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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105488 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/29/2025 |
| NAME OF PROVIDER OR SUPPLIER Riverwood Healthcare & Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 808 S Colley Rd Starke, FL 32091 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some | Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Based on observation, interview and record review the facility failed to provide midline catheter dressings changes according to professional standards of practice when the facility failed to change midline dressings according to physician orders and standards for 3 (Resident #104, #28 and #114) of 3 resident reviewed with midline catheters. Findings include:1. During an observation on 8/25/25 at 1:38 PM, Resident #104 was observed sitting in a wheelchair at their bedside with a left single lumen PICC (peripherally inserted central catheter) line. The semipermeable transparent dressing was pulling up at all the edges, there was old, dried blood at the insertion site and dressing date of 8/16/25.During an observation on 8/26/25 at 7:09 AM, Resident #104 was observed in bed with a left single lumen PICC line. The semipermeable transparent dressing was pulling up at all the edges, there was old, dried blood at the insertion site and dressing date of 8/16/25.Review of Resident #104's admission record documented diagnosis that includes chronic systolic (congestive) heart failure, chronic obstructive pulmonary disease, unspecified, emphysema, unspecified, chronic kidney disease stage 3 unspecified, hyperlipidemia, unspecified, chronic pain syndrome, major depressive disorder, recurrent, moderate, gastro-esophageal reflux disease without esophagitis, unspecified osteoarthritis, unspecified site, acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity, peripheral vascular disease, unspecified, essential (primary) hypertension, alcohol use, unspecified with unspecified alcohol-induced disorder, and paroxysmal atrial fibrillation.Review of Resident #104's form titled, Medical Certification for Medicaid Long Term Care Services and Patient Transfer Form, (3008), dated 8/14/25 read, V. Treatment devices: IV (intravenous)/PICC/Port-a-cath access date inserted 8/14/25.Review of Resident #104's physician orders from admission through 8/26/25 showed there were no orders for PICC line care, PICC line flushes or dressing changes.Review of Resident #104's discharge instructions from [Name of Hospital] dated 8/14/25 at 1340 (1:40 PM) read, New medications (1). These are new medications to start taking at home. 1. piperacillin-tazobactam-dexters [Zosyn in dextrose (iso-osm ((International Organization for Standardization-Osmolality)))] 3.375 g (grams) intravenous every 8 hours . Review of Resident #104's physician orders from admission documented no orders for piperacillin-tazobactam-dexters [Zosyn in dextrose (iso-osm) 3.375 grams intravenous every 8 hours.Review of Resident #104's physician progress note dated 8/15/25 read, Date of Service: 8/15/25, Visit Type: admission H&P (history and physical) MD (Medical Doctor). Past Medical History: MDRO (multiple drug resistant organisms) resistance, Positive E. coli (Escherichia coli) ESBL (extended-spectrum beta-lactamase) urine cx (culture) 6/3/2024. MRSA (methicillin-resistant staphylococcus aureus) (+) Nares (nostrils) 8/4/24. Assessment. Acute UTI (Urinary Tract Infection): Hospital discharge reviewed; continue Zosyn until completion via LUE (left upper extremity) PICC. Appears stable and generally asymptomatic. Will reassess UA (urinalysis) after completion of abx (antibiotics) to ensure resolution. Review of Resident #104's physician progress note dated 8/18/25 read, Past Medical History: MDRO (multiple drug-resistant organisms) resistance Positive E. coli ESBL urine cx (culture) 6/3/2024. MRSA (+) Nares 8/4/24. Diagnosis, Assessment and Plan: Assessment: Acute UTI: Patient has completed Zosyn as directed at hospital discharge. PICC line in place in LUE (left upper extremity).During an interview on 8/26/25 at 7:10 AM, Resident #104 stated, Am I going to get anything in this (the PICC line). They haven't used it since I got here. I have not gotten any antibiotics, they don't know what to give me.During an interview on 8/26/25 at 7:11 AM, Staff M, Licensed Practical Nurse (LPN) stated that (the PICC line dressing) was done on 8/16 and it has blood under it and it is rolling up. It should have been changed.During an interview on 8/26/25 at 7:39 AM, the Director of Nursing (DON) verified that the date on the dressing was 8/16/25 and there was blood under the dressing and the dressing should have been changed.During an interview on 8/26/25 at t1:32 AM, the DON stated, I believe that the medication (Zosyn) was not on the discharge medication reconciliation list and we reached out to the doctor and they didn't think she needed it. The DON verified that the discharge medication reconciliation did contain Zosyn and all other medications were checked except the Zosyn.During an interview on 8/26/25 at 2:31 PM, the DON stated, I spoke to the provider, it wasn't the doctor but the nurse practitioner, [Nurse Practitioners name], he was aware the medication wasn't given and said not to order it and he ordered a u/a (urinalysis) and labs to be done. Ultimately, it should have been ordered. I don't know why it wasn't.During an interview on 8/27/25 at 10:01 AM, the Advanced Practice Registered Nurse (APRN) stated, I did find that she [Resident #104] had not received the medication and due to the length of time since she had been administered it (the antibiotic). I decided to do a u/a as she was not symptomatic. That was on the 20th or</p> |

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| <p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure that adequate pain management was provided for 3 (Resident #43, Resident #86 and Resident #85) of 5 residents reviewed that were prescribed opioid pain medications.</p> <p>Findings include:</p> <p>1. During an interview on 08/27/2025 at 11:10 AM, Resident #43 stated, I don't remember the exact date, but when I was waiting on my pain medicine last month, pharmacy didn't bring it for a long time, and I started going through withdrawals. I was sweating and nauseous. I had a lot of anxiety. I did go to the hospital the next day for chest pains, but I don't think it was related. I was told the chest pain was due to my muscle.</p> <p>Review of Resident #43's admission record documented a admission date of 4/22/2025 with medical diagnoses that included spinal stenosis, cervical region, diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified fracture of right lower leg, central pain syndrome, and muscle spasm of back.</p> <p>Review of Resident #43's physician order dated 7/17/2025 read, OxyCODONE HCl (hydrochloride) Tablet 5 MG (milligram) Controlled Drug Give 1 tablet by mouth every 4 hours for Non acute pain.</p> <p>Review of Resident #43's care plan dated 4/23/2025 read, Focus: The resident is on opioid medication therapy. Interventions: Administer ANALGESIC medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT [every shift]. Ask physician to review medication if side effects persist. Assess pain type, location, and characteristics before and after administration and document results. Encourage adequate fluid intake. Implement non-pharmacological interventions as required. Monitor bowel habits and implement bowel regimen as ordered. Monitor for increased risk for falls.</p> <p>Review of Resident #43's MAR (medication administration record) for the month of July 2025, documented by Staff F, LPN (licensed practical nurse), showed oxycodone 5 mg (milligram) tablet scheduled for 7/22/25 at 0000 (midnight), 7/22/25 at 0400 [4:00 am], 7/27/2025 at 2000 [8:00 PM], 7/28/2025 at 0000 [midnight], and 7/28/25 at 0400 [4:00 AM] was coded as 9 = other/see nurses notes.&rdquo;</p> <p>Review of #43's eMAR (electronic medication administration record) general note, authored by Staff F, LPN dated 7/22/2025 at 2:06 AM, read, OxyCODONE HCl Tablet 5 MG Give 1 tablet by mouth every 4 hours for Non acute pain. waiting on pharmacy.</p> <p>Review of #43's eMAR general note, authored by Staff F, LPN dated 7/22/2025 at 5:02 AM, 7/27/2025 at 21:13 (9:13 PM), 7/28/2025 at 00:19 (12:19 AM), 7/28/2025 at 5:06 AM read, OxyCODONE HCl Tablet 5 MG Give 1 tablet by mouth every 4 hours for Non acute pain.</p> <p>Review of Resident #43's MAR for the month of July 2025, documented by Staff G, LPN, showed oxycodone 5 mg tablet scheduled for 7/27/25 at 1600 [4:00 PM] was coded as 9 = other/see nurses note. &rdquo;</p> <p>(continued on next page)</p> | | |

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| <p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of Resident #43&rsquo;s eMAR general note, authored by Staff G, LPN, dated 7/27/2025 at 17:18 (5:18 PM) read, OxyCODONE HCl Tablet 5 MG Give 1 tablet by mouth every 4 hours for Non acute pain.</p> <p>Review of Resident #43&rsquo;s MAR for the month of July 2025, documented by Staff A, LPN, showed oxycodone 5 mg tablet scheduled for 7/28/2025 at 0800 [8:00 AM] and 7/28/2025 at 1200 [12:00 PM] was coded as 9 = other/see nurses note.&rdquo;</p> <p>Review of Resident #43&rsquo;s eMAR general note, authored by Staff A, LPN, dated 7/28/2025 at 10:38 AM and 7/28/2025 at 13:13 [1:13 PM], read, OxyCODONE HCl Tablet 5 MG Give 1 tablet by mouth every 4 hours for Non acute pain</p> <p>Review of Resident #43&rsquo;s MAR for the month of July 2025, documented by Staff B, LPN, showed oxycodone 5 mg tablet scheduled for 7/28/2025 at 2000 [8:00 PM] and 7/29/25 at 0000 [midnight] was coded as 9 = other/see nurses.&rdquo;</p> <p>Review of Resident #43&rsquo;s eMAR general note authored by Staff B, LPN dated 7/28/2025 at 21:42 [9:42 PM] and 7/29/2025 at 00:18 [12:18 AM] read, OxyCODONE HCl Tablet 5 MG Give 1 tablet by mouth every 4 hours for Non acute pain unable to retrieve from edk [emergency drug kit], no other staff in building all agency.</p> <p>Review of Resident #43&rsquo;s MAR for the month of July 2025 showed oxycodone 5 mg tablet scheduled for 7/29/2025 at 0400 [4:00 AM] had nothing documented on MAR for that time.</p> <p>Review of Resident #43&rsquo;s MAR for the month of August 2025, documented by Staff H, LPN, showed oxycodone 5 mg tablet scheduled for 8/2/2025 at 0400 [4:00 AM], was coded as 7 = sleeping.&rdquo;</p> <p>Review of Resident #43&rsquo;s MAR for the month of August 2025, documented by Staff C, LPN, showed oxycodone 5 mg tablet that was scheduled for 8/3/25 at 0000 [midnight] was coded as 7 = sleeping.&rdquo;</p> <p>Review of Resident #43&rsquo;s MAR for the month of August 2025, documented by Staff J, LPN, showed oxycodone 5 mg tablet scheduled for 8/4/2025 at 0000 [midnight] was coded as 7 = sleeping.&rdquo;</p> <p>Review of Resident #43&rsquo;s MAR for the month of August 2025, documented by Staff K, LPN, showed oxycodone 5 mg tablet that was scheduled for 8/10/2025, at 0800 [8:00 AM], was coded as 9 =&ldquo;other/see nurses.&rdquo;</p> <p>Review of Resident #43&rsquo;s MAR for the month of August 2025, documented by Staff K, LPN, showed oxycodone 5 mg tablet that was scheduled for 8/10/2025 at 1600 [4:00 PM], was coded as 7 = sleeping.&rdquo;</p> <p>Review of Resident #43&rsquo;s MAR for the month of August 2025, documented by Staff L, LPN, showed oxycodone 5 mg tablet that was scheduled for 8/17/2025 at 0800 [8:00 AM], was coded as 7 = sleeping.&rdquo;</p> <p>(continued on next page)</p> | | |

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| <p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>During an interview on 08/27/2025 at 11:15 AM, Director of Nursing (DON) stated, There needs to be two nurses to pull a narcotic from the EDK [emergency drug kit]. Agency nurses do not usually have access to the EDK. If there were no other Riverwood staff in the building, the nurse should have called the on-call nurse. The on-call nurse can help them access the EDK. We have one phone number, and they always call the same number. Another option is that the medication also could have been ordered STAT (Latin for immediately) from the pharmacy.</p> <p>During an interview on 08/27/2025 at 1:36 PM, Staff A, LPN stated, I documented a 9 on [Resident #43's name] MAR because it was probably a time when his pain medication had run out and the script [prescription] hadn't been signed or faxed over. If the script isn't signed, we can't pull it out of the [name of electronic medication dispenser] because the pharmacy will not accept it without a signature. How the process works is we print out the script for the doctor to sign, it gets put into a book, and when the doctor comes in during the week, he signs them. The nurses are supposed to print the script when it is running low, and they are supposed to put it in the doctor's binder. Running out of medications happens a lot with agency nurses, they either don't know how to do the refills process, or they just don't want to. If one of my residents runs out of pain medication, and I can't get it, I usually call the doctor or give another PRN [as needed] pain medication if they have one ordered. I am not sure why I didn't document a note when [Resident #43's name] ran out of pain medication. I probably thought I wrote it and accidentally didn't save it, or I may have overlooked it because I was on the phone with the doctor. I did call the doctor and faxed over the script. They brought his pain medication on the next pharmacy run. I should have documented that I called the doctor.</p> <p>During an interview on 08/27/2025 at 1:51 PM, Staff B, LPN stated, "On the night of July 28th and July 29th [2025], I was the only nurse who could get into the EDK [emergency drug kit], and it takes two nurses with access to be able to pull narcotics. The only other staff working that night were agency nurses. I had authorization from the pharmacy for [Resident #43's name] oxycodone, but there were no other staff that could get into the EDK. The facility does not have anyone on call for anything like that. I didn't call anyone, because there was no one to call. They knew I was the only staff in the building. I did not call the doctor; he couldn't have done anything. The medication didn't get refilled in time. The doctor has to do a new prescription. The prior nurse had called the pharmacy; the meds came the next day. I called the pharmacy when I couldn't get it out of the EDK. I told them I couldn't get it out, and they told me they couldn't help me.</p> <p>During an interview on 08/27/2025 at 2:33 PM, the Pharmacy Order Entry Technician stated "Stat deliveries are available to Riverwood, depending on what the medication is. Oxycodone and other common pain medications are available in the [name of automated medication dispensing machine]. If the nurse couldn't access it or if it was absolutely necessary, we would stat it out. We have a minimum of a four hour turnaround for STAT runs, because we have to find a driver. We do three runs, one midday, which cuts off at 11:30 AM, an overnight run at 11:30 PM, and a sweep run that cuts off at 4:00 AM. Cut offs to get orders in for deliveries are 10:30 AM and 10:30 PM. If a nurse called and told us that they couldn't get oxycodone out for a patient, I don't know why the nurse would be told that we can't help. We would be able to send a stat run to the facility, although of course there is an additional cost to the facility.</p> <p>During an observation on 08/27/2025 at 2:44 PM, the DON logged into the automated medication dispensing machine, and showed the surveyor the emergency medications that are always available, which included oxycodone 5 mg tablets.</p> <p>(continued on next page)</p> | | |

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| <p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>During an interview on 8/28/2025 at 11:03 AM Staff C, LPN stated "I don't normally hold scheduled meds when a resident is sleeping. I held [Resident #43's name] oxycodone on August third [8/3/2025] because he didn't have any in the card and there were no other staff in the facility to help me get it out of the [name of automated medication dispensing machine] and I don't have access. For [Resident #85's name], he didn't have the Oxycodone available last night, it arrived on dayshift after I left. I don't know what's in the [name of automated medication dispensing machine], and last night we had the same staff, so we wouldn't be able to get into the [name of automated medication dispensing machine] anyway. The supervisors should have been aware, the dayshift nurse told me the pain med wasn't available during the day. I did not receive any education when I started working at Riverwood. If I had an issue, I would just call the DON. I did not call the DON when I couldn't access the [name of automated medication dispensing machine], because one of her staff members called her and told her about it last night. The DON told me she would give me access to the [name of automated medication dispensing machine] going forward, even though I am agency."</p> <p>During an interview on 08/28/2025 at 1:49 PM, Staff G, LPN stated, "I may have held [Resident #43's name] oxycodone because he was running low on the medication and asked me to save the dose for later. The process when a patient is running low is to call pharmacy to see if a new prescription is needed. If a new one is needed, I call the doctor to get the prescription. If I can get the prescription from the doctor, I call pharmacy and get a verification code from the pharmacist. It takes two nurses to be able to pull meds from the [name of automated medication dispensing machine] if it is a narcotic. There have been some situations where I am the only nurse working in the facility that has access to the [name of automated medication dispensing machine]. When that happens, I call the pharmacy and see if they can send the medication stat. That is really the only option because there has to be two nurses, we can't override it. To find out what medications are available in the [name of automated medication dispensing machine], I have to call the pharmacy and ask."</p> <p>During an interview on 08/28/2025 at 12:28 PM, Dr. [NAME] stated Withdrawals could cause harm if a patient has been out of their narcotic pain medication for a long period of time, but it would take at least two days. I've been with [Resident #43's name] for a long period of time. He has chronic nausea .usually the nurses call me if [Resident #43's name] is out of pain medication or has missed a dose.</p> <p>Review of automated medication dispensing machine inventory log of medications to be available at all times, showed that oxycodone 5 mg tablets were stocked in the automated medication dispenser.</p> <p>Review of Medication Monitoring Control Record for oxycodone 5 mg tablet dated 7/22/2025 showed the last time oxycodone was signed out for Resident #43 was 7/27/25 at 4:00 PM, remaining oxycodone tablets were 0.</p> <p>Review of Medication Monitoring Control Record showed that the next time oxycodone 5 mg tablets were delivered from pharmacy for Resident #43 was on 7/29/2025.</p> <p>Review of staff education titled Pain Management Protocols read, Scripts should be printed and ready for the physician to sign before the card is empty, typically 7 days remaining&hellip;.If a pain medication is unable to be retrieved through the [name of automated medication dispensing machine] or via stat delivery from the pharmacy, you must notify the physician and nurse manager or DON for review.</p> <p>(continued on next page)</p> | | |

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| <p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>2. During an interview on 8/27/2025 at 3:06 PM, Resident #86 stated, My pain level is an 8 right now. When I ask for it, they bring me pain medicine. It helps some. They have brought it every time I asked, but I have to ask for it.</p> <p>Review of Resident #86's admission record documented an admission date of 8/05/2022 with medical diagnoses including chronic pain syndrome, pain in left leg, pain in right leg, pain in left knee, pain in right knee, pain unspecified, restless legs syndrome, essential (primary) hypertension, and hyperlipidemia.</p> <p>Review of Resident #86's physician order dated 11/15/2024 read, Percocet Oral Tablet 10-325 MG (Oxycodone with Acetaminophen milligram) Controlled Drug Give 1 tablet enterally every 6 hours for Chronic Pain Management. Please hold for lethargy.</p> <p>Review of Resident #86's medication administration record (MAR) for June 2025, documented by Staff A, Licensed Practical Nurse (LPN), showed Percocet 10-325 mg tablet scheduled for 6/30/2025 at 1800 [6:00 PM] was coded as 9 = other/see nurses note.&rdquo;</p> <p>Review of Resident #86's electronic medication administration record (eMAR) progress note, authored by Staff A, LPN, dated 6/30/2025 at 17:27 [5:27 PM] read, Percocet Oral Tablet 10-325 MG Give 1 tablet enterally every 6 hours for Chronic Pain Management, please hold for lethargy. Pharmacy has not arrived with medication.</p> <p>Review of Resident #86's MAR for July 2025, documented by Staff E, LPN, showed Percocet 10-325 mg tablet scheduled for 7/1/2025 at 0000 [midnight] was coded as 9 = other/see nurses note.&rdquo;</p> <p>Review of Resident #86's eMAR progress note, authored by Staff E, LPN, dated 7/1/2025 at 01:37 AM read, Percocet Oral Tablet 10-325 MG Give 1 tablet enterally every 6 hours for chronic pain management, please hold for lethargy. D/C [discontinue].</p> <p>Review of Resident #86's MAR for July 2025, documented by Staff E, LPN, showed Percocet 10-325 mg tablet scheduled for 7/1/2025 at 0600 [6:00 AM], 7/25/2025 at 0600 [6:00 AM] ,was coded as &ldquo;9 = other/see nurses note.&rdquo;</p> <p>Review of Resident #86's eMAR progress note, authored by Staff E, LPN, dated 7/1/2025 at 05:19 [5:19 AM] read, Percocet Oral Tablet 10-325 MG Give 1 tablet enterally every 6 hours for chronic pain management. please hold for lethargy.</p> <p>Review of Resident #86's eMAR progress note, authored by Staff E, LPN, dated 7/25/2025 at 19:13 [7:13 PM] read, Percocet Oral Tablet 10-325 MG Give 1 tablet enterally every 6 hours for chronic pain management, please hold for lethargy, resident with family.</p> <p>Review of Resident #86's MAR for August 2025, documented by Staff D, LPN, showed Percocet 10-325 mg tablet scheduled for 8/5/2025 at 1200 [12:00 PM], 8/5/2025 at 1800 [6:00 PM] was coded as &ldquo;5 = hold/see nurses note.&rdquo;</p> <p>Review of Resident #86's eMAR progress note, authored by Staff D, dated 8/5/2025 at 13:20 [1:20 PM], 8/5/2025 at 17:52 [5:52 PM] read, Percocet Oral Tablet 10-325 MG Give 1 tablet enterally every 6 hours for chronic pain management. please hold for lethargy.</p> <p>(continued on next page)</p> | | |

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| <p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of Resident #86's MAR for August 2025 showed the documentation for Percocet 10-325 mg tablet scheduled for 8/5/2025 at 0600 [6:00 AM] and 8/7/2025 at 1800 [6:00 PM] blank.</p> <p>Review of Resident #86's progress notes documented no nursing notes to explain why the resident did not receive scheduled Percocet 10-325 mg tablet on 8/5/25 at 0600 [6:00 AM] and 8/7/2025 at 1800 [6:00 PM].</p> <p>During an interview on 8/28/2025 at 10:15 AM, Staff E, LPN, stated, "I held [Resident #86's name] Percocet in July because she refused it. She said it made her sleepy. Usually, I would write a note for that, so I am not sure why there wasn't a note. Agency nurses don't have access to the [name of automated medication dispensing machine], and they have mostly agency nurses in the building. You have to have two staff there to pull out narcotics with an authorization code. It has happened before where there weren't two staff available to be able to pull medications out of the [name of automated medication dispensing machine]. If that happens we tell the supervisor, and they get it. There is an on-call number for supervisors, I have it in my phone. I have been working for them for a while, so I don't remember how I originally got the phone number. I did receive an education packet when I first started, and I remember signing for it."</p> <p>During an interview on 8/28/2025 at 9:40 AM, Staff D, LPN, stated, "I remember [Resident #86's name], I held her Percocet on August 5th [8/5/2025] because she didn't want it at the time, she wanted Tylenol instead. I don't see that I put a note in. I probably was busy and forgot to document it. Normally I would put a note in. We are supposed to put a note in when a resident is refusing, or the medication is held.</p> <p>Review of policy and procedure titled, Pain Screening and Management reviewed 1/17/2025 read, Policy: It will be the policy of this facility to screen residents and attempt to provide effective pain and comfort management. Procedure: 3. Attempt to obtain physician's orders for pain management, if needed. 4. Administer pain medications according to physician's orders and resident request for PRN [as needed] medications.</p> <p>3. During an interview on 8/28/2025 at 12:10 PM, Resident #85 stated that he had been told something about the facility being out of his pain medication, and that was why he had missed several doses. He has pain all the time and it had been worse over the past couple of days.</p> <p>Review of Resident #85's admission record documented an admission date of 12/06/2021 with medical diagnoses including nontraumatic compartment syndrome of abdomen (a painful condition that causes an increase in pressure inside a muscle which restricts blood flow), quadriplegia, C5-C7 (cervical spine 5 through cervical spine 7) incomplete (a medical condition which causes severe loss of function of the arms and legs), and chronic pain syndrome.</p> <p>Review of Resident #85's care plan documented a focus that read, "The resident is on opioid (prescription pain medications) medication therapy r/t (related to) chronic pain with a goal that moderate to severe pain will be reduced to tolerable level. Interventions included administer analgesic (medications that relieve pain) medications as ordered by physician and monitor/document side effects and effectiveness Q-SHIFT (every shift).</p> <p>(continued on next page)</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105488 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/29/2025 |
| NAME OF PROVIDER OR SUPPLIER Riverwood Healthcare & Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 808 S Colley Rd Starke, FL 32091 | |
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| <p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of Resident #85's consultation note read, &ldquo;Pain Management 11-22-24, HPI (History of presenting illness): [Resident #85&rsquo;s name] is a [AGE] year old male who was admitted to this facility in 2021 following acute care hospitalization for central cord syndrome. He was hit by a scooter while riding his bike and sustained multiple traumatic injuries to the head and neck. Hospital records reviewed&hellip;.Plan of care: Plan of care discussed with the nursing team. Pain regimen as follows: Opioid or Narcotic Therapy - Oxycodone HCl (Hydrochloride) Oral Tablet 10 MG (milligram) Scheduled dose: 4 tablets/day = 40 mg/day; PRN (Latin for pro re nata meaning when necessary) dose: Up to 2 additional doses/day = 20 mg/day; Total maximum: 60 mg/day MME (morphine milligram equivalents)/day: 60 mg oxycodone &times; 1.5 (conversion factor) = 90 MME/day.&rdquo;</p> <p>Review of Resident #85&rsquo;s physician order dated 6/4/2025 read, &ldquo;oxycodone HCl Oral Tablet 10 MG (milligrams) (Oxycodone HCl) Give 10 mg by mouth every 6 hours for chronic non-acute pain.&rdquo;</p> <p>Review of Resident #85's Medication Administration Record (MAR) for June 2025 scheduled doses for oxycodone HCl Oral Tablet 10 MG (milligrams) (Oxycodone HCl) Give 10 mg by mouth every 6 hours for chronic non-acute pain on 6/17/25 at 12:00 AM, and 6/27/25 at 12:00 PM were not documented as administered.</p> <p>Review of Resident #85&rsquo;s progress notes for 6/17/2025 through 6/26/25 showed no documented notes regarding pain, pain medications, physician or pharmacy contact.</p> <p>Review of Resident #85's MAR for July 2025 schedule dose for oxycodone HCl Oral Tablet 10 MG (milligrams) (Oxycodone HCl) Give 10 mg by mouth every 6 hours for chronic non-acute pain on 7/26/25 at 12:00 AM was not documented as administered.</p> <p>Review of Resident #85&rsquo;s progress notes for 7/26/25 showed no documented notes regarding pain, pain medications, physician or pharmacy contact.</p> <p>Review of Resident #85's MAR for August 2025 scheduled doses on 8/12/25 at 12:00 AM, 8/12/25 at 6:00 PM, 8/21/25 at 6:00 PM, 8/26/25 at 6:00 AM, 8/26/25 at 12:00 PM, 8/26/25 at 6:00 PM, 8/27/25 at 12:00 AM, and 8/27/25 at 6:00 AM were not documented as administered.</p> <p>Review of Resident #85&rsquo;s progress note dated 8/26/2025 at 06:29 (6:29 AM) read, &ldquo;e-Mar (electronic MAR) - General Note from e-Record Note Text: oxyCODONE HCl Oral Tablet 10 MG: Give 10 mg by mouth every 6 hours for Chronic non-acute pain awaiting pharmacy</p> <p>Review of Resident #85&rsquo;s progress note dated 8/27/2025 at 00:54 (12:54 AM) read, &ldquo; e-Mar - General Note from e-Record Note Text: oxyCODONE HCl Oral Tablet 10 MG: Give 10 mg by mouth every 6 hours for Chronic non-acute pain awaiting pharmacy delivery.</p> <p>Review of Resident #85&rsquo;s progress notes dated 8/12/25 and 8/21/25 showed no notes regarding Oxycodone, pharmacy delays, or physician contact for pain medications.</p> <p>Review of the Medication Monitoring/Control Record form showed no record of available Oxycodone 10MG Tablets specifically for Resident #85 between the dates of 8/25/25 at 11:22 PM and 8/27/25 at 12:00 PM.</p> <p>(continued on next page)</p> | | |

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| <p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>During an interview on 8/27/2025 at 11:42 AM, the DON (Director of Nursing) stated that her expectation was that nurses administered medications as ordered, and if they were unable to administer the medication, they were to contact the physician and their supervisor or her.</p> <p>During an interview on 8/28/2025 at 10:42 AM, Staff D, LPN (Licensed Practical Nurse), stated that she held Resident #85's Oxycodone and marked 7 on the MAR on 8/21/25 at 6:00 PM because he appeared drowsy or lethargic, but she must have forgotten to document a note.</p> <p>During an interview on 8/28/2025 at 12:38 PM, Physician #1 stated that she did not recall being contacted earlier in the week regarding Resident #85's Oxycodone medication. If the facility had run out of the resident's prescribed Oxycodone, she thought they would obtain the necessary doses from their emergency supply until the pharmacy could refill the prescription. It was not her practice to hold a medication if the facility had run out of it.</p> <p>During an interview on 8/28/2025 at 1:37 PM, Staff O, LPN, stated that he was not sure whether he gave Resident #85's Oxycodone 10mg at 6:00 AM on 8/26/25. He wasn't sure why he would have documented a 9 in the EMR (electronic medical record). He had worked in the facility for a couple of months. He had not been provided any orientation or education to the facility&hellip; He didn't believe the facility had a (name of the automated medication dispensing machine), and if they did, he did not have access to it.</p> <p>During an interview on 8/28/2025 at 3:25 PM, Staff P, LPN, stated that she had worked in the facility one time. She did not recall Resident #85, or whether she had administered a dose of Oxycodone at 12:00 PM on 6/27/25. She had never had access to the (name of the automated medication dispensing machine) and did not receive any education or orientation from the facility. She was not provided with any information regarding an on-call nurse or a phone number for the DON (Director of Nursing).</p> <p>During an interview on 8/28/2025 at 3:42 PM, Staff Q, LPN, stated that she remembered Resident #85 and she believed that when she checked a 7 on 7/26/25 at midnight on his MAR, it was because he was sleeping, and she did not administer his scheduled dose of Oxycodone 10mg. She had not written a note or taken any other actions. There had been times when medications for her residents were not available.</p> <p>During an interview on 8/29/2025 at 12:46 PM, Staff R, LPN, stated that she remembered Resident #85 by name but did not recall taking care of him or any details regarding medication administration from 6/17/25. If she charted a 7 for his scheduled Oxycodone at midnight, she believed it would have been because he was sleeping, and she assumed that was sufficient documentation. She did not contact the doctor or take any other action steps.</p> <p>During an interview on 08/29/2025 at 2:10 PM, the Regulatory Compliance Consultant stated that they needed to ensure their residents received the care they needed, especially when it came to pain management.</p> | | |

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| <p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>(continued on next page)</p> |

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| <p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Based on observations, interviews, and record reviews, the facility failed to ensure that sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, including those employed through nurse staffing agencies, as identified through resident assessments and described in the plan of care. Findings include:1. During an interview on 8/28/2025 at 12:10 PM, Resident #85 stated that he had been told something about the facility being out of his pain medication, and that was why he had missed several doses. He has pain all the time and it had been worse over the past couple of days.Review of Resident #85's admission record documented an admission date of 12/06/2021 with medical diagnoses including nontraumatic compartment syndrome of abdomen (a painful condition that causes an increase in pressure inside a muscle which restricts blood flow), quadriplegia, C5-C7 (cervical spine 5 through cervical spine 7) incomplete (a medical condition which causes severe loss of function of the arms and legs), and chronic pain syndrome.Review of Resident #85's physician order dated 6/4/2025 read, oxycodone HCl Oral Tablet 10 MG (milligrams) (Oxycodone HCl) Give 10 mg by mouth every 6 hours for chronic non-acute pain. Review of Resident #85's Medication Administration Record (MAR) for June 2025 scheduled doses for oxycodone HCl Oral Tablet 10 MG (milligrams) (Oxycodone HCl) Give 10 mg by mouth every 6 hours for chronic non-acute pain on 6/17/25 at 12:00 AM, and 6/27/25 at 12:00 PM were not documented as administered.Review of Resident #85's progress notes for 6/17/2025 through 6/26/25 showed no documented notes regarding pain, pain medications, physician or pharmacy contact. Review of Resident #85's MAR for July 2025 schedule dose for oxycodone HCl Oral Tablet 10 MG (milligrams) (Oxycodone HCl) Give 10 mg by mouth every 6 hours for chronic non-acute pain on 7/26/25 at 12:00 AM was not documented as administered.Review of Resident #85's progress notes for 7/26/25 showed no documented notes regarding pain, pain medications, physician or pharmacy contact.Review of Resident #85's MAR for August 2025 scheduled doses on 8/12/25 at 12:00 AM, 8/12/25 at 6:00 PM, 8/21/25 at 6:00 PM, 8/26/25 at 6:00 AM, 8/26/25 at 12:00 PM, 8/26/25 at 6:00 PM, 8/27/25 at 12:00 AM, and 8/27/25 at 6:00 AM were not documented as administered.Review of Resident #85's progress note dated 8/26/2025 at 06:29 (6:29 AM) read, e-Mar (electronic MAR) - General Note from e-Record Note Text: oxyCODONE HCl Oral Tablet 10 MG: Give 10 mg by mouth every 6 hours for Chronic non-acute pain awaiting pharmacyReview of Resident #85's progress note dated 8/27/2025 at 00:54 (12:54 AM) read, e-Mar - General Note from e-Record Note Text: oxyCODONE HCl Oral Tablet 10 MG: Give 10 mg by mouth every 6 hours for Chronic non-acute pain awaiting pharmacy delivery.Review of Resident #85's progress notes dated 8/12/25 and 8/21/25 showed no notes regarding Oxycodone, pharmacy delays, or physician contact for pain medications.2. During an interview on 08/27/2025 at 11:10 AM, Resident #43 stated, I don't remember the exact date, but when I was waiting on my pain medicine last month, pharmacy didn't bring it for a long time, and I started going through withdrawals. I was sweating and nauseous. I had a lot of anxiety. I did go to the hospital the next day for chest pains, but I don't think it was related. I was told the chest pain was due to my muscle.Review of Resident #43's admission record documented an admission date of 4/22/2025 with medical diagnoses that included spinal stenosis, cervical region, diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified fracture of right lower leg, central pain syndrome, and muscle spasm of back.Review of Resident #43's physician order dated 7/17/2025 read, OxyCODONE HCl (hydrochloride) Tablet 5 MG (milligram) Controlled Drug Give 1 tablet by mouth every 4 hours for Non acute pain.Review of Resident #43's MAR (medication administration record) for the month of July 2025, documented by Staff F, LPN (licensed practical nurse), showed oxycodone 5 mg (milligram) tablet scheduled for 7/22/25 at 0000 (midnight), 7/22/25 at 0400 [4:00 am], 7/27/2025 at 2000 [8:00 PM], 7/28/2025 at 0000 [midnight], and 7/28/25 at 0400 [4:00 AM] was coded as 9 = other/see nurses notes.Review of #43's eMAR (electronic medication administration record) general note, authored by Staff F, LPN dated 7/22/2025 at 2:06 AM, read, OxyCODONE HCl Tablet 5 MG Give 1 tablet by mouth every 4 hours for Non acute pain. waiting on pharmacy.Review of #43's eMAR general note, authored by Staff F, LPN dated 7/22/2025 at 5:02 AM, 7/27/2025 at 21:13 (9:13 PM), 7/28/2025 at 00:19 (12:19 AM), 7/28/2025 at 5:06 AM read, OxyCODONE HCl Tablet 5 MG Give 1 tablet by mouth every 4 hours for Non acute pain.Review of Resident #43's MAR for the month of July 2025, documented by Staff G, LPN, showed oxycodone 5 mg tablet scheduled for 7/27/25 at 1600 [4:00 PM] was coded as 9 = other/see nurses note Review of Resident #43's eMAR general note</p> | | |

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| <p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Post nurse staffing information every day.</p> <p>Based on observation and interview, the facility failed to ensure the nurse staffing data was posted on a daily basis. Findings include: During an observation on 8/25/2025 at approximately 9:00 AM, the Daily Nursing Staffing Form, was dated August 22, 2025. (photographic evidence) During an interview on 8/28/2025 at approximately 8:45 AM, the DON (Director of Nursing) stated that the Staffing Coordinator was responsible for posting the daily staffing report. On the weekend, it was the Weekend Receptionist's responsibility to post the staffing report. Her expectation was that the staffing report would be posted 1st thing in the morning. During an interview on 8/28/2025 at 8:50 AM, the Staffing Coordinator stated that on Fridays she put the staffing reports up for Friday, and places the Saturday and Sunday reports behind it. The Weekend Receptionist switches them out each day. She puts the staffing report up daily before day shift starts at 6:45 [AM]. She confirmed that the correct staffing report was not posted at 9:00 AM on Monday.</p> |

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| <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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure food products were stored and maintained in a safe and sanitary manner in 2 of 2 nourishment rooms. Findings include: During an observation of nourishment room [ROOM NUMBER] on 8/25/2025 at 9:32 AM, there were 5 chocolate milks with an expiration date of 8/21/2025 in the bottom drawer of the refrigerator. There was a Tupperware container and a bag of sandwiches that were undated and unlabeled. During an interview on 8/25/2025 at 9:32 am, the Certified Dietary Manager in training stated that she was unaware of who is responsible to ensure all food is dated and labeled in the nourishment rooms. During an observation of nourishment room [ROOM NUMBER] on 8/25/2025 at 9:40 AM, there was a 20 ounce cup half full of liquid that was unlabeled and undated and there were two fortified nutritional shakes that were undated. During an interview on 8/28/2025 at 2:42 PM, the Administrator stated, Nursing staff should be responsible for dating/labeling food items in the refrigerators/freezers in the nourishment rooms for residents and visitors. The kitchen is responsible for dating the shakes. During an interview on 8/28/2025 at 2:34 PM, the Regional Food Service Manager stated, t we [dietary] are responsible for cleaning the refrigerators/freezers in the nourishment rooms daily and the facility is responsible for dating and labeling food items. Review of the policy titled Food: Safe Handling for Food from Visitors, last review 8/1/2025, read, Policy Statement: Residents will be assisted in properly storing and safely consuming food brought into the facility for residents by visitors. 4. When food items are intended for later consumption, the responsible facility staff member will: ensure that the food is stored separate or easily distinguishable from the facility, ensure that food are in a sealed container to prevent cross contamination, label foods with the resident name and current date.</p> | | |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to accurately and completely document resident information in the medical record for 1 (Resident #122) of 3 closed records reviewed. Findings include: Review of the admission record for Resident #122 documented an admission date of [DATE] with diagnosis that included essential (primary) hypertension, iron deficiency anemia unspecified, pain unspecified, other specified depressive episodes, heart failure unspecified, constipation unspecified, unspecified dementia unspecified severity without behavioral disturbance psychotic disturbance mood disturbance and anxiety, schizoaffective disorder bipolar type, anemia in other chronic diseases classified elsewhere, deficiency of other specified b group vitamins, other specified disorders of bone density and structure unspecified site, personal history of covid-19, tachycardia unspecified, tremor unspecified, and anxiety disorder unspecified. Review of Resident #122's nursing progress notes on [DATE] showed there was no documentation of resuscitation efforts, no progress notes, and no documentation of Resident #122's death in the facility. Review of Resident #122's form titled, SNF (skilled nursing facility)/NF (nursing facility) to Hospital Transfer Form dated [DATE] at 07:47 (7:47 AM) read, Report called into [NAME] County EMS (Emergency Medical Services). During an interview on [DATE] at 11:14 AM, Staff Q, Registered Nurse (RN) stated, I had a page code to the front in room [ROOM NUMBER]. When I got there, they were already doing CPR (cardiopulmonary resuscitation) and ambu (commonly refers to meaning using an ambu bag to provide air to a person who is not breathing) at the time. We continued until EMS arrived, they take over once they get here. He was pronounced dead by EMS while he was here. There are code documentation sheets that document what happens. The form was completed and I gave it to the DON (Director of Nursing). He (Resident #122) was not transferred to the hospital. During an interview on [DATE] at 11:17 AM, Staff R, RN stated, I had responded to the code and assisted [Nurses name] with compressions (performing CPR). EMS arrived and pronounced the resident. We should have a detailed note in the chart about what happened. He (Resident #122) was not transferred to the hospital he was pronounced here. EMS left and we do the rest. During an interview on [DATE] at 11:50 AM, the Director of Nursing (DON) stated we do not have any code sheet documentation. We checked medical records, there isn't one we can find. There should be a note in his record that he was coded and expired after EMS came. Review of the policy and procedure titled, Charting and Documentation last approval date of [DATE] read, Policy: It is the policy of this facility that services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's clinical record as is needed. Procedure: 1. Observations, medications administered, services performed, etc., should be documented in the resident's clinical record. 2. Incidents, accidents, or changes in the resident's condition should be recorded in the clinical record. 3. Entries into the clinical record should be made by the appropriate staff members. Staff providing care and services to the resident may contribute to the overall documentation in the clinical record in accordance with state and federal laws.</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and record review and policy and procedure review, the facility failed to ensure staff used appropriate Personal Protective Equipment (PPE) and performed hand hygiene upon entering and exiting residents rooms while providing care to residents on enhanced barrier precautions, failed to perform hand hygiene when administering medications in 7 of 11 observations of medication administration, when obtaining vital signs and when caring for respiratory care equipment to prevent the possible spread of infection and communicable diseases. Findings include:</p> <p>1. During an observation on 8/25/2025 at 1:40 PM, Resident #28 was observed sitting in bed with a right upper arm midline catheter with gauze under transparent dressing dated 8/18/2025. There was a completed Intravenous (IV) bag of antibiotics attached to the midline. There was enhanced barrier precaution signage on the doorway and available PPE (personal protective equipment) in the hallway. Staff O, Licensed Practical Nurse (LPN) entered the residents room to flush the midline catheter. Staff O did not don a gown, without performing hand hygiene Staff O, donned gloves and administered 10 milliliters of normal saline flush and did not clean the hub of the needleless connector. After removing the IV tubing, the hub of the needless connector fell onto the bed linens and residents arm. Staff O, LPN, removed gloves and returned to medication cart without performing hand hygiene and began to prepare medications for another resident.</p> <p>Review of Resident #28's admission record documented diagnosis that include aftercare following joint replacement surgery, presence of right artificial knee joint, disruption or dehiscence of closure of other unspecified internal operation surgical wound, subsequent encounter, and infection and inflammation reaction due to internal fixation device of other sites subsequent encounter.</p> <p>Review of Resident #28's comprehensive care plan documented a focus: "Resident is at risk for infection and enhanced barrier precautions (EBP) are indicated due to: Indwelling medical devices with interventions that included employ enhanced barrier precautions when performing high contact resident care (dressing, bathing, transferring in room/shower/therapy, personal hygiene assistance, changing linens, changing briefs, toileting, device care, wound care, therapy services).</p> <p>During an interview on 8/25/2025 at 2:01 PM, Staff O), LPN, stated, "I did not wash my hands before I put on the gloves. He [Resident #28] is on enhanced barrier precautions because of his line. I thought I didn't need to put on a gown. I guess I should have done that."</p> <p>2. During an observation on 8/27/2025 ending at 7:09 AM, Staff S, Certified Nursing Assistant (CNA) performed incontinence care on Resident #10 without gown, signage for enhanced barrier precautions was on the door and PPE (personal protective equipment) supplies were in hallway. Staff S, CNA entered the room with supplies, donned gloves without performing hand hygiene, provided care, removed gloves and exited room without performing hand hygiene.</p> <p>During an interview on 8/27/2025 at 7:15 AM, Staff S, CAN, stated, "I should have put a gown on, I thought I did use hand sanitizer."</p> <p>(continued on next page)</p> | | |

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| NAME OF PROVIDER OR SUPPLIER Riverwood Healthcare & Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 808 S Colley Rd Starke, FL 32091 | |
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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>3. During an observation on 8/27/2025 at 7:12 AM, Staff T, CNA, entered Resident #10's room, obtained vital signs without performing hand hygiene and without putting on a gown. Staff T, CAN, left the residents room at 7:14 AM and went to med cart without performing hand hygiene. Staff T, CAN, returned to Resident #10's room without performing hand hygiene and rechecked blood pressure and exited the residents room without performing hand hygiene and went to another residents room to obtain a blood pressure. On 8/27/2025 at 7:20 AM, Staff T, CAN, entered Resident #16's room without performing hand hygiene and obtained blood pressure on Resident #16. Staff T assisted resident to reposition and took residents blood pressure, exited the room without performing hand hygiene. On 8/27/2025 at 7:25 AM, Staff T, CNA, entered Resident #63's room without performing hand hygiene and obtained a blood pressure on the resident and exited the room without performing hand hygiene. On 8/27/2025 at 7:27 AM, Staff T, CNA, entered Resident #23's room without performing hand hygiene, obtained residents blood pressure and exited the room without performing hand hygiene.</p> <p>During an interview on 8/27/2025 at 8:10 AM, Staff T, CNA, stated, "I didn't realize that I didn't use hand sanitizer, I should have."</p> <p>4. During an observation of medication administration on 8/28/2025 at 5:05 AM, Staff U, LPN, wheeled medication cart down hallway, retrieved keys from their pocket, unlocked the medication cart, activated and typed on the computer and prepared medication without performing hand hygiene, entered Resident #38's room without performing hand hygiene, touched bed controls, administered medication and exited the room returning to the medication without performing hand hygiene.</p> <p>5. During an observation of medication administration on 8/28/2025 at 5:13 AM Staff U, LPN, returned to medication cart, retrieved keys from their pocket, unlocked the medication, activated and typed on the computer, and prepared medications without performing hand hygiene. Staff U, LPN, entered Resident #113's room without performing hand hygiene, removed a bipap (bilevel positive airway pressure) mask from the resident, adjusted the bed control to a higher position and administered the oral medications without performing hand hygiene, donned gloves without performing hand hygiene, prepared the nebulized medications and adjusted the face mask on Resident #113, doffed gloves and exited the room returning to the medication cart without performing hand hygiene and began preparing medications for another resident.</p> <p>6. During an observation of medication administration on 8/28/2025 at 5:16 AM, Staff U, LPN, removed keys from pocket, unlocked the medication cart, activated and typed on computer keyboard, prepared medications for Resident #85, unlocked narcotic drawer with keys, signed narcotic out on the sheet without performing hand hygiene. Staff U, LPN, entered Resident #85's room without performing hand hygiene, touched a specialty cup that was positioned on the floor with a long straw that resident used, administered the medication and exited the room without performing hand hygiene and went to the medication cart and began to prepare medications for another resident.</p> <p>During an interview on 8/28/2025 at 7:15 AM, Staff U, LPN, stated, "I should have used hand sanitizer more."</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>7. During an observation of medication administration on 8/28/2025 at 5:25 AM, Staff W, LPN, donned gloves without performing hand hygiene and obtained Resident #14's blood pressure, doffed gloves without performing hand hygiene and returned to the medication cart, removed keys from their pocket, unlocked the medication cart, activated and typed on the computer keyboard and prepared medications. Staff donned gloves without performing hand hygiene, did not don gown, entered Resident #14's room and administered gastrostomy tube medications after verifying placement. Staff W, LPN removed gloves without performing hand hygiene and returned to the medication cart to administer another residents medications.</p> <p>8. During an observation of medication administration on 8/28/2025 at 5:43 AM, Staff W, LPN, removed keys from their uniform pocket and unlocked the medication cart, activated the computer and typed on the keyboard without performing hand hygiene. Staff W, LPN, prepared medications and entered Resident #115's room without performing hand hygiene, administered the medication and exited the room without performing hand hygiene returning to the medication cart and began preparing medications for another resident.</p> <p>9. During an observation of medication administration on 8/28/2025 at 5:51 AM, Staff W, LPN, returned to the medication cart without performing hand hygiene, removed keys from their uniform pocket and unlocked the medication cart, activated the computer and typed on the keyboard without performing hand hygiene. Staff W, LPN donned gloves, and prepared medications, entered Resident #103's room with gloves, removed gloves, donned new gloves without performing hand hygiene, administered oral medications and doffed gloves, donned new gloves without performing hand hygiene, obtained blood sample for blood sugar, doffed gloves and returned to medication without performing hand hygiene. Staff W, LPN, removed keys from their uniform pocket, unlocked the medication cart, activated and typed on keyboard of computer, and attempted to find insulin but was unable to locate in medication cart. Staff W locked the medication cart went to and unlocked medication room, unlocked the medication refrigerator, obtained Resident #103's insulin returned to the medication cart, prepared the insulin, donned gloves without performing hand hygiene. Staff W, LPN, entered Resident #103's room, administered the insulin in the left arm, doffed gloves, and returned to the medication cart without performing hand hygiene and began to prepare medications for another resident.</p> <p>10. During an observation of medication administration on 8/28/2025 at 6:00 AM, Staff P, LPN, donned gloves without performing hand hygiene, assembled supplies entered the Resident #114's room without donning gown, removed intravenous tubing from the midline catheter, cleansed the needleless connector with alcohol and provided a 10 milliliter (ML) flush. Staff P, LPN, doffed gloves without performing hand hygiene and returned to the cart and began to prepare medications for another resident.</p> <p>During an interview on 8/28/2025 at 6:10 AM Staff P, LPN stated, "I don't think I would have changed anything that I did during this observation. Well, I put on gloves, and I did the flush. I don't think that I need to put on a gown. I don't think she is on enhanced barrier precautions (EBP). I don't know what the rules for the EBP are. I don't think that I'm supposed to use a gown. I should have used hand sanitizer, I don't know why I didn't.</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of the policy and procedure titled "Enhanced Barrier Precautions"; last revision date of 8/1/2025, read, "Policy: It will be the policy of this facility to implement enhanced barrier precautions for preventing transmission of novel or target multidrug-resistant organisms (MDRO). Procedure: 2. Initiation of Enhanced Barrier Precautions - b. An order for enhanced barrier precautions will be obtained for residents with any of the following: ii. Indwelling medical devices (e.g. central line, urinary catheter, feeding tube, tracheostomy/ ventilator, etc.) regardless of MDRO status colonization status. 4. For residents for whom EBP are indicated, EBP is employed when performing the high-contact resident care activities: g. Device care or use: central lines";</p> <p>Review of Policy and Procedure titled, "Hand hygiene"; last revision date of 8/1/2025 read, "Policy: This facility considers hand hygiene the primary means to prevent the spread of infections. Procedure: 2. All personnel shall follow the handwashing/hand hygiene procedures to prevent the spread of infections to other personnel, residents, and visitors. 5. Use an alcohol-based hand rub containing at least 62 % alcohol; or alternatively, soap (antimicrobial or non antimicrobial) and water for the following situations. B. Before and after direct contact with residents. C. Before preparing or handling medications: e. Before and after handling an invasive device (e.g. urinary catheters, IV access sites); After contact with residents intact skin; l. After contact with objects (medical equipment) in the immediate vicinity of the resident; m. After removing gloves. 6. Hand hygiene is the final step after removing and disposing of personal protective equipment. 7. The use of gloves does not replace handwashing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. "</p> <p>11. During an observation of Resident #38's room on 8/25/25 at 8:30 AM, the oxygen concentrator next to his bed had the water humidification bottle sitting on the floor connected to concentrator. (photographic evidence obtained)</p> <p>During an interview on 8/26/25 on 8:53 AM, the Infection Preventionist stated that the water humidification bottle should not be on the floor.</p> <p>12. During an observation on 8/27/2025 at 8:27 AM, Staff M, CNA, took a breakfast tray into Resident #26's room, asked if she was ready to eat and proceeded to close the door. She did not perform hand hygiene before entering the room or before assisting Resident #26 with her breakfast.</p> <p>During an observation on 8/27/2025 at approximately 8:40 AM, Staff M, CNA, picked up Resident #26's breakfast tray, returned it to the food cart, removed another resident's tray, without performing hand hygiene, and carried the tray into Resident #94's room.</p> <p>During an interview on 8/27/2025 at 8:45 AM, Staff M, CNA, stated that she knew she was supposed to wear gloves all the time and sanitize [her hands] before and after performing patient care.</p> | | |

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| <p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the call device was within reach for 1 (Resident #6) out of 8 residents evaluated for call device accessibility. During an observation on 08/25/2025 at 10:14 am Resident #6 was observed laying on his back, on a pad in bed, wearing nothing except a brief. The call device was hanging on the wall on the side of the resident's feet, not in reach. During an observation on 08/25/2025 at 10:26 AM Resident #6 was observed laying in the same position, on his back in bed, wearing nothing but a brief, with no call device in reach. No blankets on the bed. The overbed table containing the breakfast tray was in the same position, over the bed in the area of the resident's lap. During an observation on 08/25/2025 at 11:00 AM Resident #6 was laying in bed on his back, wearing only a brief. There was a fitted sheet and a pad on the bed, with no blankets. The breakfast tray was removed, and the over bed tablet was on the side of the bed. The call device was hanging on the wall on the left side of the resident's feet, not in reach. During an observation on 08/26/2025 at 9:04 AM Resident #6 was observed laying on his back in bed, dressed in a gown, with a blanket on. The resident appeared well-groomed, and his beard contained a white flaky substance. The call device was hanging on the wall by his feet, not in reach. During an observation on 08/27/2025 at 8:22 AM Resident #6 was observed laying flat in bed on his back, dressed in a gown, with a blanket on. The call device was on the floor at the foot of the bed. During an observation on 08/27/2025 at 8:37 AM, Resident #6 was observed sitting up in bed eating breakfast consisting of hash browns, oatmeal, and biscuits with gravy. There was a clear plastic cup containing a yellow liquid. The call device was on the floor at the foot of the bed. During an interview on 08/28/2025 at 2:48 AM, The Director of Nursing confirmed that Resident #6 should have had his call device within reach. I expect the staff to place the call devices in reach of the residents at all times. Review of Resident #6 care plan dated 6/19/2025 read, Focus: ADL [activities of daily living] CARE PLAN: The resident has an ADL/self-care performance deficit r/t ADL needs and participation may vary, cognitive impairment. Interventions: Encourage to use call bell for ADL assist. Review of policy and procedure titled, Call Lights, reviewed 1/17/2025 read, Policy: It will be the policy of this facility to respond to the resident's requests and needs via notification with the call light system.4. When the resident is in bed or confined to a chair, the call light should be within easy reach of the resident.</p> | | |