

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105434	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/24/2025
NAME OF PROVIDER OR SUPPLIER  Plaza Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  4842 SW Archer Road Gainesville, FL 32608	

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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation and interview, the facility failed to ensure food was served in a safe manner for 3 of 12 residents observed for meal service. Findings include: During a tour of the kitchen on 07/24/2025 at 12:15 PM, three black serving trays were observed in the dish cleaning area. The three trays were chipped resulting in sharp jagged edges. During an interview on 7/24/25 at 12:15 PM, the Food Services Director stated, Trays [food trays] with jagged edges could cause bleeding to the residents with fragile skin and should not be used. During an observation on 07/24/2025 at 4:55 PM, the dinner trays were being passed out to residents residing on the F Villa. Three of the food trays that were taken to residents' rooms were observed to have chips out of them resulting in jagged edges. (Photographic Evidence Obtained)</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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