

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2025
NAME OF PROVIDER OR SUPPLIER Lake Eustis Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 411 W Woodward Ave Eustis, FL 32726	
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 0807 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were served appropriate thickened liquid consistency for 2 of 7 residents, Residents #46 and #71, with physician orders for thickened liquids. On 6/1/2025, Resident #46 was ordered to have thickened liquids. On 8/19/2025, Resident #71 was ordered to have thickened liquids. On 8/27/2025 at 5:42 PM, Resident #71 was served apple juice on ice at a thin consistency. Resident #71 took sips of the apple juice, resulting in the resident coughing. Staff C, Scheduling Manager, served coffee at thin consistency to Resident #71. On 8/27/2025 at 6:01 PM, Resident #46 was served a cup that had a straw in it and contained ice and a clear thin liquid on the meal tray. Resident #46 took a sip from the cup which contained the clear thin liquid. There was a cup that had a plastic lid labeled NA (Nectar Apple). When the lid was removed the apple juice was observed to be at a thin consistency. The facility's failure to provide liquids in a form to meet the needs of Residents #46 and #71 and failure to identify the machined used to prepare and serve thickened liquids was not functioning properly led to the determination of Immediate Jeopardy at a scope and severity of isolated (J). The facility's actions placed Residents #46 and #71 at a likelihood of serious harm, such as choking, aspiration (a condition in which foods, stomach contents, or fluids are breathed into the lungs through the windpipe) and/or death. The Immediate Jeopardy began on August 27, 2025. The Administrator was notified of the Immediate Jeopardy on August 29, 2025 at 1:49 PM. Findings include: Review of Resident #71's health record showed the resident was admitted on [DATE] with diagnoses including metabolic encephalopathy (a condition where the brain's metabolism is disrupted, leading to altered brain function), heart failure, unspecified, chronic obstructive pulmonary disease, unspecified, atherosclerotic (hardening of the arteries from plaque building up gradually inside them) heart disease of native coronary artery without angina pectoris (chest pain), hypertensive heart disease with heart failure, hypo-osmolality (a condition where the overall concentration of dissolved substances in the blood is lower than normal) and hyponatremia (a condition where the sodium concentration in the blood serum is below normal); non-ST elevation (NSTEMI) myocardial infarction, cognitive communication deficit, and altered mental status, unspecified. Review of Resident #71's physician order dated 8/19/2025 read, Regular diet, dysphagia mechanical soft texture, nectar thickened fluids consistency. Review of Resident #71's care plan initiated on 8/4/2025 read, Focus. The resident has a swallowing problem r/t [related to] unable to tolerate thin liquids. Interventions Speech screen performed to determine diet. Review of Resident #71's Speech Therapy Treatment Encounter Note dated 8/19/2025 read, Precautions: Precautions = Precautions are as follows: Precautions Details: mech alt/nectar diet [mechanical altered/nectar thick liquids], edentulous. Patient was seen for skilled ST [Speech Therapy] interventions services to address dysphagia management services. Per Nursing report, Pt [Patient] has demonstrated s/s [signs/symptoms] of dysphagia and aspiration. Pt was seen via telehealth services with assistance provided from rehab staff. Upon arrival to Pt [Physical Therapy], she displayed consecutive coughing/sneezing. Pt initially consumed nectar via cup x 1 [one time] and displayed delayed cough. Pt consumed honey-thick via cup sips WFL [Within (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 105001	If continuation sheet Page 1 of 26

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F 0807 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Functional Limit]. Pt consumed nectar small sips via cup across trials WFL. Pt consumed puree snack WFL. Pt consumed mech alt snack WFL. Pt consumed thin liquid X3 [three times] and displayed mild cough. ST recommends patient consume a mech alt/nectar diet at this time as it is determined to be the safest diet for the patient to consume at this time. ST will continue to follow up with Pt. Review of Resident #71's Speech Therapy Discharge Summary read, Dates of Service 08/06/25 - 08/21/25. Skilled Interventions Provided: Patient was seen for skilled ST intervention services to address dysphagia management services to determine the safest diet for the patient to consume. Patient Progress: Progress & Response to Treatment: Patient participates well during services; however, Pt displayed s/s of aspiration concerns and required liquid diet change to nectar thick. During an observation on 8/27/2025 at 5:30 PM of the tray line service, Staff B, Dietary Aide, was verifying resident tray accuracy after the Certified Dietary Manager placed items on the trays. During an observation on 8/27/2025 at 5:42 PM, Resident #71 was sitting in a wheelchair in the room with the bedside table in front of the resident. On the bedside table, there was a cup with a straw. The cup contained apple juice of thin consistency with ice. Staff D, Certified Nursing Assistant (CNA), delivered a meal tray to Resident #71. Staff D assisted Resident #71 with the meal set up and exited the room. Resident #71's meal tray consisted of a ground fish sandwich, boiled broccoli, and dessert. No other liquids were observed on the tray. Resident #71 took a sip from the thin consistency apple juice and coughed afterwards. Staff C, Scheduling Manager, was walking in front of Resident #71's room and the resident requested coffee. Staff C asked what kind of coffee and if she would like cream and sugar. Resident #71 took a sip of the thin consistency apple juice and coughed again. Staff C returned to the room and donned personal protective equipment to enter Resident #71's room to deliver thin consistency coffee. During an interview on 8/27/2025 at 5:52 PM, Staff C, Scheduling Manager, stated, The coffee is decaf coffee. It's the regular coffee that all residents get on the floor. When asked about Resident #71's diet, Staff C reviewed the resident's meal ticket and stated, [Resident #71's name] has a nectar thickened diet. She is not able to drink thin liquids. She shouldn't have the juice or the coffee. During an interview on 8/27/2025 at 5:57 PM, the Director of Nursing (DON) stated, [Resident #71's name] was delivered thin consistency juice and coffee. The resident is nectar thickened [liquid] and should not be given thin liquids. Review of Resident #71's assessment dated [DATE] read, Change in Condition (SBAR) [Situation, Background, Assessment, and Recommendation]. Type: cough. The change in condition, symptoms, or signs observed and evaluated is/are: Pt. was coughing while drinking thin liquids. This started on 08/27/2025. Recommendation: Chest X-ray. During an interview on 8/28/2025 at 8:50 AM, Staff E, CNA, stated, We are supposed to check in the [name of software program for medical records] to see what the diet is. With meal process, we look at their ticket and look at [name of software program for medical records] first thing in the morning. Look at the ticket and see the diet or ask the nurse if not sure. The drinks come out first. On the drink cart, there is a notebook that includes the diets for the residents, and you check there. I didn't check the book before delivering the coffee to [Resident #71's name]. I went to ask [Staff G, CNA's name] who was the CNA running the drink cart. I mentioned the room and the bed, and I got distracted by someone else, so I am not sure if she checked the book. The nectar thickened drinks should come from the kitchen on their trays. Sometimes, you have to go back to the kitchen and request the thickened liquids because they don't come on the meal tray. The resident can choke if they have the wrong consistency. They can cough and lose their breath, and turn red in the face. During an interview on 8/28/2025 at 9:54 AM, Staff D, CNA, stated, I did not give [Resident #71's name] the coffee but, I did give her thin liquid juice. I did not give her thickened liquids because those normally come on the tray. There is a list on the beverage cart that tells us the liquid consistency for each resident. I delivered the drink myself. I did not check the list. I just knew it from before. I had always considered her to be thin liquids. She was sitting up, talking, and drinking. I always thought she was thin liquid. I don't know when her order changed. Speech therapy does the orders for that. It is very important to give the correct consistency because of aspiration. If they are coughing or not (continued on next page)		

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F 0807 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	making any noise. We always should check the list. I was educated on to look at the orders and slow down. During an interview via phone on 8/28/2025 at 10:10 AM, Staff G, CNA, stated, I was not responsible for the beverage cart. All the staff help and pass out the drinks. I was not approached by any staff member asking for coffee for [Resident #71's name]. They could get the coffee themselves because they are staff members. During an interview on 8/28/2025 at 11:17 AM, the Nurse Practitioner (NP) #1, stated, If she [Resident #71] actually aspirated, she could develop aspiration pneumonia. The hospital evaluates them and puts them [residents] on thickened liquids if patients have a history of stroke and dysphagia. They are evaluated in the hospital for swallowing. If there was a concern, they initiate thickened [liquids] until they have ruled out any medical concerns. When speech therapy evaluates a patient and they downgrade or establish their liquid consistency as thickened, until the diet is changed. I expect the staff to provide the ordered diet and fluids. Review of Resident #46's health record showed the resident was admitted on [DATE] with diagnoses including paroxysmal atrial fibrillation (a type of irregular heartbeat that comes and goes on its own within seven days) (admitting diagnosis), dysphagia (difficulty swallowing food or liquids), oral phase, speech and language deficits following cerebral infarction, personal history of transient ischemic attack (TIA), gastro-esophageal reflux disease without esophagitis, constipation, essential hypertension, and anemia. Review of Resident #46's physician order dated 6/5/2025 read, Regular diet, dysphagia puree texture, nectar thicken fluids consistency. Review of Resident #46's care plan did not provide for documentation of a focus related to the resident's requiring of thickened liquids. Review of Resident #46's physician progress note dated 6/19/2025 read, PMH [past medical history] of dysphagia, oral phase; other speech and language deficits following cerebral infarction. Nurse staff reports patient has had a mild intermittent dry cough. Continue with diet medication for dysphagia. Continue current treatment plan. Review of Resident #46's Pulmonary Progress Note dated 8/20/2025 read, Chief Complaint: assessment regarding cough and dysphagia. Assessment/Plan: thickened liquid to reduce any risk of aspiration. During an observation on 8/27/2025 at 6:01 PM, Resident #46 was in bed with a meal tray in front of her. There was a cup with a straw that contained ice and clear thin liquid on the meal tray. There was a cup with apple juice with a plastic lid on the cup with NA (Nectar Apple) written on top of the cup. When the lid was removed the apple juice was observed to be of a thin consistency. Resident #46 was observed taking a sip from the cup which contained clear thin liquid. During an interview on 8/27/2025 at 6:03 PM, the DON stated, [Resident #46's name] should not have thin liquids. When the DON removed the lid of the cup labeled NA of apple juice, the DON stated, This is not thickened. This cup comes from the kitchen, but it is not thickened. During an observation on 8/27/25 at 6:03 PM, the DON removed both cups with thin liquids from Resident #46's room. During an interview on 8/28/2025 at 1:53 PM, the DON stated, Yesterday, when I saw the nectar thick apple juice coming from the kitchen was not the right consistency, I had it removed and had a staff get her [Resident #46] something else to drink. I went back to the office, and I saw you guys walking down. I did not see the resident cough, and nobody came back to tell me anything else, and I called the nurse practitioner, and we did a change in condition. I did not tell the kitchen in regard to anything. During an observation on 8/27/2025 at approximately 6:10 PM, the Food Service Manager (FSM) removed the lid labeled NA (Nectar Apple) from a cup that was removed from a bin with ice on the kitchen tray line counter that was being served to the residents on thickened liquids. The FSM poured thickened water into a cup and poured the nectar thick apple juice into another cup and the consistency was not the same thickened consistency. During an interview on 8/27/2025 at approximately 6:11 PM, the FSM stated, I do not know what to call this consistency [referring to the nectar thick apple juice cup removed from the bin in the kitchen]. I don't know if it's the machine is not working or if the ice is melting and getting into the cups. During an observation on 8/27/2025 at approximately 6:14 PM, the Certified Dietary Manager (CDM) and the FSM, the CDM poured the nectar thick apple juice in a cup and also poured the honey thickened juice from the draft machine. During an interview on 8/27/2025 at approximately 6:14 PM, the CDM stated, The apple (continued on next page)		

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F 0807 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	thickened fluids are not as thick as the water. It could be more thickened. The honey thickened is not thickened. The machine might not be calibrating correctly. I would have to call the company and have them come out. The machine is to be checked every three months [by the vendor] or as needed. During an interview on 8/28/2025 at 9:35 AM, the Registered Speech Therapist stated, If the patient is nectar or honey thick, the patient should get the ordered consistency liquids. If a patient who is on thickened liquids is provided thin liquids on a consistent basis, anything can happen; silent aspiration, dysphagia, it would depend on the patient. During an interview on 8/28/2025 at 1:00 PM, Staff B, Dietary Aide, stated, I think there are five cups on the tray line prepared. I thought they were already thickened. I was not aware that there is a problem with the machine. I was going to put them on the trays to be served. During an observation on 8/28/2025 at 1:14 PM, the FSM had an open cup of red thin liquid in front of her and was opening a Thick & Easy instant food and beverage thickening powder. During an interview on 8/28/2025 at 1:14 PM, the FSM stated, I was using the machine this morning and until now. I began to pour the thickening powder just now [into the red liquid]. I did not know we should not use the machine because you [referring to this writer] did not tell us we needed to shut it down yesterday. When asked when she and the CDM observed the fluids from the machine were not the appropriate thickened consistency why she had not stopped using the machine, the FSM did not respond. When asked who is responsible for the kitchen and the proper functioning of the kitchen equipment the FSM stated, I am. During an observation on 8/28/2025 at 1:20 PM in the kitchen, Staff B, Dietary Aide, was putting drinks and food on the resident's tray. The drinks that she had sitting on the tray line were covered with a lid. Drinks on the tray covered with a lid were designated as thickened drinks. The liquids were observed to be of a thin consistency. During an interview on 8/28/2025 at 1:22 PM, the FSM stated, I thought the drink machine was fine to use. During an interview on 8/28/2025 at 1:25 PM, the Administrator stated, I was not aware of the machine not working until just now. I thought last night that they had just given the resident a wrong cup with the wrong liquid consistency. During an interview on 8/28/2025 at 2:03 PM, Staff J, Licensed Practical Nurse/ Unit Manager (LPN/UM) for South, stated, I was in the dining room for dinner last night. I checked breakfast trays this morning and told them it [referring to thickened liquids] was too thin. Just with the juices we saw, we sent them back to the kitchen because they did not seem thick enough. [Residents #46 and #71's names] had cranberry juice on their trays and we had issues with them being too thin. We got them replaced with water which was thick enough. During an interview on 8/28/2025 at 2:13 PM, Staff S, CNA, stated, When we did the cart trays for lunch, the drink was too thin for rooms [Residents #46 and #71's rooms]. I took them back to the kitchen and told the staff that the drink was too thin. For breakfast, the UM took them back when they were too thin. The CNAs check the list on the drink cart for residents who are on thickened liquids. During an interview on 8/28/2025 at 2:30 PM, the FSM stated, The tech [from the name of the draft machine, drink machine used to prepare and serve thickened liquids, service company] came in today and adjusted the flow of the juice and the thickened water by using a screwdriver to adjust the flow of the water and juice. We only sent out water this morning, I do not know how the residents needing thickened liquids got juice this morning. I was not made aware of juices being brought back to the kitchen this morning. During an interview on 8/28/2025 at 3:32 PM, the Draft Machine Service Company's Service Manager stated, The machine was delivered on June 10, 2025, and the facility has scheduled deliveries every week [thickened water and concentrate used in the machine]. The last delivery was on 8/21/2025. The driver will do the delivery and check if the machine is working. When asked if the delivery driver checks the machine with each delivery the Service Manager stated, That varies, the driver may check it out but not always. Most customers will mention if they have a problem and the driver checks into it and will fix it. It [the repair] would go on the computer document only if it's a service call and then the driver will just clear it. The machine has a water line and that mixes with the type of juice [concentrate] on the other line. The juice is not thickened; the water is thickened. The service call was that the thickened water was too thick. I see that the technician documented Brix [term used for (continued on next page)]		

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Review of text message sent on 8/28/2025 at 6:36 AM, from the FSM read, Good morning ([Name of the Draft Machine Service Company's Sales Representative's name], We seem to have an issue with the thickness of our thickened liquid. The waters are pouring correct, but the juice's are to thin. If this could be addressed asap [as soon as possible] that would be great. Unfortunately the state is in here and will be all day. They were the ones who brought it to my attention last evening. Let me know an approximate time so I can at least give them something. Thank you [the FSM]. During an interview on 8/29/2025 at 8:31 AM, the DON stated, Speech and dietary would have the education and knowledge to be able to identify that thicken liquids are not at the right consistency. If the staff suspect it is not thick enough, they always go to speech [therapist] or dietary and they will confirm the consistency. I was aware that the nursing staff had to send back some of the consistencies. It occurred for breakfast and lunch, and the consistency had to be corrected. The inconsistency happened due to dietary having some concerns with their machine. As far as for me, I was not aware the machine was not in proper order. If I was aware, I would have given other directives. To me that was a follow up because I gave directives to the CNAs to correct the consistency and I was expecting that if they are not able to fix the inconsistency they should come back to me and report if it is a dietary problem. That was not reported to me. My responsibilities are to oversee the residents, that they are getting the care that we provide. Making sure that they are getting all the care they need, if any concern in any other department, that I am made aware it, so that it is fixed in a timely manner. When asked if it is her responsibility to safeguard the residents, the DON stated, I do. It is part of my responsibility to ensure of their safety. During an interview on 8/29/2025 at 8:58 AM, the Regional Director of Operations of Rehabilitation Services, stated, The speech therapist has the education and knowledge to identify the liquid consistency. I know that in the kitchen there is a machine and they have policies in the kitchen regarding that. Definitely, if a nurse has any questions, they can reach out to the ST. There are two modes of contact for the ST, some involve speech therapist occasionally in the building and worst case scenario telehealth. It is definitely better they see it [liquid consistency] in person, but during telehealth it is likely they would be able to identify it. The rehabilitation director has an OT [Occupational Therapy] background, but I would feel it would be best if ST be the one to determine. If they are using the packets to mix by hand, it would be to read the directions in the back of the packets. To my knowledge, they have not been to the facility to check on the consistency of the draft machine to verify it [liquids] is at the right consistency. When I say kitchen policies, I mean the settings of the machines for the consistency. I think that a speech therapist should come and give a more accurate assessment of the liquids. If there was an issue with the machine, I feel it should have been reverted to manually mixing and not utilizing the machine. We do in-services, I'm not sure when the last one happened. If a long-term resident is receiving [ST] services, at least quarterly, screens or change in status assessment is conducted whether it be a negative or positive change. If there is a risk of choking, aspiration and risk for pneumonia; if [a resident] is coughing after the meal, then that will elicit a speech therapy evaluation. The quarterly screen is a standard of practice. During an interview on 8/29/2025 at 9:21 AM, the CDM stated, Everyone in the kitchen has the education and knowledge to identify if liquids are not at the right consistency. Not all nurses are able to identify consistency. They are not trained but some are so used to seeing them [thickened liquids] that they are able to identify the consistency of a liquid. The nurses should always go to the kitchen and ask the staff for (continued on next page)		

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I do angel rounds, care plan meetings, food preferences, inventory and ordering, making sure that emergency storage is good for the hurricane season. I am just covering right now; I have been here every day since Monday [8/25/2025]. I go over consistency with staff and there is also a flyer, and the recipe book [for thickened liquids]. I feel that all the staff in the kitchen working right now is able to identify the consistency correctly of the liquids. [The FSM's name] texted the Administrator to let him know [the thickened liquid machine]. I feel that as the CDM, I am responsible for safeguarding the residents in the building. Whoever is the aide assigned to drinks on the schedule. The aide should be responsible for verifying the consistency when they are pouring. She should have stopped and addressed it with me and [the FSM's name]. I would have called the company right away and checked the storage and if not go get it from the supplier [boxes of thickened liquids]. They [dietary aides] need to notify use of any problem and that is also part of the job description to notify as immediately and I am available 24/7 every day. During an interview conducted on 8/29/2025 at 9:41 AM, the Dietary, Housekeeping and Laundry District Manager stated, My regional would be over the CDM. The previous CDM was bouncing between two accounts, and we were getting lots of complaints from another account. So, we had to terminate her. The issues in this kitchen were not part of her termination. I can assume it was happening here as well because I see a trend. The first line of defense is the dietary aide. This should not have happened. I was not made aware that the machine was not working properly. I would have gone out and even bought another machine. The staff in the kitchen, this is part of their daily equipment check and they have to not use it and find a way to continue the operation. It should have been reported from the aide. During an interview conducted on 8/29/2025 at 10:00 AM, the Administrator stated, The speech therapist is who we go to if there are any questions regarding consistency. The kitchen staff also have the education and the knowledge to determine the right consistency. That is why we have the system for check points to prevent things like that [residents being served inappropriate thickened liquid beverage] from happening. They notified me yesterday. I don't remember what time, but as soon as they told me, I got on the phone with the company and told them it was urgent. It was a busy day. I don't recall if I received a text from the FSM regarding the machine that evening when the machine was identified as not properly working. I oversee the day-to-day operations. For the kitchen my responsibly is to have the tools that they need to get their jobs done. They are vendors, so they do the hire and education. We are responsible for the food. The vendor would be responsible for fixing the equipment. Everyone that works here is responsible for safeguarding the residents. I feel that the break in the system was the machine and as soon as I was aware I called to get it fixed. During an interview on 8/29/2025 at 10:36 AM, the Medical Director stated, I was aware that the [Brand name of the draft/thickened liquid machine] had malfunctioned on Wednesday and I told them to call the company and have them fix the machine and come and fix it by Thursday. They [Residents requiring thickened liquids] have a possibility of aspiration pneumonia and fatal consequences as well. The staff should not use the machine until it is fixed by the company. I recommended not to use the device until fixed. I don't recall what time on Wednesday [8/27/2025] and the DON was the one to notify me. I make sure patient safety is first, and they get the care that they need. The policies are implemented. Today we were supposed to have a meeting, but I am going out of town, and I am going on a trip since it's a long weekend. Review of an article on 8/29/2025 from the library of [NAME], one (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2025
NAME OF PROVIDER OR SUPPLIER Lake Eustis Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 411 W Woodward Ave Eustis, FL 32726	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0807 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	of the largest nonprofit academic medical centers in the US, titled Aspiration from Dysphagia under the heading, What are possible complications of aspiration from dysphagia? read, A major complication of aspiration is harm to the lungs. When food, drink, or stomach contents make their way into your lungs, they can damage the tissues there. The damage can sometimes be severe. Aspiration also increases your risk of pneumonia. This is an infection of the lungs that causes fluid to build up in the lungs. Pneumonia needs to be treated with antibiotics. In some cases, it may cause death. Article located at [NAME]-[NAME].org/health-library/diseases-and-conditions/a/aspiration-from-dysphagia.htmlReview of [Name of the Draft Machine Service Company] Invoice dated 8/28/2025 read, Problem Reported: Soda X [Name of the FSM] Texted a request for calibration of her nectar thick gun juices. She said nectar juices coming out too thick. Resolution: Brix honey & [and] nectar gun.Review of the document titled [Name of the Draft Machine Service Company] Fountain-Dispensed Beverage Solutions with an effective date of 5/5/2025 read, Purpose: This agreement is submitted to above Care Facility for the purpose of becoming the sole supplier of all dispensed beverage products. [Name of draft machine service company] will install the needed equipment, service specified equipment, and deliver specified products. Equipment: [Name of draft machine service company] will install a customized dispensing systems consisting of the following equipment: [no equipment was marked]. A. This equipment will be installed in the facilities, and be of the highest quality and subject to weekly inspection and maintenance, as well as periodic preventive maintenance. This equipment will remain the property of [Name of draft machine service company]. Service and Delivery: [Name of draft machine service company] will provide regular maintenance of all equipment and product replenishment as required by the system. There will be no cost to the above facility for these services. Emergency Service will also be available at no additional cost. Notification: The facility agrees to notify [Name of draft machine service company] of any defects of failure of the equipment that does not receive proper service by its service technician.Review of the Invoice Summary: Dated 8/29/2025 from [name of the Draft Machine Service Company] Invoice #737596, Problem reported: History soda X needs a tech ASAP [As Soon As Possible]. Machine is still not working right. Beverage Dispenser giving trouble. The Juicer needs recalibration. [Name and Phone Number of Service Provider] Urgent!!!Resolution: HIST [History] exchanged thickened water dispensing gun and recalibrated.Review of Cook/Kitchen Staff Competency assessment dated [DATE] for Staff B, Dietary Aide, read, Administrative Functions. Inspect diet trays to assure that the correct diet is served to the resident. Ensure that all food procedures are followed in accordance with established facility policies, and Assist in serving meals as necessary and on a timely basis. The required functions of the job were marked as In service Needed. Signed by the FSM.During an interview on 8/28/2025 at 10:24 AM, the Certified Dietary Manager stated, She [Staff B] was supposed to put chilled desserts, salads and modified drinks on the trays on 8/27/25 for the dinner meal trays. The Competency Assessment for [Staff B's Name] was conducted on 5/27/25 with several functions listed as In-service needed. I cannot find any in-services provided to [Staff B's Name]. I was not made aware of this assessment [the training not being completed] until today.Review of the policy and procedure titled Thickened Liquids reviewed on 1/29/2025 read, Policy: thickened liquids will be provided for residents according to physician's orders. Purpose: to ensure sufficient fluid intake for residents with reduced swallowing capabilities. Guidelines: 1. Residents with reduced swallowing capabilities will be provided with liquids thickened to mildly thick (level 2), moderately thick (Level 3), or extremely thick (level 4) based on their individual tolerance as determined by the speech therapist and as ordered by the physician. 2. Upon receipt of the physician's order, pre-thickened products will be served by dietary.The Immediate Jeopardy (IJ) was removed onsite as of August 29, 2025 after the receipt of an acceptable IJ removal plan. The facility has completed the following steps to remove the immediate jeopardy. As verified by the survey team, on 8/27/2025, the facility assessed Residents #46 and #47 and audited and evaluated 8 of 8 residents		

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility administration failed to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident by failing to implement policy and procedures related to the provision of thickened liquids. The facility failed to ensure residents were served liquids to meet their needs. On 6/1/2025, Resident #46 was ordered to have thickened liquids. On 8/19/2025, Resident #71 was ordered to have thickened liquids. On 8/27/2025 at 5:42 PM, Resident #71 was served apple juice on ice at a thin consistency. Resident #71 took sips of the apple juice, resulting in the resident coughing. Resident #71 requested coffee and Staff C, Scheduling Manager, served coffee at thin consistency to Resident #71. On 8/27/2025 at 6:01 PM, Resident #46 was served a cup with a straw that contained ice and a clear thin liquid. Resident #46 took a sip from the cup of the clear thin liquid. On 8/27/2025, the Certified Dietary Manager identified the equipment used to prepare thickened liquids was malfunctioning. On 8/27/2025, the Director of Nursing did not notify the responsible kitchen staff of Resident #46 being served non-thickened apple juice. On 8/28/2025, Staff B, Dietary Aide, placed five cups of drinks that were designated as thickened drinks on a tray. The cups were covered with a lid. The liquids inside the cups were of a thin consistency. The facility's failure to provide liquids in a form to meet the needs of Residents #46 and #71 and failure to identify the machined used to prepare and serve thickened liquids was not functioning properly led to the determination of Immediate Jeopardy at a scope and severity of isolated (J). The facility's actions placed Residents #46 and #71 at a likelihood of serious harm, such as choking, aspiration (a condition in which foods, stomach contents, or fluids are breathed into the lungs through the windpipe) and/or death. The Immediate Jeopardy began on August 27, 2025. The Administrator was notified of the Immediate Jeopardy on August 29, 2025 at 1:49 PM. Findings include: Review of the Medical Director Agreement dated 7/1/2014 read, 1. Term. This Agreement shall be in full force and effect from the date hereof for a period of one (1) year and automatically renewed for additional one (1) year periods there after. This Agreement may be terminated by either party with or without cause upon thirty (30) days prior written notice to the other party. 2. Services. Physician agrees to provide such services as are set for in Exhibit A, attached hereto and incorporated herein by reference. Exhibit A: Physician shall: Provide services in accordance with any applicable requirements of federal, state or local laws, rule and/or regulations and third-party reimbursement sources. To abide by Facility's policies and procedures. To be responsible for the overall coordination of medical care at Facility; coordination of care means Physician shares responsibility for assuring Facility is providing appropriate care as required which involves monitoring and ensuring implementation of resident care policies and providing oversight and supervision of physician services and medical care of residents. Physician agrees to evaluate and take appropriate steps to correct any problems associated with any possible inadequate care Physician identifies or about which Physician receives a report. To participate, as requested, in personnel evaluations and other quality monitoring programs established by Facility including attendance at the Facility's Quality Management Committee Meetings. Review of the job description titled Administrator read, Primary Purpose of this Position: The primary purpose of this position is to direct the day-to-day functions of the facility in accordance with current federal, state and local standards, guidelines and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to residents at all times. Duties and Responsibilities: Assume the administrative authority, responsibility and accountability for all programs in the facility. Ensure that each resident receives necessary care and services to attain and maintain the highest practical physical, mental and psychosocial well-being consistent with the resident's comprehensive assessment and plan of care. Consult with department directors concerning the operation of their departments to assist in eliminating/correcting problem areas and/or improving services. Ensure that (continued on next page)		

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the food and nutrition services program meets the nutritional needs of the residents. Safety and Sanitation Functions: Ensure that a system for maintaining and improving buildings, grounds and equipment is planned, implemented and evaluated. Review of the job description titled Director of Nursing read, Primary Purpose of this position: The primary purpose of this position is to plan, organize, develop and direct the overall operation of the nursing services department in accordance with current federal, state, and local standards, guidelines and regulations that govern the facility and as directed by the Administrator and the Medical Director to ensure that the highest degree of quality care is maintained at all times. Duties and Responsibilities: Committee Functions: Participate in risk management and safety committee to mitigate risk factors for residents and staff. Review of the job description titled Speech-Language Pathologist read, Primary Purpose of this Position: Leads, guides and directs the delivery of speech language pathology and audiology services in the facility in accordance with local, state and federal regulations, standards and established facility policies and procedures to provide appropriate care and services to residents. Duties and Responsibilities: Plans, develops, organizes, implements, evaluates and directs the delivery of speech language pathology and audiology services as well as its programs and activities, in accordance with current state and federal laws and regulations; and respective practice act (s) in the state. Promote safe work practices, safety rules, and accident prevention procedures to prevent resident/employee injury and illness. Review of job description titled Certified Dietary Manager read, Primary Purpose of this Position read, The primary purpose of this position is to plan, organize, develop and direct the operations of the food and nutrition services department in accordance with current federal, state, and local standards, guidelines and regulations and as directed by the Administrator. Duties and Responsibilities: Assist in planning, developing, organizing, implementing, evaluating and directing the food and nutrition services department, its programs and activities. Assume administrative authority, responsibility and accountability of supervising the food and nutrition services department. Review the food and nutrition requirements of each resident admitted to the facility as required and assist the attending physician in planning for the resident's prescribed diet plan. Assist in developing and implementing procedures for safe operation of all food and nutrition services equipment. Develop, implement and maintain written department policies; ensure staff is aware of and follows established facility policies. Assist in developing methods for determining quality and quantity of food served. Safety and Sanitation Functions: Ensure that all personnel operate food and nutrition services equipment in a safe manner, ensure that only trained and authorized personnel operate the department's equipment. Make periodic rounds to check equipment and to assure that necessary equipment is available and working properly. Miscellaneous Function: Be prepared to handle emergencies as they occur. Safety Requirement: Must maintain the care and use of supplies, equipment, etc , and maintain the appearance of food and nutrition service areas; must perform regular inspections of food and nutrition services areas for sanitation, order, safety and proper performance of assigned duties. Review of the job description titled Dietary Supervisor read, 1. Position Summary: The Dietary Supervisor is responsible for overseeing the daily operations of the dietary department, ensuring meals are planned, prepared and delivered in accordance with prescribed nutritional and therapeutic requirements. 2. Essential Functions: Supervised kitchen operations during assigned shift. Review of the job description titled Dietary Aide read, 1. Position Summary: Dietary aides assist with all aspects of food service operations, including food preparation, meal service, cleaning, maintenance of food service areas and equipment, and record keeping, as needed. Essential functions: prepare, serve, and assist with food selection in an efficient and pleasant manner. During an observation on 8/27/2025 at 5:30 PM of the tray line service, Staff B, Dietary Aide, was verifying resident tray accuracy after the Certified Dietary Manager placed items on the trays. Review of Resident #71's physician order dated 8/19/2025 read, Regular diet, dysphagia mechanical soft texture, nectar thickened fluids consistency. Review of Resident #71's Speech Therapy Discharge Summary read, Dates of Service 08/06/25 - 08/21/25. Skilled Interventions Provided: Patient was (continued on next page)		

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	seen for skilled ST intervention services to address dysphagia management services to determine the safest diet for the patient to consume. Patient Progress: Progress & Response to Treatment: Patient participates well during services; however, Pt displayed s/s of aspiration concerns and required liquid diet change to nectar thick. During an observation on 8/27/2025 at 5:42 PM, Resident #71 was sitting in a wheelchair in the room with the bedside table in front of the resident. On the bedside table, there was a cup with a straw. The cup contained apple juice of thin consistency with ice. Staff D, Certified Nursing Assistant (CNA), delivered a meal tray to Resident #71. Staff D assisted Resident #71 with the meal set up and exited the room. Resident #71's meal tray consisted of a ground fish sandwich, boiled broccoli, and dessert. No other liquids were observed on the tray. Resident #71 took a sip from the thin consistency apple juice and coughed afterwards. Staff C, Scheduling Manager, was walking in front of Resident #71's room and the resident requested coffee. Staff C asked what kind of coffee and if she would like cream and sugar. Resident #71 took a sip of the thin consistency apple juice and coughed again. Staff C returned to the room and donned personal protective equipment to enter Resident #71's room to deliver thin consistency coffee. During an interview on 8/27/2025 at 5:52 PM, Staff C, Scheduling Manager, stated, The coffee is decaf coffee. It's the regular coffee that all residents get on the floor. When asked about Resident #71's diet, Staff C reviewed the resident's meal ticket and stated, [Resident #71's name] has a nectar thickened diet. She is not able to drink thin liquids. She shouldn't have the juice or the coffee. During an interview on 8/27/2025 at 5:57 PM, the Director of Nursing (DON) stated, [Resident #71's name] was delivered thin consistency juice and coffee. The resident is nectar thickened [liquid] and should not be given thin liquids. Review of Resident #71's assessment dated [DATE] read, Change in Condition (SBAR) [Situation, Background, Assessment, and Recommendation]. Type: cough. The change in condition, symptoms, or signs observed and evaluated is/are: Pt. was coughing while drinking thin liquids. This started on 08/27/2025. Recommendation: Chest X-ray. During an interview on 8/28/2025 at 9:54 AM, Staff D, CNA, stated, I did not give [Resident #71's name] the coffee but yeah, I did give her thin liquid juice. I did not give her thickened liquids because those normally come on the tray. Review of Resident #46's physician order dated 6/5/2025 read, Regular diet, dysphagia puree texture, nectar thicken fluids consistency. Review of Resident #46's physician progress note dated 6/19/2025 read, PMH [past medical history] of dysphagia, oral phase; other speech and language deficits following cerebral infarction. Nurse staff reports patient has had a mild intermittent dry cough. Continue with diet medication for dysphagia. Continue current treatment plan. Review of Resident #46's Pulmonary Progress Note dated 8/20/2025 read, Chief Complaint: assessment regarding cough and dysphagia. Assessment/Plan: thickened liquid to reduce any risk of aspiration. During an observation on 8/27/2025 at 6:01 PM, Resident #46 was in bed with a meal tray in front of her. There was a cup with a straw that contained ice and clear thin liquid on the meal tray. There was a cup with apple juice with a plastic lid on the cup with NA (Nectar Apple) written on top of the cup. When the lid was removed the apple juice was observed to be of a thin consistency. Resident #46 was observed taking a sip from the cup which contained clear thin liquid. During an interview on 8/27/2025 at 6:03 PM, the DON stated, [Resident #46's name] should not have thin liquids. When the DON removed the lid of the cup labeled NA of apple juice, the DON stated, This is not thickened. This cup comes from the kitchen, but it is not thickened. During an observation on 8/27/25 at 6:03 PM, the DON removed both cups with thin liquids from Resident #46's room. During an interview on 8/28/2025 at 1:53 PM, the DON stated, Yesterday, when I saw the nectar thick apple juice coming from the kitchen was not the right consistency, I had it removed and had a staff get her [Resident #46] something else to drink. I went back to the office, and I saw you guys walking down. I did not see the resident cough, and nobody came back to tell me anything else, and I called the nurse practitioner, and we did a change in condition. I did not tell the kitchen in regard to anything. During an observation on 8/27/2025 at approximately 6:10 PM, the Food Service Manager (FSM) removed the lid labeled NA (Nectar Apple) from a cup that was removed from a bin with ice on the kitchen tray line counter that was being (continued on next page)		

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The honey thickened is not thickened. The machine might not be calibrating correctly. I would have to call the company and have them come out. The machine is to be checked every three months [by the vendor] or as needed. During an interview on 8/28/2025 at 9:35 AM, the Registered Speech Therapist stated, If the patient is nectar or honey thick, the patient should get the ordered consistency liquids. If a patient who is on thickened liquids is provided thin liquids on a consistent basis, anything can happen; silent aspiration, dysphagia, it would depend on the patient. During an interview on 8/28/2025 at 1:00 PM, Staff B, Dietary Aide, stated, I think there are five cups on the tray line prepared. I thought they were already thickened. I was not aware that there is a problem with the machine. I was going to put them on the trays to be served. During an observation on 8/28/2025 at 1:14 PM, the FSM had an open cup of red thin liquid in front of her and was opening a Thick & Easy instant food and beverage thickening powder. During an interview on 8/28/2025 at 1:14 PM, the FSM stated, I was using the machine this morning and until now. I began to pour the thickening powder just now [into the red liquid]. I did not know we should not use the machine because you [referring to this writer] did not tell us we needed to shut it down yesterday. When asked when she and the CDM observed the fluids from the machine were not the appropriate thickened consistency why she had not stopped using the machine, the FSM did not respond. When asked who is responsible for the kitchen and the proper functioning of the kitchen equipment the FSM stated, I am. During an observation on 8/28/2025 at 1:20 PM in the kitchen, Staff B, Dietary Aide, was putting drinks and food on the resident's tray. The drinks that she had sitting on the tray line were covered with a lid. Drinks on the tray covered with a lid were designated as thickened drinks. The liquids were observed to be of a thin consistency. During an interview on 8/28/2025 at 1:22 PM, the FSM stated, I thought the drink machine was fine to use. During an interview on 8/28/2025 at 1:25 PM, the Administrator stated, I was not aware of the machine not working until just now. I thought last night that they had just given the resident a wrong cup with the wrong liquid consistency. During an interview on 8/28/2025 at 2:03 PM, Staff J, Licensed Practical Nurse/ Unit Manager (LPN/UM) for South, stated, I was in the dining room for dinner last night. I checked breakfast trays this morning and told them it [referring to thickened liquids] was too thin. Just with the juices we saw, we sent them back to the kitchen because they did not seem thick enough. [Residents #46 and #71's names] had cranberry juice on their trays and we had issues with them being too thin. We got them replaced with water which was thick enough. During an interview on 8/28/2025 at 2:13 PM, Staff S, CNA, stated, When we did the cart trays for lunch, the drink was too thin for rooms [Residents #46 and #71's rooms]. I took them back to the kitchen and told the staff that the drink was too thin. For breakfast, the UM took them back when they were too thin. The CNAs check the list on the drink cart for residents who are on thickened liquids. During an interview on 8/28/2025 at 2:30 PM, the FSM stated, The tech [from the name of the draft machine, drink machine used to prepare and serve thickened liquids, service company] came in today and adjusted the flow of the juice and the thickened water by using a screwdriver to adjust the flow of the water and juice. We only sent out water this morning, I do not know how the residents needing thickened liquids got juice this morning. I was not made aware of juices being brought back to the kitchen this morning. During an interview on 8/28/2025 at 3:32 PM, the Draft Machine Service Company's Service Manager stated, The last delivery was on 8/21/2025. The driver will do the delivery and check if the machine is (continued on next page)		

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I sent him the message at 6:36 AM today [8/28/2025] to request someone to come out and take a look at the machine. During the last delivery [8/21/2025] the driver did not check the machine. They usually will check if we report an issue and I did not have anything to report. Review of text message sent on 8/28/2025 at 6:36 AM, from the FSM read, Good morning ([Name of the Draft Machine Service Company's Sales Representative's name], We seem to have an issue with the thickness of our thickened liquid. The waters are pouring correct, but the juice's are to thin. If this could be addressed asap [as soon as possible] that would be great. Unfortunately the state is in here and will be all day. They were the ones who brought it to my attention last evening. Let me know an approximate time so I can at least give them something. Thank you [the FSM]. During an interview on 8/29/2025 at 8:31 AM, the DON stated, Speech and dietary would have the education and knowledge to be able to identify that thicken liquids are not at the right consistency. If the staff suspect it is not thick enough, they always go to speech [therapist] or dietary and they will confirm the consistency. I was aware that the nursing staff had to send back some of the consistencies. It occurred for breakfast and lunch, and the consistency had to be corrected. The inconsistency happened due to dietary having some concerns with their machine. As far as for me, I was not aware the machine was not in proper order. If I was aware, I would have given other directives. To me that was a follow up because I gave directives to the CNAs to correct the consistency and I was expecting that if they are not able to fix the inconsistency they should come back to me and report if it is a dietary problem. That was not reported to me. My responsibilities are to oversee the residents, that they are getting the care that we provide. Making sure that they are getting all the care they need, if any concern in any other department, that I am made aware it, so that it is fixed in a timely manner. When asked if it is her responsibility to safeguard the residents, the DON stated, I do. It is part of my responsibility to ensure of their safety. During an interview on 8/29/2025 at 8:58 AM, the Regional Director of Operations of Rehabilitation Services, stated, The speech therapist has the education and knowledge to identify the liquid consistency. I know that in the kitchen there is a machine and they have policies in the kitchen regarding that. Definitely, if a nurse has any questions, they can reach out to the ST. There are two modes of contact for the ST, some involve speech therapist occasionally in the building and worst case scenario telehealth. It is definitely better they see it [liquid consistency] in person, but during telehealth it is likely they would be able to identify it. The rehabilitation director has an OT [Occupational Therapy] background, but I would feel it would be best if ST be the one to determine. If they are using the packets to mix by hand, it would be to read the directions in the back of the packets. To my knowledge, they have not been to the facility to check on the consistency of the draft machine to verify it [liquids] is at the right consistency. When I say kitchen policies, I mean the settings of the machines for the consistency. I think that a speech therapist should come and give a more accurate assessment of the liquids. If there was an issue with the machine, I feel it should have been reverted to manually mixing and not utilizing the machine. We do in-services, I'm not sure when the last one happened. During an interview on 8/29/2025 at 9:21 AM, the CDM stated, Everyone in the kitchen has the education and knowledge to identify if liquids are not at the right consistency. Not all nurses are able to identify consistency. They are not trained but some are so used to seeing them [thickened liquids] that they are able to identify the consistency of a liquid. The nurses should always go to the kitchen and ask the staff for confirmation. After that night, [8/27/25, when the (continued on next page)		

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	deficient practice was identified] we had called the company to come out to fix it [thickened liquid machine]. They [dietary] did not use the machine after I had left. The next day, I came in the afternoon around three. All the staff in the kitchen know any equipment that is broken should not be used. I told the staff before leaving that they should not use the machine until the company comes out to look at it since it was not working properly and instructed the staff to prepare the juices for breakfast manually. I don't know why they were using that [thickened liquid machine]. Normally, if the equipment is out of order, we need to put up a sign. There was not a sign posted before I left but [The FSM's name] knew she should put up a sign. As a CDM, I have to train all the new employees that come in. I do angel rounds, care plan meetings, food preferences, inventory and ordering, making sure that emergency storage is good for the hurricane season. I am just covering right now; I have been here every day since Monday [8/25/2025]. I go over consistency with staff and there is also a flyer, and the recipe book [for thickened liquids]. I feel that all the staff in the kitchen working right now is able to identify the consistency correctly of the liquids. [The FSM's name] texted the Administrator to let him know [the thickened liquid machine]. I feel that as the CDM, I am responsible for safeguarding the residents in the building. Whoever is the aide assigned to drinks on the schedule. The aide should be responsible for verifying the consistency when they are pouring. She should have stopped and addressed it with me and [the FSM's name]. I would have called the company right away and checked the storage and if not go get it from the supplier [boxes of thickened liquids]. They [dietary aides] need to notify use of any problem and that is also part of the job description to notify as immediately and I am available 24/7 every day. During an interview conducted on 8/29/2025 at 9:41 AM, the Dietary, Housekeeping and Laundry District Manager stated, My regional would be over the CDM. The previous CDM was bouncing between two accounts, and we were getting lots of complaints from another account. So, we had to terminate her. The issues in this kitchen were not part of her termination. I can assume it was happening here as well because I see a trend. The first line of defense is the dietary aide. This should not have happened. I was not made aware that the machine was not working properly. I would have gone out and even bought another machine. The staff in the kitchen, this is part of their daily equipment check and they have to not use it and find a way to continue the operation. It should have been reported from the aide. During an interview conducted on 8/29/2025 at 10:00 AM, the Administrator stated, The speech therapist is who we go to if there are any questions regarding consistency. The kitchen staff also have the education and the knowledge to determine the right consistency. That is why we have the system for check points to prevent things like that [residents being served inappropriate thickened liquid beverage] from happening. They notified me yesterday. I don't remember what time, but as soon as they told me, I got on the phone with the company and told them it was urgent. It was a busy day. I don't recall if I received a text from the FSM regarding the machine that evening when the machine was identified as not properly working. I oversee the day-to-day operations. For the kitchen my responsibly is to have the tools that they need to get their jobs done. They are vendors, so they do the hire and education. We are responsible for the food. The vendor would be responsible for fixing the equipment. Everyone that works here is responsible for safeguarding the residents. I feel that the break in the system was the machine and as soon as I was aware I called to get it fixed. During an interview on 8/29/2025 at 10:36 AM, the Medical Director stated, I was aware that the [Brand name of the draft/thickened liquid machine] had malfunctioned on Wednesday and I told them to call the company and have them fix the machine and come and fix it by Thursday. They [Residents requiring thickened liquids] have a possibility of aspiration pneumonia and fatal consequences as well. The staff should not use the machine until it is fixed by the company. I recommended not to use the device until fixed. I don't recall what time on Wednesday [8/27/2025] and the DON was the one to notify me. I make sure patient safety is first, and they get the care that they need. The policies are implemented. Today we were supposed to have a meeting, but I am going out of town, and I am going on a trip since it's a long weekend. Review of [Name of draft machine service company] Invoice dated 8/28/2025 read, (continued on next page)		

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Problem Reported: Soda X [Name of Food Service Manager] Texted a request for calibration of her nectar thick gun juices. She said nectar juices coming out too thick. Resolution: Brix honey & [and] nectar gun. Review of the document titled [Name of the Draft Machine Service Company] Fountain-Dispensed Beverage Solutions with an effective date of 5/5/2025 read, Purpose: This agreement is submitted to above Care Facility for the purpose of becoming the sole supplier of all dispensed beverage products. [Name of draft machine service company] will install the needed equipment, service specified equipment, and deliver specified products. Equipment: [Name of draft machine service company] will install a customized dispensing systems consisting of the following equipment: [no equipment was marked]. A. This equipment will be installed in the facilities, and be of the highest quality and subject to weekly inspection and maintenance, as well as periodic preventive maintenance. This equipment will remain the property of [Name of draft machine service company]. Service and Delivery: [Name of draft machine service company] will provide regular maintenance of all equipment and product replenishment as required by the system. There will be no cost to the above facility for these services. Emergency Service will also be available at no additional cost. Notification: The facility agrees to notify [Name of draft machine service company] of any defects of failure of the equipment that does not receive proper service by its service technician. Review of Cook/Kitchen Staff Competency assessment dated [DATE] for Staff B, Dietary Aide, read, Administrative Functions. Inspect diet trays to assure that the correct diet is served to the resident. Ensure that all food procedures are followed in accordance with established facility policies, and Assist in serving meals as necessary and on a timely basis. The required functions of the job were marked as In service Needed. Signed by the FSM. During an interview on 8/28/2025 at 10:24 AM, the Certified Dietary Manager stated, She [Staff B] was supposed to put chilled desserts, salads and modified drinks on the trays on 8/27/25 for the dinner meal trays. The Competency Assessment for [Staff B's Name] was conducted on 5/27/25 with several functions listed as In-service needed. I cannot find any in-services provided to [Staff B's Name]. I was not made aware of this assessment [the training not being completed] until today. The Immediate Jeopardy (IJ) was removed onsite as of August 29, 2025 after the receipt of an acceptable IJ removal plan. The facility has completed the following steps to remove the immediate jeopardy. As verified by the survey team, on 8/28/2025, the facility administration conducted a QAPI meeting and root cause analysis related to consistency of liquids provided to the residents. On 8/28/2025, the Dietary Manager Received 1:1 (one on one) education on the importance of notifying the administration and dietary staff with equipment concerns and to post an out of order signage by the Administrator. On 8/29/2025, the Dietary Manager received 1:1 training on lock out/tag out. On 8/29/2025, the facility Administrator and the director of Nursing Services were reeducated by the Senior VP (Vice President) of Operations on the component of F835 to ensure the facility utilizes its resources effectively and efficiently to attain and maintain the highest physical well-being of each resident and implement procedures related to consistency of liquids by identifying equipment malfunction and notification responsible staff. On 8/29/2025, the Administrator received 1:1 training regarding equipment failure, c[TRUNCATED]		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview, and record review, the facility failed to secure medications when unattended. Findings include: During an observation on 8/25/2025 at 10:24 AM, Resident #102 was sitting on the bed in his room. There was a bottle of nasal decongestant and a bottle of saline nasal spray on his bedside table. 1) During an interview on 8/25/2025 at 11:13 AM, Staff I, Registered Nurse (RN), stated, [Resident #102's name] does not have an order to self-administer [medications]. The medication must be kept in the medication cart, and the nurses will bring the medication to the resident when they are ready for the medication. None of the residents are able to keep any medications in their room. The Afrin came from the hospital, and he no longer needs it; there is no physician's order for saline nasal spray. Review of Resident #102's physician orders did not show an order for self-administration of medications. Review of the Afrin product package information it read, Do not use for more than 3 days. Use only as directed. Frequent or prolonged use may cause nasal congestion to recur or worsen. 2) During an observation on 8/25/2025 at 10:31 AM, Resident #79 was lying in bed. There was a pain roller (a cylindrical piece of foam used to apply deep, steady pressure to the muscles) with ingredients of avocado butter, hempseed oil, vitamin E, beeswax, and blend of healing oils on top of the resident's dresser. During an interview on 8/25/2025 at 10:31 AM, Resident #79 stated, I have MS [multiple sclerosis] and have pain at times. I will apply the pain roller on myself or have nursing help me at times. During an interview on 8/25/2025 at 11:15 AM, Staff I, RN, stated, [Resident #79's name] is not supposed to have any medication at bedside. Sometimes family will bring medication in and we have to tell them not to bring it in. Review of Resident #79's physician orders did not show an order for a pain roller of avocado butter, hempseed oil, vitamin E, beeswax, and a blend of healing oils or an order for the self-administration of medications. Review of an article in the verywellhealth.com/essential-oils-for-multiple-sclerosis-5201581, titled, The Health Benefits of Essential Oils for Multiple Sclerosis, Medically reviewed by [Name of physician] read, Before starting to use any essential oils, speak to your doctor. If they give you the go-ahead, you may be able to find some relief. 3) During an observation on 8/25/2025 at 10:40 AM, Resident #65 was sitting in the room in a wheelchair. There was a bottle of medicated ointment for relief of cough, sore throat, and minor aches and pains on the bedside table. During an interview on 8/25/2025 at 11:11 AM, Staff J, Licensed Practical Nurse (LPN) Unit Manager (UM), stated, [Resident #65's name] should not have Vicks VapoRub at her bedside. She does not have orders for self-administration of medication. Review of Resident #65's physician orders did not show an order for the use of Vicks VapoRub or an order for the self-administration of medications. 4) During an observation on 8/25/2025 at 11:00 AM, Resident #52 was lying in bed. There was an analgesic sore throat spray container on the bedside table. During an interview on 8/25/2025 at 11:00 AM, Resident #52 stated, My daughter bought that for me. I had a sore throat and was using it, but that was a few months back. During an interview on 8/25/2025 at 11:09 AM, Staff J, LPN UM stated, [Resident #52's name] has no orders for self-administration of medication. The medication should not be at bedside. The resident stated his daughter brought it from home. Review of Resident #52's physician orders did not show an order for an analgesic sore throat spray or an order for the self-administration of medications. During an interview on 8/28/2025 at 9:45 AM, the Director of Nursing stated, The medications are to be stored in their drawer or in a lock box. They should also have a self-administration assessment and notify the doctor. The medication should not be unattended. Review of the policy and procedure titled Pharmacy Services with the last review date of 1/29/2025 read, 11. In accordance with State and Federal laws, the facility should store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. Review of the policy and procedure titled Nursing-Self Administration Medication Program with the last review date of 1/29/2025 read, (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Purpose: It is the policy of this facility to allow the resident and or legal representative of the resident, the right to self-administer medication when it has been deemed by the interdisciplinary team that it is clinically appropriate. Procedure: b. If medications are stored at the resident's bedside, a lock box or locked drawer must be used to store the medication (s).		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure resident assessments accurately reflected each resident's status for 1 of 3 residents, Resident #45, reviewed for nutrition, and 1 of 6 residents, Resident #72, reviewed for medication management. Findings include: 1) Review of Resident #45's quarterly MDS (Minimum Data Set) assessment dated [DATE] read, Section K Swallowing/Nutritional Status. K0300 Weight Loss: Loss of 5% or more in the last month or loss of 10% or more in last 6 months: 0. No or unknown. Review of Resident #45's weights showed on 6/1/2025, Resident #45's weight was 150 pounds and on 12/10/2024, the resident weighed 167 pounds, which was a -10.2% weight loss. During an interview on 8/27/2025 at 2:58 PM, the Registered Dietitian stated, [Resident #45's name] fluctuates in her weights, but I also take into account the whole clinical picture. I would have coded it different due to the most recent weight changes now. It was a significant weight change in the last six months. During an interview on 8/28/2025 at 11:08 AM, the Minimum Data Set Coordinator Registered Nurse (MDS RN) stated, Section K should be corrected for [Resident #45's name]. Based on the RAI [Resident Assessment Instrument] it was a weight loss and needs to be corrected. 2) Review of Resident #72's MDS assessment dated [DATE] read, Section J Health Conditions: Received scheduled pain medication regimen? No. Review of Resident #72's physician order dated 7/29/2025 read, Methocarbamol Oral Tablet 500 MG [milligram] (Methocarbamol) [a muscle relaxer used to treat muscle pain]. Give 1 tablet by mouth two times a day for Pain. Review of Resident #72's Medication Administration Record (MAR) for the month of July 2025 documented methocarbamol for pain was administered on 7/30/2025 at 9:00 AM and 9:00 PM. During an interview on 8/28/2025 at 11:05 AM, the MDS RN stated, [Resident #72's name] had scheduled pain medication for the look back. The MDS is inaccurate. Review of the policy and procedure titled Minimum Data Set with the last review date of 1/29/2025 read, 3. Each person completing a section or portion of a section of the MDS signs the Attestation Statement indicating its accuracy.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents received updated Preadmission Screening and Resident Review (PASARR) evaluations when appropriate for 2 of 4 residents, Resident #66 and #80, reviewed for behavioral diagnosis. Findings include: 1) Review of Resident #66's medical record showed the resident was admitted on [DATE] with diagnosis to include major depressive disorder with an onset date of 11/7/2024. Review of Resident #66's Preadmission Screening and Resident Review (PASARR) dated 8/11/2025 did not document the resident has been diagnosed with a mental illness or suspected mental illness. Review of Resident #66's physician order dated 8/14/2025 read, "Sertraline HCl Oral Tablet 100 mg [milligram] (Sertraline HCl) give 1 tablet by mouth one time a day for depressed, withdrawn related to major depressive disorder, recurrent, in partial remission." Review of Resident #66's psychiatric admission note dated 8/19/2025 read, "Interval History: Pt [patient] reports some mild depression and anxiety due to trying to adjust being in a facility, loss of independence and treatment plan." During an interview on 8/29/2025 at 11:30 AM the Social Service Director stated, "[Resident #66's name] PASSAR needs to be corrected not all of the diagnosis were listed upon admission. 2) Review of Resident #80's medical record showed the resident was admitted to the facility on [DATE] with diagnosis to include major depressive disorder with an onset of 3/17/2025, anxiety disorder with an onset of 3/17/2025, and bipolar disorder with an onset of 07/29/2025. Review of Resident #80's PASARR dated 7/30/2025 documented anxiety disorder and depressive disorder based on documented history and medications, excluding bipolar disorder. Review of Resident #80's physician order dated 8/5/2025 read, "Divalproex Sodium Oral Tablet Delayed Release 125 mg (Divalproex Sodium), Give 1 tablet by mouth two times a day for mood disorder, related to other - bipolar disorder. Review of Resident #80's care plan dated 7/30/2025, with a revision date of 8/6/2025, read, "[Resident #80's name] is on anticonvulsant medication r/t [related to] bipolar disorder and another anticonvulsant medication for neuropathy. Review of Resident #80's psychiatry admission note dated 8/5/2025 read, "She [Resident #80] reports a history of bipolar disorder, diagnosed approximately five years ago (though she is unsure of the exact timing). During an interview on 8/29/2025 at 12:23 PM, the Social Services Director stated she was responsible for verifying the completion of the resident PASARR forms upon admission. The Social Services Director acknowledged that bipolar disorder was listed among Resident #80's diagnoses. When reviewing Resident #80's most recent PASARR, she stated, "Bipolar (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	isn't on there. I must have missed it. That's on me. Sometimes I am notified when a resident gets a new psych eval [psychiatric evaluation] done, but I usually have to go in their records and look for the new psych eval myself. She confirmed that Resident #80's bipolar diagnosis was not included in the hospital discharge documentation she used to complete the PASARR but was listed on Resident #80's new admission psychiatry evaluation.		

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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. Based on record review and interview, the facility failed to ensure staff administered blood pressure medication and monitored weights per physicians' orders for 1 of 6 residents, Resident #51, reviewed for medication administration. Findings include: Review of Resident #51's physician order dated 6/19/2025 read, weekly weights. Review of Resident #51's weights documented weights on 7/7/2025, 7/21/2025, 8/8/2025. Review of Resident #51's physician order dated 4/8/2025 read, Valsartan Oral Tablet 320 mg [milligram] (Valsartan), Give 1 tablet by mouth one time a day for HTN [hypertension] related to essential hypertension. Review of Resident #51's Medication Administration Record (MAR) for the month of August 2025 for Valsartan 320 mg documented on 8/4/2025 coded 11 [Held per parameters], 8/9/2025 coded 9 [other/see progress notes], 8/11/2025 coded 9, 8/18/2025 coded 11. Review of Resident #51's MAR for the month of July 2025 for Valsartan 320 mg documented 7/9/2025 coded 11, 7/12/2025 coded 5 [Hold /See Progress notes], 7/18/2025 coded 11, 7/26/2025 coded 11, 7/29/2025 coded 9. During an interview on 8/27/2025 at 10:49 AM, Staff O, Licensed Practical Nurse (LPN), stated, [Resident #51's name] blood pressure at times goes low and I do not give the medication. I sometimes call the provider but to be honest sometimes I forget to call. During an interview on 8/27/2025 at 10:55 AM, Staff P, Registered Nurse (RN), stated, I use my nursing judgment and my experience with other patients. The provider comes around to visit the patient. I have not called the doctor because I'll use the doctor's parameters based on other patients. During an interview on 8/27/2025 at 2:09 PM, the Director of Nursing (DON) stated, I was not able to find the weekly weights for [Resident #51's name]. It does not give a reason why there is an order for weekly weights I will have to ask. During an interview on 8/28/2025 at 11:50 AM, the Nurse Practitioner #1 stated, I know she has been sick and will refuse at times certain things. I have not had any reports from the staff that she has refused weights. I requested weekly weights because she has had pleural effusion and I wanted to see if she had any weight gain and wanted to assess for that. [Resident #51's name] has been stable. I am surprised that they have not requested to weigh her less frequently. Staff always let me know when they are holding the medication. I expect them to follow physician orders, but I want them to use their nursing judgment, but I do want them to call me and let me know so that I know to look to see if there is a pattern and make medication changes. There has been no harm to the resident related to missing weights or regarding her cardiovascular health. During an interview on 8/27/2025 at 2:25 PM, the DON stated, Nurses can use their nursing judgment put it is a doctor's order first they need to contact the doctor and let them know and document that they have communicated with the provider. Review of the policy and procedure titled Administering Medications with the last review date of 1/29/2025 read, Purpose: To ensure that medications are administered in a safe and timely manner, and as prescribed. General Guidelines: 6. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication should contact the prescriber, the resident's Attending Physician or the facility's Medical Director to discuss the concerns. Review of the policy and procedure titled Weights with the last review date of 1/29/2025 read, Procedure: 5. Weight monitoring schedules should be developed upon admission for all residents: a. weights should be recorded timely.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure enteral feeding was administered per the physician order for 1 of 2 residents, Resident #7, sampled for enteral feeding. Findings include: Review of Resident #7's medical record showed the resident was admitted on [DATE] with diagnosis including but not limited to gastrostomy status with onset date 3/10/2025. Review of Resident #7's physician order dated 6/26/2025 read, Enteral Feed; two times a day related to dysphagia following cerebral infarction. Enteral feeding type: Osmolite 1.5 liquid to run at 50 ml/hr [milliliters per hour] via pump x [for] 22 hours, break from 7 AM to 9 AM total volume to be infused: 1100 ml/24hr. Review of Resident #7's nutrition note dated 8/23/2025 read, Resident receives a tube feed and receives oral diet. Tube feed is Osmolite 1.5 @ [at] 50 ml/hr for 22 hours with a break from 7am-9am. Receives water flush q3hrs [every 3 hours] of 120 ml. Appetite can be variable, will continue to monitor weights. She has a Stage IV [4] pressure wound to sacrum, receives Prostat SF [sugar free] once a day for increased protein needs. Continue current supplements and tube feed order. During an observation on 8/25/2025 at 01:11 PM, Resident #7 was lying in bed. She had her eyes open but did not respond to verbal stimuli. The enteral feeding was running at an administration rate of 55 ml/hr, with a 120 ml flush every 3 hours. (Photographic evidence obtained) During an interview on 8/29/2025 at 11:16 AM, Staff M, Licensed Practical Nurse (LPN), stated, Having a tube feeding set to the wrong feed rate could lead to several side effects, including over or under eating, diarrhea and other GI [gastrointestinal] symptoms, and could impact a resident's comorbidities like diabetes. I don't know how much of a difference 5 ml could make, but that's wrong. During an interview on 8/29/2025 at 11:55 AM, the Assistant Director of Nursing/Unit Manager, Registered Nurse, stated, The nurses are responsible for feeding tubes; they are to double check the physician's order and make sure the feed is hanging/running during rounds. [Resident #7's name] had orders for tube feeding at a rate of 50 mL/hour. I tell them [the nurses] that it's their license. If the rate is wrong, that's a med [medication] error. If there are new orders, they should be checking daily. I believe she's [Resident #7] on 50 [ml/hour], so that would be wrong according to the order.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure oxygen was administered as ordered by the physician for 1 of 3 residents, Resident #65, sampled for oxygen administration. Findings include: During an observation on 8/25/2025 at 10:40 AM, Resident #65 was sitting in a wheelchair in her room. Oxygen was being administered at 2 liters per minute via nasal cannula. During an observation on 8/26/2025 at 10:01 AM, Resident #65 was sitting in a wheelchair in her room oxygen was being administered at 2 liters per minute via nasal cannula. (Photographic evidence obtained) During an interview on 8/26/2025 at 10:01 AM, Resident #65 stated, I am supposed to be at 3 liters [oxygen administration flow rate]. Review of Resident #65's physician order dated 7/28/2025 read, Oxy O2 @ 3L, NC [oxygen at 3 liters nasal cannula] continuous every shift related to chronic obstructive pulmonary disease with acute exacerbation. During an interview on 8/27/2025 at 8:00 AM, Staff K, Registered Nurse (RN), stated, [Resident #65's name] oxygen needs to be adjusted it is running at 2 liters but has orders for 3 liters per minute. During an interview on 8/27/2025 at 2:13 PM, the Director of Nursing stated, The nurses should notify the physician if the flow rate was incorrect and correct it. Nurses should check at the beginning of the shift and then periodically throughout. Review of the policy and procedure titled Oxygen Administration with the last review date of 1/29/2025 read, Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2025
NAME OF PROVIDER OR SUPPLIER Lake Eustis Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 411 W Woodward Ave Eustis, FL 32726	
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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. Based on record review and interview, the facility failed to ensure residents medical records were complete and accurate for medication administration for 2 of 7 residents sampled, Residents #66 and #2. Findings include: 1) Review of Resident #66's physician order dated 8/14/2025 read, "Humulin N Subcutaneous Suspension 100 unit/ml [unit per milliliters] (Insulin NPH (Human) (Isophane)) Inject 36 units subcutaneously two times a day for DM [Diabetes Mellitus]." Review of Resident #66's Medication Administration Record (MAR) for the month of August 2025 for Humulin documented on 8/15/2025 at 6:30 AM was coded 12 [insulin not required] blood sugar level was 85, and at 4:30 PM coded 12 blood sugar level was 116, 8/16/2025 at 6:30 AM blood sugar was 110 coded 12, 8/18/2025 at 6:30 AM coded 11 [Held per parameters] blood sugar level was 80, 8/20/2025 at 6:30 AM coded 11 blood sugar level was 66, 8/21/2025 at 6:30 AM coded 11 blood sugar was 102, and 8/26/2025 at 6:30 AM coded 12 blood sugar was 102. Review of the nursing progress notes for the period of 8/15/2025 through 8/26/2025 for Resident #66's did not show any documentation that the physician was notified of the resident's blood sugar results and/or the resident's refusal for administration. During an interview on 8/27/2025 at 10:57 AM, Staff Q, Licensed Practical Nurse (LPN), stated, "[Resident #66's name] will refuse insulin when his blood sugar is low. He will not want to take the medication. I will let the provider know. Normally I will send a text message notification." During an interview on 8/27/2025 at 1:37 PM, Staff R, LPN, stated, "[Resident #66's name] lets me check his blood sugar and then he will refuse to let me give him the insulin. I should have written down that he refused but I did not. I normally will notify the doctor that he refuses." During an interview on 8/27/2025 at 2:23 PM, the Director of Nursing (DON) stated, "Nurses should call the provider and let them know the resident is refusing the insulin to see what the provider wants to do. They should notify and document in the record that the resident is refusing and that they have contacted the provider." During an interview on 8/28/2025 at 11:30 AM, the Nurse Practitioner #1 stated, "A lot of times he [Resident #66] refuses. I have been there when he has refused and the staff call me when he refuses to let me know." 2) Review of Resident #2's physician order dated 7/21/2025 read, "Hydralazine hydrochloride oral tablet 50 milligrams [mg], give 1 tablet by mouth three times a day for hypertension related to essential (primary) hypertension." Review of Resident #2's Electronic Medication Administration Record (eMAR) for hydralazine hydrochloride dated 8/7/2025 at 9:00 AM read, "9" with Staff F, LPN's initials. Review of Resident #2's eMAR progress note for hydralazine hydrochloride dated 8/7/2025 at (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9:38 AM read, &ldquo;held for bp [blood pressure] 98/54.&rdquo; Review of Resident #2&rsquo;s physician order dated 7/22/2025 read, &ldquo;Metoprolol titrate oral tablet 100 mg, give 1 table by mouth two times a day for hypertension.&rdquo; Review of Resident #2&rsquo;s eMAR for metoprolol titrate for Resident #2 dated 8/7/2025 at 9:00 AM read, &ldquo;9&rdquo; with Staff F, LPN&rsquo;s initials. Review of Resident #2&rsquo;s eMAR progress note for metoprolol titrate dated 8/7/2025 at 9:38 AM read, &ldquo;held for bp 98/54.&rdquo; Review of Resident #2&rsquo;s physician order dated 7/22/2025 read, &ldquo;Diltiazem hydrochlorothiazide tablet 120 mg, give 1 tablet by mouth two times a day for hypertension.&rdquo; Review of Resident #2&rsquo;s eMAR for diltiazem hydrochlorothiazide dated 8/7/2025 at 9:00 AM read, &ldquo;9&rdquo; with Staff F, LPN&rsquo;s initials. Review of Resident #2&rsquo;s eMAR progress note for diltiazem hydrochlorothiazide dated 8/7/2025 at 9:38 AM read, &ldquo;held for bp 98/54.&rdquo; Review of the nursing progress notes dated 8/7/2025 for Resident #2 did not show any documentation that the provider was notified of Resident #2&rsquo;s blood pressure results and holding the blood pressure medications that were ordered by the physician. During an interview on 8/27/2025 at 1:55 PM, Staff F, LPN, stated, &ldquo;My signature on the eMAR is [Staff F&rsquo;s initials]. I called the nurse practitioner and let her know about any low blood pressures when I hold a blood pressure medication. I would not hold medications without talking to a provider. I just forgot to document that part.&rdquo; During an interview on 8/28/2025 at 11:50 AM, the Nurse Practitioner #1 stated, &ldquo;My expectations would be that if the resident has a medication order they would follow the order, using nursing judgement is okay but I am supposed to be notified. I believe I was notified, maybe they forgot to document it. They call me a lot with regards to that resident [Resident #2].&rdquo; During an interview on 8/29/2025 at 2:18 PM, the DON stated, &ldquo;I would expect my nurses to accurately document medication administration along with provider notification if there was a concern with administering medication.&rdquo;		

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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. Based on observation, interview, and record review, the facility failed to ensure staff performed hand hygiene during wound care and failed to ensure staff donned appropriate personal protective equipment prior to entering a contact isolation room to prevent the possible spread of infection and communicable diseases. Findings include: 1) During an observation on 8/29/2025 at 3:15 PM, Staff M, Licensed Practical Nurse (LPN), and Assistant Director of Nursing (ADON) entered Resident #7's room. Staff M and the ADON performed hand hygiene and donned gowns and gloves. Staff M placed the needed supplies on the bedside table. Staff M removed the left side of Resident #7's brief and removed the soiled dressing from Resident #7's left lateral trochanter (a prominent bump on the end of the thigh bone). Staff M removed the gloves, did not perform hand hygiene, donned a new set of gloves, and cleansed Resident #7's wound. After cleansing Resident #7's wound, Staff M removed the gloves and performed hand hygiene. Staff M returned to Resident #7's side and noticed continued wound drainage from the wound. Staff M donned a pair of gloves and cleansed the drainage from the wound three times with different 4x4 (4 inches by 4 inches) gauze. Staff M did not remove the gloves, did not perform hand hygiene, and proceeded to pack Resident #7's wound with genteel blue foam and applied a clean dressing. During an interview on 8/29/2025 at 3:40 PM, Staff M, LPN, stated, "I should have done hand hygiene between dirty and clean while doing the wound care." During an interview on 8/29/2025 at 3:41 PM, the ADON stated, "[Staff M's name] should have removed her gloves and perform hand hygiene before putting on another set of gloves. The nurses should also do hand hygiene anytime they touch dirty and are moving to clean during wound care." During an interview on 8/29/2025 at 3:49 PM, with the Director of Nursing (DON) stated, "Staff should remove the old dressing in place and wash her hands. When they remove their gloves they should wash hands before putting on a new pair of gloves. The staff should have a break in between the dirty and clean. The nurse should have changed her gloves and done hand hygiene after cleaning the wound." Review of the policy and procedure titled "Dressing-Dry/Clean" with the last review date of 1/29/2025 read, "Purpose: The purpose of this procedure is to provide guidelines for the application of Dry/Clean dressings. Procedure: 5. Perform Hand Hygiene. 6. Put on clean gloves. Loosen tape and remove soiled dressing. 7. Pull glove over dressing and discard into plastic or biohazard bag. 8. Perform hand hygiene. 9. Apply clean gloves. 10. Open dry, clean dressing by pulling corners of the exterior wrapping outward, touching only the exterior surface. 11. Label tape or dressing with date, time and initials. Place on clean field. 12. Using clean technique, open other products (i.e., prescribed dressing; dry clean gauze). Pour liquid solutions directly on gauze sponges on their papers. 13. Perform hand Hygiene. 14. Put on clean gloves." Review of the policy and procedure titled "Hand Hygiene" with the last review date of 1/29/2025 read, "Purpose: To prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Procedure: 1. All staff should perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. Before applying and after removing personal protective equipment (PPE), (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	including gloves. Before and after handling clean or soiled dressings. After handling items potentially contaminated with blood, body fluids, secretions, or excretions. When, during resident care, moving from a contaminated body site to a clean body site. 4. a. The use of gloves does not replace hand hygiene. If your task requires gloves perform hand hygiene prior to donning gloves, and immediately after removing gloves.&rdquo; 2) During an observation on 8/27/2025 at 9:03 AM, Resident #2 had a sign on the room door which read, &ldquo;Contact Precautions&rdquo; that was visible to the hall. There was a personal protective equipment caddy on the door that contained a box of size large gloves and multiple disposable blue contact gowns located inside of it. During an observation on 8/27/2025 at 9:03 AM, Staff E, Housekeeper, was walked into Resident #2&rsquo;s room with no gown or gloves on. She walked over to Resident #2&rsquo;s bed and touched the curtain and bed. During an interview on 8/27/2025 at 9:05 AM, Staff E, Housekeeper, stated &ldquo;I knew the resident was on contact precautions, but the resident is not in the room right now. I probably should have worn a gown and gloves.&rdquo; During an interview on 8/27/2025 at 9:45 AM, the Director of Housekeeping stated, &ldquo;Housekeeping staff should wear a gown and gloves when a resident is on contact isolation and have been educated on the policy.&rdquo; Review of Resident #2&rsquo;s physician order dated 8/26/2025 at 11:29 AM read, &ldquo;Contact isolation: ESBL [Extended-Spectrum Beta-Lactamase] in urine, every shift until 8/31/2025 at 11:59 PM.&rdquo; Review of the document titled, &ldquo;Daily Isolation Room Cleaning&rdquo; last reviewed on 1/29/2025 read, &ldquo;Purpose: To provide all housekeeping employees with a complete outline of the equipment and supplies necessary for isolation room cleanings, as well as the necessary tasks to be performed to complete an isolation room cleaning. Steps in the Daily Isolation Room Cleaning: Before entering: 1. Scrub hands and arms using an anti-microbial disinfectant soap for no less than 3 minutes. 2. Dress in proper isolation attire (gloves, gown, disposable mask). A cart should be set up outside the room containing proper isolation attire.&rdquo;		