STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105029	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Convalescent Center	2202 W Oak Ave Plant City, FL 33563

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide a building in good repair, related to cleanliness, holes in walls, bio growth and unpainted walls in two wings (100 East, 200 East) of the four facility wings toured. Findings included: During a tour of the facility on 08/24/2025 at 9:30 a.m., it was observed, room [ROOM NUMBER] had a hole in the wall, room [ROOM NUMBER] had a peeling ceiling, room [ROOM NUMBER] had a hole in the wall and unpainted wall, room [ROOM NUMBER] had an unpainted wall, room [ROOM NUMBER] had no baseboards and unpainted walls, room [ROOM NUMBER] had a hole in the wall, room [ROOM NUMBER] had a hole in the wall, room [ROOM NUMBER] had an unpainted wall and bio growth on the window sill.During a tour of the facility on 08/27/2025 at 1:23 p.m., it was observed, room [ROOM NUMBER] had a hole in the wall, room [ROOM NUMBER] had a peeling ceiling, room [ROOM NUMBER] had a hole in the wall and unpainted wall, room [ROOM NUMBER] had an unpainted wall, room [ROOM NUMBER] had no baseboards and unpainted walls, room [ROOM NUMBER] had a hole in the wall, room [ROOM NUMBER] had a hole in the wall, room [ROOM NUMBER] had an unpainted wall and bio growth on the window sill. During an interview with the Maintenance Director (MD) on 08/26/25 at 11:15 a.m., the MD stated, I have previously worked in long term care facilities and have an extensive background in facility maintenance. The MD said it is the MD's responsibility to maintain the building, all the equipment and the items in the facility, including mechanical and electrical. I had planned to do a comprehensive room-to-room review; however, I had not gotten that done to date. Residents can report issues with their rooms to any staff member. Once reported, the staff puts the work order into the electronic reporting system. The MD said a notification is alerted to the cell phone that there is a work order in the electronic reporting system. From there the MD prioritizes as to what gets fixed first. The system allows the MD to prioritize based on the MD experience. Once the prioritization is determined, then we just start at the top or request items from a vendor for repair and then make the necessary repairs. During a tour on 08/26/2025 at 2:10 p.m. with the MD, of rooms,122, 218, 223, 224, 225, 227, 228 and 229, the MD stated, I have no answer for the issues with the rooms.During a tour on 08/27/25 at 3:15 p.m. with the MD of room [ROOM NUMBER], the MD stated, we do not currently have any resolution to fixing the ceiling or moving the residents out of the area. Review of an unsigned undated document named, work orders open and in progress, showed only one room [ROOM NUMBER], was identified as having wall damage. Review of an undated, unsigned, job description titled Maintenance Director, showed the Maintenance Director is responsible for the overall maintenance of the facility and provides direction for all activities related to plant operations. The maintenance director ensures the facility, equipment and utilities are maintained in good working order and facility grounds are properly maintained in accordance with the facility policies and state and federal regulations.The essential Duties and Responsibilities showed:Perform minor repairs and supervise the day-to-day repair, improvement and preventative maintenance of the facility to ensure that machines continue to run smoothly, building systems operate efficiently, or the physical condition of facility does not deteriorate.Make job assignments and set priorities. Review of the facility's policy and procedure, dated 08/2024 titled Physical Environment, showed the facility will provide a safe, clean, comfortable, and home-life environment is provided for each resident, allowing the use of personal belongings to the greatest extent possible. Sufficient space and equipment in dining, health services, recreation, and program areas are provided to enable staff to provide residents with needed services. All essential mechanical, electrical, and resident care equipment is maintained in safe operating condition through the facility's Preventative Maintenance Program. (Photographic Evidence Obtained)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record reviews and interviews, the facility failed to ensure the grievance process was followed for one resident (#45) and Resident Council members out of three residents reviewed for grievances. Findings included: On 8/27/25 at 1:13 p.m., an interview with Resident #45 revealed that the resident has been missing three pairs of cargo pants, has had a second pair of pants discolored/damaged from laundry, and complains that staff is not taking his soiled linens daily to be washed. Resident #45 expressed that the facility has yet to replace the damaged and lost items despite advising Resident #45 that they will be replaced and creating a grievance for each occasion. A review of Resident #45's admission record revealed an original admission date of 2/15/2024, and a re-admission date of 8/14/2025 with diagnosis to include type 2 diabetes, and chronic kidney disease. Review of the facility's Grievance Log dated from August 2024-August 2025 showed two documented grievances for Resident #45 in regard to laundry. A review of Resident #45's Grievance/Concern Report dated 11/23/2024 initiated by Resident #45, revealed Resident #45 reported three pairs of cargo pants are missing. The conclusions for grievance dated 11/23/24 revealed a hand written note stating Unable to locate 3 pairs of cargo pants. The grievance report was not checked off on whether the issue was resolved or not. The Date Assigned for this grievance was 11/25/24, and Date Resolved By is empty. A review of Resident #45's Grievance/Concern Report dated 2/26/25 , revealed one pair of green pants were sent to the laundry and came back a rust color. Resident #45 expressed Certified Nursing Assistant (CNA) staff are not taking dirty clothes to the soiled linen room daily. The facility noted the follow-up plan was for the laundry supervisor to check the chemicals in the washing machine, and for CNAs to remove soiled linens from the resident's room. The conclusions for grievance dated 2/26/25 were Resident #45's pants were discolored from laundry, CNAs are to pick up the resident's linens, and the facility will order Resident #45 new pants. The Date Assigned for this grievance was 2/26/25, and Date Resolved By is 2/28/25. The grievance report Resolution was checked as Not Confirmed. 2. During a resident council meeting on 8/25/2025 at 3:06PM, multiple residents mentioned that the facility is slow acting on grievances and grievances being completed, especially in regard to laundry. Residents were experiencing missing and damaged clothing and have not heard back on a conclusion with grievances made pertaining to laundry. On 8/27/25 at 1:38 p.m., an interview was conducted with the Nursing Home Administrator (NHA). The NHA reported she cannot tell what has been done in regard to the grievances made by Resident #45. The NHA explained Resident #45's pants were not returned because they probably did not have an identification label and were not on the resident's inventory sheet. The NHA said clothing items that do not have a label, go on a No Name rack so staff can go and look for any missing items of residents, but Resident #45's missing items were not found there. The NHA expressed expectations were for Resident #45 to be reeducated on the process and policy of purchasing items and at least advising the Certified Nursing Assistant (CNA) or Nurse to label and add the items to the resident's inventory sheet. The NHA confirmed even though the grievances were marked as complete, there was no follow up or course of action describing the action taken by the Social Worker, and that grievances should only be marked as completed as soon as Resident #45's pants were purchased back and received by the facility. The NHA verified that the marked completed grievances were not followed out as notated, and there is no receipt or proof of repurchase by the facility. A review of the facility's Grievance/Concern Management Policy & Procedure, with an effective date of May 2025 revealed that rights also include the right to prompt efforts by the facility to resolve resident concerns, including concerns/grievances with respect to the behavior of other residents. Social services will monitor and document resident/representative satisfaction upon completion of the investigation and the summary of findings/conclusion. The facility leadership team will review and discuss concerns and the progress of an investigation(s) and resolution(s). Concerns are tracked, trended, and reported in the monthly Quality Assessment, Assurance and Compliance Committee Meeting. Complete a concern report investigation with summary and conclusion. Social Services staff will provide information regarding compliance line information for unresolved concerns.

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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 observations, record reviews, and interviews the facility failed to complete a Level II Pre-admission Screening and Resident Review (PASRR) for one resident (#3) and failed to ensure the accuracy of a Level I PASRR for one resident (#4) out of thirty-five initial pool residents. On 8/24/25 at 12:25 p.m. Resident #3 was observed lying in bed, with eyes closed and rhythmically breathing. Review of Resident #3’s admission Record showed the resident had been admitted on [DATE]. The record included diagnoses not limited to unspecified bipolar disorder, unspecified insomnia, and unspecified depression. Review of Resident #3’s PASRR dated 7/11/25 revealed it was completed at this facility and showed the resident had diagnoses of bipolar disorder, depressive disorder, and Post-Traumatic Stress Disorder (PTSD). The screening showed the resident was exhibiting signs and symptoms (s/s) of depression as spouse recently passed. The decision-making portion of the PASRR did not reveal the resident had any disorder resulting in functional limitations, did not typically have any issues with interpersonal functioning, concentration, persistence or pace, and/or adaption to change. The screening completion showed the resident did not have a diagnosis or suspicion of serious mental illness or intellectual disability therefore a Level II PASRR evaluation was not required. Review of Resident #3’s Care Plan revealed a focus for Trauma Informed Care – PTSD diagnosis due to being a war veteran and used psychotropic medications to manage bipolar disorder and insomnia. An interview was conducted on 8/27/25 at 5:33 p.m. with the Director of Clinical Reimbursement (DCR). The DCR stated if a resident had a diagnosis of PTSD and bipolar and stayed in the facility longer than 30 days a Level II PASRR was needed. 2. A review of Resident #4‘s admission Record revealed an original admission date of 1/2/2023, and a re-admission date of 6/17/2025. The diagnoses included depression (1/5/23), insomnia (1/9/23), and anxiety (9/22/23). A review of Resident #4‘s Level I PASRR, dated 1/9/23, under Section I-Part A MI (Mental Illness) or suspected MI, indicated only depressive disorder. On 8/27/2025 at 2:36 p.m., during an interview the DCR said that updating PASRRs are the responsibility of Social Services, but the Minimum Data Set personnel do a PASRR if anything such as new diagnoses needs to be added. The DCR mentioned that she started doing this task “maybe a week ago to help out. ” The DCR revealed that the PASRR process starts when the admissions packet is received. A review is done and if corrections need to be made, then they are corrected. The DCR is not sure if there is a review process for PASRRs on a regular basis and the DCR only reviews them if a change of diagnosis is made. The DCR confirmed that the PASRR for Resident #4 is missing anxiety, and mentioned that she knows some PASRRs list insomnia, but not sure if it has to be documented on the PASRR for a resident. The DCR mentioned that she is not sure why the PASRR for Resident #4 is not updated with the new diagnosis from 2023, or when Resident #4 was re-admitted to the facility. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility’s PASRR-Requirements for Completion Policy, with an effective date of August 2025 revealed that “Preadmission screening will be conducted prior to admission as the PASRR process is a federally mandated pre-admission screening program… required to be performed on all individuals prior to admission to a Nursing Home.” . “The screening is reviewed by Admissions for suspicion of serious mental illness and intellectual disability to ensure appropriate placement in the least restrictive environment and to identify the need to provide applicants with needed specialized services. ” . “The facility administration will confirm a Level I review has been completed prior to transfer to the SNF setting.” . “Determine if a serious mental illness and / or intellectual disability or a related condition exists while reviewing the PASRR form completed by the Acute Care Facility. (Trigger for Level II Completion)” . “If Serious Mental Illness or ID [intellectual disability] is indicated, determine if the resident will be admitted from a hospital for an acute care stay and the attending physician has certified that the individual is likely to require less than 30-days of Nursing Facility services. Assure that the certificate is signed and dated.” . “If the admission is a provisional admission, the Social Service Director must start a tickler file and assure the Level II is completed within the state specified time frame.” . “If the preadmission screening requires a Level II evaluation submit all required documents to CARES timely, so that a Level II can be completed within the required time frames.”

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews the facility failed to provide nail care for two residents (#97 and #45) out of five residents sampled for activities of daily living.Findings included: 1. On 8/24/25 at 12:35 p.m. Resident #97 was observed lying in bed. The resident was very pleasant and answered questions appropriately. The observation revealed the resident’s fingernails on both hands extended approximately 1/3 to ½ inch past the fingertips and were discolored. The resident reported not wanting long fingernails and staff had not offered to cut them. Resident #97 said it had been at least one month since the fingernails had been clipped. On 8/26/25 at 12:03 p.m. Resident #97 was observed with fingernails 1/3 to ½ inch past the tips of the fingers. The fingernails were discolored with a dark substance. The resident stated staff had not offered to cut them and yes, the resident would allow them to do so. On 8/27/25 at 9:09 a.m. Resident #97’s fingernails continued to be long and discolored. Review of Resident #97s admission Record showed the resident was admitted on [DATE]. The record included diagnoses not limited to unspecified dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, muscle wasting and atrophy not elsewhere classified multiple sites, other lack of coordination, and adult failure to thrive. Review of Resident #97s Certified Nursing Assistant (CNA) tasks showed staff are to perform nail care with personal hygiene/oral care. The task documentation showed the resident was to receive nail care as needed (prn). The documentation revealed staff had documented nail care had been provided eight out of twenty-seven days, and nail care had not been provided on the resident’s shower days of 8/5/25, 8/12/25, 8/15/25, 8/19/25, 8/22/25, and 8/26/25. The documentation showed the resident was to receive a shower on the 3:00 p.m. – 11:00 p.m. shift on Tuesdays and Fridays and showed the resident had not received a shower on Tuesday 8/5/25 and Tuesday 8/12/25, revealing the resident had three showers in 15 days. Review of Resident #97s care plan showed the resident had an ADL self-care performance deficit related to (r/t) weakness (and) activity intolerance. The interventions showed CNAs were to set up for oral care and personal hygiene and assist of one for bathing. The care plan revealed the resident had impaired cognitive function/dementia or impaired thought process related to (r/t) dementia and instructed staff to explain care before providing it, ask yes/no questions in order to determine the resident’s needs, and to request feedback to ensure understanding. The care plan did not include any focuses and/or interventions related to the resident’s behavior of refusing care. An interview was conducted on 8/27/25 at 11:27 a.m. with the Nursing Home Administrator (NHA). The NHA stated staff could clip fingernails on certain residents and diabetics would put on list for podiatry to see. The NHA reported believing podiatry could clip fingernails also, can file them down. An interview was conducted on 8/27/25 at 1:38 p.m. with the Director of Nursing (DON). The DON reported aides and nurses could cut fingernails and fingernails are cut by nurses for diabetic (resident's). (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 8/24/25 at 11:56 a.m., an observation of Resident #45 revealed long fingernails that had a dark brown substance caked underneath. On 8/27/25 at 1:13 p.m., an interview with Resident #45 revealed the resident preferred to be showered, and nails clipped and upkept. Resident #45 stated that the staff never mentions anything about cutting his nails, and that he would prefer them to be cut, Resident #45 also revealed that the staff has been cutting his toenails only once every two months. Resident #45 would independently cut their nails if they had the supplies to do so. Resident #45 had a scheduled shower on 8/25/25 and was still observed with long, dirty fingernails. A review of Resident #45’s admission record revealed an original admission date of 2/15/2024, and a re-admission date of 8/14/2025. A review of Resident #45’s care plan revealed ADL instruction to “Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse.” A review of Resident #45’s quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed section GG- Functional Abilities, the resident required supervision or touching assistance for shower/bathe self-assessment and is independent for personal hygiene. A review of Resident #45’s Nail Care task, with a look back over the last 30 days, revealed that Resident #45 did not receive nail care on 7/31/25, 8/2/25, 8/4/25, 8/15/25, 8/16/25, 8/17/25, 8/18/25, 8/20/25, and 8/24/25 marked as “No Nail Care.” A review of Resident #45’s bathing log revealed a shower schedule for Monday and Thursday during the evening shift. The Administrator was requested to provide the past 60 days of shower logs for Resident #45 but was only able to find shower logs for 8/18/25-8/25/25. Review of shower sheets for 8/18/25 and 8/21/25 revealed no answer was indicated for the question, “Does the resident need his/her toenails cut?” An interview on 8/27/25 at 10:56 a.m., with Staff T, Certified Nursing Assistant (CNA) said Resident #45 does not refuse ADL and nail care often, and that refusals for ADL care are documented on the resident’s shower sheets and tasks, but the reason for refusal is written in “from time to time, but most of the time it is just documented as ‘refused.” Staff T, CNA mentioned that the nurse is made aware when refusals for ADL care are made. An interview was conducted on 8/27/25 at 5:25 p.m., with Staff Q, CNA. Staff Q, CNA said “not sure” if ADL care is provided for Resident #45 and her other residents when she is pulled to do kitchen duties. Staff Q, CNA mentioned she provides ADL care for Resident #45 when she has the time and is availability to complete the task. An interview on 8/27/25 at 4:57 p.m., the Director of Nursing (DON) revealed that ADL care should be provided to residents on the following shift and day if the resident is not available for care or refuses care and should be documented along with the reason for refusal on the resident’s shower sheet. The DON reviewed Resident #45’s fingernail photograph and confirmed the state of Resident #45’s nails are not acceptable. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility’s Care and/or Treatment Declination revealed “The form will be completed and signatures obtained on all residents who choose not to accept the recommended care and/or treatment.” … “Record exactly what the resident/resident representative gives as a reason for refusing the proposed care/treatment plan.” An interview was conducted on 8/27/25 at 6:05 p.m. with the Regional [NAME] President (RVP). The RVP stated the facility did not have an ADL policy. (Photographic evidence obtained)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to provide assistance out of the bed for one dependent resident (#127) out of four residents sampled.On 08/24/2025 at 10:00 a.m., Resident #127 was observed lying down in bed with her call light within reach. She said staff will not assist her on the toilet whenever she asked them.On 08/24/2025 at 1:00 p.m., and on 08/24/2025 at 11:00 a.m., Resident #127 was observed lying down in bed. She said she has not been able to go to activities because staff will not get her up.Review of Resident #127's admission Record revealed Resident #127 was admitted to the facility on [DATE] with diagnoses to include but not limited to muscle wasting and atrophy, not elsewhere classified, multiple sites, unspecified fracture of right femur, sequela, type 2 diabetes mellitus with unspecified complications.Review of Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicated intact cognitive abilitiesReview of Resident #127's activity of daily living (ADL) care plan with an initiated date of 08/15/2025 revealed a focus for Resident #127 has an ADL self-care performance deficit. The care plan goals revealed will prevent decline in ADL self-performance through next review (revision date 08/20/2025). The care plan interventions for transfer revealed Resident #127 is an assist of one staff participation with transfers. Date initiated 08/15/2025, revision date 08/27/2025. On 08/25/2025 at 1:00 p.m. an interview was conducted with Staff AA. Certified Nursing Assistant, CNA. Staff AA said she has taken care of Resident #127 for a week. Staff AA said Resident #127 is a two person assist with the mechanical lift. She said she has not assisted Resident #127 out the bed. Staff AA said she only gets residents up whenever they ask her to get up.On 08/27/2025 at 10: 41a.m., an interview was conducted with the Director of Nursing (DON). The DON said every resident should be offered to get out the bed. It is not acceptable for staff to say they are not getting their residents up because the residents did not ask them to.Review of the Certified Nursing Assistant (CNA) Job Description, dated 07/1/2019, revealed Summary of position: Under the supervision and guidance of a licensed nurse Registered Nurse or License Practical Nurse (RN/ LPN), well as other work on the unit which supports the patient environment. The CNA assists staff to ensure optimal patient care and assists the healthcare team to provide and maintain a clean, safe, and attractive environment for patients. Work will include components of direct patient care, nutrition, observation, documentation, transportation of patients and supplies, hygiene and general maintenance of the residents/ patient's environment.Essential Duties and Responsibilities (To be completed without harming or injuring the resident/patient, co-worker, self, or others):Assists with lifting, turning, moving, positioning, and transporting residents/patients into and out of beds, chairs, bathtubs, wheelchairs, lefts, etc.Transfer residents/ patient safety. Some examples are, but not limited to: Bed to a wheelchair or wheelchair to bed.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on observations, interviews, and facility policy review, the facility failed to provide activities on three out of four days observed.Findings included:On 08/24/2025 at10:30 a.m., and 1:30 p.m., an observation was made revealing no activities were conducted throughout the day as scheduled.On 08/25/2025 at 9:30 a.m., 10:30 a.m., 11:15 a.m., 1:40 p.m. and 3:30 p.m., observations were made revealing no activities were conducted throughout the day as scheduled.Review of an Activity Calendar for the month of August of 2025, revealed on 8/24/2025 activities were scheduled at 10:30 a.m. for Pokeno 2, 1:30p.m. Blackjack, and 3:30 p. m. [Church]. On 8/25/25 activities were scheduled at 9:30 a.m. Room Visits 1,2 10:30 a.m. Movement and Music. 11:15 a.m. Sing a Long. 1:45 p.m. Bingo 1. 3:30 p.m. Movie Monday. On 08/26/2025 at 9:30a.m. Room Visits 1,2 10:30 a.m. Trivia, 1:45 p.m. [Church], 2:30 p.m. Blackjack 2, and 4:00 p.m. Game Time.On 08/27/2025 at 10:41 a.m., an interview was conducted with the Director of Nurses (DON). The DON said activities were not conducted because the Activity Director has been out since last Friday. She said the person they had assigned to cover activities had called out and there was no one to conduct activities.On 08/27/2025 at 4:00 p.m., an interview was conducted with the Nursing Home Administrator (NHA). The NHA said when the Activity Director is out there should be someone covering activities for the residents. If staff were aware the person assigned to activities had called off, then there should have been someone pulled to conduct activities for the residents.Review of the facility policy titled, Activities Overview Effective Date October 2021, revealed policy: Activities Department employees will provide activities that include sensitivity and an understanding of each individual resident's needs and requirements including medical, emotional, spiritual, therapeutic, and recreational needs, The Activity Programs will reflects individual needs and provide/promote the following: Activity will be provided at a frequency to meet the individual needs of the residents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews the facility failed to assess and obtain podiatry services for one (#114) of one resident sampled for foot care and podiatry needs. Findings included: On 8/26/25 at 12:21 p.m. , Resident #114 was observed lying in bed. The resident reported wanting to keep fingernails long however needs a podiatrist to cut toenails.On 8/26/25 at 12:35 p.m. an observation was conducted with Staff K, Licensed Practical Nurse (LPN) of Resident #114s toenails on both feet. The toenails were malformed lifting up from nailbed, thickened grayish brown in color, and extending past the tip of toes.An interview was conducted on 8/26/25 at 12:38 p.m. with Staff K. The staff member placed the resident's name in the Social Service folder and stated the resident was on the list for Social Worker to put on the podiatry list. Staff K stated the aides see resident daily and the issue with Resident #114s toenails was not brought to the staff members attention.Review of Resident #114s admission Record showed the resident was admitted on [DATE] and readmitted on [DATE]. The record included diagnoses not limited to chronic respiratory failure unspecified whether with hypoxia or hypercapnia, end stage renal disease, and dependence on renal dialysis. Review of Resident #114s physician orders showed an order dated 5/19/25 to allow for Opthalmic, Auditory, Psychological, Psychiatric, Dental, Physiatry, and Podiatry services as needed. Review of Resident #114s comprehensive assessment, dated 5/25/25 revealed a Brief Interview of Mental Status (BIMS) score of 15 of 15, indicating an intact cognition.Review of Resident #114s Certified Nursing Assistant (CNA) documentation showed the resident received nail care as needed (PRN), which did not differentiate between fingernails or toenails, as needed on 10 of twenty-seven opportunities.Review of Resident #114s care plan revealed the resident had the preference/choice of refusing recommended supplements at times. The preference/choice focus did not show the resident had refused nail care and/or podiatry care. The care plan had an Activity of Daily Living self-care performance deficit and interventions showed the resident required personal hygiene with one assist.An interview was conducted on 8/27/25 at 11:27 a.m. with the Nursing Home Administrator (NHA). The NHA stated nursing was to put in a referral for the ancillary services and did not know how often podiatry comes on a monthly basis. The NHA stated the expectation is if nursing saw an issue with a resident's feet they would notify the Social Worker of need to see the podiatrist and had heard the Social Worker ask during clinical meetings if anyone needed to see ancillary services.An interview was conducted on 8/27/25 at 1:38 p.m. with the Director of Nursing (DON). The DON stated aides and nurses would document in the Plan of Care (POC) and it would alert nursing management team to notify Social Services who is the one to put on the list to see podiatry. The podiatrist comes in monthly. The DON stated aides are supposed to let nurses know if there was an issue with toenails so nurses can assess and allow for nursing management know of an issue. The DON reported not remembering if podiatry had been at the facility the month of August.Review of Care Plan - Interdisciplinary Plan of Care from Interim to Meeting, effective February 2024, revealed The facility shall support that each resident must receive, and the facility must provide the necessary care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews the facility failed to initiate care plan interventions related to the placement and functioning of an electronic wander device for one (#97) of one resident sampled and to ensure staff followed protocol when a door alarm system alerted of an issue. Findings included: On 8/24/25 at 12:35 p.m. Resident #97 was observed in a room near the end of the 100 high hallway. The resident was very pleasant and able to answer questions appropriately. On 8/24/25 at 1:55 p.m. an alarm for the exterior double doors at the end of the 100 high hall was beeping. Staff N, Certified Nursing Assistant (CNA) was observed passing ice to two residents on the hallway, then the staff member went to the end of the hallway and shut off the alarm (keypad). The staff member did not look outside of the door. On 8/25/25 at 11:34 a.m. the alarm for the exterior double doors at the end of the 100-high hall was alarming. Resident #97 was observed lying in bed. On 8/26/25 at 12:01 p.m. Staff K, Licensed Practical Nurse (LPN) was observed shutting off the door alarm to the exterior double doors at the 100 high hall without checking the door. On 8/26/25 at 12:03 p.m. Resident #97 was observed in room, wearing short non-slip socks. The resident was not wearing an elopement bracelet on either wrist and did not appear to be wearing one on either ankle. The resident stated the bracelet was to big and having small wrists. An interview was conducted on 12:09 p.m. Staff K stated Resident #97's elopement bracelet should be on the resident's left ankle as most of the time it's on the left. On 8/26/25 at 12:11 p.m. an observation was conducted with Resident #97. The resident pulled both socks to the heel and no elopement bracelet was observed on either. An interview was conducted on 8/26/25 at 12:13 p.m. with Staff L, CNA. The assigned staff member stated Resident #97 does not leave room except with therapy and does not have an elopement bracelet. The resident has a wheelchair but barely used it except with therapy. Staff L reported the resident empties catheter bag by self and takes self to the bathroom. Staff K was observed in the hallway on 8/26/25 at 12:17 p.m. and stated it looked like the resident had taken the bracelet off. The staff member reported at 12:24 p.m. to finding the transmitter in Resident #97s sheets and stated (pronoun) took it off clean. Review of Resident #97s admission Record showed the resident was admitted on [DATE] and included diagnoses not limited to Unspecified dementia unspecified severity without behavioral disturbance, psychotic disturbance mood disturbance, and anxiety and other lack of coordination. Review of the CNA bedside tasks revealed Resident #97 was independent with bed mobility and was ambulatory with walker and wheelchair requiring supervision. The monitoring portion of the tasks did not include the monitoring for elopement. Review of Resident #97s care plan showed the resident was at risk for elopement, initiated on 8/4/25 and revised on 8/24/25. The goal showed the resident would not exit the facility without staff knowledge or appropriate supervision, initiated on 8/4/25 and on 8/24/25. The interventions included:- Apply electronic wander bracelet (check function after placed), initiated on 8/4/25 for Registered Nurse/Licensed Practical Nurse (RN/LPN), Unit Manager (UM) and Director of Nursing (DON).- Apply electronic wander bracelet due to elopement risk, initiated on 8/4/25 for RN/LPN.- Communicate to staff regarding resident elopement risk, initiated 8/4/25.- Verify the location of the electronic wander bracelet during routine care, initiated 8/4/25 for the RN, LPN, and CNA. Review of Resident #97s Treatment Administration Record (TAR) revealed the following:- Dated 8/24/25 for Electronic Wander Bracelet: check function with the transponder daily on night shift. Replace electronic wander bracelet if not working correctly every night shift.- Dated 8/24/25 at 1:04 p.m. for Electronic Wander Bracelet: check placement daily every shift. The order was discontinued on 8/26/25 at 12:25 p.m. and showed the placement was not checked on the day shift of 8/25/25. The order did not reveal the location of the wander bracelet.- Dated 8/26/25 at 12:25 p.m. for Electronic Wander Bracelet: check placement to left ankle daily every shift. An interview was conducted on 8/27/25 at 1:54 p.m. with the DON. The DON stated Resident #97 had dementia and able to be mobile so was considered an elopement risk. The DON reported never seeing the resident out of bed and should do another (elopement) assessment. She reported when a door alarm sounded staff should be going to the door to ensure a resident had not gone out the door, go outside and check grounds, and do a facility sweep. Staff should be making sure nobody went out the door. Review of the policy, Elopement - Facility Practices, dated October 2021, revealed The facility team will assess the environment to identify potential risk associated with the elopement. Facility interventions will be developed and implemented to reduce the risk of elopement and/ or hazards associated with the elopement.1. Assess the security of potential internal environmental risk factors including, but not limited to the following:-

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to maintain acceptable parameters of nutritional status, such as body weight for two (Resident #3 and #28) of three residents sampled. Review of Resident #28s admission Record revealed the resident was admitted on [DATE] and included diagnoses not limited to Muscle Wasting and Atrophy not elsewhere classified multiple sites, Iron Deficiency Anemia, Oropharyngeal Phase Dysphagia, Type 2 Diabetes Mellitus, and Depression. Review of Resident #28s weight summary showed on 4/3/25 the resident weighed 233.6# via mechanical lift, on 5/14/25 the resident weighed 224# via mechanical lift, a weight loss of 9.6#s and weight loss of 4.11%, and on 8/12/25 the resident weighed 198.2# via mechanical lift, a total weight loss of 35.4# and a total weight loss of 15.15% since admission. Review of Resident #28s Weight Change Note created on 8/18/25 by the Dietitian showed the resident triggered for significant weight loss. “Weight loss not new. Weight loss related to fluid shifts with lymphedema and diuretic treatment (Tx). No new recommendations at this time. Continue current plan of care. Will monitor and follow accordingly.” Review of Resident #28s Care Plan showed the resident is at nutritional risk related to recent hospitalization, IVFs in hospital, Advanced age, High BMI, Therapeutic diet, requires assistance with all ADL's, predicted sub-optimal oral (PO) intake, Psychotropic medications, Diuretic Tx (may affect weight/electrolytes), BLE edema, weight loss is anticipated as edema resolves, dependent on oxygen (O2), altered labs, and impaired skin integrity. The focus was initiated on 04/04/25. The goal was to maintain nutritional intake and initiated on 4/4/25. The interventions, initiated on 4/10/25, were monitor weight changes, diet as ordered, fluids as ordered, Registered Dietitian consult & follow as needed (PRN), supplements as ordered, report results to Medical Doctor (MD) and follow up as indicated, Observe/document as indicated: Meal Consumption, Amount assistance needed with meal, tolerance to diet/fluids, and Notify/Report to physician as needed. The interventions did not show any intervention was added after the resident’s significant weight loss was discovered. Review of Resident #28s Physician Order Summary Report showed an order written on 4/3/25 allowing to Delegate to dietitian the responsibility to alter, change, or modify dietary orders including oral supplements, measurement of height and weight, modification to or addition of diet restrictions/therapeutics, downgrade of diet consistency in consultation with SLP when needed, enteral feeding and water flushes. The order report showed Resident #28 was to receive a house diet of House diet, Regular texture, Regular (Thin) consistency for Diet. The order report showed Resident #28 may not have dietary liberties on special occasions. The Order Summary Report did not include the dietician’s recommendation for weekly weights. On 8/24/25 at 12:00 P.M. Resident #28 was observed laying in bed with eyes opened, and her bilateral lower extremities were red and appeared puffy. During an interview on 8/24/25 at 12:00 P.M. with Resident #28, she stated she has lost 40 pounds since she was admitted . She said, “I don’t eat the food, it’s gross.” She said when she asks for something different, the staff tell her no. She said she is not offered snacks. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/26/25 at 4:35 P.M with Staff D, she stated she could not answer questions because she was the Regional Dietitian. She said a new dietitian was hired and she started training today, 8/26/25. She said the Dietitian’s last day was yesterday. During an interview on 8/27/25 at 3:00 P.M. with the DON, she stated the dietitian looks at the weights and then decides the appropriate supplement. She said she doesn’t see any supplements for this resident. She said the dietitian will put the orders in for whatever supplement is needed to promote a stable weight. She said she didn’t know the resident had significant weight loss. She said the resident is on two diuretics. On 8/24/25 at 12:25 p.m. Resident #3 was observed lying in bed, with eyes closed and rhythmically breathing. On 8/26/25 at 12:26 p.m. Resident #3 reported losing weight, does not like the pureed diet and it’s the same thing every day. The resident reported having the one top denture (no bottom) and could not eat the food. Review of Resident #3s admission Record revealed the resident was admitted on [DATE] and included diagnoses not limited to Muscle wasting and atrophy not elsewhere classified multiple sites, (generalized) muscle weakness, oropharyngeal phase dysphasia, and gastro-esophageal reflux disease without esophagitis. Review of Resident #3s Weight Summary showed on 7/4/25 the resident weighed 158.8 pounds (#) via mechanical lift, on 7/10/25 (6 days later) the resident weighed 152.1# via mechanical lift (a weight loss of 6. 7#s, loss of 4.22%), and on 8/8/25 the resident weighed 145.6# via mechanical lift (a weight loss of 13. 2#’s), a loss of 8.31% in 32 days. The summary did not include any further weights for the resident. Review of Resident #3s Nutrition Evaluation assessment dated [DATE] showed the resident was receiving a pureed diet with nectar-thick liquids and ate 0-100% of the meals. The evaluation showed the resident was slightly overweight for height with a Body Mass Index of 24.5, was noted with a weight loss of 4.2% in 7 days and was not meeting estimated needs. The note revealed the dietician would follow up quarterly. Review of Resident #3s Nutritional Risk Evaluation Monthly dated 8/11/25 showed the resident had triggered for significant weight loss (145.6#), was receiving a pureed house diet with mildly thick liquids with no supplements/nourishments. The evaluation showed the resident’s intake was 26-75% of estimated needs and there was a greater than/equal (>=) 5% weight loss in 1 month, >= 7.5% in 3 months or >=10% in 6 months. The resident was not receiving enteral feeding and estimated 2000-2300 kilocalories per day, with the current intake did not meet the estimated needs. The documented goals and interventions showed the resident on a antidepressant which may increase appetite, recommended adding liquid nutritional supplement of 120 milliliters (mL) twice daily for an additional 510 kcal/day and 20 grams of protein/day, and weekly weights. The note showed the resident was discussed with the Interdisciplinary Team (IDT) and the dietician would monitor and follow accordingly. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3s Situation, Background, Appearance, and Review (SBAR), dated 8/13/25 by the Director of Nursing (DON) showed the resident’s weight loss started on 8/11/25 and it was unknown if the condition, symptom, or sign had occurred before. The weight was noted as 145.6# on 8/8 and the last weight prior was on 7/10/25 of 152.1#. The evaluation revealed no change was observed in the mental or functional status of the resident. The primary care clinician (unnamed) was notified on 8/13/25 at 12:00 p.m. with a recommendation of “supplement bolus feedings”. The nursing note did not include any further information. Review of Resident #3s Care Plan showed the resident was at nutritional risk related to recent hospitalization, advanced age, recent loss of spouse, high BMI, therapeutic & mechanically altered diet/fluids, require assistance with all Activities of Daily Living (ADLs), predicted sub-optimal oral (po) intake, dependent on supplemental oxygen (O2), psychotropics, antibiotics (abt), altered labs, impaired skin integrity, and diagnosis/history: urinary tract infection (UTI), atrophy, dysphagia, Coronary Artery Disease (CAD), hypertension (HTN), hyperlipidemia (HLD), hypothyroidism, insomnia, bipolar depression, atrial fibrillation (a-fib), and post-traumatic stress disorder (PTSD), weight – history of (h/o) weight loss. The focus was initiated on 7/4/25 and revised on 8/11/25. The goal was to maintain nutritional intake and included an intervention to monitor weight changes. The interventions did not show any intervention was added after the resident’s significant weight loss was discovered. Review of Resident #3s Physician Order Summary Report showed an order written on 7/4/25 allowing to Delegate to dietitian the responsibility to alter, change, or modify dietary orders including oral supplements, measurement of height and weight, modification 2 or addition of diet restrictions/ therapeutics, downgrade of diet consistency in consultation with SLP when needed, enteral feeding and water flushes. The orders showed the resident was to receive a house diet of Pureed PU 4 (pureed/extremely thick) texture, nectar/mildly thick (MT2) consistency. The report included an order dated 8/11/25 to start on 8/12/25 for 120 mL’s of liquid nutritional supplement to be administered orally (po) twice daily (BID). The report showed the resident was also to receive the following supplements: 22.5 milligram (mg) of the antidepressant, Mirtazapine (active as of 7/9/25), 25 microgram (mcg) of cholecalciferol (Vitamin D) for vitamin deficiency (active as of 7/4/25), and 325 mg Ferrous Sulfate for iron deficiency (active as of 7/4/25). The Order Summary Report did not include the dietician’s recommendation for weekly weights. Review of Resident #3s Speech Therapy notes showed Speech/Language Pathologists (SLP) had been working with the resident. A note on 7/15/25 showed Staff J, SLP saw the resident to encourage oral intake and assess tolerance of puree diet and direct thin liquid trials. A SLP note on 7/17/25 showed the resident had complained about puree texture but had informed the SLP of being unable to get soft bite-sized foods down. A trial was conducted with soft/mashable snack which the resident reported a preference. The SLP educated the resident on limitations to various types of food. Review of SLP notes showed the resident was seen by this therapy on 7/23, 7/25, 8/6, 8/11, 8/12, 8/15, 8/19, 8/20, 8/22, 8/25, and 8/26/25. The notes did not reveal the SLPs were aware of the resident’s weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 8/27/25 at 10:03 a.m. with Staff J. The staff member reported seeing Resident #3 for dysphagia, the resident did not like the puree diet and was trialing soft/bite size solids. Staff J reported being unaware of the resident’s weight loss. Staff J stated typically would know if there was weight loss, the dietician would prescribe supplements to increase caloric values and sometimes would let the staff member know about weight loss. The staff member stated would have expected collaboration regarding where the resident was in the process, interdisciplinary collaboration is crucial. An interview was conducted on 8/26/25 at 4:35 p.m. with the Director of Nursing (DON). The DON stated the Regional Dietitian was not allowed to answer questions. During an interview on 8/27/25 at 1:47 p.m. the Director of Nursing (DON) stated psychiatry had reported Resident #3 was really depressed and started on a supplement, 120 mL’s of liquid nutritional supplement twice daily. The DON stated the expectation was a collaboration between the dietitian and speech therapy (SLP). The DON stated the facility does weekly weights on the resident, then reviewed the orders and reported not seeing an order for the weekly weights. The nursing director reported the dietitian would have put the order for weekly weights in, didn’t see weekly weights just monthly weights. The DON reported the Director of Rehab (DoR) was included in clinical meetings and she had informed the director of Resident #3s weight loss and would have expected the DoR to inform SLP of the weight loss. Review of the policy – Weight Management, effective February 2025, showed, Weights are completed on admission and readmission, then weekly for four (4) weeks, then monthly unless physician orders more frequently. Residents with weight loss of 5% in 30 days, 7.5% in three (3) months, and 10% and six (6) months require physician notification, and resident/ resident representative notification. Speech therapy (ST) and/ or occupational therapy (OT) are notified as needed. Documentation of notification(s) is documented in the progress notes. The care plan and Kardex are updated with interventions. Weight loss is reviewed in Standards of Care (SOC) with the Interdisciplinary team (IDT). The SOC, areas assessed and discussed may include, but may not be limited to pain management, psychotropic use, depression, dental or oral concerns, nausea, vomiting, diarrhea, Constipation, food dislikes and dislikes, in a deadline in the ability to feed self, chew or swallow. If a resident with weight loss chooses not to take a supplement, try other nutrition interventions such as use of fortified foods or snacks. Registered Dietitian provides recommendations directly to the Director of Nursing. DON assigns follow up to Unit Managers on the next business days. Follow up response is turned into DON with verification of completion.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observations, record reviews, and interviews the facility failed to ensure the intravenous catheter dressing for one (#97) of one resident sampled for catheter dressing was changed per professional standards and per facility expectation. Findings included:On 8/24/25 at 12:40 p.m. Resident #97 was observed lying in bed. The observation showed the resident had a single lumen peripherally inserted central catheter (PICC) inserted into the right upper arm. The area under the clear inclusive dressing showed a dark dry-looking substance and a red wet-looking substance. The dressing was dated 8/19. On 8/27/25 at 9:09 a. m. Resident #97s PICC line dressing was observed, the dressing continued to be soiled and dated 8/19. Review of Resident #97s physician orders, active as of 8/27/25 at 3:24 p.m. showed orders dated 8/15/25 instructing to Change Intravenous (IV) dressing every 7 days as well as as needed (PRN) for soiling and /or dislodgement as needed and Change IV dressing every 7 days as well as PRN for soiling and/or dislodgement every evening shift every 7 day(s). Review of Resident #97s August 2025 Medication Administration Record (MAR) showed nursing staff had changed the dressing on the evening shift of 8/16 and 8/23/25. The MAR showed staff had not changed the dressing as needed for soiling and/or dislodgement. During an interview on 8/27/25 at 1:54 p.m. the Director of Nursing (DON) reported Resident #97s MAR showed the dressing was changed on 8/23 and it should not have been documented as done if it wasn't done. An observation was conducted on 8/27/25 at 2:11 p.m. the DON and the Regional Nurse Consultant (RNC) of Resident #97s PICC line dressing. The resident was pleasant and accommodating allowing for the observation. The DON confirmed the date of 8/19 on the dressing, not 8/23 and stated the dressing should be changed every 7 days and it should have been changed. The DON informed the resident she would be in to change it. Review of the policy - Infection Prevention Measures, dated 10/24, revealed the purpose was to Apply infection prevention principles to reduce the risk of infusion-related infections. The policy revealed Infection prevention measures are implemented for all infusion therapy procedures to prevent infusion and vascular access device related infections. Transparent, semi-permeable membrane (TSM) dressings are changed a minimum of every 7 days and PRN whenever the dressing integrity becomes disrupted, becomes wet, loose, or soiled or if skin integrity is compromised under the dressing.

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Community Convalescent Center	2202 W Oak Ave Plant City, FL 33563

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, record review and interviews the facility failed to post the Daily Nursing Staffing form appropriately.Findings Included: During an observation on 08/24/2025 at 9:00 a.m., the Daily Nursing Staffing form was located on the wall near the reception area. The date on the form was 08/21/2025. (Photographic Evidence Obtained)During multiple observations from 08/24/2025 thru 08/27/2025 revealed the Daily Nursing Staffing form was not posted on the 2nd floor. During an interview on 08/27/2025 at 12:30 p.m., Staffing Coordinator stated the daily nursing staffing form is only posted at the entrance. The supervisor is responsible for updating and posting the form on the weekends.During an Interview on 08/27/2025 at 2:06 p.m., the Nursing Home Administrator (NHA) stated the daily nursing staffing form is only posted up front. Nurse management or staffing is responsible for posting the form. The nursing staffing form should be posted each day. The facility did not have a policy related to this cite.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, and interview the facility failed to ensure the medication error rate was less that 5.00%. Thirty medication administration opportunities were observed and two errors were identified for one (#17) of five residents observed. These errors constituted a 6.67% medication error rate.Findings included: On 8/26/25 at 9:13 a.m., an observation of medication administration with Staff Member I, Licensed Practical Nurse (LPN), was conducted with Resident #17. The staff member dispensed the following medications:- Amolodipine 5 milligram (mg) oral tablet- Buspirone 5 mg oral tablet- Famotidine 10 mg over the counter (otc) tablet - 2 tablets- Ferrous sulfate 325 mg otc tablet- Polyethylene glycol 3350 1 capful powder- Potassium chloride Extended Release (ER) 20 milliequivalents (meq)- Senna 8.6 mg otc tablet- Sodium Chloride 1 gm, 15.4 grain otc tabletThe staff member reported having to see about changing the resident's lactobacillus tablet to the house probiotic and change the docusate from capsule to tablet. The staff member confirmed dispensing 9 medications. Staff I received order from provider (who was in the facility) to change docusate from capsule to tablet and lactobacillus to saccharomyces. The staff member changed the orders in the electronic medication profile and administered the 9 medications to the resident. On 8/26/25 at 9:36 a.m. Staff I electronically signed the medications had been administered. Review of Resident #17s August 2025 Medication Administration Record (MAR) showed an order dated 8/13/25 and discontinued on 8/26/25 at 9:33 a.m. for Docusate Sodium Oral Capsule - Give one tablet by mouth every 12 hours for constipation. The MAR showed Staff I had documented 9 other/see nurse's notes. An order for Docusate Sodium Oral tablet 100 mg - Give 1 tablet by mouth every 12 hours for constipation was ordered on 8/26/25 at 9:32 a.m and scheduled to begin at 9 p.m. on 8/26/25. The order for Resident #17s Floranex (Lactobacillus) was ordered on 8/13/25 for two times a day (9 a.m. and 5 p.m.) for probiotic and showed the medication was a otc medication provided by the facility and pharmacy was not to send. The order was discontinued on 8/26/25 at 9:30 a.m. and Staff I had documented 9. An order was written on 8/26/25 at 9:30 a.m. for Saccharomyces boulardii - one capsule by mouth two times a day for gastrointestinal (GI) upset. The order was scheduled to begin on 8/26 at 5:00 p.m. An interview was conducted on 8/27/25 at 8:31 a.m. with the Director of Nursing (DON). The observation of Resident #17s medication administration was reviewed and the DON stated both medications should have been given after the orders were changed. Review of the policy - Medication Administration Orals, dated 11/17, revealed the policy was to administer oral medications in an organized, accurate, and safe manner. The procedure included the instructions for staff to:5. Review and confirm medication orders for each individual resident on the medication administration record PRIOR to administering medication.6. Perform hand hygiene.7. Pour the correct number of tablets or capsules into the medication cup, taking care to avoid touching any medication unless wearing gloves.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observations, interviews and record review the facility failed to ensure sufficient kitchen staff for four out of eight days reviewed.Findings Included:During an observation on 08/24/2025 at 9:23 a.m., three staff members Staff P, Cook, Staff Q, Certified Nursing Assistant (CNA) and Staff R, Dietary Aide were observed in the kitchen area.Review of the punch detail report for dietary staff for 07/24/2025 thru 08/25/2025 revealed:08/24/2025 one cook and one dietary aide clocked in for the morning shift.08/22/2025 one cook and one dietary aide clocked in for the afternoon shift.08/18/2025 one cook and one dietary aide clocked in for the afternoon shift.08/17/2025 one cook and one dietary aide clocked in for the afternoon shift. Review of Staff Q, CNA and Staff N, CNA punch detail report dated 07/24/2025 thru 08/25/2025 revealed, Staff Q, CNA worked as a dietary aide 4.25 hours and Staff N, CNA worked as a dietary aide 16.00 hours. During an interview on 08/24/2025 at 11:09 a.m. Staff P, Cook, stated I was the only person in the kitchen this morning. This is normal when I work. People are scheduled off and they don't cover the position. Staff R, Dietary Aide just started and is in training. When we are short in the kitchen, they will send a CNA to help. I served breakfast on Styrofoam, and some residents got plastic ware because I did not have anyone to do the dishes. Breakfast was served late this morning because I did not have help in the kitchen.During an interview on 08/24/2025 at 1:59 p.m., Staff N, CNA stated she was called in to work at 10:30 a.m. this morning. We always work short on the floor because kitchen staff call off and they take CNAs off the floor. When they pull me from the floor to work in the kitchen, they don't cover my assignment, and it causes residents to not get showers. If state was not here, they would not have called me in to fill in on the floor.During an interview on 08/25/2025 at 9:50 a.m., Staff S, Food Services Manager (Interim Certified Dietary Manager) stated she was not sure if the kitchen was fully staffed. She was asked to come and cover because the Dietary Manager is out. She would have to check with the Nursing Home Administrator to confirm how many staff the kitchen had and if it is fully staffed. She thinks they are interviewing for kitchen positions as well.During an interview on 08/27/2025 at 12:30 p.m., the Staffing Coordinator stated CNA's have had to fill in in the kitchen. But it's not frequent. If they need help in the kitchen, and if they let her know ahead of time and she will make sure there is staff to be able to help in the kitchen. They called her on Sunday 08/24/2025 and asked if the aides can go in the kitchen. Most of the time we have an overflow with aides on the weekends. If a CNA is moved from the floor to the kitchen the supervisor is responsible for adjusting the assignments on the floor. She is not responsible for the kitchen staff schedule; the Dietary Manager is the one who does that schedule and takes calls for call outs.During an interview on 8/27/2025 at 5:25 p.m., Staff Q, CNA stated she is asked to help in the kitchen a few times a month. I was most recently pulled from the floor to work in the kitchen on 8/21 and 08/24. When I cover in the kitchen no one covers my assignments on the floor. During an interview on 08/27/2025 at 2:45 p.m., the Nursing Home Administrator (NHA) stated on Sunday (08/24/2025) they had call outs in the kitchen, so they used a CNA from the floor to help in the kitchen. She stated when they have call outs in the kitchen the Dietary Manager is responsible for getting coverage or they should come in and cover the shift. CNA's are pulled from the floor to help in the kitchen. CNAs are not given any additional training when working in the kitchen because they are only helping with tray service. They already do tray service on the floor so they would not need any additional training. If kitchen staff are not coming into their shift this would cause a delay in meal services to residents.Review of the facility policy titled Staffing, dated August 2024 revealed.The projected staffing plans are reevaluated on an ongoing basis and response to changes in the facility, resident population, or other circumstances. Staffing is monitored on an ongoing basis through reviews conducted by the facility. The facility administrator and director of nursing should evaluate staffing on a daily basis. Ongoing Monitoring 1. Monitor open positions and call offs throughout the day and respond to staffing needs as needed. 2.Evaluate the adequacy and appropriateness of facility specific projected staffing plans throughout the day.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews and record review the facility failed to provide a clean and sanitary environment in the kitchen related to undated, unlabeled food items, properly disposing of food items, and following hand hygiene practices for staff. Findings Included: On 8/24/2025 at 9:21 a.m., an initial tour of the facility’s kitchen revealed Staff P, Cook, preparing breakfast plates, and Staff Q, Certified Nursing Assistant (CNA) plating trays. Food trays on a meal cart were observed with Styrofoam containers. A three compartment sink behind the cook side of the meal service line was observed with dirty pots and pans. On the sink was a bag of boiled eggs and bags of pancakes. Clean plate covers next to an open trashcan near the dish washing area. (photographic evidence obtained) On 8/24/25 at 9:24 a.m., an observation of Staff P, [NAME] doing multiple tasks in between plating breakfast without proper glove and hand hygiene being taken was made. On 8/24/25 at 9:25 a.m., an observation of the kitchen’s dishwashing temperature log had multiple dates missing: 8/2/25, 8/9/2025, 08/10/25, 8/16/25, 8/18/25. For the date on the dishwashing temperature log of 8/22/25 at 9:25 a.m., the breakfast and lunch temperature check was already filled out. On 8/24/25 at 9:28 a.m., an observation of the walk in fridge revealed, no temperature log. An observation of the Inside of the walk in fridge revealed 1 open gallon of milk, prepared fruit bowls with an open mouth hole as coverings, a food service tray with clear cups with red and yellow liquids, a silver dish with a clear plastic covering, a clear container with a blue lid, and a clear container with a green lid all undated and unlabeled. On the top of a gray metal rack there was a box of “Smoked Ham and Water Product”, an opened package of sliced ham wrapped in plastic wrap, underneath on the second shelf was a gray food service tray with clear cups with an orange liquid covered with slitted lids. On the same shelf a metal container with two cantaloupes were observed with white and gray bio growth. On another gray metal rack was a clear container with a white substance with black hand writing “made 04/18”, a white block wrapped in plastic wrap, a brown bag secured with rubber bands, a clear bag of lettuce, a box of cucumbers with several cucumbers showing soft, sunken spots, covered in fuzzy white and green bio growth, a box of tomatoes with several tomatoes showing soft, sunken spots covered in black and white bio growth, and three boxes of raw chicken in bags with “08/21” hand written on the box. (photographic evidence obtained) On 8/24/25 at 9:30 a.m., an observation of the walk-in freezer revealed the freezer door was frozen shut. The floor within the freezer had a thick slippery ice build-up. Many items in the walk-in freezer were observed opened, unlabeled and not dated, such as tater tots, pie crusts, and breakfast sausage patties. (photographic evidence obtained) On 08/24/2025 at 9:40 a.m., an observation of the dry storage area revealed an open white bag of tortilla chips, two open clear and blue bags of uncooked pasta, an open lidless liquid thickener carton, an open bottle of soy sauce all undated with no open date. On the floor of the dry storage room underneath a metal was a brown dried substance. (photographic evidence) (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 08/24/2025 at 11:40 a.m., an observation of the first floor nourishment room revealed on top of the fridge was a pink and white box of meal replacement shakes. Inside of the refrigerator several items were identified to be undated with no resident information. Items included a clear bottle with a red and yellow label, a clear jar with a purple lid, several gray and brown grocery bags with containers inside, a yellow bag with a clear container with the date “08/3/2025”, clear cups with a sticky brown substance, and an open clear container with a black label, and a white bag with a Styrofoam container with green and white bio growth on an unidentifiable item. An observation of the freezer revealed a clear cup with a white label, and a red and white candy wrapper. (photographic evidence obtained) On 08/24/2025 at 11:50 a.m., an observation of the second floor nourishment room revealed on top of the fridge a brown box with an open undated blue box. Inside the refrigerator was three unlabeled yogurts, an open clear bottle with a blue label, a yellow bag with a container inside, a can of soda with brown writing, an open undated carton of liquid thickener, and three clear zip lock bags with black writing “8/23” with a clear and white separating liquid. On 08/24/2025 at 3:50 p.m., an observation of Staff X, Dietary Aide revealed her cutting cucumbers. Behind her was a box of cucumbers with several cucumbers showing soft, sunken spots, covered in fuzzy white and green bio growth. On 08/25/2025 at 9:50 a.m., an observation of a brown box with coffee was observed on a metal shelf next to a red handled bucket with a clear liquid and a blue rag. On 08/26/2025 at 1:30 p.m., an observation of the dish machine area revealed a brown insect stuck to the wall. Underneath the dish machine on a metal wire rack there were food particles. An observation of the garbage disposal revealed black winged insects stuck to a hose. In the sink of the garbage disposal there was food particles. Black bio growth was observed on the wall and sink of the dish area. Underneath the clean side of the dish machine was an unpainted, peeling wall with a brown and black build up. Review of the facility’s Food Temperature logs for August revealed: On 08/02, 08/03, 08/05, 08/06, 08/07, 08/08, 08/11, 08/12, 08/13, 08/14, 08/19, 08/20, and 08/22 dinner temperatures were not recorded. On 08/01, 08/04, 08/09, 08/10, 08/15, 08/16, and 08/17 the food temperature logs were blank. There were no temperature logs for 08/18, 08/23 or 08/24. The facility was asked to provide four weeks of kitchen cleaning logs. This was not provided during the time of the survey. On 8/24/25 at 9:54 a.m., an interview with Staff P, [NAME] revealed the chicken stored in the walk-in fridge was pulled in preparation for todays lunch. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/24/25 at 1:20 p.m., Staff X, Dietary Aide, was on the prep line and was observed changing tasks during the tray prep line and performing no hand wash in between tasks. [NAME] line staff was observed scratching their head, and picking items up off of the floor, and proceeding to continue line prep duties without a glove change or hand wash. A bin of single-serve milk cartons was also viewed sitting on the prep line with no ice to keep them cool while lunch was being plated on trays. On 08/24/2025 at 4:00 p.m., Staff X, Dietary Aide, stated the cucumbers she was cutting did have bio growth on them and were soft to the touch. “I am cutting off the bad parts and washing them really well. Yes, I am going to serve them for dinner tonight.” On 08/24/2025 at 4:03 p.m., the Nursing Home Administrator stated she would have to look to see what the policy is for food storage and when food should be discarded. “We will call someone to go get new cucumbers and discard of those.” On 8/25/25 at 9:59 a.m., Staff W, Dietary Aide was observed doing a temperature check on the low-temperature dishwasher. Staff W, Dietary Aide took off her gloves after running the dishes and began to do a temperature check on the dishwasher without a hand-wash after completing a dish run-through. Staff S, Dietary Aide stated only dietary aids do the temperature dish check, and that new staff have not yet been educated on performing temperature checks on the dishwasher. On 8/26/25 at 11:25 a.m., Staff V, Cook, was observed performing the temperature check of foods and the tray prep line for lunch. During this observation is was noted that Staff V, [NAME] was performing multiple different tasks, i.e., cooking food on the stove and going back to plating food, performing temperature checks on foods in between plating lunch trays with no hand hygiene in-between. Staff P, [NAME] was also observed assisting in tray line and changing tasks with no hand hygiene being performed or gloves being worn. Staff S, Food Service Manager was observed performing tasks to assist Staff V, [NAME] with getting foods ready to be served without completing hand hygiene in-between every task. On 8/26/25 at 2:58 p.m., an interview with Staff V, [NAME] revealed that a in service education pertaining to the storing of food items was completed back in “May or June,” and a large focus was on labeling and dating food items as they come into the facility and are used. Staff V, [NAME] mentioned that if an item does not have a label it needs to be thrown away, and that if an item was dated back in April, it needs to be thrown out. Staff V, [NAME] revealed that if there is raw chicken stored in the walk-in fridge, it needs to be thrown out in three days. Staff V, [NAME] revealed that the kitchen has a daily, weekly, and monthly cleaning schedule. They used to do a deep cleaning once a month but is unsure what happened to do that. Staff V, [NAME] mentioned that hand hygiene needs to be performed after completing each task before moving on to the next task. Staff V, [NAME] explained that if a box of food is old or has bio growth on it the entire box should be discarded and not served. During an interview on 08/27/2025 at 10:43 a.m., Staff Y, CNA stated dietary is the one who is responsible for the fridge in the nourishment rooms. They have a temp log they keep but dietary is responsible for the fridge and cleaning it out. During an interview on 08/27/2025 at 10:54 a.m., Staff Z, CNA stated dietary is responsible for cleaning the nourishment rooms. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/27/25 at 2:45p.m., an interview was conducted with the Nursing Home Administrator, Regional Dietitian, Staff S, Food Service Manager, and Dietician revealed the NHA stated dishes are expected to be ran after every meal, all seven days of the week. Staff S, Food Service Manager explained it is the duty of the food service manager to do daily checks during morning walk-through of the dishwashing, fridge, freezer, and temperature logs to ensure that they are being completed on a daily and timely basis, and that all kitchen cleaning and temperature logs should be put into the file after they are completed. We were not able to locate any cleaning logs for the month of August. Dating and labeling expectations for open containers is all foods get a date and are labeled when they first come into the facility, and immediately after they are opened. This process goes for all items in the fridges, freezers, and dry storage areas, and if an item is not labeled it is to be discarded. Raw meat are to be pulled no more than 3 days before they are going to be prepared and put into the fridge either in their container or on a sheet pan. If there are contaminated or foods with bio growth in the fridges, freezers, or dry storage they are to be thrown away, not washed, skinned and served. Food items in the fridge or freezer are not to be near any raw meats, and should have coverings with no holes. All staff in the kitchen are to wash their hands prior to each shift, and in between each change of task. All staff are responsible for cleaning the nourishment rooms. Nourishment rooms should be gone through weekly to ensure they are clean and items are being discarded. A review of the facility’s safe handling, storage, and reheating of food from visitors or outside source-Policy & Procedure revealed that “Residents will be assisted in properly storing and safely consuming food items brought into the facility for residents by visitors.” . “When food items are intended for later consumption, the nursing staff will: 1. Ensure the food item(s) are in sealed container, stored in the nourishment room/pantry refrigerator label with the current date and name of the resident. 2. Food will be stored for up to 3 days and then discarded.” . “Temperatures will be logged” . “Food and Nutrition Services department is responsible for cleaning the refrigerator weekly. Nursing staff will check the refrigerator daily for temperature, expired food, and is responsible for cleaning up spills on an as needed basis.” A review of the facility’s Cleaning and Sanitizing Policy and Procedure revealed that “The facility promotes a safe, clean and sanitary environment for its employees, residents and visitors. The food and Nutrition Services team maintains clean and sanitary kitchen facilities. Walls, floors, ceiling, equipment, dishware and utensils are clean and/or sanitized and in good, working order.” . “The Food Service Manager will review the completed Food and Nutrition Services Master and Cleaning Schedule to ensure all kitchen equipment in the operation is included.” . “The Food and Service Manager or designee will inspect kitchen sanitation Daily, Weekly, and Monthly using the Kitchen Sanitization Checklist. ” . “The Food Service Manager will train new staff on proper cleaning techniques and appropriate cleaning agents to use.” . “Food and Nutrition Services staff will follow appropriate procedures for cleaning and sanitizing kitchen equipment.” . “Record dish machine temperatures and chemical saturation PPM three (3) times daily using the Dish machine Log to ensure dishes are clean and sanitized.” . “Ensure no cross contact occurs; change gloves and wash hands when working from dirty to clean.” . “Cover trashcans with a lid when not in use and when taking them to the dumpster.” A review of the facility’s Dish Machine Policy & Procedure indicated “To monitor dish machine temperatures and chemical saturation (parts per million [PPM]) for both high and low temperature machines at each meal prior to dishwashing to assure proper cleaning and sanitizing of dishes.” . “Record wash and rinse temperatures under appropriate meal and column initial.” (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility’s Hand Washing and Glove Use Policy & Procedure revealed “Hand washing is a vital role in infection control, reducing the surface microorganisms on our hands.” . “Hands must be washed prior to beginning work, after using the restroom, after smoking, when working with different food sources, following contact with unsanitary surfaces, and before wearing gloves. ” . “Gloves should be changed frequently, single use task.” . “Hands must be washed between changing gloves.” A review of the facility’s Storage Policy & Procedure revealed “To store food and dishware in a safe manner.” Dry Storage Procedure instructed to “Label products with delivery dates indicating the month and year of the product was received. Discard food by expiration or use by date.” . “Store baking ingredients and cereal in original containers or plastic containers with lids and label include the expiration or use by date.” . “Never store scoops in ingredient bins or ice machines. Always place in a separate container.” . “Pour contents of opened canned goods into plastic containers with label and date and place into refrigerator storage.” . “Dry goods may be placed in plastic bags and sealed or placed in plastic containers with label including expiration or use by date. ” Refrigerator Storage Procedure instructed to “Store raw meat away from vegetables and cooked foods. Raw and/or thawing meat must be stored on the bottom shelves of the unit to prevent dropping on other foods.” . “Label products with delivery date indicating month and year the product was received.” . “Discard refrigerated leftovers after 72 hours.” . “Cover all pre-dished items with plastic wrap or foil to prevent off-flavors, drying, and/or cross-contamination.” . “Label all prepared items with the product name, preparation date and use by date.” . “Record temperatures of all refrigeration units during each shift, every day using the Refrigerator Log. ” Freezer Storage Procedure states to “Label products with delivery date indicating month and year the product was received.” … “Label all prepared items with the product name, preparation date and use by date.” … “Record temperatures of all freezer units during each shift, every day using the Freezer Log.” A review of the facility’s Preparation Policy and Procedure revealed “To conserve nutritive value, enhance flavor, and prevent foodborne illness.” … “Wash hands properly and as often as needed. Note: Wash hands prior to putting on gloves and after taking off gloves.” … “Change gloves: With each new task.” … “Discard foods: Contaminated”

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	105029	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Convalescent Center	2202 W Oak Ave Plant City, FL 33563

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to update the facility-wide assessment to determine emergency plans, staff competencies needed for care of residents with different types of acuities and specific staffing needs for each shift.Findings Included: Review of the facility assessment dated [DATE] revealed there was not a section for emergency plans, staff competencies needed for care of residents with different types of acuities and specific staffing needs for each shift.During an interview on 08/27/2025 at 12:30 p.m., the Staffing Coordinator stated she staffs the facility daily to meet the needs of the residents based off of the daily census. She was unsure what the facility assessment was.During an Interview on 08/27/2025 at 2:06 p.m., the Nursing Home Administrator stated she just updated the facility assessment in July when she first got to the building so she would have a snapshot of the building. The facility assessment asses every aspect of the facility, residents, services, and list any employees and tracks their length of employment. It also includes any services we provide and how many residents need those services. You use the assessment to identify if there are any areas that need improvement. The facility did not provide a policy related to this cite.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews the facility failed to implement an effective Infection Control program related to ensuring meal carts were closed when unattended not offering residents hand hygiene prior to meals on one (100-high) of 4 hallways and two dining rooms observed, failed to remove red-stained towel from under one (#114) of one dialysis resident, failed to ensure sharps container was managed in a manner promoting safety, and failed to ensure one of one laundry room was clean. Findings included: An observation on 8/24/25 at 9:12 A.M. of a meal tray cart on the first floor was opened and contained multiple unused food trays. The food is contained in Styrofoam trays. An additional meal cart was observed at 9:15 A. M. on second floor was opened and contained multiple unused food trays. The food to be served to the residents are contained in foam take out trays. A tour of the Laundry Room on 8/27/25 at 1:00 P.M. revealed a personal cell phone on the table for folding linens. The wall air conditioning unit accordion panels behind the table for folding linens had dust and the unit was running. A floor fan facing toward the table for folding linens was resting on two black milk crates and on running high speed. There was dust wrapping the cage of the fan. In the room with 3 dryers, dryer number (#) 2 was not working and clothes were inside the dryer. The vents under dryer #1 and dryer #3 contained small balls of lint in the corners. The other room had 2 washers. The blue washer (#1) was running, while the other washer (#2) was not running. The front of the washer #2 contained three uncleanable porous foam tubes with crusty unknown substances on under the door of the washer. In front of washer #2 contained a folded wet and soiled blanket. There was a soiled folded blanket sitting on milk crate behind the washers next to drainage area. There was a rusty and uncleaned flap above the door on washer #2. The floor around both washers were dirty, unkept, and contained water stains. An interview with Staff E on 8/27/25 at 1:00 P.M. was conducted. He said the wall air conditioning unit accordion panels behind the table for folding linens are cleaned every week. He said the room where the staff folds the laundry is cleaned every morning. He said that dryer #2 is not working and maintenance has ordered the part. He said the front of the washer #2, the three uncleanable porous foam tubes has been there since before he started. He said he was unaware of the blanket behind the washers. He said the blanket in front of the washer was placed there because there is a leak under the floor of washer #2. An interview with Staff F on 8/27/25 at 1:05 P.M. was conducted. She said she cleans the floor fan facing toward the table for folding linens with a toothbrush to remove the dust. She said she is using dryer #2 as storage for clean clothes because her table where she folds clothes is full and she didn’t want to stop the dryer with the wet linens. An interview with Staff G on 8/27/25 at 1:19 P.M. was conducted. He said he started here on 7/8/25. He said he noticed the porous foam tubes on washer #2 after he started working here. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility policy titled, “Infection Prevention and Control Program” effective in October 2021, reads “The Infection Prevention and Control Program (IPCP) is comprehensive program that addresses detection, prevention and control of infections and communicable diseases among residents, visitors, volunteers, those individuals providing services under contractual agreement and personnel. The goals of the IPCP are to: a: Provision of a safe sanitary, and comfortable environment; b: Decrease the risk of infection and communicable diseases development and transmission to residents, volunteers, visitors, individuals providing services under a contractual arrangement and personnel; d: Identify and correct problems relating to infection control and prevention practices.” The major activities of the program are: a: Surveillance of infections and communicable diseases; b: Antibiotic Stewardship; c: Implementation of infection control and prevention measures; d: Prevention of Infection and Communicable Diseases. On 8/24/25 at 9:28 a.m. an observation was conducted on the 100-high hallway showing meal trays with foam food containers and utensils placed directly onto paper napkins. The observation showed staff leaving the cart open and unattended in the hallway outside of room [ROOM NUMBER] while other meal trays were delivered. On 8/24/25 at 2:17 p.m. an observation showed a wheeled cart with 3 shelves contained 4 meals brought to the 100-high hallway. The meal trays contained covered plates and cups while eating utensils were left open to the environment and unattended while staff passed the meal trays. On 8/24/25 at 11:23 a.m. Resident #114 was observed with a towel stained with bright red spots under the left upper arm. The resident stated the dialysis site had started bleeding the other day. The dressing on the resident’s left upper arm was white without staining. The resident reported dialysis time was on Monday, Wednesday, and Fridays. On 8/24/25 at 4:32 p.m. Resident #114 was observed with fingernails extending approximately ½ inch past fingertips. The fingernails appeared to be dirty with unknown substance. On 8/26/25 at 12:21 p.m. Resident #114 reported wanting to keep fingernails long and staff do not offer hand hygiene before meals. Review of Resident #114s comprehensive assessment, dated 5/25/25 revealed a Brief Interview of Mental Status (BIMS) score of 15 of 15, indicating an intact cognition. On 8/26/25 at 12:31 p.m. the meal cart for 100-high arrived on the hall, Staff L, Certified Nursing Assistant (CNA) was sitting behind the nursing station and at 12:32 p.m. Staff O, CNA came out of a resident’s room on the hallway. On 8/26/25 at 12:41 p.m. Staff K, Licensed Practical Nurse (LPN) began checking trays in the meal cart. On 8/26/25 at 12:44 p.m. Staff L, CNA was observed delivering a meal tray to a resident in room [ROOM NUMBER] without offering hand hygiene to the resident and Staff O delivered a tray to a resident in room [ROOM NUMBER] without offering hand hygiene. On 8/24/25 at 11:10 a.m., a sharps container attached to a treatment cart parked next to the nursing station on the first floor was overfilled with syringes. The observation showed syringes were sticking out of the container. The sharps container label read “Do not fill above this line”. The contents of the container was clearly above the line. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy - Hand Hygiene effective October 2021 did not address providing residents with hand hygiene. Photographic evidence was obtained.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on record reviews and interviews, the facility failed to implement its protocol for antibiotic use and failed to monitor actual antibiotic use. On review, the monitoring was not completed for four months. A review of the Antibiotic Stewardship Book on 8/27/25 at 1:40 P.M. revealed the antibiotic surveillance for August 2025 was missing. A review of May, June, and July 2025 revealed the surveillance forms are incomplete. The forms did not have the required information based on policy. The forms contained spaces for required documentation to be completed. The book did not contain mapping of infections throughout the building for months May 2025 through August 2025. An interview with the Director of Nursing (DON) on 8/27/25 at 2:25 P.M. was conducted. She said she is the facility's dedicated Infection Preventionist. She said the Antibiotic Stewardship Policy is reviewed annually. She said she uses McGeer's Criteria form and mapping for surveillance of infections. She could not locate a copy of the form. She said her expectation is that the nurse fills out the top form and she fills out the bottom portion. She said she hasn't educated the nurses on properly filling out the forms. She said she could not locate the surveillance documentation for August 2025. The DON said she always starts making the surveillance list at the end of the month, and then she documents on the facility map where each infection is located. She said she hasn't educated the staff on infection control. She said the interdisciplinary team reviews Antibiotic Stewardship in Quality Assurance meetings monthly but could not provide evidence of discussion for May, June, and July 2025. She could not locate a copy of the point prevalence rate for May, June, and July 2025. She said she doesn't allow physicians to write antibiotic orders prophylactically. A review of the facility's policy Antibiotic Stewardship - Tracking: Monitoring Antibiotic Prescribing, Use, and Resistance, effective in April 2017, revealed the procedure is Residents will have complete clinical assessment documentation at the time of the antibiotic prescription. Audits of antibiotic prescriptions for completeness of documentation, regardless of whether the antibiotic was initiated in the facility or a transferring facility. Antibiotic prescribing elements will be addressed for the presence: 1. Dose; 2. Route; 3: Duration; 4. Start Date; 5. End Date; 6: Planned days of therapy; 7. Indication. The policy revealed community acquired infection antibiotic prevalence data will be monitored and information presented during the monthly Quality Assurance and Performance Improvement Committee meeting, by the Infection Preventionist. The policy revealed by tracking antibiotic usage of those residents admitted into the facility, the total risk of individuals at risk for complications from antibiotic use can be followed. The policy revealed when providing point prevalence rates, the Infection Preventionist will obtain census information from the electronic documentation system and generate a midnight census report for the date in question. New antibiotic starts will be monitored by the Infection Preventionist as part of their surveillance activities.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record reviews and interviews, the facility failed to ensure residents were offered the Influenza vaccine annually and offered the Pneumococcal Vaccine for four (Resident #3, #88, #110, and #119) of five residents sampled. Review of Resident #3, #88, and #119 records showed the resident was not offered the Influenza Vaccine. Review of Resident #110 records showed the resident was offered the Influenza Vaccine and no documentation that indicated the resident received the Influenza Vaccine.Review of Resident #88 and #119 records showed the resident was not offered the Pneumococcal Vaccine. Review of Resident #3 records showed the resident was offered the Pneumococcal Vaccine and no documentation that indicated the resident received the Pneumococcal Vaccine.An interview with the Director of Nursing (DON) on 8/27/2025 at 2:25 P.M. was conducted. She said she is the facility's dedicated Infection Preventionist. She said she is waiting on a new code from Florida Shots. She said she hasn't checked any of the residents' immunization status. She said her expectation is the residents are offered Influenza, Pneumonia, and COVID vaccine every 5 years. She said she hasn't educated any residents at the facility, but there should be a form the staff completes when the education is provided. Review of the facilities policy titled, Immunizations - Pneumococcal, Influenza, and Other Recommended Vaccinations effective in December 2024, reads, Influenza vaccine will be administered by a licensed nurse who is following the facility's protocol to obtain an order on admission for the administration of an annual influenza vaccine injection. Immunization will be offered from October to March. The Infection Prevention Coordinator/DON will coordinate the Influenza and Pneumococcal immunizations. The facility will continue to offer vaccines to unvaccinated persons and newly admitted residents all throughout the Influenza season as recommended. The Procedure section of the policy reads, 2. Obtain consent for immunization or immunization declination on the Pneumococcal and Annual Influenza Vaccination Information and Request Form. The Influenza vaccination will be offered annually, and a new request form will be signed annually, and a new physician order will be obtained. 3. Obtain a physician order for all vaccines to include Influenza, COVID-19, or booster and the Pneumococcal (if indicated) immunization. 6. Document the administration of the vaccination in the electronic medical record.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Number of residents sampled: Number of residents cited: Based on record reviews and interviews, the facility failed to ensure residents were offered the COVID Vaccine for three (Resident #3, #88, and #119) of five residents sampled.Review of Resident #3 records showed the resident was not offered the COVID Vaccine. Review of Resident #88 and #119 records showed the resident was offered the COVID Vaccine and no documentation that indicated the resident received the COVID Vaccine.An interview with the Director of Nursing (DON) on 8/27/2025 at 2:25 P.M. was conducted. She said she is the facility's dedicated Infection Preventionist. She said she is waiting on a new code from Florida Shots. She said she hasn't checked any of the residents' immunization status. She said her expectation is the residents are offered Influenza, Pneumonia, and COVID vaccine every 5 years. She said she hasn't educated any residents at the facility, but there should be a form the staff completes when the education is provided.Review of the facilities policy titled, Immunizations - Pneumococcal, Influenza, and Other Recommended Vaccinations effective in December 2024, reads, Influenza vaccine will be administered by a licensed nurse who is following the facility's protocol to obtain an order on admission for the administration of an annual influenza vaccine injection. Immunization will be offered from October to March. The Infection Prevention Coordinator/DON will coordinate the Influenza and Pneumococcal immunizations. All residents, regardless of age and medical condition, will be offered the COVID-19 primary series vaccinations and all eligible and recommended boosters unless there is documented evidence of prior administration, documented medical contraindication, refusal, or no order. The Procedure section of the policy reads, 1. COVID-19 primary series and any boosters - Document dates and types in the immunization tab in the medical record. 2. Obtain consent for immunization or immunization declination on the Pneumococcal and Annual Influenza Vaccination Information and Request Form; and on the COVID-19 Vaccination or boosters on the vaccination consent or declination forms. 3. Obtain a physician order for all vaccines to include Influenza, COVID-19, or booster and the Pneumococcal (if indicated) immunization. 6. Document the administration of the vaccination in the electronic medical record.