STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105436	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowpark Health and Rehabilitation Center	870 Patricia Ave Dunedin, FL 34698

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure grievances regarding a room change were addressed in a timely manner for two residents (#14 and #34) of 20 sampled residents. Findings Included: During a tour on 05/11/2026 at 09:02 AM, Resident #14 and Resident #34 reported verbally cursing each other and not wanting to be roommates. Resident #14 explained not being able to get along with the roommate. Resident #34 stated the situation had been reported to the staff and both stated being agreeable to a room change at the time.During an interview on 05/13/2026 9:09 AM, Staff E, Licensed Practical Nurse (LPN)/ Unit Manger (UM), explained being notified by Resident #34's family member, of Resident #14 cursing at Resident #34. Staff E stated having spoken to the Social Services Director (SSD) and stated a grievance had been opened for the situation. During an interview on 05/13/2026 at 09:22 AM, the SSD stated the facility had a care plan meeting with Resident #34 a few weeks prior. The SSD stated having heard Resident #14 used explicit words at Resident #34. The SSD stated Resident #14 said, We just don't get along. The SSD stated when something like that is heard, immediate action is required. The SSD stated there were no grievances filed related to Resident #14 and Resident #34. During an interview on 05/13/2026 at 09:51 AM, Staff F, LPN, stated around a month ago on a weekend, Resident #14 called Resident #34 a expletive. Staff F explained having told the SSD about the situation. Staff F stated Resident #34 wanted a room change at the time. During an interview on 05/13/2026 at 10:08 AM, with Staff G, Lead MDS Coordinator and Staff H, MDS Coordinator, Staff H stated there was a care plan meeting on 05/05/2026, involving Resident #34, the family member of Resident #34, Staff E LPN/ UM, Staff H, and the SSD. Staff H stated during the care plan meeting, Resident #34 explained being cursed by Resident #14 a month prior. Staff H stated a grievance should have been filed for the resident. Record review for Resident #14 revealed the resident admitted into the facility on [DATE]. Medical diagnosis included major depressive disorder, recurrent, adult failure to thrive, and morbid (severe), obesity. Review of Resident #14's quarterly Minimum Data Set (MDS), Section C, dated 04/21/2026, revealed a Brief interview Mental Status (BIMS), of 11, which meant moderate cognitive impairment.Record review for Resident #34 revealed the resident was admitted to the facility on [DATE]. Resident #34's medical diagnosis included: morbid (severe), obesity, contracture of muscle, left hand, muscle spasm, shortness of breath, spinal stenosis, and Guillain-Barre syndrome, and dysphonia. Review of Resident #34's quarterly MDS, Section C, dated 02/08/2026, revealed Resident #34 had a BIMS of 15, which meant cognition was intact.During an interview on 05/13/2026 at 05:16 PM, the Director of Nursing (DON) and the Nursing Home Administrator) NHA stated when residents curse at each other, call each other names and so forth, the expectation is for the residents to be separated. They stated staff should report the allegation to the supervisor, DON, or NHA. They stated staff should go to the room to make sure the residents are safe and not hurt. The NHA stated the staff should get to the root cause, of the resident's disagreement. The NHA stated a grievance should have been opened and the NHA should have been notified. Review of a facility policy titled, Grievances, Revised 7/2024, revealed: Guideline, The Administrator and staff will make prompt efforts to resolve grievances to the (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	satisfaction of the resident and/or representative. 1. Any resident, family member, or appointed resident representative may file a grievance or complaint concerning the care, treatment, behavior of other residents, staff members, theft of property, or any other concerns regarding his or her stay at the facility. 5. Grievances and/or complaints may be submitted orally or in writing and may be filed anonymously. 10. The Grievance Officer, Administrator and Staff will take immediate action to prevent further potential violations of resident rights while the alleged violation is being investigated.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure care plans were revised to reflect personal care preferences related to contracture management and use of orthotics/splints for one resident (#2) out of 20 sampled residents.Findings included: During room visits on 5/11/2026 at 11:40 a.m., 5/12/2026 at 8:50 a.m., 1:50 p.m., 5/13/2026 at 8:30 a.m., and on 5/14/2026 at 8:25 a.m. and 10:00 a.m., Resident #2 was observed lying flat in bed. Resident #2 was not able to answer any questions related to his care needs. Resident #2's upper extremities to include hands and fingers were severely contracted. Resident #2 was not wearing any type of hand orthotics/splints/braces during these observations. The room was observed without any orthotics/splints/braces.On 5/13/2026 at 10:00 a.m. Resident #2's assigned Certified Nursing Assistant (CNA) for the 7-3 shift, Staff D, revealed he was not aware of Resident #2 utilizing or having the need to use hand orthotics/splints/braces. Staff D confirmed Resident #2 had contractures and he required full staff assistance (dependent on staff) for all ADL (Activities of Daily Living) tasks. Staff D, CNA looked at Resident #2 and around the room and confirmed there were no orthotics/splints/braces. On 5/13/2025 at 10:25 a.m. an interview with Staff B, Licensed Practical Nurse (LPN) revealed he was unaware Resident #2 currently uses or has ever utilized hand orthotics/splints/braces. Staff B had worked with Resident #2 regularly and confirmed he had contractures on both hands but could not remember the last time he used orthotics/braces/splints. He was not sure if Resident #2 was receiving therapy or if he was on a Restorative Nursing Program (RNP) for contracture management. On 5/14/2026 at 8:25 a.m. during an interview with Resident #2's assigned Certified Nursing Assistant (CNA), Staff C revealed she was aware of Resident #2's care and denied he used or had currently any hand orthotics/splints/braces. She confirmed Resident #2 did have contractures on both of his hands and required full staff assistance with (ADL) tasks. Staff C remembered Resident #2 did have hand splints to use for his contracture management in the past, but that was many months ago. She confirmed Resident #2 at times refused to wear the splints. She was not sure if Resident #2 has stopped utilizing the splints totally or if the splints had been lost. Staff C, CNA looked around Resident #2's room and confirmed there were no hand orthotics/splints/braces for Resident #2 to use. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include but not limited to: Cerebral infarction, COPD, Narcolepsy, Encephalopathy, Protein calorie malnutrition, Chrohn's, Embolism, Contracture of muscle (multiple sites), GERD, Major depression, Anxiety. Review of the current physician orders for the month 5/2026 revealed there were no current orders for use of hand orthotics/splints/braces.Review of the MD (Medical Doctor) assessment/visit report dated 3/14/2026 19:08 revealed; ROM: PROM (Passive Range of Motion) in arms and legs is slow and decreased, no dislocation noted. Strength: pt (patient) able to slightly squeeze with right thumb and pointer, Neuro: pt does move with light touch BLE (bilateral lower extremities), UE (upper extremities)contracted 2-3 on the modified [NAME] scale. Left hand contracted, speech delayed moderately. Review of the nurse's progress notes dated 2/1/2026 to 5/17/2026 did not reveal any documented evidence of resident refusing use of hand orthotics/splints/braces for both of his contracted hands. Review of the current care plans with a next review date 6/23/2026 revealed areas to include but not limited to: Resident #2 has need for RNP (Restorative Nursing Programs) for PROM and Splint/Brace application with RNP for donning and doffing of Left Wrist splint, Left Elbow splint, and Right Elbow splint, apply splint/brace, Apply splint/brace in am after PROM performed and remove as tolerated. Monitor skin surfaces under device and notify D of abnormal findings. The resident may remove device per preference, with interventions in place to include: Encourage and educate resident how to apply and care for brace/splint, Educate and encourage resident to observe and report skin concern with splint/ braces, (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe skin when removing brace/splint and report any changes to nurse. Has potential for ADL self-care deficit related to general weakness status post hospital stay. ADL needs and participation vary, with interventions in place to include: Encourage and educate resident with increased independence as tolerated and assist with ADL tasks as indicated, including locomotion/ambulation, bathing, bed mobility, transfers, toiling tasks, meals, personal/oral hygiene, etc., Encourage resident to do as many ADL tasks for themselves as possible, PT/OT (Physical Therapy/Occupational Therapy) evaluation/treatment/screen as indicated and/or as ordered, ADL care: the resident may need dependent assistance x1 or x2 for ADL care. This may fluctuate with weakness, fatigue, and weight bearing status, Bathing: The resident is dependent on staff for bathing needs, including transfer into and out of shower. On 5/14/2026 at 9:32 a.m. an interview with the Rehabilitation Director confirmed Resident #2 was no longer on PT/OT case load. He provided the last PT/OT certification period assessment/care plan and discharge summary, which revealed; PT Discharge Summary for services 2/10/2026 - 3/16/2026. The assessment/notes in the Discharge summary dated [DATE] revealed the resident was being seen and treated for contracture management. OT Discharge Summary for services 2/10/2026 - 3/16/2026. The assessment/notes in the Discharge summary dated [DATE] did not reveal use of orthotics/splints/braces for contracture management. On 5/14/2026 at 10:00 a.m. an interview with the Care Plan Coordinator revealed Resident #2 had a care plan with problem areas and goals and interventions related to contracture management. She confirmed Resident #2 was no longer on a contracture management program or Restorative Nursing Program (RNP) and no longer uses hand splints and or hand orthotics due to his continued refusal. The Care Plan Coordinator could not provide documentation to support Resident #2 ever refused the use of hand orthotics/splints/braces. The care plan coordinator also confirmed she should have developed a care plan to support the resident's continued behaviors of refusing care and services specifically not wearing hand splints/orthotics. She also revealed since he is no longer on a contracture management program, she should have revised the care plan by taking away the contracture management program problem area, goals and interventions. She further stated there should not be a contracture management care plan. On 5/14/2026 at 11:00 a.m. the Nursing Home Administrator (NHA) provided the Standards and Guidelines: Comprehensive Assessments and Care Plans policy and procedure with a last revision date 12/2024 for review, revealing; 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. Under the guidelines section of the policy showed: #6 (d) Any updated information based on the details of the comprehensive care plan, as necessary.#9 The development of the comprehensive care plan will be prepared by the interdisciplinary team, involving, that includes, but is not limited to the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of food and nutrition services staff and, to the extent practicable, the participation of the resident and the resident's representative(s). Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by resident can participate. #10 The plan of care reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure nail care was offered/provided for one resident (#2) of 20 sampled residents.Findings included: During room visits on 5/11/2026 at 11:40 a.m., 5/12/2026 at 8:50 a.m., 1:50 p.m., 5/13/2026 at 8:30 a.m., and on 5/14/2026 at 8:25 a.m. and 10:00 a.m., Resident #2 was observed lying flat in bed. Resident #2 was not able to answer any questions related to his care needs. Further observations revealed both of Resident #2's hands had finger nails that were elongated, and with dark brown debris under the fingernail bed. Most of the finger nails were observed at least a quarter inch to over a half inch in length from the tips of the finger.On 5/13/2026 at 10:00 a.m. an interview was conducted with Staff D, Certified Nursing Assistant (CNA) who stated he normally cared for Resident #2 and knew he is totally dependent on staff for all ADL (activities of daily living) Staff D observed Resident #2's fingernails on both hands and confirmed they were very long and soiled under the finger nail beds. Staff D, CNA was not sure who was responsible to clip Resident #2's fingernails.On 5/14/2026 at 8:25 a.m. an interview was conducted with Staff C, CNA who was observed assisting Resident #2 with eating assistance with his breakfast meal,. Staff C stated having Resident #2 on her assignment regularly. She confirmed Resident #2 was not verbal and was fully dependent on staff with all his ADL. Staff C confirmed Resident #2 could not complete personal hygiene care to include fingernail care on his own. Staff C confirmed Resident #2's fingernails were long and she did not know who was supposed to cut his nails. She was unsure if Resident #2 had ever refused nail care but felt he should not have had finger nails that long and also felt his fingernail beds should be free from debris as well. On 5/13/2026 at 10:25 a.m. an interview with Staff B, Licensed Practical Nurse (LPN) revealed residents who need nail care will typically request, oy by staff's observations. He stated staff should be on the lookout for elongated fingernails on a daily basis and if a resident cannot make their needs known, then they (staff) will make the decision if the nails need to be clipped. Staff B, LPN was not aware Resident #2 was in need for nail care. He then observed Resident #2 and confirmed his nails were long and needed clipping. Staff B also was not aware of Resident #2 ever refusing fingernail care. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of the current Minimum Data Set (MDS) significant change assessment dated [DATE], revealed; (Cognition/Brief Interview Mental Status or BIMS score not scored. However, assessment revealed Short Term/Long Term memory problem with severely impaired decision-making skills); (ADL - Impaired both sides upper and lower extremities, Showers - Dependent, Personal Hygiene - Dependent, Transfers - Dependent).Review of the nurse progress notes dated 2/1/2026 to 5/17/2026 did not reveal any documented evidence of resident refusing personal hygiene to include nail care/nail trimming. Review of the following shower sheets for the months of March to May 2026 revealed nail care was not checked or completed on the following dates: 3/12/2026, 3/13/2026, 3/18/2026, 3/31/2026, 4/1/2026, 4/21/2026, 4/22/2206, 4/24/2026, 5/5/2026, 5/6/2026, 5/7/2026 and 5/12/2026 Review of the current care plans with a next review date 6/23/2026 revealed areas to include but not limited to: ADL care: the resident may need dependent assistance x1 or x2 for ADL care. This may fluctuate with weakness, fatigue, and weight bearing status, Bathing: The resident is dependent on staff for bathing needs, including transfer into and out of shower. Review of a facility policy titled, Standards and Guidelines: ADL Care and Services, revision date 1/2024, revealed: Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).The Guideline section revealed; Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.The Procedure section revealed: Residents will be provided with care, treatment, and services to ensure that their activities of daily living (ADLs) are met. 4 . Appropriate care and (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with, including but not limited to: Hygiene (bathing/showers, dressing, grooming, nail care, oral care).

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure call light buttons/call light cords were placed within reach for three residents (#2, #59 and #97) out of forty-three sampled residents.Findings included: During a room visit on 5/11/2026 at 11:40 a.m., and on 5/13/2026 at 8:30 a.m. Resident #2 was observed lying flat in bed and the resident's call light button was not anywhere on the bed, or near Resident #2. It was noted a push pad call light button was on the floor and slightly under the bed frame foot stand. Resident #2 would not be able to use the call light, as it was out from his reach. On 5/13/2026 at 8:33 a.m. an interview with Certified Nursing Assistant (CNA), Staff C confirmed the call light pad, and cord was lying on the floor back behind Resident #2 and under the bed frame foot stand. Staff C stated that all residents should always have the call light placed within their reach when they are in bed. On 5/14/2026 at 10:00 a.m. an interview with Staff B, Licensed Practical Nurse (LPN) revealed he worked with Resident #2 regularly. Staff B confirmed Resident #2 had cognitive deficits preventing him to speak related to his medical care and services but was able to use the call light device at times. Staff B confirmed all residents should have the call light placed within their reach while in bed and staff should regularly look in rooms to make sure the call light is not on the floor, and out from their reach. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include but not limited to: Cerebral infarction, COPD, Narcolepsy, Encephalopathy, Protein calorie malnutrition, Chrohn's, Embolism, Contracture of muscle (multiple sites), GERD, Major depression, Anxiety. On 5/11/2026 at 10:39 a.m. an observation was made of the call light in Resident #59's room and bathroom not working. When the call light cord was pulled, the system did not illuminate. Furthermore, the light above the door indicating a resident needed assistance, did not illuminate.Review of Resident #59 admission record revealed an original admission date of 12/16/2024. Resident #59 was admitted to the facility with diagnosis to include but not limited to autistic disorder, and developmental disorder of speech and language.Review of Resident #59 care plan revealed an intervention of using the call bell and keeping it in reach for a focus area of risk of falls, and alteration in musculoskeletal status.On 5/11/2026 at 10:43 a.m. an observation was made of Resident #97's call light. The box that the call light was connected to in the wall was hanging out, causing the cords to be exposed. The call light was not within reach as it was hanging off the bed on the resident's left side.Review of Resident #97 admission record revealed an original admission date of 6/23/2025. Resident #97 was admitted to the facility with diagnosis to include but not limited to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, repeated falls, and difficulty in walking.Review of Resident #97 Minimum Data Set (MDS) revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15 indicating adequate mental cognition.Review of Resident #97 care plan revealed an intervention of using the call bell for staff assistance.On 5/13/2026 at 9:13 a.m. an interview was conducted with Resident #97 who stated he did not know where the call light was. Resident #97 said the call light was under the bed the day before and he could not reach it at that time either. While this interview was being conducted, Staff A, Certified Nursing Assistant (CNA) walked into the room to check on Resident #97. Staff A could not find the call light as the cord was seen stuck between the mattress and bed frame. Staff A said the call light was technically not where it was supposed to be.On 5/13/2026 at 12:30 p.m. an interview was conducted with Staff A, CNA. Staff A said residents were to use the call light if they required assistance from their room. Call lights were to be placed near the resident and within reach.On 5/13/2026 at 9:53 a.m. an interview was conducted with Staff B, LPN. Staff B stated residents were to use the call light if they required assistance from their room. Call lights were to be placed within reach of the resident.On 5/14/2026 at 1:18 p.m. an interview was conducted with the Regional Nurse Consultant who said facility policy stated call lights were to be placed within reach of the residents. Review of a facility policy and procedures titled, Call lights with (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a revision date of 01/2024, showed a Standard: Resident will have a call light to summon facility personnel to ensure the resident's needs will be met. Guideline: Resident's call light is to be within reach and answered promptly by facility personnel. Procedure: .6. Ensure the call light is within reach.