STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105269	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Groves Center	512 S 11th St Lake Wales, FL 33853

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, the facility failed to implement and maintain an infection prevention and control program to mitigate and prevent the spread of infection related to: 1) not ensuring staff were donning appropriate Personal Protective Equipment (PPE) when entering a resident room under transmission based precautions, 2) not ensure residents were offered handy hygiene prior to meal service for one of four halls observed and 3) did not ensure the laundry area was kept in a manner to prevent the spread of infection.Findings included: An observation was made on 2/2/26 at 12:52 p.m. of staff delivering meal trays to residents on the 400-hall. The observations showed: At 1:02 p.m. Staff E, Licensed Practical Nurse (LPN) was observed delivering tray to room [ROOM NUMBER], A-bed. The staff member did not offer hand hygiene to the resident. At 1:03 p.m. Staff E delivered tray to room [ROOM NUMBER], A-bed. The staff member did not offer hand hygiene to the resident. At 1:05 p.m. Staff M, Risk Manager brought tray to room [ROOM NUMBER] B-bed and did not offer the resident hand hygiene. At 1:09 p.m. Staff E delivered tray to room [ROOM NUMBER] an did offer hand hygiene to the resident. At 1:11 p.m. Staff J, Traveling Social Service Director, brought Resident #9 to room and Staff M, Risk Manager brought tray to resident. The staff members did not offer the resident hand hygiene. At 1:16 p.m. Staff N, Registered Nurse (RN) delivered another tray to room [ROOM NUMBER] A-bed, offering to cut potato and meat. The staff member did not offer hand hygiene to the resident. An interview was conducted on 2/4/26 at 9:39 a.m. with Staff C, LPN/Clinical Reimbursement Specialist (CRS). Staff C, LPN/CRS stated passing meal trays at breakfast and lunch. Staff C stated hand sanitizer is provided in multiple locations. The staff member reported offering hand hygiene to residents. An interview was conducted on 2/4/26 at 9:51 a.m. with Staff O, Certified Nursing Assistant (CNA). Staff O, CNA said I sometimes offers hand hygiene in the dining room. An interview was conducted on 2/4/26 at 10:37 a.m. with Staff P, CNA. Staff P, CNA said hand hygiene is offered when passing meal trays. Staff P said before meals I get the hand sanitizer from (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the wall (waving hand toward wall dispenser in hallway). An interview was conducted on 2/4/26 at 10:40 a.m. with Staff H, LPN. Staff H, LPN said residents do not have hand sanitizer wall dispensers in room, some have individual bottles. Interviews were conducted with a five random residents on the 100, 300, and 400 hallways. The residents reported eating in their rooms. The residents stated hand hygiene is not offered before meals. An observation and interview was conducted on 2/4/26 at 8:25 a.m. of the laundry area with the Nursing Home Administrator (NHA), Account Manager (AM), and Staff Q, laundry aide (LA). Staff Q, LA moved through a narrow walkway with a wooden frame table on one wall and carts on the opposite wall. Above the table was a rack with personal items, hanging barely above top of the table. The table was holding stacks of folded bed linens and gowns with a small area for folding. The laminate top of the folding table was separating from the wood underneath, making an uncleanable surface. Mechanical equipment was observed with exposed wires near ceiling. The wires were smothered with dust. Staff Q, LA stated not cleaning the wires. Staff Q, LA stated only cleaning the laundry every other day. An observation was conducted on 2/4/26 at 10:50 a.m. revealed Staff Q, LA pulling laundry from the washer. The rim of the washer, behind the door was missing a portion of a black-colored gasket and the area had a tan and white colored flaking material, the linens were in contact with this flaking material. The NHA stated she was aware there were issues with the area. An interview was conducted on 2/4/26 at 10:50 a.m. with the NHA. The NHA reported the housekeeping supervisor was responsible for the upkeep and auditing of the laundry area. Photographic evidence was obtained. An observation on 2/4/26 at 11:11 a.m., the Director of Nursing (DON) entered room [ROOM NUMBER] without personal protective equipment (PPE) or performing hand hygiene. room [ROOM NUMBER] had an infection control caddy and a sign on the entrance displaying droplet precautions. The DON exited the room without performing hand hygiene. The DON re-entered the room without gloves or gown and touched the privacy curtain; donned the gown that she was holding while inside the room; and grabbed a clear bag displaying disposable vital sign equipment. The vital sign equipment had not been opened. The DON removed the PPE and exited the room without performing hand hygiene. An interview on 2/4/26 at 11:20 a.m. with the DON was conducted. The DON said her expectation for staff entering a room on droplet precautions are staff need to don a gown, mask, gloves, and face shield. A review of a facility provided policy effective October 2021 titled, Infection Prevention and Control Program revealed: The infection prevention and control program (IPCP) is a comprehensive program that addresses detection, prevention, and control of infections and communicable diseases among residents, visitors, volunteers, those individuals providing services under contractual agreement, and personnel. The goals for the IPCP are to: a. Provision of a safe, sanitary, and comfortable environment; b. Decrease the risk of infection and communicable diseases development and transmission to the residents, volunteers, visitors, individuals providing services under a contractual (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	agreement, and personnel. Procedure: The major activities of the program are: . c. Implementation of infection control and prevention measures Prevention of the spread of infection is accomplished by use of standard precautions, organism specific precautions, and other barriers, appropriate treatment and follow-up, and employee work restrictions for illness; d. Prevention of infection and communicable diseases Staff, volunteers, visitors, those individuals providing services under contractual bases and resident education is done to focus on the risk of infection and practices to decrease risk.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to maintain an ongoing antibiotic stewardship program for 11 of 12 months reviewed.Findings include: An interview was conducted with Staff A, Infection Preventionist (IP) and the Director of Nursing (DON) on 2/4/26 at 10:37 a.m. Staff A, IP said she did not have the infection control logs prior to December 2025. The DON said she had not been able to locate the logs. Staff A, IP said the facility had one resident that was positive for influenza and that resident was being treated with an antibiotic. The DON stated, an antibiotic is not appropriate for a viral infection but that is what the resident was admitted with. The DON said the resident should have been treated with an antiviral medication. Staff A, IP said she does not know if the pharmacist reviews the medications to ensure appropriateness of medications. Staff A, IP said she follows McGeer's Criteria {a standardized surveillance used in long-term care facilities to identify and track infections to prevent the overuse of medications}. Staff A, IP said she had not been completing the McGeer's criteria form and does not know if the facility wants her to complete the form. Staff A, IP said she had not completed hand hygiene audits and review of the hand hygiene audit book revealed the last audit had been completed on 4/22/25. The DON said the facility reviews the infection control prevalence rates each month in the quality assurance meeting; the DON was unable to provide prevalence rates at the time of the interview. The DON was not able explain how tracking was being completed or audited. No documentation was provided for review for antibiotic use, handwashing, or infection tracking including signs and symptoms, prior 12 months was requested. A review of a facility policy effective March 2017 titled, Antibiotic Stewardship revealed, The Centers for Disease Control and Prevention (CDC) recommends that all nursing homes take steps to improve antibiotic prescribing practices and reduce inappropriate use. Per CDC, 40-75% of antibiotics prescribed in nursing homes may be unnecessary or inappropriate. Harm for the fail and older adult can include the risk for diarrheal infections, increased adverse drug events and drug interactions, colonization and/or infection with antibiotic-resistant organisms. Actions taken to improve antibiotic use will reduce adverse events, prevent emergence of resistance, and lead to better outcome for residents. The procedure is as follows: . 3: The Director of Nursing and the Infection Preventionist will monitor for compliance with the Antibiotic Stewardship policies. 4: Antibiotic use and resistance data will be reviewed at the quality assurance and performance improvement meeting and as needed. A review of a facility policy effective April 2017 titled, Antibiotic Stewardship Tracking: Monitoring Antibiotic Prescribing, Use, and Resistance revealed: . measurements of antibiotic use: . monthly prevalence studies regarding antibiotic usage will be presented to quality assurance and performance improvement committee (QAPI). This information can also be located in the infection prevention and control monthly summary manuals. Information provided during the QAPI meeting regarding measurements of antibiotic use will include: 1: days of antibiotic therapy . 2: antibiotic prevalence rate . A review of a facility policy effective April 2017 titled, Antibiotic Stewardship: Actions to Improve Antibiotic Prescribing and Use revealed: . Consultant Pharmacist Support: The facility pharmacy will review antibiotic courses for appropriateness of administration and/or infection. The facility pharmacy will notify staff for clinical/laboratory monitoring to prevent adverse drug events from antibiotic use.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observations, record reviews, and interviews, the facility failed to ensure an assessment of self-administration of medications for one resident (#16) of one resident reviewed.Findings included: During an observation on 02/02/2026 at 10:10 a.m., Resident #16 was observed sitting in a wheelchair near the side of a bed, holding a clear mask with white fog coming from the mask from the nebulizer treatment. The resident stated the nurse brings in the medication for me, and I turn the machine off once I am done. Review of Resident #16's admission record revealed an admission date of 08/04/2025. Resident #16 was admitted to the facility with diagnosis to include chronic obstructive pulmonary disease with (acute) exacerbation, other asthma, respiratory failure, unspecified, unspecified whether with hypoxia or hypercapnia, and other pulmonary embolism without acute cor pulmonale. Review of Resident #16's Minimum Data Set (MDS), section C. Cognitive Patterns revealed a brief mental status (BIMS) of 15 out of 15 showing intact cognition. Review of Resident #16's care plan dated 08/05/2025 revealed there was no care plan for self-administration of medications. During an interview on 2/03/2026 at 2:20 p.m., Staff I, Licensed Practical Nurse (LPN)/Unit Manager (UM), stated when giving a nebulizer treatment the nurse should stay in the room until the treatment is complete. It is best practice to keep the resident in eyesight. During an interview on 02/03/2026 at 2:24 p.m., the Director of Nursing (DON stated when a resident is doing a nebulizer treatment, the nurse should go back in 15 mins to check on the resident. the DON stated the nurse does not need to stay in the room until the treatment has finished. Review of the facility policy titled, Medication Administration, Nebulizer (updraft), dated 01/23 revealed: Policy: to allow for safe, accurate, and effective administration of medication using a small volume nebulizer.Procedures.13. Remain with the resident for the treatment unless the resident has been assessed and authorized to self-administer.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews the facility failed to obtain a blood test to monitor the therapeutic level of a medication used as a psychotropic, for one (#118) of five residents sampled for unnecessary medications. Findings included: On 2/2/26 at 10:25 a.m. Resident #118 was observed lying curled up in bed, covered with a blanket. During random tours of the facility on 2/2 through 2/4/26 the resident was seen sitting in wheelchair in hallway and on covered porch leading to smoking area. Review of Resident #118's admission Record showed the resident was admitted on [DATE] with diagnoses not limited to generalized anxiety disorder (GAD), unspecified recurrent major depressive disorder (MDD), unspecified mood (affective) disorder, and unspecified anxiety disorder. Review of Resident #118's active physician orders included but not limited to the following physician orders: Depakote Oral Tablet Delayed Release 125 milligram (mg) (Divalproex Sodium) - Give 3 tablet(s) by mouth two times a day for mood disorder, ordered 10/13/25. Depakote Valproic Acid levels quarterly every night shift every 90 days, ordered 8/14/25. Review of Resident #118's laboratory testing results from September 2025 to current revealed one Valproic Acid (Depakote) level had been obtained 9/17/25. The result showed a subtherapeutic level of 31 for the medication (reference range 50 - 100). The laboratory results did not show any other Depakote level had been obtained. Review of Resident #118's November 2025 Treatment Administration Record (TAR) showed a Depakote Valproic Acid level was to be obtained on 11/12/25. The TAR did not reveal the sample had been completed (administered), the box allowing for nursing documentation was blank. Review of Resident #118's progress notes from 11/9 - 11/16/25 did not include any documentation from staff revealing the resident had refused the blood draw to be completed or the physician had been notified the lab test had not been obtained on 11/12/25.Review of the policy - Lab/Radiology Process Guidelines, undated, showed staff were to obtain the order for labs/radiology test from the physician, complete the lab/radiology log sheet in the lab/radiology book behind the date of ordered labs/test, and complete and print the electronic requisition sheet and labels then place form behind lab/radiology log sheet under the day the lab/test should be done. The staff, upon receiving the results, notify the physician and resident/resident representative of the results and file the results in the medical record under Labs/Radiology tab, document in a progress note the labs/radiology tests received and who the results were reported to including any additional follow up or new physician orders received, and if a resident refuses the lab/radiology test document the physician was notified along with any guidance and the notification of the resident/resident representative. Review of Resident #118's psychiatry progress note, dated 11/4/25, revealed tapering of the resident's medication would not achieve the desired therapeutic effects therefore a gradual dose reduction was contraindicated. The review of systems showed the resident had a depressed mood, loss of energy, irritability, not able to control worry with aggravating factors of being in the facility, ongoing medical problems, and life stressors. Review of Resident #118's psychology note, dated 1/21/26, revealed the resident was socially isolated and had discussed issues with anxiety and depressed mood. The resident had discussed the difficulty of dealing with loss and dealing with grief, sadness of health conditions, and talked about missing things. The resident had appeared sad, wary, irritable, attentive, communicative, normal weight, casually groomed, and unhappy. The resident was tearful, thought content was depressed, and body posture and attitude conveyed an underlying depressed mood. An interview and online lab review was conducted on 2/3/26 at 4:04 p.m. Staff H, Licensed Practical Nurse (LPN). The staff member was unable to locate any Depakote lab results other than the one on 9/16/25. An interview was conducted on 2/4/26 at 10:28 a.m. with the Director of Nursing (DON). The DON stated in the future staff are to ensure labs are done and if not to let the physician know and ask if they want to order them stat. The DON stated she was unable to locate the Depakote results (ordered for 11/12/25).

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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 interview and record review, the facility failed to ensure residents with a serious mental disorder(s)/diagnoses were referred to the State's Mental Health authority for a Level II Preadmission Screening and Resident Review (PASRR) review for two residents (#9 and #10) out of five residents sampled. Findings included: 1. Review of Resident #10's admission record showed the resident was admitted on [DATE]. The record included diagnoses not limited to unspecified schizophrenia, unspecified depression, unspecified anxiety disorder, and chronic post-traumatic stress disorder. Review of Resident #10's Minimum Data Set (MDS) dated [DATE], Section N- Medications revealed antipsychotic, antianxiety, and antidepressant usage.Review of Resident #10s Pre-admission Screening and Resident Review (PASRR) dated 1/28/26 revealed anxiety disorder, depressive disorder, schizophrenia, chronic post-traumatic stress disorder, and unspecified insomnia marked in Section A. These findings were based on documented history, individual, legal representative or family report, and medications. The screening showed the resident had no functional limitations in major life activities, no interpersonal functioning, no concentration, persistence, and pace; no difficulty with adaptation to change, and no recent treatment for mental illness requiring psychiatric treatment more intensive than outpatient care or significant disruption to normal living. A review of Resident #10's psychiatric note dated 1/21/26 showed the resident has continued anxiety symptoms, feelings of depersonalization, persistent worry, depression related symptoms, and feelings of grief. Review of Resident #10's care plan revealed a focus- Psychotropic medication, the resident uses psychotropic medications related to antidepressant to manage depression, antianxiety to manage anxiety, and anti-psychotic to manage schizophrenia with delusions.On 2/3/26 at 4:33 p.m., an interview was conducted with the Director of Nursing (DON). She reviewed Resident #10's PASRR and stated a Level II may not be necessary if the Resident is not currently affected by the mental illness. On 2/4/26 at 10:15 a.m., an interview was conducted with Staff J, Travelling Social Services Director (SSD). Staff J stated a Level II PASRR is not automatically submitted solely based off the resident having a diagnosis of schizophrenia. Staff J stated if the symptoms are managed through medication and the resident is not exhibiting disruptive behaviors, the resident does not need a Level II. 2. Review of Resident #9's admission Record showed the resident was admitted on [DATE] and 2/18/22. The record included diagnoses not limited to bipolar type schizoaffective disorder (2/18/22), cognitive communication deficit (6/28/20), unspecified schizophrenia (2/18/22), adjustment disorder with mixed disturbance of emotions and conduct (1/24/18), and unspecified recurrent major depressive disorder (12/12/17).Review of Resident #9's record on 2/2/26 at 2:21 p.m. revealed a Pre-admission Screening and Resident Review (PASRR) dated 12/13/23 and completed at the facility. The screening revealed diagnoses of anxiety disorder, bipolar disorder, depressive disorder, schizoaffective disorder, schizophrenia, cognitive communication disorder, adjustment disorder, and psychosis. Review of Resident #9's psychiatry note, dated 1/23/26, showed the resident denied changes in mood or concerning exacerbations with regards to psychotic features relevant to past psychiatric history. The plan was to continue with Depakote and Risperdal related to unspecified schizophrenia, unspecified recurrent major depressive disorder, and bipolar type schizoaffective disorder. The note revealed the patients chart was reviewed on 10/21/25 for confirmation of the diagnosis and report from a behavioral health facility confirmed the diagnosis with alteration in mood, hallucinations, and delusions of God (12/5/17). Review of Resident #9's PASRR dated 2/3/26 included diagnoses of depressive disorder, schizoaffective disorder, schizophrenia, adjustment disorder with mixed disturbance of emotions and conduct, bipolar type schizoaffective disorder, and cognitive communication deficit based on documented history, individual, legal (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	representative or family report, and medications. The review showed the resident did not have a disorder resulting in functional limitations in major life activities, did not have or may have had serious difficulty with interpersonal functioning, concentration, persistence, and pace, and/or adaptation to change. The screening showed the resident did not have a diagnosis of dementia or related neurocognitive disorder, and a Level II evaluation was not required due to the resident not having a diagnosis or suspicion of a serious mental illness or intellectual disability. An interview was conducted on 2/3/26 at 4:28 p.m. with the Director of Nursing (DON). The DON reviewed the resident's PASRR and stated if it was not affecting them at the moment they may not need a Level II. An interview was conducted on 2/4/26 at 9:56 a.m. with Staff J and Staff L, facility Social Service Director (SSD). Staff J reported doing the PASRR's and had completed online tutorial training with contracted PASRR provider and other staff. Staff J described the process of putting resident's diagnoses based on history, behaviors, and medications and the system triggers a Level II. The staff member stated a PASRR should be completed at time of admission and are reviewed by self and other clinical staff at time of admission during clinical meetings and if the resident was having changes or conditions. If the resident doesn't have a PASRR at admission the SS will do it or ask transferring facility to provide so it will be completed same day as the admission. The staff member reviewed Resident #9s PASRR and stated if they are being managed by medications, seeing psych, and not displaying any behaviors they are stable, and they are controlled. Staff J stated schizophrenia was not an automatic (Level II) if the resident was not exhibiting behaviors. Staff J said, Schizophrenia is a mental illness, I don't determine if it is a serious mental illness, (State Approved Vendor) does. Review of the policy, PASRR – Requirements for Completion, effective August 2025 showed Preadmission screening will be conducted prior to admission as the PASRR process is federally mandated pre-admission screening program (see 42 CFR 483.100) required to be performed on all individuals prior to admission to a nursing home. The Screening is reviewed by admissions for suspicion of serious mental illness and intellectual disability to ensure appropriate placement in the least restrictive environment and to identify the need to provide applicants with needed specialized services. ASR screening applies to all new admissions into a Medicaid certified nursing facility and includes private pay, Medicare, and Medicaid admissions regardless of payer source. The procedure revealed:1. During the admissions process, admissions will communicate with the facility regarding prospective admissions. A level 1 PASR will be provided prior to admission to the skilled nursing facility. The facility administration will confirm that a level 1 review has been completed prior to the transfer to the SNF setting.2. Determine if a serious mental illness and/ or intellectual disability or a related condition exists while reviewing the PSR form completed by the acute care facility. (Trigger for Level II Completion)3. If serious mental in illness or ID is indicated, determine if the resident will be admitted from a hospital for an acute care stay and the attending physician has certified that the individual is likely to require less than 30 days of nursing facility services. Assure that the certification is signed and dated.4. If the physician indicates the state will likely be less than 30 days SNF services, the resident can be admitted to an SNF. If the anticipated stay becomes longer than 30 days a level II must be completed prior to day 40.The Florida specific guidelines of the policy revealed staff were to ensure that sections 1 - 5 are completed prior to admission. If the pre admission screening requires a level 2 evaluation submit all required documents to [State Approved Vendor] timely, so a level II can be completed within the required time frames.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews the facility failed to ensure Pre-admission Screening and Resident Review (PASRR) screenings were completed accurately at the time of admission for two (#42 and #118) of six residents sampled for the accuracy of PASRRs.Findings included: Review of Resident #42's admission Record showed the resident was admitted on [DATE] with diagnoses not limited to cognitive communication deficit, dementia in other diseases classified elsewhere unspecified severity with anxiety, moderate recurrent major depressive disorder, generalized anxiety disorder, and unspecified Alzheimer's disease. Review of Resident #42's PASRR level I located in the paper chart, on 2/2/26 at 3:05 p.m. revealed a screening dated 11/11/25 showing the resident did not have any mental illness, suspected mental illness, and/or intellectual disability based on documented history. The screening showed the resident had no indication of a disorder resulting in functional limitations in major life activities did not have difficulty with interpersonal functioning, concentration, persistence, and pace, or adaptation to change. The screening showed the individual had not exhibited actions or behaviors that may make them a danger to themselves or others, did not have a primary diagnosis of dementia or related neurocognitive disorder, and did not have a secondary diagnosis of dementia, related neurocognitive disorder and the primary diagnosis was a serious mental illness or intellectual disability. The screening showed a Level II evaluation was not required. Review of Resident #42's care plan showed the resident was noted with the following behaviors: Attempted to get out of bed without assistance, resident becomes agitated easily, resident noted with preference of being on floor at times, resident has verbal and physical behaviors directed at others at times. The focus was initiated on 11/14/25 and revised on 1/31/25. Review of Resident #42's psychiatry note dated 1/20/26 revealed the review of systems shown a loss of energy related to depression, obsessions/compulsions related to anxiety and an impairment of complex attention, learning and memory and perceptual motor related to dementia. The aggravating factors were being in the facility, ongoing medical problems, and life stressors. The resident was lethargic and non-responsive, lethargic and detached with a limited fund of knowledge, poor judgement and poor attention and concentration. Review of a facility provided Level I PASRR, dated 2/2/26 showed diagnoses of anxiety disorder, depressive disorder, dementia in other diseases classified elsewhere unspecified severity with anxiety, and unspecified Alzheimer's disease. The screening showed the resident had no indication of a disorder resulting in functional limitations in major life activities did not have difficulty with interpersonal functioning, concentration, persistence, and pace, or adaptation to change. The screening showed the individual had not exhibited actions or behaviors that may make them a danger to themselves or others, did not have a primary diagnosis of dementia or related neurocognitive disorder, and did not have a secondary diagnosis of dementia, related neurocognitive disorder and the primary diagnosis was a serious mental illness or intellectual disability. The screening showed a Level II evaluation was not required. During an interview on 2/3/26 at 4:27 p.m. the Director of Nursing (DON) reviewed the Level I PASRR completed on 11/11/25 and stated the PASRR should have been redone to include all diagnoses. During an interview on 2/4/26 at 10:07 a.m. Staff J reviewed the PASRR completed on 11/11/25 and stated they did an audit this week and it had been redone on 2/2/26. 2. Review of Resident #118's admission Record showed the resident was admitted on [DATE] and 8/14/25. The record included diagnoses not limited to generalized anxiety disorder (10/13/24), unspecified recurrent major depressive disorder (10/13/24), unspecified insomnia (12/10/25), uncomplicated unspecified cannabis use (10/12/24), unspecified mood (affective) disorder (10/12/24), and unspecified anxiety disorder (10/12/24). Review of Resident #118's record on 2/2/26 at 2:33 p.m. did not show a PASRR had been uploaded into the electronic record. The PASRR in the resident's paper chart reviewed on 2/2/26, was dated 9/19/24 and completed at an acute care facility did not show the resident had any mental illnesses, suspected (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mental illness, and/or intellectual disability. Review of Resident #118's PASRR, which the facility provided on 2/3/26, was dated 2/3/26 and included Resident #118s diagnoses of anxiety disorder, depressive disorder, substance abuse, unspecified insomnia, and unspecified mood (affective) disorder. The screening showed the resident had no functional limitations in major life activities, no interpersonal functioning difficulty, no concentration, persistence and/or pace difficulties, no adaption to change difficulty, or and a recent treatment requiring more intensive than outpatient or a significant disruption to the normal living situation. Review of Resident #118's psychology note dated 1/21/26 showed continued stress-related symptoms had been reported by the resident, was having anxiety symptoms, having episodes of crying, feelings of bitterness and irritability had occurred, and had been preoccupied with feelings of loss and sadness. The resident had discussed a depressed mood, issues with anxiety, difficulty of dealing with loss and grief during the session. An interview was conducted on 2/3/26 at 4:25 p.m. with the Director of Nursing (DON). The DON reviewed Resident #118's PASRR and stated it should have been redone prior. During an interview on 2/4/26 at 10:09 a.m. Staff J (Traveling Social Service Director) confirmed the PASRR had missing diagnoses and reported redoing the PASRR on 2/3/26 as the facility had done an audit and it was time to do it. Review of the policy, PASRR - Requirements for Completion, effective August 2025 showed Preadmission screening will be conducted prior to admission as the PASRR process is federally mandated pre-admission screening program (see 42 CFR 483.100) required to be performed on all individuals prior to admission to a nursing home. The Screening is reviewed by admissions for suspicion of serious mental illness and intellectual disability to ensure appropriate placement in the least restrictive environment and to identify the need to provide applicants with needed specialized services. ASR screening applies to all new admissions into a Medicaid certified nursing facility and includes private pay, Medicare, and Medicaid admissions regardless of payer source. The procedure revealed:1. During the admissions process, admissions will communicate with the facility regarding prospective admissions. A level 1 PASR will be provided prior to admission to the skilled nursing facility. The facility administration will confirm that a level 1 review has been completed prior to the transfer to the SNF setting.2. Determine if a serious mental illness and/ or intellectual disability or a related condition exists while reviewing the PSR form completed by the acute care facility. (Trigger for Level II Completion)3. If serious mental in illness or ID is indicated, determine if the resident will be admitted from a hospital for an acute care stay and the attending physician has certified that the individual is likely to require less than 30 days of nursing facility services. Assure that the certification is signed and dated.4. If the physician indicates the state will likely be less than 30 days SNF services, the resident can be admitted to an SNF. If the anticipated stay becomes longer than 30 days a level II must be completed prior to day 40.The Florida specific guidelines of the policy revealed staff were to ensure that sections 1 - 5 are completed prior to admission. If the pre admission screening requires a level 2 evaluation submit all required documents to CARES timely, so a level II can be completed within the required time frames.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to update and revise the person-centered comprehensive care plan for one resident (#50) of six residents sampled.Findings included: A review of the admission record for Resident #50 showed she was admitted to the facility on [DATE] with diagnoses including but not limited to needing assistance with personal care and type 2 diabetes mellitus with foot ulcer. A review of Resident #50's Minimum Data Set (MDS), Section C, dated 1/05/2026 revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating cognitively intact. A review of Resident #50's evaluations revealed skin checks completed within the last two months revealed no skin impairments. A review of Resident #50's care plan revealed she is care planned for an actual wound on her left heel. The goal was to minimize additional wound from developing. The interventions included treatment as ordered; and observe that dressing is covered and adhering. An interview on 2/4/2026 at 9:29 A.M. with Staff B, Registered Nurse. She said Resident #50 does not have any wounds or redden areas on her bottom or feet. An observation on 2/4/2026 at 9:58 A.M. of Resident #50's skin revealed resident does not have a wound on the left heel or on her bottom. The observation was conducted with Staff C, Licensed Practical Nurse, (LPN) present. An interview was conducted at that time with Staff C, LPN. She said she is responsible for updating Resident #50's care plan. She said she does not know why Resident #50's care plan reveals that she had a wound; she said she does not remember her ever having a wound. An interview on 2/4/2026 at 10:02 A.M. with the Director of Nursing (DON) was conducted. She said Resident #50 does not have a wound on her bottom or her feet. She said she does not know why Resident #50 was care planned for an actual wound on her left heel. A review of a facility provided policy effective October 2021, titled, Wound Prevention and Treatment Overview revealed, 5: Review and revise plan of care as need. A review of a facility provided policy effective February 2024, titled, Care Plan - Interdisciplinary Plan of Care from Intern to Meeting was reviewed. The policy is as follows: The comprehensive care plan is an interdisciplinary communication tool. It includes measurable objectives and time frames and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan is reviewed and revised periodically, and the services provided or arranged are consistent with each resident's written plan of care. The procedure is 2: update to care plans, a: ongoing updates to care plans are added by a member of the interdisciplinary team, as needed. 3: Dates and documentation of the plan of care, a: new, revised, or discontinued problems, goals, or interventions are dated for the date the documentation was made.

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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 observations, record reviews, and interviews the facility failed to provide one resident (#42) of two residents an environment that was free from avoidable accidents and hazards related to implementation of adequate non-slip material under moveable floor mats.Findings included: An observation was made on 2/2/26 at 10:55 a.m. of Resident #42 lying on floor in between a low bed (pushed against wall) and an oversized floor mat (approximately same height as bed). The air mattress on bed was uneven full of distinct lumps, bumps and irregular surface. The resident was fidgeting on the floor and appeared to be trying to raise up. The resident grasped back of head and said ouch. Staff J, Traveling Social Service Director (SSD) was walking by room and notified of the resident being on the floor. Review of Resident #42's Situation, Background, Appearance, and Recommendation (SBAR) dated 2/2/26 at 11:15 a.m. showed the nurse was notified that the resident had rolled from the mattress onto the floor. The resident was immediately removed from the floor using a Hoyer lift. Resident was assessed and vital signs were within normal limits. MD (Medical Doctor) and family notified. Resident will be transferred for CAT (Computed Tomography) scan of head. Review of Resident #42's care plan showed the resident was at risk for falls or fall related injury because of deconditioning (and) gait/balance problems. The interventions included but not limited to : (name brand - non slip material) between floor and fall mat to prevent movement Floor mats bilateral to sides of bed while in bed.An observation was conducted on 2/3/26 at 1:14 p.m. with Staff K, Certified Nursing Assistant (CNA) of the floor under Resident #42's floor mat. The observation revealed the floor mat was folded in half widthwise with no non-slip material visible. The staff member moved the floor mat without difficulty and revealed 2 pieces of non-slip material, one approximately 4-inch x 6 inch and the other approximately 6-inch x 8 inch. Staff K stated those (pieces of non-slip material) were not going to stop the floor mat from moving. The floor mat was approximately 3-foot-wide x length of bed x 6-8 inches tall. An observation was attempted on 2/3/26 at 1:36 p.m. of the pieces of non-slip material with the Director of Nursing (DON). Staff K was assisting Resident #42 with eating. Photographic evidence was shown to the DON who stated she did not feel that there would be enough non-slip material to keep it (floor mat) sticking to the ground.Review of the policy - Fall and Injury Reduction Policy, effective March 2023, revealed The facility has designated and implemented processes, which strive to reduce the risk for falls and injuries. This policy guides the identification, implementation of appropriate interventions, and management. It is expected this policy will assist the facility with reducing the likelihood of a fall or injury while maintaining or maximizing dignity and independence through education of staff and residents, early identification of risk factors by collecting data, identifying resident behavior which may increase the likelihood of such occurrence. The guidelines included:1. Evaluate and review to identify risk factors for falls and injuries. a. Review the completed admission/ readmission data collection and baseline care plan, as a recent fall pre admission places the resident at risk, interventions to be implemented based on why the resident fell previously and current risk factors.2. Review/ evaluate other interdisciplinary data collection tools such as Brief Interview of mental status (BIMS) score or other cognition assessment, mobility etc.3. Discuss goals and interventions with resident/ resident representative/ family for inclusion in the plan of care.4. Implement a plan of care based on individual resident needs.5. Communicate interventions during shift report, daily clinical rounds and/ or entry on electronic care communication tool to the caregiving team.7. Review and revise the plan of care as needed to reflect resident current needs. Photographic evidence was obtained.

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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 observations, record reviews, and interviews the facility failed to implement pharmacy recommendations for one resident (#118) of five residents sampled for unnecessary medications.Findings included: On 2/2/26 at 10:25 a.m. an observation was made of Resident #118 lying in bed tucked into blanket with eyes closed. Other random observations showed the resident propelling self in wheelchair in hallway and on covered porch leading to the smoking area. Review of Resident #118's pharmacy recommendations showed the Consultant Pharmacist had recommended on 10/20/25 to Please add to Medication Administration Record (MAR) monitoring for signs and symptoms of bleeding due to orders for aspirin and clopidogrel. The recommendation showed an unknown person had written Added on the recommendation. Review of Resident #118's Order Summary Report with active physician orders showed an order had been added instructing staff to Monitor for signs and symptoms of bleeding and thromboembolism during each nursing shift. Notify prescriber If resident experiences any of the following: signs/symptoms (s/s) of bleeding: dark/ discolored urine, black tarry stools, nosebleeds, vomiting and/ or coughing up blood. S/S Of thromboembolism: pain or tenderness and swelling of upper and lower extremity: increased warmth, edema and/or erythema of affected extremity; Unexplained shortness of breath (SOB); chest pain; Coughing; hemoptysis; feeling every shift. The order date was 2/3/26 and started on 2/3/26. An interview was conducted on 2/4/26 at 12:16 p.m. with the Director of Nursing (DON). The DON reported recommendations are forwarded from the consultant pharmacist to the DON and as far as she was concerned when the pharmacist sends the recommendations, she prints them and gives to the physician to review, and they either accept or decline it. A review of Resident #118's December 2025 MAR and Treatment Administration Record (TAR) was conducted and the order for monitoring was not found. Review of the current physician orders revealed the order had been ordered on 2/3/26 and she stated, they just added it. She stated they should have added it prior to this. Review of the facility policy titled, Medication Regimen Review and Reporting, dated 01/24, showed - Medication Regimen Review (MRR) or Drug regimen review is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risk associated with medication. The Mr. Includes review of the medical record in order to prevent, identify, report, and resolve medication related problems, medication errors, or other irregularities. The MRI also involves collaborating with other members of the interdisciplinary team (IDT), including the resident, their family, and/ or resident representative. The procedure guidelines showed 8. The nursing care center follows up on the recommendations to verify that appropriate action has been taken. Recommendations should be acted upon within 30 calendar days or per facility specific protocols. c. For recommendations that do not require physician intervention, the director of nursing or licensed designee will address the recommendations.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, record review and interviews, the facility failed to ensure a medication error rate of less than 5.00%. Thirty-nine medication administration opportunities were observed, and four errors were identified for one resident (#31) of five residents observed. These errors constituted a 10.26% medication error rate.Findings included: On 2/3/26 at 9:03 a.m. an observation of medication administration with Staff I, Licensed Practical Nurse (LPN)/Unit Manager (UM)) was conducted with Resident #31. The staff member dispensed the following medications into separate medication cups: Amiodarone 100 milligram (mg) tablet Vitamin C 500 mg tablet 2 - Depakote Delayed Release 125 mg sprinkles capsules Eliquis 5 mg tablet Metoprolol Tartrate 50 mg tablet Sodium Bicarbonate 650 tabletDuring the continued obnservation,Staff I, LPN, confirmed 7 oral tablets as the multi-vitamin tablet could not be crushed and stated the order would need to be changed to liquid. Staff I crushed each medication placing it back into the medication cup before stacking them together alternating an empty cup. The staff member entered the room, obtaining approximately 4 ounces of tap water from the sink inside the room before donning a gown and gloves. The staff member removed a 60 cubic centimeter (cc) syringe and repositioned the resident with a Certified Nursing Assistant (CNA) assistance. The staff member inserted the syringe into Resident #31's gastrostomy tube (g-tube) and flushed with approximately 30 cc of water, the staff member then poured water of unknown amount (approximately 5-10 cc) into the medication cup and used spoon to swish the liquid around before pouring into the syringe and then placed more water in cup using spoon to stir and poured into the syringe. [NAME] residual was observed in the bottom of the cup and along the sides. The staff member poured an unmeasured amount of water into the syringe, identifying it as 30 cc's, and poured the unknown amount of water into a cup and using a spoon to stir, poured into the syringe before flushing. Staff I poured an unmeasured amount of water into the cup using a spoon to stir and poured the medication into the syringe. The staff member refilled the water into the med cup, stirring the mixture. Fragments of medications were seen floating in the med cup before the staff member poured it into the syringe, the staff member poured a small amount of water (approximately 5 cc's) into the med cup. More fragments of medications were seen in the syringe. Staff I flushed the syringe and poured water into the medication cup stirring the mixture with a spoon before pouring it into the syringe. [NAME] residual was seen along the bottom and side of the medication cup. The staff member repeated the process before flushing again and closing the tube. Staff I reviewed the medication cups and confirmed the powdered remnants of medication in the bottom and sides of four medication cups. Staff I confirmed the resident had not received the full prescribed dosage. Staff I stated their process was to dissolve medications at the bedside.Review of the observation did not reveal Staff I had either checked placement of gastrostomy tube or checked for residual prior to the administration of medications per the facility's medication administration policy. An interview was conducted with the Director of Nursing (DON) on 2/3/26 at 4:31 p.m. The DON stated she was aware of the issues with the medication pass. The DON acknowledged there were late meds, throwing lancet (on floor), and crushing of medications. She stated her expectation was for medications to be crushed individually, administered individually, and to pour water back in (medication cup) to make sure the medication was completely gone.Review of the policy titled Medication Administration Enteral Tubes, dated 01/25, revealed The nursing center assures the safe and effective administration of enteral formulas and medications. Selection of enteral formulas, routes and methods of administration, and the decision to administer medications via enteral tubes are based on nursing assessment of the resident's condition, in consultation with the physician, dietitian, and the pharmacist. The policy showed #10: Crushed medications are not mixed together. The powder from each medication is mixed with water before administration. The souffle cup is rinsed with water to get all of the medication contained within the cup to facilitate the ordered dose. The procedure instructed staff in the following:2. Prepare medications for administration.b. Crush each immediate-release tablet, one at a (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time, into a fine powder, and dissolve in water (or follow manufacturer's specification for dissolving).c. Open each immediate release capsules, one at a time, crush contents into a fine powder, and dissolve in water (or follow manufacturer's specification for dissolving).3. Provide privacy4. Put on gloves5. Explain procedure to the resident.6. If resident is in bed, elevate head of bed to an approximate 30-to-45-degree angle (semi- or high-Fowler's position).8. Verify tube placement per facility protocol.9. Check gastric content for residual feeding Return residual volumes to the stomach. Report any residual above 100 milliliters (mL)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observations, record review and interviews the facility failed to ensure two residents (#36 and #11) of five observed residents received medications within the scheduled time frame and failed to ensure the physician was notified prior to the administration of late medications.Findings included: Review of the facility Medication Administration Times schedule showed daily medications were scheduled at 9:00 a.m., twice daily was scheduled for 9:00 a.m. and 5 p.m., and three times a day was scheduled for 9:00 a.m., 1:00 p.m., and 5 p.m. The time schedule revealed with meals medications were scheduled for 8:00 a.m. and 6 p.m. On 2/3/26 at 11:52 a.m. Staff B, Registered Nurse (RN) was observed in the hallway standing at the medication cart. The observation revealed Resident #36's medication profile was colored red, indicative of late medications. Staff B, RN was observed dispensing the following medications: Eliquis 2.5 milligram (mg) tablet Gabapentin 400 mg capsule Metoprolol tartrate half tablet of 25 mg's = 12.5 mg Potassium extended release 10 milliequivalents (meq) Torsemide 20 mg tablet Tramadol 50 mg tablet Valproic acid 250 mg/5 milliliter (mL) = 10 mLStaff B confirmed dispensing 6 oral medications and one liquid. The staff member crushed the medications, opened the capsule of gabapentin, and stirred them with a scoop of pudding. The staff member handed the cup to the resident while watching the resident. Review of the Resident #36's Medication Administration Record (MAR) revealed the following orders with scheduled times: Eliquis 2.5 mg - Give 1 tablet by mouth two times a day for thrombotic disorder, scheduled for 9:00 a.m. and 5:00 p.m. Neurontin oral capsule 400 mg (gabapentin) - Give 1 capsule by mouth two times a day for convulsions, scheduled for 9:00 a.m. and 5:00 p.m. Ultram tablet 50 mg (tramadol) - Give 1 tablet by mouth two times a day for pain, scheduled for 9:00 a.m. and 5:00 p.m. metoprolol tartrate - Give 12.5 mg by mouth one time a day related to essential (primary) hypertension, scheduled for 9:00 a.m. potassium chloride oral packet 10 meq - Give 10 meq by mouth one time a day for hypokalemia, scheduled for 9:00 a.m. torsemide 20 mg - Give 1 tablet by mouth one time a day for fluid retention, scheduled for 9:00 a.m. valproic acid 250 mg/5 mL - Give 10 mL by mouth two times a day for seizures, scheduled for 9:00 a.m. and 5:00 p.m. Review of Resident #36's Medication Admin Audit Report revealed the following medications and the times when administered. The report showed twice daily medications were administered within approximately 5 hours and 45 minutes of doses. Eliquis administered at 11:53 a.m. and 5:41 p.m. Neurontin administered at 11:54 a.m. and 5:41 p.m. Ultram administered at 11:57 a.m. and 5:41 p.m. Valproic acid administered at 11:59 a.m. and 5:41 p.m. The audit revealed Resident #36's 9:00 a.m. medications were administered 3 hours after the scheduled time and 2 hours after the accepted one hour before, one hour after administration time. Review of Resident #36's progress notes including electronic MAR notes, on 2/3/26 at 12:47 p.m. did not show the medications were given outside to the scheduled time and/or the physician was notified of late medications prior to the administration. 2. On 2/3/26 at approximately 12:08 p.m. Staff I, RN was observed dispensing medications for Resident #11. The resident's med profile was colored red, revealing medications were late. The staff member dispensed the following medications: Amiodarone 100 mg tablet Eliquis 5 mg tablet Furosemide 40 mg tablet Gabapentin 300 mg capsule Hydralazine 10 mg tablet Jardiance 25 mg tablet Magnesium oxide 400 mg tablet Metformin 1000 mg tablet metoprolol tartrate sacubitril-valsartan 24-26 mg tablet tolterodine tartrate 2 mg tablet insulin glargine 100 unit/mL - 20 unitsThe staff member obtained a blood glucose level of 254 from the resident's right first finger. Review of Resident #11s Medication Administration Record (MAR) revealed the following physician orders: amiodarone 100 mg - give 1 tablet by mouth one time a day for atherosclerotic heart disease of native coronary artery without angina pectoris. eliquis 5 mg - give 1 tablet by mouth two times a day for atrial fibrillation (afib). furosemide 40 mg - give 1 tablet by mouth two times a day related to unspecified systolic (congestive) heart failure. gabapentin 300 mg - give 2 capsules by mouth two times a day for seizures. hydralazine 10 mg - give 1 tablet by mouth three times a day related to essential (primary) hypertension. empagliflozin (Jardiance) 25 mg - give 0.5 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tablet by mouth one time a day for diabetes mellitus (dm). magnesium oxide 400 mg - give 1 tablet by mouth two times a day for supplement, metformin 1000 mg - give 1 tablet by mouth two times a day related to type 2 diabetes mellitus with hyperglycemia. metoprolol tartrate 50 mg - give 1 tablet by mouth two times a day related to essential (primary) hypertension, give with meals. sacubitril-valsartan 24-26 mg - give 1 tablet by mouth two times a day for hypertension (htn). tolterodine tartrate 2 mg - give 2 mg by mouth two times a day for urinary retention. Lantus subcutaneous solution 100 unit/mL - inject 20 unit subcutaneously one time a day related to type 2 diabetes mellitus with hyperglycemia. Review of Resident #11s Medication Admin Audit Report for 2/3/26 revealed the following administration times for the scheduled 9:00 a.m. medications and subsequential administrations: Amiodarone was administered at 12:14 p.m. (scheduled one time a day at 9:00 a.m.) Eliquis was administered at 12:14 p.m. and 7:29 p.m. (scheduled for 9:00 a.m. and 5:00 p.m.) Furosemide was administered at 12:15 p.m. and 7:29 p.m. (scheduled for 9:00 a.m. and 5:00 p.m.) Gabapentin was administered at 12:16 p.m. and 7:29 p.m. (scheduled for 9:00 a.m. and 5:00 p.m.) Hydralazine was administered at 12:16 p.m., 2:02 p.m., and 7:29 p.m. (scheduled for 9:00 a.m., 1:00 p.m., and 5:00 p.m.) Empagliflozin was administered at 12:17 p.m. (scheduled for 9:00 a.m.) Magnesium oxide was administered at 12:17 p.m. and 7:29 p.m. (scheduled for 9:00 a.m. and 5:00 p.m.) Metformin was administered at 12:19 p.m. and 7:29 p.m. (scheduled for 9:00 a.m. and 5:00 p.m.) Metoprolol tartrate was administered at 12:20 p.m. and 8:20 p.m. (scheduled for 9:00 a.m. and 9:00 p.m.) Sacubitril-valsartan was administered at 12:21 p.m. and 8:20 p.m. (scheduled for 9:00 a.m. and 9:00 p.m.) Tolterodine tartrate was administered at 12:22 p.m. and 7:29 p.m. (scheduled for 9:00 a.m. and 5:00 p.m.)Insulin glargine 100 unit/mL (20 units) was administered at 12:28 p.m. (scheduled for 9:00 a.m.)Review of the scheduled times and the audit report showed the medications were given outside of the accepted one hour before and one hour after parameters with a few exceptions on the evening shift. The resident's metoprolol was ordered to give with meals but scheduled for 9:00 p.m. at night, after meals had been served. The resident received two doses of hydralazine within one hour and 46 minutes of each other. Review of Resident #11's progress notes including electronic MAR notes, on 2/3/26 at 12:41 p.m. did not show documentation that the medications were given outside to the scheduled time and/or the physician was notified of late medications prior to administration. During an interview on 2/3/26 at 4:31 p.m. the Director of Nursing (DON) acknowledged being aware of the issues with med pass - late meds, throwing a lancet in garbage and crushing of medications. An interview was conducted on 2/4/26 at 9:35 a.m. with Staff B, Registered Nurse (RN). The staff member stated the issue with the medication pass (on 2/3/26) was trying to find residents and stated being new, so working on time management. Staff B reported being aware prior to yesterday of the protocol to notify someone that meds were late. An interview was conducted on 2/4/26 at 11:17 a.m. with the Consulting Pharmacist (CP). The CP stated she would expect facility staff to administer medications on time and believed twice daily medications were scheduled for 9:00 a.m. and 5:00 p.m. Review of the late medications administrations for Resident #36 and Resident #11 were discussed and the pharmacist stated, 100% agree with the Eliquis, needs to be given at same time to stay stable, she elaborated saying some medication like Prozac can stay in the body. The CP agreed medications are to be given within 1 hour (of scheduled times) and Lantus doesn't stay in the body to be given 3 hours late, also the gabapentin and metoprolol should be given within the time frames.Review of the policy - Medication Administration General Guidelines dated 01/25, revealed Medications are administered as prescribed in accordance with manufacturers specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they've familiarized themselves with the medication. The policy instructed: 3. Medication administration timing parameters include the following: b. Medications to be given with meals are to be scheduled for administration at the resident's meal times. 14. Medications are administered within 60 minutes of scheduled time, except before after meal orders, which are administered based on meal times period unless otherwise specified by the prescriber, routine (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105269	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Groves Center	512 S 11th St Lake Wales, FL 33853

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications are remastered according to the established medication administration schedule for the nursing care center. Medication should not be given at meal times or in the dining room unless specifically ordered with meal.The documentation should include: 2. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (for example, the resident is not in the nursing care center at scheduled dose time, or an initial dose of antibiotic is needed), the nurse shall document either in the electronic medication administration record or the paper MAR that the dose was withheld, refused, or given at other than scheduled time, and enter an explanatory note (reverse side of paper MAR or in the designated area of the electronic health record).