STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105138	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jacksonville Rehabilitation and Nursing	5377 Moncrief Road Jacksonville, FL 32209

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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 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 observations, interviews, record review, and a review of facility in-service training, the facility failed to follow proper dish sanitation practices to prevent the outbreak of foodborne illness, with the potential to affect all residents receiving food from the facility's kitchen. The facility also failed to log proper temperatures for the dish machine. Sanitation is important in health care settings serving nursing home residents. The findings include:On 04/27/2026 at 9:50 AM, during an interview with Dietary Aide (DA) C, she was asked if she was the person responsible for cleaning the residents' dishes and operating the facility's low-temperature dishwasher. She replied yes. She was asked to demonstrate her process for cleaning the dishes. She ran the dishwasher. The temperature on the machine's temperature gauge did not change and remained at 120 degrees Fahrenheit. She did not test the sanitation level. She did not record the temperature or the sanitation level on the dishwasher log. She was asked to demonstrate her process again. She asked if she could get another employee to assist her. Dietary Director (DD) F ran the dishwasher. The temperature gauge remained at 120 degrees Fahrenheit. DD F tested the sanitation level in the machine. The testing strip did not change colors. DD F replaced the sanitation bucket connected to the dishwasher. DD F ran the dishwasher again. The temperature gauge remained at 120 degrees Fahrenheit. The facility moved to serving food on paper products.An observation of the kitchen's dish machine log for the months of November 2025, December 2025, January 2026, February 2026, March 2026, and April 2026 revealed a consistent temperature recording of 140 degrees Fahrenheit for the rinse and wash after breakfast, lunch and dinner. Dietary Aide (DA) C ran the dishwasher once and the temperature gauge remained at 120 degrees Fahrenheit. Dietary Director F ran the dishwasher twice and the temperature gauge remained at 120 degrees Fahrenheit. A review of dishwasher in-service training dated 04/27/2026, the date of the above mentioned observations, revealed:Aides must run the dishwasher twice before washing dishes. First run make sure that the temperature (temp) (120-140) is accurate and then prime the sanitizer for accurate ppm (parts per million) (50-100). Second run is to double check temp make sure temp is moving between (120-140). After checking the temp, get a test strip and test sanitizer. Sanitizer ppm must be between (50-100). If thermostat don't move from 120, use a thermometer to make sure the temp is correct. Please inform your supervisor if thermostat is not moving.The policy and procedure provided did not address the issue of concern. Furthermore, no other kitchen policy was supplied prior to the exit interview.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, and a review of the facility's policies and procedures, the facility failed to provide transfer/discharge notification to the Long-Term Care (LTC) Ombudsman's office prior to or as soon as was practicable for eight (Residents #12, #115, #92, #64, #31, #25, #23 and #18) of 12 residents reviewed for transfer/discharge. Appropriate notification of the LTC Ombudsman's office provides added protection for residents from being inappropriately transferred or discharged , provides residents with access to an advocate who can inform them of their options and rights, and ensures that the LTC Ombudsman's office is aware of facility practices and activities related to transfers and discharges. The findings include:On 04/29/2026 at 10:00 AM, the Director of Nursing (DON) provided a list of resident transfers/discharges for February 2026 and March 2026. On 04/29/2026 at 12:15 PM an email was received from the LTC Ombudsman's office confirming that there had been no Nursing Home Transfer/Discharge notifications from this facility in February 2026 or March 2026.1.A review of Resident #12's medical record revealed a re-entry from an acute-care setting on 11/29/2022 with diagnoses including dementia, psychotic disturbance, mood disturbance and anxiety. The resident was discharged from the facility on 03/24/2026. A review of the Minimum Date Set (MDS) Discharge Return Not Anticipated assessment with an Assessment Reference Date (ARD) of 03/24/2026 revealed a planned discharge.There was no evidence in the resident's EMR of a Nursing Home Transfer/Discharge Form (CMS Form 3120) or notification of the LTC Ombudsman's office. 2.A review of Resident #115's medical record revealed an admission date of 11/13/2025 with diagnoses including syncope and collapse. The resident transferred to an acute care hospital on [DATE]. There was no evidence in the resident's EMR of a Nursing Home Transfer/Discharge Form (CMS Form 3120) or notification of the LTC Ombudsman's office. 3.A review of Resident #92's medical record revealed an admission date of 09/24/2021, with a re-entry on 10/18/2024 and diagnoses including metabolic encephalopathy. The resident transferred to an acute care hospital on [DATE]. There was no evidence in the resident's EMR of a Nursing Home Transfer/Discharge Form (CMS Form 3120) or notification of the LTC Ombudsman's office. 4.A review of Resident #64's medical record revealed an admission date of 04/15/2025 with diagnoses including cerebral infarction (stroke). The resident had a planned discharge home on [DATE]. There was no evidence in the resident's EMR of a Nursing Home Transfer/Discharge Form (CMS Form 3120) or notification of the LTC Ombudsman's office. 5.A review of Resident #31's medical record revealed an admission date of 03/09/2026 with diagnoses including tinea unguium (fungal infection). The resident was transferred to an acute care hospital on [DATE]. There was no evidence in the resident's EMR of a Nursing Home Transfer/Discharge Form (CMS Form 3120) or notification of the LTC Ombudsman's office. 6.A review of Resident #25's medical record revealed an admission date of 03/18/2026 with diagnoses including acute cholecystitis (swelling and inflammation of the gallbladder). The resident was transferred to an acute care hospital on [DATE]. There was no evidence in the resident's EMR of a Nursing Home Transfer/Discharge Form (CMS Form 3120) or notification of the LTC Ombudsman's office. 7.A review of Resident #23's medical record revealed an admission date of 02/05/2026 with diagnoses including osteomyelitis (infection) of the lumbar vertebra. The resident had a planned discharge home on [DATE]. There was no evidence in the resident's EMR of a Nursing Home Transfer/Discharge Form (CMS Form 3120) or notification of the LTC Ombudsman's office. 8.A review of Resident #18's medical record revealed an admission date of 04/23/2025 with a re-entry on 10/21/2025 and diagnoses including muscle wasting and atrophy - multiple sites. The resident had an unplanned discharge to an acute care hospital on [DATE]. There was no evidence in the resident's EMR of a Nursing Home Transfer/Discharge Form (CMS Form 3120) or notification of the LTC Ombudsman's office. The facility's 03/16/2026 performance improvement plan regarding its discharge (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	planning process was offered for review. The facility identified inconsistencies in discharge coordination due to interdisciplinary communication gaps. Nothing in the plan addressed notification of the LTC Ombudsman's office of transfers/discharges. Audits conducted included whether the discharge summary was completed prior to discharge, whether the medication reconciliation was completed, whether discharge medications were provided with instructions, whether follow up appointments were arranged, and whether education was completed with the resident/family prior to discharge.On 04/30/2026 at 4:24 PM, an interview was conducted with the Administrator who confirmed that the facility lost their Social Services Director (SSD), and the task of notifying the LTC Ombudsman's office of transfers/discharges fell on nursing management. He also stated notification of the LTC Ombudsman's office was occurring monthly, typically by fax. On 04/30/2026 at 4:29 PM, an interview was conducted with Social Services Director (SSD) K, who had been working with the facility for about a week. He was asked if he was responsible for transfer/discharge notification of the LTC Ombudsman's office. He stated he was responsible for managing transfer/discharge notifications, ordering durable medical equipment (DME), completing transfer forms, completing discharge summaries, and notifying the receiving facilities of the residents' condition upon transfer/discharge. He stated the LTC Ombudsman's office should be notified every time the facility transferred or discharged a resident. On 04/30/2026 at 4:36 PM, an interview was conducted with the DON who confirmed that the responsibility of notifying the LTC Ombudsman's office had fallen onto the DON and the Administrator for the last 6-8 weeks while they did not have a Social Services Director in place. He confirmed that the facility had been forwarding a monthly log of transfers and discharges to the LTC Ombudsman's office via email at the end of every month for that month. A review of the facility's policy and procedure titled Discharges/Discharge Planning (effective date: 12/2008, revision date: 08/2023), revealed that it did not address notification of the LTC Ombudsman's office upon transfer or discharge of a resident.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observations, interviews, record review and a review of the facility's policies and procedures, the facility failed to provide a nourishing, palatable, and well-balanced diet that met the daily nutritional and special dietary needs of its residents, taking into consideration their preferences, by failing to adhere to therapeutic diet orders for a pescatarian diet and follow standardized recipes and portion control in accordance with professional standards for food service. These practices affected nine residents/resident meal trays (Residents #86, #24, #39, #75, #88, #61, #73, #28 and #81) observed during meal service on 4/27/26 and 4/30/26 and placed all residents receiving food from the facility's kitchen at nutritional risk, potentially impairing their ability to heal and/or contributing to a decline in their overall health status. The findings Include:1.On 04/27/2026 during the lunchtime dining observation on the 300 hallways between 11:30 AM and 1:00 PM, Resident #86's meal tray revealed two vegetable servings and one fruit serving. Her meal ticket identified her diet as No Added Salt (NAS), Mechanical Soft texture, dislikes chicken and pork; other: Pescatarian. Resident #86 reported that the meal components received were what the kitchen provided because she was a Pescatarian (someone who follows a vegetarian diet but adds fish and other seafood). (photographic evidence obtained)During a tour of the kitchen on 04/29/2026 at 10:56 AM, Resident #86's meal ticket identified her diet as No Added Salt (NAS), Mechanical Soft texture, dislikes chicken and pork; other: Pescatarian; Resident #86 was provided one vegetable and two starch servings. (photographic evidence obtained)On 04/30/2026 at 11:45 AM, another tour of the kitchen was conducted. The lunch menu on the tray line included drumettes/wingettes, French fries, green beans and a dessert. [NAME] E stated a serving of protein was four drumettes/wingettes.2.During tray line service on 04/30/2026 at 11:45 AM, Resident #24's meal ticket identified his diet as Consistent Carbohydrate Diet (CCD), NAS, large portions (one serving). Resident #24 was provided with one protein serving (4 drumettes/wingettes), one vegetable and one starch serving. 3. During tray line service on 04/30/2026 at 11:45 AM, Resident #39's meal ticket identified his diet as General Regular, large portions (one serving). Resident #39 was provided with one protein serving (4 drumettes/wingettes), one vegetable and one starch serving.4. During tray line service on 04/30/2026 at 11:45 AM, Resident #75's meal ticket identified his diet as Consistent Carbohydrate Diet (CCD), NAS, large portions (one serving). Resident #75 was provided with one protein serving (4 drumettes/wingettes), one vegetable and one starch serving. 5. During tray line service on 04/30/2026 at 11:45 AM, Resident #88's meal ticket identified his diet as General Regular, large portions (one serving). Resident #88 was provided with one protein serving (4 drumettes/wingettes), one vegetable and one starch serving. 6. During tray line service on 04/30/2026 at 11:45 AM, Resident #61's meal ticket identified his diet as General Regular, large portions (one serving). Resident #61 was provided with one protein serving (4 drumettes/wingettes), one vegetable and one starch serving. 7. During tray line service on 04/30/2026 at 11:45 AM, Resident #73's meal ticket identified his diet as General Regular, double portions (one serving). Resident #73 was provided with one protein serving (4 drumettes/wingettes), one vegetable and one starch serving.8. During tray line service on 04/30/2026 at 11:45 AM, Resident #28's meal ticket identified his diet as General Regular, double portions (one serving). Resident #28 was provided with one protein serving (4 drumettes/wingettes), one vegetable and one starch serving. (photographic evidence obtained)9. During tray line service on 04/30/2026 at 11:45 AM, Resident #81 was provided with an alternate meal(two sandwiches). No vegetables were provided. The resident's diet order was for a Regular, Mechanical Soft, Regular/Thin consistency, nutritional supplement three times a day, snacks three times a day.On 04/30/2026 at 2:03 PM, Dietary Aide (DA) C was asked to explain the process that occurred when the kitchen ran out of the vegetable that was listed on the menu. She replied, offer another vegetable. She was asked to explain what happened when the kitchen ran out of the protein that was listed on the menu. She replied, serve the alternate (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	protein or meat. DA C was asked how often the kitchen provided substitutes. She replied, just this week. She was not aware of whether or not substitutes were documented or tracked. She was asked what was considered a large portion. She replied, large starch, large vegetable. She was asked what was considered a double portion. She replied, double the meat, vegetable and starch.On 04/30/2026 at 2:18 PM, DA D was asked to explain the process that occurred when the kitchen ran out of the vegetable that was listed on the menu. She replied, they provide something else/another food item. She was asked to explain what happened when the kitchen ran out of the protein that was listed on the menu. She replied, it would be the same. She was asked how often the kitchen provided substitutes. She said she was not sure but stated it happens sometimes. DA D was asked what was considered a large portion. She replied, If macaroni is served, provide 2 scoops/servings of macaroni. She was asked what was considered a double portion. She replied, If a sandwich is served, provide two sandwiches.On 04/30/2026 at 2:30 PM, [NAME] E was asked to explain the process used to determine how much food should be prepared for each menu to ensure there was enough food available for all residents. She replied, I prepare using the census report and use different size spoons to measure the amount provided to residents. She was asked to explain the process that occurred when the kitchen ran out of the vegetables listed on the menu. She replied, provide an alternate vegetable. She was asked to explain what happened when the kitchen ran out of the protein that was listed on the menu. She replied, provide an alternate protein/meat. [NAME] E stated substitutions were not provided often. She was asked how substitutions were tracked. She stated substitutions were not tracked. If a resident did not want a particular food item, they served an alternate food item. [NAME] E was asked what was considered a large portion. She replied, double vegetable and double protein. She was asked what was considered a double portion. She replied, double meat.On 04/30/2026 at 2:47 PM, the Dietary Director confirmed that the [NAME] determined how much food to prepare by using the census report, identifying how many large and double portion diets were needed, and by following the recipe book. The Dietary Director was asked to explain the process that occurred when the kitchen ran out of the vegetables listed on the menu. She replied, That normally does not happen. An extra and alternate vegetable is always prepared. She was asked to explain what happened when the kitchen ran out of the protein that was listed on the menu. She replied, There is normally extra protein in the steamer. The Dietary Director stated substitutions were provided maybe once monthly. Substitutions were tracked on the substitution log. If a resident did not want a particular food item served, an alternate was provided. The Dietary Director stated she was responsible for ordering the food. The census reports and large and double portion diets were used to determine how much food to order. The [NAME] determined how much of a food component to serve on the resident's plate by following the recipe and using proper serving scoops. The Dietary Director confirmed a large portion was one scoop and half or four ounces serving of vegetables would be six ounces. If a resident asked for double meat, they were provided with double meat. If a resident asked for double carbohydrate, they were provided with double carbohydrate. When she was asked who determined whether a resident could have double portions, she replied, The Registered Dietitian (RD) will add the order in the electronic medical record and call to inform the manager; meal tickets are audited each morning for changes.On 04/30/2026 at 5:07 PM, the Registered Dietitian (RD) was asked what was considered a large portion. She replied, extra portions, one or two scoops extra, or a larger portion on the plate. She was asked what was considered a double portion. She replied, double every food item including the dessert, two beverages; two trays. When she was asked if she was aware of Resident #86's diet order specifying a pescatarian diet, she replied no, but she said she knew of a few residents who did not eat chicken, pork or beef. She did not recall a resident on a pescatarian diet. She stated the RD and Dietary Manager created the diet slips. When asked to explain what was provided for Resident #86, who was Pescatarian, she replied, No chicken; they get the rest of the menu. We do not cook fish every day. Resident #86's diet consists of no meat. She is provided with double vegetables and double carbohydrates. When she was asked how the protein was (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	supplemented, she replied, I don't have an automatic substitute if they don't eat the meat.On 04/30/2026 at 5:12 PM, a copy of the standardized recipe used to prepare the lunch meal (fried chicken) was requested from the Dietary Director. The Dietary Director stated, I don't have recipes for lunch. I did not know we were supposed to have a recipe for fried chicken. A short time later, the Dietary Director produced a recipe titled, Golden [NAME] Oven Fried Chicken. The provided recipe was inconsistent with the actual product prepared and served to the residents, which was fried drumettes/wingettes.A food and nutrition policy regarding menu planning and preferences was requested. The documentation provided was unrelated to this subject matter; therefore, no applicable policy was available for review.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary environment and to help prevent the development and transmission of communicable diseases and infections, by failing to 1) Ensure nursing staff properly performed hand hygiene while working with three (Residents #93, #70 and #74) of six residents observed during medication administration, and 2) Ensure urinary catheter bags did not rest on the floor for one (Resident #107) of nine residents observed with urinary catheters. The findings include:1.During an observation of medication administration on 04/30/2026 at 7:55 AM, Licensed Practical Nurse (LPN) A proceeded to pull medications from the medication cart for Resident #93 then entered Resident #93's room without performing hand hygiene upon entering. LPN A administered Resident #93's medications and exited the resident's room without performing hand hygiene. Upon returning to her medication cart at 8:00 AM, she proceeded to pull medications from the cart for Resident #70 then entered Resident #70's room without performing hand hygiene upon entering. LPN A administered Resident #70's medications and exited the resident's room without performing hand hygiene.2.During an observation of medication administration on 04/30/2026 at 8:10 AM, LPN B proceeded to pull medications from the medication cart for Resident #74 then entered the resident's room without performing hand hygiene upon entering. LPN B administered Resident #74's medications and exited the resident's room without performing hand hygiene.During an interview on 04/30/2026 at 8:30 AM, when asked to provide the policy regarding hand hygiene, the Director of Nursing (DON) expressed disappointment with his staff regarding their failure to perform hand hygiene appropriately. The DON then provided an in-service training attendance record with directives written out to perform hand hygiene . before preparing or administering medications, before opening the medication cart, before handling medication packages, before pouring/preparing meds, and to perform hand hygiene before/after each resident.A review of the facility's policy and procedure titled Hand Hygiene (reviewed January 16, 2025), revealed:Policy Explanation and Compliance Guidelines: 6.a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.3. On 4/27/2026 at 12:02 PM, Resident #107 was observed lying in bed. His urinary catheter bag was lying on the floor beside his bed. (photographic evidence obtained)On 4/29/2026 at 4:45 PM during an interview with Certified Nursing Assistant (CNA) N, she was asked if she was caring for Resident #107. She stated yes and confirmed that she provided urinary catheter care for this resident. She was asked if the urinary drainage bag should be resting on the floor. She stated, No, the bag should never touch the floor.On 4/29/2026 at 4:55 PM, during an interview with Registered Nurse (RN) O, he was asked if he cared for Resident #107. He confirmed that he did. When he was asked about preventative interventions to try to minimize possible infection from the urinary catheter, he replied that good hand hygiene, changing gloves constantly, and keeping the catheter as clean as possible were important. He said the catheter/bag should never touch the floor. He was asked to observe Resident #107's urinary catheter bag. He confirmed that the resident's urinary catheter bag was resting on the floor. (photographic evidence obtained) He stated, Yes, I see it's on the floor. Sometimes when the beds are in low position like his is, the bags will touch the floor.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interview, the facility failed to ensure that ten (Residents #20, #119, #129, #8, #110, #77, #62, #72, #87 and #120) of 66 residents sampled, had adequately equipped communication systems allowing them to call for staff assistance and relaying the call directly to a staff member or to a centralized staff work area from each resident's bedside. Failing to ensure each resident has a working call light for summoning staff when assistance is needed can result in preventable falls, increased pain and anxiety. The findings include:A tour of the facility began on 04/28/2026 at 11:32 AM. During the tour several call lights on the third floor were found to be inoperable (rooms 301A, 301B, 302A, 302B, 303B, 303C, 304A, 304B, 307A, 307B, 307B, 307B, 307C and 308B). The call light box for 308C was disconnected from the wall socket and there was no call light in room [ROOM NUMBER]C at 11:45 AM. (photographic evidence obtained)On 04/29/2026 at 10:45 AM, an interview was conducted with the Director of Maintenance. He was asked if there were any concerns with the call light system. He stated there had been some concerns with some of the facility's call lights in the past but it doesn't happen often. He stated the call lights may have needed to be reset. While seated at the nurses' station on the third floor, he began to press several buttons on the call light box which revealed two error alert messages: Critical Alert. A critical alert has been detected in the Dome Light system, and Warning. A problem has been detected in the Wireless Devices system. This system may be partially functional. The system gave the same error alert for rooms #313A, 313B and 313C. (photographic evidence obtained) He again stated the system may need to be reset. He then went into an engineering room located near the nurses' station on the third floor. When he returned to the nurses' station he began pressing several buttons again. All of the error alerts remained illuminated. He then unplugged the system. He waited a few minutes before plugging it back in. There were no changes. The error alerts remained. He could not provide any evidence and/or documentation of previous repairs and/or replacements for the call lights identified. He was asked to conduct a tour of the rooms where concerns with call lights had been identified. The call lights were tested. The call lights in rooms 301B, 302A, 302B, 303B, 303C, 307B, 307C and 308B remained inoperable and did not illuminate outside of the residents' room doors or at the call box located at the nurses' station. He confirmed that the call light in 308C would need to be secured into the wall. The Maintenance Director stated he would have to notify facility administration about the inoperable call lights.A tour of room [ROOM NUMBER]C was conducted on 4/29/2026 at 11:01 AM with Unit Manager/Licensed Practical Nurse (LPN) S. She was asked about the missing call light. She stated she was not sure what had happened to the resident's call light and that he should have had one. She stated that she would notify the Maintenance Director.

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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 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. Based on observations, interviews and record review, the facility failed to ensure that the resident environment for one (Resident #62) of 24 residents reviewed for safety, was as free of accident hazards as was possible, by allowing hazardous, sharp objects to remain accessible in Resident #62's room without identified safety parameters, which could negatively impact Resident #62 or any other resident who entered the resident's room and accessed these objects. The findings include:On 04/27/2026 at 12:02 PM, a white Bible was observed on Resident #62's tray table containing a pair of scissors. A multi-colored pocketknife was observed on the resident's windowsill, as well as a pack of razors. (photographic evidence obtained)On 04/29/2026 at 10:30 AM, the same white Bible containing a pair of scissors was observed, along with a pack of razors, on the resident's windowsill. (photographic evidence obtained)On 04/29/2026 at 11:19 AM, an interview was conducted with Licensed Practical Nurse (LPN)/Unit Manager S. She was asked about residents keeping sharp objects in their rooms. She asked for clarification of the question. She was accompanied to Resident #62's room and her attention was directed toward the white Bible on the windowsill containing the scissors. She replied, Oh when she saw the scissors. She was asked if the resident should have scissors in his possession. She confirmed that he should not. She retrieved the scissors from the bible concealing them in her hand. She was shown a photograph of and was advised of the pocketknife observed in the resident's room on 4/27/2026 at 12:02 PM. She held the scissors and scanned the resident's room then walked out.An interview was conducted on 04/29/2026 at 12:17 PM with the Director of Nursing (DON). He was advised of the items observed in Resident #62's room. He confirmed that residents were not to have sharps in their possession. He stated the items were part of the resident's art supplies. He was asked about the facility's policy related to residents' possession of sharp objects. The DON advised that the facility did not have a policy that addressed residents possession of sharp objects or anything that identified hazardous items that residents were prohibited from having in their rooms.A review of Resident #62's medical record revealed an admission date of 05/06/2025 with diagnoses including depression. He was later diagnosed with other specified persistent mood disorders on 03/16/2026. Resident #62 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 possible points, indicating intact cognition. He was completely independent for Activities of Daily Living (ADLs) and required little to no supervision from facility staff. A progress note from Resident #62's psychiatry and psychology visit on 02/10/2026 revealed the resident was, seen today due to major depressive disorder, recurrent, moderate and other specified anxiety disorder. They report experiencing low interest in activities and a depressed mood for approximately 12/14 days. They also report low energy and poor appetite nearly every day. Additionally, they report experiencing anxiety and uncontrolled worry nearly every day. The patient noted that these distressing symptoms initially began approximately one and one half years ago. They report that their current symptoms have been present since self-admission for back problems/lymphoma of unknown origin . They report worrying frequently about their health but state that they take things one day at a time. The patient also reported wanting to leave the facility and feeling depressed most of the time while in placement. Overall, these symptoms are causing mild subjective distress according to the GAD-7 (test used to screen for anxiety and measure it's severity), although the PHQ-9 (tool used to screen, diagnose and measure the severity of depression) indicates moderate distress based on the frequency of symptoms.