laundry area</p> <p>On 3/13/2025 at 11:00 AM, an observation of the laundry area was made. The area behind the washing machine and dryer had a dark color on the tiles. The sink was observed with dirt and debris and an orange stain in the sink with a dark green and blackish film around the inside of the sink. (photos obtained)</p> <p>The laundry area for facility linens had a blackish color film on the sink. (photo obtained)</p> <p>The area behind the dryers and washing machines had dust and lint observed on the floor and pipes where the detergent was sitting. The handwashing sink was observed with multiple clear plastic bags hanging next to it and a tube of caulk laying on the sink.</p>		