STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105346	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Montgomery Health and Rehabilitation Center	1270 SW Main Blvd Lake City, FL 32055

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident's representative was notified of the resident's refusal of medication administration for 1 of 4 residents, Resident #1, reviewed for medication administration.Findings include:Review of Resident #1's admission Data documented the resident was admitted on [DATE] with medical diagnoses to include type 2 diabetes mellitus with foot ulcer; difficulty in walking, not elsewhere classified; and non-pressure chronic ulcer of other part of right foot with necrosis of muscleReview of Resident #1's MDS (Minimum Data Set) Evaluation, quarterly assessment dated [DATE], documented the resident had a BIMS (Brief Inventory of Mental Status) Score of 09 out of 15, which indicated some cognitive impairment.Review of Resident #1's MAR (Medication Administration Record) for 11/01/2025 - 11/30/2025 read, HumaLOG KwikPen (an insulin pen) 100 UNIT/ML (100 units per milliliter) solution pen injector: Inject as per sliding scale: if [blood sugar reading] 151 - 200 = 2; 201 - 250 = 4; 251 - 300 = 6; 301 - 350 = 8; 351 - 400 = 10 Call MD, subcutaneously before meals and at bedtime for DM (diabetes mellites) - Start Date 09/08/2025 0630 (6:30 AM) -D/C (discontinue) Date 12/22/2025 1232 (12:32 PM). Documented for the Hours of 0630 [6:30 AM] dated 11/1/2025, 11/19/2025, and 11/30/2025 the MAR for BS [blood sugar] was documented NA (not applicable). Dated 11/24/2025 the MAR was blank. For the Hours of 1130 (11:30 AM) dated 11/13/2025, 11/16/2025, 11/19/2025, 11/20/2025, 11/25/2025, and 11/27/2025 the MAR was documented as NA. For the Hours of 1630 (4:30 PM) dated 11/25/2025 and 11/26/2025 the MAR documented NA. For the Hours of 2100 (9:00 PM) dated 11/18/2025, 11/24/2025, and 11/30/2025 the MAR was documented as NA. Dated 11/25/2025 the MAR was documented with an X. This resulted in a total of 16 occurrences of the resident having refused and/or the staff did not monitor the resident's blood sugar as ordered by the physician to determine if insulin injections were required. Review of Resident #1's medical record for 11/1/2025 through 11/30/2025 did not contain documentation in the record of the resident's representative having been notified of the medication not having been administered per the resident's refusal and/or staff not administering the medication.Review of Resident #1's MAR for 11/01/2025 through 11/30/2025 read, Lantus SoloStar (an injectable insulin) 100 UNIT/ML solution pen-injector. Inject 15 units subcutaneously at bedtime for DM - Start Date 08/13/2025 2100 (9:00 PM) - D/C Date 12/02/2025 1513 (3:13 PM). Lantus SoloStar was documented dated 11/18/2025, 11/24/2025, 11/25/2025 and 11/30/2025 as a 2. Review of the Chart Codes/Follow Up Codes read, 2 = Drug Refused. This resulted in a total of four doses not having been administered due to the resident's refusal. Review of Resident #1's medical record did not provide documentation the resident's representative was notified of the resident's refusal of the medication.Review of Resident #1's MAR for 12/01/2025 through 12/20/2025 read, Lantus SoloStar 100 UNIT/ML solution pen-injector. Inject 25 units subcutaneously at bedtime for DM - Start Date 12/02/2025 2100 - D/C Date 12/22/2025 1232 [12:32 PM]. The MAR documented 2 dated 12/2/2025, 12/7/2025, 12/10/2025, 12/11/2025, and 12/14/2025. For a total of (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	five doses of the medication not being administered due to the resident's refusal.Review of Resident #1's medical record for 12/01/2025 through 12/20/2025, the record did not contain documentation the resident's representative was notified of the resident's refusal of the medication. Review of Resident #1's MAR for 12/1/2025 through 12/20/2025 read, HumaLOG KwikPen 100 UNIT/ML solution pen-injector Inject as per sliding scale: if 151 - 200 = 2; 201 - 250 = 4; 251 - 300 = 6; 301 - 350 = 8; 351 - 400 = 10 Call MD, subcutaneously before meals and at bedtime for DM - Start Date 09/08/2025 0630 (6:30 AM) - D/C Date 12/22/2025 1232 (12:32 PM). For the Hours of 0630 dated 12/02/2025, 12/03/2025, 12/13/2025, 12/16/2025, and 12/17/2025 the MAR was documented as NA. For the Hours of 1130 dated 12/05/2025, 12/07/2025, 12/08/2025, 12/10/2025, and 12/11/2025 the MAR was documented as NA. For the hours of 1630 dated 12/08/2025 the MAR was documented as NA. For the Hours of 2100 Dated 12/02/2025, 12/10/2025, 12/11/2025, and 12/14/2025 the MAR was documented with an X. This resulted in 15 occurrences of the resident's blood sugar value not being monitored.Review of Resident #1's medical record for 12/01/2025 through 12/20/2025, the record did not contain documentation the resident's representative was notified of the resident's refusal of and/or staff not monitoring the resident's blood sugar value to determine if insulin administration was required. During an interview on 1/29/2026 at 11:52 AM Resident #1's Representaitve stated, I was not aware that he was refusing his blood sugar checks. I was never told that he was not compliant or that he was refusing.During an interview on 1/29/2026 at 3:38 PM Staff B, LPN (Licensed Practical Nurse) stated, From what I'm understanding when a patient refuses their medications, if it's often, we call the doctor. I have called family, but not for him. I didn't notify the family.During an interview on 01/29/2026 at 5:01 PM the Director of Nursing stated, The expectation is that the nurses notify family and the provider and document it [if a resident refuses medications or treatments]. We had discussed him [Resident #1] refusing his insulin in morning meeting.Review of the policy and procedure titled Notification of Changes, with an implementation date of 11/2020 and a revision date of 8/16/2022 read, Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Compliance Guidelines: The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include: Clinical complications. Additional considerations: 1. Competent individuals: a. The facility must still contact the resident's physician and notify residents representative, if known. c. When a resident is mentally competent, such a designated family member should be notified of significant changes in the resident's health status because the resident may not be able to notify them personally.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure resident care plans regarding advanced directives were updated for 1 of 4 residents, Resident #1, reviewed for accuracy of care plans.Findings include:Review of Resident #1's admission Data documented the resident was admitted into the facility on [DATE] with an Advanced Directive of Full Code status (if a resident is absent of life the health care team is to use all available and necessary life-saving measures to resuscitate).Review of Resident #1's Care Plan read, Focus: Advanced Directives: Resident has an established CPR [cardiopulmonary resuscitation] (Full Code) order in place. Date Initiated: [DATE]. Created on: [DATE].During an interview on [DATE] at 1:09 PM the DON (Director of Nursing) stated, I see that his [Resident #1] Care Plan was not updated. He came in as a Full Code, and he changed it in October to a DNR [Do Not Resuscitate]. During an interview on [DATE] at 5:14 PM the MDS LPN (Minimum Data Set Licensed Practical Nurse) stated, When the order [for code status] changes we should be updating the care plan, but that didn't happen. It's discussed in morning meetings and then we update the care plans.During an interview on [DATE] at 5:27 PM the Social Worker Director stated, I recall [Resident #1's name]. I attend the morning clinical meetings. We look at advanced directives. If the care plan was not updated, it must have been missed. We all look at it in the clinical meeting. It was just probably missed. Care plans are reviewed and updated through the clinical meetings.Review of the policy and procedure titled Advanced Directives Code Status, with an implementation date of 1/2024 and a revision date of 1/2026 read, Standard: It is the policy of the facility to honor advanced directives, code status and do not resuscitate orders in accordance with state and federal regulations. Guideline: Change of code status/review of code status: Social Services and nursing must document in a progress note that code status was changed as per resident/representative request and orders were obtained. Code status/advanced directives care plan must be updated.

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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 interview and record review, the facility failed to ensure complete and accurate records for 1 of 4 residents, Resident #1, reviewed for medication administration. Findings include:Review of Resident #1's MAR (Medication Administration Record) for 11/01/2025 - 11/30/2025 read, HumaLOG KwikPen (an insulin pen) 100 UNIT/ML (100 units per milliliter) solution pen injector: Inject as per sliding scale: if [blood sugar reading] 151 - 200 = 2; 201 - 250 = 4; 251 - 300 = 6; 301 - 350 = 8; 351 - 400 = 10 Call MD, subcutaneously before meals and at bedtime for DM (diabetes mellites) - Start Date 09/08/2025 0630 (6:30 AM) -D/C (discontinue) Date 12/22/2025 1232 (12:32 PM). Documented for the Hours of 0630 [6:30 AM] dated 11/1/2025, 11/19/2025, and 11/30/2025 the MAR for BS [blood sugar] was documented NA (not applicable). Dated 11/24/2025 the MAR was blank. For the Hours of 1130 (11:30 AM) dated 11/13/2025, 11/16/2025, 11/19/2025, 11/20/2025, 11/25/2025, and 11/27/2025 the MAR was documented as NA. For the Hours of 1630 (4:30 PM) dated 11/25/2025 and 11/26/2025 the MAR documented NA. For the Hours of 2100 (9:00 PM) dated 11/18/2025, 11/24/2025, and 11/30/2025 the MAR was documented as NA. Dated 11/25/2025 the MAR was documented with an X. This resulted in a total of 16 occurrences of the resident having refused and/or the staff did not monitor the resident's blood sugar as ordered by the physician to determine if insulin injections were required. Review of Resident #1's medical record for 11/1/2025 through 11/30/2025 did not contain documentation in the record of the resident's physician having been notified of the medication not having been administered per the resident's refusal and/or staff not administering the medication.Review of Resident #1's MAR for 11/01/2025 through 11/30/2025 read, Lantus SoloStar (an injectable insulin) 100 UNIT/ML solution pen-injector. Inject 15 units subcutaneously at bedtime for DM - Start Date 08/13/2025 2100 (9:00 PM) - D/C Date 12/02/2025 1513 (3:13 PM). Lantus SoloStar was documented dated 11/18/2025, 11/24/2025, 11/25/2025 and 11/30/2025 as a 2. Review of the Chart Codes/Follow Up Codes read, 2 = Drug Refused. This resulted in a total of four doses not having been administered due to the resident's refusal. Review of Resident #1's medical record did not provide documentation the resident's physician was notified of the resident's refusal of the medication.Review of Resident #1's MAR for 12/01/2025 through 12/20/2025 read, Lantus SoloStar 100 UNIT/ML solution pen-injector. Inject 25 units subcutaneously at bedtime for DM - Start Date 12/02/2025 2100 - D/C Date 12/22/2025 1232 [12:32 PM]. The MAR documented 2 dated 12/2/2025, 12/7/2025, 12/10/2025, 12/11/2025, and 12/14/2025. For a total of five doses of the medication not being administered due to the resident's refusal.Review of Resident #1's medical record for 12/01/2025 through 12/20/2025, the record did not contain documentation the resident's physician was notified of the resident's refusal of the medication. Review of Resident #1's MAR for 12/1/2025 through 12/20/2025 read, HumaLOG KwikPen 100 UNIT/ML solution pen-injector Inject as per sliding scale: if 151 - 200 = 2; 201 - 250 = 4; 251 - 300 = 6; 301 - 350 = 8; 351 - 400 = 10 Call MD, subcutaneously before meals and at bedtime for DM - Start Date 09/08/2025 0630 (6:30 AM) - D/C Date 12/22/2025 1232 (12:32 PM). For the Hours of 0630 dated 12/02/2025, 12/03/2025, 12/13/2025, 12/16/2025, and 12/17/2025 the MAR was documented as NA. For the Hours of 1130 dated 12/05/2025, 12/07/2025, 12/08/2025, 12/10/2025, and 12/11/2025 the MAR was documented as NA. For the hours of 1630 dated 12/08/2025 the MAR was documented as NA. For the Hours of 2100 Dated 12/02/2025, 12/10/2025, 12/11/2025, and 12/14/2025 the MAR was documented with an X. This resulted in 15 occurrences of the resident's blood sugar value not being monitored.Review of Resident #1's medical record for 12/01/2025 through 12/20/2025, the record did not contain documentation the resident's physician was notified of the resident's refusal of and/or staff not monitoring the resident's blood sugar value to determine if insulin administration was required. During an (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 01/29/2026 at 2:37 PM the APRN (Advanced Practice Registered Nurse) stated, I've known him [Resident #1] for quite some time. That was something he [Resident #1] also did at [Name of a different facility], refuse blood sugar monitoring and/or insulin. He was stubborn and fairly independent. I saw him a couple of days prior to him going out. I had just gotten notification from the nurses that he had again refused his insulin. I told him that his wound would not heal. They definitely would notify me. Maybe they didn't document it. I had quite a few conversations. They would call me after he refused. Any time they give a higher dose, they spoke with me. I don't typically have a concern regarding notification of refusal of medications. They notify me pretty often. I am in constant contact with the DON and the unit managers, and the wound care nurse. He would take his insulin if he was feeling bad. During an interview on 01/29/2026 at 3:38 PM Staff B, LPN (Licensed Practical Nurse) stated, Usually he [Resident #1] would take his medications, but on certain days he would refuse his insulin and accu-checks (used to measure blood sugar levels). It was usually on my shift. I would call his doctor. It should be documented when I called. For the most part we called her [Resident #1's Primary Care Physician/Advanced Practice Registered Nurse]. There are probably times, I'm not going to lie, that I didn't document it. From what I'm understanding, when a patient refuses their medications, if it's often, we call the doctor and document it.During an interview on 01/29/2026 at 5:01 PM the DON (Director of Nursing) stated, The expectation is that the nurses notify family and the provider and document it [if a resident refuses medications or treatments].Review of the policy and procedure titled Physician Services, read, Intent: it is the policy of the facility to provide physician services in accordance with state and federal regulations. Procedure: 8. All physician orders will be followed as prescribed and if not followed, the reason shall be recorded on the resident's medical record during that shift.Review of the policy and procedure titled Medication Administration, read, Policy: medications are administered by licensed nurses, 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. Policy explanation and compliance guidelines: 22. Report and document any adverse side effects or refusals.