STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105735	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orange City Nursing and Rehab Center	2810 Enterprise Rd Debary, FL 32713

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48947 Based on record review, interviews, and facility policy and procedure review, the facility failed to develop and implement a care plan for anticoagulant use for one (Resident #68) of five residents reviewed for medication use, from a total survey sample of 34 residents. The findings include: A record review revealed that Resident #68 was admitted to the facility on [DATE] with diagnoses including chronic ischemic heart disease, diabetes mellitus - type 2 due to underlying condition with diabetic kidney disease, and unspecified displaced fracture of the surgical neck of the right humerus. A review of Resident #68's physician's orders revealed an order for Apixaban (anticoagulant) 5 mg (milligrams) by mouth twice daily (order dated 7/12/24). The resident's physician's orders did not include orders to monitor the resident for side effects related to anticoagulant use. A review of the resident's Significant Change MDS (minimum data set) assessment, dated 1/22/25, revealed that the resident scored 15/15 on a BIMS (brief interview for mental status), indicating intact cognition. She was also documented as receiving anticoagulant medication. A review of the resident's care plan (initiated on 7/11/24), revealed no focus area addressing anticoagulant use. A review of the resident's April 2025 MAR (medication administration record) revealed that it did not include a monitoring tool for side effects of anticoagulant use. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/27/25 at 2:34 PM, an interview was conducted with Licensed Practical Nurse (LPN) E/Unit Manager. She was asked if a resident was receiving medications and staff were not familiar with the resident, where they would find information about the medications the resident was receiving. She stated, Under the orders. She was asked if the resident was receiving an anticoagulant, what would the physician's orders include. She stated, The type of medication it was, how much they take, monitor for signs and symptoms of bleeding, skin check frequency and those types of things. She was asked where else she would expect to find information about how to care for a resident receiving anticoagulant medications. She replied, It would depend on which anticoagulant they were taking, like for Coumadin, there would be labs ordered and dose changes. She was asked where else information would be found in the resident's record that would inform the nurse about how to care for the resident receiving anticoagulant medications. She stated, The care plan would include information about how to care for the resident taking anticoagulants. She was asked what should be included in the care plan and she replied, Monitoring for signs and symptoms of bleeding; there would be others but I'd have to look; I can't recall off the top of my head, but definitely that should be there. On 03/27/25 at 3:01 PM, another interview was conducted with LPN E/Unit Manager. She was asked to access the anticoagulant care plan for Resident #68 in the electronic medical record (EMR). She was able to provide a care plan focus area for anticoagulant use, but confirmed that the care plan reflected anticoagulant use after the above 2:34 PM interview. She was unable to provide evidence of anticoagulant side effects monitoring on the resident's MAR. A review of the facility's policy and procedure for Anticoagulant Therapy (SHCRC30004.30 - revised 8/2023) revealed: Purpose: To effectively monitor residents receiving anticoagulant therapy and reduce the risk of bleeding by maintaining therapeutic blood levels in accordance with physicians' orders. 8. Throughout anticoagulant therapy, monitor the resident for signs and symptoms of bleeding . A review of the facility's policy and procedure for Comprehensive Person-Centered Care Plans (SHCO40001. 08 - revised 8/2023) revealed: Policy: The center will develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychological needs that are identified in the comprehensive assessment. Fundamental Information: The comprehensive plan of care will include the following: Resident's individual needs . Reflect current standards of professional practice. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include interventions to avoidable decline in function or functional level. Interventions to attempt to manage risk factors. Procedure: 3. Develop goals and approaches for each problem and/or condition that are: Realistic Specific Measurable, and Include interventions/approaches that relate to each stated long- or short-term goal.