

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105401	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2025
NAME OF PROVIDER OR SUPPLIER Ayers Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 606 NE 7th St Trenton, FL 32693	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from accidents and hazards by failing to ensure wound cleanser containing chemicals were secure when not in use for 1 (Resident #1) of 5 residents with wound care needs. On August 3 and 4, 2025, [Brand Name] Wound Care Cleanser was observed unattended in Resident #1's room at different times by three staff members. The wound cleanser was not removed. Resident #1 consumed the wound cleanser, complained of burning to his mouth and stomach resulting in Resident #1 being transferred to a higher level of care. The facility failed to ensure residents were free from accidents and hazards by failing to ensure wound cleanser containing chemicals were secure when not in use led to the determination of Immediate Jeopardy at a scope and severity of isolated, (J). The facility's actions placed Resident #1, who had a diagnosis of dementia, at a likelihood of serious harm, such as gastrointestinal irritation, nausea, vomiting, or diarrhea. The Administrator in Training was provided the Immediate Jeopardy Template on August 12, 2025 at 4:09 PM. The Immediate Jeopardy began on August 4, 2025 and was removed on site on August 6, 2025. Findings include: During an interview on August 11, 2025 at 9:00 AM, the Director of Nursing (DON) stated, I was notified on 8/5, [August 5, 2025] that a resident [Resident #1] had potentially ingested wound cleanser by the night shift nurse. He [Resident #1] reported to the nurse he had drunk some [wound cleanser] and his mouth was burning. He did not say why only stated he knew it was wound cleanser, and he drinks whatever is in front of him. He is still in the hospital as far as I am aware. He went to [Name of Hospital]. He was a short-term patient. I have not heard any updates. His wife came in Friday and got his belongings. We don't typically leave wound cleanser in the room. A newer Licensed Practical Nurse (LPN) took the wound cleanser in the room. The MD [Medical Doctor] and poison control informed the nurse to send him out for eval [evaluation] due to the ingredients and due to his throat burning. Poison control compared it to potential laundry soap. He [Resident #1] came in Friday afternoon and this happened on Monday. He was in an isolation room. During an interview on August 11, 2025 at 2:40 PM, Staff E, Certified Nursing Assistant (CNA) stated, I worked the four hour shift that day, 7:00 pm to 11:00 pm. I notified the nurse [Staff C, Licensed Practical Nurse] that the wound cleanser was in the room because I was assisting the resident to the bathroom and it fell off the bedside table. When asked why she did not remove it from the room she stated, I was not sure why she [the nurse] did not remove it, maybe because I thought the nurse was not through with it or had left it for later. I really don't know why I did not remove it. During an interview via telephone on August 11, 2025 at 2:42 PM, Resident #1's physician stated, It was life-threatening and could have been worse. The staff called the poison control and due to the ingredients poison control recommended he be sent to the hospital and that is what the facility did. During a telephone interview on August 11, 2025 at 2:44 PM, Staff A, CNA, stated, The resident [Resident #1] was in the isolation room, and I had just come back from break and went to check on him and he was lying in bed, and he stated his mouth was burning and he held up the bottle and read it to me: 'wound cleanser' and that he had been 'drinking wound cleanser.' I took the wound cleanser from him and notified the nurse who then called someone, not sure who, if it was the doctor or poison control. EMS [Emergency Management Services] arrived 20 to 30 minutes later. During an interview on August 11, 2025 at 3:18 PM, Staff D, CNA, stated, I saw the wound cleanser in the room that day [August 4, 2025]. When asked why she did not remove it from the room she stated, We as CNAs are not allowed to touch it, only nurses. I notified his nurse, Staff C, LPN, who stated she would take care of it. During an interview on August 12, 2025 at 11:54 AM, Staff E, CNA, stated, I had come on [August 4, 2025 at] 7pm - 11PM to work and it was sometime around 8PM - 8:30 PM when his [Resident #1] bed alarm started going off. I walked into his room, and he was walking to the bathroom, and he didn't seem very stable. His bedside table was in the path to the bathroom. I stepped around it to get to him and the wound cleanser fell to the ground. After, I got him back in bed. I put the wound cleanser back on the table because I didn't think anything about it because CNAs do not do wound care. I know that I should have just taken it out of the room. I was not told in report that he tried to drink urine or anything else of the sort. He didn't show any signs like that when I was taking care of him. He was trying to urinate in the sink. I only worked four hours that night and had no additional encounters with him. During an interview on August 12, 2025 at 12:14 PM, Staff C, LPN, stated The day before he drank the wound cleanser, I was his nurse. The CNA [Staff D] came to me and told me he was trying to drink his urine. I went to the room and went to move the urinal out of the way. The wife was at bedside and said no don't do that he</p>		