STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106045	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brynwood Health and Rehabilitation Center	1656 South Jefferson Street Monticello, FL 32344

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 45951 Based on observations and interviews, the facility failed to maintain the laundry areas in a clean and sanitary manner. The findings include: A tour of the facility was conducted on 12/11/24 at 2:27 PM with the facility's Environmental Services Director. During this tour, the surveyor reviewed the soiled utility and shower rooms on each hallway along with the facility's laundry area. Photographic evidence was obtained of all the following areas of concern. The Infectious Waste room located within the nursing station on the North/Rehab hallway contained a handwashing sink. Closer observation revealed there was no paper towel holder present despite a sign present which stated for staff to wash hands prior to returning to work. Within this room, the surveyor also noted the soiled linen cart had no cover and the linens were not properly bagged. The Soiled Utility room on the North/West hallway contained a specimen refrigerator in which the freezer had a large build-up of ice, requiring defrosting. Upon entering the laundry area, there were 2 washing machines and 2 dryers observed. There was a large build-up of lint in the dryer lint traps of both dryers and a brown melted substance throughout the drums of both dryers. Staff A, Laundry Aide, stated the maintenance staff cleaned the drums and lint areas quarterly but could not recall when it was done last. Staff A further stated the laundry staff should be cleaning the lint traps every hour.

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45951 Based on observations, interviews, and record review, the facility failed to ensure medications were stored in a secure manner for 2 of 20 residents reviewed (Resident #37 and #16). The facility also failed to ensure medications were locked in a secure manner during 2 of 5 medication administration observation times. The facility also failed to properly dispose of medications during 2 of 5 medication observation times. The findings included: Resident #37 During a tour of the facility conducted on 12/10/24 at 8:58 AM, the surveyor observed a tube of Arthritis Cream on the nightstand of Resident #37. (photographic evidence obtained) A review of Resident #37's medical record revealed she was initially admitted to the facility on [DATE] and was last readmitted on [DATE]. A review of Resident #37's physician orders revealed there was no active order for arthritis cream. A review of Resident #37's Quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #37 had a Brief Interview of Mental Status (BIMS) score of 13, which indicates she was cognitively intact. Further review of the medical record revealed no assessment was found to indicate if Resident #37 was safe to self-administer her medications. Resident #16 During a tour of the facility conducted on 12/10/24 at 9:02 AM, the surveyor observed a bottle of Saline Nasal Spray on the nightstand of Resident #16. (photographic evidence obtained) A review of Resident #16's medical record revealed she was initially admitted to the facility on [DATE] and was last readmitted on [DATE]. A review of Resident #16's physician orders revealed there was no active order for nasal spray. A review of Resident #16's Quarterly MDS, dated [DATE], revealed Resident #16 had a BIMS score of 14, which indicates she was cognitively intact. Further review of the medical record revealed no assessment was found to indicate if Resident #16 was safe to self-administer her medications. An interview was conducted with the facility's Director of Nursing (DON) on 12/10/24 at 9:05 AM. During this interview, the DON stated neither of these residents were assessed as being safe to self-administer their medications. Medication administartion observation (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon approaching Staff B, Registered Nurse (RN), for a medication administration observation on 12/10/24 at 8:09 AM, Staff B was observed with two medication cups present on top of her medication cart, one with tablets and one with crushed medications, while she was actively placing medications into a third medication cup located in her hand. Staff B then walked away from her medication cart, leaving the computer screen on, the medication cart unlocked, and the two medication cups on top of the cart to administer the medications in the cup that was in her hand to Resident #3. Staff B then entered a resident's room to wash her hands, again leaving the computer screen on, the medication cart unlocked, and the two medication cups on top of the cart unattended. Staff B then returned to the medication cart, picked up the medication cup with the crushed medications, mixed pudding into the crushed medications, and walked away from the medication cart, again leaving the computer screen on, the medication cart unlocked, and the remaining medication cup on top of the cart to administer the medications to Resident #6. Staff B then returned to her cart, picked up the final medication cup and walked down the hallway away from the medication cart, again leaving the computer screen on and the medication cart unlocked, to administer the medications to Resident #53. Upon completion of the observation, Staff B was asked why she had medications cups prepared for three separate residents. Staff B responded that she had intended to give Resident #53 his medications first, but that he was not in his room when she entered to administer his medications. She said that, when she returned to her medication cart, Resident #6 then approached her asking for his medications. While she prepared his medications, Resident #3 approached her asking for his medications because he had an appointment. She explained this was why she had medications for three residents prepared at one time. She further stated she knew she should not have pre-poured medications present on top of her cart, but that she did not want to get in trouble by putting the medication cups into the medication cart before she could give them. Staff B was informed that the concern was that the medication cart was left unlocked numerous times, and the medications were left unattended. Upon approaching Staff E, a Licensed Practical Nurse (LPN), for a medication administration observation on 12/10/24 at 3:50 PM, the surveyor observed Staff E return to her medication cart from within a resident room and pull the lock button of the medication cart out with her fingers without using a key, indicating the cart was not locked properly/securely. A medication administration observation was conducted on 12/10/24 at 4:00 PM with Staff E for Resident #45. Staff E retrieved from the medication cart an inhaler and a plastic box which she explained contained Resident #45's glucometer and three insulin pens. Staff E further stated one of the insulin pens was new and not opened yet. Staff E then entered Resident #45's room to perform a blood glucose check, leaving the three insulin syringes and inhaler unattended on top of the medication cart. After returning to the medication cart, Staff E prepared Resident #45's two insulin pens for administration. Upon re-entering Resident #45's room at 4:09 PM, Staff E again left the remaining (third) insulin pen and inhaler unattended on top of the medication cart. Throughout the medication administration observation, each time Staff E returned to the medication cart, she instinctively pulled at the cart drawers, indicating she did not typically lock her cart securely. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon completion of the observation, Staff E was asked if she should have secured the medications in the medication cart while she was in Resident #45's room obtaining her blood glucose result and administering the insulin. Staff E stated she should have secured the medications in the cart instead of leaving them unattended in the hallway. When asked how she opened her cart initially without the use of a key, Staff E did not respond. Upon approaching Staff F, LPN, for a medication administration observation on 12/10/24 at 3:55 PM, the surveyor observed Staff F return to her medication cart from within a resident room and pull the lock button of the medication cart out with her fingers without using a key, indicating the cart was not locked properly/securely. Further observation revealed Staff F try four separate keys before being able to unlock her cart with the correct key. Throughout the medication administration observation, each time Staff F closed her medication cart, she pushed the lock button in, but it did not make a click sound to indicate it was properly locked. Then, each time Staff F returned to the medication cart, she inserted the key into the lock, which pushed the lock button into the cart all the way, causing the lock to make its click sound. Upon completion of the observation, the surveyor asked Staff F how she opened her cart initially without the use of a key. Staff F did not respond. An interview was conducted with the facility's DON on 12/10/24 at 4:45 PM. During this interview, she stated the staff were instructed to properly lock their medication carts and secure all medications prior to leaving their carts. Review of the facility policy titled Medication Storage, date revised January 2024 revealed all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper security and all drugs and biologicals will be stored in locked compartments (i.e. medication carts). Only authorized personnel will have access to keys to locked compartments. During medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. Medication disposal A medication administration observation was conducted on 12/10/24 at 8:38 AM with Staff C, LPN, for Resident #67. While preparing Resident #67's medications, a blood thinner medication tablet fell on to the top of the medication cart. Staff C picked up the pill and put it in the sharps container located on the side of the medication cart. Upon completion of the observation, Staff C was asked why she disposed of the tablet in the sharps container. She stated it had fallen onto the medication cart and could not be administered to the resident. When asked if the facility's procedure was to use a pill buster solution as opposed to disposing of medications in the garbage or sharps container, Staff C stated she did not know. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A medication administration observation was conducted on 12/10/24 at 8:51 AM with Staff D, LPN, for Resident #40. While preparing Resident #40's medications, Staff D verbalized that Resident #40 preferred for her medications to be crushed and mixed with pudding. After crushing the medications, Staff D disposed of the crushing plastic packet into the open garbage can located on the side of the medication cart. Closer observation revealed a whole medication tablet in a medication cup sitting on the top of the open garbage in the can. When asked, Staff D stated, it was an extra Eliquis (which is a blood thinner medication). Staff D was asked if it was appropriate for the medication to be thrown into the garbage or if they used a pill buster solution. Staff D stated they did have a pill buster solution on each medication cart but that it was only used for narcotics. When asked again if it was appropriate for the blood thinner tablet to be thrown into the garbage, Staff D did not reply. An interview was conducted with the facility's DON on 12/10/24 at 9:05 AM. During this interview, she stated the staff were instructed to use a pill buster solution to dispose of any and all unused medications. Review of the facility policy titled Disposal of Medications and Medication-Related Supplies, date revised January 2018 revealed options to dispose of prescription drugs include-mix the drug with an undesirable substance, put the mixture into a disposable container with a lid.

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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. 45951 Based on observations, interviews, and policy review the facility failed to ensure infection control standards were maintained during 2 of 5 medication administration observations. The findings include: A medication administration observation was conducted on 12/10/24 at 4:00 PM with Staff E, Licensed Practical Nurse (LPN) for Resident #45. Staff E stated Resident #45 was due to receive two insulin shots. After appropriately obtaining Resident #45's blood glucose result, Staff E prepared the insulin pens for administration. Upon entering Resident #45's room, Staff E washed her hands, then approached Resident #45, cleaned the right and left upper quadrants of Resident #45's abdomen, and proceeded to administer the two types of insulin without first donning gloves. Upon completion of the observation, Staff E was asked if she should have donned gloves prior to administering the insulin doses. Staff E confirmed she should have donned gloves. Medication administration observations were conducted on 12/10/24 at 8:09 AM with Staff B, Registered Nurse (RN). Staff B was observed administering medications to Resident #6 in the hallway and then return to her medication cart and prepare medications for Resident #53 without washing her hands in between the residents. Staff B then administered medications to Resident #53 and then returned to her medication cart to prepare medications for Resident #76 without washing her hands. Staff B then took the blood pressure cuff from on top of her medication cart and entered Resident #76's room to attain her blood pressure prior to administering her medications. Upon returning to the medication cart, she placed the used blood pressure cuff back on top of her medication cart and proceeded to finish preparing Resident #76's medications. After administering Resident #76's medications, Staff B returned to her medication cart without washing her hands. Staff B did not clean the blood pressure cuff. Upon completion of the observation, Staff B was asked if she should have washed her hands and cleaned her blood pressure cuff between residents. Staff B confirmed she should have washed her hands and cleaned her blood pressure cuff. Interviews were conducted with the facility's Director of Nursing, Corporate Nurse Consultant, and Administrator on 12/10/24 following the medication administration observations. They all confirmed the nurses should have washed their hands and equipment between residents and that Staff E should have donned gloves prior to injecting the insulin. Review of the facility policy titled Insulin Pen, date revised January 2024 revealed the proper procedure for administration of insulin included the staff member donning gloves prior to the injection.