

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105304	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Avante at Leesburg, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 Edgewood Ave Leesburg, FL 34748	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain food service equipment and food storage areas in a clean and sanitary condition by failing to ensure the kitchen ice machine and 2 of 2 nourishment room refrigerators and freezers were maintained free of debris and contamination. During an observation of the main kitchen on 07/19/2026 at 9:17 AM, the ice machine was observed with a significant amount of black substance and brown colored substance on the dispensing spout where ice falls into the storage bin. (Photographic evidence was obtained.) During observations of the facility nourishment rooms on 07/19/2026, the refrigerators and freezers in both rooms were observed to contain food debris and spilled liquid on interior surfaces. On 07/19/2026 at 10:13 AM, the Administrator and Director of Nursing confirmed the condition of the ice machine. During an interview on 07/21/2026 at 9:33 AM, the Dietary Manager stated that, based on the photographs taken on 07/19/2026, he could not say the ice machine had been cleaned properly on 07/17/2026 and acknowledged it could have been cleaned better. He stated maintenance staff were responsible for cleaning the ice machine and confirmed they were expected to follow the facility's Ice Machine Cleaning and Maintenance - Weekly procedure. During an interview on 07/21/2026 at 2:35 PM, the Maintenance Director stated he received the task to clean the ice machine but believed the kitchen staff were responsible for cleaning of the machine. Review of a [Third Party Food Service Company] invoice dated 07/20/2026 revealed the technician documented, The kitchen ice machine was in poor condition, heavily impacted with dirt and debris, preventing completion of preventive maintenance in its existing condition. Review of the facility's policy Ice Machine Cleaning and Maintenance - Weekly, last reviewed on 1/28/26 instructed staff to wipe the exterior, underside of the ice maker, dispensing spout, and ice bin with a clean cloth and appropriate cleaner. Review of the Ice Machine Cleaning and Maintenance - Quarterly procedure instructed staff to remove all ice, clean and sanitize the ice-making components, and scrub the interior of the ice bin, spouts, drain board, and surrounding components before rinsing with warm water.		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Minimum Data Set (MDS) assessments were accurate for 2 of 7 residents reviewed (Residents #2 and #73). Findings include: 1.) Review of Resident #2's physician orders dated 05/30/2026 revealed orders for Keppra Solution 100 mg/mL, 10 mL via G-tube (gastrostomy tube) twice daily, and Lacosamide Oral Solution 10 mg/mL, 10 mL via G-tube twice daily, for seizure disorder. Review of Resident #2's physician orders dated 05/31/2026 revealed an order to maintain an indwelling urinary catheter for urinary retention and a Stage 3 sacral wound. Review of Resident #2's physician orders dated 06/08/2026 revealed an order to reinsert an 18 French Foley catheter as needed for obstructive uropathy. Review of Resident #2's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Section I (Active Diagnoses) did not identify obstructive uropathy or seizure disorder as active diagnoses. During an interview on 7/21/2026 at 11:38 AM with the MDS Register Nurse Lead stated, [Resident #2's name] does have a diagnosis of seizure disorder and obstructive uropathy, the MDS section will need to be corrected. 2.) Review of Resident #73's physician order dated 6/2/2026 read, COPD [Chronic Obstructive Pulmonary Disease] /Asthma: HOB [head of bed] elevated, r/t SOB [related to shortness of breath] when lying flat or avoid lying flat due to SOB. every shift. Review of Resident #73's physician order dated 6/2/2026 read, Oxygen continuous at 3L [liters] via NC [nasal cannula] Medical DX [Diagnosis]: COPD every shift related to Acute Respiratory Failure, Unspecified whether with hypoxia or hypercapnia. Review of Resident #73's Minimum Data Set (MDS) titled Quarterly dated 7/5/2026 Section I Active Diagnoses did not document Asthma (COPD) as an active diagnosis. During an interview on 7/21/2026 at 11:38 AM with the MDS Register Nurse Lead stated, [Resident #73's name] does have a diagnosis of COPD, the MDS section will need to be corrected. Review of the facility policy and procedure titled Resident Assessment Instrument (RAI) with a last review date of 1/28/2026 read, Policy: It is the policy of the facility to adhere to the following procedures related to the proper documentation and utilization of a resident's Minimum Data Set (MDS) to ensure a comprehensive and accurate assessment of residents will be completed in the format and in accordance with time frames stipulated by the Department of Health and Human (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Services Center for Medicare and Medicaid Services. The assessment system will provide a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacities and assist staff to identify health problems for care plan development.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and interview, the facility failed to ensure residents with newly evident or known diagnosis of serious mental disorders have a coordinated Preadmission Screening and Resident Review (PASRR) for 3 of 7 residents, Residents #4, #11, #36 reviewed for PASRR. Findings include: Review of Resident #11's admission record documented an initial admission date of 7/26/22 and a most recent admission date of 3/6/26 with diagnosis of Specified Persistent Mood Disorders dated 4/22/2025. Review of Resident #11's Preadmission Screening Resident Review (PASRR) dated 7/24/2023 did not have a diagnosis of Specified Persistent Mood Disorders documented. Review of Resident #11's Minimum Data Set Section I notes dated 6/1/2026 documented DX [diagnosis]: F34.89 Other Specified Persistent Mood Disorders. Review Of Resident #11's Palliative Care Note dated 3/12/2026 documented [diagnose]: Other Specified Persistent Mood Disorders. Review of Residents #11's Medication Administration Record dated 7/2026 documented: trazodone HCl Oral Tablet 100 MG (Trazodone HCl) Give 1 tablet by mouth at bedtime for Depression -Start Date 07/05/2026. During an interview on 7/21/2026 at 10:25 AM, Director of Nursing stated, Any new diagnosis should be updated to the PASRR, and it is not the policy of the facility to not update PASRR's. 2.) Review of Resident #4's admission record, date of original admission 7/25/2019, revealed Resident #4 had been assigned a diagnosis of adjustment disorder with anxiety on 1/9/2024. Review of Resident #4's preadmission screening and resident review (PASRR), completed 5/12/2025, showed anxiety disorder, bipolar disorder, depressive disorder and insomnia entered as MI [mental illness] or suspected MI [mental illness] in Section I: PASRR Screen Decision-Making. Resident #4's PASRR had not been updated to include her diagnosis of adjustment disorder with anxiety. During an interview on 7/21/2026 at 11:08 AM, the Director of Nursing stated, Resident's Level I PASRRs should include all residents' mental health diagnoses. She stated she did not know how Resident #4's diagnosis of adjustment disorder with anxiety was overlooked. 3.) Review of Resident #36's admission record, date of original admission 3/5/2026, revealed Resident #36 had been assigned a diagnosis of Brief Psychotic Disorder or 3/5/2026. Review of Resident #36's preadmission screening and resident review (PASRR), completed 3/4/2026, (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showed schizophrenia and mood disorder entered as MI [mental illness] or suspected MI [mental illness] in Section I: PASRR Screen Decision-Making. Resident #36's PASRR had not been updated to include his diagnosis of Brief Psychotic Disorder following his admission to the facility. During an interview on 7/21/2026 at 11:08 AM, the Director of Nursing agreed residents' Level I PASRRs should include all residents' mental health diagnoses. She stated she did not know how Resident #36's diagnosis of brief psychotic disorder was overlooked. Review of the policy titled Coordination Pre-admission Screening and Resident Review (PASRR) Program, last reviewed 1/28/2026, read It is the policy of the facility to assure that all residents admitted to the facility receive a Pre-admission Screening and Resident Review, in accordance with State and Federal Regulations.		

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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 record review and interview, the facility failed to ensure the completion of the Preadmission Screening and Resident Review (PASRR) prior to admission for a resident's serious mental disorder for 1 of 7 residents, Resident #107, reviewed for PASRR. Findings include: Review of Resident #107's admission record resident was admitted on [DATE] with a diagnosis including but not limited to depression [onset date 5/5/2026]. Review of Resident #107's State of Florida Agency for Health Care Administration Preadmission Screening and Resident Review (PASSR) dated 5/1/2026 did not document depressive disorder. Review of Resident #107's Balance Wellbeing Psychology Evaluation Note dated 5/6/2026 read, Chief Complaint: Depression. During an interview on 7/22/2026 at 8:24 AM the Director of Nursing stated, [Resident #107's name] PASSR upon admission was not corrected; it should have been reviewed, and depressive disorder should have been included.		

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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. Based on interview and record review, the facility failed to develop and implement a comprehensive care plan for 1 of 5 residents, Resident #3 reviewed for diabetes management. Findings include: Review of Resident #3's admission record revealed an admission date of 04/10/26 with diagnoses including but not limited to Diabetes Mellitus Type II. Review of Resident #3's care plan dated 04/11/26 did not contain a focus area for Diabetes Mellitus Type II. During an interview on 07/21/26 at 02:27 PM, the MDS Coordinator stated that diabetes should have been added to Resident #3's care plan and needed to be corrected. During an interview on 07/21/26 at 03:22 PM, the Director of Nursing stated that residents with a diagnosis of Diabetes Mellitus Type II should be included in that resident's care plan. She stated that Resident #3's care plan should have been changed to include a focus for diabetes. Review of the facility's Comprehensive Care Plans policy dated 10/19/22 read, The care plan will contain information about the physical, emotional/psychological, psychosocial, spiritual, educational and environmental needs as appropriate.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview and record review the facility failed to administered pain medication based on parameters for 1 of 6 residents, Resident #107, reviewed for medication management and failed to provide dressing changes for 1 of 3 residents, Resident #3, reviewed for skin conditions. Findings include: Review of Resident #107's physician order dated 5/8/2026 read, Tylenol Oral Tablet 325 MG [milligram] (Acetaminophen) give 2 tablet by mouth every 6 hours as needed for pain pain scale 1-4 Do Not Exceed 3000mg/24hr [hour]. Review of Resident #107's physician order dated 6/1/2026 read, Percocet Oral Tablet 5-325 MG (Oxycodone w/ Acetaminophen) *Controlled Drug* give 1 tablet by mouth every 6 hours as needed for nonacute pain. Hold for Lethargy pain scale 6-10 Do not exceed 3000mg/24 hr. Review of Resident #107's Medication Administration Record for the Month of July 2026 Percocet 5-325MG was administered on 7/13/2026 at 0900 [9:00AM] pain level of 4. Review of Resident #107's Medication Administration Record for the Month of July 2026 Tylenol 325MG was given on 7/1/2026 at 1028 [10:28 AM] with a pain level of 5 and on 7/17/2026 at 1337 [1:37PM] with a pain level of 5. Review of Resident #107's Medication Administration Record for the Month of June 2026 Percocet 5-325MG was administered on 6/4/2026 at 1858 [6:58 PM] with a pain level of 5, on 6/13/2026 at 1137 [11:37AM] pain level of 0, 6/15/2026 at 1338 [1:38PM] pain level of 5, on 6/18/2026 at 0130 [1:30 AM] with a pain level 4, and on 6/27/2026 at 0348 [3:48AM] with a pain level 5. Review of Resident #107's Medication Administration Record for the Month of June 2026 Tylenol 325MG was given on 6/14/2026 at 0025 [12:25 AM] with a pain level of 9. Review of Resident #107's Medication Administration Record for the Month of May 2026 for Tylenol 325MG was given on 5/24/2026 at 2100 [9:00 PM] with a pain level of 7. During an interview on 7/21/2026 at 2:15 PM Staff D Licensed Practical Nurse (LPN), I cannot recall. A check mark means that the medication was given. Normally, I read the order and follow the parameters. During an interview on 7/21/2026 at 2:55 PM Staff E LPN stated, I don't recall why the medication was given out of parameters. During an interview on 7/21/2026 at 4:45 PM Staff F Registered Nurse (RN), stated, I think that [Resident #107's name] was telling me 4, 4.5 or 5 and I did not know which one to document, and I think I put a 5. I don't remember. If he has greater pain he studders or guards himself. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/22/2026 at 8:24 AM with the Director of Nursing stated, Staff are to follow physician orders unless it is a request from the resident, then the nurse should call the provider and get clarification. This should be documented in the record. If the resident has no preference, then orders should be followed. Review of the facility policy and procedure titled Medication Administration with a last review date 1/28/2026 read, Policy: Medications are administered by licensed nurse, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. 2.) During an observation on 07/21/26 at 09:05 AM, Resident #3 was observed in his bedroom, sitting upright in bed. There was a wound covered by a dressing dated 07/17 on his right forearm. [photographic evidence obtained]. During an interview on 07/21/26 at 09:08 AM, Resident #3 stated that his dressing was not changed yesterday. Review of Resident #3's physician's orders revealed an order dated 07/02/26 that read skin tear (2) to right lower arm. Cleanse with NS [normal saline], pat dry. Apply xeroform and cover with DSD [dry sterile dressing] every three days and prn if becomes soiled or dislodged until resolved; every evening shift every 3 day(s) for skin integrity AND as needed for skin integrity. Review of Resident #3's Treatment Administration Records for 07/20/26 revealed the order, skin tear (2) to right lower arm. Cleanse with NS [normal saline], pat dry. Apply xeroform and cover with DSD [dry sterile dressing] every three days and prn if becomes soiled or dislodged until resolved; every evening shift every 3 day(s) for skin integrity AND as needed for skin integrity, was not documented as completed on 07/20/26. During an interview on 07/21/26 at 03:03 PM, Staff I, Licensed Practical Nurse [LPN], confirmed that Resident #3's dressing was not changed as ordered. During an interview on 07/21/26 at 03:05 PM, Staff I, LPN, confirmed that the Treatment Administration Record for 07/20/26 indicated that the dressing change was not completed as ordered. She stated that all nurses are instructed to check off orders as scheduled when they are complete, and if the nurse can't complete a scheduled order, there must be a note. During an interview on 07/21/26 at 03:43 PM, the Director of Nursing stated that Resident #3's dressing was not changed on 07/20/26 as ordered. Review of the facility's policy titled, Clean Dressing Change, last reviewed on 1/28/26 shows it read, Verify and review physician's order for procedure; apply clean dressing as ordered and ensure the dressing is dated; document the completion of the dressing change on the treatment record.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure the resident environment remains as free of accident hazards as is possible for 21 residents currently residing in the facility's Memory Care Unit. During an observation on 07/19/26 at 09:35 AM, an uncapped safety razor was observed at Resident #43's bedside on the nightstand [photographic evidence obtained]. Resident #43 resides in the Memory Care Unit, and the bedroom door was not secure from the outside. During an interview on 07/19/26 11:38 AM, Staff F, Registered Nurse, stated that residents should not keep safety razors in their rooms. [Resident #43's Name] is supervised while shaving because he has the functional ability to do so, but it must have been left with him. She stated, That's not supposed to be there. During an interview on 07/21/26 at 03:22 PM, the Director of Nursing said, I wouldn't expect there to be safety razors on the floor, that would be a safety concern. She explained that CNAs [Certified Nursing Assistants] are in charge of shaving the residents, and the CNA responsible for shaving Resident #43 should have removed the razor when finished. A policy on accident hazards was requested on 07/21/26 at 04:35 PM and was not provided by the facility.		

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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. Based on observation, interview, and record review the facility failed to provide oxygen at the prescribed rate for 1 Resident (Resident #33) and store oxygen supplies appropriately when not in use for 3 of 6 residents, Residents #2, #28, and #33, reviewed for respiratory services. Findings include: During an observation on 07/19/2026 at 9:35 AM Resident #28 was lying in bed resting calmly, with eyes closed. Resident #28's oxygen concentrator was off and the nasal cannula not bagged. The bag was dated 7/12 [2026]. [photographic evidence obtained] During an observation on 7/20/2026 at 8:01 AM Resident #28 was lying in bed. The oxygen concentrator was not in use. The nasal cannula dated 7/12 was not bagged. During an interview on 7/20/2026 at 8:01 AM Resident #28 stated, I am supposed to use oxygen at night. Review of Resident #28's physician order dated 6/30/2026 read, 6/30/2026 Oxygen continuous at [Blank] liters/ min via [Blank].Medical DX: [Blank]. every shift. Review of Resident #28's physician order dated 6/30/2026 read, Change Oxygen Set Up And Bag Weekly And As Needed every night shift every Sat. (Saturday) Place in labeled O2 bag and tie to handle of O2 concentrator. During an interview on 7/20/2026 at 12:45 PM Staff B, Licensed Practical Nurse (LPN) stated tubing should be bagged when not in use. [Resident #28's Name] oxygen order is not completed. It reads continuous, but there is no flow rate. I would have to find out if it is prn or continuous. During an interview on 7/20/2026 at 12:50 PM Staff B, LPN confirmed Resident #28's oxygen tubing was not bagged, the bag was dated 7/12 and the oxygen was off at time of interview. Staff B, LPN, stated, The bag is no good, it should have been changed with the tubing. She [Resident #28] states she uses at nighttime only. During an interview on 7/21/2026 at approximately at 11:00 AM, the Director of Nursing stated, Oxygen tubing should be bagged when not in use. The tubing is changed once a week usually during the night shift on Saturday from 11:00PM to 7:00 AM. Order should include the accurate documentation of how many liters and if it is as needed or continuous. The nurses should have called to clarify the order. 2.) During an observation on 7/22/2026 at 5:58 AM with Staff C, LPN, Resident #33 was lying in bed. Oxygen was running at 4 liters via tracheostomy mask, Staff C readjusted the oxygen concentrator to 5 liters. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/22/2026 at 5:58 AM Staff C, LPN confirmed Resident #33's oxygen was running at 4 liters per minute and stated, [Resident #33's Name]'s oxygen is supposed to be at 5 liters. Review of Resident #33's physician order dated 7/20/2026 read, Continuous [sic] O2 [oxygen] at 5L/min [liters per minute]. via trach [tracheostomy]. During an interview on 7/22/2026 at 6:30 AM with the Director of Nursing stated, The nurses should check the oxygen flow rate every shift to make sure it is running at the prescribe rate. Review of the facility policy and procedure titled Oxygen Administration with a last review date 1/28/2026 read, Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and resident's goals and preferences. Policy Explanation and Compliance Guidelines: 1. Oxygen is administered under orders of a physician, except in the case of an emergency. 3.) During an observation on 07/20/2026 at 8:49 AM, Resident #2's nebulizer cup and tubing was observed lying directly on the resident's bed following a respiratory treatment. The nebulizer equipment was not stored in a clean, protected manner and remained in contact with the resident's bed linens.		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on interview and record review the facility failed to collect laboratory exams ordered by the physician for 1 of 2 residents, Resident #15 reviewed for laboratory services. Findings include:Review of Resident #15 physician's order dated 06/17/26 read, BMP in 10 days.Review of Resident #15 results did not document lab results for 06/27/26.Review of Resident #15's Treatment Administration Record for June 2026 revealed that labs were not drawn according to the physician's order dated 06/17/26 that read, BMP in 10 days.During an interview on 07/21/26 at 10:35 AM, Staff I, Licensed Practical Nurse (LPN), explained that when labs are ordered, the receiving nurse is supposed to enter the order in the facility's online system and set the appropriate date to be completed. She stated that the evening nurse would be responsible for collecting Resident #15's lab sample.During an interview on 07/21/26 at 03:43 PM, the Director of Nursing explained that the physician's order dated 06/17/26 that read, BMP in 10 days, was not entered into the system with the correct collection date. She stated that the lab sample was not collected as ordered.Review of the facility's Diagnostic Services policy dated 03/02/19 read, it is the policy of this facility to ensure that laboratory, radiology, and other diagnostic services meet the needs of residents, that the results are reported promptly to the ordering provider to address potential concerns and for disease prevention, provide for resident assessment, diagnosis, and treatment, and that the facility has established policies and procedures, and is responsible for the quality and timeliness of services whether services are provided by the facility or an outside resource.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105304	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Avante at Leesburg, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 Edgewood Ave Leesburg, FL 34748	
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to maintain complete and accurate clinical records for 13 (Resident #2, 6, 11, 17, 18, 25, 29, 39, 45, 56, 59, 66 and 104) out of 19 Residents, reviewed for medication orders and administration documentation. Findings include: 1.) Review of the Resident #2's physician's orders revealed an order dated 06/01/2026 to flush the resident's G-tube with 340 mL of water four times daily while tube feeding was infusing for a total of 1,360 mL of free water daily. Review of Resident #2's physician's orders dated 06/03/2026 revealed an additional order to administer 235 mL of water via G-tube every four hours for hydration. Review of the July 2026 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed nursing staff documented administration of both active free-water flush orders. Review of the Registered Dietitian's comprehensive nutrition evaluation dated 06/01/2026 recommended administration of 340 mL water flushes four times daily for a total of 1,360 mL of free water each day. During an interview on 07/21/2026 at 9:47 AM, the Registered Dietitian reviewed the physician's orders and acknowledged two active free-water flush orders were present in the resident's medical record. During an interview on 07/22/2026 at 8:50 AM, the Director of Nursing (DON) stated the expectation was for nursing staff to obtain clarification when conflicting physician orders were identified to ensure the resident received the correct free-water flush regimen and the medical record accurately reflected the intended treatment. 2) During an observation on 7/21/2026 at 10:15 AM Staff G Licensed Practical Nurse (LPN) was preparing medication for Resident #29. Staff G stated Resident #29 had refused Novolog insulin that was scheduled to be administered at 8:00AM. Staff G prepared medication for Resident #29 and administered the medications. Staff G checked Resident #29 blood sugar which was 341. Staff G returned to the computer verified she was supposed to give 6 units of insulin aspart and administered the insulin subcutaneously. Staff G return to the computer and checked off all the medications for Resident #29. Review of Resident #29's Medication Administration Record for the month of July 2026 documented Novolog solution 100 UNIT/ML (Insulin Aspart) was administered at 0800 [8:00 AM] on 7/21/2026. Review of Resident #29's Medication Administration Record for the month of July 2026 documented (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 7/21/2026 Insulin Aspart at 11:30 AM blood sugar level was 308. During an interview on 7/22/2026 at 11:24 AM, the Director of Nursing stated, I spoke to [Staff G's Name] and she does not know why the blood sugar shows as 308 she thinks she might have forgotten to hit save. For the Novolog it was a documentation mistake. [Resident #29's name] refused, but it self-populated what previously had been saved. During an observation on 7/21/2026 beginning at 10:15 AM of Staff G's computer screen, the electronic medication administration record had a total of 11 residents [Resident #6, #11, #17, #18, #39, #25, #46, #56, #59, #66, #104] names highlighted in red. During an interview on 7/21/2026 at approximately 10:45 AM with Staff G LPN stated, Residents in red mean that medications would still be pending. I already gave them all their medications, but I did not check them off. I give them (Residents) the medication and then will go back into the system later and check off I gave them the medication. During an observation on 7/21/2026 at 10:55 AM the Director of Nursing confirmed a total of 11 residents were showing in the system in red color as if medications had not been given. During an interview on 7/21/2026 at 10:55 AM, the Director of Nursing stated, I would expect staff to check off medication as given when the medication is given and completed. During an interview on 7/21/2026 at 12:49 PM with Resident #11 stated, The nurse gave me my medication early this morning. During an interview on 7/21/2026 at 12:51 PM with Resident #104 stated, The nurse gave me my medication this morning. It was on time. Review of the facility policy and procedure titled Documentation in Medical Record with a review date of 1/28/2026 read, Policy: Each resident's medical record shall contain an accurate representation of the actual experience of the resident and include enough to provide a picture of the resident's progress through complete, accurate, and timely documentation.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review the facility failed to follow prevent the spread of potential infectious diseases by not performing hand hygiene and following sterile procedure for 1 of 3 residents, Resident #33, reviewed for tracheostomy care, failed to follow enhanced barrier precautions in 1 of 3 units , and failed to contain soiled linen in the soiled utility room in the laundry room. Findings include: During an observation on 7/20/2026 at 2:01 PM with Staff B, Licensed Practical Nurse (LPN) entered Resident #33's room, donned a gown and performed hand hygiene. Staff B don surgical gloves and removed the old tracheostomy dressing. Staff B proceeded to remove her gloves and wash her hands. Staff B then open the tracheostomy care kit, donned sterile gloves and a bottle of normal saline from the kit was opened. Gauze was moistened with the normal saline, and the area beneath one side of the tracheostomy flange was cleaned. Staff B dispose of the gauze and used another moisten gauze to clean the opposite side of the flange. After completing the stoma care, Staff B removed the disposable inner cannula and discarded it. Without changing the gloves that had been used to clean around the stoma and tracheostomy flange, Staff B inserted a new sterile inner cannula. Staff B then removed the gloves, performed hand hygiene, and donned new pair of surgical gloves. While preparing for suctioning, Staff B searched through the bedside drawer, removed old suction tubing from the suction machine, discarded it, and retrieved a new suction catheter package, placed it on the bedside table, and removed her surgical gloves. Staff B then touched her personal eyeglasses. Staff B did not perform hand hygiene after touching the glasses. Staff B then opened the suction catheter. package, donned sterile gloves, opened the normal saline connected the suction catheter to the suction tubing and perform tracheal suctioning. During an interview on 7/20/2026 2:26 PM with Staff B, LPN, stated, I should have kept sterility more throughout the procedure. Review of Resident #33 physician order dated 6/21/2026 read, Trach-Provide trach care every day and PRN [as needed]. Change trach ties daily and PRN. as needed for Trach Care. During an interview on 7/21/2026 at 1:35 PM with the Director of Nursing stated, The dirty first and then move onto the clean. At least clean gloves. The nurse should not go from dirty to clean. Hand hygiene should have been performed in between. I would not consider change of gloves to be hand hygiene. Review of the facility Validation Checklist Tracheostomy Care read, Procedure Observed. 22. Maintained clean/sterile technique and observed any isolation precautions. Review of the facility policy and procedure titled Respiratory/Tracheostomy Care and Suctioning with a last review date of 1/28/2026 read, Policy: The facility will ensure that residents who need respiratory care, including tracheostomy care and tracheal suctioning, is provided such care consistent with professional standards of practice, the comprehensive person-centered plan and resident goals and preferences. 2.) During an observation on 7/20/2026 at approximately 2:10 PM Staff A, CNA entered Resident #57's room and stated she would help the resident transfer from her wheelchair to her bed. Staff A closed the door behind her. When surveyor knocked on the door Staff A stated, patient care. Staff A was wearing gloves, but no gown and was assisting Resident #57 to get out of the wheelchair with her hands holding Resident #57. Review of Resident # 57's physician's order dated 2/16/2026 read, Enhanced Barrier Precautions: Chronic Wound. For wound every shift for multiple drug-resistant organism precautions. During an interview on 7/21/2026 at 1:28 PM the Director of Nursing stated, Staff are supposed to wear gown and gloves if they are going to actually come in contact with a patient with enhanced barrier precautions. Gown, gloves. They should be wearing both. They should wear a gown when transferring a patient. During an observation on 7/22/2026 at 5:58 AM, Staff C Licensed Practical Nurse (LPN) entered Resident #33's room, performed hand hygiene and donned a (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pair of gloves. Staff C did not don a gown. Staff C checked for placement and residual and began to administered medications to Resident #33 via her gastric tube.During an interview on 7/22/2026 at 6:24 AM with Staff C, LPN stated I forgot to put on a gown.During an interview won 7/22/2026 at 6:30 AM with the Director of Nursing stated, Staff should wear a gown and gloves when coming into contact with a resident's gastric tube.Review of the facility policy and procedure titled Enhanced Barrier Precautions with a last review date of 1/28/2026 read, Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organism. Definitions: Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug resistant organism that employs targeted gown and gloves use during high contact resident care activities. Policy Explanation and Compliance Guidelines: 3. Implementation of Enhance Barrier Precautions: b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. 4. High-contact resident care activities include: c. transferring, f. changing briefs or assisting with toileting. g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes.3) During an observation on 7/21/2026 at 3:20PM with the EVS Director of the laundry room the soiled utility room/laundry room, multiple soiled linen carts were noted to be overfilled, with linen extending above the rim of the carts. Linen visibly contained with dark substance was observed exposed rather than fully contained within the carts.During an interview on 7/21/2026 at 3:25 PM with the EVS Director stated soiled clothing should be covered.During an interview on 7/22/2026 at 11:24 AM with the Director of Nursing stated, Linen should be contained.Review of the facility policy and procedure titled Infection Control-Linen Management with a last review date of 1/28/2026 read, Policy: It is the policy of the facility to ensure linens are handlining in a way to prevent cross-contamination and the spread of infection in accordance with State and Federal Regulations, and national guidelines. Procedure: 6. Dirty linens are contained in a closed container or bag.		

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. Based on observation, record review, and interview, the facility failed to implement its smoking policies and procedures to ensure smoking materials were maintained by nursing staff for 1 of 3 residents reviewed for smoking safety (Resident #74). Findings include: During an observation on 07/21/2026 at 11:42 AM, Resident #74 was observed carrying a lighter and cigarettes in his vest pocket. The resident removed the items from his pocket. During an interview on 07/21/2026 at 11:43 AM, Resident #74 stated he kept them on his person because residents and staff took cigarettes and lighters from the designated smoking box. During an interview on 07/21/2026 at 11:45 AM, Staff H, housekeeper stated residents were expected to place their cigarettes and lighters in the designated smoking box after smoking. She stated there had been frequent issues with cigarettes and lighters being taken from the smoking box, resulting in residents keeping the items on their person. During an interview on 07/22/2026 at 8:50 AM, the Director of Nursing (DON) stated her expectation was that facility staff would follow the facility's smoking policy by maintaining residents' smoking materials in the designated smoking box. Review of the facility's policy and procedure titled Resident Smoking and Smokeless Tobacco Use, last reviewed 01/28/2026, revealed, All smoking and smokeless tobacco materials of residents who use them will be maintained by nursing staff.		