STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105796	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EDGEWATER AT WATERMAN VILLAGE	300 BROOKFIELD AVE MOUNT DORA, FL 32757

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 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** Based on observation and interview, the facility failed to ensure medications were labeled when opened on 2 of 3 medication carts in a total of 7 medication carts and failed to ensure expired medications were not stored with working stock in 1 of 2 medication storage rooms. Findings include: On 09/14/2020 at 11:40 AM, an observation of medication cart 2 on the [MEDICATION NAME] Unit showed one 1.5 ML (milliliter) bottle of [MEDICATION NAME] 0.2% eye drops in the working stock drawer that was not documented with the date the eye drops were opened for Resident #21. The label instructions read to discard 28 days after opening. One 0.5 ML bottle of refresh tears eye drops in the working stock drawer that was not documented with the date the eye drops were opened for Resident #21. The label instructions read to discard 28 days after opening. One bottle of [MEDICATION NAME] Propionate nasal spray was opened on 03/05/2020 for Resident #44. Review of the manufacturer's instructions read to discard opened bottle after 90 days. Three 0.5 ML bottles of refresh tears eye drops in the working stock drawer that was not documented with the date the eye drops were opened for Resident #44. The label instructions read to discard 28 days after opening. One vial of refresh Laci-lube eye ointment in the working stock drawer that was not documented with the date the eye ointment was opened for Resident #44. The label instructions read to discard 28 days after opening. One 2.5 ml vial of Latanoprost ophthalmic eye drops in the working stock drawer that was not documented with the date the eye drops were opened for Resident #65. The label instructions read to discard 42 days after opening. During an interview on 09/14/2020 at 11:52 AM, Staff D, Licensed Practical Nurse (LPN) stated, I don't know why the eye drops and eye ointment were opened and undated in the working stock drawer of the medication cart. The eye drops should have shown the date they were opened. The nasal spray was expired and should not have been in the draw. On 09/14/2020 at 12:00 AM, an observation of medication cart 3 on the [MEDICATION NAME] Unit showed one pack of 27 [MEDICATION NAME] 0.5 MG (milligrams) expired on 04/30/2020 for Resident #60. During an interview on 09/14/2020 at 12:20 PM, Staff E, LPN, stated, I just overlooked the expiration date on the narcotic. I just forgot to check it this morning for the expiration date. On 09/14/2020 at 12:23 PM, an observation of the medication storage room on the [MEDICATION NAME] Unit showed one 1500 ML bottle of Glucerna 1.2 Cal expired on 05/01/2020. During an interview on 12:28 PM, the [MEDICATION NAME] hallway Unit Manager stated, I see the Glucerna expired as of 05/01/2020. On 09/14/2020 at 12:30 PM, an observation of medication cart 4 on the Transitional Care Unit (TCU) showed one pill pack containing [MEDICATION NAME]-[MEDICATION NAME] 5-325 MG for Resident #28 expired on 07/18/2020. One bottle of 0.5 ML refresh tears in the working stock drawer that was not documented with the date the eye drops were opened for Resident #43. The label instructions read to discard 28 days after opening. One bottle of 0.5 ML refresh ointment in the working stock drawer that was opened on 07/11/2020 for Resident #43. The label instructions read to discard 28 days after opening. During an interview on 09/14/2020 at 12:36 PM, Staff E, Registered Nurse (RN), stated, I just overlooked the expiration date on the [MEDICATION NAME]-[MEDICATION NAME] 5-325 MG. I forgot to check the expiration date this morning. I don't know why the eye ointment and eye drops were opened and undated in the working stock drawer of the medication cart. On 09/14/2020 at 12:41 PM, an observation of cart 1 cart on the TCU unit showed one 1.8 oz ML bottle of [MEDICATION NAME] ophthalmic ointment 0.5% in the working stock drawer that was not documented with the date the eye drops were opened for Resident #58. The label instructions read to discard 28 days after opening. One (5) ML bottle of [MEDICATION NAME]/[MEDICATION NAME]) ophthalmic suspension 0.3- 0.1% in the working stock drawer that was not documented with the date the eye drops were opened for Resident #58. The label instructions read to discard 28 days after opening. During an interview on 09/14/2020 at 12:46 PM Staff G, RN, stated, I don't know why the eye drops in the working stock drawer of the medication cart are expired. The medications are supposed to be checked on the cart by the nursing staff each shift.
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview and record review, the facility failed to serve food in accordance with professional standards for food service safety. Findings include: On 09/16/2020 beginning at 7:45 AM, during an observation of the tray line in the facility's satellite kitchen, Staff B, Lead Server, dropped a plate gripper utensil on the kitchen floor. Staff B picked the plate gripper utensil off the floor and placed it on the steam table counter above the pureed food being served. Staff B continued to serve food from the tray line and did not change her gloves after picking the plate gripper utensil off the floor. During an interview on 09/16/2020 at 7:54 AM, the Registered Dietician confirmed that Staff B, Lead Server, did not change gloves after picking up the plate gripper off the kitchen floor. The server should have removed her gloves, washed her hands, and put on clean gloves after picking up the dropped plate gripper utensil off the floor before serving food again. Review of the Florida Administrative Code, Chapter 646E-11, Food Hygiene Standards amended 09/26/2018, read, Food while being transported, stored, prepared, displayed, served must be protected from unclean equipment and utensils.
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 observation, record review, and interview, the facility failed to implement an infection prevention and control program to prevent the possible spread of infection by using mattresses that were unable to be cleaned and disinfected properly for other residents, and failed to monitor to ensure adequate cleaning and disinfection of resident rooms. Findings include: On 09/14/2020 beginning at 11:30 AM, Staff A, Housekeeping Aide, was observed cleaning the bed mattress in Resident #30's Room. The gray vinyl part of the mattress was worn, leaving holes, cracks and missing areas of the vinyl that were too numerous to count. The areas were located on each side with a length of approximately four feet. When the mattress was lifted to clean the bottom of the mattress, there were holes and disintegrated vinyl with a surface area of approximately two feet wide and three feet long. There was no liner protecting the cushion material in the mattress. Staff A was observed to wash and put the mattress back down on the bed (Photographic evidence obtained). Review of the facility records revealed Resident #30 was discharged to home on 09/14/2020 at approximately 10:00 AM. During an interview on 09/14/2020 at 12:00 PM, Staff A, Housekeeping Aide, confirmed the mattress had numerous holes and worn areas with the vinyl missing. She stated they were supposed to report it. She confirmed she knew the mattress needed repair or replacement but

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

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) did not report it. When asked she denied a supervisor or designated staff observed her job performance. She stated she was allowed 45 minutes to one hour to complete the cleaning of the room and it was not enough. Review of Resident #30's closed facility medical record revealed the resident required incontinent care documented on the care plan. Review of Resident #30's Minimum Data Set ((MDS) dated [DATE] revealed the resident was frequently incontinent of urine and always incontinent of bowel. During an interview with the Administrator and the Director of Laundry and Housekeeping on 09/15/2020 at approximately 10:00 AM, a request was made for documentation of when the mattresses were inspected for needed repair or replacement. The Director of Laundry and Housekeeping stated there was no report for mattress repair or replacement in their system. The staff would have to report if there were needed repairs or replacement of mattresses. No documentation was provided. A request was made for documentation of the cleaning process and repair inspection. The Director of Laundry and Housekeeping stated they would confirm the inspection of the rooms for compliance with the facility's cleaning and repair process after the process was finished. No documentation was provided. A request was made for the housekeeping staff's training and documentation of performance evaluations. The Director of Laundry and Housekeeping stated after an employee was trained, they had no documentation about any performance observations or training. They confirmed they had no documentation or checklist completed while a supervisor or designated worker observed the staff while cleaning the room. A request was made for documentation of the training provided to the housekeeping staff for reporting needed repairs in the system. No documentation was provided to note the housekeeping staff was trained on how to use the system or how to report repairs when needed. Review of the documentation provided by the facility revealed there was no checklist or other documentation of supervisory or designated staff review of housekeeping staff during their job performance. A Quality Indicator form dated August 2020 was provided, which the facility staff use in meetings to determine the level of compliance by the housekeeping staff. The areas inspected were given a percentage score, but there were no criteria provided for the score, the date, time or person conducting the observation nor an identifier of the last cleaning staff in that area. There was no documentation provided for the process of cleaning the rooms. No documentation was provided regarding the report of mattresses in need of repair or replacement. Review of the facility policy titled Work Order System, revised 10/15/2019, revealed the procedure directs staff to access any facility desktop, and enter the information needed for the repair. The work is then assigned, and all work orders received are reviewed weekly to determine the number of open orders.