STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Crossing Rehabilitation Center	701 Victoria St Brandon, FL 33510

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on interview and record review, the facility failed to notify the resident's family/responsible party and the resident's physician of a change in condition for two (#1, #12) of 12 sampled residents. Findings included: 1. Review of the Medical Record for Resident #1 showed he was admitted to the facility on [DATE] and discharged on [DATE]. Resident #1's diagnoses included acute respiratory failure, acute pulmonary edema, intestinal pulmonary disease, Chronic Obstructive Pulmonary Disease (COPD), Alzheimer's disease and dependence on renal dialysis. Review of a progress note for Resident #1 signed by Staff C, Registered Nurse (RN) dated [DATE] at 7:41 a.m., showed during morning rounds, the night shift nurse reported the patient spent the night calling family members and asking for help. This nurse went to the patient's room, and he was confused, but stable. Family member called 911, but patient refused to be transferred to the hospital. On [DATE] at 2:01 p.m., an interview was conducted with Resident #1's family member. The family member stated they called and requested the nurse who was working the night shift to send the resident out, but the nurse refused. The family member stated the nurse kept saying Resident #1 was fine and hung up on the family member. The family member reported feeling frustrated and calling 911. She stated when Emergency Medical Technicians (EMTs) arrived to the facility, they did not take the resident to the hospital. The family member said the day nurse called. She did not say anything about the doctor seeing my dad. She kept saying, he [Resident #1] refused to go. The family member stated the resident was sick and confused. We pled with them to send him [Resident #1] out. No one cared. Review of Resident #1's medical record showed there were no notes in the resident's record related to his on-going calls to family members requesting help on [DATE] or prior to the 7:41 a.m. note on [DATE]. There was no documentation of a Change in Condition (CIC), physician notification or interventions to address Resident #1's needs the night of [DATE] or the early morning hours of [DATE]. Review of a progress note for Resident #1 signed by the Assistant Director of Nursing (ADON) dated [DATE] at 4:40 p.m., showed results of a urine culture were received revealing the resident was positive for an UTI (Urinary Tract Infection), and the antibiotic started on [DATE] was appropriate to treat the UTI. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a care plan for Resident #1 showed a focus initiated on [DATE], for Urinary Tract Infection. Interventions included to encourage adequate fluids, give antibiotic therapy as ordered. Monitor/document side effects and effectiveness. Monitor vital signs. Notify MD (Medical Doctor) of significant abnormalities. Monitor/document/report to MD PRN (as needed) for signs and symptoms of UTI. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Review of the medical record showed there was no documentation regarding the resident's care and monitoring prior to a progress note dated [DATE] at 05:52 p.m. which showed patient expired. On [DATE] at 2:31 p.m., an interview was conducted with Staff C, RN. She said, I was working that morning. I remember a family member called between 8 a.m. and 10 a.m., and said she had called 911 because the resident had told her he did not feel good. I asked her why she did not tell me. She said he had reported he was short of breath. I went to him and saw he was a little confused. He could answer to Yes or No questions. I started to prepare to send him out when the EMT came and said he had refused to go. When he said he was okay, and he did not want to go, we left him alone. Staff C stated she had assessed the resident but there was no documentation. Staff C stated she had contacted the Director of Nursing (DON) who said to send the resident out anyway. Staff C said, I spoke to the DON, and I said the family wanted us to send him out. She said to go get the EMTs and tell them to take him if that was what the family wanted. By the time I got to them (EMTs), they were gone. I did not call them back. Staff C stated she thought she had called or texted the physician. Staff C could not show the communication on her phone. Staff C said, I think I called him. I don't know why I don't have that. I don't remember speaking to the doctor. I believe I sent him a message. It was my bad, and I did not document. I don't know what he said. On [DATE] at 3:33 p.m., an interview was conducted with the DON. She stated the nurse had called her on the morning of [DATE] and said EMS (emergency medical services) was at the facility. The nurse reported they went and spoke to the resident, and he refused to go to the hospital. The DON stated neither she nor the Unit Manager had documented their assessments on the resident. She confirmed there was no documentation regarding family notification of the on-going changes the night the resident expired. The DON stated the physician had been notified the resident was not feeling well. She said, He was notified by the nurse. I don't know if the doctor came. It should be documented. I'll ask him for the notes. The DON reviewed the residents medical record and said, I see, it is not documented right now. There is no CIC or any skilled notes. The DON stated they should have documented when the physician was contacted regarding the change and when the nurse spoke with the family. On [DATE] at 12:38 p.m., an interview was conducted with Staff A, RN/UM (Unit Manager). She stated if a resident experienced any change of status, the first thing to do would be assess the resident, notify the physician, and then call the family or responsible party. She stated she would then document the CIC under evaluations and follow up with a skilled note. She stated the nurse should continue to assess the resident if they are not sent out. She stated the skilled notes should show the resident's progress and physician's response. On [DATE] at 12:27 p.m., an interview was conducted with Staff B, Licensed Practical Nurse (LPN.) She stated if a resident had a change in status, she documents in the evaluation section. She conducts an assessment and notifies the physician and then family. She stated she follows physician orders, if they want the resident sent out or if medications are ordered or if the nurse should continue monitoring. She stated it should all be documented during the point of care. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:30 a.m., an interview was conducted with the Medical Director and his ARNP (Advanced Registered Nurse Practitioner). He said, He refused to go the hospital. We can't force him. The residents have a right to refuse care. I don't remember hearing an ambulance came. No, I did not call his family. Staff called me many times about this man. He was non-complaint. I told him many times, if you continue refusing dialysis, with all the problems you have, it will kill you. The doctor stated he never spoke to this resident's family. He said, I never had any interaction with them. The Nurses relayed their concerns. I was never told they ever asked for me to call them. I said, you could die without further treatment. He stated he did not contact the family to let them know of his concerns related to the non-compliance. He stated he should be notified if a resident was refusing medications and treatment. He stated he had notes documenting this resident's care and his non-compliance. He stated between him and his ARNP, he was seen many times. The ARNP stated she could not recall how often she had seen the resident and was not sure when she last saw him. She stated she would provide her notes. Physician notes during this resident's CIC were requested and not provided. There were no physician notes documenting Resident #1's treatment refusal. Review of a facility policy titled, change in condition, dated [DATE], showed the purpose was to identify and communicate changes in condition to the physician and other employees and possibly prevent hospitalization . Procedure showed all staff are encouraged to promptly report any changes in condition to the charge nurse, supervisor, DNS (Director of Nursing Services)/ADNS (Assistant Director of Nursing Services) or designee immediately. This may include but not limited to a significant change in the resident's physical mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include life threatening conditions or clinical complications. Circumstances that may require a need to alter treatment. This may include new treatment and/discontinuation of current treatment due to adverse consequences, acute condition, or worsening of a chronic condition. A complete assessment may need to be conducted of all systems including but not limited to functional status, respiratory evaluation, cardiovascular evaluation, abdominal pain or GI evaluation, urine evaluation, skin evaluation, pain evaluation and vital signs. The physician/nurse practitioner shall be made aware of the condition change and pertinent assessment findings. The residents shall be monitored until conditions significantly improves. An interdisciplinary team conference may be held if needed to address concerns/changes. A care plan may be initiated and or updated on the reason of the change in condition, goals and interventions. The resident's family/legal representative/healthcare agent should be notified about the change in condition as required. 50732 2. An interview was conducted with the Director of Nursing (DON) on [DATE] at 5:10 pm regarding a change in condition for Resident #12. She said Resident #12's family and physician should have been notified of the resident's leg wound, but she does not see any documentation of notification of either in the medical record. Review of Resident #12's Admission Record shows the resident was admitted to the facility on [DATE] with admitting diagnoses to include type 2 diabetes mellitus, end stage renal disease, acquired absence of right leg below knee, and acquired absence of left leg below knee. Review of Resident #12's Minimum Data Set (MDS) dated [DATE] shows the resident had a Brief Interview for Mental Status (BIMS) score of 9 indicating moderate cognitive impairment. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan with an initiation and revision date of [DATE] showed a focus for potential for pressure injury development related to decreased mobility, incontinence and multiple co-morbidities. Goal: The resident will have intact skin, free of redness, blisters or discoloration by/through review (target date: [DATE]). Interventions: Follow facility policies/protocols for the prevention/treatment of skin breakdown. Inform the resident/resident representative of any new area of skin breakdown. Monitor/document/report PRN any changes in skin status. Review of Resident #12's Skin Evaluation done on [DATE] revealed two skin issues were noted: right stump dark area with small opening, no drainage noted. Review of Resident #12's Assessments and Progress Notes showed no Situation, Background, Assessment and Recommendation (SBAR) or Change in Condition was completed as a result of the Skin Evaluation completed on [DATE]. Review of Resident #12's Assessments and Progress Notes showed no documentation indicating the resident's physician was called regarding the results of the Skin Evaluation completed on [DATE]. Review of Resident #12's Assessments and Progress showed no documentation indicating the resident's family/responsible party was notified of the change in condition of the resident regarding the results of the Skin Evaluation completed on [DATE]. 46234 An interview was conducted on [DATE] at 4:51 p.m. of Staff A, RN/UM. She reviewed Resident #12's skin assessment, dated [DATE], noting skin changes on the sacrum and right stump. She said at the time of that assessment, a change in condition should have been completed and the provider notified. Staff A reviewed the resident's medical record and confirmed no change in condition was completed or provider notified. An interview on [DATE] at 5:14 p.m. with the DON revealed with the [DATE] skin assessment changes noted for Resident #12, she would have expected a change in condition to be completed.

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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** 46234 Based on observation, interview, and record review, the facility failed to provide wound assessments and wound care for 1 (Resident #12) of 1 sampled residents for wounds. Findings included: An observation and interview was conducted on 9/5/24 at 4:51 p.m. of Staff A, Registered Nurse (RN)/Unit Manager (UM) going to Resident #12's room and looking at the resident's bilateral lower extremities. The left lower extremity knee had a scab with small spots of blood. The posterior end of the right lower extremity stump was noted to be covered with a large area of necrotic eschar with small open areas of slough. The resident complained of pain, said she, told the nurses she needed wound care, and no one ever came. (Photographic evidence obtained with resident permission.) Following the observation, Staff A, RN/UM reviewed Resident #12's medical record. She confirmed the wound care team was not following the resident and there were no wound care orders in place. She said Resident #12 should be getting looked at and treated for her wounds. An interview was conducted on 9/5/24 at approximately 5:10 p.m. with the Director of Nursing (DON.) She reviewed the photographs of Resident #12's right posterior stump and said the resident should at least have orders for betadine and the wound should be assessed. The DON also stated Resident #12 should have been followed by the wound care providers since there were concerns about the resident's wound. The DON stated skin sweeps were ordered, but she did not see documentation the skin sweeps were done. The DON said Resident #12's family and physician should have been notified, but she does not see any documentation of notification in the medical record. 50732 Review of Resident #12's Admission Record showed the resident was admitted to the facility on [DATE] with admitting diagnoses to include type 2 diabetes mellitus, end stage renal disease, acquired absence of right leg below knee, and acquired absence of left leg below knee. Review of Resident #12's hospital records provided prior to the resident's admission to the facility noted the right leg below knee amputation (BKA) was well healed without wounds. Review of Resident #12's Minimum Data Set (MDS) dated [DATE] showed the resident had a Brief Interview for Mental Status (BIMS) score of 9 indicating moderate cognitive impairment. Review of Resident #12's Care Plan initiated on 8/11/2024 initiated on 8/18/2024 revealed: Focus: The resident has actual impairment to skin integrity of the left knee related to infection. Goal: The resident will maintain or develop clean and intact skin by the target date of 11/26/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions: Follow facility protocols for treatment of injury. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Review of Resident #12's Care Plan initiated and revised on 8/12/24 revealed: Focus: The resident has actual potential potential for pressure injury development related to decreased mobility, incontinence and multiple co-morbidities. Goal: The resident will have intact skin, free of redness, blisters or discoloration by/through review with a target date of 11/26/24. Interventions: Follow facility policies/protocols for the prevention/treatment of skin breakdown. Inform the resident/resident representative of any new area of skin breakdown. Monitor/document/report PRN (as needed) any changes in skin status. Review of Resident #12's Physician Orders showed an order from 08/11/2024 revealed an order for weekly skin sweeps to begin on 08/14/2024 to be done on Wednesday every day shift every Wednesday. Review of Resident #12's Skin Evaluation done on 08/18/2024 revealed right stump dark area with small opening, no drainage noted. Review of Resident #12's Assessments and Progress Notes showed no Situation, Background, Assessment and Recommendation (SBAR) or Change in Condition was completed as a result of the Skin Evaluation completed on 08/18/2024. Review of Resident #12's Assessments and Progress Notes showed no documentation indicating the resident's physician was called regarding the results of the Skin Evaluation completed on 08/18/2024. Review of Resident #12's Assessments and Progress showed no documentation indicating the resident's family/responsible party was notified of the change in condition of the resident regarding the results of the Skin Evaluation completed on 08/18/2024. An interview was conducted with the Nursing Home Administrator (NHA) on 09/05/2024 at 6:25 PM. The NHA stated the facility does not have a Wound Care Policy and a Skin Assessment Policy.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on interviews and record review, the facility failed to ensure Hemodialysis (HD) care was provided per physician orders for one (#1) of two dialysis residents reviewed. Findings included: Review of the medical record for Resident #1 showed he was admitted to the facility on [DATE] with diagnoses to include dependence on Renal Dialysis. Review of Active Physician orders as of 08/21/24 showed orders to: Assess dialysis site for signs and symptoms of infection every shift. Assess dialysis site and indicate yes/no. If yes, please indicate in progress note. Assess dressing site for bleeding upon return from dialysis and after dressing removal every shift. Call MD (Medical Doctor) if bleeding. Check venous access device every shift for bleeding and infection. If bleeding is noted apply adequate continuous pressure to site x 10 minutes and reassess. Repeat x 1 if necessary. Inform MD as needed. Review of a care plan for Resident #1 showed a focus initiated on 08/19/24 showing Resident #1 needed dialysis related to renal failure. Interventions included check and change dressing daily at access site, right upper chest port. If bleeding is noted . notify MD. Encourage resident to go to the scheduled dialysis appointments. Hemodialysis on Tuesday, Thursday and Saturday. Chair time at 0800. Monitor vital signs. Notify MD of significant abnormalities. Monitor/document/report any signs and symptoms of infection to access site. Work with resident to relieve discomfort for side effects of the disease and treatment. Review of dialysis communication forms for Resident #1 showed: 8/20/24, the form showed errors revealing incomplete pre and post dialysis care. 8/15/24 the form showed missing pre and post dialysis documentation. 8/8/24 the form showed pre and post dialysis care was incomplete. On 09/05/24 at 12:27 p.m., an interview was conducted with Staff B, Licensed Practical Nurse (LPN.) She stated for pre-dialysis care, the nurse is supposed to check vitals, separate meds, those that need to be held or administered and document accordingly. She stated the assessment is part of the dialysis form and should be completed at the time of care. She stated the nurse receiving the resident after dialysis should monitor site, obtain vitals and document as ordered. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/05/24 at 3:42 p.m., an interview was conducted with the Director of Nursing (DON). She stated pre and post dialysis care should be documented on the dialysis form. She stated the nurse assessing the resident should document. A dialysis policy was requested and not received.

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46234 Based on observations, interview, and record review the facility failed to ensure proper infection control practices were in place on one out of four units related to proper personal protective equipment (PPE) use, timeliness of contact precaution orders, and hang hygiene. Findings included: An observation was conducted on 9/5/24 at 9:46 a.m. of Staff E, Registered Nurse (RN) during medication administration. Upon exiting a resident room after administering mediation, Staff E did not perform hand hygiene. The nurse proceeded to the medication cart, touched the computer and other items on the cart. An observation was conducted on 9/5/24 at 10:03 a.m. of a visitor in the room of Resident #11. The room had a Contact Precaution sign on the door and the visitor had on no PPE. An observation was conducted on 9/5/24 at 10:21 a.m. of an unknown staff member in Resident #11's room with no PPE. An interview was conducted on 9/5/24 at 10:23 a.m. with a family member of Resident #11. The family member said the resident is on contact precautions for a urinary tract infection (UTI). The family member said they are at the facility daily and staff do not wear PPE in the room unless they are doing something with the resident's urine. The family member said staff told the family that is the only time they would need to wear it also. Review of Admission Records showed Resident #11 was admitted on [DATE] with diagnoses including urinary tract infection, extended spectrum beta lactamase (ESBL) resistance, and carrier or suspected carrier of methicillin resistant staphylococcus aureus. Review of Resident #11's lab results, dated 8/30/24, showed Escherichia coli and ESBL in the urine. The results were reported to the facility on [DATE] at 11:02 a.m. Review of Resident #11's orders showed an order for Isolation Contact Precautions for UTI ESBL positive entered on 9/3/24 at 3:00 p.m. An interview was conducted on 9/5/24 at 3:25 p.m. with Staff B, Licensed Practical Nurse (LPN) and Staff D, LPN. Staff B was confused about the precautions and proper PPE use for Resident #11 due to the bacteria being in the urine and the resident having a catheter. Staff D said PPE should be worn anytime a person enters the resident's room while she is on contact precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 9/5/24 at 3:47 p.m. with the Director of Nursing (DON.) She said staff should be performing hand hygiene immediately upon exiting a resident room and nurses should not be touching the medication cart prior to performing hand hygiene. The DON said when a resident is on contact precautions, staff should do what the sign tells them to do. She said for a resident on contact precautions a gown and gloves should be worn anytime someone enters the room. The DON reviewed the lab results and orders for Resident #11. She said she would have expected the order for contact precautions to have been put in place on 9/2/24, the day the lab results were reported to the facility. Review of a facility policy titled Nursing-Infection Control Prevention and Control Program, dated 2/21/23 showed the following: Purpose: The facility shall 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. Procedure: 3. Transmission-Based Precautions (Isolation Protocols): a. A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current CDC guidelines. Review of a facility policy titled Isolation-Initiating Transmission Based Precautions, dated 4/1/22, showed the following: Purpose: Transmission-Base Precautions should be initiated when there is a reason to believe that a resident has a communicable infections disease. Transmission-Based Precautions include Contact Precautions, Droplet Precautions, or Airborne Precautions .