STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105193	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Meadows Healthcare & Rehabilitation Center	3250 SW 41st Place Gainesville, FL 32608

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments were accurate for 1 of 5 residents reviewed for unnecessary medications (Resident #67), 1 of 2 residents reviewed for communication (Resident #112), 1 of 3 residents reviewed for respiratory services (Resident #12), and 1 of 4 residents reviewed for infections (Resident #10).Findings include: 1) Review of Resident #67's Quarterly MDS assessment dated [DATE] showed the resident is taking diuretics under Section N- Medications. Review of Resident #67's physician orders showed no order for diuretics. Review of Resident #67's Medication Administration Record (MAR) for February 2026 showed no diuretics were administered. During an interview on 4/23/2026 at 10:21 AM, Staff D, MDS Licensed Practical Nurse (LPN), stated, [Resident #67's name] is currently taking Hydralazine. Review of Resident #67's physician order dated 5/29/2024 read, Hydralazine HCl [hydrochloride] Tablet 50 MG [milligram], Give 50 mg by mouth three times a day for Hypertension, Hold if BP [Blood Pressure] less than 110/60. During an interview on 4/24/2026 at 8:24 AM, the Director of Nursing (DON) stated, Hydralazine is not a diuretic. During an interview on 4/24/2026 at 10:50 AM, Staff D, MDS LPN, stated, I was wrong [Resident #67's name] is not on diuretics. His assessment will need to be corrected. 2) During an interview conducted in Spanish on 4/20/2026 at 10:05 AM, Resident #112 stated that he did not speak English, she did not understand English and needed an interpreter when staff came to speak to her. Review of Resident #112's MDS assessment titled Modification of Quarterly/Medicare 5 day dated 3/17/2026 read, Section A- Identification Information. A1110. Language: B. Do you need or want an interpreter to communicate with a doctor or health care staff? 0. No. Review of Resident #112's skin exam dated 4/15/2026 read, History of Present Illness: Patient does not speak English, translator used through [name of an application] app and patient's son via the telephone. (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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/22/2026 at 1:41 PM, Staff T, LPN Unit Manager, stated, [Resident #112's name] doesn't speak much English. She would prefer Spanish. Her son is at bedside at times; if not, we will get staff to translate. During an interview on 4/22/2026 at 1:43 PM, Staff U, Certified Nursing Assistant (CNA), stated, [Resident #112's name] is a Spanish-speaking resident. I can understand a little bit of Spanish and if not, I will have another staff translate for me. During an interview on 4/23/2026 at 6:39 AM, the Director of Nursing stated, Resident #112's name] speaks more Spanish than English. During an interview on 4/23/2026 at 10:22 AM, Staff D, MDS LPN stated, [Resident #112's name] is Spanish speaking only. I don't know why it is coded this way. It will need to be corrected. 3) Review of Resident #12's admission record showed the resident was admitted on [DATE] with diagnoses to include tracheostomy status (onset date of 1/29/2026). Review of Resident #12's MDS assessment dated [DATE] showed the resident does not receive tracheostomy care under Section O- Special Treatments, Procedures, and Programs. Review of Resident #12's physician orders showed an order with a start date of 1/30/2026 that read, Change trach-as needed every 3 months. During an interview on 4/23/2026 at 10:22 AM, Staff D, MDS LPN, stated, [Resident #12's name] has a tracheostomy. The assessment will need to be corrected. 4) Review of Resident #10's quarterly MDS assessment dated [DATE] showed Septicemia (a life-threatening, emergency bloodstream infection that requires immediate hospital treatment) documented under Section I- Active Diagnoses. Review of Resident #10's physician order dated 12/25/2025 read, Cipro Oral Tablet 500 MG (Ciprofloxacin HCl), Give 500 mg by mouth two times a day for UTI [Urinary Tract Infection] for 7 Days. Review of Resident #10's physician orders revealed no additional antibiotics were ordered after 12/25/2025. Review of Resident #10's MAR from 12/25/2025 through 4/21/2026 revealed the resident received Cipro from 12/25/2025 through 1/01/2026. There was no additional documentation for the administration of antibiotics. Review of Resident #10's urinalysis and urine culture results dated 1/17/2026 showed no growth in 48 hours. Review of Resident #10's urinalysis and urine culture results dated 2/28/2026 showed no growth in 48 hours. During an interview on 4/23/2026 at 11:15 AM, Staff D, MDS LPN, stated that Resident #10's last quarterly assessment was completed on 2/12/2026 and confirmed that the MDS was inaccurate. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/23/2026 at 12:45 PM, the DON stated she was aware that there was a lot wrong with residents' MDS assessments, and there had been a lot of staff turnover in the MDS office. Review of the facility policy and procedure titled Comprehensive Assessments and Care Plan with the last review date of 1/28/2026 read, Standard: It will be the standard of this facility to make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. Guidelines: 1. The facility will conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment for each resident's functional capacity.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a safe and clean homelike environment for 2 of 5 residents reviewed, Residents #87 and #66. Findings include: 1) During an observation on 4/20/2026 at 1:45 PM, Resident #87 had his right arm in a splint and was using his left arm and hand to move items in the room. The pull string to turn on the light over the resident's bed was not within reach of the resident. The pull string does not reach the bed (Photographic evidence obtained). During an interview on 4/20/2026 at 1:45 PM, Resident #87 voiced concerns about not being able to reach the pull string to turn on the light that was over his bed. He commented he had spoken to maintenance and administration. Review of Resident #87's admission record showed the resident was admitted on [DATE] with diagnoses to include hemiplegia and hemiparesis following cerebral infarction (stroke) affecting right dominant side. During an observation on 4/21/2026 at approximately 1:00 PM, the pull string to the light over Resident #87's bed was not within reach of the resident. During an observation on 4/22/2026 at approximately 9:30 AM, the pull string to the light over Resident #87's bed was not within reach of the resident. During an interview on 4/24/2026 at 10:21 AM, the Administrator stated, I did observe the light string was not close enough to his [Resident #87's] bed to accommodate his needs and needs to be modified to make it longer. 2) During an observation on 4/21/2026 at 10:21 AM, there was a black colored substance around the base of the toilet in Resident #66's room (Photographic evidence obtained). During an interview on 4/22/2026 at 8:38 AM, the Environmental Services Director (ESD) stated, The rooms in the memory care unit are cleaned twice a day, once in the morning and once in the afternoon. The ESD verified there was a black colored substance around the base of the toilet in Resident #66's bathroom. During an interview on 4/22/2026 at 8:42 AM, Staff BB, Certified Nursing Assistant, stated, Housekeeping cleans twice a day and are very good. When it's clean it's nice [Resident #66's bathroom] but will wear off. The men in Resident #66's room will urinate on the floor.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to coordinate Preadmission Screening and Resident Review (PASRR) for the residents with newly evident or possible serious mental disorder for 2 of 4 residents reviewed for behavioral health (Residents #13 and #117).Findings include:1) Review of Resident #117's admission record showed the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses to include brief psychotic disorder (onset date of 2/26/2026), other recurrent depressive disorders (onset date of 2/26/2026), and post-traumatic stress disorder (onset date of 2/25/2026).Review of Resident #117's PASRR dated 1/27/2026 showed anxiety disorder and depressive disorder documented under mental illness or suspected mental illness in Section I. PASRR Screen Decision-Making. No brief psychotic disorder and post-traumatic stress disorder was documented.Review of Resident #117's psychiatry subsequent note dated 3/23/2026 read, Chief Complaint: Brief psychosis and depression.Review of Resident #117's physician order dated 4/4/2026 read, Escitalopram Oxalate Tablet 5 MG [milligram], Give 1 tablet by mouth one time a day for Depression.Review of Resident #117's physician order dated 4/6/2026 read, Aripiprazole Tablet 10 MG, Give 1 tablet by mouth one time a day for Brief psychotic disorder.2) Review of Resident #13's admission record showed the resident was admitted on [DATE] with diagnoses to include unspecified mood (affective) disorder (onset date of 4/2/2026] and major depressive disorder, recurrent (onset date of 3/27/2026).Review of Resident #13's PASRR dated 3/8/2026 showed no mental illness or suspected mental illness documented under Section I. PASRR Screen Decision-Making.Review of Resident #13's psychiatry subsequent note dated 3/12/2026 read, Chief Complaints: Depression, insomnia. Plan of Action: Start medication. Start Trazodone (Desyrel) 25 mg by mouth twice daily for daytime anxiety/depressive symptoms and 50 mg by mouth at bedtime for insomnia and depressive symptoms.During an interview on 4/21/2026 at 2:33 PM, the Director of Nursing stated, [Resident #117's name and Resident #13's name] are missing diagnosis on their PASSR Level I and they need to be corrected.Review of the facility policy and procedures titled Role of Admissions and Social Services in PASRR with the last review date of 1/28/2026 read, Policy: The facility will ensure each resident in a nursing facility is screened for mental disorder (MD) or intellectual disability (ID) prior to admission and that individuals identified with MD or ID are evaluated and receive care and services in the most integrated setting appropriate to their needs by coordinating with the appropriate, State-designated authority. The facility will ensure that individuals with mental disorder or intellectual disabilities continue to receive the care and services they need in the most appropriate setting, when a significant change in their status occurs.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident-centered care plans were developed and implemented for 4 of 33 residents reviewed (Residents #11, #58, #39, and #112).Findings include: 1) Review of Resident #11's admission record showed the resident was admitted on [DATE] and readmitted on [DATE] with medical diagnoses to include hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, overactive bladder, and other artificial openings of urinary tract status, and acute candidiasis of vulva and vagina. Review of Resident #11's care plan read, Focus: The resident has an artificial opening for bowel elimination (ostomy). Date initiated: 11/27/2025. Revision on: 03/05/2026. Interventions: Report any changes in bowel output to nurse such as swollen abdomen, resident complaining of pain, any change in color or consistency of the output. During an interview on 4/23/2026 at approximately 11:45 AM, Staff C, Minimum Data Set (MDS) Licensed Practical Nurse (LPN), stated, [Resident #11's name] had a nephrostomy catheter inserted. It was an error that [Resident #11's name] care plan had a focus area for a colostomy. [Resident #11's name] did not have a colostomy. During an interview on 4/23/2026 at 12:45 PM, the Director of Nursing (DON) stated, [Resident #11's name] did not have a colostomy. She had a nephrostomy. 2) Review of Resident #58's admission record showed the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses to include pulmonary fibrosis, morbid (severe) obesity due to excess calories, moderate protein-calorie malnutrition, feeding difficulties, malignant neoplasm of glottis, dysphagia, and gastro-esophageal reflux disease without esophagitis. Review of Resident #58's care plan read, Focus: [Resident #58's name] is a smoker/tobacco user. Date initiated 05/05/2016. Revision on: 03/14/2023. During an interview on 4/21/2026 at 8:37 AM, Resident #58 stated that she used to be a smoker but no longer smoked. During an interview on 4/22/2026 at 2:35 PM, Staff A, LPN, stated that Resident #58 did not get out of bed or go outside to smoke. During an interview on 4/23/2026 at 12:45 PM, the DON stated Resident #58 used to be a heavy smoker. She got up in the chair if she wanted, but she was mostly in bed. The DON confirmed that Resident #58 had not had a recent smoking evaluation because she no longer was an active smoker. 3) Review of Resident #39's admission record showed the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses to include hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, other seizures, other specified disorders of brain, unspecified dementia of unspecified severity with other behavioral disturbance, and restlessness and agitation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #39's care plan read, Focus: [Resident #39's name] has self care deficits AEB [as evidenced by] the needs for assistance for all ADL's [activities of daily living] care tasks. Resident needs help with dressing, grooming, bathing R/T [related to]: CVA [cerebrovascular accident] with (R) [right] hemiparesis/hemiplegia. Date initiated: 08/11/2022. Revision on: 0/21/2025. Interventions: Provide hands on assistance with dressing, grooming, bathing as needed. During an interview on 4/21/2026 at 3:00 PM, Staff G, LPN, stated, [Resident #39's name] is mostly independent. He is pretty steady. He moves on his own, and he shaves himself. His last care plan was done in June of 2025. During an interview on 4/21/2026 at 3:13 PM, Staff H, LPN Unit Manager, stated that Resident #39 was mostly independent. During an interview on 4/21/2026 at 3:15 PM, Staff C, MDS LPN stated that shaving was part of personal hygiene in the MDS Assessment. Resident #39 had his last MDS Assessment on 3/16/2026 and he was assessed as independent for personal hygiene. Staff C confirmed that Resident #39 had care plan focus areas that documented he needed assistance with all ADL activities. During an interview on 4/21/2026 at 4:45 PM, the DON confirmed that the most recent date of a care plan for Resident #39 was 6/29/2025 and that the focus areas in his care plan related to ADLs documented that he needed assistance. The DON stated that MDS assessments and care plans needed to align. During an interview on 4/22/2026 at 9:01 AM, Resident #39 stated, I have to obtain a razor from CNAs [Certified Nursing Assistants], but I get out of bed and shave on my own. During an interview on 4/22/2026 at approximately 4:45 PM, Staff C, MDS LPN, stated, The care plans in the facility are all jacked up. We are aware that the residents' care plans were not up to date. During an interview on 4/23/2026 at 12:45 PM, the DON stated she was aware that there was a lot wrong with residents' care plans and there had been a lot of staff turnover in the MDS office. 4) During an interview conducted in Spanish on 4/20/2026 at 10:05 AM, Resident #112 stated that he did not speak English, she did not understand English and needed an interpreter when staff came to speak to her. Review of Resident #112's care plan did not show a focus for communication. Review of Resident #112's skin exam dated 4/15/2026 read, History of Present Illness: Patient does not speak English, translator used through [name of an application] app and patient's son via the telephone. During an interview on 4/22/2026 at 1:41 PM, Staff T, LPN Unit Manager, stated, [Resident #112's name] doesn't speak much English. She would prefer Spanish. Her son is at bedside at times; if not, we will get staff to translate. During an interview on 4/22/2026 at 1:43 PM, Staff U, Certified Nursing Assistant (CNA), stated, [Resident #112's name] is a Spanish-speaking resident. I can understand a little bit of Spanish and if not, I will have another staff translate for me. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/23/2026 at 6:39 AM, the DON stated, Resident #112's name] speaks more Spanish than English. During an interview on 4/23/2026 at 10:22 AM, Staff D, MDS LPN, stated, [Resident #112's name] is Spanish speaking only. I don't see a focus for communication in her care plan. It will need to be added. Review of the facility policy and procedure titled Comprehensive Assessments and Care Plan with the last review date of 1/28/2026 read, Standard: It will be the standard of this facility to make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. Guidelines: 10. The plan of care reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. 11. The services provided or arranged by the facility, as outlined by the comprehensive care plan, will be provided by qualified persons in accordance with each resident's written plan of care and will also be culturally-competent and trauma-informed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, record review, and interview, the facility failed to ensure residents received their medications as prescribed by their physician for 2 of 10 residents reviewed for medication management (Residents #90, and #93) and failed to ensure the wound dressings were changed for 2 of 4 reviewed for skin conditions (Residents #112 and #119).Findings include: 1) Review of Resident #93's physician order dated 2/28/2026 read, Insulin Glargine Solution 100 units per milliliter (units/mL), inject 10 units subcutaneously once daily for diabetes; notify physician for blood sugar less than 70 milligrams per deciliter (mg/dL). Review of Resident #93's Medication Administration Record (MAR) for administration of Insulin Glargine for March 2026 showed the medication was held by Staff CC, Registered Nurse (RN), on the following dates: 3/2/2026 for blood sugar of 82 mg/dL; 3/3/2026 for blood sugar of 105 mg/dL; 3/6/2026 for blood sugar of 96 mg/dL; 3/9/2026 for blood sugar of 103 mg/dL; 3/10/2026 for blood sugar of 117 mg/dL; 3/11/2026 with no documented blood sugar; 3/13/2026 with no documented blood sugar; 3/15/2026 for blood sugar of 85 mg/dL; 3/16/2026 for blood sugar of 79 mg/dL; 3/20/2026 for blood sugar of 107 mg/dL; 3/23/2026 for unavailability; 3/25/2026 for blood sugar of 105 mg/dL; and 3/29/2026 for blood sugar of 84 mg/dL. Review of Resident #93's MAR for administration of Insulin Glargine for April 2026 showed the medication was held by Staff CC, RN, on the following dates: 4/6/2026 for blood sugar of 64 mg/dL; 4/7/2026 for blood sugar of 80 mg/dL; 4/10/2026 with no blood sugar documented; 4/13/2026 with no blood sugar documented; 4/17/2026 for blood sugar of 98 mg/dL; and 4/20/2026 for blood sugar of 77 mg/dL; During an interview on 4/21/2026 at 4:49 PM, Staff CC, RN, stated she misread the physician order, held the insulin, and did not recall notifying the physician. During an interview on 4/22/2026 at 2:55 PM, the Director of Nursing (DON) stated, It is the expectation that nursing staff follow physician orders when administering medications. During an interview on 4/23/2026 at 11:10 AM, Medical Doctor 2 stated he did not recall being notified that the insulin was being held. 2) During an observation on 4/22/2026 at 8:58 AM, Staff A, Licensed Practical Nurse (LPN), was pouring medication for Resident #90. Staff A crushed Zunveyl Oral Tablet Delayed Release 10 mg (milligram). During an interview on 4/22/2026 at 8:58 AM, Staff A, LPN, was requested to clarify if the medication Zunveyl should be crushed for Resident #90. Staff A stated she would get clarification from the provider. Staff A administered the medication without obtaining clarification from the provider. During an interview on 4/22/2026 at approximately 1:20 PM, Staff A, LPN, stated I clarified the medication and it is a delayed release medication even though the blister pack do not say it. When asked if the medication should have been crushed, Staff A stated, It is not enteric coated, its delayed release. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #90's physician order dated 2/16/2026 read, Medications to be started after delivery form pharmacy. May crush meds unless contraindicated and administer together. Review of Resident #90's physician order dated 2/26/2026 read, Zunveyl Oral Tablet Delayed Release 10 MG (Benzgalantamine Gluconate), Give 10 mg by mouth two times a day for Dementia. During an interview on 4/23/2026 at 6:51 AM, the DON stated, The nurse should not crush delayed release medication. They should first call pharmacy or the doctor to get clarification before giving the medication. The medication should not have been given. Review of the facility policy and procedures titled Medication Administration with the last date of 1/28/2026 read, Policy: It will be the policy of this facility to administer medications in a timely manner and as prescribed by the physician, unless otherwise clinically indicated or necessitated by other circumstances such as lack of availability of medication or refusal of medication by the resident. Procedure: 3. Medications should be administered in a timely manner and in accordance with physician's orders. 5. Should a dosage seem excessive considering the resident's age and medical condition, or a medication order seems to be unrelated to the resident's current diagnosis or medical condition, the person preparing/administering the medication shall contact the resident's physician or the facility's Medical Director for further instructions. 3) During an observation on 4/20/2026 at 10:14 AM, Resident #112 was sitting up in bed. There was a dressing dated 4/16/2026 on the left side of her neck (Photographic evidence obtained). During an interview on 4/20/2026 at 10:14 AM, Resident #112 stated, Dermatology came to see me and decided to biopsy an area on my neck. During an observation on 4/21/2026 at 8:10 AM, Resident #112 was lying in bed. There was a dressing on the left side of the resident's neck dated 4/16/2026. During an interview on 4/21/2026 at 8:10 AM, Resident #112 stated, They have not changed my dressing. The nurse said she would change it today. Review of Resident #112's physician order dated 4/15/2026 read, Wound care left neck- wash with soap and water, pat dry, apply petroleum jelly, cover with nonstick bandage every day shift for biopsy site for 7 days. During an interview on 4/21/2026 at 4:36 PM, Staff W, RN, stated, I don't remember the date on the dressing. During an interview on 4/21/2026 at 4:46 PM, Staff V, LPN, stated, I didn't see orders for dressing changes. I know they were talking about a biopsy on her neck today. During an interview on 4/22/2026 at 8:04, Staff B, LPN Wound Care Nurse, stated, There was a lot going on Saturday [4/18/2026]. Normally when I do wound care, I wait to do it to check it off. I cannot recall what happened. 4) During an observation on 4/20/2026 at 10:16 AM, Resident #119 was sitting in his wheelchair. There was a dressing dated 4/16 on his right knee (Photographic evidence obtained). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/20/2026 at 10:16 AM, Resident #119 stated, He had fallen at home and had a wound on his right knee. Review of Resident #119's physician order dated 4/14/2026 read, Cleanse right knee with wound cleanser and apply Iodosorb gel and cover with border gauzes three times a week every day shift every Tue [Tuesday], Thu [Thursday], Sat [Saturday]. During an interview on 4/22/2026 at 8:04 AM, Staff B, LPN Wound Care Nurse, stated, I did work on 4/18. I did not do his [Resident #119] dressing on Saturday [4/18/2026] because he was up. During an interview on 4/23/2026 at 6:37 AM, the DON stated, The staff should follow physician orders and do wound care as ordered. Review of the facility policy and procedures titled Wound Care with the last review date of 1/28/2026 read, Policy: It will be the policy of this facility to provide assessment and identification of residents at risk of developing injuries, other wounds and the treatment of skin impairment. Procedure: 6. Wound care procedures and treatments should be performed according to physician orders.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents with limited mobility received appropriate services to maintain or improve mobility for 1 of 4 residents reviewed for therapy services (Resident #16).Findings include:During an observation on 4/20/2026 at 10:33 AM, Resident #16 was sitting in a wheelchair next to his bed. The resident was not wearing a splint, or an AFO (Ankle Foot Orthoses).During an observation on 4/21/2026 at 11:05 AM, Resident #16 was sitting in a wheelchair at the nurses' station. The resident was not wearing an AFO.During an interview on 4/22/2026 at 2:52 AM, Staff A, Licensed Practical Nurse (LPN), stated, [Resident #16's name] is often up in his wheelchair when I come in at 7:00 AM and is not always wearing his AFO. Staff A was not able to provide any specific dates.During an observation on 4/22/2026 at 3:00 PM, Resident #16 was lying in bed. The resident was not wearing an AFO. There was an AFO stored on a shelf in the closet.Review of Resident #16's physician order dated 1/28/2026 read, Apply orthosis to right ankle following restorative nursing program. Monitor skin integrity when applying and removing. The order was discontinued on 4/2/2026.Review of Resident #16's physician order dated 4/2/2026 read, Apply R [right] ankle orthosis (AFO) during transfers and when OOB [out of bed] to improve positioning. Monitor for skin integrity.During an interview on 4/23/2026 at 10:00 AM, the Director of Rehab stated, [Resident #16's name] AFO is to be applied when he is getting up with the mechanical sit to stand, and remain on to stabilize the position [of his foot/lower leg]. [Resident #16's name] has been on physical therapy case load. In January, the [physical] therapist turned the AFO application over to the Restorative team.During an interview on 4/23/2026 at 10:15 AM, Staff H, LPN Unit Manager, stated, PT [Physical Therapy] gave their recommendations to the two restorative aids. If it is a new skill for applying splints for a resident, therapy will work with the restorative aids for training. The Unit Manager will then give approval for the task to be taken on independently by the Restorative Aids. Review of Resident #16's Task List or application of AFO for April 2026 showed X was documented from 4/2/2026 through 4/8/2026 and no entry on 4/20/2026 and 4/22/2026.During an interview on 4/23/2026 at 10:40 AM, Staff Q, Restorative Certified Nursing Assistant (CNA), stated that Restorative was not applying Resident #16's AFO; they were working with him and applying the carrot for his right hand. Resident #16 liked his foot brace and his carrot, and when he saw her, he would raise his leg or arm up indicating he wanted her to put on his AFO and his carrot. During an interview on 4/23/2026 at 11:05 AM, Staff R, CNA, stated that she knew Resident #16 was supposed to have his AFO on when transferring, but she sometimes took it off when he was sitting up in his wheelchair because she thought he did not like to wear it.Review of the facility policy and procedures titled Contracture Management with the last review date of 1/28/2026 [NAME], Policy: It will be the policy of this facility that the facility must ensure that a resident with a limited range of motion (ROM) receives appropriate treatment to increase range of motion and/or prevent further decrease in ROM. A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Procedure: 3. Treatment may include, restorative nursing programs, positioning or splinting to prevent further loss of ROM. 4. If splinting is used, a schedule for wearing the splint must be developed. 5. Application of devices should be documented in the clinical record and should be present in the 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. Based on observation, record review, and interview, the facility failed to ensure a safe and hazard-free environment for 1 of 4 residents reviewed (Resident #39).Findings include: During an observation on 4/20/2026 at 10:15 AM, there was a disposable razor on the back of Resident #39's bathroom sink (Photographic evidence obtained). During an observation on 4/21/2026 at 1:25 PM, there was a black disposable razor on the sink in Resident #39's bathroom. During an interview on 4/21/2026 at 1:27 PM, Staff F, Certified Nursing Assistant (CNA), stated that Resident #39 was using the razor earlier that day, and Resident #39 was somewhat independent. During an interview on 4/21/2026 at 3:00 PM, Staff G, Licensed Practical Nurse (LPN), stated that Resident #39 was mostly independent, he was steady, he moved on his own, and he shaved himself. During an interview on 4/21/2026 at 3:13 PM, Staff H, LPN Unit Manager, stated that Resident #39 was mostly independent. Residents should be observed while shaving and the razor should be disposed of after the resident shaved. During an interview on 4/21/2026 at 4:45 PM, the Director of Nursing (DON) stated that Resident #39 should be observed while shaving. The CNA would have known he was shaving as she would have had to give the razor to Resident #39 and she should have picked it up after he was finished. During an interview on 4/22/2026 at 9:01 AM Resident #39 stated that he did not shave today and did not have a razor in his room. He had to obtain a razor from the CNAs. Staff did not observe him when he was shaving and did not always pick up the razor after he used it. His bathroom was shared with his roommate. Other residents did have access to the bathroom. Review of the facility policy and procedures titled Disposable Resident Care Product Utilization with the last review date of 1/28/2026 read, Policy: It is the policy of this facility to ensure products utilized for the provision of personalized resident care are available, utilized appropriately and discarded when no longer needed. Procedure: 6. When the disposable item is no longer needed it should be discarded in the appropriate receptacle. Razors must be discarded in the Sharps Container.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, record review, and interview, the facility failed to ensure residents received appropriate enteral feeding for 1 of 7 residents reviewed for nutrition and dining services (Resident #58).Findings include:During an observation on 4/20/2026 at 10:05 AM, Resident #58 was lying in bed. The resident's tube feeding pump was alarming. The bottle of enteral feeding was dated 4/18/2026, and the bag of water attached was dated 4/15/2026 (Photographic evidence obtained).During an interview on 4/22/2026 at 10:20 AM, Staff A, Licensed Practical Nurse (LPN), stated that more than likely when the bottle of enteral feeding was low, they would change the set-up. Changing [of the bottle and tubing] was based on what was left in the bottle. She thought the set-up was good for 24 hours. She would look at what time it was actually hung.During an observation on 4/22/2026 at 2:40 PM, Staff A, LPN, attached the tubing for the enteral feeding, set the feeding pump according to the order and started the pump. Staff A did not check for residual prior to the initiation of the enteral feeding.During an interview on 4/22/2026 at 2:50 PM, Staff A, LPN, stated that she did not check for residual for Resident #58's G-tube (Gastrostomy) prior to medication administration or prior to the initiation of her enteral feeding.During an interview on 4/22/2026 at approximately 4:00 PM, the Director of Nursing (DON) stated that tube feeding set-ups (tubing enteral feeding and water flush) should be changed every day. The expectation was that the nurse would confirm placement of the feeding tube which included checking for residual.Review of Resident #58's physician order dated 11/12/2025 read, Enteral Feed Order every shift Jevity 1.5 at 50 cc [cubic centimeter]/hour via feeding tube for 20 hours with autoflush at 50 cc/hour for 20 hours. On at 1400 [2:00 AM] and off at 1000 [10:00 AM].Review of Resident #58's physician order dated 3/29/2026 read, Check tube residual to verify placement prior to administration of feeding, prior to administration of medication, and prior to flush. If residual is 100 ML [milliliter] or more, hold feeding and notify physician every shift,Review of Resident #58's physician order dated 3/29/2026 read, May be off feeding tube/pump for short periods of time for ADL [Activities of Daily Living] care, activities, or appointmentsReview of the facility policy and procedures titled Enteral Tube Feeding with the last review date of 1/28/2026 read, Policy: It will be the policy of this facility to provide nourishment to the resident who is unable to obtain adequate nourishment orally via use of enteral tube feeding. Procedure: 3. Verify/obtain orders related to water flushes per shift for additional hydration, auto- flush for additional hydration, flushes prior to and after medication administration. Standard order for flushes prior to and after medication administration should be 30-50 mL or as ordered by physician. Flushes between medications administered are 5-10 mL or as ordered by physician. 7. Verify placement of feeding tube and gastric residual volumes per physician orders or as needed. 9. For residents receiving enteral tube feeding with the use of a pump or via gravity infusion - Replace infusion sets every 24 hours for open tube systems or 48 hours for closed tube feed systems or per manufacturer's guidelines.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interview, the facility failed to ensure the providers acted upon the pharmacist recommendations for 2 of 5 residents reviewed (Residents #66 and #67).Findings include: 1) Review of Resident #66's Consultant Pharmacist Recommendation to Physician dated 9/17/2025 read, This resident is receiving the antipsychotic agent Quetiapine 100 mg po [orally] QHS [every night at bedtime] (9/11/25) but lacks an allowable diagnosis to support its use. Please adjust the diagnosis code as clinically indicated. There was no response or signature from the provider. Review of Resident #66's Pharmacist Recommendations (DON/Medical Director Copy)for recommendations created between 10/1/2025 and 10/28/2025 read, This resident is using the following duplicate antidepressant therapy. Paroxetine HCl Tablet 10 MG, Give 2 tablet by mouth one time a day related to major depressant disorder. Active 09/18/2025. Trazodone HCl oral tablet 100 MG (Trazodone HCl), Give 1 tablet by mouth three times a day for depression. Active 09/18/2025. There was no response or signature from the provider. During an interview on 4/22/2026 at 12:43 PM, the Nursing Consultant stated that the Pharmacy Monthly consultations provided is all that there is. 2) Review of Resident #67's Consultant Pharmacist Recommendation to Physician dated 8/15/2025 read, A reference range for Keppra has not been well established. Most patients display optimal response to Keppra with serum levels 10-40 ug/ml [micrograms/milliliter]. Some patients may respond well outside this range or may display toxicity within the therapeutic range, thus interpretation should include clinical evaluation. Toxic levels have not been established. Therapeutic ranges are based on specimen drawn at trough. There was no response or signature from the provider. Review of Resident #67's Pharmacist Recommendations (DON [Director of Nursing]/Medical Director Copy) for recommendations created between 10/1/2025 and 10/28/2025 read, This resident is using the following duplicate antidepressant therapy: Sertraline HCl [hydrochloride] Tablet 50 MG [milligram], Give 2 tablet by mouth at bedtime for Depression. Active 10/12/2023. Trazodone HCl Oral Tablet 50 MG (Trazadone HCl), Give 2 tablet by mouth at bedtime related to Depression. Active 10/17/2024. There was no response or signature from the provider. Review of Resident #67's physician order dated 10/12/2023 read, Sertraline HCl Tablet 50 MG, Give 2 tablet by mouth at bedtime for Depression. Order Status: Active. Review of Resident #67's physician order dated 10/17/2024 read, Trazodone HCl Oral Tablet 50 MG (Trazadone HCl), Give 2 tablet by mouth at bedtime related to Depression. Order Status: Active. During an interview on 4/22/2026 at 5:21 PM, Medical Doctor #1 stated, I do admit I have gotten delayed. I get the recommendations in bulk. It is more on me than the pharmacy. During an interview on 4/23/2026 at 6:57 AM, the Director of Nursing stated, I review the recommendations and give them to each doctor. I will send them an email or put it in their book. [Medical Doctor #1's name] signs the recommendations and them and gives them back to us so we can out them in and that is a hit or miss. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy and procedures titled Pharmacist Recommendations with the last review date of 1/28/2026 read, Policy: It will be the policy of this facility to provide pharmacist services to meet the needs of the residents through monthly regimen review (MRR) and properly addressing recommendations per federal and state guidelines.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on record review and interview, the facility failed to ensure residents were free from unnecessary medications for 2 of 8 residents reviewed (Residents #50 and #55).Findings include:1) Review of Resident #55's physician order dated 3/29/2026 read, Metoprolol Succinate ER [Extended Release] Oral Tablet Extended Release 24 Hour 50 MG [milligram] (Metoprolol Succinate), Give 1 tablet by mouth two times a day for HTN [hypertension], hold for SBP [Systolic Blood Pressure] less than 110 or DBP [Diastolic Blood Pressure] less than 60.Review of Resident #55's Medication Administration Record (MAR) for April 2026 for administration of Metoprolol Succinate showed the medication was administered on 4/7/2026 at 9:00 AM for blood pressure (BP) of 111/58 (SBP/DBP), 4/14/2026 at 9:00 PM for BP of 110/54, 4/15/2026 at 9:00 PM for BP of 93/51, 4/17/2026 at 9:00 PM for BP of 108/90, and 4/19/2026 at 9:00 PM for BP of 108/65.During an interview on 4/22/2026 at 1:28 PM, Staff J, Licensed Practical Nurse (LPN), stated, I administered the medication in error.2) Review of Resident #50's physician order dated 1/31/2026 read, Voltaren Arthritis Pain External Gel 1% (Diclofenac Sodium (Topical)), Apply to both hands topically two times a day for pain. The order was discontinued on 4/20/2026.Review of Resident #50's MAR for April 2026 for application of Voltaren Gel showed the medication was applied at 9:00 AM and 9:00 PM on 4/1/2026 through 4/12/2026 and on 4/14/2026 through 4/19/2026.During an interview on 4/22/2026 at 1:44 PM, Staff M, LPN, stated, When I administer the medication, I put on gloves and massage it into the resident's hands. I don't remember specifically how much I applied.During an interview on 4/22/2026 at 2:55 PM, the Director of Nursing (DON) stated, It is the expectation that nursing staff clarify incomplete or unclear medication orders with the provider and document the response, and that staff are expected to follow physician-ordered parameters when administering medications.During an interview on 4/22/2026 at 1:53 PM, Medical Doctor #1 stated, I am aware that residents [Residents #50 and #55] have received medications outside of ordered parameters. I have reviewed the residents and feel that the administrations did not result in any adverse events.Review of facility policy and procedures titled Medication Administration with the last review date of 1/28/2026 read, Policy: It will be the policy of this facility to administer medications in a timely manner and as prescribed by the physician.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals used in the facility were stored in accordance with accepted professional principles in 3 of 4 units.Findings include: 1) During an observation on 4/20/2026 at 9:59 AM, there were two vials of nebulizer treatment on top of Resident #137's drawer. During an observation on 4/21/2026 at 4:25 PM, there were two clear plastic ampules of nebulizer treatment on top of Resident #137's drawer. During an interview on 4/21/2026 at 4:58 PM, Staff W, Registered Nurse (RN), stated, [Resident #137's name] should not have medication at bedside. 2) During an observation on 4/20/2026 at 10:28 AM, there was zinc oxide ointment and packets of vitamin A and D ointment on top of Resident #59's drawer. During an interview on 4/20/2026 at 10:28 AM, Resident #59 stated, The nurses assist me to apply the ointment on my skin. During an interview on 4/21/2026 at 4:53 PM, Staff W, RN, stated, [Resident #59's name] should not have medications at bedside. 3) During an observation on 4/21/2026 at 11:00 AM, Resident #151 had a clear medication cup with clear gel like ointment and was applying it to hands. During an interview on 4/21/2026 at 11:00 AM, Resident #151 stated, I use this [clear gel ointment] on my dry skin. During an interview on 4/21/2026 at 4:50 PM, Staff W, RN, stated, [Resident #151's name] should not have medication at bedside. When I offered the ointment, he said he had his own, but I did not understand what he was referring to. I did not see it at bedside when I went in. 4) During an observation on 4/22/2026 at 9:21 AM, Resident #3 was lying in bed. There was a bottle of TUMS on top of her bedside table. During an interview on 4/22/2026 at 9:30 AM, Staff X, RN, confirm the bottle of TUMS was on the bedside table and stated, [Resident #3's name] is not able to self-administer medications and should not have medication at bedside. During an interview on 4/23/2026 at 6:36 AM, the Director of Nursing stated, Medication should not be left unattended at bedside. In order to self-administer medication, we would evaluate the resident and provide a lock box for them. 5) During an observation on 4/23/2026 at 10:15 AM, in memory care unit, the medication cart was unattended with a medication card pack on top of the cart turned upside down with no patient (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	information visible. One of the blister bubbles remained sealed and a tablet was present in the package tablet #25 of Coreg 6.25 MG (milligrams) prescribed to Resident #54 for hypertension. During an interview on 4/23/2026 at 10:15 AM, the Assistant Director of Nursing stated, The nurse must have stepped away to the restroom and thought that card was empty. My expectation is for all meds to be secured. During an interview on 4/23/2026 at 10:17 AM, Staff E, LPN, stated, I thought it was empty and I was going to reorder it. Review of the facility policy and procedure titled Medication/Biological Storage with the last review date of 1/28/2026 read, Policy: It will be the policy of this facility to store medication, drugs and biologicals in a safe, secure, and orderly manner. Procedure: 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications, drugs, and biologicals shall be locked when not in use and trays or carts used to transport such items shall not be left unlocked if out of a nurses view.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on record review and interview, the facility failed to obtain laboratory services to meet the needs of the residents for 2 of 9 residents reviewed for laboratory services (Residents #96 and #97).Findings include:1) Review of Resident #97's provider visit note dated 3/19/2026 read, Today patient is being seen for a follow up visit related to AMS [Altered Mental Status] and possible UTI [Urinary Tract Infection]. Patient had a fall last night. On exam she seems slightly more confused and drowsy than her baseline. Assessment/Plan: AMS, Fall Last night, Possible UTI? order UA [urinalysis] with C&S [Culture and Sensitivity] today, send out stat, follow up after results-history of recurrent UTIs.Review of Resident #97's physician order dated 3/25/2026 read, UA C&S D/T [due to] increased confusion and urinary frequency one time only for Confusion for 1 Day.Review of eMAR (electronic Medication Administration Record) note dated 3/26/2026 read, UA C&S D/T increased confusion and urinary frequency one time only for Confusion for 1 Day Pt [patient] Urine in Fridge.Review of Resident #97's provider visit note dated 3/26/2026 read, Today patient is being seen for acute care visit on dysuria with AMS. UA was ordered earlier in week, but wasn't sent out. Patient has concerns today still for UTI. Assessment/Plan: Dysuria, UA wasn't done earlier in week, today with straight catheter per bedside RN, discussed importance of urine send out prior to starting abx [antibiotic therapy] due to hx [history] of recurrent UTI with MDR [multidrug resistance], can start empiric treatment after urine sent out-cipro 250 mg BID [twice a day].Review of Resident #97's records did not show a urinalysis with culture and sensitivity on 3/19/2026 or 3/26/2026.During an interview on 4/22/2026 at 11:34 AM, the Director of Nursing stated, Urine will be collected and placed in lab refrigerator. The staff will do a lab requisition and add it the book unless it's a stat and they pick up usually within an hour or two. The doctors put the orders in unless they spoke to the nurse.During an interview on 4/22/2026 at 11:45 AM, the Advance Practice Registered Nurse #1 stated, I do feel there was a delay. This is the first time this has happened. There were two nurses involved. The one nurse collected the urine, and it spilled. The second nurse recollected the urine it was never logged and the lab did not pick it up.During an interview on 4/22/2026 at 12:06 PM, the Director of Nursing stated, [APRN #1's name] never told me what happened. I expect the nurses to follow the orders and if there is any problems to let me know.During an interview on 4/22/206 at 12:10 PM, Staff Y, Registered Nurse (RN), stated, The UA order previously placed was not collected and the provider walked up to me and told me to collect the urine specimen. It was a verbal order. I collected the specimen and labeled it and put it in the refrigerator. I told the night nurse to put in a lab requisition. When the [APRN #1's name] asked me about the urine, the patient was already sent to the hospital. She asked me what happened and I told her I collected the urine and apparently something happened that they didn't take the urine.2) Review of Resident #96's physician order dated 4/9/2026 read, U/A C&S May straight Cath If necessary one time only for 1 Day,Review of Resident #96's laboratory results did not document a UA for April 2026.During an interview on 4/22/2026 at 4:12 PM, Medical Doctor #1 stated, I can't recall if it was a verbal order. I cannot recall the reason why we ordered the UA. I cannot recall if it was due to altered mental status.During an interview on 4/22/2026 at 4:14 PM, Staff E, Licensed Practical Nurse (LPN), stated, Therapy was saying he was more confused and I messaged [Medical Doctor #1's name] to let him know.During an interview on 4/23/2026 at 6:40 AM, the Director of Nursing stated, I spoke to the nurse who signed off on the order, but don't see where they collected the urine. I spoke to the nurse, but she does not remember what happened.During an interview on 4/23/2026 at 7:15 AM, Staff Z, LPN, stated, I don't remember what happened with his order. I had picked up an extra shift and cannot recall. I have no idea he has been confused but able to answer questions. I don't know why they order the labs his confusion has been baseline.During an interview on 4/23/2026 at 11:57 AM, Laboratory Medical Biller stated, The only thing I have for [Resident #96's name] is on 4/1 for blood work. No UA ordered. For [Resident #97's name] last thing I have is February 20; nothing more recent.Review of the facility policy and (continued on next page)

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	105193	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Meadows Healthcare & Rehabilitation Center	3250 SW 41st Place Gainesville, FL 32608

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	procedures titled Diagnostics Labs Radiology Notification with the last review date of 1/28/2026 read, Policy: It will be the policy of this facility to provide or obtain timely laboratory, radiology and diagnostic services when ordered by a physician; physician assistant (PA); nurses practitioner (NP) or clinical nurse specialist (CNS) in accordance with State law, including scope of practice laws.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, record review, and interview, the facility failed to ensure complete and accurate medical records for 2 of 4 residents reviewed for skin conditions (Residents #112 and #119).Findings include: 1) During an observation on 4/20/2026 at 10:14 AM, Resident #112 was sitting up in bed. There was a dressing dated 4/16/2026 on the left side of her neck (Photographic evidence obtained). During an interview on 4/20/2026 at 10:14 AM, Resident #112 stated, Dermatology came to see me and decided to biopsy an area on my neck. During an observation on 4/21/2026 at 8:10 AM, Resident #112 was lying in bed. There was a dressing on the left side of the resident's neck dated 4/16/2026. During an interview on 4/21/2026 at 8:10 AM, Resident #112 stated, They have not changed my dressing. The nurse said she would change it today. Review of Resident #112's physician order dated 4/15/2026 read, Wound care left neck- wash with soap and water, pat dry, apply petroleum jelly, cover with nonstick bandage every day shift for biopsy site for 7 days. Review of Resident #112's Treatment Administration Record for April 2026 for left neck wound care showed wound care was performed on 4/17/2026, 4/18/2026, and 4/20/2026. During an interview on 4/21/2026 at 4:36 PM, Staff W, Registered Nurse (RN), stated, I don't remember the date on the dressing when I changed it today [4/21/2026]. During an interview on 4/21/2026 at 4:46 PM, Staff V, Licensed Practical Nurse (LPN), stated, I didn't see orders for dressing changes. I know they were talking about a biopsy on her neck today. I am not sure why I checked it off it was probably a mistake. During an interview on 4/22/2026 at 8:04 AM, Staff B, LPN Wound Care Nurse, stated, There was a lot going on Saturday [4/18/2026]. Normally, when I do wound care, I wait to do it to check it off. I cannot recall what happened. 2) During an observation on 4/20/2026 at 10:16 AM, Resident #119 was sitting in his wheelchair. There was a dressing dated 4/16 on his right knee (Photographic evidence obtained). During an interview on 4/20/2026 at 10:16 AM, Resident #119 stated, He had fallen at home and had a wound on his right knee. Review of Resident #119's physician order dated 4/14/2026 read, Cleanse right knee with wound cleanser and apply Iodosorb gel and cover with border gauzes three times a week every day shift every Tue [Tuesday], Thu [Thursday], Sat [Saturday]. Review of Resident #119's Treatment Administration Record for April 2026 for right knee wound care showed the wound care was provided on 4/18/2026. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/22/2026 at 8:04 AM, Staff B, LPN Wound Care Nurse, stated, I did work on 4/18. I did not do his dressing on Saturday [4/18/2026] because he was up. I am trying to think what happened. My days are blurred. I don't remember what happened on Friday. That was the day I had to wait to get relieved and do the dining room and there was a lot of things going on for me. During an interview on 4/23/2026 at 6:37 AM, the Director of Nursing stated, The staff's documentation should be accurate and not check off wound care as completed unless it is done. Review of the facility policy and procedures titled Charting and Documentation with the last review date of 1/28/2026 read, Policy: It is the policy of this facility that services provided to the resident, or any changes in the resident's medical condition, shall be documented in the resident's clinical record as is needed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure staff used appropriate Personal Protective Equipment (PPE) when entering a contact precautions room for 1 of 3 residents reviewed for transmission-based precautions (Resident #41), failed to ensure staff performed hand hygiene while administering medication administration and providing care for 3 of 8 residents reviewed (Residents #1, #11, and #90), and failed to ensure respiratory care equipment were appropriately maintained for 2 of 4 residents reviewed for respiratory services (Residents #12 and #97), to prevent the possible spread of infection and communicable diseases.Findings include: 1) During an observation on 4/21/2026 at 11:18 AM, Staff AA, Licensed Practical Nurse (LPN), entered Resident #41's room. Staff AA did not wear a gown or gloves. Resident #41's room had a contact-precaution sign posted on the door and a bin with PPE outside of the room. During an interview on 4/21/2026 at 11:30 AM, Staff AA, LPN, stated, I forgot. I saw the light and went in. I know I should were gloves and gown before entering. Review of Resident #41's physician order dated 12/16/2025 read, Contact isolation - Candida Auris. All care provided in room every shift. During an interview on 4/23/2026 at 4:07 PM, the Assistant Director of Nursing/Infection Preventionist stated, Staff should be wearing gown and gloves before entering the room even if it is to answer a call light because you don't know what might happened in there. During an interview on 4/24/2026 at 8:24 AM, the Director of Nursing stated, The staff should follow the contact precautions guidelines and put on gown and gloves before entering the resident room. Review of the facility policy and procedures titled Transmission-Based Precautions with the last review date of 1/28/2026 read, Contact- direct contact with skin, or indirect contact with contaminated surfaces, and physical transfer of organism (usually on the hands of healthcare workers) from an infected or colonized person to a susceptible host. Guidelines for Contact Precautions. Gowns: 1. [NAME] gown upon entry into the room or cubicle. 2) During an observation on 4/22/2026 at 8:58 AM, Staff A, LPN, was preparing Resident #90's medications. Staff A was crushing acetaminophen. The package fell on the floor. Staff A proceeded to pick up the package from the floor. Staff A proceeded to dispose of the medication and clear medication plastic. Staff A did not wash her hands and proceeded to pour acetaminophen again and crush the medication. Staff A administered the medication to the resident without washing her hands. During an interview on 4/22/2026 at 9:16 AM, Staff A, LPN, stated, I did not do hand hygiene because I touched the package by the top and threw it away immediately. During an interview on 4/23/2026 at 6:37 AM, the Director of Nursing stated, Staff should perform hand hygiene after picking anything off the floor before resuming to pour medication for a resident. 3) During an observation on 4/20/2026 at 10:23 AM, Resident #97 was resting with her eyes closed. The nasal cannula tubing was on the floor. The tubing was dated 4/19/2026 (Photographic evidence obtained). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/21/2026 at 8:19 AM, Resident #97 was resting in bed. The nasal cannula was wrapped on the bed rail. The oxygen tubing was dated 4/19/2026. During an observation on 4/22/2026 at 8:36 AM, Resident #97 was lying in bed, with oxygen being administered by nasal cannula. The nasal cannula was dated 4/19/2026. 4) During an observation on 4/20/2026 9:53 AM, Resident #12 was sitting up in bed. The oxygen tubing connected to the trach mask was dated 4/5 (Photographic evidence obtained). During an observation on 4/21/2026 at 8:10 AM, Resident #12 was lying in bed, with oxygen being administered via the trach mask. The oxygen tubing was dated 4/5. During an interview on 4/22/2026 at 8:37 AM, Staff W, Registered Nurse (RN), stated, Oxygen tubing should be stored in a respiratory bag when not in use. If it falls on the floor, it should be changed and the tubing is changed every week. During an interview on 4/23/2026 at 6:50 AM, the Director of Nursing stated, The tubing is to be changed weekly on Sundays. If the tubing is not in use, it should be stored in a bag and if it falls on the floor it should be replaced. Review of the facility policy and procedures titled Oxygen Administration with the last review date of 1/28/2026 read, Policy: It is the policy of this facility to provide guidelines for safe oxygen administration. Procedure: 3. Assemble the equipment and supplies as needed. 7. Weekly oxygen tubing changes can be documented in the medical record as a reminder to the staff but is only required to have tubing dated appropriately demonstrating that the tubing was changed. 5) During an observation on 4/22/2026 at 11:26 AM, Staff B, LPN Wound Care Nurse, cleaned Resident #1's wound and disposed of the soiled gauze and the soiled gloves. Without performing hand hygiene, Staff B donned a clean pair of gloves and applied the wound dressing. During an interview on 4/22/2026 at 2:32 PM, Staff B, LPN Wound Care Nurse, stated that maybe she should have washed her hands when she changed her gloves during Resident #1's wound care. Review of Resident #1's physician order dated 4/14/2026 read, Cleanse sacrum with wound cleanser and apply anti-microbial (AMD) and cover with ABD once daily every day shift. 6) During an observation on 4/23/2026 at 2:10 PM, Staff A, LPN, performed nephrostomy catheter dressing change for Resident #11. After removing the soiled dressing, Staff A removed the soiled gloves. Staff A did not perform hand hygiene and donned a clean pair of gloves to clean the nephrostomy catheter insertion site. After cleaning the catheter insertion site, Staff A removed the soiled gloves. Without performing hand hygiene, Staff A donned a clean pair of gloves and applied a transparent dressing over the nephrostomy catheter insertion site. During an interview on 4/23/2026 at 2:17 PM, Staff A, LPN, confirmed that she did not perform hand hygiene after removing the soiled gloves and reapplying clean gloves twice during nephrostomy catheter dressing change. During an interview on 4/23/2026 at 12:50 PM, the Director of Nursing stated that nurses should wash their hands after removing soiled gloves, before putting on clean gloves while doing wound care or a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dressing change. Review of Resident #11's physician order dated 12/18/2025 read, Change nephrostomy dressing q [every] night and prn [as needed]. Observe for s/s [sign and symptoms] of infection every night shift. Review of the facility policy and procedures titled Hand Hygiene with the last review date of 1/28/2026 read, Policy: This facility considers hand hygiene the primary means to prevent the spread of infections. Procedure: 2. All personnel shall follow the handwashing /hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 5. Use of an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: h. Before moving from a contaminated body site to a clean body site during resident care; k. After handling used dressings, contaminated equipment, etc.; m. After removing gloves. 7. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare associated infections.