STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105401	A. Building B. Wing	07/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayers Health and Rehabilitation Center	606 NE 7th St Trenton, FL 32693

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, interview, and record review the facility failed to provide an accurate assessment for 3 (Resident #22, #44, and #109) of 7 residents reviewed for respiratory services.Findings include:1)Review of Resident #22's physician ordered dated 4/12/2026 read, Oxygen: Administer Oxygen @ (at) _3_L [liters] via nasal cannula, face mask, CONTINUOUS.Review of Resident #22's Minimum Data Set (MDS) titled Quarterly dated 6/13/2026 Section O Special Treatments, Procedures, and Programs did not document the use of oxygen.Review of Resident #22's Weights and Vitals Summary documented on 6/13/2026 at 01:05 oxygen saturation was 93 % (Oxygen Via Nasal Cannula), 6/12/2026 at 19:39 oxygen saturation was 93% (Oxygen via Nasal Cannula) through 6/7/2026 at 02:30 oxygen saturation was 98% (Oxygen via nasal Cannula).During an interview on 7/9/2026 at 9:43 AM with the MDS Coordinator stated, That one [assessment] was done by the MDS consultant. Most of them are oxygen saturation documented using oxygen via nasal cannula. It needs to be coded yes with continuous oxygen order. This one needs to be modified. 2)Review of Resident #44's MDS's titled Quarterly dated 4/15/2026 Section O Special Treatments, Procedures, and Programs did not document oxygen use.Review of Resident #44's physician order dated 4/12/2026 read, Oxygen: Administer oxygen @ 2L via nasal cannula to keep oxygen saturation greater than 90%. Contact provider if oxygen saturation goes below 90% as needed for Hypoxemia/SOB [shortness of breath].Review of Resident #44's Weights and Vitals Summary documented on 4/14/2026 at 21:54 oxygen saturation was 95% (oxygen via nasal cannula), 4/13/2026 at 21:30 oxygen saturation was 95% (oxygen via mask), 4/13/2026 15:54 oxygen saturation was 96% (oxygen via nasal cannula), 4/13/2026 at 11:09 oxygen saturation was 97% (oxygen via Nasal Cannula), 4/13/2026 at 06:30 oxygen saturation was 96% (Oxygen via Nasal Cannula), 4/12/2026 at 19:25 oxygen saturation was 96% 2L/MIN [liters per minute] (Oxygen via Nasal Cannula), and 4/12/2026 at 12:25 oxygen saturation was 98% 2L/MIN (Oxygen via Nasal Cannula).During an interview on 7/9/2026 at 9:53AM with the MDS Coordinator stated, [Resident #44's name] assessment should be modified, there is documentation of oxygen use.3)Review of Resident #109's MDS titled Quarterly dated 5/21/2026 Section O Special Treatments, Procedures and Programs did not document oxygen use.Review of Resident #109's physician order dated 4/12/2026 read, Oxygen: Administer Oxygen @ 2 L via nasal cannula PRN. as needed for Hypoxemia.Review of Resident #109's Weights and Vitals Summary documented on 5/20/2026 at 22:42 oxygen saturation was 97% (oxygen via Nasal Cannula), 5/18/2026 at 23:09 oxygen saturation was 98% (oxygen via Nasal Cannula), 5/18/2026 at 10:35 oxygen saturation was 98% (Oxygen via Nasal Cannula), and on 5/17/2026 at 23:26 oxygen saturation was 97% (Oxygen via Nasal Cannula).During an interview on 7/9/2026 at 10:03 AM the MDS Coordinator stated, [Resident #109's name] vitals look back period for 5/21 [2026] documented resident was using oxygen. If they would have not documented, that it would have been different. Should be modified since documented oxygen used.During an interview on 7/10/2026 at 8:50 AM the Director of Nursing stated, The facility follows the RAI [Resident Assessment Instrument].

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to update the State of Florida Agency of Health Care Administration Preadmission Screening and Resident Review (PASRR) for 1 (Resident #22) of 4 residents reviewed for behavioral services. Findings include:Review of Resident #22's admission Record resident was first admitted on [DATE] and has diagnosis including but not limited to Major Depressive Disorder [onset date 5/20/2026].Review of Resident #22's State of Florida Agency for Health Care Administration Preadmission Screening and Resident Review (PASRR) dated 8/28/2025 did not documented any mental or suspect mental illness.Review of Resident #22 Balance Wellbeing Psychology Evaluation Note dated 5/6/2026 read, Chief Complaint. Depression. History of Presenting Illness. The patient presents today for evaluation of major depressive disorder, recurrent, moderate. They reported symptoms including decrease interest in activities, persistent depressed mood, sleep disturbances, fatigue, and changes in appetite occurring on more than half of the days. The current episode has persisted for the past three months, also linked to ongoing health concerns. These symptoms are causing the patient moderate subjective distress.During an interview on 7/9/2026 at 10:31 AM with the Director of Nursing (DON) stated, [Resident #22's name] PASSR should have been updated to reflect depression. Balance Wellbeing will be the ones to update that. That is a service they provide to us.Review of the Facility policy and procedure titled Resident Assessment-Coordination with PASARR Program with a last review date of 3/25/2026 read, Policy: This facility coordinates assessments with preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs.

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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 care plan for 1 (Resident #22) of 4 residents reviewed for behavioral services. Findings include:Review of Resident #22's admission Record resident was first admitted on [DATE] and has diagnoses including but not limited to Major Depressive Disorder [onset date 5/20/2026].Review of Resident #22's Balance Wellbeing Psychology Evaluation Note dated 5/6/2026 read, Chief Complaint. Depression. History of Presenting Illness. The patient presents today for evaluation of major depressive disorder, recurrent, moderate. They reported symptoms including decrease interest in activities, persistent, depressed mood, sleep disturbances, fatigue, and changes in appetite occurring on more than half of the days. The current episode has persisted for the past three months, also linked to ongoing health concerns. These symptoms are causing the patient moderate subjective distress.Review of Resident #22's Balance Wellbeing Psychology Evaluation Note dated 6/24/2026 read, Chief Complaint: Depression. History of Presenting Illness. The patient is being seen today due to symptoms associated with Major Depressive Disorder, Recurrent, Moderate. The patient shares experiencing a persistent depressed mood along with a marked loss of interest and altered sleep patterns. They also report experiencing fatigue. Overall distress is evaluated as moderate, with symptoms occurring over multiple days.Review of Resident #22's MDS (Minimum Data Set Assessment) titled Quarterly dated 6/13/2026 documented Section I Active Diagnosis of depression.Review of Resident #22's Care Plan did not document a focus area of depression.During an interview on 7/9/2026 at 10:08 AM with the MDS Coordinator stated, [Resident #22's name] has been followed by Balance Wellbeing since 12/2025. The diagnosis was put in on 5/20 [2026]. Depression is not included in the care plan and it should be. I will have to add a focus of depression without medications.During an interview on 7/9/2026 at 12:07 PM the Director of Nursing stated, [Resident #22's name] should be care planned for depression.Review of the facility policy and procedure titled Comprehensive Care Plans with a last review date of 3/25/2026 read, Policy: It is this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.

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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 provide care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 of 1 residents reviewed (Resident #113) by failing to provide timely post-procedure wound care following a dermatology procedure and by failing to implement physician-ordered aspiration precautions.Findings include:Review of physician orders dated 06/16/2026 revealed Resident #113 was referred to UF Health Dermatology for evaluation and treatment of a skin growth.Review of Resident #113's medical record revealed the resident underwent a dermatology procedure on 07/06/2026 and returned to the facility with dressings covering biopsy sites on the head and face.Review of the Resident #113's Dermatology Visit Summary dated 07/06/2026 revealed wound care instructions that read, Allow any pressure dressing applied by your physician to remain in place for 24 hours. Remove dressing and care for the site as noted below . Clean the wound gently every day with mild soap and water and pat dry. Apply white petrolatum to the wound then cover it with a Band-Aid once a day until the area heals.During an observation on 07/07/2026 at 9:46 AM, Resident #113 was observed resting in bed with dressings covering the biopsy sites on the head and face. The dressings were not dated.During an observation on 07/08/2026 at 1:20 PM, Resident #113 was observed resting in bed with dressings covering the biopsy sites on the head and face. The dressings were not dated.Review of Resident #113's medical record revealed no documentation the biopsy sites were assessed upon the resident's return from the dermatology procedure and no documentation wound care was performed on 07/07/2026 or 07/08/2026.During an interview on 07/08/2026 at 1:35 PM, the Director of Nursing (DON) stated that when a resident returns from a procedure, she expects nursing staff to provide wound care as ordered by the physician. She further stated that if a resident returns without wound care instructions, nursing staff are expected to contact the physician to obtain wound care orders.Review of Resident #113's medical record revealed a Fiberoptic Endoscopic Evaluation of Swallowing (FEES) performed on 04/29/2025 demonstrated silent penetration with straw sips of thin liquids.Review of Resident #113's physician orders dated 11/03/2025 revealed the resident was ordered an easy-to-chew diet with no straws.Review of Resident #113's care plan revealed the resident had dysphagia and instructed staff not to provide beverages with a straw.During an observation on 07/09/2026 at 8:30 AM, Resident #113 was observed drinking water from a cup containing a straw.During an interview on 07/09/2026 at 8:31 AM, Staff G, CNA stated, Well how else are we supposed to give him a water cup, we have to provide water.During an interview on 07/09/2026 at 9:30 AM, the Speech-Language Pathologist (SLP) stated the resident's FEES demonstrated silent penetration with straw use. She stated the resident was then placed on a no-straw precaution.During an interview on 07/09/2026 at 11:40 AM, the Medical Director stated he expected staff to follow physician orders and aspiration precautions for residents with dysphagia to reduce the risk of aspiration.

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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 follow standards of care for oxygen use when failing to provide accurate oxygen flow rate and change tubing weekly for 2 (Resident #5 and #6) of 7 residents reviewed for respiratory services. Findings include: 1)During an observation on 7/7/2026 at 10:10 AM Resident #5 was not in her room. There was an oxygen concentrator machine in the room. The oxygen tubing was stored in a bag hanging from the oxygen concentrator. The tubing was dated 6/26.During an observation on 07/08/2026 at 8:35 AM Resident #5 was lying in bed being administered oxygen via nasal cannula at 3 liters per minute. The oxygen tubing was dated 6/26. During an observation on 7/9/2026 at 8:02 AM Resident #5 was lying in bed. Resident #5's oxygen was running at 3 liters and tubing was dated 6/26.During an interview on 7/9/2026 at 8:21 AM Staff F Registered Nurse (RN) confirmed Resident #5's tubing was dated 6/26 and oxygen was being administered at 3 Liters.Review of Resident #5 physician order dated 1/7/2025 read, Oxygen: Administer Oxygen @ _2_L via nasal cannula, Continuous. every shift for infiltrate of left lung. During an interview on 7/9/2026 at 8:21 AM with Staff F, RN, stated, Oxygen tubing gets changed every week by a respiratory therapist that comes into the building. The tubing should have been changed last week. [Resident #5's name] is running at 3 liters but has orders for 2 liters of oxygen.2)During an observation on 07/07/2026 10:10 AM Resident #6 was lying in bed. The resident was being administered oxygen at 4 liters per minute. During an observation on 07/07/2026 at 12:12 PM Resident #6 was lying in bed. Oxygen was being administered at 4 liters per minute via nasal cannula. During an observation on 7/8/2026 at 8:02 AM Resident #6 was lying in bed. Oxygen was being administered at 4 liters per minute via nasal cannula.Review of Resident #6's physician order dated 3/18/2026 read, Oxygen: Administer Oxygen @ 3L via nasal cannula continuous. every shift for Chronic Respiratory Failure with Hypoxia.During an interview on 7/9/2026 at 8:18 AM Staff F RN entered Resident #6's room and confirmed resident's oxygen was being administered at 4 liters.During an interview on 7/9/2026 at 8:18 AM Staff F Registered Nurse stated, [Resident #6's name] has orders for oxygen at 3 liters. It should not be at 4 liters.During an interview on 7/9/2026 at 12:16 PM the Director of Nursing stated, Nursing staff should check oxygen flow rate every shift and as needed. The tubing should be changed weekly. We have a respiratory therapist who changes the tubing.Review of the facility policy and procedure titled Oxygen Administration with a last review date of 3/25/2026 read, Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goal and preferences. Policy Explanation and Compliance Guidelines: 1. Oxygen is administered under orders of a physician, except in the case of an emergency. In such case oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control. 5.b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow professional standards of practice leaving on attended medication in 1 of 4 hallways and in dinning room area and expired medication in 1 of 5 medication carts. Finding include: During an observation on [DATE] at 9:34 AM Resident #36 was lying in bed. Behind a picture frame on top of the nightstand there was a clear medication cup with a white cream. [photographic evidence obtained] During an interview on [DATE] at 9:34 AM Resident #36 stated, The nurses apply that cream to my groin area. During an interview on [DATE] at 10:08 AM Staff C Registered Nurse stated, [Resident #36's name] is not able to self-administer medication. During an interview on [DATE] at 10:17 AM with Staff D, Certified Nursing Assistant stated, I went in to change [Resident #36's name] and she told me she had cream on her nightstand. Nurses are the ones who are supposed to apply that, they are not to leave it at bedside. 2) During an observation on [DATE] at 9:57 AM Resident #24 was sitting up in bed. There was a medication cup on top of the bedside table with two white circular tablets. During an interview on [DATE] at 9:57 AM with Resident #24 stated, The nurse left this medication for me to take. It is for gases and over the counter. During an interview on [DATE] at 10:03 AM with Staff C, RN, stated, Resident #24 is not able to self-administer medication. He takes Simethicone at night, I have not administered any medication this morning. During an interview on [DATE] at 10:03 AM Staff C, RN, entered Resident #24's room and confirmed medication was unattended at bedside. 3) During an observation on [DATE] at 9:00AM Resident #21 was sitting in the memory care dining room eating breakfast. There was a medication cup with a total of five tablets on the table. The nurse was at the left side corner of the entrance of the dining room with his back towards the residents facing his medication cart. During an interview on [DATE] at 9:07 with Staff E, LPN stated, [Resident #21's name] is really good at taking her medication. I thought she had taken all her medications before I walked away. I thought we were good, but we were not. Staff E confirmed Resident #21 had medication still inside the medication cup next to her breakfast. During an interview on [DATE] at 12:22 PM with the Director of Nursing stated, When staff are administering medications they are to stay with the resident and make sure the medications are consumed. [Resident #24's name] and [Resident #21's name] are not able to self-administer medication. Medications are not to be left unattended. During an observation on [DATE] at 9:17 AM with Staff H, Licensed Practical Nurse (LPN) of the Garden Gate Hallway Medication Cart there was two expired bottles of Brimonidine Tartrate Ophthalmic Solution 0.2% with an open date of [DATE] and one with an open date of [DATE] and one expire bottle of Olopatadine Hydrochloride Ophthalmic Solution with an open date of [DATE]. During an interview on [DATE] at 9:20 AM Staff H, LPN, stated Normally open eye drops will be good for 30 days. Expired medication should be discarded. During an interview on [DATE] at 9:19 AM the Director of Nursing stated, The eye drops were expired. Normally expired medication should be disposed and reordered. Review of the facility policy and procedure titled Medication Storage with a last review date [DATE] read, Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacture's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy Explanation and Compliance Guidelines: 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. 8. Unused Medications: The pharmacy and all medication rooms are routinely inspected by consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn. illegible, or missing labels, These medications are destroyed in accordance with out destruction of (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Unused Drugs Policy. Review of Ophthalmic Medications Beyond-Use Date Guide read, From the Centers for Medicare and Medicaid Services (CMS). If the manufacturer does not provide stability data for once the preparation is opened, current practice guidelines recommend to discard the medication after 28 days due to concerns of stability and sterility. The following chart list several ophthalmic medications for which the manufacture has been contacted to determine the expiration date once the preparation has been opened. This list may not be inclusive. Florida Pharmaceutical Product. Brimonidine Sol 0.2% OP Expiration Date. 28 days from opening.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on record review and interview, the facility failed to ensure physician-ordered laboratory services were provided for 1 of 1 residents reviewed for laboratory monitoring (Resident #13).Findings include:Review of Resident #13's physician's orders dated 06/26/2025 revealed an order for Levothyroxine Sodium 137 mcg (Microgram), give one tablet by mouth daily for low thyroid hormone, repeat TSH (Thyroid Stimulating Hormone) in three weeks.Review of Resident #13's medical record revealed the ordered thyroid-stimulating hormone (TSH) laboratory test was not obtained. Resident #13 continued to receive levothyroxine therapy without the physician-ordered laboratory monitoring.Review of Resident #13's consultant pharmacist's monthly medication regimen review dated April 2026 recommended a TSH level recheck in six months to one year. Review of the medical record revealed no documentation the recommended laboratory monitoring had been completed.Review of Resident #13's physician progress notes from January 2026 through July 2026 revealed no documentation indicating the physician discontinued or modified the original order to obtain the TSH laboratory study.During an interview on 07/09/2026 at 9:50 AM, the ADON (Assistant Director of Nursing) stated the resident's last TSH was obtained in 2024, and was unsure why follow-up laboratory testing had not been completed.During an interview on 07/10/2026 at 8:30 AM, the DON (Director of Nursing) stated she would have expected the TSH laboratory order to have been entered.During an interview on 07/10/2026 at 8:45 AM, Physician #1 stated the TSH order should have been placed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure 3 out of 4 Residents (Resident #3, #118 and #120) reviewed for discharge had a discharge order in their medical record. Findings include: Review of medical record for Resident #120 shows admittance to the facility on [DATE] for diagnosis of, but not limited to Type I diabetes mellitus with hyperglycemia, gastroparesis, muscle weakness, unsteadiness on feet, need assistance with personal care, schizophrenia, depression, hypothyroidism of coordination, other lack abnormalities gait and mobility, hyperlipidemia, anemia, essential primary hypertension, cognitive communication deficit, dysphagia oropharyngeal, and long-term use of insulin. Review of Resident #120's Health status note dated 5/15/26 reads, Resident discharged back to ALF (Assisted Living Facility) in stable condition. Vital signs stable (VSS), afebrile, and skin intact. Discharge instructions provided and explained, including administration of long-acting and short-acting insulin. Resident/caregiver verbalized understanding. Sent with all personal belongings. Transportation arranged and provided by facility staff. During an interview on 7/8/26 at 11:30AM the Director of Nursing stated, We did not obtain orders for discharge. Review of medical record for Resident #3 shows admittance to the facility on 3/4/26 with diagnoses of Hyperkalemia, lack of coordination, encounter for attention of gastrostomy, hypertensive chronic kidney disease with stage 1 through stage 4, Acute kidney failure, type 2 diabetes mellitus with diabetic chronic kidney disease, COPD, atherosclerotic heart disease of native coronary artery, anemia in chronic kidney disease, muscle weakness, psoriasis, hyperlipemia, major depressive disorder, insomnia, presence of aortocoronary, peripheral vascular angioplasty status with implants and grafts, and nicotine dependence. Review of Resident # 3's progress noted dated 3/8/26 shows it read, MD(Doctor) reviewed labs, MD order resident sent to hospital for (not completed in record). During interview on 7/9/26 at 12:04PM the Director of Nursing stated, Paperwork for [Resident #3's Name] had been completed for discharge, but no physician order was written. Record review of medical record for Resident #118 shows an admittance to the facility on [DATE] for diagnoses of but not limited to metabolic encephalopathy, Type 2 diabetes mellitus, hypertensive heart disease with heart failure, dysphagia following cerebral vascular accident (CVA), muscle weakness, and dysphagia. During an interview on 07/10/2026 at 08:50 AM the DON stated All verbal orders should have a written order in the Residents record for discharge, whether going to the emergency room or being discharged to the community. If a resident is discharged from the facility they should have an order for the discharge in their medical record. Record review of Resident #118's progress note dated 05/20/2026 at 11:36 PM reads, Nurse (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessed resident and vitals were not within normal limits, resident was visibly in respiratory distress and altered mental status. Medical Doctor (MD) was notified and ordered to send to emergency room (ER). Review of Resident #118's physician orders does not reveal an order to be transferred from the facility to the hospital. Review of the facility policy and procedure titled Transfers and Discharge (including AMA) dated March 25, 2026, showed it read, Policy Statement: It is our policy of this facility to permit each resident to remain in the facility and not transfer or discharge the resident from the facility, except in limited circumstances. This policy applies to all residents regardless of their payer source. Guidelines for Emergency Transfers to Acute Care, the facility will obtain a physician's order for emergency transfer or discharge, stating the reason the transfer or discharge is necessary on an emergency basis. Guidelines for Anticipated and Discharge to the Community, Facility will obtain a physician's order for transfer or discharge and instructions or precautions for ongoing care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105401	A. Building B. Wing	07/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayers Health and Rehabilitation Center	606 NE 7th St Trenton, FL 32693

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow infection control standards for hand hygiene for 2 of 5 medication administration observations and failed to follow infection control standards for storage of tubing and nebulizer treatment pieces for 3 (Resident #2, #45, and #121) of 7 residents reviewed for respiratory services. Findings include: 1)During an observation on 7/9/2026 at 8:22 AM Staff B Registered Nurse (RN) was pouring medication for Resident #110. Staff B poured a white circular pill into her hand from the medication blister pack and poured the medication into the medication administration cup. Staff B entered Resident #110's room and administered the medication to the resident. During an observation on 7/9/2026 at 8:24 AM Staff B, RN performed hand hygiene, placed a tissue as a barrier and on top of the tissue placed a clear medication cup. Staff B began to pour medication for Resident #79. Staff B was pouring Hydroxychloroquine Sulfate Oral Tablet 200 MG [milligram] and the tablet fell onto the top medication cart. Staff B grabbed the tablet Hydroxychloroquine and disposed of the medication. Staff B without performing hand hygiene continue to pour medications. A tablet of Eliquis fell onto the tissue that was being used as a barrier and Staff B without wearing gloves grabbed the tablet of Eliquis and poured the medication into the medication cup. Staff B poured a tablet of Divalproex Sodium into her hand and then placed the tablet into the medication cup. Staff B finished pouring all the medication into the medication cup and proceeded to enter Resident #79's room and administer the medication. Review of Resident #79's physician order dated 4/15/2026 read, Hydroxychloroquine Sulfate Oral Tablet 200 MG (Hydroxychloroquine Sulfate) Give 1 tablet by mouth in the morning for lupus. Review of Resident #79's physician order dated 7/4/2026 read, Divalproex Sodium Oral Tablet Delayed Release 250 MG (Divalproex Sodium) Give Alternating Dose of 1 tablet/2 tablet by mouth two times a day related to other seizures (G40.89) Take 1 tablet in the morning and 2 tablets at bedtime. Review of Resident #79's physician order dated 7/8/2026 read, Eliquis Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day for DVT. During an interview on 7/9/2026 at 8:47 AM with Staff B, Registered Nurse stated, I should have performed hand hygiene after disposing of the table that fell onto the top of the medication cart. I thought if my hands are clean, I could touch the medication without using gloves. During an interview on 7/9/2026 at 12:19 PM with the Director of Nursing stated, Staff should not be popping the medication into their hands. If the medication falls on top of the barrier the staff should use gloves when touching medication and should perform hand hygiene after disposing of medication before continuing to pour medication. Review of the facility policy and procedure titled Medication Administration with a last review date of 3/25/2026 read, Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in the state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Explanation and Compliance Guidelines: 14. Remove medication from source, taking care not to touch medication with bare hand. 20. Wash hands using facility protocol and product. Review of the facility policy and procedure titled Hand Hygiene with a last review date of 3/25/2026 read, Policy: All Staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Hand Hygiene Table. Before preparing or handling medications. 2) During an observation on 7/9/2026 at 8:35 AM Staff B, RN, entered Resident #45's room and removed a Nebulizer T-Mouthpiece from a gray plastic basin located on top of the nightstand. The mouthpiece was not stored in a bag. Staff B poured the Albuterol Sulfate Nebulization solution and handed the nebulizer to Resident #45 to provide the treatment. Review of Resident #45 physician order dated 12/27/2025 read, Albuterol Sulfate Nebulization Solution (2.5 MG/3ML) 0.083% 3 ml [milliliter] inhale orally via nebulizer three times a day for Shortness of Breath. During an interview on 7/9/2026 at 8:47 AM Staff B, RN stated, Normally the nebulizer mouthpiece is stored in a bag when not in use. The mouthpiece was not bagged. I should have gotten a new one and discarded the one not bagged before giving the treatment. During an interview on 7/9/2026 at 12:18 PM the Director of Nursing stated, The nebulizer mouthpiece and mask should be stored in a bag when not in use. The staff should have disposed of the mouthpiece and gotten a new one. Review of the facility policy and procedure titled Oxygen Administration with a last review date of 3/25/2026 read, Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goal and preferences. Policy Explanation and Compliance Guidelines: e. Keep delivery devices covered in plastic bag when not in use. 3)Record Review of medical records reveals Resident #2 was admitted on [DATE] with diagnoses of but not limited to hypertensive heart and chronic kidney disease with heart failure, congestive heart failure, type two diabetes, and anemia. During an observation on 07/07/26 at 9:10 AM Resident #2's bedside table, a nebulizer mask was sitting next to the nebulizer machine. The machine was not currently running. The mask was left open to air, not being secured in a labeled bag. Photo documentation provided. During an observation on 07/09/26 at 08:50 of Resident #2's empty room the bed is made. On the bedside table, a nebulizer mask is located next to the machine, not covered appropriately. Photo documentation provided. During an interview on 07/09/2026 at 12:20 PM the DON stated, My expectations for the staff who administer the nebulizer is to store the equipment in a bag labeled for the Resident when the nebulizer mask and tubing is not in use. If identified the equipment had not been stored appropriately, the equipment should have been removed and switched out for new equipment. Record review of orders for Resident #2 read on 05/01/2026 at 02:56 AM order for (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 1 vial inhale orally every 4 hours as needed for COPD. Review of the MAR indicates this medication has been given for the month of July on the 2nd at 08:52 AM, the 6th at 10:22 AM, the 7th at 1:59 PM, and the 8th at 3:12 PM.