

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER The Lodge Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 635 SE 17th Street Ocala, FL 34471	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure food was stored under sanitary conditions by failing to label and date food items in the facility kitchen walk in cooler, in 1 of 3 nurses' station nourishment areas, and in 1 of 3 nourishment room refrigerators. Findings include: During an observation on 6/7/26 at 9:16 AM of the kitchen's walk-in cooler, located on a shelf was a small igloo cooler with no label or date. The contents inside consisted of a glass container with a plastic blue lid, the contents in the glass container were unidentifiable, and there was no label or date on the contents. During an interview on 6/7/26 at 9:20 AM Staff H, Cook, stated that there should be no personal food in the refrigerator and the contents should have been labeled and dated. During an interview on 6/8/26 at 8:45 AM the Certified Dietary Manager, stated absolutely no personal food should be kept in the walk-in kitchen refrigerator. During an observation on 6/7/26 at 9:30 AM of the nourishment area at the nurses station on Boston/[NAME] Hall, there was a plastic sealed clear container with a lid containing two peanut butter and jelly sandwiches inside dated 6/3/26. Another plastic container with various plastic bags of snacks that were not labeled or dated. During an interview on 6/7/26 at 9:32 AM Staff I, Dietary Aide stated the sandwiches should have been thrown out. Snacks should be labeled and dated. During an observation on 6/7/26 at 10:09 AM in the nourishment room refrigerator located on the Williamsburg Hall there was a half gallon of ice cream that was not labeled or dated in the freezer. During an interview on 6/7/26 at 10:12 AM the Dietary Manager stated that the ice cream should be labeled and dated. Review of the policy and procedure titled, Foods Brought in from the Outside with a review date of 2/24/26 read, It will be the policy of this facility to provide safe and sanitary storage, handling, and consumption of all food including food and beverages brought to residents by family and other visitors. Label containers with food item, name and date received. 6. Any item noted without a label or date will be discarded.		

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to provide necessary grooming and hygiene services for 1 of 3 residents, Resident #21, sampled for activities of daily living (ADLs). Findings include: Review of Resident #21's clinical record documented medical diagnoses to include dementia, fractured left femur requiring orthopedic aftercare, embolism and thrombosis (clots in blood stream) of the left lower extremity, falls, and dislocated shoulder. Review of Resident #21's care plan dated 5/21/2026 documented the resident had a self-care deficit with dressing, grooming, and bathing related to impaired mobility, left femur fracture, and generalized weakness. Interventions included gathering and setting up supplies for care, allowing the resident time to participate in ADLs, encouraging assistance as needed, and explaining care during provision of services. Review of Minimal Data set (MDS) admission dated 5/27/2026 Section GG documented the resident required Substantial/Maximal Assistance with bathing. During an observation on 6/7/2026 at 11:00 AM, Resident #21 was observed sitting up in bed holding a baby doll. The resident's nails were long and there was a brown substance beneath the resident's fingernails on both hands. During an observation on 6/8/2026 at 9:43 AM, Resident #21 was observed lying in bed holding a baby doll. The resident's nails were long and there was a brown substance beneath the resident's fingernails on both hands. (Photographic evidence obtained). During an observation on 6/8/2026 at 10:02 AM, Resident #21's nails were long and there was a brown substance beneath the resident's fingernails on both hands. (Photographic evidence obtained). During an interview on 6/8/2026 at 9:43 AM, Resident #21 stated, I do not get bed baths or showers and I want it all. Review of the physician orders for Resident #21 did not document restrictions related to nail care or grooming. During an observation on 6/8/2026 at 2:15 PM, Resident #21 was observed eating a meal in the dining area. The resident's fingernails remained long. While most nail beds appeared cleaner than earlier observations, dark substance remained under both thumbnails. During an interview on 6/8/2026 at 2:15 PM, Staff F, Certified Nursing Assistant (CNA) stated the resident is showered every Wednesday and Saturday and receives frequent incontinent care. The CNA further stated, I did try to scrub her nails, and she pulls her hands away from me. I can cut fingernails, but I don't know if she wants her fingernails cut because she cannot tell me. I have only seen the son one time, and I do not have his number, so I have never tried to call him and have not talked to the nurse. During an interview on 6/8/2026 at 2:22 PM, Staff E, Licensed Practical Nurse (LPN) when asked regarding Resident #21's long finger nails and the brown substance under the resident's finger nails Staff E stated she would discuss the concern with the interdisciplinary team, Unit Manager, and Director of Nursing. During an interview on 6/8/2026, the Director of Nursing stated, I was just told that the resident was digging in her brief and her nails are dirty. She should have been cleaned up, and we should have addressed her nails with the family. The CNAs are expected to clean and trim fingernails. Review of the policy and procedure titled ADL dated 2/24/2026 read, It will be the policy of this facility to provide the resident with Activities of Daily Living (ADL) care and assistance while attempting to maintain the highest practicable level of function for the resident. 7. ADL assistance needs should be reflected on the person-centered plan of care.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure care and services were provided for a PICC (Peripherally Inserted Central Catheter) access device in accordance with professional standards of practice for 1 of 3 residents, Resident #110 reviewed for PICC access devices. Findings include: Review of Resident #1's clinical record documented the resident was admitted on [DATE] to the facility with diagnosis that include but not limited to cellulitis (infection in skin) of left lower limb, cellulitis of right lower limb, methicillin resistant staphylococcus aureus infection (bacterial infection), local infection of the skin and subcutaneous tissue (first layer of skin), non-pressure chronic ulcer of left lower leg. During an observation on 6/9/2026 at 06:03 AM Resident #110 was lying in the bed. There was a PICC line inserted into the resident's left arm. Over the PICC line insertion site there was a transparent dressing covering the insertion site. Under the transparent dressing was a 2 x 2 gauze which prevented observation of the insertion site. The transparent dressing covering the insertion site and 2 x 2 gauze was dated 6/1/2026. (Photographic evidence obtained). Review of Resident #110's physician orders dated 6/1/2026 read, Insert/maintain PICC, LUA (left upper arm) every shift. Review of Resident #110's physician orders dated 5/31/2026 read, Heparin flush solution 10 unit/ml [milliliters]. Use 5 ml intravenously every night shift for patency observe site for signs and symptoms of infection infiltration, extravasation. Review of Resident #110's physician orders dated 6/8/2026 read, Sodium chloride solution 0.9% use 10 ml intravenously one time a day for line patency until 06/09/2026 flush with 10 ml normal saline before and after medication administration. Review of Resident #110's physician orders dated 6/4/2026 read, Change PICC line dressing on Thursday 7-3 shift and PRN [as needed] every day shift every Thu [Thursday]. Review of Resident #110's physician orders dated 6/3/2026 read, Vancomycin HCL [hydrochloride] intravenous solution reconstituted 1 GM [gram] use 1 gram intravenously one time a day for cellulitis LLE [left lower extremity] until 6/9/2026 23:59 Review of Resident #110's Treatment Administration Record (TAR) documented a dressing change was completed to the PICC line insertion site on 6/4/2026. During an observation on 6/9/2026 at 06:03 AM Staff G, Registered Nurse (RN) administered vancomycin via Resident #110's PICC located in the resident's left upper arm. During an interview on 6/9/2026 at 06:15 AM Resident #110 stated, I came into the facility with the catheter from the hospital and the dressing was changed a couple days later. During an interview on 6/9/2026 at 06:20 AM Staff G, RN stated that the dressing is changed every week. She did not know that it should have been changed because of the gauze that was under the transparent dressing. During an interview on 6/9/2026 at 7:20 AM Staff J, LPN stated that she changed the dressing on 6/4/2026 and placed gauze under the transparent dressing because the site was oozing, she must have dated the dressing change wrong. During an interview on 6/9/2026 at 07:22 AM the Director of Nursing stated, The PICC dressing has to be changed 24 hours after admission or if gauze is used under the transparent dressing the dressing has to be changed. The dressing was changed on the 4th, and the date was wrong or smeared off. If Gauze is placed under the dressing because the site is oozing, then the dressing has to be changed within 24 hours, it was not changed since the 4th. Review of the policy and procedures titled PICC/Midline IV [intravenous] line dated 2/24/2026 read, It will be the policy of this facility to adhere to IV/PICC/Midline administration guidelines as set forth by infection control, state, and federal law. Dressing changes: 1. Sterile dressing change using transparent dressings is performed: 24 hours post-insertion or upon admission if not dated upon admission, at least weekly, if the integrity of the dressing has been compromised (wet, loose, or soiled) 2. Dressing changes will be documented in the clinical record. Review of the cdc.gov/infection-control/hcp/intravascular-catheter-related-infections/summary-recommendations.html#cdc_g read, 6. Catheter Site Dressing Regimens. Recommendations for catheter site dressing regimens. Recommendation: 6. Replace dressings used on short-term CVC [central venous catheter] sites every 2 days for gauze dressings.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals used in the facility were securely stored in accordance with accepted professional principles for 4 of 5 resident halls. Findings include: 1) During an observation on 6/7/2026 at 9:52 AM, Resident #94 was observed resting in bed. A bottle of Nystatin 100,000 units/gram topical powder was observed sitting on the resident's dresser. (Photographic evidence obtained). During an interview on 6/7/2026 at 9:52 AM, Resident #94 stated, That powder is for my rash on my breast. 2) During an observation on 6/7/2026 at 10:02 AM, Resident #78 was observed sleeping in bed. A bottle of Hydrogen Peroxide 3% Topical Solution was observed on the resident's bedside table. (Photographic evidence obtained). During an interview on 6/7/2026 at 9:55 AM, the Director of Nursing (DON) stated that medications should not be left at the bedside and that his expectation is for staff to follow the facility policy regarding the storage of medications. 3) Review of Resident #38's clinical record documented admission on [DATE] with diagnosis including but not limited to diabetes, muscle weakness, heart failure (heart does not pump efficiently) and cellulitis (infection in the skin). During an observation on 6/7/2026 at 11:45 AM at 10:53 AM of Resident #38's room there was one bottle of hydrogen peroxide 3% topical solution -16 fluid ounces (oz) - 473 milliliters (ml) on the bedside table unsecured. During an observation on 6/8/2026 at 2:42 PM with Staff D, License Practical Nurse (LPN) of Resident #38's room one bottle of hydrogen peroxide 3% topical solution 16 fluid oz - 473 ml was on the bedside table unsecured. (Photographic evidence obtained). 4) Review of Resident #45's clinical record documented an admission date of 9/22/2025 with diagnosis including but not limited to muscle weakness, diabetes, anemia, hepatic fibrosis and anxiety. During an observation on 6/7/2026 at 11:20 AM of Resident #45's room there were two bottles of vitamin B-12 and one bottle of multi vitamins on the bedside table not secured. During an observation on 6/8/2026 at 09:00 AM with Staff D, LPN of Resident #45's room there were two bottles of vitamin B-12 and one bottle of multi vitamins on the bedside table not secured. (Photographic evidence obtained). During an interview on 6/8/2026 at 09:00 AM Staff D, LPN stated medications cannot be left in the rooms. All medications must be secured in the medication cart and labeled with the resident's name. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/8/2026 at 3:00 PM the Director of Nursing stated, Medications must be secured and cannot be left in the rooms. 5) During an observation on 6/7/2026 at 10:10 AM Resident #30 was lying in bed with the head of the bed elevated watching television. There was zinc oxide ointment in the room unsecured. During an interview on 6/7/2026 at 10:10 AM Resident #30 stated, I do not know what the zinc ointment is for. During an interview on 6/8/2026 at 12:50 PM Staff A, LPN stated, There should not be any medication in the rooms. During an interview on 6/8/2026 at 1:00 PM Staff B, RN (Registered Nurse) Unit Manager stated, There should not be any medications in the residents' rooms. Review of the policy and procedure titled Medication/Biological Storage dated 2/24/2026 read, It will be the policy of this facility to store medications, drugs and biologicals in a safe, secure and orderly manner. 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 nurse's view.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident care equipment was cleaned and disinfected between uses in accordance with facility policy for 1 of 3 sit-to-stand assistive devices, Device #7, failed to conduct hand hygiene, and failed to wear personal protective equipment (PPE) while conducting wound care for Resident #66. Findings include: 1) During an observation on 6/7/2026 at 10:20 AM, the Sit-to-Stand assistive device, Device #7, was observed on the [NAME] Hall with a maroon-colored substance splattered on the floor/platform portion of the device. During a subsequent observation with the Director of Nursing on 6/8/2026 at 1:20 PM, the Sit-to-Stand assistive device, Device #7, was observed on Boston Hall with the same, maroon-colored substance splattered on the floor/platform portion of the device. (Photographic evidence obtained). During an interview on 6/8/2026 at 1:22 PM, the Director of Nursing stated, It is our expectation that the equipment is cleaned before and after each use with purple disinfectant wipes, it [Device #7] needs to be cleaned. Review of the policy and procedure titled Transmission Based Precautions, dated 2/24/2026, read, Resident Care Equipment: 1. Handle resident care equipment and instruments/devices according to Standard Precautions. 2. Use disposable noncritical resident care equipment or implement resident-dedicated use of such devices. If the use of equipment for multiple residents is unavoidable, clean and disinfect such equipment before use on another resident. 3. Use of standard facility disinfectants is adequate. 2) Review of Resident #66's clinical record documented an admission date of 4/7/2025 with diagnosis not limited to diabetes mellitus, atherosclerosis (chronic inflammatory disease of cells) of arteries of left leg with ulceration of other part of foot. Review of Resident #66's physician orders dated 4/14/2026 read, Requires enhanced barrier precautions r/t [related to] wound on left foot/toes every shift for wound. Review of Resident #66's physician orders dated 5/27/2026 read, Wound care: left great toe: clean with normal saline/wound cleanser, pat dry, apply meta honey and cover with bordered gauze dressing every evening shift for wound care. During an observation on 6/8/2026 beginning at 2:42 PM Staff D, License Practical Nurse (LPN) entered Resident #66's room, did not perform hand hygiene, did not don gloves or gown, and removed the resident's sock from the resident's left foot that revealed the left big toe with a dressing dated 6/5/2026. Staff D, LPN did not perform hand hygiene, did not don gloves or a gown and proceeded to remove the soiled dressing from the left toe. The wound dressing was saturated with a dark substance. Staff D, LPN walked out of Resident #66's room, into the hall, returned to the room and then returned to the wound treatment cart where she proceeded to go through the wound treatment cart touching and gathering supplies with her bare hands to include 4 x 4 loose gauze. Staff D, LPN returned the packet that held the loose 4 x 4 gauze back into the wound treatment cart. Staff D, LPN stated she was unable to locate wound cleanser. Staff D, LPN closed the wound treatment cart and proceeded to a different supply area to retrieve the wound cleanser needed. Staff D, LPN did not perform hand hygiene prior to exiting the room. During an interview on 6/8/2026 at 2:52 PM Staff D, LPN stated, There are no sanitizers in the room for me to complete hand hygiene. I should have completed hand hygiene with soap and water. I should have placed on a gown and gloves prior to providing wound care. During an interview on 6/8/2026 at 3:10 PM the Director of Nursing stated, Hand hygiene should have been completed, and gown and gloves should have been utilized prior to removing an old dressing. Hand hygiene should be completed before and after each patient contact and before and after wound care. Enhanced Barrier precautions which include gown and gloves are to be worn anytime wound care is provided. Review of the policy and procedure titled Hand Hygiene dated 2/24/2026 read, Using alcohol-based hand rubs. 5. Use an alcohol-based rub containing at least 62% alcohol; or alternatively soap and water for the follow situations: b. before and after direct contact with residents. g. before handling clean or soiled dressings, gauze pad, etc.; i. after contact with a resident's intact skin, k. after handling used dressings, contaminated equipment, etc.; n. before (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and after entering isolation precaution setting.; 6. hand hygiene is the final step after removing and disposing of personal protective equipment. 1. apply generous amount of product to palm of hand and rub hands together. Review of the policy and procedure titled Transmission Based Precautions dated 2/24/2026 read, Hand Washing/Hand Antisepsis 1. MDROs (Multi drug resistant organisms) are transmitted primarily by contaminated hands of staff. The single most effective means of reducing the potential for MDRO transmission is hand antisepsis before and after contact with residents, including after glove removal. 2. Washing hands can accomplish hand antisepsis with an antimicrobial soap and water or by using a waterless alcohol-based hand antiseptic. Gloves 1. In addition to wearing gloves as outlined under Standard Precautions clean, nonsterile gloves are worn when providing direct care (changing clothing, toileting, bathing, dressing changes, etc.) to residents. 2. Wear gloves whenever touching the resident's intact skin or surfaces and articles near the resident. [NAME] gloves upon entry into the room or cubicle. Review of the policy and procedure titled Enhanced Barrier Precautions dated 2/24/2026 read, It will be the policy of this facility to implement enhanced barrier precautions for preventing transmission of novel or targeted multidrug-resistant organisms. b. Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves. 4. For residents for whom EBP are indicated, EBP (enhanced Barrier Precautions) is employed when performing the following High-contact resident care activities. h. wound care: any skin opening, requiring a dressing.		