STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105820	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Crossing	6210 Beach Blvd Jacksonville, FL 32216

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 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** 28892 Based on observations, interviews, and record review, the facility failed to ensure that one (Resident #151) of two residents reviewed for activities of daily living (ADLs) assistance, out of 29 residents in the total survey sample, received necessary services to maintain good grooming and personal hygiene, specifically fingernail care. The findings include: A review of the medical record revealed that the resident was admitted to the facility on [DATE] with diagnoses including the following: Surgical aftercare following surgery on the circulatory system, acute combined systolic and diastolic heart failure, major depressive disorder, muscle weakness (generalized), hypertension, shortness of breath, diabetes mellitus and legal blindness. On 12/16/24 at 9:35 AM, Resident #151 was observed with the fingernails on both of his hands extending approximately 1/4 of an inch beyond the nail bed. When the resident was asked if he preferred having his fingernails at the current length, he replied that he asked facility staff to trim his nails and was told someone would come trim them. He further explained that he was fearful of scratching himself with such long nails. (Photographic evidence obtained) On 12/17/24 at 10:48 AM, Resident #151 was observed with the fingernails on both of his hands extending approximately 1/4 of an inch beyond the nail bed. (Photographic evidence obtained) On 12/19/24 at 10:45 AM, Resident #151 was observed with the fingernails on both of his hands extending approximately 1/4 of an inch beyond the nail bed. (Photographic evidence obtained) A review of the 2/6/24 minimum data set (MDS) assessment for Resident #151, revealed a brief interview for mental status (BIMS) score of 13 out of a possible 15 points, indicating intact cognition. He had had no indicators of psychosis, physical or verbal behaviors directed toward others, rejection of care, or wandering behaviors documented in the assessment. ADLs were documented as his having no impairment to the upper or lower extremities; eating and oral hygiene required set-up or clean-up assistance; toileting hygiene, lower body dressing and putting on/taking off footwear required partial to moderate assistance. The resident was assessed as independent for self-bathing/showering. Upper body dressing required supervision or touching assistance. For mobility, the resident required supervision or touching assistance. He received scheduled and as needed pain medication. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/19/24 at 10:56 AM, an interview was conducted with Certified Nursing Assistant (CNA) A, who reported she had worked at the facility for approximately seven and a half years. She explained that she completed rounds to check on residents every two hours and every hour for residents who were deemed a fall risk. During her rounds, she checked whether residents needed water, needed use the bathroom, or would like to participate in scheduled activities. She also observed her assigned residents' appearance. If a resident's nails appeared soiled, she would use an orange stick to clean underneath the nails. She explained that fingernails extending 1/4 of an inch would be considered too long for a male resident. If a resident's nails were long, she would tell her nurse because CNAs were not permitted to clip residents' fingernails. At 11:02 AM, CNA B observed Resident #151 and verified that his nails were too long and needed to be shortened. On 12/19/24 at 11:11 AM, an interview was conducted with Licensed Practical Nurse (LPN) B, who reported she was agency staff and had worked at the facility for three months. She explained that during administration of medication, she would conduct head-to-toe visual assessments of residents' appearances. She stated nail length beyond the nail bed is too long for a male resident. If the resident was okay with long nails, the resident's preference would be adhered to. She further explained that if she saw a male resident with quarter-of-an-inch long nails, she would ask a CNA what to do about trimming the resident's fingernails, as different facilities she works at through the agency had different practices regarding nail care. She stated she would notify the unit manager and request the resident's fingernails to be clipped. On 12/19/24 at 11:17 AM, LPN B was accompanied to the resident's location. She observed his fingernails and stated they were too long. A review of the facility's policy titled Podiatry and Nail Care (last reviewed 06/2024, effective date 10/2013), revealed that the purpose of the policy was to establish podiatry and nail care for the resident. The policy documented that the community would arrange for or make available foot and nail care. Procedure 1. Caregivers monitor the length and condition of the toe and finger nails of residents receiving bathing, dressing or grooming services. 3. Caregivers (CNAs and nursing) can provide nail care when indicated.

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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 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** 28892 Based on observations, record review, and interviews, the facility failed to ensure that one (Resident #154) of one resident observed for respiratory care, from a total survey sample of 29 residents, received respiratory care consistent with professional standards of practice and the resident's care plan. Resident #154 was not receiving oxygen at the flow rate ordered by the physician. The findings include: On 12/16/24 at 10:13 AM, Resident #154 was observed receiving oxygen through a nasal cannula at a flow rate of three liters per minute. (Photographic evidence obtained) On 12/17/24 at 10:35 AM, a second observation was made of Resident #154 receiving oxygen through a nasal cannula at a flow rate of three liters per minute. (Photographic evidence obtained) On 12/17/24 at 11:56 AM, a third observation was made of Resident #154 receiving oxygen through a nasal cannula at a flow rate of three liters per minute. (Photographic evidence obtained) A review of the resident's medical record revealed an admitted [DATE] with diagnoses including acute respiratory failure with hypoxia, pulmonary hypertension, acute on chronic diastolic heart failure, chronic kidney failure - stage 4 (severe), atrial flutter, and dysphasia. A review of Resident #154's 12/6/24 minimum data set (MDS) assessment, revealed that the resident had a brief interview for mental status (BIMS) score of 13 out of a possible 15 points, indicating intact cognition. She displayed no rejection of care and received continuous oxygen therapy via nasal cannula. A review of the care plan initiated on 12/02/24, revealed a focus area for chronic obstructive pulmonary disease (COPD). The care plan goal noted the resident would be free of signs or symptoms of respiratory infections through the review date. Interventions included oxygen (02) settings via nasal cannula per the physician's orders. A review of the active physician's orders for Resident #154 revealed the following: Administer oxygen at 4 liters via nasal cannula with a start date of 11/21/24. An interview was conducted on 12/19/24 at 10:33 AM, with Licensed Practical Nurse (LPN) C, who reported she had worked at the facility for one year. She said she was assigned to Resident #154 and was aware that the resident received oxygen therapy. She was accompanied to the resident's room to check the resident's oxygen flow rate. She reported that the oxygen flow rate was set at 3 liters per minute. She was asked to check the resident's oxygen order. LPN C checked the orders and reported the order for oxygen was for 4 liters per minute via nasal cannula. She explained her process for residents receiving oxygen therapy included checking the resident in the morning at the beginning of her shift. She checked to ensure that the oxygen tubing was in place and the flow rate was accurate. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 12/19/24 at 10:53 AM, with Certified Nursing Assistant (CNA) D, who reported that she had worked at the facility for two months. She explained that for residents who received oxygen therapy, she would make sure the nasal cannula was inserted correctly and look at the flow rate to ensure the flow rate was accurate. If she saw in inaccurate flow rate, she would inform the nurse. She explained that she was familiar with the Resident #154's care needs and never noticed that the resident's flow rate was inaccurate. A review of the facility's policy and procedure titled Medication Administration (last reviewed on 04/2024, effective 05/2024), revealed that the purpose of the policy was to ensure that all medications were administered safely, accurately, and in a timely manner. Medications are administered safely, accurately, and promptly in accordance with procedures specified. .