

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105657	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/23/2025
NAME OF PROVIDER OR SUPPLIER  Diamond Ridge Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2730 W Marc Knighton CT Lecanto, FL 34461	

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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interview, the facility failed to coordinate assessments for the residents with newly evident mental disorder for 5 of 6 resident reviewed (Residents #1, #12, #14, #87, and #139).</p> <p>Findings include:</p> <p>1) Review of Resident #12's Preadmission Screening and Resident Review (PASRR) dated 10/4/2023 revealed anxiety disorder was checked under mental illness. No other diagnosis was checked.</p> <p>Review of Resident #12's admission record revealed the resident was admitted on [DATE] and was subsequently diagnosed with recurrent mild major depressive disorder with onset date of 12/12/2023 and Post Traumatic Stress Disorder (PTSD) with onset date of 10/5/2023.</p> <p>Review of Resident #12's clinical records failed to reveal documentation that Resident #12 was later identified with a newly evident or possible serious mental disorder and was referred to the appropriate state designated authority for evaluation.</p> <p>2) Review of Resident #14's Level I PASRR dated 8/19/2024 revealed anxiety disorder was checked under mental illness. No other diagnosis was checked.</p> <p>Review of Resident #14's admission record revealed the resident was admitted on [DATE] and was subsequently diagnosed with bipolar disorder with onset date of 9/10/2024.</p> <p>Review of Resident #14's clinical records failed to reveal documentation that Resident #14 was later identified with a newly evident or possible serious mental disorder and was referred to the appropriate state designated authority for evaluation.</p> <p>During an interview on 7/22/2025 at 12:50 PM, the Director of Nursing (DON) stated that Resident #12's and Resident #14's Level I PASRR should have been revised to show the new diagnosis and initiate a Level II PASRR screening.</p> <p>3) Review of Resident #1's PASRR dated 6/16/2025 revealed no diagnosis was checked under mental illness.</p> <p>Review of Resident #1's admission record showed the resident was admitted on [DATE] and was subsequently diagnosed with major depressive disorder with onset date of 6/20/2025.</p> <p>(continued on next page)</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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #1's psychiatry evaluation note dated 6/20/2025 read, &amp;ldquo;History of Present Illness: This is an [AGE] year old patient with a past psychiatric history of depression and anxiety.&amp;rdquo;</p> <p>4) Review of Resident #87's PASRR dated 6/16/2025 revealed no diagnosis was checked under mental illness.</p> <p>Review of Resident #87's admission record revealed the resident was admitted on [DATE] and was subsequently diagnosed with adjustment disorder with depressed mood with onset date of 6/23/2025 and major depressive disorder with onset date of 6/24/2025.</p> <p>Review of Resident #87's psychiatric evaluation note dated 6/24/2025 read, &amp;ldquo;History of Present Illness: This is a [AGE] year old patient with past psychiatric history of depression and dementia.&amp;rdquo;</p> <p>5) Review of Resident #139's PASRR dated 6/16/2025 revealed no diagnosis was checked under mental illness.</p> <p>Review of Resident #139's admission record showed the resident was admitted on [DATE] and was subsequently diagnosed with major depressive disorder and anxiety with onset date of 6/20/2025.</p> <p>Review of Resident #139's psychiatry evaluation note dated 6/20/2025 read, &amp;ldquo;History of Present Illness: This is an [AGE] year old patient with a past psychiatric history of depression.&amp;rdquo;</p> <p>During an interview on 7/22/2025 at 12:43 PM, the DON stated, &amp;ldquo;The PASRR's [for Resident #1, #87, and #139] were not correct and should have been updated.&amp;rdquo;</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on observation, interview, and record review, the facility failed to implement a person-centered comprehensive care plan for 1 of 3 residents reviewed for falls (Resident #15). Findings include: During an observation on 7/20/2025 at 11:22 AM, Resident #15 was lying flat in the bed. There was a fall mat lying on the left side of bed and no fall mat on the right side of the bed. There was a fall mat folded up and lying under the bed (Photographic evidence obtained). During an observation on 7/21/2025 at 9:46 AM, Resident #15 was lying flat in the bed. There was a fall mat lying on the left side of bed and no fall mat on the right side of the bed. There was a fall mat folded up and lying under the bed. During an observation on 7/21/2025 at 3:50 PM, Staff A, Certified Nursing Assistant (CNA), stated, There is no mat on the right side of the bed because she only gets up on the left side of the bed. Review of Resident #15's physician order dated 4/9/2025 read, Floor mats at bedside while Res. [Resident] in bed every shift for monitoring. Review of Resident #15's care plan initiated on 1/24/2024 read, Focus: [Resident #15's name] is at risk for falls r/t [related to] visually impaired, poor safety awareness, gait/balance problems, psychotropic med use, hx [history of] fall, weakness. Interventions. Bilateral floor mats on both sides of bed while resident in bed. Date Initiated: 04/10/2025. During an interview on 7/21/2025 at 8:10 AM, the Director of Nursing stated, The physician orders must be followed, and floor mats should be placed on both sides of the bed on the floor.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on record review and interview, the facility failed to ensure physician-ordered parameters for administering hypertension medications were followed for 2 of 7 residents reviewed for medication administration (Residents #39, #139).</p> <p>Findings include:</p> <p>1) Review of Resident #139's physician order dated 6/20/2025 read, "Olmesartan Medoxomil Tablet 20 MG [milligram], Give 1 tablet by mouth one time a day for hypertension, hold for SBP [Systolic Blood Pressure] less than 130."</p> <p>Review of Resident #139's Medication Administration Record (MAR) for July 2025 for administration of Olmesartan Medoxomil showed the medication was administered outside the ordered parameters on 7/2/2025 for blood pressure of 121/63, on 7/3/2025 for blood pressure of 121/66, on 7/12/2025 for blood pressure of 114/63, on 7/16/2025 for blood pressure of 129/62, and on 7/18/2025 for blood pressure of 124/62.</p> <p>During an interview on 7/23/2025 at 7:45 AM, the Director of Nursing (DON) stated that the documentation indicated that the medication was administered outside parameters for the above referenced dates.</p> <p>2) During an observation on 7/22/2025 at approximately 9:20 AM, Staff C, Licensed Practical Nurse (LPN), picked out medications to administer for Resident #39. Staff C took a manual blood pressure for the resident, which read 128/78 with a pulse of 70 beats. Staff C entered the resident room with a medication cup containing Losartan to administer to the resident. The Surveyor stopped Staff C and requested her to step out of the resident room to interview.</p> <p>Review of Resident #39's physician order dated 7/18/2025 read, "Losartan Potassium Oral Tablet 25 MG (Losartan Potassium), Give 0.5 tablet by mouth one time a day, hold for SBP &lt; 130."</p> <p>During an interview on 7/22/2025 at 9:27 AM, Staff C, LPN, stated, "I look for SBP parameters at less than 110 or 120. This parameter is 130. I did not see that."</p> <p>During an interview on 7/22/2025 at approximately 11:30 AM, the DON stated, "My expectation is for the nurses to follow doctors' orders as written with the parameters should be followed."</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy and procedure titled "Medication Administration General Guidelines" with the last review date of 1/8/2025 read, "Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling, and administration). The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. Procedure... 4) Five Rights- Right resident, right drug, right dose, right route and the right time are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away."</p>

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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>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents received respiratory services as per physician order for 1 of 3 residents reviewed for respiratory services (Resident #39). Findings include: During an observation on 7/20/2025 at 10:05 AM, Resident #39's nebulizer mask was lying on the bedside table not covered and dated 7/19/2025. Resident #39 was receiving oxygen via nasal cannula (NC) at 4 liters per minute. There was no padding or ear cushions noted on the NC tubing for skin protection (Photographic evidence obtained). During an interview on 7/20/2025 at 10:05 AM, Resident #39 stated, I receive my nebulizer treatments randomly. I received my treatments last week. My oxygen varies from 2 liter to 4 liters. I do not touch the regulator. Sometime the cushion is on the tubing and other times when the tubing is changed, the cushion is not there. During an observation on 7/21/2025 at 9:36 AM, Resident #39's nebulizer mask was lying on the bedside table not covered and dated 7/19/2025. Resident #39 was receiving oxygen via nasal cannula (NC) at 4 liters per minute. There was no padding or ear cushion noted on the tubing for skin protection. Review of Resident #39's physician order dated 6/4/2025 read, Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML [milligram/3 milliliters] 1 vial inhale orally every 6 hours as needed for SOB [shortness of breath]. Review of Resident #39's physician order dated 6/5/2025 read, Oxygen Nasal cannula ear cushions/padding every shift for pressure reduction. During an observation on 7/21/2025 at 3:50 PM with Staff B, Licensed Practical Nurse (LPN), Resident #39's nebulizer mask was at bedside not covered and the resident had no padding or ear cushion on the NC tubing. During an interview on 7/21/2025 at 3:50 PM, Staff B, LPN, stated, The nebulizer must be bagged, and I will get him NC with cushion/padding. During an interview on 7/22/2025 at 8:10 AM, the Director of Nursing stated, Nebulizer mask must be bagged, and the physician orders must be followed for the NC cushion/padding. Review of the facility policy ad procedure titled Respiratory Therapy Equipment with the last review date of 1/8/2025 read, Purpose: The purpose of this procedure is to provide guidelines to help prevent nosocomial infections associated with respiratory therapy equipment, including ventilators, and to prevent transmission of infections to residents and staff. procedure. Oxygen Administration. 7. Keep oxygen cannula and tubing used PRN [as needed] in a plastic bag when not in use.</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Post nurse staffing information every day.</p> <p>Based on observation and interview, the facility failed to ensure accurate nurse staffing information was posted on a daily basis. Findings include: During an observation on 7/20/2025 at 9:00 AM, the posted nurse staffing information was dated 7/18/2025 (Photographic evidence obtained). During an interview on 7/21/2025 at 9:00 AM, the Administrator stated, Upon my arrival to the facility, I noticed the posting was not updated. The expectation is for the staffing to be posted daily. The Staffing Coordinator is responsible on Friday before leaving to print the reports for the weekend to include Monday.</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>Based on observation, interview, and record review, the facility failed to ensure staff used appropriate personal protective equipment (PPE) while providing high-contact care to the residents on enhanced barrier precautions (EBP) for 1 of 2 residents reviewed for intravenous medication administration (Resident #159) to prevent the possible spread of infection and communicable diseases. Findings include: During an observation on 7/22/2025 at 9:00 AM, Staff C, Licensed Practical Nurse (LPN), entered Resident #159's room, which had a signage for enhanced barrier precaution (EBP) on the door indicating the providers and staff must wear gloves and a gown for the high-contact resident care activities such as device care or use including central line. Staff C donned gloves. Staff C did not wear a gown. Staff C primed the peripherally inserted catheter central catheter (PICC) line on the resident's upper right arm and set the intravenous (IV) pump. Staff C proceeded to connect the PICC line to the IV medication and began to administer Vancomycin. During an interview on 7/22/2025 at approximately 9:10 AM, when asked if a gown was needed for providing care to Resident #159, Staff C, LPN, stated, I thought it was direct contact only. The IV is contained. That is my interpretation of the EBP and IV. During an interview on 7/22/2025 at approximately 11:30 AM, the Director of Nursing (DON) stated, The nurse should be wearing a gown during IV administration. Review of the facility policy and procedure titled Enhanced Barrier Precautions with the last review date of 1/8/2025 read, Policy Statement, Enhanced barrier precautions (EBPs) are utilized to prevent spread of multi-drug resistant organisms (MDRO's) to residents. Policy Interpretation and Implementation. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include. g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.</p>		