

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105375	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER South Campus Care Center and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 715 E Dixie 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.			
(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 - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain a homelike physical environment when access to the pull cords for the lighting fixtures behind the resident's beds were unavailable for residents for one of three hallways. Findings include: During an interview on 1/5/2026 at 9:40 AM, Resident #128 stated, Since I have been here, I cannot turn on my over-the-bed light because there is no string to pull. It has been like this since I was admitted . I have told nursing. During an observation on 1/5/26 at 9:40 AM, the light was off behind Resident #128's bed and there was no cord attached to the pull chain that would enable the resident to turn the light on himself. During an interview on 1/5/26 at 10:45 AM, Resident #125 stated, 'The environment needs repair. I cannot access the light cord behind the bed. During an observation on 1/5/26 at 10:45 AM, the light cord for light behind Resident #125's bed was not long enough for her to control the light. During an interview on 1/6/26 at 8:30 AM, Resident #45 stated, I cannot turn on the light behind my bed because there is no string. I have told them and it has been like that since I arrived. During an observation on 1/6/2025 at 8:30 AM, Resident #45 was in bed sitting up with head of bed elevated. There was no chord attached to the pull chain to the light fixture on the wall behind his bed. Resident does not have independent control to turn on and off the light behind his bed. During an interview on 1/7/2025 at 5:30 PM, the Administrator stated, We have guardian angels (Department leaders) assigned to make daily rounds with all of the residents and if they identify that there are environmental issues or repairs needs, they enter a work order into [name of maintenance software]. The guardian angels utilize a checklist that includes the environment observation regarding cleanliness etc. I will provide you the check list tomorrow morning. During an interview on 1/7/2025 at 5:40 PM, the maintenance director stated, It is an easy fix to attach a cord to the light chain. During an interview on 1/8/2026 at 8:30 AM, the provided the surveyor with an updated checklist that includes checking to be sure that light cord is within reach and he stated, we will be checking all of the lights today. During an observation on 1/8/2026 at 9:30 AM, the following 8 rooms did not have a light cord attached or long enough for the resident to use while in bed to turn on the over bed light: room [ROOM NUMBER] B, room [ROOM NUMBER] B, room [ROOM NUMBER] B, room [ROOM NUMBER] B, room [ROOM NUMBER] A, room [ROOM NUMBER] B, room [ROOM NUMBER] A and room [ROOM NUMBER] B.		

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 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 interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 1 (Resident # 0) of 8 residents reviewed. Findings include: During an interview on 1/5/2025 at 11:08 AM, Resident #50 stated, The port was when I was getting chemotherapy. During an observation on 1/5/2026 at 11:08 AM, Resident #50 had a venous access port (a small, implanted device placed under the skin to provide long term access to a vein for medications, fluids, and blood draws) near her left shoulder with a dressing covering it. The dressing is dated 12/5/2025. Photographic evidence obtained on 1/5/2025 at 11:08 AM. During record review of Resident #50's resident centered plan of care, there is no care plan for Resident #50's venous access port. During interview on 1/7/2026 at 10:10 AM, [NAME] Unit Manager, Licensed Practical Nurse (LPN) stated, I do not see a care plan for the resident for her access port. There should have been a plan of care for her venous access port. Record review of facility policy titled, Comprehensive Assessments and Care Plans, with last review date of 4/1/2022, reads, Standard: It will be the standard of this facility to make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS (Center for Medicare & Medicaid Services). The assessment will include at least the following: (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure residents unable to carry out activities of daily living, receive the necessary services to maintain good grooming and clean clothing for 1 of 7 residents (Resident #33) reviewed for activities of daily living. Findings include: On 1/5/26 at 11:04 AM, Resident #33 was observed in a visibly soiled jacket and pants, facial hair unkempt in appearance and had a sour body odor. Resident was pleasantly confused, standing at the doorway to his room. On 1/6/26 at 9:58 AM, Resident #33 was observed in the same visibly soiled jacket and pants, partially fallen due to missing belt loops, facial hair unkempt in appearance, and a foul/sour body odor. Resident is observed standing in the hallway next to the door of his room. On 1/7/26 at 8:52 AM, Resident #33 was observed in the same visibly soiled jacket and pants, partially fallen due to missing belt loops, facial hair unkempt in appearance, and a foul/sour body odor. Resident #33 is observed walking the hallway in the unit. Review of Resident #33's admission record documented an admission date of 11/2/23 with a diagnosis that include metabolic encephalopathy, vascular dementia, and muscle weakness. Review of Resident #33's person centered care plan, revised 12/2/25, documented, [Resident #33's Name] has a self-care deficit with dressing, grooming, bathing r/t [related to]: generalized weakness, visual limitations. Interventions included provide hands on assistance with dressing, grooming, bathing as needed. Review of Resident #33's person centered care plan, revised 12/22/23, documented, [Resident #33's Name] needs assistance with ADL's r/t muscle weakness. Interventions include assist/provide ADL care and support as needed. Review of Resident #33's person centered care plan did not document shower refusals or behavior concerns with ADL care. Review of Resident #33's progress notes found no documentation of refusal of showers. During an interview on 1/6/26 at 9:58 AM, Resident #33 was asked if he had another jacket and pants to change. Resident #33 stated, this is my jacket, I got it on. Resident #33 was unable to understand question regarding changing his clothing, Resident #33 was observed to remove glasses and started talking about his wife. During an interview on 1/7/26 at 12:22 PM, Staff A, Licensed Practical Nurse (LPN), stated, [Resident #33's Name] did not get a shower last night, it is documented as resident was not available. I know that [Resident #33's Name] can refuse showers and be difficult. During an interview on 1/7/26 at 12:26 PM, Staff B, Certified Nursing Assistance (CNA), stated, [Resident #33's Name] dresses himself, always pick out the same outfit each day. We will help [Resident #33's Name] get ready for the day or change and then [Resident #33's Name] goes right back to picking out the same clothes. An observation of Resident #33's closet was observed with CNA and the resident does have other jackets, shirts and pants in closet. During an interview on 1/7/26 at approximately 2:20 PM, Director of Nursing (DON), stated, If a resident refuses a shower, the CNA responsibility is to let the nurse know so the resident can be approached another time. Then document that the resident refused to be able to address possibly on the next shift. During an interview on 1/8/26 at 9:20 AM, Administrator stated, the shower was provided last night, the documentation was in error. [Resident #33's Name] clothing has a peculiar odor from re-wearing the same clothing items. Review of the facility policy titled, Showers/Bathing, issued 4/1/2022. Read, Policy: It will be the policy to assure that showers/bathing are offered at least two times weekly or per resident/resident representative preference, unless specifically ordered otherwise by the physician or care planned otherwise. Procedure 4. Refusals for shower/bathing should be reported to nursing staff via placement on the 24 hour report, verbally comment via denotation of refusal in the electronic health record POC [point of care] system or in any other acceptable means to ensure the nurse is aware of the refusal.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to adhere to professional standards of practice for the care and maintenance of a venous access catheter port for 1 (Resident #50) of 2 residents reviewed. Findings include: Review of the medical record for Resident #50, documented tunneled venous access catheter was in place for the administration of chemotherapy for cancer. During an interview on 1/5/2026 at 11:05 AM, Resident #50, stated I had the port placed for chemotherapy. They are not using it now. During an observation on 1/5/2026 at 11:05 AM, Resident #50 has a venous access port (implanted device to provide long term access for medications) near her left shoulder with a dressing covering it. The dressing is dated 12/5/2025. (Photographic evidence obtained) During an interview on 1/7/2026 at 10:10 AM, the [NAME] Unit Manager/Licensed Practical Nurse (UMLPN) stated, Our policy is an access port needs to have weekly changes of the Huber needle and dressing. The dressing should have been changed. Review of the facility policy and procedures titled, Implanted Venous Port with a last review date of 2/2019, read, Purpose: To provide the guidance for the care of the venous port, to access the venous septum to administer medication, and proper procedure to de-access the non-coring port needle from the port. 14. A folded 2 inch by 2 inch sterile gauze may be placed under the wings of the non-coring needle if it does not obscure the insertion site. This would be done if needle is not at same level as the port to stabilize it, or for protection of the skin. This is not considered to be a gauze dressing and can stay in place for 7 days. 15. Cover needle with transparent sterile dressing, making sure that edges of the dressing are firm against the skin. Use skin protecting agent (e.g., Skin Prep) on skin first, if necessary, and let dry before placing dressing on skin. 16. Label dressing with date, time, and initials of person who is performing procedure.		

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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 observation, interview, and record review the facility failed to maintain complete and accurate medical records for 1 (Resident #117) of 3 residents reviewed for advance directives and respiratory services. Findings include: Review of the admission record for Resident #117 documented an initial admission date of 12/2/25 and a re-admission date of 1/3/26. On 1/5/25 at 10:50 AM, Resident #117 was observed wearing oxygen (O2) via nasal cannula on 2 liters with the oxygen concentrator. During an interview on 1/5/26 at 10:50 AM, Resident #117's significant other, who was at resident's bedside, stated [Resident #117's Name] was hospitalized for Respiratory Syncytial Virus (RSV) and was brought back to facility on Saturday after the hospital said she was stable to return. The cough has been persistent since diagnosis of RSV and has improved. [Resident #117's Name] being on oxygen is new and never [had] been on oxygen prior to this episode. On 1/6/26 at 3:24 PM, Resident #117 was observed in bed wearing O2 on 2 liters with the oxygen concentrator, resident is being repositioned by significant other and facility staff. On 1/7/26 at 11:20 AM, Resident #117 was observed in bed wearing O2 on 2 liters with the oxygen concentrator. Review of the Medical Certification for Medicaid Long Term Care Services and Patient Transfer Form dated 1/3/26 documented in Section V: Treatment Devices the resident was transferred on 2 liters of continuous oxygen. Review of physician orders for Resident #117 for the period of 1/3/2026 through 1/7/2026 documented no physician orders for Oxygen therapy. Review of the clinical record for Resident #117 showed a yellow document titled Do Not Resuscitate (DNR) signed and dated 9/8/25. Review of Progress notes dated 12/4/25 read, Resident admitted for Long Term Care diagnosis hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant aphasia. Resident spouse is Durable Power of Attorney (DPOA) and is currently a DNR. Review of physician orders for Resident #117 dated 1/3/25 read, Advanced Directive: Full Code. During an interview on 1/5/26 at 1:20 PM, the Administrator stated, The code status should have been checked on admission by nursing. During an interview on 1/7/26 at 11:39 AM, the Director of Nursing stated, The expectation is for the nurse to review the incoming orders and transcribe into [Name of clinical record software]. The weekend nursing supervisor should go through the admission packet to verify all orders are transcribed correctly. Review of the facility policy titled, Admissions Policy, issued 4/1/2022, reads, Policy: It will be the policy of this facility to provide appropriate admission guidelines when admitting residents to the facility in accordance with federal guidelines. The facility will evaluate/ assess and document the resident condition upon admission, confirm orders with the physician and obtain appropriate demographic and contact information. Procedure: 7. At the time each resident is admitted, the facility must have physician's orders for the resident immediate care. In the event the resident arrives to the facility without specific instructions the nursing staff should reach out to the medical director or physician assigned to a newly admitted resident to receive orders for care and services. 9. The newly admitted resident should have diet/type of nourishment, medications and treatments and advanced directives verified by the physician, communicated to the pharmacy for delivery and transcribed to the MAR/ TAR or entered into the electronic health record.		