

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105796	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/25/2024
NAME OF PROVIDER OR SUPPLIER  Edgewater at Waterman Village		STREET ADDRESS, CITY, STATE, ZIP CODE  300 Brookfield Ave Mount Dora, FL 32757	

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 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>46523</p> <p>Based on observation, interview, and record review, the facility failed to ensure the comprehensive care plans were implemented for 2 of 4 residents reviewed for positioning, Residents #73 and #74.</p> <p>Findings include:</p> <p>1) During an observation on 9/23/2024 at 9:59 AM, Resident #74 was resting with her eyes closed. The resident's feet were not offloaded while in bed. There was a yellow pillow with white cover on top of the wheelchair.</p> <p>During an observation on 9/23/2024 at 12:14 PM, Resident #74 was lying in bed with her eyes closed. The resident's feet were not offloaded while in bed.</p> <p>During an observation on 9/23/2024 at 12:53 PM, Resident #74 was lying in bed with her eyes closed. The resident's feet were not offloaded while in bed.</p> <p>During an observation on 9/24/2024 at 7:45 AM, Resident #74 was lying in bed with her eyes closed. The resident's feet were not offloaded while in bed. There was a yellow pillow with white cover on top of the wheelchair.</p> <p>During an observation on 9/24/2024 at 8:40 AM, Resident #74 was sitting up in bed with breakfast tray in front of her. The resident's feet were not offloaded. There was a yellow pillow with white cover on top of the wheelchair.</p> <p>During an observation on 9/24/2024 at 11:06 AM, Resident #74 was resting with her eyes closed. The resident's feet were not offloaded while in bed. There was a yellow pillow with white cover on top of the wheelchair.</p> <p>Review of Resident #74's care plan dated 7/12/2024 showed it read, Approaches. Float heels when in bed.</p> <p>2) During an observation on 9/23/2024 at 10:00 AM, Resident #73 was lying in bed, with the bed being at the lowest position. The resident's feet were not offloaded while lying in bed.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 9/23/2024 at 12:15 PM, Resident #73 was lying in bed, with the bed at being the lowest position. The resident's feet were not offloaded while lying in bed.</p> <p>During an observation on 9/24/2024 at 7:46 AM, Resident #73 was resting with her eyes closed. The resident's feet were not offloaded while in bed. There was a pillow on top of the chair in the room.</p> <p>During an observation on 9/24/2024 at 8:41 AM, Resident #73 was sitting up in bed. The resident's feet were not offloaded. There was a pillow on top of the chair in the room.</p> <p>During an observation on 9/24/2024 at 11:07 AM, Resident #73 was lying in bed with her eyes closed. The resident's feet were not offloaded. There was a pillow on top of the chair in the room.</p> <p>Review of Resident #73's care plan dated 4/16/2024 showed it read, Approaches. Float heels when in bed.</p> <p>During an interview on 9/24/2024 at 11:10 AM, Staff A, Licensed Practical Nurse (LPN), stated, I would have to look for [Resident #73's name and Resident #74's name] to see if they have orders to offload feet while in bed.</p> <p>During an observation on 9/24/2024 at 11:10 AM, Staff A, LPN, entered Resident #74's room and woke the resident up and asked her if she could place the pillow that was on the chair under her feet. Resident #73 stated, Sure, I do not care. Staff A placed the pillow under the resident's feet. Staff A returned to the medication cart and reviewed orders for Resident #73.</p> <p>During an interview on 9/24/2024 at 11:12 AM, Staff A, LPN, stated, [Resident #73's name] and [Resident #74's name] both have orders for floating heels. Both residents are hard to follow command. We have to provide a lot of education, and they are very confused and combative at times. You might do something and then not be there.</p> <p>During an interview on 9/25/2024 at 7:50 AM, the Director of Nursing stated, If a resident is care planned for offloading, it should be done.</p> <p>Review of the facility policy and procedure titled Care Plan- Comprehensive with the last review date of 7/19/2024 showed it read, Policy Interpretation and Implementation. 1. An interdisciplinary assessment team, in coordination with the resident and his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>46523</p> <p>Based on observation, interview, and record review, the facility failed to ensure the drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles.</p> <p>Findings include:</p> <p>1) During an observation on 9/23/2024 at 9:44 AM, Resident #46 was sitting in her wheelchair in her room. There was a bottle of Biofreeze fast-acting menthol pain relief gel roll-on on top of the nightstand (Photographic evidence obtained).</p> <p>During an interview on 9/23/2024 at 9:44 AM, Resident #46 stated, I have arthritis and have the girls put it on at night for me.</p> <p>2) During an observation on 9/23/2204 at 10:08 AM, Resident #2 was sitting up in her bed. On top of the resident's bedside table, there were one bottle of Biofreeze fast-acting menthol pain relief gel roll-on, one Voltaren cream, and one Lotrimin Clotrimazole cream.</p> <p>During an interview on 9/23/2024 at 10:08 AM, Resident #2 stated, I use the Biofreeze for my neck and the cream is a muscle relaxer that I use.</p> <p>During an observation on 9/24/2024 at 11:15 AM with Staff A, Licensed Practical Nurse (LPN), there were one bottle of Biofreeze, one Voltaren cream and one Lotrimin Clotrimazole cream on top of Resident #2's bedside table.</p> <p>During an interview on 9/24/2024 at 11:15 AM, Staff A, LPN, stated, Sometimes the family will bring in medication without us knowing. Medication should not be at the bedside.</p> <p>3) During an observation on 9/23/2024 at 10:10 AM, Resident #41 was lying in bed. There were two bottles of eye drops in the resident's cabinet.</p> <p>During an interview on 9/23/2024 at 10:10 AM, Resident #41 stated, I cannot reach the eye drops. I am not sure what they are for.</p> <p>During an observation on 9/24/2024 at 8:40 AM, Resident #41 was lying in bed. There was one bottle of eye drops on top of the resident's cabinet (Photographic evidence obtained).</p> <p>During an interview on 9/24/2024 at 8:40 AM, Resident #41 stated, Yesterday, they took one of the eye drop bottles and only left that one.</p> <p>During an observation on 9/24/2024 at 11:18 AM with Staff A, LPN, there was one bottle of eye drops on top of the Resident #41's cabinet. There was no one in the resident's room.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/24/2024 at 11:18 AM, Staff A, LPN, stated, As far as I know, [Resident #41's name] does not have orders for eye drops.</p> <p>During an interview on 9/25/2024 at 7:48 AM, the Director of Nursing stated, Medication should not be left at the bedside.</p> <p>Review of the facility policy and procedure titled Storage of Medication with the last review date of 7/19/2024 showed it read, Policy: Medications and biologicals shall be stored in a safe, secure, and orderly manner. Policy Interpretation and Implementation . 6. Compartments containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended. (Compartments include, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.)</p>