STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	686127	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adventhealth Deland	701 W Plymouth Ave 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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30969 Based on a review of resident and facility records, and interviews with staff, the facility failed to electronically transmit encoded, accurate, and complete minimum data set (MDS) assessment data to the Centers for Medicare and Medicaid Services (CMS) within the required timeframe of 14 days after completion for three (Residents #1, #4 and #7) of three residents reviewed for resident assessments, from a total survey sample of 22 residents. The findings include: A review of Resident #1's medical record found he was admitted to the facility on [DATE] and discharged on [DATE]. The record revealed a Discharge Return Not Anticipated MDS assessment with an assessment reference date (ARD) of 3/8/24 had been completed and exported from the system. A review of Resident #4's medical record found she was admitted to the facility on [DATE] and a discharged on [DATE]. The record revealed a Discharge Return Not Anticipated MDS assessment with an ARD of 3/7/24 had been completed and exported from the system. A review of Resident #7's medical record found she was admitted to the facility on [DATE] and discharged [DATE]. The record revealed a Discharge Return Not Anticipated MDS assessment with an ARD of 3/7/24, had been completed and exported from the system. An interview was conducted with the Regional Nurse (RN) on 8/6/24 at approximately 4:30 p.m. She was asked to print a copy of the MDS 3.0 NH (Nursing Home) Final Validation Report for these three residents. She did so, and presented the report for review. The report revealed a Warning Message advising that the submission date for the discharge MDS assessments for Residents #1, #4 and #7 was more than 14 days after the completion date. The assessments had not been electronically transmitted to CMS within the required timeframe. The Regional Nurse explained that she and the facility's MDS Coordinator had discovered that Residents #1, #4 and #7's Discharge Return Not Anticipated MDS assessments had been exported from the electronic database, but not transmitted. The Regional Nurse transmitted them today. She said she would be auditing other assessments completed around that same time frame to determine the number of missed transmittals.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. 42442 Based on observation, interview, and record review, the facility failed to to appropriately store residents' medications, by leaving medication at bedside for two (Residents #320 and #315) of 22 residents in the total survey sample. These residents had not been assessed for self-administration of medication and therefore, were at risk of inappropriate use. These medications were also accessible to other residents who should not have access to them. The findings include: 1. On 8/6/24 at 11:00 a.m., Flonase nasal spray was observed on Resident #320's bedside table. A review of Resident #320's physician's orders revealed an order dated 7/26/24 for Fluticasone (Flonase - nasal steroid) nasal spray, administer one spray in each nostril daily. Shake gently. Before the first use, prime the pump before use (Press pump six times until fine spray appears.) After use, clean tip and replace cap (Photographic copy obtained) Further review of the medical record revealed no documented assessment indicating that Resident #320 could self-administer this medication. On 8/8/24 at 3:00 p.m., Flonase nasal spray for Resident #320 was still on the bedside table. (Photographic evidence obtained) In an interview on 8/8/24 at 4:07 p.m., Resident #320 stated he was not sure why the nurses left the medication at bedside. He could not explain how to take the medication. 2. During medication administration observation on 8/8/24 at 8:40 a.m., Registered Nurse (RN) A was observed preparing medication for Resident #315. She obtained medication from the Pyxis (automated medication dispensing machine), but she did not obtain the Calcitonin nasal spray. She entered the resident's room and administered the oral medication. She then asked the resident if the nasal spray was stored in his room. Resident #315 replied, I don't know. The nurses gave it to me only two times since I have been here and I don't know what happened to it. RN A left the resident's room and rechecked the Pyxis. She could not find the medication. She stated medication should be stored in the patient-specific medication bin and it was not there. She added that she was floated from another unit and she would have to verify with the Director of Nursing (DON). She asked another nurse who was at the nurses' station where the medication could be, and was asked to check in the resident's room or check with the resident. She went back to Resident #315's room and searched in the nightstand drawer. She found the medication under the hygiene bucket. She administered the medication and returned it to the Pyxis. When asked if the medication should be left at bedside, RN A stated the resident should have an assessment for self-administration if medication is left at bedside. She was asked if Resident #315 had such an assessment, and she replied that she was new to the unit and would verify this with the DON. A review of Resident #315's physician's orders revealed an order dated 7/29/24 for Calcitonin (Miacalcin) nasal spray, administer one spray to one nostril daily. Alternate nostril daily. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 8/8/24 at 3:32 p.m., she stated residents could have medication at bedside if the physician/pharmacist indicated that medication could be left at bedside; otherwise, the resident should be assessed for self-administration before medication was left at bedside. She confirmed that Resident #320 and Resident #315 did not have self-administration of medication assessments; therefore, the medication should not be left at bedside. A review of the facility's policy and procedure titled Storage and Security of Medications (reviewed on 5/9/23), revealed: Medications are stored only in those places and under conditions approved by the Director of Pharmacy and in accordance with all state and federal regulatory requirements. The policy further noted that access to medication was controlled through maintenance and utilization of appropriate drug distribution and security systems. All medication will be stored behind a minimum of one lock located in a secure area that is either inaccessible to unauthorized personnel or under continuous surveillance.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30969 Based on observation, resident record reviews, and interviews with staff, the facility failed to maintain residents' medical records that were complete and accurately documented for one (Resident #266) of one resident reviewed for enteral nutrition, from 22 residents in the total survey sample. The findings include: An observation of Resident #266 was made on 8/8/24 at 11:42 a.m. Registered Nurse (RN) B was preparing to administer his tube feeding (delivery of liquid nutrition through a tube inserted directly into the stomach or small intestine). After performing hand hygiene, donning gloves and preparing for the procedure, RN B flushed the feeding tube with 75 milliliters (ml) of water. She then administered 480 ml of Glucerna (enteral nutrition) via gravity and flushed the tube again with 75 ml of water. RN B then clamped the tube closed, explaining as she demonstrated that the the tube feedings and flushes, along with assessments of the tube, were put into the electronic medical record (EMR) under the section titled: View Flowsheet - I/O (intake/output) - Enterostomy (PEG/Gastrostomy/Jejunostomy) Gastrostomy 1 20 Fr LUQ (French left upper quadrant). A review of Resident #266's EMR revealed he was admitted to the facility on [DATE] and had diagnoses including, but not limited to, Parkinson's disease, diabetes mellitus and protein-calorie malnutrition. He had a physician's order, dated 7/29/24, for bolus (a single dose given all at once) tube feeding of Glucerna 480 ml for four feedings per day with a flush of 75 ml of water before and after each bolus. There were no scheduled times for the feeding intervals. (Photographic evidence obtained) A review of the resident's flow sheets revealed no documentation of the administration of Resident #266's tube feedings, and no documented assessment of the percutaneous endoscopic gastronomy (PEG) tube status from 8/5/24 to 8/8/24. Further review of the record revealed there was no documentation veridying that Resident #266's enteral feedings were being provided four times daily as ordered. (Photographic evidence obtained) An interview was conducted with the Director of Nursing (DON) on 8/8/24 at 12:12 p.m. When asked how the nurses knew when to administer Resident #266's bolus tube feedings, or when the last bolus was completed, she said the nurses recorded their tube feeding times on a sheet at the nurses' station, then passed it on during report and discussed it in their huddle meetings. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Assistant Director of Nursing (ADON) on 8/8/24 at 12:33 p.m. When asked how the nursing staff knew when to administer bolus tube feedings and when the last bolus was completed, she stated tube feeding times, administration and care were passed on to nursing staff in daily huddle meetings. When asked where documentation of administration and assessment could be found in the EMR, the ADON stated it was sometimes documented in a nurse's note. The ADON was asked to find documentation of the administration of tube feedings and assessments of Resident #266's PEG tube in the EMR. The DON and ADON left the room briefly then returned and provided printed copies of nurses' notes from Resident #266's electronic medical record (EMR). Huddle notes were also provided. There was no documented evidence that nurses were noting administration times or other related information. The DON and ADON confirmed that there was no documentation of the administration and assessment of the PEG tube from 8/5/24 to 8/8/24 except for one nurse's note on 8/7/24 at 6:49 p.m., which states, [Resident #266] was then given Glucerna per g-tube. (Photographic evidence obtained)

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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** 30969 Based on observation, record review, and interview, the facility failed to establish and maintain an infection prevention and control program related to Enhanced Barrier Precautions (EBPs) for two (Residents #319 and #266) of four residents on EBPs, from a total survey sample of 22 residents. Failure to follow infection control standards could result in the transmission of infections. The findings include: 1. On 8/6/24 at 12:09 p.m., Resident #319 was observed in his room in bed. He had a left upper arm double-lumen (two separate tubings and two caps) peripherally inserted central catheter (PICC - thin, flexible tube inserted into a vein in the upper arm and threaded into a large vein above the right side of the heart) and left abdominal [NAME] drain (temporary drain placed during surgery that is composed of a fluid collector, a hollow tube, and an egg-shaped bulb). No EBP sign was posted. A review of Resident #319's medical record revealed an admission to the facility on [DATE]. His diagnoses included, but were not limited to: Perforated viscous status (intestinal or bowel perforation (hole) post exploratory laparotomy (surgical incision in the abdomen for diagnosis or preparation for surgery), abdominal washout, small bowel resection x 2 (surgery to remove part of the small bowel), drainage of intra-abdominal abscess, and sepsis (extreme immune response to infection that can lead to tissue damage, organ failure or death). Further review of the record revealed that the resident's PICC line was placed on 6/20/24; a closed suction drain was inserted in the upper abdominal quadrant on 7/1/24, and the resident had a surgical incision/wound at the right lower flank. A review of the resident's 8/6/24 laboratory results revealed that the resident had Extended Spectrum Beta-Lactamase (ESBL), Klebsiella, Bacteremia and Vancomycin Resistant Enterococcus (VRE) abdominal abscess/peritonitis. A review of the resident's active physician's orders revealed an order dated 8/6/24 for Ceftriaxone (Rocephin - antibiotic), 2 grams (g) in Normal Saline (NaCl) 0.9% 100 milliliters (mL) intravenous piggyback (IVPB) every day (QD) for 7 days. A treatment order dated 7/17/24, noted to strip [NAME] drains once every shift and inform the surgeon of any changes to the volume, quality, texture, or color of the drain output. (Photographic evidence obtained) In an interview with the Assistant Director of Nursing (ADON)/Infection Preventionist on 8/8/24 at 11:11 a.m., she stated EBPs were initiated for residents with PICC/Midline IVs (intravenous lines), Foley catheters (urinary catheters), enteral feeding tubes, wounds, and those with antibiotic resistant organisms. When she was asked how residents on EBPs were identified, she said, There should be an isolation cart outside of the resident's door, and as soon as you open the door, the type of isolation should be posted. She was asked how many residents were currently on EBPs. She said she had not updated her list during the survey week, so there could be more added this week. From what I can recall, there are four residents, room [ROOM NUMBER] - peg tube, room [ROOM NUMBER]- wound vac, colostomy, Foley, room [ROOM NUMBER] - Foley, and room [ROOM NUMBER] - PICC and drain. On 8/8/24 at 11:39 a.m., the ADON was accompanied on a facility tour. During the tour, the ADON confirmed that rooms [ROOM NUMBERS] had no PPE carts or EBPs signs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/8/24 at 2:21 p.m., a follow-up interview was conducted with the ADON who stated Resident #319 (room [ROOM NUMBER]) did not qualify to be on EBP per the criteria for EBP, because the resident did not have to have anything invasive. She was asked if the resident had a PICC line and [NAME] drain. She replied, Oh yes, we can add him then. On 8/8/24 at 4:01 p.m., during an interview with the Director of Nursing (DON), she stated she participated in infection control meetings. She explained that all PICC/Midline/Central line dressing changes were completed every Wednesday hospital wide, including TCU (Transitional Care Unit). She confirmed that Resident #319 had a PICC line and a [NAME] drain, and was currently receiving antibiotics. When she was asked about the facility's EBP protocol, she said that only residents with colonized antibacterial resistant organisms should be on EBP. When she was asked if there were any residents on EBP, she replied, I would have to check with the infection preventionist. She returned shortly thereafter and confirmed that Resident #319 should have been on EBP. When asked for the facility's EBP policy, she said, We don't have any since the EBP thing is still new. 2. On 8/8/24 at 11:42 a.m., an observation was made of Resident #266. Registered Nurse (RN) B was preparing to administer his tube feeding (delivery of liquid nutrition through a tube inserted directly into the stomach or small intestine). After performing hand hygiene, RN B donned gloves and a mask. She flushed Resident #266's g-tube (feeding tube) with 75 milliliters (ml) of water. She then administered 480 ml of Glucerna (enteral nutrition) via gravity and flushed the tube again with 75 ml of water. RN B clamped the tube closed. While RN B wore the gloves and a mask during the procedure, she never donned a gown. Additionally, no sign requiring the use of EBP was posted in or outside of Resident #266's room (room [ROOM NUMBER]) during the three-day survey, from 8/5/24 through 8/7/24. An interview was conducted with the ADON on 8/8/24 at 12:33 p.m. She stated anytime actual patient care was being given, caregivers should be wearing gowns and gloves during tube feedings.