STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105287	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westside Oaks Rehabilitation & Nursing Center	2061 Hyde Park Rd Jacksonville, FL 32210

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide accurate Preadmission Screening and Resident Reviews (PASRRs) for seven (Residents #23, #62, #63, #65, #76, #101, and #167) of eight residents sampled for PASRRs and identified with a mental disorder (MD) and/or intellectual disability (ID), and failed to ensure that the residents were properly evaluated and received care and services in a setting appropriate for their needs. The findings include:1.A review of Resident #23's medical record revealed an admission date of 5/8/2025 with the latest readmission on [DATE]. His diagnoses included generalized anxiety disorder (5/12/2025), schizophrenia (5/08/2025), brief psychotic disorder (5/12/2025), major depressive disorder (5/12/2025), and alcohol abuse (5/8/2025).A review of the resident's active care plan revealed focus areas including:7/8/2025: [Resident #23] has potential for impaired or inappropriate behaviors r/t Dementia: AEB (as evidenced by) refusing blood pressure, cognitive loss, ineffective coping skills.9/5/2025: [Resident #23] has had a history of past traumatic events/histories with anxiety, crying, isolation, nightmares, sleeplessness, acting fears, voice of upsetting, withdrawal, refusal of treatments/activities, etc., that has the potential to affect care while at facility.8/16/2025: [Resident #23] is an elopement risk/wanderer r/t (related to) brief psychotic disorder Impaired safety awareness.A review of the resident's PASRR, dated 4/22/2025, revealed that no MDs and/or IDs for the resident were identified. (Photographic evidence obtained) 2.A review of Resident #62's medical record revealed an admission on [DATE] with her latest readmission on [DATE].Her diagnoses included dementia with other behavioral disturbance (10/01/2022 and 5/23/2025); bipolar disorder (11/14/2025 and 1/10/2023); major depressive disorder (5/23/2025); anxiety disorder (5/23/2025).A review of the resident's active care plan revealed focus areas including:4/17/2023: Behavioral - [Resident #62] is at risk for socially inappropriate/disruptive behavioral symptoms.2/16/2024: [Resident #62] is/has potential to be verbally aggressive towards other residents r/t dementia and mental/emotional illness.4/22/2024: [Resident #62] has potential to be physically aggressive r/t dementia.7/09/2025: [Resident #62] has behaviors - resident exhibits obsessive behaviors over roommate, leading to potential conflict and care disruption.8/19/2025: [Resident #62] is an elopement risk r/t dementia.A review of the PASRR dated 3/11/2024 revealed that no MDs and/or IDs for the resident were documented. (Photographic evidence obtained) 3.A review of Resident #63's medical record revealed an admission date of 5/1/2024. Her diagnoses included depression (5/1/2024); psychosis (5/1/2024); anxiety disorder (5/1/2024); dementia with other behavioral disturbance (5/1/2024); major depressive disorder (5/23/2024), and anxiety disorder (5/23/2024).A review of the resident's active care plan revealed focus areas including:7/03/2025: [Resident #63] exhibits s/s (signs and symptoms) of behaviors related to eating paper. She has also been found to have other non-food items (condiment packet) in her mouth.9/20/2024: [Resident #63] is an elopement risk/wanderer r/t dementia, disoriented to place, impaired safety awareness. Resident wanders aimlessly.2/12/2026: [Resident #63] shows signs of delirium AEB (as evidenced by) inattention and disorganized thinking. She also has diagnoses of frontotemporal neurocognitive disorder, dementia, mood disorder and anxiety.A review of the PASRR dated 10/22/2024 revealed no documented MDs and/or IDs. (Photographic evidence obtained) (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105287	A. Building B. Wing	03/05/2026

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4.A of Resident #65's medical record revealed an admission date of 9/14/2023 with the most recent readmission on [DATE].Diagnoses included: major depressive disorder (5/23/2025); dementia (5/23/2025); psychotic disturbance, mood disturbance, and anxiety (5/23/2025), and bipolar disorder (9/19/2023).A review of the active care plan revealed focus areas including:7/08/2025: Potential for impaired or inappropriate behaviors r/t cognition and ineffective impulse control AEB inappropriate urination putting self on floor/tipping wheelchair backwards shaving self without assistance.7/03/2025: Resident exhibits s/s of BPSD (behavioral and psychological symptoms of dementia) or sexually inappropriate behaviors.5/13/2025: The resident has behaviors of sitting on the floor, crawling or putting himself on his knees.10/17/2024: Potential for impaired or inappropriate behaviors r/t (non-compliant to care): AEB Stress.9/27/2023: The resident has impaired cognitive function/dementia or impaired thought processes r/t Difficulty making decisions, Impaired decision making, Short term memory lossA review of the PASRR dated 8/24/2023 revealed that none of the resident's identified MDs or IDs were documented. (Photographic evidence obtained) 5.A review of Resident #76's medical record revealed an admission on [DATE] with the most recent readmission on [DATE].Her diagnoses included bipolar disorder (11/02/2023); dementia, psychotic disturbance, mood disturbance, and anxiety (11/03/2025); depression (11/03/2023), and major depressive disorder (05/23/2025).A review of the resident's active care plan revealed focus areas including:4/17/2024: [Resident #76] makes disruptive sounds/grunting. Potential for impaired or inappropriate behaviors r/t bipolar disorder and cognitive/communication deficit.12/11/2024: [Resident #76] has an ADL (activities of daily living) self-care performance deficit r/t bipolar disorder, dementia, muscle weakness.7/23/2025: Potential for impaired or inappropriate behaviors r/t cognitive impairment.11/17/2025: [Resident #76] has little or no community life involvement r/t bipolar disorder, dementia and major depressive disorder.11/24/2023: [Resident #76] has behaviors: disruptive sounds.A review of the PASRR dated 11/2/2023 revealed that none of the resident's identified MDs or IDs were documented. (Photographic evidence obtained)6.A review of Resident #101's medical record revealed an admission date of 8/25/2023.His diagnoses included schizoaffective disorder, bipolar type (8/25/2023); alcohol abuse (8/25/2023); major depressive disorder (9/20/2023); anxiety disorder (5/23/2025); alcohol dependence (5/23/2025); anxiety disorder (8/25/2023).A review of the active care plan (Date initiated: 09/11/2023) revealed focus areas including:[Resident #101] has potential for impaired or inappropriate behaviors r/t dementia with cognitive decline, AEB ineffective impulse control, insufficient safety awareness, history of elopement.[Resident #101] has impaired cognition and/or impaired thought processes r/t mental illness.The resident is/has potential to be verbally aggressive towards others r/t depression and mood disorder.The resident is an elopement risk/wanderer r/t dementia.[Resident #101] has impaired cognitive function/dementia or impaired thought processes r/t dementia with a history of alcohol abuse.A review of the PASRR dated 8/22/2023 revealed that the identified MDs/IDs for Resident #101 were not documented. (Photographic evidence obtained) 7.A review of Resident #167's medical record revealed an admission on [DATE] with the most recent readmission on [DATE].Her diagnoses included depression (5/31/2022); dementia, psychotic disturbance, mood disturbance, and anxiety (7/18/2020); bipolar disorder (1/25/2021); major depressive disorder (5/23/2025); anxiety disorder (5/23/2025); bipolar disorder (5/23/2025), and major depressive disorder (7/19/2020).A review of the active care plan revealed focus areas including:9/04/2025: Resident has a history of anxiety and withdrawal that has the potential to affect care while at facility - Trauma Informed Care.4/18/2023: [Resident #167] has a behavior problem r/t sexual behaviors and inappropriate sexual comments. Refuses medications. The resident attempted to expose herself to others. [Resident #167] will bite and kick at staff when she is agitated.8/18/2025: The resident is an elopement risk/wanderer r/t dementia.A review of the PASRR dated 5/28/2021 revealed that none of the identified MDs/IDs for Resident #167 were documented. (Photographic evidence obtained) An interview was conducted on 3/4/2026 at 11:55 AM with the Social Services Director (SSD) who (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated she had been employed as the SSD for more than a year. She further stated she was supposed to have two assistants; however, she had not had one since occupying the position. She stated she assisted the Director of Nursing (DON) with the PASRRs. The DON usually completed the PASRRs, as he was the only person with a log-in. She stated she checked the PASRRs upon resident admission. She and the DON reviewed them. She stated she looked for non provisional to see if they met the skilled criteria. She stated she, the DON, and the Assistant Director of Nursing (ADON) checked the forms to ensure all of the necessary diagnoses were included. The PASRRs were reviewed daily in the morning meeting. She stated there were no additional audits of the forms. They were only reviewed at admission. If the resident had a change in condition which identified an MD/ID, the Unit Manager would be responsible for reporting it.An interview was conducted on 3/4/2026 at 1:40 PM with the DON who stated he was responsible for checking the PASRRs in the morning meeting when there were new admissions. He stated they checked to see if it was not a provisional admission. He stated assisted with the Level II PASRRs if they were required. He sent them out for the Level II. He stated the clinical team was responsible for ensuring all pertinent diagnoses were listed. He completed a new PASRR if corrections were necessary. He stated the resident's History and Physical from the hospital was used to confirm the MDs/IDs. When asked if the information was reviewed during a resident's stay for any updates/corrections, he stated audits were performed; however, he did not provide any documentation to verify this during the course of the survey. He stated if a resident had a new MD/ID, it would be updated in the resident's chart and a new PASRR would be completed. The psychiatric provider would notify him if a resident had a newly identified MD/ID. Again, he stated that a new PASRR would be completed if that occurred.A follow-up interview was conducted on 3/05/2026 at 12:48 PM with the DON. The PASRRs for Resident's #23, #62, #63, #65, #76, #101 and #167 were individually reviewed with the DON. He consulted the electronic medical record for each resident. He confirmed the PASRRs provided to the survey team were all that were available for each of the residents. As he compared the PASRRs to the residents' documented diagnoses, he confirmed that the PASRRs were inaccurate. He confirmed that diagnoses were excluded from each of the residents' PASRRs. He stated the SSD would have been responsible for identifying this so that he could update the PASRRs with the proper diagnoses. The facility's policy, Preadmission Screening (PASSAR / PASSR) (Effective 6/2025), revealed:Policy: It is the policy of the center to follow the Federal and State regulations with regard to pre-screening residents with a mental disorder and individuals with intellectual disability for individuals requiring more than 30 days in the Center. Procedure: 1. A level II PASSR must be completed if the individual has a primary or secondary diagnosis of dementia or related neurocognitive disorder, or a suspicion or diagnosis of serious mental illness, intellectual disability, or both. A PASSR level II may only be terminated by a PASSR Level II Evaluator.2. Mental illness diagnoses added after admission should have a PASSR Level II completed again to ensure proper screening.3. Recommendations from the Level II PASSR should be reviewed and added to the plan of care.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, and a review of facility policies and procedures, the facility failed to ensure that eight (Residents #5, #34, #11, #166, #91, #19, #82, and #159) of 73 sampled residents received appropriate ADL (activities of daily living) care necessary to maintain good grooming, by failing to ensure fingernails were clean/trimmed/clipped, hair was shampooed, and/or facial hair was removed. The findings include: 1.An interview was conducted on 3/2/2026 at 9:20 AM with Resident #5. He was observed sitting up in bed watching TV. The resident's hair was oily and disheveled. The resident stated he did not know the last time he received a shower or complete bed bath. He raised his hand to show his nails which were visibly stained, uneven and jagged. He stated he was receiving Hospice services and that in the past, they bathed him; however, they had not done so for quite some time. He stated he would like to get a real shower. I'm so nasty. I feel like my skin is crawling. He stated he only had one arm and one leg, and that staff were not turning and repositioning him every two hours as they should. Another observation of Resident #5 was made on 3/5/2026 at 11:13 AM. The resident had been moved to a new room. He was sitting up in bed, and his hair was oily and slicked back against his head in clumps. The resident stated he was wheeled in his bed to the new room and that he still had not received a shower. He stated his nails were still nasty while holding up his hand to show them. His nails were dark in color with debris underneath them. A review of Resident #5's medical record revealed and admission date of 6/30/23 with the most recent readmission on [DATE]. His diagnoses included cerebral infarction; major depressive disorder; acquired absence of left shoulder; atherosclerotic heart disease; non-pressure chronic ulcer of left heel and mid foot with fat layer exposed; pressure ulcer of sacral region - stage III; post-traumatic stress disorder (PTSD); peripheral vascular disease (PVD), and embolism and thrombosis of superficial veins of left lower extremity. A review of Resident #5's minimum data set (MDS) assessment , dated 1/30/2026, revealed adequate hearing/vision requiring no corrective lenses; clear speech; understands and is understood. He scored 14 out of 15 possible points on his brief interview for mental status (BIMS), indicating intact cognition. He had impairment on one side of both upper and lower extremities and required a wheelchair for mobility. He was independent with eating and dependent for toilet hygiene, oral hygiene, shower/bathe self, upper/lower body dressing and personal hygiene. He was always incontinent of bladder/bowel. A review of the resident's active care plan revealed: Impaired skin integrity - left foot ulcer/gangrene. PVD (peripheral vascular disease) present. Requires assistance with the completion of his ADLs related to (r/t) cerebral infarction, depression, absence of left shoulder, PTSD (post-traumatic stress disorder) and muscle weakness. Date Initiated: 12/10/2024 Revision on: 09/23/2025 [Resident #5] will maintain current level of function through the review date. Date Initiated: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/10/2024 Revision on: 09/30/2025 Target Date: 05/11/2026. Assist with ADLs as needed. Date Initiated: 01/16/2025. Bathing preference is a bed bath. Date Initiated: 01/16/2025 Revision on: 01/16/2025. An interview was conducted on 3/05/2026 at 12:31 PM with Licensed Practical Nurse (LPN) M who stated she was familiar with Resident #5. She stated he was on Hospice and that he did not refuse care. She stated she was not aware that the resident had a Hospice CNA. She was asked about the resident's shower schedule. She provided his shower schedule and shower sheets (1/3/26; 1/6/26& 2/7/26). She stated the facility staff were responsible for giving him baths and performing all ADL care. She stated the resident was compliant with care and could make his needs known. He loved to drink lots of water (and soda) which would cause him to wet a lot. She stated he would call for help when he wanted to be changed. She confirmed that the documentation on the shower sheets she had provided for review indicated that no baths had been documented since 2/2/2026. An interview was conducted on 3/05/2026 at 12:34 PM with LPN L who stated the resident had been assigned to her for more than six months. She stated he was sent out to the hospital in December 2025 and when he returned in January 2026, he was moved to another room and assigned to then assigned to LPN M. She stated there was a time when the resident was assigned a Hospice CNA (certified nursing assistant) who came in and provided baths/showers. She stated the resident was out of the facility in an in-patient Hospice facility for a period of time before he returned to the facility. She stated he was able to make his needs known and had no complaints. He would call for assistance when he needed to be changed. She stated he had no behaviors. An interview was conducted on 3/4/2026 at 2:39 PM with Staff Developer (SD) Q who stated when an individual was hired, they attended a two-day training session. They had to perform competencies related to their duties which included hands-on demonstrations. She provided instructions to the CNAs about how to complete the bathing task. The information was also provided on their staffing sheet. She stated when a new hire was a new CNA, she had them demonstrate how to perform a resident bath using a life-sized mannequin. She had them do it then she showed them how it should be done. She stated if there were any concerns with how they were performing the task, she would address them at that time. She stated the CNAs should be shaving the residents as required, adding that female residents should not have facial hair. She added that some of the women were self-conscious about having facial hair and that privacy in this matter was important. She stated the CNAs could perform this task for women in the privacy of their rooms stating it would be based on the resident's preference. Staff were responsible for cleaning the residents' fingernails. They should go under their nails with a Q-tip or washcloth. This should be done when they were washing the residents' arms during their baths. If debris remained and additional cleaning of the nails was required, staff were to soak the resident's hands in water and clean their nails again. She stated all of the information that she provided to the surveyor was included in the staff education, adding that return demonstration on the life-sized mannequin was required. If a resident could not make their needs known, then staff should be taking the initiative to perform the appropriate care. A review of the facility's CNA shower schedule revealed that Resident #5 was scheduled for weekly showers on Mondays, Wednesdays, and Fridays during the 11 PM to 7 AM shift. (Photographic evidence obtained) LPN M , previously assigned to Resident #5, could only provide documentation that the resident received a bath/shower on 1/3/2026, 1/6/2026 and 2/7/2026. (Photographic evidence obtained) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Quarterly MDS (minimum date set) assessment dated [DATE], revealed the resident's BIMS (Brief Interview for Mental Status) score was 7 out of 15 possible points, indicating severe cognitive impairment. He was independent with eating and dependent with toileting, personal hygiene, bed mobility and transfers. A review of the active care plan revealed the following focus areas: FOCUS: The resident has an ADL/self-care performance deficit r/t (related to) cerebral infarction affecting right side Date Initiated: 12/11/2024 Revision on: 04/28/2025. Goal: The resident will maintain current level of function through the review date. Date Initiated: 12/11/2024 Revision on: 01/30/2026 Target Date: 04/06/2026. Interventions: Assist with ADLs as needed. Date Initiated: 12/24/2024, Personal Hygiene - Dependent Date Initiated: 12/11/2024 Revision on: 02/18/2026, Shower and Bathe - Dependent Date Initiated: 12/11/2024 Revision on: 02/18/2026. 4.On 03/03/2026 at 10:10 AM, Resident #166 was observed resting in bed. The fingernails on his left hand were elongated with brown matter underneath. He was asked if he wanted his fingernails trimmed and he replied, Yes, but I'm going to be leaving soon to go to dialysis. On 03/05/2026 at 9:54 AM, Resident #166 was observed resting in bed. The fingernails on his left hand were elongated with brown matter underneath. He was asked if the staff had offered him fingernail care and he confirmed they had not. On 03/05/2026 at 10:57 AM, an interview was conducted with LPN F who was asked to observe the resident's fingernails. She was asked if she believed Resident #166 needed fingernail care. She confirmed that the resident needed fingernail care. She confirmed that any nursing staff member could provide fingernail care whenever it was needed. A record review revealed that Resident #166 was admitted to the facility on [DATE] with diagnoses including hemiplegia/hemiparesis following a nontraumatic subarachnoid hemorrhage affecting his left dominant side. A review of the Quarterly MDS, dated [DATE], revealed that the resident had a BIMS score of 15 out of 15 possible points, indicating intact cognition. He was independent with eating and dependent with toileting and personal hygiene. A review of the care plan revealed the following focus areas: FOCUS: Resident has an ADL self-care performance deficit r/t ESRD (end-stage renal disease), hemiplegia/hemiparesis, depression, diabetes, and dependence on renal dialysis. Date Initiated: 12/10/2024 Revision on: 08/09/2025. Goal: The resident will maintain current level of function through the review date. Date Initiated: 12/10/2024 Revision on: 02/10/2026 Target Date: 05/08/2026. Interventions: Assist with ADLs as needed. Date Initiated: 12/24/2024, Bathing preference (bed bath) Date Initiated: 12/24/2024 Revision on: 12/24/2024. Personal Hygiene - Dependent Date Initiated: 12/10/2024. 5.On 03/02/2026 at 12:05 PM, Resident #91 was observed sitting up on the side of his bed watching television. His fingernails were elongated with brown matter underneath the nails on his left hand. The resident's right hand was contacted, and observation of his fingernails was obstructed. He was asked if the staff cared for his fingernails. He stated, Nobody. He was asked if he wanted fingernail (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care. He stated, Yes, but nobody is doing nails around here. On 03/05/2026 at 9:57 AM, Resident #91 was observed resting in bed. His fingernails were elongated with brown matter underneath the nails on his left hand. He was asked if he had refused fingernail care. He confirmed that he did not refuse care. A record review revealed that Resident #91 was admitted on [DATE] with diagnoses including hemiplegia/hemiparesis following a cerebral infarction (stroke) affecting his left non-dominant side. A review of the admission MDS, dated [DATE], revealed that the resident had a BIMS score of 14/15, indicating intact cognition. He had no identified behaviors. He required supervision or touching assistance with eating and partial/moderate assistance with toileting and personal hygiene. A review of the care plan revealed the following focus areas: FOCUS: Resident requires assistance with completion of his functional abilities' r/t recent CVA (stroke), cellulitis and CKD (chronic kidney disease - stage 3. Date Initiated: 12/01/2025 Revision on: 12/01/2025. Goal: Resident's needs will be met. Date Initiated: 12/01/2025 Revision on: 01/30/2026 Target Date: 03/10/2026. Interventions: Assist with ADLs as needed. Date Initiated: 12/01/2025, Eating - Supervision/Touching assist Date Initiated: 12/01/2025 Revision on: 12/01/2025. Personal Hygiene - Partial/Mod assist Date Initiated: 12/01/2025 Revision on: 12/01/2025. Shower and Bathe Self - Substantial/Max assist Date Initiated: 12/01/2025 Revision on: 12/01/2025. 6.On 03/02/2026 at 12:55 PM, Resident #19 was observed sitting up at bedside with elongated jagged fingernails with brown matter underneath the nails on his left hand. A record review revealed that Resident #19 was admitted on [DATE] with diagnoses including encephalopathy, anxiety, depression, generalized muscle weakness, a need for assistance with personal care and hydrocephalus. A review of the Quarterly MDS assessment dated [DATE], revealed a BIMS score of 07/15, indicating severe cognitive impairment. No behaviors were indicated and the resident was noted independent with eating, toileting and personal hygiene tasks. A Care Plan review revealed the following focus problem: FOCUS: Resident has an ADL deficit related to deconditioning following hospitalization, date initiated: 03/27/2025, revision date: 08/27/2025. Goal: The resident will improve current level of self ADL care through the review date. Date initiated: 03/27/2025, revision date: 06/05/2025, target date: 03/06/2026. Interventions: Assist with ADLs as needed, initiated 03/27/2025, Personal hygiene: supervision/touching assistance, initiated 03/27/2025, revision date: 12/06/2025, Shower/Bath: supervision/touching assistance, initiated 03/27/2025, revision date: 12/06/2025. A review of pertinent progress notes revealed that the resident was documented as refusing medications on 3/3/26, 2/25, 2/24, 2/23, 2/19 and 2/18/2026. There was no documentation during this timeframe that indicated refusal of ADL care, specifically fingernail care. On 02/13/2026, a Psychiatry Encounter note documented that the residents received no psych meds. As per collected information and interview, it appears that the patient is at baseline with no acute (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westside Oaks Rehabilitation & Nursing Center	2061 Hyde Park Rd Jacksonville, FL 32210

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	symptoms or behaviors. There was no documentation indicating that the resident refused ADL care. On 03/03/2026 at 9:53 AM, an interview was conducted with Registered Nurse (RN) A. She was asked how often the residents received grooming care and what the grooming care consisted of. She confirmed that grooming was provided to the residents weekly and consisted of hair care, nail care, haircuts, and sometimes the staff would paint the ladies' toenails. She was asked how often fingernail care was provided and what the facility's process was if the resident refused fingernail care. She confirmed that fingernail care was provided by the nursing staff on the weekends and if the residents refused fingernail care the staff was to educate them on the importance of care. 7.On 03/03/26 at 10:27 AM, Resident #82 was observed resting in bed with thickened, rigid, and overgrown fingernails on both hands that were extending approximately 1/2 inch beyond the nailbed. (Photographic evidence obtained) The resident said he did not like his fingernails so long and was afraid he may scratch himself. He explained that staff had not offered to assist him by trimming his nails. On 03/04/26 at 1:35 PM, another observation was made of Resident #82's fingernails. The nails on both hands remained thickened, rigid, overgrown, and extending approximately 1/2 inch beyond the nailbed. (Photographic evidence obtained) A review of Resident #82's medical record revealed that he was admitted on [DATE] with diagnoses including type 2 diabetes mellitus, human immunodeficiency virus (HIV), unsteadiness on feet, muscle weakness (generalized), other reduced mobility, need for assistance with personal care, hypertension, acquired absence of left leg below knee, acquired absence of right leg above knee, and a pressure ulcer of the sacral region - stage 2. A review of the MDS assessment dated [DATE] revealed a BIMS score of 11 out of 15 possible points, indicating moderate cognitive impairment. The resident was not documented with indicators of psychosis, physical or verbal behavioral symptoms directed towards others, or rejection of care. He was noted as requiring supervision for hygiene as well as partial assistance for personal hygiene. A review of Resident #82's care plan, revised on 02/05/26, revealed a focus area indicating that the resident had an ADL performance deficit related to bilateral amputee, cognitive issues and a need for assistance with daily care tasks. Interventions included that personal hygiene required partial assistance. 8.On 03/03/26 at 9:42 AM, Resident #159 was observed in his room thickened, rigid, and overgrown fingernails on both hands that extended approximately ¾ inch beyond the nailbed. (Photographic evidence obtained) The resident explained that he did not like his fingernails so long and staff had not offered to help trim his fingernails. On 03/04/26 at 1:00 PM, another observation was made of Resident #159's fingernails, which looked the same as they had on 03/03/26 at 9:42 AM. (Photographic evidence obtained). A review of Resident #159's medical record revealed an admission on [DATE] and diagnoses including diabetes mellitus with diabetic neuropathy, hemiplegia/hemiparesis following cerebral infarction (stroke) affecting left non-dominant side, acquired absence of eye, absolute glaucoma, left eye, muscle weakness (generalized), other reduced mobility, need for assistance with personal care, and frontal lobe and executive function deficit following cerebral infarction. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Westside Oaks Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2061 Hyde Park Rd Jacksonville, FL 32210	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of an MDS assessment dated [DATE] revealed a BIMS score of 12 out of 15 possible points, indicating moderate cognitive impairment. There were no indicators of psychosis, no physical or verbal behavioral symptoms directed towards others, and no rejection of care noted. The resident's functional abilities were assessed as requiring supervision and/or touching assistance. A review of Resident #159's active care plan (dated 02/20/26), revealed that the resident required assistance with completing his ADLs related to adult failure to thrive, hemiplegia/ hemiparesis following cerebral infarction and absence of his left eye. The goal noted that the resident's needs would be met. Interventions included that the resident required assistance with ADLs. Personal hygiene required supervision and/or touching assistance. On 03/04/26 at 2:39 PM, an interview was conducted with CNA T, who reported that she had been employed by the facility for one month. She verified the following resident's nails were too long – Residents in rooms/beds 19B, 36D, 40C, 49B, 52A and 52D. She stated received ADL training during orientation. She said if she observed a resident with long nails, she would ask the resident if they would like their nails trimmed. If the resident was independent for grooming, specifically nail care, she would provide the resident with nail clippers and a nail file. On 03/04/26 at 3:00 PM, an interview was conducted CNA U, who stated she had been employed by the facility since 02/25/25 and received ADL training during orientation. She explained that if she saw a resident with long, jagged or soiled nails, she would ask the resident if they wanted their nails trimmed. She would proceed to gather supplies, including nail clippers and nail files located in the supply room. If the resident was confined to bed, she would provide nailcare at bedside. If the resident was in a chair, she would provide nailcare chairside. She would then document nailcare in the resident's chart. A review of the facility's policy and procedure titled Activities of Daily Living (ADLs) Maintain Abilities (Date: January 2024), revealed: Procedure: 3. The facility will provide care and services for the following activities of daily living: a. Hygiene-bathing, dressing, grooming, and oral care. 4. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on review of staff records, and interviews conducted with the Administrator, the facility, which is licensed for 180 beds, failed to ensure the full-time social worker was qualified, and failed to verify educational requirements were met, with the potential to negatively impact the overall health, safety, and quality of life to all 172-residents present during the recertification survey.The findings include:On 3/05/2025 at 1:37 PM, a personnel record review was conducted for the Social Services Director (SSD) that revealed she did not have a bachelor's degree in social work, or a similar human services field.During an interview with the Administrator on 03/05/2026 at 1:49 PM, she reported having problems with the SSD's performance, and after she was promoted, a request for a copy of her master's degree in social work, transcripts, and her social worker license was made, but was never provided. The Administrator further reported that she asked the SSD to go home and get her degree and credentials during the recertification survey, and at the time of exit from the survey after 6:30 PM, the Administrator confirmed that the SSD never returned to the facility or contacted her.

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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 that one (Resident #82) of 73 residents in the total survey sample was provided with adequate and comfortable lighting at his bedside. Inadequate lighting can result in an increased risk for falls/accidents as well as potential psychological distress (anxiety/depression). The findings include: On 03/03/26 at10:27 AM, Resident #82 was observed resting in bed. The resident, in room [ROOM NUMBER] Bed D, shared a room with three other residents. His area of the room was observed to be dark without a light source. (photographic evidence obtained) Resident #82 stated he did not know why he did not have a light in his area of the room and it bothered him that it was so dark. Resident #82's roommate in Bed C stated he used to be in Bed D but had asked to move to Bed C so that he would have a working light fixture over the bed. room [ROOM NUMBER] Beds A, B and C were equipped with light fixtures on the wall at the head of the bed. The light fixtures were approximately four feet long and six inches high. (photographic evidence obtained) On 03/04/26 at 11:54 AM, an interview was conducted with the Director of Housekeeping and Laundry, who stated she had been employed by the facility for three years. She explained that daily and deep cleaning processes included dusting the light fixtures on the wall above the residents' beds. She verified that Bedroom [ROOM NUMBER], Bed D had no light fixture, but she had not reported that to Maintenance. A review of Resident #82's medical record revealed an admission date of 01/22/26 and diagnoses including unsteadiness on feet, generalized muscle weakness, other reduced mobility, absence of left leg below the knee and absence of right leg above the knee. A review of the resident's minimum data set (MDS) assessment, dated 01/28/26, revealed that the resident had a brief interview for mental status (BIMS) score of 11 out of 15 possible points, indicating moderate cognitive impairment. The resident had no indicators of psychosis, no physical or verbal behavioral symptoms directed towards others, and no rejection of care or wandering behaviors. The resident's functional abilities were assessed as: dependent for bed to chair transfer, eating with supervision; dependent for lower body dressing; substantial assistance for lying to sitting on side of bed; partial assistance for personal hygiene and upper body dressing; and substantial assistance for sit to lying and sit to stand. A review of Resident #82's care plan, revised 02/05/26, revealed a focus area indicating the resident had an activity of daily living (ADL) performance deficit related to bilateral amputee, cognitive issues and need for assistance with daily care tasks. Interventions included personal hygiene required partial assistance. A review of the facility's Resident Rights Policy, dated 07/2025, revealed: .Each resident has the right to be treated with dignity and respect .8. Reasonable Accommodations of Needs/Preferences .33. Safe/Clean/Comfortable/Homelike Environment . A review of the facility's Dignity Policy, dated 08/22/22, page 1 of 1, revealed: The Center must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life .

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure residents requiring respiratory care received such care, consistent with professional standards of practice, by failing to ensure that two (Residents #54 and #49) of two residents reviewed for respiratory care, received oxygen at the flow rate prescribed by their physicians.The findings include: 1. On 3/3/2026 at 9:30 AM, Resident #54's oxygen concentrator flow rate was observed to be set at 2.5 l/min (liters per minute). On 3/4/2026 at 9:00 AM, Resident #54's oxygen concentrator flow rate was observed to be set at 2.5l/min. During an interview on 3/4/2026 at 9:05 AM, Registered Nurse (RN) D stated, I check my oxygen concentrators when I arrive to check the settings. When asked if a resident had orders for oxygen at 2 liters per minute via nasal cannula, how that oxygen should be delivered, RN D stated, It should be at 2 liters a minute via nasal cannula. RN D was asked if she knew what Resident #54's oxygen flow rate should be set at and she replied, It should be at 2 liters a minute. RN D was accompanied to the resident's room, and she checked his flow rate setting. It was set at 2.5 l/min. RN D adjusted the flow rate to 2.0 l/min. A review of the resident's electronic health record revealed an admission date of 5/5/2022. Resident #54's diagnoses included chronic obstructive pulmonary disease. A physician's order, dated 10/17/2025, was for oxygen at 2 l/min. to be delivered via nasal cannula. 2. On 03/03/26 at 9:39 AM, Resident #49 was observed wearing a nasal cannula attached to an oxygen concentrator, which was set at a flow rate of 5 l/min. (Photographic evidence obtained) The resident stated, I don't touch the oxygen flow rate settings. A review of the resident's medical record revealed a physician's order for an oxygen flow rate of 2.0 l/min. as needed (prn) with a start date of 05/14/24. On 03/04/26 at 1:50 PM, another observation was made of Resident #49 wearing a nasal cannula attached to an oxygen concentrator with a flow rate set at 5 l/min. (Photographic evidence obtained). On 03/04/26 at 1:58 PM, an interview was conducted with Licensed Practical Nurse (LPN) F, who stated she had been employed by the facility for eight months. She was accompanied to Resident #49's room and she checked Resident #49's oxygen flow rate. LPN F stated the resident's flow rate was set all the way to five. She reviewed Resident #49's medical record and said the resident had a physician's order for oxygen at 2 l/min. as needed. She explained that her process to ensure residents received oxygen at the correct flow rate began at the beginning of her shift. When she started her shift, she checked resident electronic records for her assigned residents to review their oxygen orders. While making her rounds, she checked oxygen flow rates to ensure they were set correctly per the physicians' orders. She also checked oxygen saturation levels and oxygen tubing. When she was asked whether or not she was aware of the ramifications of a resident receiving an excess of oxygen beyond the physician's order, she was unable to answer the question. 2.A review of Resident #49's medical record revealed an admission date of 7/7/23 with diagnoses (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	including: wheezing, human immunodeficiency virus (HIV) disease, myocardial infarction, and chronic obstructive pulmonary disease (COPD) with (acute) exacerbation. A review of Resident #49's minimum data set (MDS) assessment dated [DATE], revealed that the resident's brief interview for mental status (BIMS) score of 14 out of 15 possible points, indicated intact cognition. The resident was documented as independent with activities of daily living (ADLs). A review of Resident #49's active care plan, revised 04/11/25, revealed the following focus area: The resident uses oxygen therapy PRN related to a diagnosis of COPD with a cough. The goal noted the resident would be free from signs and symptoms of respiratory distress through the next review date. The care plan interventions included administering medications (oxygen) as ordered. A review of the facility's policy and procedure titled Oxygen Administration, Respiratory Care (Dated April 2022), revealed: Page two: 12. Adjust the delivery device so that it is comfortable to the resident and the proper flow of oxygen is being administered. A review of the facility's policy and procedure titled Administration of Drugs, Nursing Policy Manual (Dated 01/2026), revealed: Drugs will be administered in a timely manner and as prescribed by the resident's attending physician or the Center's Medical Director. 2. Drugs must be administered in accordance with the written orders of the attending physician . 6. Medications must be administered in a manner that reduces the risk of medication errors and ensures patient safety using the 5 Rights of Medication Administration: c. Right Dose – ensure that the dose is correct by checking the dose against the order.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to 1) Ensure privacy curtains were provided to five (Residents #192, #116, #5, #82 and #105) of 30 residents sampled for privacy curtains, and 2) Ensure privacy curtains were not stained for two (Rooms 9B and 9D) of 32 privacy curtains observed.The findings include:On 03/03/26 at 10:36 AM, Resident #82 was observed in his bedroom, which lacked a privacy curtain track and privacy curtain. (Photographic evidence obtained)On 03/03/26 at 2:19 PM, resident room [ROOM NUMBER], beds 9B and 9D's curtains were observed to be heavily stained. Bed 9D had black scratch marks covering the lower portion of the privacy curtain. Bed 9B had large dark spots covering the upper right portion of the privacy curtain. (Photographic evidence obtained) On 03/04/26 at 9:51 AM, another observation was made of bed 9D with black scratch marks covering the lower portion of the privacy curtain and bed 9B with large dark spots covering the upper right portion of the privacy curtain. (Photographic evidence obtained) On 03/04/26 at 11:54 AM, an interview was conducted with the Director of Housekeeping and Laundry, who reported she had been employed by the facility for three years. She explained in relation to privacy curtains, that rooms were deep cleaned once a month or more as needed. During the deep cleaning process, privacy curtains were removed and sent to the laundry where they were washed. If laundry services washed a privacy curtain and noticed permanent stains, they informed her, and she placed the room and bed placement in a queue to replace the privacy curtain. She explained that during daily cleaning, if a soiled or stained privacy curtain was discovered, housekeeping staff would retrieve and attach a clean privacy curtain before removing the soiled privacy curtain so that the resident maintained their privacy. She further explained that housekeeping staff should inform her if a resident room was missing a privacy curtain. On 03/04/26 at 12:01 PM, the Director of Housekeeping was accompanied to room [ROOM NUMBER] and she verified curtains for bed B and bed D were heavily stained. She reported that the Administrator provided five new curtains each month and he kept a log of stained curtains that needed replacement. On 03/05/26 at 10:00 AM, Resident #192 and Resident #5 were observed in their bedroom, which lacked a privacy curtain track and privacy curtain. (Photographic evidence obtained) On 03/05/26 at 10:30 AM, Resident #116 was observed in her bedroom, which lacked a privacy curtain track and privacy curtain. (Photographic evidence obtained) On 03/05/26 at 1:52 PM, Resident #105 was observed in his bedroom, which lacked a privacy curtain track and privacy curtain. (Photographic evidence obtained)Review of the facility's Resident Rights Policy (Dated 07/2025), revealed: Each resident has the right to be treated with dignity and respect . 8. Reasonable Accommodations of Needs/Preferences . 33. Safe/Clean/Comfortable/Homelike Environment .

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview and record review, the facility failed to ensure a call light or hand bell was within reach for three (Residents #13, #43 and #149) of 73 sampled residents. The findings include:1.On 03/02/26 at 2:12 PM, Resident #13 was observed lying in bed with his eyes closed. A hand bell was observed on top of the light above the head of the bed. It was not within the resident's reach and was approximately 3.5 feet above the resident's bed. (Photographic evidence obtained). The resident did not respond to questions related to the call light or hand bell. The resident's roommate stated Resident #13 could not talk and that the resident was provided with a hand bell because his call light was not working.On 03/02/26 at 3:30 PM, the Director of Nursing (DON) was interviewed and was accompanied to Resident #13's room. He was asked if the resident was physically capable of reaching the hand bell above the light. The DON reported that the hand bell was provided to the resident because the call light was not working. The DON stated the resident was bedbound and would not be capable of reaching above his bed to retrieve the hand bell. On 03/03/26 at 9:00 AM, Resident #13's hand bell was observed on the resident's bed adjacent to the resident's left arm. 2.On 03/03/26 at 1:50 PM, Resident #43 was observed resting in his room. The Resident's call light was observed on the floor under the bed frame at the head of the bed. (Photographic evidence obtained) The resident said that he did not know where the call light was. On 03/04/26 at 9:37 AM, another observation was made of Resident #43's call light on the floor under the bed frame at the head of the bed. (Photographic evidence obtained) 3.On 03/03/26 at 1:50 PM, Resident #149 was observed resting in his room. The Resident's call light was observed on the floor behind the head of the bed. (Photographic evidence obtained). The resident said he did not know where it was. On 03/04/26 at 9:37 AM, another observation was made of Resident #149's call light on the floor behind the head of the bed. (Photographic evidence obtained) A review of the facility's Call Light Policy (Dated April 2022), revealed: 5. When the resident is in bed or confined to a chair, be sure the call light is within easy reach of the resident.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide a safe environment for two (Residents #17 and #79) of 172 residents currently living in the facility, by failing to keep sharp, potentially dangerous items out of resident rooms. The findings include: 1.During a tour of the facility on 3/2/2026 at 12:26 PM, resident room [ROOM NUMBER] on the secured Memory Care Unit located on the bottom floor of the facility was observed. In the room was a wooden dresser located near a window at the foot of Bed B (Resident #97) and Bed C (Resident #17). An open drawer revealed a clear plastic bag containing several blue razors and large nail clippers. (Photographic evidence obtained) A follow-up tour was made on 3/4/2026 at 4:04 PM. The clear plastic bag containing the blue razors and large nail clippers remained in the top drawer. Resident #17 was seated in his wheelchair near the end of the bed near the wooden dresser. He confirmed the dresser was his. He also confirmed the bag of razors and clippers were his. On 3/4/2026 at 4:39 PM, Registered Nurse (RN) P was accompanied to room [ROOM NUMBER]. Resident #17 remained seated in his wheelchair near the wooden dresser. Upon seeing the contents of the open drawer, RN P immediately removed the clear plastic bag. Resident #17 asked her if there was a problem. She advised him that he should not have those items in his room. She explained to him that when he wanted to shave, he would have to notify the staff and they would assist him. He responded by shrugging his shoulders stating, Well, that's how they gave it to me. He did not identify who they were. RN P exited the resident's room with the clear plastic bag. She confirmed that Resident #17 should not have had those items in his possession. She stated none of the residents were permitted to have those kinds of items in their rooms. 2.Resident #79 was observed in his room at 1:28 PM on 3/2/2026 sitting in his wheelchair preparing to eat his lunch. A pair of adult comfort grip scissors with a pointed tip was observed on the resident's table. He was asked what he was using the scissors for. He replied, To stab you with them. On 3/4/2026 at 3:09 PM, a pair of adult comfort grip scissors with a pointed tip as well as a cigarette lighter were observed on Resident #79's table. The resident was not in his room at the time. On 3/5/2026 at 1:32 PM, a pair of adult comfort grip scissors with a pointed tip and a cigarette lighter were observed on Resident #79's table. The resident was not in his room at the time. On 3/5/2026 at 3:25 PM, an interview was conducted with the Director of Nursing. He confirmed that no resident should have sharps/scissors in their room or possession of same at any point in time. On 3/5/2026 at 4:05 PM, an interview was conducted with Certified Nursing Assistant J, who was accompanied to Resident #79's room. The scissors that had been observed on the resident's table since Monday were pointed out to the CNA. He was asked if the resident was permitted to have the cigarette lighter and scissors in his room. CNA J said No and picked up the items. He was asked what he did when he finds items like this in a resident's room. He replied that he would remove the items first, notify the nurse, and then document the incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105287	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westside Oaks Rehabilitation & Nursing Center	2061 Hyde Park Rd Jacksonville, FL 32210

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled Nursing Home Code of Conduct (Dated February 16, 2024 and updated February 10, 2025), revealed: 2. Prohibited Items: - No weapons, including guns, knives, or any items that could potentially harm others, are allowed within the facility.