STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105301	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Hills Health and Rehabilitation Center	1350 Sleepy Hill Rd Lakeland, FL 33810

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to serve food in accordance with professional standards for food service safety related to one of one dish washing machines was not operated per its specifications. Findings included: On 4/27/2026 at 9:45 a.m. the kitchen was toured with the Certified Dietary Manager (CDM), and the Regional Dietary Manager. The CDM stated the kitchen operates a low temperature dishwashing machine. The CDM further stated the machine's operation includes wash temperatures to reach at least 140 degrees Fahrenheit (F), and the final rinse temperature to reach at least 120 degrees F. The CDM continued to state the machine provides a chemical sanitizer and with a litmus test strip for chemical sanitizer testing to reach 50 - 100 parts per million (ppm). On 4/27/2026 at 10:02 a.m. an observation of the dishwashing machine room occurred with the CDM. Staff were already utilizing the machine and were running soiled crates of dishes through the dishwashing machine. On 4/27/2026 at 10:03 a.m. an interview and observation with a Staff J, Dietary Aide (DA) occurred. Staff J, DA stated they have been operating the machine since 9:30 a.m. and have run many crates of dishes through the machine. Staff J was observed spraying soiled dishes with a water hose and setting up dishes and trays in crates. He then was observed to run the crates of soiled dishes and trays through the machine to be cleaned. On the other side of the machine, Staff K, DA was observed receiving the crates of dishes/trays from the clean side of the dish machine. Staff J and K confirmed the dish machine wash temperatures should reach 140 degrees F., and the rinse temperatures should reach 120 degrees F. On 4/27/2026 at 10:04 a.m. a crate of meal trays was put through the machine. The wash temp reached above 140 degrees, and the rinse temp reached above 130 degrees. Staff K conducted the sanitizer testing utilizing litmus paper test strip. Staff K placed the test strip in an area of pooled water, on one of the trays that was just washed. The white colored test strip did not change color and remained white. Staff K, DA proceeded to get another strip, repeated the process and the same outcome occurred. Staff J, DA pushed a priming button on the sanitizer dispenser and ran another crate of trays through the dish machine. On 4/27/2026 at 10:08 a.m. Staff J, DA put a crate of dishes through the dish machine. The wash temp reached above 140 degrees F, and the rinse temp reached above 120 degrees F. [NAME] this demonstration, there was a crate of bowls and plates that ran through the entire wash and rinse cycle, and the dishes were observed with food debris remaining. Staff K, DA picked out the soiled dishes and placed them in a soiled rack but took the rest of the plates and put them in the clean area. A chemical sanitizing test was not demonstrated since dishes came out of the machine still soiled. On 4/27/2026 at 10:12 a.m. a crate of meal trays was put through the dish machine. The wash temp reached above 140 degrees F., and the rinse temp reached above 130 degrees F. Staff K and Staff U, Assistant Dietary Manager (ADM) both placed a separate litmus test paper strip on a wet side of the washed meal trays. The strips did not change color and remained white. This indicated there was no chemical sanitizer getting into the machine, and the dishes. The CDM stated the litmus paper chemical sanitizer test strip should have turned a medium to dark purple color which would indicate PPM of 50 -100. The color grid could be verified on the test strip bottle. On 4/30/2026 at 4:00 p.m. the (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Nursing Home Administrator provided the Dish Machine Use policy and procedure with a date of 6/2025 for review. The policy revealed; Dishware, eating utensils, and meal trays are washed and sanitized by use of the mechanical dish machine. The policy interpretive and implementation section revealed;The following guidelines will be followed when dishwashing:Wash hands before and after running dishwashing machine, and frequently during the process.Flatware:Presoak the flatware.Run the flatware through the dishwashing machine in a pallet.Wash the flatware in the utensil holder with eating end pointed upward.Presoak dishes or pots that contain dried or burnt food.Do not overcrowd racks.Use overhead spray to remove loose food particles.After running items through entire cycle, allow to air-dry.Clean dish machine after each meal.Dish machine chemical sanitizer temperature and concentration will be as follows: Type of solution = Chlorine, Minimum concentration = 50-100 ppm, Minimum temperature = 120 degrees F. or as per manufacturers recommendation.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, interviews and record review, the facility failed to ensure a comfortable, homelike and clean environment to include; 1. Resident room water temperatures not hot; 2. Shower room bathing equipment with bio-growth in two of six community shower rooms, and 3. Loud alarm noises during meal services during four of four days observed (4/27/2026, 4/28/2026, 4/29/2026, and 4/30/2026). Findings included: On 4/27/2026 at 10:45 a.m., 4/28/2026 at 10:15 a.m., and again on 4/30/2026 at 8:30 a.m., the following was observed by turning on the sink hot water, letting it run for over three minutes and using the back of the hand to feel the actual water temperature:1. Resident room [ROOM NUMBER] bathroom sink had no water pressure. There was only air spraying out from spigot after turning both hot and cold turn knobs.2. Resident room [ROOM NUMBER] bathroom sink hot water was not hot, it was less than lukewarm. 3. Resident room [ROOM NUMBER] room sink hot water was not hot, it was less than lukewarm almost cold. 4. Resident room [ROOM NUMBER]/118 bathroom sink hot water was less than lukewarm. 5. Resident room [ROOM NUMBER] room bathroom sink hot water was not hot, it was less than lukewarm. 6. Resident room [ROOM NUMBER] room sink hot water was less than lukewarm.7. Resident room [ROOM NUMBER] room sink hot water was less than lukewarm.8. Resident room [ROOM NUMBER]/106 room sink hot water was less than lukewarm.9. Resident #194's bathroom sink hot water was not hot, it was cold. Resident #194 confirmed the hot water in the room never gets hot. Resident #194 stated he has spoken to staff about it in the past but things never change10. Resident room [ROOM NUMBER] room sink hot water was cold. Bathroom sink hot water tested as cold11. Resident #182's bathroom sink hot water was cold. An interview with Resident #182, confirmed there is usually never any hot water, and he does turn it on for a long period of time with it still not getting hot. He had complained about shower water temperatures not getting hot as well. The resident stated he has spoken to staff repeatedly about this concern with no changes12. Resident room [ROOM NUMBER] bathroom sink hot water was cold. 13. Resident room [ROOM NUMBER] bathroom sink hot water was cold. 14. Resident room [ROOM NUMBER] bathroom sink hot water was cold. Also, the room sink hot water was less than lukewarm.15. Resident room [ROOM NUMBER] room sink did not get hot. The bathroom water did not get hot, it was cold.16. Resident room [ROOM NUMBER] room sink and bathroom sink did not get hot, it was cold.17. Resident #3's room and bathroom sink water did not get hot, it was cold. An interview with the Resident #3, revealed the room and bathroom never get hot enough and in the shower room, the water takes, forever to get even warm. She had complained about this to staff but things have not changed. 18. Resident #4's room and bathroom sink hot water did not get hot, it was cold to lukewarm. Interview with Resident #4, confirmed the water in his room and bathroom sink never get hot, and is always less than lukewarm. He stated he has brought this up to the attention of staff for months, but there has not been any changes. An attempt to interview the maintenance director on 4/29/2026 at 3:00 p.m. revealed he terminated his services that day and was not able to be interviewed with relation to how water temperatures were audited and maintained to a comfortable level for residents. An interview with the Nursing Home Administrator (NHA) on 4/30/2026 at 4:00 p.m. confirmed the Maintenance Director had terminated his employment on 4/29/2026. The NHA would not be able to show how the water heater water temperatures are set, as well as not able to show how the temperatures are audited in each resident room. The NHA did find past water temperature logs dated 4/23/2026. The NHA confirmed she did not have water temperature logs for resident rooms the week of 4/27/2026 – 4/30/2026. She was not able to show what resident room water temperatures were held at. On 4/28/2026 at 11:30 a.m., 4/30/2026 at 8:30 a.m. the following was observed in community shower rooms. 1. The community shower room in hallway 200 - 209 was observed with; 1. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Water to the shower did not turn on. There was a small plastic trash can in the shower stall with a plastic bag almost full of water; 2. One of one plastic shower chair was observed with black and pink bio-growth on each of the legs near the wheel castors; There was a shelf with various items to include open and used plastic straight razors, used combs and brushes which were not labeled 2. The Community shower room across from the 200 hall unit station was observed with; 1. 2 of 2 plastic shower chairs with black bio-growth on all four chair legs near the wheel castors. 2. The wall mounted shower sprayer was turned on and turned on to hot. After three minutes and with use of the back of the hand, the water was less than lukewarm. On 4/30/2026 at 2:45 p.m. the Housekeeping Director was interviewed related to cleaning protocols in community shower rooms and with resident shower/bathing equipment. The Housekeeping Director revealed the shower chairs are to be cleaned by nursing staff if there are any observations of matter and to clean and sanitize in between each use. She continued to say housekeeping will start to develop a plan for deep pressure wash treatment for shower chairs. She said she is developing a plan but had not implemented it just yet. She also confirmed she did not have any type of documentation to support the shower chairs are routinely cleaned. On 4/28/2026 at 3:00 p.m. the 400 main dining room was entered. There were no residents in the room at the time, but the room was identified as used for residents to dine in during meal services. While seated in the chair at a table, the dining room layout revealed twelve tables with red tablecloths on them. The room was very large, and one end of the room led into a hallway that goes to the 400 unit, the other end of the dining room had a windowed alarmed door that led outside. It was observed staff were using this door to either come in from outside or were coming from the 400 hall to use the dining room windowed door to go outside. It was found staff use the door from this dining room as a short cut to get to another part of the building. The door was observed with a code key lock and a screamer alarm affixed to the top corner. It appeared when staff used the door to come inside or to go outside, staff needed to press the Screamer alarm button prior to it triggering/alarming, and disarming when alarming. It appeared this door was being used at least fifteen times during a time period of 3:00 p.m. to 3:10 p.m. It was found that some staff did not press the Screamer button fast enough, and therefore the alarm sounded very loudly. There were no residents in this dining room at the time. A dining observation will be made on 4/29/2026. On 4/29/2026 at 12:20 p.m. the 400-unit main dining room was entered and there were two residents seated at a table and talking with one another. Each had what appeared to be a hydration drink. They were both awaiting the lunch meal service. At 12:22 p.m. a staff member opened the windowed alarmed door from the outside and did not press the Screamer alarm prior to the alarm sounding. The alarm sounded for approximately five seconds before the alarm was turned off. At 12:32 p.m. a staff member opened the windowed alarmed door from the outside and did not press the Screamer alarm prior to the alarm sounding. The alarm sounded for approximately five seconds before the alarm was turned off. At 12:34 p.m. a staff member was observed to walk from the 400 unit down the hallway and into the main dining room and proceeded to walk to the windowed alarmed door and walked outside. The staff member did not press the Screamer alarm prior to the alarm sounding. The alarm sounded for approximately five seconds before the alarm was turned off. At 12:35 p.m. a staff member was observed walking from the 400 unit down the hallway and into the main dining room and proceeded to walk to the windowed alarmed door and walked outside. The staff member did not press the Screamer alarm prior to the alarm sounding. The alarm sounded for approximately five seconds before the alarm was turned off. At 12:45 p.m. the dining room was observed with 12 residents seated at tables and awaiting their lunch meal tray. The kitchen staff brought in meal tray carts for the dining room. There were three staff members in the room and they began to pull trays from the cart and placed them on the table in front of residents. At 12:49 p.m. a staff member opened the windowed alarmed door from the outside and did not press the Screamer alarm prior to the alarm sounding. The alarm sounded for approximately five seconds before the alarm was turned off. At 12:52 p.m. a staff member was observed to walk from the 400 unit down the hallway and into the main dining room and proceeded to walk to the windowed alarmed door and (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	walked outside. The staff member did not press the Screamer alarm prior to the alarm sounding. The alarm sounded for approximately five seconds before the alarm was turned off. Every time the alarm sounded, there were at least two residents who would place their hands over their ears due to the very loud noise. At 12:59 p.m. two staff members were observed walking from the 400 unit down the hallway and into the main dining room and proceeded to walk to the windowed alarmed door and walked outside. The staff members did not press the Screamer alarm prior to the alarm sounding. The alarm sounded for approximately five seconds before the alarm was turned off. At 1:00 p.m. the 400-unit dining/activity room was observed with ten residents who were still eating and enjoying their meal. At 1:02 p.m. a staff member opened the window alarmed door from outside and did not press the Screamer alarm prior to the alarm sounding. The alarm sounded for approximately five seconds before the alarm was turned off. At 1:12 p.m. a staff member opened the windowed alarm door from the outside and did not press the Screamer alarm prior to the alarm sounding. The alarm sounded for approximately five seconds before the alarm was turned off. At 1:15 p.m. the 400-unit dining/activity room was observed with three residents, who were still eating and enjoying their meal. At 1:22 p.m. a staff member was observed to walk from the 400 unit down the hallway and into the main dining room and proceeded to walk to the windowed alarmed door and walked outside. The staff member did not press the Screamer alarm prior to the alarm sounding. The alarm sounded for approximately five seconds before the alarm was turned off. At 1:35 p.m. one resident remained eating in the dining room with staff supervision and a staff member had opened the windowed alarm door from the outside and did not press the Screamer alarm prior to the alarm sounding. The alarm sounded for approximately five seconds before the alarm was turned off. Interview with over five various staff members (unknown names and position titles), all confirmed they use the door to go to another unit, and they try to press the screamer alarm disarm button before it alarms. The staff also confirmed the alarm sounds pretty quickly and they used the door during meal services when residents were in the room. On 4/30/2026 at 9:30 a.m. an interview with the Dietary Manager confirmed staff do use the door leading out and in from the 400-dining room, which is next to the kitchen. She confirmed she hears the alarm from the door sounding all day including when residents are in the room eating for all three meal services. She confirmed staff use this door to go to another side of the building and vice versa. The Dietary Manager stated she will tell staff not to use the door while residents are dining, but there is just too much staff traffic going in and out, that it's impossible to catch them all. The Dietary Manager was not aware if the Nursing [NAME] Administrator was aware of staff using this door as means as a short cut. On 4/30/2026 at 2:00 p.m. an interview with the Nursing Home Administrator stated she had just found out that staff were using the 400-unit dining room door to go outside to another unit, or staff coming on to the 400 unit from other parts of the building. She confirmed that when residents dine in that area, staff should not be using that door to go in and out. She did say there is a Screamer alarm attached but residents should be kept with a homelike dining experience when eating. On 4/27/2026 at 9:58 a.m., an observation of room [ROOM NUMBER] the vanity top material was not attached to the wood underneath it. The laundry basket under the sink contained 2 used gloves and appeared to have crumbs of unknown substances in it. On 4/27/2026 at 10:19 a.m. an observation of room [ROOM NUMBER] showed on the bathroom wall above the door appeared black and brown bio-growth. On 4/27/2026 at 10:20 a.m. an observation of room [ROOM NUMBER] showed the area surrounding the Packaged Terminal Air Conditioner (PTAC) had crumbling wallboard in the area between the unit and the decorative molding. The baseboards in the area were covered with a brownish-gray substance and the wall above the PTAC unit had an area of splitting paint. On 4/27/2026 at 10:30 a.m. an observation of room of the 400-hall unit nurses' station showed pieces of tiling missing in the doorway of one of two 400 hall and the nursing station area of the unit. The missing pieces were approximately 5 inches by 4 inches. The hole was off centered in the hallway and left an indentation of the depth of a floor tile. A smaller hole was observed in the doorway nearer the hinges. On 4/27/2026 at 10:55 a.m. an observation of room Resident 12's low air loss (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	control unit hanging from footboard of bed frame. A black substance was noted within the indented of the weight selector dial. On 4/29/2026 at 11:35 a.m. another observation of the weight selector dial showed the black substance continued to surround the dial. On 4/27/2026 at approximately 11:10 a.m. an observation was made of room [ROOM NUMBER]. The privacy curtain to the left of doorway had a dried brown substance attached to it. The Packaged Terminal Air Conditioner (PTAC) had yellow duct tape attached to the molding and surrounding the unit on three sides. The tape was loosening on one corner. The sink vanity in the room had chipped and flaking paint. On 4/29/2026 at 11:00 a.m. an observation of the 500-hall dining room showed a package of crackers had fallen on floor, 10 crackers had spilled from the package. The baseboard near the package had staining of previously spilled liquids, the tiles next to the baseboards were discolored a tannish-yellow color with black/gray/brown unknown material. The observation showed areas of patching with unmatched wall coloring, the corners of the baseboards showed black attached unknown substances, the chair rail in the room was stained with dried splattering of unknown substances, the wall to the right of fish aquarium near the baseboard was an area of cracked wallboard approximately 2 foot in length. The cracked wallboard appeared to have been previously repaired. A square table next to the aquarium without anyone sitting at it, was unclean with a liquid on it. The 500-hall dining room was also used as the activity room for the secured unit. During the observation Staff S, Licensed Practical Nurse/Unit Manager (LPN/UM) reviewed the observations and stated she had not noticed the cracked wallboard but would report it now. The staff member stated housekeeping was responsible for wiping down tables after meals. An interview was conducted on 4/29/2026 at 11:20 a.m. with Staff W, Housekeeper. Staff W reported not mopping the 500-hall dining room as she doesn't want people to fall, she just sweeps it. The staff member reported the facility doesn't have floor technicians and night shift was supposed to mop it. The staff member stated the stains on walls aren't able to be cleaned, they need to be bleached. An interview on 4/30/2026 at 8:55 a.m. was conducted with Staff S, LPN/UM. Staff S reports the floors in the building were being redone but the 500 hall is last on the list and portions of the dining room had been repainted on 4/29/2026. Staff S was shown the area where the breakfast cart had been pushed into the nearly repaired area next to the aquarium. An interview on 4/30/2026 at 10:47 a.m. was conducted with the Nursing Home Administrator (NHA). The NHA reported being Maintenance Director as the previous one had left on 4/29/26. Review of the policy – Cleaning and Disinfecting Residents' Rooms, revised August 2013, revealed it's purpose was to provide guidelines for cleaning and disinfecting residents' rooms. The general guidelines included:1. Housekeeping surfaces (e.g. Floors, table tops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled.2. Environmental services will be disinfected (or cleaned) on a regular basis (e Daily, three times per week) and when surfaces are visibly saw failed.4. Walls, blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled. Review of the facility policy and procedure titled Environmental Services – Safe Environment not dated. The policy stated; IN accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. Definitions: Comfortable and safe temperature levels means that the ambient temperature should be in a relatively narrow range that minimizes residents' susceptibility to loss of body heat and risk of hypothermia or hyperthermia or and is comfortable for the residents. Comfortable sound levels means levels that do not interfere with the resident's hearing, levels that enhance privacy when privacy is desired, and levels that encourage interaction when social participation is desired. Environment – refers to any environment int the facility that is frequented by residents and visitors, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas. A homelike environment is one that de-emphasizes the institutional character of the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	setting, to the extent possible, and allows the resident to use those personal belongings that support a homelike environment. A determination of homelike should include the resident's opinion of the living environment. Sanitary includes, but not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes, but not limited to, equipment used in completion of activities of daily living. The procedure section of the policy revealed;1. The facility will create and maintain, to the extent possible, a homelike environment that de-emphasizes the institutional character of the setting. E . Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment.I . The facility will provide and maintain comfortable and safe temperature levels in all areas.a. The facility should strive to keep the temperature in common resident areas within a range established by regulation.1. The facility will maintain comfortable sound levels in the facility. 2. General Considerations:C . Maintain minimal use of alarms, using alternative interventions, unless otherwise indicated by the care plan.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews the facility failed to provide life enriching activities and assistance with activities for cognitively impaired residents residing on the secured unit of one cognitively impaired unit reviewed, failed to provide activities to one (Resident #7) of one bedridden residents, and failed to facilitate and assist one (Resident #120) of one residents with outside activities.Findings included: On 4/27/26 at 11:30 a.m. twelve of the forty-one residents residing in the 500-hall secure unit were sitting in dining room during a sensory activity with eyes closed and heads bowed. Staff Y, Activity Aide (AA), was observed sitting at a corner table occupied by one resident assisting with a jigsaw puzzle. The observation did not show the aide interacted or encouraged other residents. Review of the monthly 500-unit calendar showed Sensory Club was scheduled on 4/27/26 at 11:00 a.m. On 4/27/26 at 4:20 p.m., Staff Z, Certified Nursing Assistant (CNA) was observed sitting at table in the 500- hall dining room with Staff Y, AA. Twenty residents were observed in the room and a television was playing. On 4/27/26 at 4:26 p.m. an unknown female resident was observed at the end of the low 500 hall opening and shutting the window blinds. On 4/27/26 at 4:33 p.m. Staff Y, AA was observed escorting three female residents to the back patio of the 500-hall (did not include the unknown female seen at 4:26 p.m.). Staff T, Licensed Practical Nurse (LPN) was observed unlocking the patio door. At the time of the observation 24 residents were sitting in the dining room with Staff S, Licensed Practical Nurse/Unit Manager (LPN/UM) tossing beach ball, nine of the residents were interacting with one resident refusing, leaving 14 residents unencouraged to participate. An interview was conducted on 4/27/26 at 4:47 p.m. with Staff S, LPN/UM. Staff S stated usually the Activity Aide can take five residents outside for Patio Chat. The AA can take more if additional staff are able to go outside, as well. Staff S, states she even takes them out but can't remember the last time she did. Staff S reported not knowing how many residents usually went out because she was not normally at the facility this late. On 4/27/26 at 4:49 p.m. the patio door was opened by Staff T, LPN for this writer. Staff T stated they don't take residents outside, they do activities in the dining room. Staff Y, AA was observed sitting under a covered porch directly outside of the exit door with three female residents. Resident #186 stated always enjoying being outside. Staff Y stated coming outside was based on who was available as there isn't always coverage in the dining room but they are able to come outside about once a week. Staff Y stated being able to take up to five residents out, and tries to bring a couple in wheelchairs and a couple of residents with walkers. The staff member put code into keypad, which did not work, saying there was usually a key hanging next to the door. An observation was made of the courtyard area revealed a covered gazebo in the middle with pathways leading to it. Staff Y, AA stated they don't go any further than this covered porch. The three female residents were escorted back inside at 4:59 p.m. as the door was unlocked by Staff S and spending 26 minutes outside sitting under a covered porch. The female resident who was earlier seen opening and shutting the blinds (at (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4:26 p.m.) attempted to exit the door. Staff S, LPN/UM informed Staff T, LPN she would take the resident outside. Staff T asked when Staff S wanted to come back in, Staff S stated, 5 minutes. On 4/27/26 at 5:04 p.m. Staff AA, CNA was observed in the 500-hall with 26 residents. The staff member wrinkled up nose and stated she doesn't go outside with the residents. On 4/27/26 at 5:09 p.m. Staff S, LPN/UM and the unknown female resident who was taken outside were at the nursing station. Review of the 500-unit Activity Calendar revealed at 4:30 p.m. every day, seven days a week the activity of Patio Chat was scheduled. On 4/28/26 at 10:18 a.m. an observation of the 500-hall dining room revealed the daily 10:00 a.m. scheduled refreshment activity had not occurred. Staff S, LPN/UM was observed entering the room with a bag of packaged cookies and crackers and exited with the bag. On 4/28/26 at 10:20 a.m. an observation of two CNA's entered the room with the bag of cookies and crackers. Staff BB, AA entered and asked for drinks which one of the CNA's stated they could get from the dining room. On 4/29/26 at 2:08 p.m. the door to the 500-hall dining room was shut. Staff S, LPN/UM stated, they're in there cleaning and staff were taking resident's outside for activities. An observation was made of the fenced courtyard with gazebo where 13 residents were sitting under and around the gazebo smiling and interacting with each other, only one resident appeared to have eyes closed. A family member who wished not to be identified stated this was the first time they had seen residents outside and visits regularly at different times of the day. An interview was conducted on 4/30/26 at 1:51 p.m. with the Recreation Director (Activity Director, AD). The AD reported the activity department was fully staffed with one person on each unit. The AD reported doing an in-room form for bedridden residents, it asked them what they enjoyed doing, if they wanted in-room visits. The activities included music, sensory, tactile, hand massages, socialization, reminiscing, playing cards, reading to them, and whatever they want us to do. The bedridden residents are visited 2-3 times a week per the AD. The AD stated residents are allowed to go outside if they are not smokers, the area outside of the 100 and 300 halls are available. They have a gardening area and one of the activity staff had a green thumb. The AD stated one resident from the 400-hall went out often, residents did need a staff or family escort, and usually is on the calendar for outside time, in-room residents are sometimes taken out, but there is not a schedule. The AD reported activities for the cognitive impaired residents were tactile, magnetic building blocks, hand massages, singalongs, read to them, and (wrinkled nose) outside time. The AD stated we try to do weekly. With cognitively impaired residents once or twice a week. The AD stated we try to do our best regarding interacting with the cognitively impaired residents, staff should interact during a planned activity. The AD stated staff are to assist residents with different activities, for example: puzzle, sing during the singalong, guide them to do building blocks, hand them balloon to toss, and move around the room. The AD stated she encourages staff to interact. The AD reported Patio Chat was outside time. During Patio Chat different activities can be completed for example: reminiscing, socializing, snacks, whatever the residents would like. The AD re-stated the cognitively impaired outside time was mostly daily as it was on the calendar for daily. Regarding the 500-hall the AD stated most of the time 5-10 residents go outside, the other day it was 3-5, we don't want to limit them being outside. The AD stated if activity staff are outside she doesn't know what the other staff are doing with the residents who remain (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	inside. The AD stated outside time is usually for 20-30 minutes per day, it's supposed to happen daily. On 4/27/26 at 12:57 p.m., an interview occurred with Resident #120. Resident #120 stated the staff used to take them outside, but they no longer do. Resident #120 stated enjoying the activities within the facility but would like the opportunity to be outside and enjoy the fresh air and sunshine more frequently. Resident #120 stated they feel confined in their room and need to be able to get outside to make their stay at the facility more enjoyable. A review of Resident #120's admission record revealed an initial admission date of 4/11/2025, and a readmission date of 8/20/25 with diagnoses to include unspecified dementia, major depressive disorder and generalized anxiety disorder. A review of Resident #120's Quarterly Minimum Data Set (MDS) assessment, dated 4/7/26, revealed a Brief Interview Mental Score (BIMS) of 11/15, indicating Resident #120 is moderately impaired. Preferences revealed that Resident #120 scored a 1, indicating going outside to get fresh air when the weather is good is very important to them. A review of Resident #120's Activities task revealed that the resident participated in activities for the last 30 days, no activities were provided or offered outside. A review of Resident #120's current Care Plan revealed the resident enjoys being outside. On 4/29/26 at 2:15 p.m., an interview was conducted with Staff H, CNA. Staff H, CNA stated they do not ask Resident #120 to go outside, and they would not take the resident outside if they asked because they have to be able to complete their assignments/tasks with other residents, there is not enough time. On 4/27/26 at 1:47 p.m., an interview occurred with Resident #7 laying in their bed watching TV with the privacy curtain pulled around the resident's bed. Resident #7 stated the activities department does not come and visit in the room. Resident #7 stated not being able to get up and is the room all the time. Resident #7 stated they feel forgotten because no one comes to do activities with them, and is very bored saying watching television is not enough for an activity. A review of Resident #7's admission record revealed an initial admission date of 1/5/22, and a readmission date of 6/21/22 with diagnoses to include bipolar disorder, major depressive disorder, generalized anxiety disorder, post-traumatic stress disorder, and schizoaffective disorder. A review of Resident #7's Quarterly Minimum Data Set (MDS) assessment, dated 2/5/26, revealed a BIMS of 15/15, indicating Resident #7 is cognitively intact. Preferences revealed that Resident #7 scored a 2, indicating it is somewhat important for Resident #7 to do their favorite activities. A review of Resident #7's current Care Plan revealed the resident will maintain involvement in cognitive stimulation, social activities as desired; and to invite Resident #7 to activities. A review of Resident #7's activities task for the last 30 days revealed Resident #7 was offered/attended activities 3 of the 30 days. Review of Resident #7's chart did not reveal any In Room Visit Forms for activities on file. These documents were requested from the facility and were unable to be provided for Resident #7 during the (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	time of the survey. On 4/29/26 at 2:10 p.m., an interview was conducted with Staff G, CNA. Staff G, CNA stated Resident #7 rarely gets out of bed to participate in facility activities, and due to their chronic back pain they do not stay long in the activity before wanting to be put back in bed. Staff G, CNA stated Resident #7 had not participated or been offered to go to an activity since last week at least. Staff G, CNA said Resident #7 should be offered alternative activities for in bed more often than they are now. On 4/30/26 at 3:00 p.m., an interview was conducted with the AD. The AD stated for residents who are bedridden, activities is to go into the resident's room [ROOM NUMBER]-3 times per week, but they have not yet gone to Resident #7's room to provide activities. The AD explained the activities and care staff are expected to take the residents outside if they are not smokers. The AD said refusals to participate in activities should be documented by staff. The AD stated each resident is provided with a form for in room one to one (1:1) activities for each attempt, and that there should be documents for Resident #7's in-room activities being provided. The AD said television is not a sufficient form of activity, and the resident should be offered to play cards, reminisce and talk about their past, do puzzles, and color. On 4/30/26 at 4:15 p.m., an interview was conducted with the AD. The AD stated based on the documentation, neither resident had been offered and/or provided with in-room activities, or with the option of going outside. The AD stated she was not the one who provided these activities to these residents, so they cannot confirm if they were provided; but according to the documentation, Resident #7 was not provided activities and Resident #120 was not taken outside. Review of the facility policy and procedure titled Activity Department Planning and Programming not dated revealed: POLICY Activities should be provided for each resident according to an individualized therapeutic plan which is based on the needs and interests identified within the Interest Survey and Assessment.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews the facility failed to implement and maintain an effective infection control program related to 1) cleanliness and maintenance of the laundry room, 2) educate staff on hand hygiene and personal protective equipment required for the prevention of spreading Clostridioides difficile (C. diff) after two (#41 and #91) of two residents tested positive for the highly contagious bacteria and two (#1 and #39) of two sampled residents were actively being tested for the bacteria and 3) provide Pneumococcal immunization for one (R#20) of five residents sampled for the administration of vaccinations.Findings included: On 4/29/26 at 10:13 a.m. the facility laundry room was observed with the Housekeeping Director (HD) and the Nursing Home Administrator (NHA). The observers entered the clean area of the laundry area. The HD stated the area was swept multiple times a day. The observation revealed wire shelving units to the right of the doorway (facing from door into area) with miscellaneous bed linens folded and plastic bags filled with unknown objects. The bottom shelf appeared to be fuzzy with gray dust/lint-like material, under the unit was wadded up paper and dust, in front of the unit was a piece of blue plastic. An opened personal-sized bottle of purified water was observed sitting amongst folded linens. The HD observed the bottle and stated it should not be there. The area to the left of the door revealed a folded piece of white terry cloth with 2 pieces of dust/lint like substance attached to it. The HD took the item down, unfolded it and stated the pieces were part of the writing on the material. A continued observation with the HD showed the 2 pieces of substance continued to be attached to the material and was not part of the writing in black marker. Several flakes of a white/cream colored material littered the floor under the air duct. On the ceiling next to air duct were 2 areas showing previous repairs had been completed and the seams of the repair appeared wet and joint tape was hanging down from the ceiling. The HD stated the area had started leaking yesterday from the [NAME] fixing the roof. A dusty slipper and bits of plastic were observed under a white plastic shelving unit parked against the wall. The HD reported folding occurred on the 2 metal tables in the area, one to the right of door and the other to the left. On the left table inside a crate sitting on a dark colored dusty towel was a bottle of peach air fragrance. The HD stated the bottle should not be on the table.Observation was conducted of a room containing two washing machines. The outside of both washers was covered with fuzzy gray dust/lint material. On the floor between the wall and first washer was dusty terra [NAME] tiles with a blue rubber-type glove and remnants of white paper-like material. The conduit beside and behind the washers had the same fuzzy gray material attached to them. A fan attached to the wall behind the washers had a piece of opaque plastic inside the cage and the cage was covered with the gray fuzzy material. Next to the second washer on the floor was plastic hangers, a bag of pillows, and wadded up white linens. The HD stated they had used the blankets to soak up the water leaking from the roof in the folding area and confirmed the items should not be left on the floor next to the washer. The conduit running from electrical boxes to the ceiling had dust attached to them. The HD stated staff swept the floor every shift but did not wipe down the outside of washers. The third room of the laundry area contained one washer, metal lockers, and a sink. The gasket between the frame and drum of washer had white paper and brown crumbs of an unknown substance. On the floor next to the washer and in front of the lockers was a black plastic comb, on the other side of the washer behind an overflowing trash bin was a wadded-up blanket, and between the bin and sink on the floor was pieced of white wadded-up pieces of paper. The exhaust fan above the area was covered with the fuzzy gray material and had an opaque piece of plastic inside the cage. The sorting area contained multiple large plastic black bags stacked along the back wall and on top of a linen cart. Staff Q, laundry aide (LA) reported not knowing what was in the bags. Staff Q open one and stated pillows were in them. The staff member was asked to demonstrate how to fold a blanket. The staff member obtained an unfolded blanket, dragged a corner of it on the floor, held the blanket against self, and folded it into a neat square. Immediately (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following Staff Q, LA demonstration, the NHA informed the HD the staff member would need further education on how to fold the blanket, to include not dragging it on ground nor touching the staff members unprotected clothing. On 4/30/26 at 11:12 a.m. an observation was made of the laundry area containing one washer, metal lockers, and sink. The fan on wall near sink continued to be covered with gray fuzzy material and opaque plastic was still located within the blade cage. The facility failed to provide a policy regarding cleanliness of laundry room. 2.During an interview on 4/30/26 at 12:00 p.m. the Interim Director of Nursing/Infection Preventionist (DON/IP) reported the facility had two (R#91 and R#41) confirmed cases of Clostridioides difficile (C. diff) and one (R#1) resident was currently being tested for it. The line listing for April showed two residents were positive for C. diff and did not include information related to the third resident (R#1). The IP stated hand hygiene was to be done with soap and water instead of alcohol-based hand rub (ABHR) for C. diff. The IP reported no re-education on hand hygiene had been started for staff regarding the use of soap and water for C. diff but would start. The IP stated not knowing what constituted as an outbreak. Review of the April 2026 Infection Control Log did not reveal Resident #1 and Resident #39's information. Review of Resident #41's clinical record showed a stool sample had been obtained on 4/20/26. On 4/23/26 the results showed positive for the bacteria C. difficile. Review of monthly infection control log for the 300-hall showed Resident #41 was admitted on [DATE] with an onset of C. diff on 4/20/26 and the antibiotic Vancomycin (Vanco) started 4/22/26. Review of Resident #91's clinical record showed the resident was admitted to the secured unit on 10/14/25. The record showed a stool sample had been obtained on 4/16/26 and the sample tested positive for C. Diff Toxins A& B. The results were reported on 4/18/26 to the facility. Review of the monthly infection control log for the 500-hall (Resident #91's unit) showed the onset of infection was 4/14, culture was taken on 4/16 and the antibiotic vancomycin (Vanco) was started on 4/19/26. Review of Resident #1's clinical record showed the resident was admitted on [DATE] and moved to the secure unit on 1/8/26. Review of Resident #1's laboratory results showed the resident had tested positive for the bacteria, C. Difficile. Review of the monthly infection control log for the 500- hall showed Resident #1's information had been added after the interview with the IP on 4/30/26. The log showed Resident #1 had been tested on [DATE] with positive results. The resident started on the antibiotic Vanco on 4/30/26. Review of Resident #39's progress note dated 4/28/26 at 12:49 p.m. showed Resident #39 was alert and oriented. A note dated 4/28/26 at 2:27 p.m. revealed the resident had complaints of diarrhea, and an as needed (prn) dose of anti-diarrheal medication had been administered and the physician ordered STAT (to be completed immediately) blood work to include complete blood count (CBC) and comprehensive metabolic panel (CMP). The notes showed on 4/29/26 at 11:03 a.m. the physician had ordered the facility to check stool for C. Diff. The notes showed Resident #39 received another dose of anti-diarrheal medication on 4/29/26 at 8:45 p.m. A note on 4/30/25 at 7:05 a.m. revealed staff had been unable to collect a stool sample overnight due to no bowel movements. The notes showed on 4/30/26 at 10:16 am., Resident #39 was moved to the 300-hall without a documented reason. Review of Resident #39's clinical record showed the resident resided on the 400-hall since 1/31/25 and had moved to the 300-hall on 4/30/26. Review of the monthly infection control log for 300 and/or 400-hall, dated 4/15 - 4/30/26 did not reveal Resident #39 was being tested for an infection and if a culture had been obtained. 3.Review of Resident #20's vaccine consent form, dated 1/3/26 showed the legal representative had chosen for the resident to receive the pneumococcal, respiratory syncytial virus (RSV), and shingles vaccinations. Review of Resident #20's admission Record revealed the resident was admitted on [DATE] with diagnoses not limited to unspecified dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, moderate recurrent major depressive disorder, and brief psychotic disorder. Review of Resident #20's January 2026 Medication Administration Record (MAR) did not show the consented vaccinations had been ordered and/or administered. Review of Resident #20's progress notes, dated 1/3 to 1/5/26 did not reveal the resident refused the vaccinations and/or the legal representative had rescinded the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	consent. During an interview on 4/30/26 at 12:00 p.m. the Interim Director of Nursing/Infection Preventionist (DON/IP) reported the facility does not offer RSV or shingles vaccinations. The IP reported not knowing why the resident did not get vaccinated (at time of consent) with pneumococcal vaccine. The DON/IP said if a resident refuse (staff) should retry, contact the family and physician, and document (the refusal). Review of the policy - Pneumococcal Vaccine, revised August 2016, showed All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. The interpretation and implementation revealed the following:1. Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contradicted or the resident has already been vaccinated.2. Assessments of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission.4. Pneumococcal vaccines will be administered to residents (unless medically contradicted, already given, or refused) per our facilities physician-approved Pneumococcal vaccination protocol.5. Residents/ representatives have the right to refuse vaccination. If refused, appropriate entries will be documented in each residence medical record indicating the date of the refusal of the pneumococcal vaccination.6. For residents who received the vaccines, the date of the vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the residence medical record. Review of the policy - Infection Prevention and Control Program, undated, revealed And in infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.1. The IPCP is developed to address the facility-specific infection control needs and requirements identified in the facility assessment and the infection control risk assessment. The program is reviewed annually and updated as necessary.2. The program is based on accepted national infection prevention and control standards.The elements of the IPCP included but not limited to:1. Coordination and Oversight d. Surveillance data and reporting information is used to inform the committee of potential issues and trends. Some examples of committee reviews may include:3. Surveillance and reporting b. Surveillance tools are used for identifying the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infection, monitoring adherence to infection prevention and control practices, and dictating unusual pathogens with infection control implications.4. Antibiotic Stewardshipa. Culture reports, sensitivity data, and antibiotic usage reviews are included in surveillance activities.b. Medical criteria in standardized definitions of infections are used to help recognize and manage infections.6. Outbreak Management a. Outbreak management is a process that consists of: (1) determining the presence of an outbreak; (3) preventing the spread to other residents; (6) educating the staff and the public;7. Prevention of Infection a. Important facets of infection prevention include:(3) Educating staff and ensuring that they adhere to proper techniques and procedures;9. Monitoring Employee Health and Safetya. The facility has established policies and procedures regarding infection preventions and control among employees, contractors, vendors, visitors, and volunteers, including:b. Those with potential direct exposure to blood or body fluids are trained in and required to use appropriate precautions and personal protective equipment.(1) The facility provides personal protective equipment, checks for its proper use, and provides appropriate means for needle disposal.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observations, interviews and record reviews, the facility failed to ensure call light accessibility for one (Resident #94) of 10 residents reviewed.Findings included: During an observation on 4/27/2026 at 9:57 a.m. Resident #94 ?s call light was seen tangled with the roommate's call light, located under the roommate's bed.Review of Resident #94 admission record revealed an admission date of 2/9/2023 and a readmission date of 5/13/2023. Resident #94 was admitted to the facility with diagnosis to include but not limited to gastritis, atherosclerotic heart disease of native coronary artery without angina pectoris, persistent mood disorders, hyperlipidemia, major depressive disorder, insomnia, hemorrhage of anus and rectum. During an interview with the Director of Nursing (DON) on 4/27/2026 at 10:00 a.m. the DON stated Resident #94's call light was not within reach and was located under the bed.During an interview on 4/29/2026 at 1:57 p.m. Staff N, Certified Nursing Assistant (CNA) said call lights should be located next to residents. Staff N always checked call light accessibility during the morning rounds. During an interview on 4/29/2026 at 2:01 p.m. Staff M, Registered Nurse (RN) said call lights were to be located within reach. Staff M checked call light accessibility when providing care, and every now and then. When a call light was on, there was a machine located at the nurse's station which would indicate this. The light above each of the residents' rooms also indicated a call light was on. Review of a facility policy and procedures titled Call light, Answering with no revision date showed Purpose: The purpose of this procedure is to respond to the resident's requests and needs. Key procedural points: .4. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. (Photographic evidence was obtained)

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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 interview and record review the facility failed to ensure Preadmission Screen and Annual Review (PASRR) was accurate for one (Resident #81) of two residents reviewed for PASRR. Findings Include: Review of Resident #81's admission record revealed she was admitted to the facility on [DATE] with diagnoses to include anxiety, major depressive disorder, bipolar disorder, and dementia. Review of Resident #81's admission Minimum Data Set (MDS) dated [DATE] indicated the resident's Brief Interview for Mental Status (BIMS) score was 14/15, which reflected intact cognition; and acknowledged Feeling down, depressed or hopeless 7-11 days a week. Review of the psychiatry progress note dated 4/10/26 revealed . Depression: Little interest in doing things, Feeling down/depressed/hopeless, Trouble falling or staying asleep, Feeling tired, Appetite problems, Feeling bad about self, Trouble concentrating, Moving or speaking slowly. Review of the medical records revealed no evidence of a Level II PASRR (Preadmission Screening and Resident Review) for a secondary diagnosis of dementia with a diagnosis of major depressive disorder was submitted to the State Mental Health Authority for review for evaluation and determination of whether the individual required specialized services for Resident #81. During an interview on 04/30/2026 at 4:42 PM the Nursing Home Administrator (NHA) confirmed that a Level IIPASRR evaluation had been submitted to the State Mental Health Authority for Resident #81.The NHA stated they had started a performance improvement plan (PIP) and a previous member of her administrative team was trying to fix the PASRR's. For Resident #81, the NHA asked what specifically was incorrect on the Level I PASRR form. The NHA confirmed question 6 in section II; dementia was not marked as a secondary diagnosis therefore no level 2 was submitted. Review of the PASRR Policy with no revision date revealed the following. Policy: The Admissions Coordinator/Designee is responsible for ensuring that the Level I PASRR Screen and Level II PASRR Evaluation and Determination, if applicable, are completed prior to admission. Procedure: 2. A Level I PASRR must be fully and accurately completed . Upon or prior to admission, if the facility finds the Level I to be incomplete or inaccurate, a corrected Level I PASRR must be completed by the hospital staff or appropriate Nursing Facility staff . 4. When applicable, a request for a PASRR Level II evaluation must be made .

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Hills Health and Rehabilitation Center	1350 Sleepy Hill Rd Lakeland, FL 33810

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and record review, the facility failed to develop and implement care plan problem areas related to oxygen therapy for one (Resident #11) of six sampled residents. Findings included:On 4/27/2026 at 10:30 a.m., 4/28/2026 at 8:45 a.m., 10:45 a.m., 2:00 p.m. and on 4/29/2026 at 8:10 a.m. Resident #11 was observed with oxygen being delivered by the way of a nasal canula with a flow rate of 1.5 liters per minute (lpm). Resident #11 was not able to answer questions related to his medical care and services. Review of the medical record revealed Resident #11 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of the advance directives revealed Resident #11 had a Power of Attorney to make his medical and financial decisions. Review of the diagnosis list revealed no specific diagnosis related to respiratory functions.Review of the current month 4/2026 Physician's Order Sheet revealed orders to include but not limited to: Oxygen (O2) at 2 lpm, as need for Shortness Of Breath (SOB), (Order date 4/16/2026).Review of the Medication Administration Record (MAR)/Treatment Administration Record (TAR) for month of 4/2026 revealed daily O2 saturation rates were documented as 92% and above each shift. The MAR revealed order 4/16/2026 - Titrate Oxygen to keep above 92% as needed to support labored breathing Titrate to keep above 92%. Documentation started on 4/17 - current 4/30/2026 as provided.Also, the MAR revealed Oxygen 2L as need for SOB and checked as completed from 4/1/2026 - 4/15/2026. Revie of the current Minimum Data Set (MDS) Significant Change assessment dated [DATE], revealed; (Cognition/Brief Interview Mental Status or BIMS score - 3 of 15, which revealed Resident #11 would not have been able to speak related to his medical care and service); (Activities of Daily Living ADL - Impairment both sides lower extremity, Dependent on staff with most to all ADLS); (Treatment - not checked for use of oxygen.) Review of the current care plans with a next review date 7/2/2026 revealed no care plan problem areas, goals and interventions related to use of oxygen. It was found resident #11 was receiving oxygen therapy routinely since 4/16/2026 and there had not been any care plans developed for the use of.On 4/29/2026 at 10:05 a.m. an interview with the MDS/Care Plan Coordinator revealed she is responsible for care planning development, along with the Interdisciplinary Team (IDT). She confirmed Resident #11 was ordered for Oxygen therapy at 2 liters per minute and with an order date of 4/16/2026. The Care Plan Coordinator reviewed Resident #11's current care plans with a next review date 7/2/2026 and confirmed there were no care plans with problem area, goals and interventions related to oxygen therapy. The Care Plan Coordinator also stated the care plan should have been developed by now. She stated she had received reports of residents who needed to have care plans updated, and Resident #11 for some reason was not on that report.On 4/30/2026 at 12:25 p.m. an interview with the 200 Unit Manager Staff E, revealed she was just made aware Resident #11 was now using oxygen routinely and that was something hospice services had changed but never brought to their attention to make the change. She confirmed Resident #11 should have by now been developed with a care plan to reflect the use of oxygen therapy. On 4/30/2026 at 3:20 p.m. an interview with the Director of Nursing and Nursing Home Administrator confirmed Resident #11 who utilized oxygen therapy, whether routinely or as need, should have been developed with a care plan problem area to identify oxygen therapy, and with goals and interventions related to it.On 4/30/2026 at 4:00 p.m. the Nursing Home Administrator provided the Resident Assessment Instrument Comprehensive Care Plan Policy, with an effective date of September 2024 for review. The policy stated; To ensure each resident in the facility receives individualized and appropriate care based on a thorough assessment using the Resident Assessment Instrument (RAI), and to comply with State and Federal regulations.The Policy Statement revealed; The facility will utilize the RAI process to assess residents' needs, develop individualized care plans, and ensure the delivery of quality care. This process will involve interdisciplinary team members and (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be revised to reflect resident condition changes.The Procedure section of the policy #3 revealed;Developing the care Plan;An individualized care plan will be created for each resident within 7 days after completing the comprehensive MDS,The care plan will address physical, emotional, social, and cognitive needs, as well as any other relevant areas (e.g. nutritional, safety, mobility, medication management),The care plan will specify measurable objectives and timelines and include input from the residents and family where appropriate. #5 of the procedure revealed;The care plan will be reviewed quarterly and revised as necessary,The care plan must be updated in response to changes in the resident's condition, new assessments, or input from the resident/family,Significant changes in the residents' condition will trigger a new MDS assessment, guiding further revisions to the care plan.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure access to vision services for one (Resident #73) of one resident reviewed for communication and sensory problems.Findings included: On 4/27/2026 at 1:13 p.m., an interview was conducted with Resident #73 in her room. Resident #73 stated she would like to visit an ophthalmologist (eye doctor). She said staff told her she was placed on a list months ago. She does not know why they have not followed up with her on this request. She said she can see with her current glasses but due to her glaucoma she would like an examination. A review of Resident #73's admission Record showed Resident #73 was admitted to the facility on [DATE] with a diagnosis including but not limited to glaucoma. A review of Resident #73's quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating intact cognition and showed she uses corrective lenses. Review of Resident #73's active Care Plan dated 7/25/25 revealed Resident #73 has impaired visual function related to Glaucoma. The interventions for this care plan state to observe, document and report as needed any signs or symptoms of acute eye problems. On 4/29/2026 at 12:46 p.m., an interview was conducted with Staff A, Certified nursing assistant (CNA). Staff A, remembers there was an eye doctor that would see the residents here, and she is not sure if they currently still have this process in place. She said, if a resident reported they needed to see an eye doctor, she would report this to her nurse. Staff A said, if she recalls accurately the Unit Manager would handle the arrangements to see an eye doctor. On 4/29/2026 at 12:54 p.m., an interview was conducted with Staff B, Licensed Practical Nurse (LPN). Staff B said, Resident #73 did request a couple months ago that she would like to see an ophthalmologist. Staff B looked for a logbook to report this, could not find the logbook for vision care needs. Staff B said they didn't have a Unit Manager at the time, so she reported this to the previous Director of Nursing (DON). On 4/29/2026 at 12:54 p.m., an interview was conducted with the interim Director of Nursing (DON). The DON stated the process for a vision exam is to notify the nurse or supervisor first. Then determine if the resident would prefer the in-house optometrist, or if an outpatient appointment is needed. The DON stated they have two staff members that will handle appointment arrangements and transportation. The DON said, she is not aware of Resident #73 requesting to have a vision appointment for over two months. The DON acknowledged the process did not get the outcome expected for Resident #73. Review of the Resident Rights Policy with no revision date revealed the following. Policy: The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The facility must protect and promote the rights of the resident. The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, and reprisal from the facility.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and manufacturer specification review the facility failed to maintain the settings of a low air loss mattress for one (#12) of two residents investigated for the worsening and/or development of pressure ulcers. Findings included: On 4/27/26 at 10:55 a.m. Resident #12 was observed lying in bed atop of a low-air mattress, the resident refused to have staff and writer observe surgical area on lateral right leg. The elderly resident appeared to be of a weight consistent with age. The pump for the mattress was hanging from the foot board end of the bed, was set for static, low pressure and the weight (pounds) setting revealed 350 pounds, the highest setting possible. The dial for setting the weight was manual, requiring staff to turn the knob to then correct weight of the resident. On 4/29/26 at 11:35 a.m. Resident #12's air mattress was observed; the resident was out of bed. The pump settings continued to be set for static, low pressure and 350 pounds. During an interview and observation on 4/29/26 at 11:42 a.m. Staff V, Registered Nurse (RN) stated Resident #12 was tiny. The staff member observed the resident's mattress setting and confirmed it was set for 350 pounds (#). Staff V reported a setting set high would make the mattress full firm and a firm mattress could cause pressure injuries. The staff member readjusted the mattress to an approximate weight of the resident. An observation and interview was conducted with Staff S, Licensed Practical Nurse/Unit Manager (LPN/UM) on 4/29/26 at 11:46 a.m. Staff S stated an air mattress should be set per weight of the resident. Staff S said an incorrect weight setting of 350# was too firm and could cause pressure injuries. The staff member reported staff should be checking the weight setting. An interview was conducted on 4/30/26 at 1:41 p.m. Staff P, Licensed Practical Nurse (LPN) reported an air mattress should be set per resident's weight and Resident #12 did not weigh 350#. Review of Resident #12's admission Record showed the resident was admitted on [DATE] and 2/20/26. The record included diagnoses not limited to pressure-induced deep tissue damage of right heel (onset 3/4/26), unspecified protein-calorie malnutrition, and unspecified dementia unspecified severity with other behavioral disturbance. Review of Resident #12's active physician orders revealed an order dated 2/25/26 at 5:19 p.m. for Device: Mattress Air. every shift for off-loading. The order was to be included on the resident's Treatment Administration Record (TAR) and did not include specific settings for the mattress. Review of Resident #12's wound care physician notes revealed the following:4/7/26. The note revealed a history on 3/4/26 of an initial evaluation of a right heel deep tissue injury. The evaluation on 4/7/26 was for follow-up and management of an unstageable pressure injury to the right heel which showed no change. The note showed the resident weight was 110.99 #'s, the unstageable pressure injury measurements were 3-centimeter (cm) length x 4 cm width with no measurable depth with 100% necrosis. The interventions included daily dressing change per treatment plan and a pressure redistribution mattress.4/14/26. The patient was seen today for follow-up and management of an unstageable pressure injury of the right heel which shows deterioration. The measurements were 5 cm in length x 5 cm in width with no measurable depth. The wound bed showed 50% slough and 50% necrosis with the periwound exhibiting callus. The note revealed a mechanical debridement was performed and 100% of the wound was debrided. The post-debridement measurements were 5 cm x 5 cm x 0.3 cm depth and staged as unstageable. The barriers to healing was dementia, impaired mobility, incontinence, inevitable effect(s) of aging, and malnutrition.4/21/26. The note showed improvement with the right heel pressure ulcer. The wound measured 5 cm x 5 cm with no measurable depth, 80% slough, and 20% necrosis. The healing was expected to be delayed due to the identified barriers of healing. The pressure redistribution mattress was to be continued.4/28/26. The wound showed improvement with measurements of 4.8 cm x 4.7 cm with no measurable depth. The resident weight continued to be 110.99#. The goals included to promote epithelial wound edge advancement and reduce or control modifiable risk factors. Review of Resident #12's significant change in condition Minimum Data Set (MDS) dated [DATE] revealed (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #12 required substantial/maximum assist with bed mobility and transfers. Review of Resident #12's care plan showed the resident did have an unstageable pressure ulcer on right heel related to (r/t) reduced mobility. The interventions included but were not limited to the use of a low air loss mattress. The intervention did not include information related to setting the mattress per weight of the resident. Review of the facility policy - Skin care and Wound Management, identification and early intervention plans, undated, revealed the facility would identify residents a risk for developing pressure ulcers and will initiate early prevention plans. The procedure showed the facility would: complete the Braden Scale (pressure ulcer risk) at admission/readmission, change in condition, and no less than quarterly.Identify areas of concern by completing either Section L of the Nursing Admission/readmission Screening History or the weekly skin sweepDevelop the care plan for skin care (preventative and wound management using the baseline care plan at admission/readmission and the Interdisciplinary Care Plan Tea would develop a comprehensive care plan.The policy did not reveal any specific early prevention plans, the procedure for pressure ulcer treatments, or reveal staff would be educated on the management of pressure ulcers including the use of low air loss mattresses. The manufacturer advertisement for the alternating pressure low air loss mattress, provided by the facility, showed alternating Pressure low air loss pump and mattress system facilitates the prevention of wounds for individuals at minimum to moderate risk and provides treatment for wounds at various stages. Through alternating pressure, the mattress can dynamically change to accommodate the patients preferred pressure points and improve patient circulation. The features included: static mode for easy resident transfer, 10-minute cycle for alternating pressure, and adjustable setting allows for customized pressure by resident weight. The advertisement was not for the same mattress system (observed pump) utilized by Resident #12. According to the mattress control unit (for a labeled model) operating instructions (located athttps://proactivemedical.com/wp-content/uploads/2018/06/Protekt-Aire-2000-Manual-1.pdf) utilized by Resident #12. The steps included:Step 3: press the static button for a quicker inflationStep 6: Determine the patient's weight and set the control knob to that weight setting on the control unit.Step 7: Press the static button to shift between alternating mode and static mode.Note! In Static mode, the overlay provides a firm service that makes it easier for the patient to transfer or reposition. The static mode will help ensure the patient does not bottom out when in a sitting position.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure one (Resident #13) received meals prior to going to dialysis out of one resident reviewed for dialysis.Findings included: On 04/29/2026 at 8:30 AM observed Resident #13 at the nurses' station in wheelchair. He stated he was going for dialysis and would talk with me when he got back from dialysis. He did not have any belongings or food with him. On 04/29/2026 at 4:00 PM an interview with Resident #13 was conducted. He stated he does not get his meal before he leaves for dialysis. He stated he used to, but it has been like this for about the past month. He stated he goes to dialysis on the Monday, Wednesday, Friday (MWF) schedule. Review of Resident #13's admission Record revealed he was admitted to the facility on [DATE] with a re-admission on [DATE]. He had diagnoses to include end-stage renal disease (ESRD), hypertension, diabetes mellitus type 2, major depressive disorder and generalized anxiety disorder. Review of Resident #13's Quarterly Minimum Data Set (MDS) dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 13/15 indicating intact cognition; it also showed no behaviors and a special treatment of Dialysis. Review of Resident #13 active physician orders showed:-Patient (Pt) to go to (Dialysis Center Name and phone number) Monday, Wednesday and Friday, up in wheelchair by 9:00 AM. Chair time is 10:15 AM. Pt must have Hoyer pad underneath him in wheelchair.-Low Concentrated Sweets/NAS (No Added Salt) diet, Regular texture, thin consistency for diet Review of Resident #13's active Care Plan showed:-(Resident #13) has dehydration or potential fluid deficit related to (r/t) ESRD/dialysis; With interventions to include: ., recent/sudden weight loss, .-(Resident #13) is at risk of malnutrition and altered nutrition status r/t (related to) Dx (Diagnoses): ESRD on dialysis, DM2 (diabetes mellitus type 2), anemia, dementia, depression, obesity, Bilateral amputee, . Triggers for a significant weight loss for 30 days. With interventions: Explain and reinforce to the resident the importance of maintaining the diet ordered. Encourage the resident to comply. Explain consequences of refusal, ESRD/obesity/malnutrition risk factors. Observe/record/report to MD (medical doctor) PRN (as needed) s/sx (signs and symptoms) of malnutrition: . significant weight loss: 3 pounds (lbs) in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. Provide, serve diet as ordered. Review of Resident #13's Progress Notes showed:-4/16/2026 Nutrition/Dietary Note -(Dietician)Note Text: Following resident due to significant weight loss of approximately 5.9% over 30 days (-11 lbs from 188 lbs on 03/06/2026 to 176.8 lbs on 04/14/2026). Current BMI (Body Mass Index) 51.8 (obese). Most of the weight loss occurred between 03/06/2026 and 04/14/2026. Resident on a Low Concentrated Sweets/NAS diet, Regular texture, thin consistency, with intake ranging 26-100%, mostly 76-100%. Resident is independent for feeding. No current swallowing concerns noted. On 04/30/2026 at 10:37 AM an interview with the Certified Dietary Manager was conducted. She stated Resident #13 frequently comes to the kitchen to ask for more milk and cereal. She is not aware if he does not get his tray prior to leaving for dialysis. She stated the trays go up at 7:30 AM, and he would be one of the first to receive it. She stated he should be getting his breakfast before he leaves for dialysis. On 04/30/2026 at 10:41 AM an interview with Staff E, Licensed Practical Nurse/Unit Manager (LPN/UM) was conducted. She stated he should get his breakfast tray before dialysis. On 04/30/2026 at 10:43 AM an interview with Resident #13 was conducted. He confirmed he does not get his breakfast tray most days before dialysis. He said once in a while he will get it, just depends on if the kitchen is backed up. On 04/30/2026 at 1:00 PM an interview was conducted with the Interim Director of Nursing (DON). She said dialysis residents should be getting their breakfast tray prior to going to dialysis.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to ensure medication error rate was not greater than 5%. A total of 27 opportunities were observed with 2 errors constituting an error rate of 7.41%. Findings included:1. On 04/29/2026 at 8:34 AM a medication observation was conducted with Staff C, Licensed Practical Nurse (LPN) for Resident #131. Staff C dispensed the following medications:-Amlodipine 2.5 mg (milligram) -1 tablet-Aspirin 81mg chewable -1 tablet-Zyrtec 10mg -1 tablet-donepezil 5 mg -1tablet-Famotidine 10mg -4 tablets-Losartan 25 mg -1 tabletStaff C, LPN confirmed the tablets prior to administration.Review of Resident #131's admission Record showed she was admitted to the facility on [DATE] with diagnoses to include: cerebral atherosclerosis, vascular dementia, dementia, and hypertension. Review of Resident #131's active orders showed:-Donepezil HCl (hydrochloride) Tablet 5 mg; Give 10 mg by mouth one time a day for dementia.2. On 04/29/2026 at 4:30 PM a medication observation was conducted for with Staff D, LPN for Resident #194.Staff D obtained a blood glucose level of 234. Staff D then dispensed the Humalog KwikPen and turned the dial to show 3 units. Staff D, LPN stated she does not prime the pen prior to administration. Staff D administered the dose in the left lower abdomen and held dose knob for approximately 2 seconds.Review of Resident #194's admission Record showed he was admitted to the facility on [DATE] with diagnoses to include diabetes mellitus type 2.Review of Resident #194 active orders showed: -HumaLOG KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML (milliliter) (Insulin Lispro) Inject as per sliding scale: if 0 - 110 = 0 units for blood sugar less than 70 notify physician; 111 - 149 = 1 units; 150 - 199 = 2 units; 200 - 249 = 3 units; 250 - 299 = 4 units; 300 - 349 = 5 units; 350 - 399 = 6 units ; 400+ = 6 units for blood sugar greater than 399 give 6 units and notify physician, subcutaneously before meals and at bedtime for DM (diabetes mellitus).On 04/30/2026 at 1:00 PM an interview was conducted with the Interim Director of Nursing (DON). She said she has not provided education to staff regarding insulin pen priming. She was not able to provide a proper demonstration of how to prime an insulin pen. DON said it was necessary to prime an insulin pen to provide the resident with the correct dose of insulin. Reviewed with DON regarding findings of the medication administration observations. The DON confirmed the correct dose of milligrams should have been administered, and the nurse should have primed the insulin-pen.Review of the manufacturer's KwikPen U-100 instructions for use 3mL single-patient-use pen found on the manufacturer's website at: https://uspl.lilly.com/humalog/humalog.htm#ug1 showed the following:Step 5: Priming your Pen. Prime before each injection.-Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the Pen is working correctly.-If you do not prime before each injection, you may get too much or too little insulin.Giving your injectionStep 11:-Insert the needle into your skin.-Push the dose knob all the way in.-Continue to hold the dose knob in and slowly count to 5 (5 seconds) before removing the needle.Review of the Policy Administering Medications with a revision date of April 2019 showed: Medications are administered in a safe and timely manner, and as prescribed. 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on record reviews and interviews, the facility failed to provide timely laboratory services for one (Resident #130) of three residents reviewed.Findings included: Review of Resident #130's admission record revealed an admission date of 5/2/2024. Diagnosis includes but not limited to fracture of the lower end of right radius, nondisplaced fracture of right ulna styloid, chronic diastolic heart failure, and convulsions. Review of Resident #130's progress notes revealed a nursing note on 3/13/2026 at 10:11 p.m. showing Resident #130 had swelling of the right arm and right hand, felt hard and a little warm to touch. The resident's cast was removed from this arm on 2/19/2026 from a previous fracture. The note also said Resident #130 had range of motion within normal limits (ROM WNL), hospice and facility physician were notified. Review of Resident #130's progress notes revealed a nursing note on 3/14/2026 at 6:15 a.m. that a new order was placed for a venous ultrasound of the right upper extremity. Review of Resident #130's progress notes revealed a nursing note on 3/15/2026 at 9:56 p.m. that stated a call was placed to a mobile radiology vendor regarding Resident #130's doppler that was ordered. The facility was told someone would visit that same day however they had not come to do the venous doppler. Review of the procedure results showed on 3/17/2026 at 11:01 a.m. Resident #130 had an occlusive radial deep venous thrombosis. Review of Resident #130's care plan showed Resident #130 was at risk of cardiac complications. There was an intervention to notify physician of significant abnormalities and observe/document/report any color/warmth of extremities. During an interview on 4/30/2026 at 1:40 p.m. Staff Q, Certified Nursing Assistant (CNA) stated swelling was to be reported to the nurses right away who will then check on the resident. During an interview on 4/30/2026 at 1:42 p.m. Staff P, Licensed Practical Nurse (LPN) stated change in condition, such as swelling, was to be reported immediately. This included night shift nurses as there is an on call physician. Staff P did not know why there was a delay in testing after swelling was found on Resident #130's arm. Staff P said if radiology was ordered through a vendor and they did not show up, the facility would follow up with the vendor within that same shift. During an interview on 4/30/2026 at 12:48 p.m. the Director of Nursing (DON) stated swelling in residents with a history of chronic heart failure was to be reported right away. If this occurred during night shift, staff should not wait until morning to report it. The DON said if an outside vendors was to conduct a procedure but had not shown up yet, staff must call again to find out, what happened. Nurses are to confirm with the doctor and ensure the test(s) are ordered stat. The DON said she was unsure why there was a delay in care especially if there was swelling involved. Review of the facility's LPN position description revealed a Basic function: To deliver nursing care to residents of this facility. Essential Function: .3. Makes observations and reports pertinent information related to the care of the resident. The Coordination of Care: 1. Co-workers are informed of changes in residents conditions or of any other changes occurring on the unit. 2. Information is relayed to other members of the health care team (LE., physicians.)Review of the facility's Registered Nurse (RN) position description revealed a Basic Function: To plan and deliver nursing care to patients/residents requiring long-term of rehabilitative care. Essential Functions:.7. Maintains knowledge of necessary documentation requirements. The Coordination of Care: 1. Co-workers are informed of changes in residents conditions or of any other changes occurring on the unit. 2. Information is relayed to other members of the health care team (LE., physicians.)