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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105651	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blue Palms Health and Rehabilitation Center of Day	325 S Segrave Street 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 0582

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 38804

Based on interviews and record review, the facility failed to provide documented evidence of having informed each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility's per diem rate. This could have a potentially negative affect on 65 of the 82 residents currently in the facility who actively receive Medicare/Medicaid.

The findings include:

During the Entrance Conference on [DATE] at 10:37 a.m., the Administrator was asked to provide a list of Medicare beneficiaries who were discharged from a Medicare covered Part A stay with benefit days remaining in the past six months prior to the survey. The instructions were to exclude residents who: Received Medicare Part B benefits only; were covered under Medicare Advantage insurance; who expired during the sample date range and/or who were transferred to an acute care facility or another skilled nursing facility (SNF).

On [DATE] at 3:50 p.m., the information provided for review by the facility contained the names of residents who had expired as well as residents who had been discharged to another SNF. The document was returned to the Social Services Director (SSD). She was reminded of the instructions which stated these residents were not to be included in the selection. She stated she would make the corrections.

On [DATE] at 8:58 a.m., the list was returned to the survey team. The Administrator was asked to provide Beneficiary Notices for three random residents.

On [DATE] at 5:13 p.m., the survey team inquired about the Beneficiary Notices requested the previous day. The Administrator stated she did not recall the request. The Administrator was given a second written request for the same three beneficiary notices.

On [DATE] at 9:40 a.m., the SSD returned the notices, which were incomplete. She was advised that the entire form needed to be completed. They were returned to her for correction.

(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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 11:40 a.m., the information was returned to the survey team. The Administrator was advised that the information was still not correct. The documents were incomplete and did not include the notices. On [DATE] at 12:33 p.m., the Beneficiary Notices provided were still not accurate. The SSD was asked who was responsible for providing the information to the residents. She stated the Admissions Office got the information and forwarded it to her, then she completed them. On [DATE] at 2:26 p.m., the SSD was reminded that the requested Beneficiary Notices had not been received. She stated she was still gathering the information. She asked for clarity about what was being requested. The surveyor explained to the SSD what was being requested to meet the requirement. She stated the Beneficiary Notices requested did not meet the requirements. She stated she could provide the documents for three other residents. On [DATE] at 2:54 p.m., the SSD advised the survey team that she was informed the information she previously provided to the survey team was not accurate. She stated she only had partial information. At the time of the survey exit on [DATE] at approximately 3:40 p.m., the facility still had not provided the survey team with the requested information.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48947 Based on observations, interviews, record review, and a review of facility policy, the facility failed to report to the State Agency, injuries of unknown origin for one (Resident #43) of 31 residents in the total survey sample. The findings include: A review of Resident #43's medical record revealed an admitted [DATE] with diagnoses including atherosclerotic heart disease, protein-calorie malnutrition, dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and adult failure to thrive. Further review of the record revealed a progress note dated 7/18/24 at 5:25 a.m., which documented that facility staff observed a left elbow hematoma and left lower leg hematomas with dried blood. The note indicated that the resident had some confusion and was unable to explain what happened. No additional notes mentioning these injuries were found between 7/18/24 and 8/1/24. A review of the active physician's orders revealed an order dated 3/20/23 instructed nursing to complete skin observations weekly per the schedule. No orders for care of the resident's shins were located in the record. On 7/29/24 at 12:57 p.m., Resident #43 was observed with several skin tears and bruises on both of his shins. On 7/31/24 at 10:09 a.m., Resident #43 was observed with several bruises and skin tears on both of his shins. The resident's care orders for these areas and a copy of the skin check from 7/28/24 were requested from the Director of Nursing (DON). They were not received during the survey. On 8/1/24 at 9:31 a.m., the same bruises and open areas/skin tears were again observed on both of the resident's shins. (Photographic evidence obtained) A review of the Weekly Skin Checks for 6/21/24, 6/28/24, 7/5/24, 7/14/24, 7/21/24, and 7/28/24, revealed that none noted multiple bruises/hematomas or open areas to the right or left shin. A review of the Quarterly minimum data set (MDS) assessment, dated 5/10/24, revealed a brief interview for mental status (BIMS) assessment had not been conducted with the resident because he was rarely or never understood. The assessment was documented as having been conducted with staff and the resident was noted with moderately impaired cognitive skills for daily decision making. Decisions were poor and cues/supervision were required. There were no behaviors indicated. The resident required supervision or touching assistance for personal hygiene tasks, and he was receiving hospice care. A review of the resident's Care Plan revealed the following Focus Area: Resident has the potential for impaired skin integrity related to incontinence, altered cognition, decreased physical mobility, and malnutrition. Resident had a history of pressure ulcers and poor safety awareness. (initiated 8/28/2022, revised, 5/20/2024). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/24 at 10:03 a.m., a telephone interview was conducted with Licensed Practical Nurse (LPN)/Unit Manager H for the North Wing and the Hope Unit. She was asked to explain the facility's process for weekly skin checks. She stated, The skin is checked during showers. Any nurse can go in and observe the skin and document the skin check. She was asked about the most recent skin check that she documented on 7/28/24, and why the documentation did not match the current condition of the resident's skin. She stated, The nurse that works the 11-7 shift had already written a note in the medical record on 7/18/24, and he had already reported to me that the staff observed the resident's legs, so I didn't include it on the skin check report. When I did the skin check, the areas looked like they were not new. She was asked if the facility was ever able to determine how the resident acquired the injuries. She replied, No, we never found out. LPN H was asked if these injuries of unknown origin were investigated. She replied, I don't want to say that it was investigated, but I don't really know. She was asked how the facility addressed injuries of unknown origin. She stated, We notify the doctor and the family, and whatever orders we receive, we put them in and carry them out. The nurses usually treat skin tears. On 8/1/24 at 1:12 p.m., a telephone interview was conducted with Hospice Registered Nurse (RN) J. She stated, I was out to see him (Resident #43) yesterday. He was in a social setting, so honestly, I didn't disrobe him or try to take him to his room. She was asked if the facility notified her of the condition of his lower legs, specifically, an open area and several skin tears. She stated she couldn't recall being notified of that, but she was aware that he had some scratches. She stated, I was just out there yesterday and he seemed fine, but I can come back tomorrow and address the issue. On 7/31/24 at 1:17 p.m., an interview was conducted with the DON. She was asked to describe the facility's process for a circumstance in which a resident was observed with an injury of unknown origin. She stated, We ask the resident what happened first. If they can't tell us how the injury occurred, we start an investigation. We talk to the staff about the resident's behaviors , any habits that may have contributed to the injury, and any redirection issues that the resident may have. We start abuse and neglect training and continue to monitor. We also contact family and the doctor. The unit managers usually make the contact. If we cannot figure out how the resident was injured, we report it to DCF (Department of Children and Families) and ACHA (Agency for Health Care Administration. The DON was asked who was responsible for the reporting. She stated, [Administrator] keeps track of that, and the incident is documented in the medical record under incidents. She was asked what tools the facility had for making the staff aware of resident injuries of unknown origin. She stated, We typically discuss any incidents in the morning meeting. A review of facility's policy for Incidents and Accidents (implemented 4/4/24, revised: 4/4/24), revealed an accident refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident. Policy Explanation: The purpose of incident reporting can include: Meeting regulatory requirements for analysis and reporting of incidents and accidents. Compliance Guidelines: 4. Incidents that rise to the level of abuse, misappropriation, or neglect, will be managed and reported according to the facility's abuse prevention policy and will be reported accordingly. The following incidents/accidents require an incident/accident report but are not limited to: unobserved injuries.

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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** 42630 Based on observations, staff and resident interviews, and medical record review, the facility failed to ensure that three residents who were unable to carry out activities of daily living (Residents #34, #43, and #66) from a total survey sample of 31 residents, received necessary care and services to maintain grooming and personal hygiene. The findings include: 1. On 7/29/24 at 1:00 p.m., Resident #34 was observed lying in bed, awake. His feet were uncovered. His toenails were elongated on both feet with his right great toenail observed to be curled around his toe. The resident was asked if he had toenail care or had been seen by podiatry since arriving at the facility. He replied no. (Photographic evidence obtained) On 7/31/24 at 8:21 a.m., Resident #34 was observed lying in bed, awake. He was asked if anyone had trimmed his toenails. He pulled his bedcovers back and said, Nope! I can't trade my feet. His toenails were observed in the same condition as on 7/29/24 at 1:00 p.m. A review of Resident #34's medical record revealed he was admitted on [DATE]. A review of his physician's orders revealed an order dated 6/15/24: Monitor skin weekly. Further review of the orders revealed no orders for podiatry services. A review of weekly skin checks for the past six weeks revealed the following: 7/27/24: nails cleaned and trimmed? No. 7/20/24: nails cleaned and trimmed? No 7/13/24: nails cleaned and trimmed? No 7/06/24: nails cleaned and trimmed? Yes 6/29/24: nails cleaned and trimmed? Yes 6/22/24: nails cleaned and trimmed? Yes A review of the Quarterly Minimum Data Set (MDS) assessment, dated 5/31/24, revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 possible points, indicating moderate cognitive impairment. No behaviors were documented. He required supervision for personal hygiene. A review of the resident's person-centered care plan (3/21/24, revised 6/10/24) revealed: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident requires supervision assistance with some activities of daily living (ADLs) related to a history of cerebral vascular accident (CVA - stroke), anemia, neuropathy, chronic obstructive pulmonary disease (COPD), and shortness of breath upon exertion during ADLs. Goal: Resident will maintain current level of function through the review date. Interventions: Personal Hygiene: Requires staff supervision. A review of the progress notes from 6/4/24 through 8/1/24 revealed no notes regarding toenails, care of toenails, or podiatry services. During an interview with the Director of Nursing (DON) on 7/31/24 at 3:52 p.m., she was asked for the facility's policy for the care of resident fingernails and toenails. She stated, We don't have a policy. She was asked to provide podiatry notes for Resident #34. She was unable to provide any notes. She was asked who provided toenail care for the residents. She stated, We have a podiatrist. She was asked how often the podiatrist came to the facility. She stated, They were here on July 21st. She was asked again how often they came to the facility. She stated, It's supposed to be monthly, but we did have one or two months we were without one. She was asked how residents were added to the schedule to be seen by the podiatrist. She stated, Social Services handles that. She was asked if staff were permitted to trim residents' toenails. She stated, No, only the podiatrist trims toenails. The DON was shown photographs of Resident #34's toenails and was asked if the length, cleanliness, and curving onto the skin of the toes in these photos was an acceptable standard of practice. She agreed that this was not acceptable. She was asked if this resident had been seen by a podiatrist since he had been at the facility. She stated she wasn't sure and would check his medical record. She was not able to provide verification of the resident having been seen by podiatry since his admission to the facility on [DATE]. On 7/31/24 at 4:05 p.m., during an interview with the Social Services Director (SSD), she was asked if she set up podiatry services for the residents. She stated, Yes, we have a service in place that came out to see our first set of people and they'll be back next Saturday. I have asked for the entire building to be seen. I had priority people set to be seen right away. She was asked how long the facility had not had a podiatrist coming out to see the residents. She replied, We had one and asked him to leave, because he only had one set of tools, so we asked that he not come back. We have been without a podiatrist for several months. She was asked how she was made aware of which residents needed to be seen by podiatry. She replied, The nurses let me know and we keep a list. I will send that list over to the podiatrist as to who needs to be seen. She was asked if Resident #34 was on her priority list. She stated, He is on the list to be seen next for the upcoming podiatrist. She was asked when the last time was that Resident #34 had been seen by a podiatrist. She stated, I don't know. My emails don't go that far back; they are set up to auto erase. It's just how they are set up, I'm not sure why. October 2023 was the last time I can see he was seen by podiatry on my email. She was asked to provide the notes for the October 2023 visit. She stated, Yes, I just have to go to my computer to get that. She was asked how often residents should be seen by podiatry. She stated, They should be seen every six weeks. That's what I was always taught. She was asked if there was a facility policy for the frequency of toenail care or for podiatry services. She stated, No, the lady who taught me said it's every six weeks, but no longer than three months. The SSD was unable to provide any podiatry notes for Resident #34. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/24 at 4:20 p.m., in an interview with the Administrator, she stated the facility had been trying to get a podiatrist in place and had emails to show the attempts, as well as cancellations of visits with their former podiatrist. She was asked if the facility had sought an alternative for residents, such as a policy allowing registered nurses to trim residents toenails. She stated no. 48947 2. On 7/29/24 at 12:57 p.m., Resident #43 was observed with long, jagged fingernails. On 7/31/24 at 10:09 a.m., Resident #43 was observed with long, jagged fingernails. The resident's orders and a copy of the skin check for 7/28/24 were requested from the Director of Nursing (DON). They were not provided during the survey. On 8/1/24 at 9:31 a.m., Resident #43 was again observed with long, jagged fingernails. (Photographic evidence obtained) A review of Resident #43's medical record revealed that he was admitted to the facility on [DATE] with diagnoses including atherosclerotic heart disease, protein-calorie malnutrition, dementia without behavior disturbance, psychotic disturbance, mood disturbance, anxiety, and adult failure to thrive. A review of his active physician's orders revealed an order dated 3/20/23 instructed nursing to complete skin observations weekly per schedule. Weekly Skin Checks were reviewed revealing a note dated 7/28/24 documenting that the resident's fingernails were trimmed. (One day before the resident was observed with long, jagged nails) A review of the Quarterly minimum data set (MDS) assessment, dated 5/10/24, revealed a brief interview for mental status (BIMS) assessment had not been conducted with the resident because he was rarely or never understood. The assessment was documented as having been conducted with staff and the resident was noted with moderately impaired cognitive skills for daily decision making. Decisions were poor and cues/supervision were required. There were no behaviors indicated. The resident required supervision or touching assistance for personal hygiene tasks, and he was receiving hospice care. A review of the Care Plan revealed the following Focus Area: Impaired cognitive function and impaired thought processes related to a diagnosis of dementia. Resident has decreased ability to complete and verbalize thought processes, decreased ability to state basic needs, and long/short term memory loss. (initiated 9/1/22, revised 5/20/24). Focus Area: Resident has an ADL (activities of daily living) self-care performance deficit related to altered cognition, decreased physical mobility due to dementia. (initiated 8/28/2022, revised 5/20/2024), and Focus Area: Resident has the potential for impaired skin integrity related to incontinence, altered cognition, decreased physical mobility, and malnutrition. Resident has a history of pressure ulcers and poor safety awareness. (initiated 8/28/2022, revised, 5/20/2024). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/24 at 10:03 a.m., a telephone interview was conducted with Licensed Practical Nurse (LPN)/Unit Manager H for the North Wing and the Hope Unit. She was asked who was responsible for providing the residents' fingernail care. She stated, The CNAs (certified nursing assistants) cut the nails if the resident is not diabetic; the nurses cut the fingernails for diabetics. A policy for fingernail care was requested, but no policy was provided for review during the survey. 3. A review of Resident #66's medical record revealed that he was admitted on [DATE] with diagnoses including muscle wasting and atrophy of the right lower leg, major depression, non traumatic ischemic infarction of left lower leg, muscle weakness, and dependence on supplemental oxygen. A review of his 5-Day MDS assessment, dated 6/17/24, revealed that he had a brief interview for mental status (BIMS) score of 14 out of 15 possible points, indicating intact cognition. No behaviors were indicated. He required supervision/touching assistance for eating, and was dependent for bed mobility, transfers, toileting, and personal hygiene. A review of Resident #66's Care Plan (dated 6/24/24) revealed the following Focus Area: Risk for Self-Care Deficit: Bathing, Dressing, Feeding. Further review of the medical record revealed no documented evidence of podiatry visits from the resident's admission through 8/1/24. On 7/31/24 at 1:53 p.m., Resident #66 was observed lying in bed. His toenails were elongated. (Photographic evidence obtained) On 8/1/24 at 10:03 a.m., a telephone interview was conducted with LPN/Unit Manager H for the North Wing and the Hope Unit. She stated, The podiatrist cuts all toenails. A policy for toenail care was requested, but no policy was provided for review during the survey.

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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** 48947 Based on observations, interviews, record review, and a review of facility policy, the facility failed to ensure that a resident who required oxygen therapy received such therapy per the physician's orders for one (Resident #38) of one resident reviewed for oxygen therapy, from 31 residents in the total survey sample. The findings include: On 7/29/24 at 12:49 p.m., Resident #38 was observed lying in bed receiving oxygen via nasal cannula. The oxygen flow rate was set at 2.5 L/min (liters per minute). (Photographic evidence obtained) On 7/30/24 at 9:40 a.m., Resident #38 was observed sitting up on the side of his bed receiving oxygen via nasal cannula. The oxygen flow rate was set at 2.5 L/min. (Photographic evidence obtained) A review of Resident #38's medical record revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and cognitive/communicative deficit. A review of the resident's physician's orders revealed a 9/3/23 order for Oxygen at 2 liters per nasal cannula continuous via concentrator/tank. A review of the Quarterly minimum data set (MDS) assessment, dated 6/13/24, revealed a brief interview for mental status (BIMS) score of 11 out of 15 possible points, indicating moderately impaired cognition. No behaviors were indicated. He was documented with shortness of breath on exertion, when at rest, or when lying flat, and oxygen therapy was indicated. A review of the Quarterly minimum data set (MDS) assessment, dated 3/13/24, revealed a brief interview for mental status (BIMS) score of 12 out of 15 possible points, indicating moderately impaired cognition. No behaviors were indicated. He was documented with shortness of breath when lying flat, and oxygen therapy was indicated. A review of the Quarterly minimum data set (MDS) assessment, dated 9/11/23, revealed a brief interview for mental status (BIMS) score of 12 out of 15 possible points, indicating moderately impaired cognition. No behaviors were indicated. He was documented with shortness of breath with exertion and when lying flat. Oxygen therapy was indicated. A review of the resident's Care Plan (completed 6/24/24), revealed the following Focus Areas: Resident has oxygen therapy related to shortness of breath upon exertion and while lying flat, and Resident has a diagnosis of COPD, and he has shortness of breath upon exertion and when lying flat. A review of the resident's Progress Notes revealed no behavioral issues or non-compliance with oxygen therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/24 at 1:29 p.m., an interview was conducted with Licensed Practical Nurse (LPN) I. She was asked to review Resident #38's oxygen orders. She opened the electronic medical record (EMR) and stated, He has an order for 2 liters via nasal cannula, continuous for (COPD) chronic obstructive pulmonary disease. She was asked to accompany this surveyor to the resident's room to check the current flow rate against the physician's order. The flow rate was set at 2.5 L/min. The nurse stated, When he comes in from smoking he turns that oxygen up, and I told him that he is doing himself more harm than good. She adjusted the flow to the appropriate rate. A review of the facility's policy titled Oxygen Administration (implemented 4/4/24, reviewed 4/4/2024), revealed: Policy Explanation and Compliance Guidelines: 1. Oxygen is administered under orders of a physician, except in the case of an emergency.

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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. 42630 Based on observations, staff interview, medical record review, and a review of facility policies, the facility failed to maintain infection prevention and control standards for one (Resident #538) of 31 residents in the total survey sample, by leaving the resident's enteral nutrition line uncapped and open to air when it was not in use. The facility also failed to maintain infection prevention and control standards when one (Licensed Practical Nurse (LPN) A) of six nurses observed during medication administration failed to clean/disinfect a blood pressure cuff between resident uses. This practice could negatively impact any resident having their blood pressure checked by this nurse using this cuff. Written standards, policies, and procedures must include standard and transmission-based precautions to be followed to prevent the spread of infections. Policies must define and explain standard precautions and their application during resident care activities, including routine cleaning and disinfection of resident care equipment including equipment shared among residents (e.g., blood pressure cuffs, etc.). The findings include: On 7/29/24 at 12:50 p.m., Resident #538 was observed lying in bed with his eyes closed. His enteral nutrition bottle, dated 7/29/24, was spiked/open with approximately 100 milliliters (ml) missing from the 1000 ml bottle. The bottle was hanging on the pole but was not connected to the resident. The tubing was also hanging on the pole. The open end of the tubing had no cap or protective device, and was open to air. (Photographic evidence obtained) On 7/30/24 at 9:00 a.m., Resident #538 was observed sitting up in a Geri chair (large, padded, reclining chair). The enteral nutrition bottle was not connected to the resident. The bottle was dated 7/30/24, was spiked/open and half empty. The bottle was hanging on a pole at the resident's bedside. The tubing connected to the enteral nutrition bottle was also hanging on the pole. The open end of the tubing had no cap or protective device, and was open to air. (Photographic evidence obtained) A review of Resident #538's active physician's orders, revealed an order for Nepro (liquid nutrition) 1.8 cal (calorie) by gastric tube at 600 ml per hour, continuous for 24 hours per day. On 8/1/24 at 7:10 a.m., Licensed Practical Nurse (LPN) A was observed coming out of Resident #538's room. She confirmed that she was caring for this resident today. She was asked if the feeding was stopped or held, would the same bottle and tubing be reconnected when it was restarted. She stated, Yes, as long as it's less than 24 hours old. On 8/1/24 at 7:18 a.m., Licensed Practical Nurse (LPN) A was observed while checking a resident's blood pressure. In an interview with LPN A at the time of the observation, she stated she preferred to check her residents' blood pressures herself, as she was responsible for them. She was then observed removing the blood pressure cuff from the resident and placing it back in the case on her medication cart without cleaning it. When she was asked to explain the process for disinfecting the blood pressure cuff, she stated she usually cleaned it once per shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105651	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blue Palms Health and Rehabilitation Center of Day	325 S Segrave Street 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled Standard Precautions for Infection Control (revised 4/4/24) revealed: Policy: All staff are to assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. Therefore, all staff shall adhere to Standard Precautions to prevent the spread of infection to residents, staff, and visitors. Policy Explanation and Compliance Guideline: 5. Resident Care-Equipment and Instruments/Devices: a. Policies and procedures have been established for containing, transporting, and handling resident-care equipment and instruments that may have been contaminated with blood or bodily fluids. Personnel are trained in the use of these procedures. (No other policy and procedure was provided that addressed how staff were to contain, transport and/or handle resident care equipment and instruments that were potentially contaminated.) A review of the facility's policy titled Care and Treatment of Feeding Tubes (revised 4/4/24) revealed: Policy: It is a policy of this facility to utilize feeding tubes in accordance with the current clinical standards of practice, with interventions to prevent complications to the extent possible. 7. Direction for staff on how to provide the following care will be provided: d. Use of infection control precautions and related techniques to minimize the risk of contamination. (No specifics were included in the facility's policy regarding how to minimize contamination.) On 8/1/24 at 1:30 p.m., during an interview with the Administrator, she was asked for any other Infection Prevention and Control Policies. She stated there were no other policies. According to the National Library of Medicine at https://pubmed.ncbi.nlm.nih.gov/28079411 (accessed on 8/21/24 at 11:00 a.m.): The contamination of enteral feed can often be overlooked as a source of bacterial infection. Enteral feeds can become contaminated in a variety of different ways. Most often infections result in extended lengths of stay in hospital and patients also need additional therapies and treatments in order to resolve these infections. According to the National Library of Medicine at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3086084 (accessed on 8/21/24 at 11:10 a.m.): (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Failure to place a sterile cap on the end of a reusable intravenous (IV) administration set that has been removed from a primary administration set, saline lock, or IV catheter hub, with the tubing left hanging between uses. Result: The tip of the set is exposed to potential contaminants; this can lead to infection if the non-sterile IV set is reconnected to the patient ' s IV access. Now it appears that many practitioners are not considering the risk of contamination; they are not placing a sterile cap on the exposed tubing. a compatible sterile covering should be aseptically attached after each intermittent use. Capping the tubing end and disinfecting the port should be documented in the institution ' s policies and procedures. The capping procedure should emphasize that a new sterile cap must be used each time the tubing is capped. According to the World Health Organization at https://www.who.int/docs/default-source/documents/health-topics/standard-precautions-in-health-care.pdf?sfvrsn=7c453df0_2 (accessed on 8/21/24 at 11:20 a.m.): Standard precautions are meant to reduce the risk of transmission of bloodborne and other pathogens from both recognized and unrecognized sources. They are the basic level of infection control precautions which are to be used, as a minimum, in the care of all patients. The control of spread of pathogens from the source is key to avoid transmission. Promotion of a safety climate is a cornerstone of prevention of transmission of pathogens in health care. Develop policies which facilitate the implementation of infection control measures. 50369