STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106061	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgecrest Healthcare and Rehabilitation Center	1200 North Stone Street Deland, FL 32720

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure adequate monitoring and assessment of Resident #102's skin integrity to prevent further deterioration. There were two residents reviewed for skin condition from a total survey sample of 44 residents.The findings include:During a facility tour on 01/25/26 at 2:29 PM, Resident #102 was observed with her right hand wrapped with gauze (Kerlix wrap). Her right middle and ring fingers were smeared with blood. The blood penetrated through the gauze and an open area was observed on her lateral ring finger. The nail beds of the fingers of the left hand had red debris that appeared to be blood.In an interview on 01/25/26 at 2:31 PM, Resident #102 confirmed that her right-hand ring finger was bleeding. She could not state what happened or whether or not a dressing change was being done. She stated she had been bleeding for a while.During an observation on 01/26/26 at 12:55 PM, Resident #102 was observed in bed. Her right hand was uncovered; the lateral ring finger and lateral right thumb were bleeding and the resident was holding her hand with a tissue. She stated someone (could not recall the name) unwrapped the gauze and looked at her bleeding finger but never returned.On 01/27/26 at 12:43 PM, Resident #102 was observed in bed. Her right hand had no dressing on it, but the middle digit had blood on it. The resident had used a tissue to wipe the blood and placed the blood covered tissues on her food tray that was on the bedside table.In an interview on 01/27/26 at 12:45 PM, Resident #102 stated no one had provided treatment to her right hand.A review of the medical record revealed that Resident #102 was admitted to the facility on [DATE]. Her diagnoses included, but were not limited to: syncope and collapse, chronic respiratory failure with hypoxia or hypercapnia, CVA (stroke) and chronic obstructive pulmonary disease (COPD).A review of her active Physician's Orders revealed orders for: Clopidogrel 75 mg (milligrams), one tablet daily (QD) for blood clots, dated 12/13/24. Aspirin 81 mg, one tablet QD for anticoagulant, dated 12/13/24.No treatment for the resident's hand/fingers was noted. A review of the resident's Annual Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 11/19/25, revealed that the resident had a brief interview for mental status (BIMS) score of 13/15, indicating intact cognition. There were no skin-related problems or major joint replacement/surgeries noted. A review of the resident's care plan (revised 08/27/25), revealed that the resident was at risk for abnormal bleeding related to the use of antiplatelet therapy and a history of cardiovascular accident (CVA - stroke). Interventions included: Advise resident/responsible party to report any symptoms of unusual bleeding or bruising. Daily skin inspection. Report abnormalities to the nurse. report to the physician signs and symptoms of bleeding or hemorrhage. Further review of care plan revealed that the resident had potential/actual impairment to skin integrity of the right ring finger, 4th digit. Interventions indicated that the resident had an appointment with a hand surgeon on 08/28/25 at 11:30 AM. Avoid scratching and keep hands body parts from excessive moisture. Keep fingernails short. Keep skin clean and dry.A review of the orthopedic surgeon's notes, dated 08/28/25, revealed: Resident has had right arm numbness as well as stiffness from possibly a stroke and from previous infections. She has numbness for the last several years. She does have a history of cervical spine surgery many years ago. Have recommended an EMG (electromyography) and nerve conduction study to the bilateral upper extremities. She picks (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at the excoriations causing them to worsen, and I have recommended an arthritis glove to the right hand to try to prevent her from picking at the scabs. Clean daily with soap and water. Follow-up after studies. Follow-up date noted as 10/02/25 at 4:15 PM.A review of the weekly skin checks dated 01/19/26 and 01/26/26 revealed no skin issues noted. In an interview on 01/27/26 at 4:04 PM, Licensed Practical Nurse (LPN) J/ Wound Care Nurse, stated she had been employed by the facility for about a year as the wound care nurse. She stated she was notified of skin issues in different ways such as reports from staff, resident admission notes, new orders reviews, weekly skin checks, and risk management notes. She further explained that once a new issue was identified, the assigned nurse should contact the provider and obtain the initial treatment, notify family and complete a skin note. She added that she reviewed any new issues by the next business day. When asked about Resident #102's wounds, she stated the resident had a deformity of her right hand and had no open wounds. She confirmed that the resident was not on her caseload for wound care. She explained that the resident preferred to have the hand covered for dignity reasons. When asked if the resident had been seen by the orthopedic provider for the deformity, LPN J stated she did not know. When notified that the resident was observed with an open area to her right hand for three days, LPN J reviewed the physician's orders and treatment administration record (TAR), and confirmed that there was no treatment in place or a risk management note about any incident having occurred. On 01/27/26 at 4:28 PM, the wound care nurse was accompanied to Resident #102's room. The resident was observed lying in bed with her right hand wrapped in a napkin. The resident unwrapped the napkin that was saturated with blood revealing her right ring finger and thumb with open skin and a bruise to the lateral and top of the finger near the palm. The resident stated it had been like that for several days and no one had done anything about it. The resident stated she was not sure what happened. The wound care nurse stated the assigned nurse should have obtained an order due to the active bleeding and then notified the family.During an interview on 01/28/26 at 2:15 PM, LPN L stated she was assigned to Resident #102 for the last three days. She further stated the resident was alert and oriented to place, person and time. The resident was incontinent and preferred to stay in bed . She stated she worked through an Agency and was not sure what was wrong with the resident's hand as it was always wrapped in something. She explained that the wound care nurse was responsible for providing any treatments. LPN L stated she was not aware of any follow up needed for Resident #102. She reviewed the physician's orders and stated there were no upcoming appointments.During an interview with the Director of Nursing (DON) on 01/28/26 at 4:14 PM, she stated Resident #102 had chronic wounds to her right hand. She stated the resident picked healed scabs until they bled. She added that the resident should be checked daily and if a wound was bleeding, it should dressed. When she was asked for the orthopedic follow up on 10/02/25, the DON stated she was not sure about that as there was no paperwork. She added that there was an upcoming appointment scheduled in February.A review of the facility's policy and procedure titled Skin and Wounds (revised 1/25/21), revealed:Standard: It will be the standard of this facility to provide assessment and identification of residents at risk of developing pressure injuries, other wounds and the treatment of skin impairment.Guidelines:Skin will be assessed/evaluated for the presence of developing pressure injuries or other changes in skin condition on a weekly basis at least once each week or as needed by a licensed nurse.Nurses are to be notified to inspect skin if newly developed skin changes are identified.The admission evaluation may identify pre-existing signs (such as purple or very dark area that is surrounded by profound redness, edema or induration) suggesting that deep tissue damage/injury has already occurred and additional deep tissue loss may occur which may lead to the appearance of an unavoidable pressure injury or progression of skin impairment related to trauma or pressure prior to admission to the facility.The comprehensive assessment, which includes the Resident Assessment Instrument (RAI)/Minimum Data Set (MDS), may be used to evaluate the intrinsic risks, skin condition and other causal factors which place resident at risk for developing pressure injuries and/or experiencing delayed healing to which the resident may be subjected.Wound (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care procedures and treatments should be performed according to physician orders.Wound care treatment should maintain proper technique, as is indicated by the type of wound and physician orders.Preventative measures, such as barrier creams, can be employed to help maintain skin integrity as well as utilization of pressure relieving surfaces, floating heels, protective boots and use of positioning devices. Use of barrier creams may vary according to product and may be used following incontinent care for additional prevention, provided there is no clinical contraindication.Document in the clinical record when treatments are performed.Document the progression of the wound being treated. Such observations should include items size, staging (if applicable), odors, exudate, tunneling, etiology, etc.Contact the physician for additional order changes as is appropriate or to notify of skin condition changes or refusals of care.The presence of skin impairment should be denoted on the person-centered plan of care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure that each resident received adequate supervision to prevent accidents, by failing to ensure that one (Resident #73) of two residents reviewed for smoking, was assessed for safe smoking to prevent accidents prior to smoking on the facility premises. There were 14 residents in the facility who were active smokers.The findings include:On 1/25/26 at 3:30 PM, Resident #73 was observed in the smoking area in the company of three other residents. She was smoking cigarettes and there was no staff member providing supervision.During an interview on 1/26/26 at 11:09 AM, Resident #73 stated she was permitted to smoke between 8:00 AM and 8:00 PM. She mentioned that they (smoking residents) were not normally supervised by facility staff. She stated smoking supplies were to be given to the receptionist after smoking. On 1/26/26 at 3:00 PM, Resident #73 was observed outside smoking. No staff member was supervising.During another observation on 1/27/26 at 11:00 AM, Resident #73 was observed smoking in the facility's designated smoking area. No staff member was supervising.A review of the medical record revealed that Resident #73 was admitted to the facility on [DATE]. Her diagnoses included but were not limited to: Type 2 diabetes mellitus with hyperglycemia, needs for assistance with personal care, chronic pain syndrome, fibromyalgia, nicotine dependence and restless leg syndrome. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/17/25 revealed that the resident had a brief interview for mental status (BIMS) score of 15/15, indicating intact cognition. She had no impairment to her upper or lower extremities noted. A review of the active care plan (revised 12/31/25) revealed that the resident was a smoker based on her history of smoking per the hospital history and physical. Interventions included: Instruct the resident about tobacco use risks and hazards and about smoking/tobacco use cessation aids that were available. Observe clothing and skin for cigarette burns. The care plan also indicated that the resident was able to smoke unsupervised. Smoking supplies were stored at the reception desk.A review of the smoking assessments revealed no smoking assessment for Resident #73.A review of the facility's active smoking list, dated 1/25/26, revealed that Resident #73 was not included on the list.In an interview on 1/28/26 at 2:58 PM, Certified Nursing Assistant (CNA) M stated she was assigned to Resident #73. She explained that the resident was alert, oriented and able to make her needs known. She required a mechanical lift with two-staff member assistance for transfers. She added that the resident smoked unsupervised between 8:00 AM and 8:00 PM.On 1/28/26 at 3:18 PM, Licensed Practical Nurse (LPN) N/Unit Manager, stated the residents were assessed for safe smoking on admission, annually and with any change in condition. She confirmed that Resident #73 was an active cigarette smoker and smoked unsupervised. When she was asked Resident #73's smoking assessment, she confirmed that she could not find a smoking assessment for this resident.In an interview with the Director of Nursing (DON) on 1/28/26 at 4:14 PM, she stated the smoking assessments were conducted on admission, quarterly and with any change in condition. She further stated the smoking assessment determined whether or not residents were safe smokers. She added that most of the active smokers in the facility were deemed safe and smoked unsupervised between 8:00 AM and 8:00 PM. When she was asked if Resident #73 was an active smoker, she said, Yes, she smokes unsupervised and she is always out on the smoking porch. When the DON was asked for the smoking assessment verifying that Resident #73 was a safe smoker, she confirmed that no assessment was available for Resident #73. A review of the facility's policy and procedure titled Safe Smoking Policy (revised 1/1/2021), revealed:Standard: It is the policy of this facility to provide a smoke-free environment for all residents and staff. Visitors and Residents are prohibited from smoking inside any facility buildings. All children and adolescents under the age of 18 are prohibited from smoking. The use of illegal paraphernalia is completely prohibited.Smoking by residents is (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	restricted to a minimum and intended to:- Reduce risks to residents who smoke, including possible adverse effects on treatment;- Reduce risks of passive smoking for others; and- Reduce the risk of fire.Guidelines: Written notice of the smoking policy will be provided and explained to each resident and/or responsible party upon admission and as needed.SMOKING PRIVILEGES:This facility respects resident rights and provides an opportunity for an independent homelike environment that permits the residents to smoke; however, smoking will occur in the designated locations that are environmentally separate from all resident care areas. The designated area is located outdoors with appropriate shelter from excess sun or rain. Electronic vapor cigarettes will be addressed and accommodated per the same guidelines as noted below for actual cigarettes.SMOKING ACCOMMODATION:Smoking should occur in the facility's designated area.The facility accommodates supervised smoking opportunities for residents who require supervision. NOTE - Facility staff may request NOT to participate in smoking supervision duties.Residents that are smokers may not keep lighters/ignition material on their person or in their room unless provided by the nurse to be used during smoking opportunities. Lighters/ignition materials must be maintained at the resident's designated nurses' station or other centralized location specific for this.Smoking is discouraged for health reasons.Residents may not smoke while using ANY form of portable oxygen. The residents deemed as an unsafe smokers will be provided an opportunity to smoke with staff assistance/supervision to provide determined degree of supervision and protective gear.DESIRED OUTCOMES:Resident - The resident who smokes does so in a safe environment and in a safe manner.Staff Members - The IDT (Interdisciplinary Team) determines if a resident is a safe smoker or an unsafe smoker before the resident exercises the privilege to smoke.INTERVENTIONS:Screening - A Safe Smoking Screen is performed on admission for a resident who wishes to smoke.- Assesses the resident's cognitive status to determine if the resident is capable of safe smoking.- Interview the resident to determine their ability to verbalize their understanding that smoking materials are for use in designated areas only.- Observe the resident's ability to smoke in a safe manner.- Reassessment of the resident occurs annually and/or after a significant change in condition, as is needed.- The completed screen is placed in the resident's medical record.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, medical record reviews, and a review of facility policies and procedures, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections by failing to 1) Remove visible soil from one (room [ROOM NUMBER]) of 23 enhanced barrier precautions (EBC)-designated resident rooms for two consecutive days, and 2) Follow hand hygiene practices consistent with accepted standards of practice during residents' lunch meal service.The findings include:1.On 1/25/26 at 11:26 AM, resident room [ROOM NUMBER] was observed with multiple areas of a brown-colored substance, resembling feces, on the floor in the center of the room that were visible from the hallway.On 1/26/26 at 10:00 AM, another observation of resident room [ROOM NUMBER] was made. The floor remained soiled with the same multiple areas of brown-colored substance in the center of the room as were there on 1/25/26 at 11:26 AM. On 1/27/26 at 1:50 PM, an interview was conducted with Housekeeper O, who reported that she had only been employed by the facility for a few months now. She confirmed that she was assigned to service resident room [ROOM NUMBER] and reported no trouble cleaning that room each shift she worked. On 1/28/26 at 1:04 PM, an interview was conducted with Certified Nursing Assistant (CNA) G, who stated she washed her hands, sanitized, and followed the guide on the door for EBP-designated rooms to decrease the spread of infection. She further stated the housekeeping staff were responsible for maintaining the overall cleanliness of the facility, including resident rooms.On 1/28/26 at 1:27 PM, Licensed Practical Nurse (LPN) I was interviewed. She stated any concerns with infection control were reported to the Assistant Director of Nursing (ADON), who was also the facility's Infection Preventionist. Activities of Daily Living (ADL) care for the residents was provided by the assigned CNAs and included getting the residents up and out of bed, showered, dressed, and linens changed. The housekeeping staff were responsible for cleaning the residents' rooms, collecting the trash and mopping the floors each day and when there was a spill or an accident - that should be cleaned up immediately. She further stated resident rooms were not being cleaned thoroughly or consistently as they should.On 1/28/26 at 3:48 PM, an interview was conducted with the Director of Nursing (DON), who reported that she was the facility's infection preventionist, and it was her expectation that resident rooms were cleaned daily to help prevent the potential spread of infection. She acknowledged the environmental concerns, and stated there was an Environmental Performance Improvement Plan (PIP) in place; however, infection control and prevention was not covered in that plan. She further stated she would be updating the current PIP to include resident room and care areas. On 1/28/26 while providing a copy of the facility's PIP documentation titled F584/Physical Environment Clean and Homelike/F585 Grievances (Environmental), the facility Administrator confirmed that infection control environmental concerns were not covered in the PIP. 2. On 1/27/26 at 12:15 PM, the lunch meal service was observed taking place in the main dining room and for the 200-hall nursing unit. In the main dining room, a rolling cart was observed with a grey-colored bin filled partially with ice. Three beverage pitchers of different colored liquid (with paper identifying labels) were resting inside the bin with the ice visibly surrounding the pitchers. The cart was situated at the front of the dining area. Staff were observed picking up the pitchers to pour drinks in resident cups and then placing the pitchers back into the grey bin with ice. Meal trays were observed on the 200-hall nursing unit at 1:00 PM. At 1:16 PM, trays were delivered to the dining room where nine residents were seated. At 1:25 PM, the ADON was observed coming into the dining room with her hands resting on her hips. She asked if there was anything she could do. A resident seated at the table asked for a straw. The ADON was observed picking up a paper-covered straw with her bare hands. She held the top of the straw with one hand and ripped the paper off the bottom of the straw with her other hand. She proceeded to place the bottom of the straw, that she was now holding with (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her bare hand, into a cup, when the Resident stated, Hey, you touched my straw with your hand. The ADON chuckled and replied, No, I didn't touch your straw with my hand, you're always playing. The ADON then left the dining room. On 1/27/26 at 1:39 PM, the ADON returned to the dining room. With her bare hands, she reached into the grey bin located on the nourishment cart with the three drink pitchers. She scooped ice from that bin, using a clear cup, into a white Styrofoam cup. She then took the pitcher that was labeled Tea and began pouring into the cup she just placed the ice into. She then walked out of the dining room.On 1/27/26 at 2:02 PM, an interview was conducted the ADON, who reported that she was training to be the facility's infection preventionist. She reported that during meal service, she would round and assist with tray deliveries. The CNAs usually passed drinks before the meal trays arrived using the nourishment cart that had the grey bin/container with ice, and drink pitchers provided by the kitchen staff at each meal service. They cleaned the bin, filled the bin with the ice, drink pitchers were also filled and placed in the ice, and then the kitchen staff brought the beverage cart to the floor. The ADON reported that the ice bin was used to keep the drink pitchers cold, but the ice we use if the resident request ice in their drinks. She was asked if it was normal practice to use bare hands and a plastic cup when providing beverages to residents with ice. She replied, Yes, we use that small plastic cup in the bin to scoop the ice from the bin. I was asked by a resident for a drink when I was walking by, so I came back, and that's when you saw me scoop the ice. Then I poured him some tea and provided him with the requested drink.On 1/28/26 at 1:04 PM, an interview was conducted with CNA G, who reported that the facility utilized a nourishment cart during mealtimes. The dietary team brought the cart to the nursing unit up to an hour before the meal service. Pitchers contained coffee, tea, water, and the cart also had hot chocolate packets on it. The ice she got from the ice machine located on the 100-hall, because the 200-hall's ice machine was broken. CNA G stated she would never grab ice from the grey bin that held the drink pitchers, because that ice was just to keep the drink pitchers cool. That's nasty and contaminated. She could not recall if she received training on this topic specifically, but she stated, I thought that was just common sense. On 1/28/26 at 1:27 PM, LPN I was interviewed. She stated the CNAs were responsible for passing out nourishments. Water was located on the nursing unit and was refilled throughout the day. The ice came in a cooler from the 100-hall unit because the ice machine on the 200-hall was not working. The kitchen staff brought drinks during mealtimes on a beverage cart. Juice, coffee and iced tea were poured in pitchers that were set in ice in a container/bin to keep the drinks cold. No cup should be sitting in the bin holding that ice, because that was dirty ice. That ice should never be served to a resident. She reported never seeing anyone use the ice in those containers/bins for resident drinks and would report it immediately if she did.On 1/28/26 at 3:48 PM, an interview was conducted with the Director of Nursing (DON), who confirmed that all staff, both clinical and non-clinical, received infection control and prevention training to include hand hygiene training prior to working on the floor with no exceptions. She reported that she was shocked when she was made aware of a hiccup during tray pass yesterday with hand hygiene, and that concern had now been incorporated into a PIP with education provided with the ADON.A review of the facility's policy and procedure titled Infection Prevention and Control Program Manual-Infection Prevention and Control Program (Revised 1/20/2024), revealed: The primary mission is to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The policy interpretation and implementation indicated: Page 1, 2) c. Standard and transmission-based precautions to be followed to prevent the spread of infections. h. The hand hygiene guidelines to be followed by staff involved in direct resident contact. Page 10. 2) Practices: b. Assure that products and guidelines for cleaning and disinfection of surfaces and equipment are appropriate. c. Managing food safety, including employee's health and hygiene, pest control, investigating potential food-borne illnesses.