STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105429	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
First Coast Health and Rehabilitation Center	7723 Jasper Avenue Jacksonville, FL 32211

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review, interviews and a review of facility policies and procedures, the facility failed to 1) Complete the notice of transfer or discharge (Discharge/Transfer Notice AHCA 3120-002 form), and 2) Send a copy of the notice of transfer/Discharge to the representative of the Office of the State Long-Term Care Ombudsman's office for three (Residents #90, #92 and #23) of three residents reviewed for discharge requirements. The findings include:1.A review of Resident #90's medical record revealed an initial admission date of 11/26/25 and a re-entry date of 12/4/25. The resident was then discharged to an acute care hospital via emergency medical services for shortness of breath/respiratory distress on 12/29/25. A physician's order, dated 12/29/25, instructed nursing staff to send the resident to the hospital for respiratory distress.An SBAR (Situation, Background, Assessment, Recommendation) Summary revealed that on 12/29/25 at 20:20 (8:20 PM), Resident #90 had a change in condition (shortness of breath) with provider recommendations to Send resident to the hospital via 911.No Discharge/Transfer Notice AHCA 3120-002 form was found in the resident's medical record. There was no indication that the Ombudsman's office was notified of the discharge.2. A review of Resident #92's medical record revealed an admission date of 12/13/25 and a discharge date of 12/16/25. The resident was transferred/discharged to an inpatient rehabilitation facility per the resident's request. No Discharge/Transfer Notice AHCA 3120-002 form was found in the resident's medical record. There was no indication that the Ombudsman's office was notified of the discharge.3. A review of Resident #23's medical record revealed an admission date of 10/23/25 and a discharge date of 12/18/25. The resident was discharged per the family's request to a facility in Ohio, closer to family. No Discharge/Transfer Notice AHCA 3120-002 form was found in the resident's medical record. There was no indication that the Ombudsman's office was notified of the discharge.On 1/22/26 at 11:04 AM, during an interview with the Director of Social Services (DSS), she was asked to explain the facility's Discharge Process. She stated she met with residents upon admission to determine their projected length of stay, and throughout their stay, she periodically followed up to see if anything had changed. She was asked how often she notified the Ombudsman's office of resident transfers/discharges. She stated, I'm not aware of that; that's not something I've done but you can speak to the DON (Director of Nursing) or the Administrator.On 1/22/26 at 11:25 AM, an interview was conducted with the Administrator. She was asked whose responsibility it was to notify the Ombudsman's office of resident transfers or discharges. She stated, You know. It's Social Services.On 1/22/26 at 11:39 AM, an interview was conducted with the DON who was asked whose responsibility it was to notify the Ombudsman of resident transfers or discharges. She stated, It's Social Services; we didn't have anyone in that position for a while and then we had someone on December 4, 2025, and then the current social worker started on December 30, 2025. She was asked how often the Ombudsman was notified of resident transfers or discharges. She replied, I'm not sure but I will get back with you on that. She was asked to provide evidence of Ombudsman notification of discharged or transferred residents for December 2025. On 1/22/26 at 12:15 PM, the DON confirmed that the facility's frequency for notifying the Ombudsman of resident transfers/discharges was monthly and that no notification of transfers or discharges was sent to the Ombudsman in December (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2025. The DON provided a list or residents who transferred or discharged from the facility in December 2025. Residents #90, #92 and #23 were listed. A review of the facility's policy and procedure titled Discharge Documentation (effective November 2024, 8.1.8, 3 pages), revealed that for external transfers for medical services at a higher level of care, the following forms/documents were required:Long Term Care Ombudsman Council Request for Review of Nursing Home Transfer Discharge.Procedure: Discharges:1.Should the facility decide to discharge the resident while the resident is hospitalized , the facility will send Form 3120, Notice of Discharge/Transfer, to the resident and resident representative. A copy of the discharge notice will also be sent to the Office of the State LTC (long-term care) Ombudsman at the same time as the Notice of Discharge/Transfer is provided to the resident and resident representative.2.For any other types of facility-initiated discharges, the facility will provide the Notice of Discharge/Transfer to the resident and representative along with a copy of the notice to the Office of the State LTC Ombudsman at least 30 days prior to the discharge or as soon as possible. A copy of the notice is sent to the Ombudsman at the same time as Form 3120 (Discharge/Transfer Notice AHCA 3120-200 form) is provided to the resident and resident representative.Emergency Transfers:1.When a resident is temporarily transferred on an emergency basis to an acute care facility, Form 3120, Notice of Transfer, is provided to the resident and resident representative as soon as practicable, but within 24 hours of the transfer.2.Copies of Form 3120 for emergency transfers are sent to the Ombudsman as soon as practicable, such as in a list of residents every month.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to maintain an effective pest control program, as evidenced by repeated observations of live roaches and fruit flies in four (#101, #103, #105, and #214) of 39 resident rooms and two (100 hall and 300 hall) of three hallways. Failure of the facility to eradicate pests can pose health risks to vulnerable residents including transmission of diseases, allergic reactions and discomfort/infection related to bug bites. Pests can potentially threaten sanitation, contaminate food and cause residents emotional distress.The findings include: On 1/20/26 at 8:34 AM, a live roach was observed crawling on the floor from room [ROOM NUMBER] into the hallway. (photographic evidence obtained)On 1/20/26 at 8:35 AM, an interview was conducted with Certified Nursing Assistant (CNA) E, who witnessed and confirmed the live roach crawling from room [ROOM NUMBER] into the hallway. CNA E stated sightings of roaches and flies occurred daily.On 1/20/26, small flying insects were observed in Resident Rooms #101, #105 and #214.On 1/22/26 between 1:00 PM and 3:45 PM during the Life Safety facility tour, a live roach was observed crawling on the floor of the 300 hall near the nursing station.On 1/23/26 at 2:50 PM, a live roach was observed crawling on the floor of the 100 hall.On 1/23/26 at 7:30 AM, an interview was conducted with Licensed Practical Nurse (LPN) G who stated she had been employed by the facility for approximately eight months. She further stated roaches and fruit flies were observed in the facility daily. LPN G said she last killed a roach on 1/22/26 in the 100 hall. The facility's protocol was to write the sightings in the logbook for pest control to check when they came in.On 1/23/26 at 1:18 PM, an interview was conducted with LPN D who stated she had been employed by the facility for four months. She explained that she had observed small flies in room [ROOM NUMBER] today. She denied seeing any roaches. LPN D further explained that pest sightings were documented in the pest log at the nurses' station, and the pest control technician initialed the log when he came to the facility for service.On 1/23/26 at 1:29 PM, an interview was conducted with the Maintenance Director who stated he had been employed with the facility for three months. He explained that the facility had pest control service who came out every two weeks; however, he stated he would be communicating with the Manager now, because he did not feel the treatment being provided as adequate. The Maintenance Director stated the roach sightings had decreased over the last three months, but the facility did have a problem with fruit flies. He further stated he was not permitted to spray anything in the facility between service calls, but he had not made any additional service treatment calls. A review of the pest control logbook with the Maintenance Director was conducted at the time of the interview. On 1/22/26, roaches were documented as having been sighted in rooms #103, #105 and #107. (photographic evidence obtained)A review of the pest control service record dated 1/7/26 revealed: flies activity in rehab center. (photographic evidence obtained) A review of the pest control service record dated 12/10/25 from the pest control company revealed: Tile in the kitchen has been found to be broken or missing allowing food and water to accumulate underneath. This allows harborage of small filth flies and cockroaches. Please replace the tile or seal cracked area with caulk. (photographic evidence obtained)A review of the facility's policy titled Pest/Insect Control (dated August 2024), revealed that the facility will evaluate effectiveness of services and contact pest control agency if additional services are needed. (photographic evidence obtained)