

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105539	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER Healthcare and Rehab of Sanford		STREET ADDRESS, CITY, STATE, ZIP CODE 950 Mellonville Ave Sanford, FL 32771	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promote dignity when administering injectable medications to 1 of 1 resident reviewed for dignity, out of a total sample of 5 residents, (#4). Findings: Review of resident #4's medical record revealed he was admitted to the facility on [DATE] with diagnoses including muscle wasting and atrophy, type 2 diabetes, infection of an amputation stump, and heart failure. Review of resident #4's Minimum Data Set admission assessment with an Assessment Reference Date of 10/19/25 revealed a Brief Interview for Mental Status score of 15 out of 15, indicating intact cognition. The MDS assessment noted the resident did not reject evaluation or care necessary to achieve his goals for health and well-being. During a tour of the facility on 12/10/25 at 9:57 AM, a nurse was observed administering an injection to resident #5's abdomen while the resident sat in a wheelchair in a common area near rooms [ROOM NUMBERS]. There were five additional residents present in the common area at the time of the observation. On 12/10/25 at 10:00 AM, Registered Nurse (RN) A stated she began working at the facility on 11/11/25 and had been licensed as a nurse since 2016. RN A confirmed she administered a Lantus insulin injection to resident #4 in the common area. She explained the resident was already out of his room and she thought it was acceptable to administer the injection there. RN A shared she had previously administered oral medications in the common area before and did not believe this practice was problematic. She reiterated she administered the injection outside the resident's room because he was already out of his room. RN A stated she had never been told injections could not be administered outside a resident's room and was unaware this was an issue. Review of resident #4's Order Summary Report revealed a physician's order for Lantus insulin, 6 units subcutaneously once daily for hyperglycemia. Review of resident #4's Medication Admin Audit Report revealed 6 units of Lantus documented as administered by RN A at 10:00 AM on 12/10/25. On 12/10/25 at 3:25 PM, the Wing One Unit Manager (UM) stated nurses were expected to administer medications and perform treatments inside residents' room to ensure privacy. The UM confirmed she observed RN A administer the injection to resident #4 in the common area. The UM shared although RN A was new to the facility, she had been a nurse for many years and should have known this practice was inappropriate. Review of the Medication Administration Skills Checklist, signed by RN A and dated 11/12/25, revealed RN A received orientation to the facility's medication administration policy and procedure. Review of the facility's policy and procedure titled Medication Administration dated 9/18 revealed privacy was to be provided as appropriate when administering medications. Review of the facility's policy and procedure titled Resident Rights dated August 2025 revealed the facility's intent to ensure each resident had a dignified existence and to protect and promote the rights of each resident.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 105539	If continuation sheet Page 1 of 4

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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 interview and record review, the facility failed to accurately document administered medications on the Medication Administration Record (MAR) for 1 of 3 residents reviewed for medications, of total sample of 5 residents, (#1). Findings: Review of resident #1's medical record revealed he was admitted to the facility on [DATE] and readmitted on [DATE] from an acute care hospital. His diagnoses included pneumonia, resistance to multiple antimicrobial drugs, Escheria coli infection, quadriplegia, and dementia. Review of resident #1's physician orders revealed an order dated 11/30/25 for Cefiderocol 2 grams intravenously every 8 hours for the treatment of pneumonia, through 12/08/25. Review of resident #1's MAR for December 2025 revealed blank entries for Cefiderocol doses scheduled on 12/03/25 at 2:00 PM and 12/08/25 at 6:00 AM. The MAR also reflected an X for the scheduled dose on 12/01/25 at 2:00 PM; however, there was no documentation in the medical record indicating the reason the medication was not administered or evidence the physician was notified. On 12/10/25 at 5:49 PM, Regional Nurse Consultant (RNC) B stated the antibiotic was present in the facility on 12/01/25. RNC B indicated there were no progress notes or documentation in the medical record explaining why the medication was not administered on the above-mentioned dates and times. She stated the facility was attempting to contact the nurses assigned to resident #1 on those dates. On 12/11/25 at 1:12 PM, the Administrator (NHA) along with the Unit Manager (UM), RNC C, and Licensed Practical (LPN) D participated in a follow up call regarding the missing documentation for Cefiderocol. RNC C stated the medication was not administered only once, on 12/01/25 at 2:00 PM, because it was delivered to the facility at 3:20 PM. RNC C stated LPN D was assigned to resident #1 on 12/01/25 and reportedly contacted the physician to report the missed dose; however, LPN D stated he was very busy that day and forgot to document the notification. LPN D acknowledged this information during the call. RNC C further stated a similar issue occurred on 12/03/25 when Registered Nurse E forgot to document the administration on the MAR after it was given. RNC C stated the nurse who administered the medication on 12/08/25 also failed to document the administration on the MAR. When asked whether resident #1's medical record accurately reflected the administration of medications in December, neither the NHA nor RNC C provided a response. RNC C stated she collected written statements from the nurses who reported they forgot to document their actions in resident #1's medical record. Review of the facility's policy and procedure titled Medication Administration dated 9/18 read, The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</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 - Many</p>	<p>Based on record review and interview, the facility failed to develop and implement a comprehensive system to monitor antibiotic use, failed to effectively document and maintain infection surveillance during a Coronavirus disease 2019 (COVID-19) outbreak, and failed to ensure appropriate infection control practices were implemented to prevent the spread of infection in 2 of 2 units. Findings: Review of an Infection Control Assessment and Response Report (ICAR) conducted on 10/20/25 by the Florida Department of Health (DOH) revealed the visit was initiated due to a COVID-19 outbreak affecting residents and staff. The ICAR included recommendations related to transmission-based precautions (TBP) and environmental services (EVS), including limited access to hand sanitizer pumps and the requirement to use Environmental Protection Agency (EPA)-approved disinfectants for Candida auris in appropriate rooms. The ICAR further identified frontline staff had not received adequate training on which isolation precautions required the use of Viresept disinfectant versus Virex disinfectant, resulting in incorrect disinfectant being used in rooms under TBP. Review of the facility's Infection Prevention and Control Program policy and procedure effective October 2021 revealed the program was intended to address the detection, prevention, and control of infections and communicable diseases among residents, visitors, and staff. The documented goals included monitoring the occurrence of infections and identifying and correcting problems related to infection control and prevention practices. The major activities of the program included surveillance of infections and communicable diseases, antibiotic stewardship, and the implementation of infection control and prevention measures. During an interview on 12/10/25 at 10:14 AM, housekeeper F demonstrated uncertainty regarding cleaning chemicals and infection control practices. She showed a bottle labeled Oxivir Five 16 Concentrate and stated the contents were actually Virex, explaining she had filled the bottle with Virex. She then showed a bottle labeled TrueKleen U-power Heavy Duty and stated it was probably window cleaner but was not sure. During the interview, the Housekeeping Director stopped by at 10:23 AM and informed Housekeeper F the TrueKleen bottle was a degreaser. Housekeeper F stated she did not participate in staff meetings or in-services and had not received education regarding TBP or signage posted on resident room doors. She indicated that while personal protective equipment (PPE) was sometimes available, there were occasions when PPE was not present, and she was told to just put a mask on. She stated no one explained the expectations to her and staff assumed she already knew. When asked about the frequency of deep cleaning in resident rooms, she presented a deep cleaning schedule dated December 2023 from a binder on her cart and stated she was not aware of any recent deep cleaning being conducted. On 12/10/25 at 11:15 AM, the Wing One Unit Manager (UM) stated she did not attend Quality Assurance and Performance Improvement (QAPI) meetings. The UM shared the Infection Preventionist (IP) was previously the Assistant Director of Nursing; however, that individual left the facility and the Director of Nursing (DON) assumed the IP role. The UM stated she currently assisted the DON with IP functions including ensuring residents on TBP had appropriate signage and PPE. She indicated she began assisting with antibiotic stewardship for Wing One in December 2025. The UM reported the facility experienced a COVID-19 outbreak in September 2025 affecting fewer than 10 residents and some staff, and facility wide testing was conducted. She stated she did not attend the DOH meeting in October and was unaware of any recommendations made. On 12/10/25 at 11:56 AM, the Administrator (NHA) confirmed DOH conducted a visit during the COVID-19 outbreak on 10/20/25 but stated he could not locate any documentation related to the visit. He stated he was unaware of any deficiencies or corrective actions identified by DOH. The NHA indicated the DON and nursing staff met with DOH, but he did not attend the meeting. He stated the DON was out of the facility this week and attempts to contact her were unsuccessful. He indicated the UM searched the Infection Control (IC) binder but did not locate documentation related to the DOH visit. During a joint interview with the UM and the NHA on 12/10/25 at 1:29 PM, the UM presented the IC binder containing data collected by the IP through 2025. The NHA stated a review conducted on 11/21/25 revealed the IC binder lacked infection surveillance reports and antibiotic stewardship documentation for the months of August, September, and October 2025. The UM reviewed the binder and was unable to locate COVID-19 testing results from the recent outbreak with the exception of documentation dated 10/06/25. The UM stated once deficiencies were identified, the DON completed the November 2025 report retrospectively, however, no data was available for August, September or October. The NHA then presented a QAPI containing forms dated 11/21/25. Review of the documentation revealed a Problem Statement indicating the facility failed to follow proper Infection Control and Prevention</p>		