STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105524	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Port Charlotte Rehabilitation Center	25325 Rampart Blvd Port Charlotte, FL 33948

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, review of facility's policies and procedures and staff interviews, the facility administration failed to provide effective oversight to ensure ongoing implementation of a water management program to reduce the risk of growth and spread of Legionella (water-borne disease causing bacteria), and failed to minimize the risk of ongoing exposure to Legionella for 145 residents from potentially contaminated water sources, in response to a resident's confirmed diagnosis of Legionnaires' Disease (potentially fatal form of pneumonia caused by Legionella bacteria) that may have been acquired at the facility.The findings included:Refer to F880Review of the facility provided list of Key Facility Staff revealed:The Administrator's date of hire was 6/18/24.The Director of Nursing/Infection Preventionist's date of hire was 6/24/24.The Maintenance Director's date of hire was 7/19/19.Review of the Administrator's job description revealed the position overview was, Responsible for overall operations and daily management of the facility by planning, developing, directing, monitoring and supporting all operational, administrative, clinical . activities for the facility programs and services . Safety Awareness: Follows safety program guidelines . consistently follows infection control and universal precautions and other guidelines; identifies and corrects hazardous condition . Essential job duties . Provides expectations and monitors performance of department manager team. Provides overall supervision and guidance to department managers to ensure compliance in all areas and tracks progress and performance of each area .Review of the RN (Registered Nurse) Infection Preventionist (IP)position overview revealed the Infection Preventionist Serves as a resource to all departments and personnel . Essential Functions . Must be able to plan, develop, organize, implement, and evaluate a high quality infection prevention and control program (IPCP) to prevent, recognize, and control the onset and spread of infection to the extent possible . Must be able to serve as a QAPI (Quality Assurance and Performance Improvement) Committee member, with the responsibility of reporting on infection prevention and control elements . Must be able to serve as a resource for all departments, employees, and licensed independent practitioners on infection prevention and control matters. Must be able to conduct outbreak tracking, symptom monitoring, investigation, and reporting in accordance with local health and state agency as required by law.Review of the Maintenance Supervisor position overview revealed, Responsible for the overall supervision and operation of the maintenance department, including maintenance of physical plant, mechanical, electrical and resident care equipment in accordance with laws, regulations and facility guidelines. competencies of Position . Safety awareness: Follows safety program guidelines . consistently follows infection control . and other guidelines; identifies and corrects or reports hazardous conditions to supervisors . Essential Job Duties . Oversees all areas of maintenance, including heating and air, water, gas, electrical, mechanical, carpentry, repairs . Identifies, diagnoses and repairs technical and mechanical problems . Ensures compliance with building and safety codes . Oversees the facility safety program in conjunctions with the Environmental Services department and Administrator. Makes recommendations to the Facility Administrator regarding repairs and maintenance needs.Review of the facility's Water Management Program revealed that the facility will make the responsibility of managing this Water Management (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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Plan part of a Water Management Program committee made up of facility staff and their meeting and minutes shall be part of the Safety Committee's agenda. The Water Management Program Committee shall be comprised of the following: Administrator, Director of Nursing, Medical Director and Maintenance Supervisor. The Water Management Plan noted that at any time a suspected case of Legionnaires disease occurs, decontamination processes shall occur according to the CEMP (Comprehensive Emergency Management Plan), WMP or the Infection Control Policy . Water quality will be measured throughout the system to ensure changes (such as drop in chlorine levels, etc.) are not occurring. Water heaters will be maintained at appropriate temperatures.Review of the facility's Policy and Procedure titled, Infection Surveillance-Infection Prevention Overview CCHC0113, Copyright 2013 revealed, the facility uses prevention strategies to reduce the risk of transmission of infections including, but not limited to . cleaning, disinfecting, and education. Any questions or problems pertinent to the Infection Prevention Program will be directed to the facility's Infection Control Coordinator. Procedure . Follow current infection prevention standards and procedures for aseptic, precautionary, and sanitation techniques as written . Provide staff education and training following the collection and analysis of data to improve infection prevention/control outcome.Review of Resident #1's clinical record revealed an admission date of 3/20/26. Diagnoses included pneumonia (unspecified organism), acute respiratory failure with hypoxia (low level of oxygen in the tissues). On 4/11/26, Resident #1 was emergently transferred to an acute care hospital with respiratory distress.Review of the Department of Health (DOH) emails to the Director of Nursing (DON) revealed:On 4/24/26 the DOH notified the DON that Resident #1 became symptomatic for Legionella while staying at the facility and was at the facility for the entirety of the incubation period.On 5/4/26, the DOH provided recommendations and guidance to the facility regarding possible Legionella exposure.On 5/5/26, the DOH notified the facility that during the onsite assessment completed on 5/1/26 they found conditions that could support the growth of Legionella bacteria within the facility's plumbing. The DOH specified that their recommendations were provided to mitigate and eliminate the risk to the residents and employees and should be implemented regardless of testing results because as they previously stated at the assessment, negative results do not indicate that the plumbing is free of Legionella bacteria.On 5/1/26 at 10:30 a.m., in an interview, the DON verified that she has been the Infection Preventionist since she started employment at the facility on 6/24/24. She said that on 4/20/26, the DOH called and notified her that Resident #1 tested positive for Legionella. The DON said that she did not oversee the Water Management Program as part of Infection Prevention and Control and did not initiate preventive measures on 4/20/26 to minimize the risk of residents' exposure to potentially contaminated water. She said the Maintenance Director was in charge of the water management program.On 5/1/26 at 10:30 a.m., a tour of the facility with the Maintenance Director revealed: The facility had a total of 3 mixing valves used for 7 water heaters. The 3 mixing valves (allow the water inside the heater to remain at a germ-killing 140 degrees F to prevent bacterial growth like Legionella and blends hot and cold water to prevent scalding) were non-operational. The temperature gauge of 5 of the 7 water heaters were non-functional. Observation of the Tarpon Unit revealed that the circulation pump (continuously circulates hot water through the system to prevent stagnation and bacterial growth) was unplugged. The water temperature in the water tanks ranged between 114 degrees F to 117 degrees F.On 5/1/26 at 11:15 a.m., in an interview, the Maintenance Director verified that he was responsible for the facility's water management program. He said that the mixing valves had been non-operational since he started employment as the Maintenance Director at the facility 6 years ago. The Maintenance Director verified that no attempts were made in six years to repair the mixing valves.On 5/5/26 at 10:35 a.m., in an interview, the Administrator verified that on 4/20/26 he was notified of Resident #1's diagnosis of Legionella and that on 4/24/26, he was aware of the DOH recommendations. The Administrator said that on 4/20/26, he did not implement the interventions listed on the facility's Water Management Plan when he was informed of Resident #1's diagnosis. The Administrator said (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	that the DOH recommendations were just ideas to consider and not requirements. On 5/5/26 at 1:50 p.m., a joint interview was conducted with the Regional Director of Clinical Services and the DON to review the facility's Infection Prevention and Control Program.The Regional Director of Clinical Services said that the DON notified her of the DOH's recommendations on 4/29/26. She reviewed Resident #1's clinical record and was convinced that he had Legionella prior to his admission to the facility.The DON verified that she has been the Infection Preventionist for the facility since 6/24/24. She said that on 4/20/26 when the DOH notified her that Resident #1 tested positive for Legionella, she reported it to the Administrator and the Maintenance Director but made no recommendation to minimize the risk of exposure to Legionella from potentially contaminated water for the current residents. She said that they all felt that Resident #1 had Legionella before his admission to the facility and that he had only taken one shower during his stay.The Safety Committee Meeting Minutes dated 5/4/26, provided by the facility were reviewed with the Regional Director of Clinical Services and the DON. The Regional Director of Clinical Services and the DON verified that the facility held the meeting on 5/4/26, 14 days after the facility was notified of Resident #1's diagnosis of Legionella and 10 days after the DOH notified the facility on 4/24/26 that further environmental investigation was necessary since Resident #1 became symptomatic while staying at the facility and was in the facility for the entirety of the incubation period.Documentation of the facility's risk assessment of the water flow system to identify areas where Legionella could grow and spread, the monitoring such as visual inspection, temperature check and disinfectant checks were requested from the facility and not provided. Review of the agenda items for the safety committee meeting minutes noted, Possible Legionella case in [NAME] Bay (Room #). Initiate PIP (Performance Improvement Plan)/visit 5/1/2026 from FDOH (Florida Department of Health). Enacting of our Legionella Plan. Temp rise in all building water heaters. Deep cleaning. Water sample test.Review of the Performance Improvement Plan dated 5/4/26 revealed:On 4/21/26, the room occupied by Resident #1 during his stay at the facility was deep cleaned.The following action steps were implemented on 5/4/26, 14 days after the DOH notified the facility of Resident #1's diagnosis:Current facility residents were reviewed to determine potential for exposure and signs and symptoms of Legionella.Sample was collected and sent to the lab from water sources identified as having the potential to contain Legionella.Superheating/hyperchlorination of water system was completed. Monitoring initiated and to occur every 2 weeks for 3 months.Water dispensing faucets were observed for scale, follow up based on findings.The following Action Steps had no date listed and the status was left blank:Employee education related to Legionella/Legionella Plan.Ongoing Legionella Management to be completed as required and reviewed during the facility QAPI (Quality Assurance and Performance Improvement) Committee Meeting.The Performance Improvement Plan dated 5/4/26 did not include all the recommendations made by the Department of Health on 4/24/26 to address the possible Legionella exposure.Review of the DOH recommendations to the facility dated 4/24/26 revealed to:Obtain professional consultation from a qualified water system expert for proper assessment and remediation of the facility's water system.Store domestic hot water at a minimum of 140 degrees F for maintenance of the premise plumbing system and to minimize growth of Legionella.Flushing shower and sink faucets when cleaning rooms after discharging patients. Flush shower and sink faucets every 2-3 days to prevent stagnant water accumulating in the pipes.Let the showerheads hang to allow the water to fully drip out.On 5/5/26 at approximately 12:00 p.m., observation of the room occupied by Resident #1 during his stay at the facility revealed the showerhead was tucked between the wall and the handrail and did not hang to allow the water to fully drip out. On 5/6/26 at 12:15 p.m., in an interview, the Medical Director for the facility said that the facility had just informed him of the case of Legionella that may have occurred at the facility. The Medical Director said that he should have been notified earlier. He said that even if there was the possibility of Legionnaires' Disease originating in the facility, the DOH recommendations should have been followed.On 5/8/26 at 4:00 p.m., during a meeting with the Administrator, the DON, the Regional Director of Clinical Services, (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	the concerns related to the facility administration failure to provide effective oversight to ensure ongoing implementation of the water management program and the failure to implement immediate and effective corrective measures with a resident's confirmed diagnosis of Legionella resulting in the determination of Immediate Jeopardy were reviewed.The Administrator said, I am perplexed and don't understand how you've come to this decision from a laboratory result from an outside entity.When asked about the need to follow the Department of Health recommendations, the Administrator replied that the facility's policy and procedure did not say we should do this.On 5/20/26, the Department of Health provided the results of the testing from the water and swab samples collected on 5/1/26 during the DOH's environmental assessment.The water and swab samples obtained from the room that Resident #1 occupied during his stay at the facility and another room tested positive for Legionella pneumophila (a bacterium that causes Legionnaires' Disease).

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, review of facility's policies and procedures, and interviews, the facility failed to establish and implement a water management program to mitigate the risk of Legionella (waterborne disease-causing bacteria) exposure. The facility failed to minimize the risk of ongoing exposure to Legionella from potentially contaminated water sources in response to a resident's confirmed diagnosis of Legionnaire's disease (potentially fatal form of pneumonia caused by Legionella bacteria) that may have been acquired at the facility.The findings included:Refer to F835Review of the facility's Water Management Program (WMP) revealed, Legionnaires' disease is a serious type of pneumonia caused by bacteria called Legionella which live in water. Legionella can make people sick when they inhale contaminated water from building water systems that are not adequately maintained. Approximately 70% of building water systems are contaminated with Legionella bacteria. These bacteria thrive in water temperatures between 68 degrees F (Fahrenheit) to 135 degrees F and most often the highest concentration of bacteria is found where there is stagnation in the water system. Legionnaires' disease is deadly for about 10% of people who contact it. CDC (Center for Disease Control) investigations show almost all outbreaks were caused by problems preventable with more effective water management. The following policy and procedure, risk assessment, and testing and documentation processes make up this Water Management Program that will reduce the risk of Legionella and improve the quality of life of the residents within the facility. Policy: the facility will make the responsibility of managing this Water Management Plan part of a WMP Committee made up of facility staff and their meetings and minutes shall be part of the Safety Committee's agenda. The WMP committee shall be comprised of the following:Administrator, Director of Nursing, Medical Director, Maintenance Supervisor. The Water Management Plan Committee shall assure the following components are contained in the plan: Describe the building water systems using text and flow diagrams. Identify areas where Legionella could grow and spread. Describe where control measures should be applied and how to monitor them. Establish ways to intervene when control limits are not met. Ensure the program is running as designed and is effective. Document and communicate all activities. A risk assessment will describe the flow of water and distribution of man-made systems and identify where hazardous conditions could occur. Each potentially hazardous condition shall be addressed with control point measures and limits, accordingly. Both a narrative and flow chart are included as a result of the risk assessment.Any time a suspected case of Legionnaires disease occurs . decontamination processes shall occur according to the CEMP (Comprehensive Emergency Management Plan), WMP or the Infection Control Policy . Procedures: . Water quality will be measured throughout the system to ensure changes (such as drop in chlorine levels, etc.) are not occurring. Water heaters will be maintained at appropriate temperatures. The following describes the types of monitoring that will occur at various locations within the facility water system to reduce the risk of growth and spread of Legionella. Visual inspection and Check Temperature: Kitchen/Laundry/Bistro, Ice Machines, Sinks/showers/Appliances, Community Baths/Hydro Spas/CPAP (Continuous Positive Air Pressure (CPAP) systems, AC (Air conditioning) Units/PTACs (Packaged Terminal Air Conditioner), Hot Water Heaters. Check Disinfectant: Kitchen/Laundry/Bistro, Community Baths/Hydro Spas/CPAP Systems . Corrective Actions (flushing and decontamination of the systems) shall be taken when systems are performing outside of control limits (manufacture specifications) . The facility will test various systems on a quarterly basis during the year and will follow the protocols of the testing authority. Each system shall be tested at least once, on an annual basis and reports will be provided regarding the results . The Infection Control Policies shall be activated and followed regarding Legionella issues according to the facility policy and at the direction of the Infection Control Nurse . Documentation: The facility shall document the results of the periodic testing processes, report about the (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	effectiveness of the plan by ensuring proper control measures are in place and being monitored, and provide for any corrective actions taken that may have been necessary to clean, disinfect, flush or otherwise reduce the risk of exposure to Legionella. Documentation will also include the minutes from meetings where the Committee discusses the Plan and the effectiveness, etc.Review of the clinical record for Resident #1 revealed an admission date of 3/20/26. Diagnoses included Pneumonia (unspecified organism), acute respiratory failure with hypoxia (low level of oxygen in the tissues).Review of the Change in Condition and Transfer form dated 4/11/26 at 7:40 a.m., revealed that Resident #1 was presenting with respiratory distress. Unable to get Oxygen saturation above 88% (requires immediate medical attention). Resident #1 was placed on an oxygen tank. The Oxygen Saturation went up to 93% with oxygen at 8 Liters. On 4/11/26, Resident #1 was emergently transferred to an acute care hospital via Emergency Medical Services.On 4/27/26, in an email, the Department of Health notified the Agency for Health Care Administration (AHCA) that There has been one confirmed case of Legionella at this facility resulting in one death . The case was a patient at this facility during their entire incubation period. The email noted that they will conducting an environmental assessment at the facility on 5/1/26 if someone from AHCA would like to join.On 4/27/26, the Department of Health provided the Agency for Health Care Administration with emails sent to the facility:Review of the Department of Health (DOH) email to the Director of Nursing (DON) dated 4/24/26 revealed that DOH was reaching out to you regarding the patient whose lab work came back positive for legionella. As the patient became symptomatic while staying at Port [NAME] Rehabilitation Center and was in the facility for the entirety of the incubation period, further environmental investigation is necessary. The email noted that it would entail an onsite assessment with the Department of Health in order to collect water samples. The Department of Health also requested to know the water source that the facility uses, what type of disinfectant is used for it, as well as a copy of the facility's water management plan prior to being on site.On 5/1/26, an environmental assessment visit was conducted with representatives of the Department of Health.On 5/1/26 at 10:20 a.m., in an interview, a representative of the DOH said that on 4/20/26, the DOH called the facility and notified the DON about Resident #1's confirmed case of Legionella.On 5/1/26 at 10:30 a.m., in an interview, the DON/Infection Preventionist verified that on 4/20/26 the DOH called and notified her that Resident #1 tested positive for Legionella. She said that she informed the Administrator and the Maintenance Director but was not aware of an investigation or testing that may have been done to address the concern. She said the Maintenance Director was in charge of any action taken or testing. On 5/1/26 at 10:25 a.m., in an interview, the Maintenance Director said that the facility had requested a water testing kit from the lab but they had not received it yet. He said they had re-sanitized the room that Resident #1 occupied and flushed the toilet in the room every day. The Maintenance Director said the facility had not done anything else since the Department of Health notified the facility on 4/20/26 that Resident #1 tested positive for Legionella. On 5/1/26 at 10:30 a.m., a tour of the facility with the Maintenance Director revealed: The facility had a total of 3 mixing valves used for 7 water heaters. The 3 mixing valves (allow the water inside the heater to remain at a germ-killing 140 degrees F to prevent bacterial growth like Legionella and blends hot and cold water to prevent scalding) were non-operational. The temperature gauge of 5 of the 7 water heaters were non-functional. Observation of the Tarpon Unit revealed that the circulation pump (continuously circulates hot water through the system to prevent stagnation and bacterial growth) was unplugged. The water temperature in the water tanks ranged between 114 degrees F to 117 degrees F.On 5/1/26 at 11:15 a.m., in an interview, the Maintenance Director verified that the 3 mixing valves were not working, the temperature gauges of 5 of the water tanks were non-functional, the circulation pump of the Tarpon Unit was unplugged and the water temperature in the water tanks were below 140 degrees F and measured between 114 degrees F to 117 degrees F. The Maintenance Director said that the mixing valves have been non-operational since he started employment as the Maintenance Director at the facility 6 years ago.On 5/1/26 at 11:30 a.m., in an interview the Administrator said the facility (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	was waiting for the Department of Health's visit to give them directions and do the water testing since they had ordered testing kits and had not received them yet. On 5/1/26 at approximately 2:00 p.m., in an exit interview with the Administrator, the DON, the Maintenance Director and the newly hired Infection Preventionist, the DOH provided verbal recommendations to the facility, including:Check sink and faucet for buildup in the room Resident #1 occupied during his stay at the facility.Daily flushing and let faucets run with hot water.Set water heater temperature higher to 140 degrees F.Flush and run water in all vacant rooms.Hang shower heads to prevent collection of bacteria.Collect samples and send them for testing for Legionella, in addition to the samples collected by the Department of Health. If samples test positive for Legionella, hire a water management company.On 5/4/26 in an email addressed to the DON, the DOH noted, Thank you again for meeting with us on 5/1/26 to discuss recommendations for your facility regarding possible Legionella exposure. All recommendations as well as general guidance have been provided in the attached letter .Review of the attached letter to the facility, provided by the DOH revealed, The onsite assessment conducted by FDOH (Florida Department of Health) -[NAME] on 5/1/2026 did indicate conditions in the premise plumbing and the spa that could harbor and breed biofilms and Legionella bacteria. FDOH-[NAME] is making the following recommendations to you: We recommend you obtain professional consultation1 from a qualified water system expert for proper assessment and remediation of your water system. The remediation action plan must be reviewed by FDOH-[NAME] and results of follow-up monitoring must be provided to FDOH-[NAME]. We have attached some accepted remediation and maintenance guidelines for your information and consideration.We recommend post-remediation testing following a detailed plan that is submitted to FDOH-[NAME] along with results from each post-remediation sampling event. Post-remediation samples should be collected at least 48 hours after the water system or device has been restored to normal operating conditions through at least a six-month period post-remediation.We recommend a sampling approach described in HICPAC (Health Care Infection Control Practices Advisory Committee) guidance, in which environment samples are collected for culture at two-week intervals for three months and if no Legionella is detected in cultures during three months of monitoring at two-week intervals, continue to collect monthly for another three months.2,3 A sampling approach may be adjusted over time based on trend data. FDOH-[NAME] must be notified of any adjustments to the established sampling plan. If Legionella is detected in one or more cultures, you should:Review and modify the water management plan (WMP).Perform additional remediation, if indicated.Implement a new six-month period for post-remediation follow-up sampling.We recommend that facility either install 0.2 micron biological point-of-use filters on any showerheads or sink/tub faucets intended for use until remediation of your premise plumbing has occurred or restrict the use of showers to reduce the risk to guests during this investigation until further notice. For maintenance of the premise plumbing system and to minimize growth of Legionella, domestic hot water should be stored at a minimum of 140 F and delivered at a maximum of 120 F to all points of delivery as per AHCA guidelines. Minimum temperatures of 122 F are required to prevent new growth of Legionella within hot water systems.It is also recommended your facility monitor hot water temperatures at distal locations from the boilers/hot water heaters. Annual inspections of the entire water system are advisable. These should include periodic draining, cleaning with a chlorine solution, and flushing of all water storage tanks to remove biofilm, scale, and sediment. The importance of maintaining complete documentation of the facility premise plumbing maintenance, water management efforts, and temperature logs cannot be overstated.Report all possible cases of Legionnaires' disease (staff or residents) immediately to the Epidemiology Department in [NAME] County.Review your written water safety management plan (WMP) for the prevention and control of Legionella. Provide FDOH-[NAME] with a copy of your facility WMP.Continue to flush shower and sink faucets when cleaning rooms after discharging patients. If a room has been vacant for a prolonged period of time, please ensure to flush shower and sink faucets every 2-3 days to prevent stagnant water accumulating in the pipes.Similarly, it is recommended to let (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	the showerheads hang to allow the water to fully drip out.Ensure that the ice machine is cleaned according to manufacturer's recommendations.On 5/5/26 at 9:45 a.m., in an interview, the Maintenance Director said 3 of the mixing valves were still not working. They raised the water temperature on 5/4/26 to 150 degrees F for approximately one hour and flushed the system. The Maintenance Director said that he received training on how to collect samples for testing for Legionella but not where to collect the samples. He said the facility did not test the municipal water coming into the building for purity.On 5/5/26 at 10:35 a.m., in an interview, the Administrator said that on 4/24/26, he was notified of the DOH recommendations but had not started implementing the interventions because they were just ideas to consider and not requirements. He said that the [NAME] President of Clinical would make those decisions and she had not instructed him to initiate any interventions. The Administrator said that Resident #1's positive result for Legionella was done at another facility, therefore was not a reliable source of information. The facility felt that Resident #1 was admitted to the facility with Legionella, due to recent history of pneumonia, even though the DOH told him the incubation period occurred at his facility.On 5/5/26 at approximately 12:00 p.m., observation of the room occupied by Resident #1 during his stay at the facility revealed the showerhead was tucked between the wall and the handrail and did not hang to allow the water to fully drip out.On 5/5/26 at 1:50 p.m., a joint interview was conducted with the DON and the Regional Director of Clinical Services.The Regional Director of Clinical Services said that the DON shared the DOH's email and recommendations to her on 4/29/26. She said she reviewed Resident #1's clinical record and was convinced that he had Legionella prior to admission to the facility.The DON said that on 4/20/26, when the DOH notified her that Resident #1 tested positive for Legionella, she informed the Administrator and the Maintenance Director. They told her that the routine water testing for Legionella done in the past have all been negative, therefore there was no need for her to do anything else. She said no one from the corporate office gave the facility any directions on what to do. The DON said they all thought that Resident #1 had Legionella prior to admission to the facility. She said that Resident #1 had only taken one shower during his stay at the facility. No special precautions have been initiated for the current residents to prevent exposure to Legionella from possible contaminated water.When asked about documentation of the facility's risk assessment of the water flow system to identify where hazardous conditions could occur with control points and limits, the facility provided documentation of negative test results for Legionella, obtained on 3/31/25. The samples were obtained from the Tarpon Ice Machine, the Bistro water dispenser, the Dolphin water dispenser and the courtyard fountain.The facility was not able to provide additional documentation of monitoring of areas in their water system where Legionella could grow.When asked about documentation of safety committee minutes verifying the WMP program was running as designed and was effective, the facility provided documentation of a Safety Committee Meeting Minutes dated 5/4/26 with an agenda to discuss possible Legionella case.Review of the DOH email to the DON dated 5/5/26 at 4:06 p.m., revealed, During the onsite assessment, we found conditions that could support the growth of Legionella bacteria within your premise plumbing. Our recommendations are provided to mitigate and eliminate the risk to your residents and employees and should be implemented regardless of testing results because, as previously stated at the assessment, negative results do not indicate that the plumbing is free of Legionella bacteria.On 5/6/26 at 12:15 p.m., in an interview, the Medical Director said that the facility had just informed him of the case of Legionella that may have occurred at the facility. He said that he should have been notified earlier and had not had any input in this situation. He said he had not had a case of Legionella in 27 years. He would have contacted the Infectious Disease Specialist for directions. The Medical Director said that even if there was the possibility of Legionnaires' disease originating in the facility, the DOH recommendations should have been followed, and he would make sure that the facility addressed all the Department of Health recommendations. On 5/7/26 at 3:15 p.m., in an interview, the Maintenance Director said that the facility contracted the services of a plumber to repair the mixing valves. The plumber has not been (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105524	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Port Charlotte Rehabilitation Center	25325 Rampart Blvd Port Charlotte, FL 33948

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	able to complete the repairs due to missing isolation valves.On 5/20/26, after the survey, the DOH provided the results of the testing from the water and swab samples collected on 5/1/26. The water and swab samples tested positive for Legionella pneumophila (a bacterium that causes Legionnaires' Disease) in the room that Resident #1 occupied during his stay at the facility, and another resident room.