

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105547	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Flagler Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Dr Carter Boulevard Bunnell, FL 32110	
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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on a review of facility staffing information, the facility failed to ensure that a Registered Nurse (RN), other than the Director of Nursing, provided services for at least eight consecutive hours a day, seven days a week when the resident census exceeded sixty (60) for two (11/09/25 and 11/23/25) of 29 days reviewed. The findings include: A review of the staffing assignment sheets for November 9, 2025, failed to identify an RN on the schedule, listing only Licensed Practical Nurses (LPN) for the 12 nursing staff assigned to provide patient care on all three shifts (Day, Evening, Night). Further review of the Unit assignment sheets for this day listed only staff identified on the assignment sheet, all of whom were LPNs. A review of the staffing assignment sheets for November 23, 2025, failed to identify an RN on the schedule, listing only LPNs for the 11 nursing staff assigned to provide patient care on all three shifts (Day, Evening, Night). Further review of the Unit assignment sheets for this day listed only staff identified on the assignment sheet, all of whom were LPNs. On 12/4/25 at 2:30 PM, an interview was conducted with the scheduler who reviewed the nursing hours for 11/09/25 and 11/23/25 on her computer and verified that there was not an RN assigned to work on those days. She stated she was not aware they had not met their hours on these days.		

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews with staff, the facility failed to label and date opened refrigerated food, maintain food preparation equipment in a clean and sanitary manner, and ensure canned goods intended for consumption were stored off the floor. Unsafe food storage and handling present the potential to affect all residents who consume foods prepared in the facility's kitchen. The findings include: During an initial kitchen tour with the Director of Dietary Services (DDS) on 12/01/2025 at 10:20 AM, the walk-in refrigerator was found to contain two steam table pans containing a thick brown substance resembling gravy. Each was covered with clear plastic wrap, but neither was labeled with a date that the gravy was opened and dished into the pans. A block of orange pre-sliced cheese was opened, partially used and wrapped loosely in plastic wrap so that the cheese was exposed to air. There was no label or date on the cheese. Two packages of opened and partially used cold cut meats were wrapped and unlabeled. In reach-in refrigerator #1, a plastic bowl filled with unidentifiable, orange-colored food was covered with a plastic lid but not labeled with the contents or dated. The dry storage room was observed with a #10 tin can of spaghetti sauce that had been placed strategically on the floor to prop the door open. The low shelf that housed the boxes of juice for the juice dispenser were soiled with food particles and unidentified debris. The wall under the 3-compartment sink had what appeared to be water damage, evidenced by peeling paint and a black biological substance resembling mold or mildew. The plastic sink pipes and tile baseboard were coated with a similar black matter. Debris had accumulated under the sink. The kitchen's deep fryer had caked-on thick buildup of oil on the housing, sides and tile floor underneath it. The fryer oil contained a foamy strip of food crumbs which had migrated to the front of the fryer's reservoir. (Photographic evidence obtained) During a return visit and tour of the kitchen on 12/03/2025 at 11:50 AM, the visiting DDS stated he had been made aware of and acknowledged the findings from 12/01/2025 and that they had since been corrected. He recognized an alternate method of propping open the door to the dry storage room for deliveries should be used rather than a #10 can of food. The visiting DDS also confirmed the conditions under the 3-compartment sink and that cleaning and maintenance was needed.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, interviews, medical record review, and facility policy and procedure review, the facility failed to ensure accurate administration of time-sensitive medications, specifically insulin ordered to be administered before breakfast, for five (Residents #46, #120, #10, #119, and #108) of seven residents reviewed who had medications ordered to be administered prior to breakfast. The findings include: On December 3, 2025 at 5:40 a.m., Registered Nurse (RN) C was advised that her medication pass would be observed. RN C stated, Oh, I finished already. If I knew you were coming, I would have waited for you. She was asked whether any residents had received insulin that morning, and she confirmed that Resident #10 had received two units of sliding-scale regular insulin at approximately 5:30 a.m. She was asked what time breakfast was served on the unit and she stated approximately 7:00 a.m. She confirmed that the insulin order was written to be administered before breakfast. On December 3, 2025 at 5:50 a.m., Licensed Practical Nurse (LPN) D and LPN V confirmed they had completed their 6:30 a.m. medication pass. Both confirmed that residents on their assignments had received insulin that morning. When asked what time breakfast trays arrived on the unit, LPN D stated trays typically began arriving around 7:00 a.m. Breakfast tray carts were observed to have been delivered to the units on December 3, 2025, starting at 7:30 a.m., with the final cart having been delivered at 8:10 a.m. On December 4, 2025 at 6:45 a.m., RN C was again advised that her medication pass would be observed. She confirmed that she had already completed her 6:30 a.m. medication pass. When asked what time a medication ordered before meals should be administered, she stated 30 minutes before the meal, then stated 30 minutes to an hour before the meal. When asked what time breakfast trays arrived on the unit, she stated it varied, sometimes 8:00 a.m., and sometimes earlier like 7:30 a.m. LPN E who worked the day shift, was asked what time breakfast trays arrived on the unit and she stated delivery times varied but that tray delivery typically occurred between 7:30 a.m. and 8:00 a.m. When asked whether she administered medications ordered before breakfast, she replied that the night shift nurses administered those medications. Breakfast tray carts were observed to have been delivered to the nursing units on December 4, 2025 starting at 7:45 a.m., with the final cart having been delivered at 8:15 a.m. On December 4, 2025 at 9:06 a.m., during an interview with the Director of Nursing (DON), she was asked when a medication ordered before meals should be administered. She said she would need to review the policy, but then stated medications ordered before meals should be given around the meals and that staff were directed to administer before-meal medications at 6:30 a.m., describing this as close to a meal. When asked who directed this practice, she replied, the company. When asked whether it was the facility's policy to administer medications ordered before meals prior to 6:00 a.m., the DON stated she was unsure and reported that she had been in the position for two months and would need to clarify. She confirmed that breakfast trays were generally delivered to the units between 7:30 a.m. and 8:00 a.m. A list of medications ordered to be administered at 6:30 a.m. on December 3, 2025 and December 4, 2025, including administration timestamps, was requested from the DON. A review of these records, along with the corresponding Medication Administration Records (MAR) revealed the following: Resident #46 was ordered Novolog insulin (100 units/milliliter), per sliding scale, subcutaneously before meals. Nine (9) units were administered for a blood glucose level of 315 on December 3, 2025 at 6:15 a.m., and 11 units were administered for a blood glucose of 400 on December 4, 2025 at 6:06 a.m. Meal tray delivery began at 7:30 a.m. and ended at 8:10 a.m. on December 3, 2025. Meal tray delivery began at 7:45 a.m. and ended at 8:15 a.m. on December 4, 2025. Resident #120 was ordered Lispro insulin (100 units/milliliter), per sliding scale, subcutaneously before meals and received three (3) units for a blood glucose level of 215 on December 4, 2025 at 6:05 a.m. Meal tray delivery began at 7:45 a.m. and ended at 8:15 a.m. on December 4, 2025. Resident #10 was ordered Novolin Regular insulin (100 units/milliliter), per sliding scale, subcutaneously before meals and received two (2) units for a blood (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	glucose level of 186 on December 3, 2025 at 5:35 a.m. Meal tray delivery began at 7:30 a.m. and ended at 8:10 a.m. on December 3, 2025. Resident #119 was ordered Humalog insulin (100 units/milliliter), per sliding scale, subcutaneously before meals and received two (2) units for a blood glucose level of 155 on December 3, 2025 at 5:34 a.m. Meal tray delivery began at 7:30 a.m. and ended at 8:10 a.m. on December 3, 2025. Resident #108 was ordered Humalog insulin (100 units/milliliter), per sliding scale, subcutaneously before meals and received four (4) units for a blood glucose level of 204 on December 3, 2025 at 5:33 a.m. Meal tray delivery began at 7:30 a.m. and ended at 8:10 a.m. on December 3, 2025. All before-breakfast insulin administration for the abovementioned residents occurred one and one-half to two hours prior to breakfast tray delivery. On December 4, 2025 at 3:55 p.m., during an interview with the facility's Medical Director, who was also the attending physician for Residents #46 and #10, he was asked when medications ordered to be given before meals should be administered. He stated one hour before the meal is the clinical expectation. When asked whether administering fast-acting sliding-scale insulin at 5:30 a.m. would be too early if breakfast was served between 7:30 a.m. and 8:00 a.m., he reiterated that one hour prior to the meal was appropriate. On December 4, 2025 at 4:45 p.m., during an interview with the physician for Resident #119, he was asked when medications ordered to be given before meals should be administered. He stated he expected administration within 30 minutes prior to the meal and did not want insulin administered two hours before a meal. When asked whether administering sliding-scale fast-acting insulin between 5:30 a.m. and 6:30 a.m. would be considered too early when breakfast was served between 7:30 a.m. and 8:00 a.m., he stated it should be administered with the meal and that administering insulin two hours prior would result in a diminished therapeutic effect. A review of the facility's policy and procedure titled Medication Administration (revised 1/2004) revealed: Standard: Medications are ordered and administered safely and as prescribed. Procedure: 2. The Director of Nursing supervises and directs all personnel who administer medications and/or who have related functions. 3. Medications are administered in accordance with prescriber orders, including any required time limit. 4. Medication administration times are determined by resident needs, preference, and benefit, not staff convenience. 6. Medications are administered within one (1) hour before or after their prescribed time, unless otherwise specified (for example, before and after meal orders, at bedtime). According to the Mayo Clinic, rapid-acting or short-acting insulins are ideal for use before meals and, when taken with a meal, help bring blood sugar back down toward baseline and blunt the sugar spikes that occur after eating. Rapid-acting insulins sometimes begin working in as few as five to 15 minutes. Short-acting insulins start working about 30 minutes after injection. Examples of rapid-acting insulins include lispro (Humalog) and aspart (NovoLog), and examples of short-acting insulins include regular human insulin (Humulin R, Novolin R). Rapid-acting or short-acting insulins are typically administered shortly before meals to match the timing of carbohydrate absorption from the meal. These pharmacokinetic properties support the clinical expectation that mealtime insulins should be given in close proximity to the meal being covered rather than substantially earlier than meal service. Mayo Clinic states that rapid-acting insulins are ideal for use before meals because they start to work much faster than long-acting or intermediate-acting insulins and are intended to be taken shortly before a meal to be effective. This guidance is consistent with manufacturer labeling that specifies rapid-acting insulins should be taken within a defined window before a meal to align insulin action with postprandial [after a meal] glucose needs. Mayo Clinic further explains that rapid-acting insulins begin to work within 5 to 15 minutes of administration and have a shorter duration of action, making timing relative to meal ingestion important for therapeutic effect (Mayo Clinic, August 2023).		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, interviews, record review, and facility policy and procedure review, the facility failed to provide activities of daily living (ADL) care (specifically fingernail care) for two (Residents #54 and #90) of two dependent residents sampled for ADL care. The findings include: 1. On 12/01/2025 at 11:30 am, Resident #54 was observed lying in bed awake. His fingernails were elongated and jagged on both hands. He was asked if he preferred his fingernails that long. He replied no and stated, I need to do something about them. They used to take care of them for me here, but they don't anymore. I think the girl that used to do them left. (Photographic evidence obtained) On 12/02/2025 at 9:30 am, Resident #54 was observed lying in bed with his eyes closed. He did not respond to his name being called. His fingernails remained elongated and jagged, as they were observed yesterday, 12/01/2025, at 11:30 am. On 12/02/2025 at 11:25 am, Resident #54 was observed in his room, lying in bed awake. His fingernails remained elongated and jagged. He stated he wished they would trim his fingernails like they used to, and that he might have to ask his nephew to trim them. On 12/03/2025 at 9:55 am, Registered Nurse (RN) A was asked who provided fingernail care for the residents. She stated she wasn't sure and would ask the other nurse on the floor. Licensed Practical Nurse (LPN) B interjected stating, I know Activities does nails, and the certified nurses' aides (CNAs) can clean and file them. She was asked who trimmed the fingernails for diabetic residents. She replied, The nurses do the diabetics' fingernails. She was asked if there was a schedule for fingernail care. She said no. She was asked how the nurses knew if a diabetic resident needed their fingernails trimmed. She stated, by looking at the nails or the CNAs will tell us. RN A was asked if she was caring for Resident #54 today. She replied yes. She was asked if Resident #54 was diabetic. She stated, I will need to look that up; I'm not sure. After looking up the information, she stated, Yes, he is a diabetic. She was asked to observe Resident #54's fingernails. She observed the resident's fingernails and confirmed that they were elongated and jagged. The resident asked RN A when someone could cut his fingernails. He stated, I can't do it myself. On 12/03/2025 at 12:10 pm, during an interview with the Director of Nursing (DON), she was asked if the facility had a policy for fingernail cleaning and trimming for residents who were diabetic and those who were not. She stated she wasn't sure. She was asked what the facility's policy stated for this kind of care. She stated staff could clean and trim fingernails for residents. She was asked if staff could provide this care for diabetic residents. She stated, Yes, the nurses and the CNAs can provide that care. She was asked how often this care was provided. She stated, Upon request and on shower days they are checked for cleanliness and length per the patient's preference. She stated she would look for a facility policy for fingernail cleaning and trimming. On 12/3/2025 at 3:30 PM, the Regional Registered Nurse confirmed that the facility's policy for fingernail care was what was written in the ADL policy. He confirmed there was no separate policy specific to fingernail care and confirmed there was no specific policy for the care of the diabetic residents' fingernails. A review of Resident #54's medical record revealed that his diagnoses included CVA (Cerebral Vascular Accident). (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the annual Minimum Data Set (MDS) assessment (dated 10/23/2025), Section C, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 possible points, indicating intact cognition. Further review of the MDS assessment (Section GG) revealed upper extremity impairment on both sides with partial/moderate assistance required for personal grooming. A review of the resident's MDS assessment (Section E) revealed the resident did not exhibit any behavioral concerns and did not refuse any care offered/provided. A review of the person-centered care plan for Resident #54 revealed: Focus: (9/16/2025) The resident has skin impairment; itching skin. Goal: (revised 11/4/2025) The resident's skin will show signs of healing without complications by/through the review date. Interventions: The person-centered care plan did not contain any interventions regarding fingernail care or trimming. Focus: (9/16/25) Resident has a potential for ADL self-care deficit related to activity intolerance, ADL needs and participation may vary, chronic medical conditions, CVA, fatigue, hemiplegia, imbalance. Goal: Resident will maintain and/or improve ADL functioning through the next review date. (revised 11/4/25) Interventions: The person-centered care plan did not contain any interventions regarding fingernail care or trimming. 2. During an observation of Resident #90 on 12/02/2025 at 10:35 AM, she was in her wheelchair outside of the main dining room. The fingernails on her right hand were elongated, and each of the five nails had unknown dark buildup under the tips. When asked if staff assisted her with nail care, she confirmed they did. Resident #90 was asked about the current condition of her nails. She looked at them, did not respond and wheeled herself away. On 12/03/2025 at 10:56 AM, Resident #90 was observed in the main dining room. The nails on her right hand were in the same condition as they were on 12/02/2025 at 10:35 AM, with a buildup of unidentified dark matter under each tip. During an observation on 12/04/2025 at 10:40 AM, Resident #90's fingernails on her right hand were still soiled with the unknown dark substance, but the buildup was now thicker under her thumbnail. An interview was conducted with Certified Nursing Assistant (CNA) N on 12/04/2025 at 2:36 PM. She stated residents received scheduled baths/showers typically three days per week and as needed in between, such as when they were soiled. Resident #90 was cooperative with care, but dependent on staff for her personal hygiene needs. Facility-employed CNAs performed nail care for the residents. Since CNA N worked for a staffing agency, she did not help with nail care for safety reasons. CNA N was accompanied to Resident #90's room to check her nails, but upon inspection, the resident's nails (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were clean and with very little of the remaining dark matter present. CNA N explained that Resident #90 had just received a shower. CNA N said Resident #90 dug at or in her adult incontinence briefs; the dark matter under her nail tips may have been feces. She was not sure. An interview was conducted with CNA T on 12/04/2025 at 2:50 PM. She said CNAs filed and cleaned residents' nails, but the nurses were responsible for clipping them. CNAs did not perform any nail care for residents with diabetes; the nurses did that. A medical record review for Resident #90 revealed she was not diagnosed with diabetes. The Quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/17/25 revealed a brief interview for mental status (BIMS) score of 9 out of 15 possible points, indicating moderate cognitive impairment. She required substantial assistance with personal hygiene and partial to moderate assistance with bathing. Resident #90 was care planned on 9/12/22 with the last revision on 10/16/25 for dementia/conversion disorder. Activities of daily living (ADL) and participation vary. The goal was met as evidenced by a lack of unpleasant body odors and a neat and clean appearance on a daily basis. Interventions included, but were not limited to, needs assistance of one with ADL care; this may fluctuate with weakness, fatigue and weight bearing status. Bathing: resident needs assistance limited to extensive of 1 to 2 based on the same factors. Resident #90 was care planned 11/13/25 for resistiveness to care and refusing care and bathing at times. The goal was for participation in care and decreased episodes of noncompliance through the next review date. Interventions instructed staff to encourage participation, explain all care activities and if resistive to care or ADLs, leave and return at a later time/negotiated time. (Photographic evidence obtained) Further review of the record revealed that Resident #90's bath/shower schedule was twice weekly. Shower sheets dated 11/25/25 and 11/27/25 showed Resident #90 refused showers both days. Despite these refusals, there was no documentation related to attempted nail care over the seven days leading up to the last observation of Resident #90's nails (11/27/25 through 12/04/25). (Photographic evidence obtained) A review of the facility policy titled ADL Care and Services (revised 1/2024), revealed: Guideline: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Procedure: 1.Residents will be provided with care, treatment, and services to ensure that their activities of daily living (ADLs) are met. 4.Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident, and in accordance with the plan of care, including appropriate support and assistance with, but not limited to: a. Hygiene (bathing/showers, dressing, grooming, nail care, oral care). (Photographic evidence obtained)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the timely assessment and implementation of appropriate care orders for surgical wounds for two (Residents #64 and #108) of two residents sampled for surgical wounds. The findings include: 1. On 12/02/25 at 11:04 AM, an interview was conducted with Resident #64, during which he stated his dressings had not been changed since he was admitted and he had staples in his chest that were supposed to come out. He stated he had knee surgery, and no one had changed his dressing there either. On 12/03/25 at 10:04 AM, a follow-up interview was conducted with Resident #64, during which he stated the dressing to his left chest had not been changed since October 23, 2025. Observation of the bandage revealed no date written to identify when it had last been changed. The resident also offered that the dressing change on his left leg had been performed on 12/2/25 for the first time. He reported that he had been told today that he had a follow-up appointment with his surgeon on December 15, 2025. On 12/03/25 at 2:45 PM, an observation was made with the wound care nurse of Resident #64. The wound care nurse stated both dressings on the resident's chest had been changed since he was admitted to the facility and verified that the bandage over his left chest was not dated. She stated she did not always date the dressings. She said when she first started her employment at the facility about a month ago, she did not do wound care for surgical wounds/incisions, but the facility realized these wounds were not being addressed so she started doing them. When asked when this started, she stated she wasn't sure. A record review for Resident #30 revealed he was admitted to the facility on [DATE] with diagnoses including lower end left femur closed fracture; anterior displaced type II DENS fracture (fracture through the bony projection that extends upward from the second cervical vertebra), displaced fracture of the first cervical vertebra; fracture of the fourth thoracic vertebra; fracture of first lumbar vertebra, wedge compression fracture of the first lumbar vertebra; injury of the right vertebral artery; multiple fractures of ribs, left side, fracture of the shaft of the left tibia; fracture of the left clavicle; nondisplaced fracture of the medial malleolus of left tibia; dislocation of the left ankle joint, and lung laceration. A review of the hospital discharge instructions, dated [DATE], revealed under wound care: Keep your dressing/wound clean and dry at all times. Do not rub your incision or apply creams/ointments/lotions over the operative site until the wound is well healed (to be determined at your future clinic visits). Do not begin to shower and get operative site wet; do not scrub or soak your incisions. No submersive activities (swimming/bathing) until your wound is well healed (to be determined at your future clinic visit). Follow up: Please follow up with (name of physician) on 11/17/25 at 8:15 AM at (location of physician's office). You will be seen in the Trauma and Acute Care Surgery clinic on 11/19/25 at 2:30 PM for follow up. A review of the resident's physician's orders revealed no surgical incision care orders. Monitoring of the wounds was not ordered until 11/18/25. A review of the physician's progress note dated 11/13/25 revealed no information related to care and (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment of the resident's surgical incisions. A review of the Nurse Progress note dated 12/1/25, revealed that Licensed Practical Nurse (LPN) H documented at 12:58 PM, Contacted (orthopedic surgeon) regarding post-op appt (Post operative appointment) for 11/17/25. Nurse from orthopedics will be giving call back to reschedule appt (appointment) in 24-48 hours. A review of the November 2025 Medication Administration Record (MAR) revealed that monitoring of the resident's surgical wounds did not begin until 11/19/25. Monitor surgical site neck back and left side of body for drainage and redness change bandage if soiled one time a day. A review of the wound evaluation documentation revealed facility staff did not begin until 11/27/25. On this day the wound care nurse documented the resident had a surgical left leg with 0 documented under length, width, and depth. Under When was wound identified was noted a date of 11/25/25. Under Additional information was noted surgical down the left side of patient left leg current has staples and stiches o drainage noted. Under current treatment was noted Monitor surgical site neck back and left side of body for drainage and redness change bandage if soiled. A review of the skilled documentation note dated 11/13/25 revealed under the skin section that the resident had a surgical wound. In the summary of skilled services including teaching the nurse was documented Alert ad responsive with VSS (vital signs stable), in skilled facility r/t (related to) post MVA (motor vehicle accident), multiple fractures, medicated for pain with + (positive) effect, requires multiple staff members to assist with care, PT/OT (physical therapy and occupational therapy) evaluation today, currently resting in bed with call light by his side for safety. Further review of the skilled documentation notes for 11/15/25, 11/17/25, 11/21/25, 11/22/25, 11/24/25, 11/26/25 and 11/27/25, none of the assessments mentioned wound care under the skin assessments or in the summary of skilled services including the teaching section of the note. A review of the base line plan of care, dated 11/13/25, revealed that the resident was cognitively intact, had exhibited behaviors of reports will curse if has pain. Resident has skin impairment, type identified as surgical. A review of the Surgical Care Plan revealed a focus of The resident has a surgical wound to left abd (abdomen), upper chest, neck area, spine, left leg, arm, ankle and is at risk for complications. Goals included: surgical wound will show s/s (signs and symptoms) of healing/resolution without complications by/through next review date; educate resident/family/caregiver regarding treatments, labs, and diagnostics as well as importance regarding the need to reposition frequently, follow up with surgeon/physician as ordered/indicated; medicate for pain as needed proper to wound care treatments; notify MD (physician) of any s/s (signs/symptoms) of infection (redness, increased pain, purulent drainage, swelling, foul odor, etc.); observe/monitor for s/s of potential complication of wound. Notify MD as indicated; surgical wound treatments as ordered. A review of the resident's Plan of Care (POC) revealed: At risk for skin impairment r/t (related to) weakness/decreased mobility, use of neck brace, use of back brace, splints to left leg and knee (11/13/25). The resident has a surgical wound to left abdomen, upper chest neck area, spine, left leg, arm, ankle and is at risk for complications (11/13/25). Follow up with surgeon/physician as ordered/indicated (11/13/25). Notify MD (Medical Doctor) for any s/s (signs and symptoms) of infection (redness, increased pain, purulent drainage, swelling, foul odor, etc.) Observe/monitor for s/s of potential complications of wound. Notify MD as indicated. Surgical wound treatments as (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordered (11/13/25). On 12/04/25 at 10:09 AM, an interview was conducted with the wound care nurse who stated new orders for wound care popped up on her computer and she could run a report. She stated she saw all new admissions and saw Resident #64 when he was admitted but did not document anything. She offered that the nurses did skin assessments on admission, but she was not sure they did them accurately or at all, so she felt she had to do them herself. On 12/04/25 at 10:31 AM, an interview was conducted with the Director of Nursing (DON) during which she stated when a resident was admitted, the information from the hospital was put into the system until an MD told staff otherwise. If there were no orders for surgical incision wound care, staff should call the MD or the hospital to get orders. The nurse should document the incisions on the admission assessment. Nursing staff did skin sweeps upon admission and weekly. There was a schedule of when they were done. Skin tears, excoriation, etc., anything staff saw was put on the skin sweep form, including stage IV sacral wounds, until resolved, were documented on the skin sweep. On 12/04/25 beginning at 11:20 AM, interviews were conducted with six nursing staff who were all asked when skin sweeps were conducted. All six reported that skin sweeps were conducted on admission and if there was a change in condition. Registered Nurse (RN) G (11:20 AM); Licensed Practical Nurse (LPN) H (11:26 AM); LPN I (11:31 AM); LPN O (11:49 AM); LPN P (11:52 AM), and LPN Q (3:34 PM). On 12/04/25 at 4:00 PM, the facility's Medical Director was interviewed. When asked about expectations for care of surgical wounds on admission, he stated while he would not expect staff to remove a surgical wrap unless ordered, he would expect staff to assess the wound and contact the provider for orders. He stated wound care nurses and nursing staff were responsible for assessing and addressing wounds. On 12/04/25 at 4:45 PM, an interview was conducted with Resident #64's physician who stated surgical wound care should begin within 24 hours after admission and that wound care should be contacted immediately within hours as well as the wound care physician. He stated waiting two weeks to consult wound care was too long and the incisions should be looked at least every other day, and daily if they were bad. 2. On 12/01/25 at 11:00 AM, Resident #108 was observed lying in bed, awake, with his son at the bedside. The resident's left lower extremity below-the-knee amputation site was covered with an Ace-wrap dressing, and no date was observed on the outer dressing. The son stated the resident was primarily Spanish-speaking, but he could interpret as needed. He reported the resident had been admitted approximately one and a half weeks earlier and he did not believe staff had changed the wound dressing since the resident's admission. He stated he planned to ask staff about it today. On 12/02/25 at 9:05 AM, the resident was again observed awake in bed, listening to a podcast. A translator application was used to interview him. He stated he was doing well and rated his pain in the left lower extremity as 1 out of 10 with 10 being the worst possible pain. The Ace-wrap dressing remained in place without a date. The resident's right lower extremity was observed to have a square foam dressing over the shin, also without a date. When asked if staff at the facility had changed either dressing since his admission on [DATE], the resident stated, No, no one has changed either dressing since I left the hospital. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/02/25 at 11:10 AM, the resident's son was interviewed. He stated the right shin dressing appeared to be the same one placed at the hospital after the resident sustained a skin tear prior to discharge. He said he had not seen staff change it. Regarding the left lower extremity Ace wrap, he stated he did not believe it had been changed since admission. When he asked the resident directly during the interview whether anyone at the facility had changed either dressing, the resident again stated no. On 12/02/25 at 4:04 PM, the resident was observed awake in bed while talking on the phone. The Ace-wrap dressing on the left lower extremity and the square dressing on the right lower extremity both remained in place and undated. On 12/03/25 at 8:39 AM, the Director of Nursing (DON) was interviewed and asked to provide the facility's policy related to surgical wound care. She stated, We don't have a policy for surgical wound care. On 12/03/25 at 1:45 PM, the resident's second son was interviewed in the resident's room. He stated his father was at therapy. When asked whether any staff had changed the resident's left lower extremity dressing, he stated the nurse had changed it earlier today. He reported the dressing had not been changed prior to that since the resident's admission on [DATE]. He stated he took a picture of the wound during the dressing change today, and the nurse told him the sutures were intact but there was a fluid-filled sac on the stump. He stated the right lower extremity dressing also appeared unchanged since the hospital. On 12/03/25 at 2:05 PM, the wound care nurse was interviewed. She stated Resident #108 was a new admission on my list today, though the resident was admitted on [DATE]. She confirmed this was her first assessment of his wounds. She stated the left lower extremity stump had intact sutures and a dry, intact fluid-filled sac. She stated she did not yet have treatment orders and needed to call the surgeon. When asked about assessments performed since admission, she stated the admission nurse documented the first assessment and she follows behind, but she was unaware that she was the first nurse to assess the wound since admission. Regarding the right lower extremity dressing, she stated she had not yet assessed it, did not have any orders related to it, and had not had a chance to see it. On 12/03/25 at 2:35 PM, the wound care nurse was observed assessing the resident's right lower extremity wound for the first time. With the son interpreting, the resident again stated no staff had removed or assessed the dressing since he was admitted . The wound care nurse removed the dressing, revealing a small amount of dried dark red drainage. When asked whether anyone at the facility had removed or assessed the left lower extremity amputation site prior to that morning, the resident stated today was the first time, and that the dressing had been in place since the hospital. The wound care nurse stated she had not realized that no one had assessed the wounds prior to her doing so. On 12/04/25 at 9:58 AM during a follow-up interview, the wound care nurse stated she documented wound notes under Assessments. When asked for the notes for the wound care she provided on 12/03/25, she stated she had not written any yet and had not got to it. She confirmed no weekly skin sweep assessments had been documented since admission. She reported she spoke with the vascular surgeon on 12/03/25 and received instructions to cleanse the wound with normal saline and apply skin prep. When asked about the existing order dated 11/26/25 directing staff to monitor the left BKA (below knee amputation) site every shift for signs of infection, dehiscence, or other complications, she stated this order required the dressing to be removed and the wound observed each shift. She (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she could not confirm that any nurse had completed such assessments prior to her evaluation on 12/03/25. She stated only she and the DON performed all wound care and skin sweeps, and that this workload contributed to delays in documentation. On 12/04/25 at 10:31 AM, the DON stated upon admission, hospital information was entered into the system and staff must contact the provider if no wound care orders are present. She stated admission nurses were expected to document surgical incisions on the admission assessment, and that nursing staff completed skin sweeps upon admission and weekly thereafter. On 12/04/25 at 4:00 PM, the facility's Medical Director was interviewed. When asked about expectations for care of surgical wounds on admission, he stated he would not expect staff to remove a surgical wrap unless ordered, he would expect staff to assess the wound and contact the provider for orders. He stated wound care nurses and nursing staff were responsible for assessing and addressing wounds. A review of the medical record revealed that the resident was admitted on [DATE] with a left below-the-knee amputation (BKA) and type II diabetes. The care plan initiated on 11/29/25 identified the surgical wound and risk for complications, with a goal of healing without complications. Interventions directed staff to observe for complications, notify the physician, provide surgical wound treatments as ordered, and observe the wound as needed for infection, drainage, pain, temperature changes, and signs of circulation concerns. Orders dated 11/26/25 instructed staff to monitor the LLE (left lower extremity) BKA site every shift for signs of infection, dehiscence, or other complications and to call the surgeon for concerns. There was no order addressing care of the right lower extremity skin tear. R A review of the resident's November 2025 and December 2025 Treatment Administration Records (TARs) revealed that the LLE wound monitoring order was signed as completed each shift from 11/26/25 through 12/03/25, although no evidence was found that any wound assessment occurred during that period. The TARs contained no entries related to the right lower extremity dressing. A review of the admission nursing assessment for Resident #108, dated 11/25/25, revealed a dressing on the right lower extremity from the hospital and a dressing on the left lower extremity amputation site. There was no assessment of either wound charted with the admission assessment. Further review of the medical record revealed no assessments of either wound until 12/3/25. The facility's policy and procedures titled Prevention of Skin Impairments/Pressure Injury (revised 1/2024), required a comprehensive skin assessment upon admission, evaluation and documentation of changes in skin condition, notification of the physician and resident or representative of changes, and evaluation of surgical areas per physician orders.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, interviews, medical record and facility policy and procedure review, the facility failed to ensure that two (Residents #4 and #95) of two residents reviewed for continuous oxygen therapy, out of three residents who received continuous oxygen therapy, received oxygen as ordered and consistent with professional standards of practice. The findings include: 1. An observation was made of Resident #4 was on 12/01/2025 at 1:15 PM. He was in bed eating lunch with a nasal cannula in place and his oxygen (O2) concentrator running. The concentrator was delivering oxygen at a rate of 4 liters per minute (LPM). When asked what his orders for O2 were, Resident #4 stated he was supposed to receive oxygen at 4 LPM. On 12/04/2025 at 10:30 AM, Resident #4 was observed in bed eating breakfast with the nasal cannula in place. Oxygen was flowing at a rate of 4 LPM. An interview was conducted with Licensed Practical Nurse (LPN) P on 12/04/2025 at 10:46 AM. She explained that Resident #4 received continuous O2 at a rate of 2 LPM. She reviewed the record and verified that O2 delivery was ordered at a flow rate of 2 LPM. On 12/04/2025 at 11:11 AM, Resident #4 was observed in bed with his nasal cannula in place and O2 running at 4 LPM. Upon inspection of the concentrator, the filter on the back of the machine was coated with a copious amount of light grey powdery buildup resembling dust. (Photographic evidence obtained) LPN P was accompanied to the resident's room to look at the oxygen flow rate setting and the condition of the concentrator's filter. She looked at the concentrator flow rate setting and confirmed that O2 was running at a rate of 4 LPM. She sighed and shook her head. No. LPN P was then asked who was responsible for maintaining the concentrators. She responded, Housekeeping. When shown the condition of the filter on the back of the concentrator, she acknowledged the buildup and said she would report it to Housekeeping immediately. The remainder of the 200 nursing unit was toured at this time, and there was only one additional resident on the unit using continuous oxygen, Resident #95. She was lying in bed with her oxygen concentrator running at 3 LPM and a nasal cannula in place. When asked what the order for her oxygen delivery rate was, she stated it was supposed to be set at 3 LPM. A record review for Resident #4 revealed diagnoses including but not limited to emphysema (lung condition that causes difficulty breathing due to damaged sacs in the lungs) and chronic respiratory failure with hypercapnia (too little oxygen or too much carbon dioxide in the body). Resident #4 had a physician's order for oxygen via nasal cannula at 3 LPM, not 4 LPM as observed and reported by the resident. 2. A record review for Resident #95 revealed a diagnosis of chronic obstructive pulmonary disease (COPD, a progressive lung disease characterized by inflamed and damaged airway). Resident #95 had a physician's order dated 12/02/2025 for O2 via nasal cannula (NC) or mask. Encourage and assist resident to use O2 at 4 LPM via NC as needed for shortness of breath. (Photographic evidence obtained) An interview was conducted with LPN O on 12/04/2025 at 12:25 PM. She was asked about Resident #95's O2 use. She stated Resident #95 has been on continuous oxygen for a long time at 2 LPM. When advised that the current order was for 4 LPM, she looked in the electronic record and confirmed that was the order. LPN O was accompanied to the resident's room, and she observed that the concentrator was set for 3 LPM. She adjusted the dial to 4 LPM with no explanation. An interview was conducted with the Director of Nursing (DON) on 12/04/2025 at 5:30 PM. When advised of the observations on the nursing floor for oxygen delivery, she acknowledged the findings and said she had heard about that. A review of the facility standards and guidelines for Oxygen Administration (issued 10/2019, revised 12/2023), revealed: Standard: The purpose of this procedure is to provide oxygen administration. Procedure: Review the physician's order for oxygen administration. The guidelines further instructed staff to adjust oxygen delivery so that the appropriate flow of oxygen was being administered according to the residents' needs. (Photographic evidence obtained)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of resident records and interviews with staff, the facility failed to 1) Ensure that one resident's (#110) medications were held according to the physician's prescribed parameters, and 2) Ensure sufficient monitoring for one resident (#77) receiving psychotropic medication for mood and behavior, from a total of six residents reviewed for unnecessary medications. The findings include: 1.A review of Resident #110's medical record revealed that he was admitted to the facility on [DATE] and then readmitted on [DATE] with diagnoses including hypotension. Further review of the record revealed a physician's order dated December 1, 2025 which read: Midodrine 10 mg (milligrams), give one tablet by mouth every eight hours as needed for a systolic blood pressure of less than 100. A review of Resident #110's December 2025 Medication Administration Record (MAR) revealed the following blood pressure readings documented in association with Midodrine 10 mg signed off as having been administered: On December 1, 2025 at 10:00 p.m., blood pressure was recorded as 122/68. On December 2, 2025 at 6:00 a.m., blood pressure was 119/64. On December 3, 2025 at 6:00 a.m., blood pressure was 103/67. On December 3, 2025 at 2:00 p.m., blood pressure was 111/63. On December 3, 2025 at 10:00 p.m., blood pressure was 116/65. On December 4, 2025 at 6:00 a.m., blood pressure was recorded as 100/68. All of these blood pressure readings were documented at or above the ordered systolic parameter of less than 100. On December 4, 2025 at 6:35 a.m., during an interview with Licensed Practical Nurse (LPN) D, she was asked to review the medications she administered to Resident #110 that morning. She was asked specifically about the Midodrine 10 mg marked as administered and what the resident's blood pressure was at the time. She stated the resident's blood pressure was 115/68. Upon reviewing the MAR, it showed a blood pressure entry of 100/68 at 6:00 a.m. with the medication marked as administered. LPN D stated, I didn't give that to him this morning. LPN D was asked to provide the medication card for Resident #110's Midodrine. The medication card label indicated one card of one card dispensed by the pharmacy on November 30, 2025. The card was observed to be missing six tablets. Further review of the MAR indicated a total of eight doses having been signed off as administered between December 1, 2025 and December 4, 2025. LPN D confirmed this was the only card of Midodrine available for the resident in the medication cart. The MAR further revealed that the resident did not receive any documented doses of Midodrine on November 30, 2025, the date of readmission. On December 4, 2025 at 9:00 a.m., during an interview with the Director of Nursing (DON), she was asked to confirm whether a check mark on the MAR indicated a medication was administered. She (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated a check mark indicated the medication was given. Nurses were trained to mark medications when administered. When asked what was expected if a medication was not administered, she stated the nurse should use the appropriate code to indicate why the medication was not given. She was asked to review whether Resident #110 was documented as having received six doses of Midodrine when the blood pressure parameters were not met. After reviewing the MAR, she stated it may have been signed when the blood pressure was taken. I can see what you are saying; it looks like the medication was given the way it's written. When advised that the medication card showed six tablets missing and asked whether only two doses should have been administered based on the ordered parameters, she stated unless a pill fell out of the card, the medication must have been given. On December 4, 2025 at 4:45 p.m., during an interview with the physician responsible for the care of Resident #110, he was asked whether he was aware that the resident had received Midodrine 10 mg every eight hours as needed for a systolic blood pressure of less than 100 on six occasions when documented blood pressures were at or above the ordered parameter. He stated he did not recall and indicated that his on-call service or nurse practitioner may have addressed it. When asked about potential effects of administering Midodrine outside of ordered parameters, he stated if it was being given daily he would schedule it routinely, as some patients were chronically hypotensive, and if he felt there was risk, he would schedule it once daily. According to the Mayo Clinic, Midodrine is used to treat low blood pressure and works by tightening blood vessels to increase blood pressure. The Mayo Clinic states that Midodrine may cause supine hypertension, which is high blood pressure when lying down, and advises that this medication should be taken exactly as directed because taking it when blood pressure is not low can increase the risk of adverse effects. Reported side effects include high blood pressure, pounding heartbeat, headache, dizziness, and blurred vision, and the medication should not be taken when blood pressure is normal or elevated due to the risk of excessive blood pressure increase (Mayo Clinic, 2023). A review of the facility's policy titled Medication Administration (revised January 2004), revealed that medications were to be ordered and administered safely and as prescribed. The policy read that the Director of Nursing supervised personnel who administered medications, that medications were administered in accordance with prescriber orders including required parameters, and that the individual administering medications must verify the right resident, right medication, right dose, right time, and right route prior to administration. The policy further required verification of vital signs when necessary, prior to medication administration. 2.An observation of Resident #77 on 12/01/2025 at 2:44 PM revealed she was awake in bed with one non-skid sock on; the other sock was on the floor across the room. When greeted, Resident # 77 loudly and repeatedly demanded, Miss, Miss, pick me up, pick me up! or I need my sock. or Need medicine, get the nurse! LPN O was advised, who reported that this was typical behavior for this resident. She stated she had administered PRN (pre re nata, or as needed) Ativan (a medication used to treat anxiety). She also explained that Resident #77 was receiving Depakote (a medication used to treat seizure disorder or mood), scheduled Ativan and ABH gel (a topical formula containing Ativan, Diphenhydramine Hydrochloride [Benadryl, an antihistamine], and Haloperidol [an antipsychotic medication used to treat psychiatric conditions). On 12/02/2025 at 3:57 PM, an interview was conducted with LPN P. She volunteered that Resident #77 was very difficult. She could be combative, aggressive and yelled out all day to Pick me up! and Get my phone!. The resident previously resided in another nursing home, but her family reported over-sedation and did not want her on too many medications. The Ativan and ABH gel prescribed her (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	doesn't touch her. During an observation of Resident #77 on 12/03/2025 at 1:55 PM, she waved down two surveyors and demanded a cookie several times. You give me a cookie! In a second interview with LPN P on 12/04/2025 at 10:57 AM, she explained that Resident #77 was very difficult and could not be redirected if she began perseverating about what she wanted. The demand I want coffee. got stuck and the resident continued to repeat the demand even after it was fulfilled. This also included demands to pick her up, then put her back down (in bed) then pick her up again. Medications don't touch the behavior, nothing does. She responds positively to family visits and at times, can be calm as a lamb in the main dining room; however, she won't go there for activities; she screams, Take me back! Music doesn't calm her either. When she is in behavior, staff try to talk with her or meet her demands. In an interview with Certified Nursing Assistant (CNA) T on 12/04/2025 at 2:55 PM, she reported that Resident #77 was always asking for something. Get up, go down . CNA T stated the resident did not really respond to activities, but staff accommodated all requests, otherwise she would try to get up and fall. She stated the resident liked it when her family visited and she would be calm, but no activities really suited her. Multiple passes by Resident #77's room were conducted by three surveyors during the 12/1/25 to 12/4/25 survey to find the resident yelling out and agitated, requiring frequent attention from licensed staff. A review of Resident #77's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included, but were not limited to, metabolic encephalopathy (brain dysfunction caused by organ failure or illness that affects normal brain activity), cognitive communication deficit, anxiety disorder, major depressive disorder, unspecified dementia without behavioral disturbance and mood disturbance. Per her admission 5-day Minimum Data Set (MDS) assessment, she had a brief interview for mental status (BIMS) score of 3 out of 15 possible points, indicating severe cognitive impairment. No behaviors were noted during the assessment look-back period. She required maximum to total assistance from staff with activities of daily living. Resident #77 was care planned on 9/30/25 for a history of exhibiting impulsivity, physical aggression, scratching/clawing at staff, hollering out repeated phrases; when asked what she needs, will stare then keep hollering out; will grab onto staff and hold tightly in an attempt to dig nails in. The goal was to have fewer episodes of the identified behavior through the next review date of 12/16/25. Interventions included administration of medications as ordered, monitor/document for side effects and effectiveness, and monitor behavior episodes and attempt to determine the underlying causes. Document behavior and potential causes. Psychiatry services as needed. Resident #77 was care planned on 9/16/25, with revision on 9/29/25, for a mood problem, anxiety. The goal was to have an improved sleep pattern and mood state through the next review date. Interventions included: monitor/record/report acute episode feelings or sadness, loss of pleasure or interest in activities, feelings of worthlessness or guilt, change in appetite/eating, change in sleep patterns, diminished ability to concentrate or changes in motor control to the physician. (Photographic evidence obtained) (continued on next page)		

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Centers for Medicare & Medicaid Services

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #77 had a physician's order dated 10/23/25 for Mirtazapine (a medication used to treat depression but can also treat anxiety and insomnia) 7.5 milligrams (mg) every night at bedtime for anxiety, Ativan 1 mg every 6 hours as needed for anxiety (ordered 12/2/25, end 12/16/25), ABH topical gel, apply to upper back topically every 6 hours as needed (start 12/2/25 end 12/16/25), and Depakote Sprinkles 125 mg 10 capsules two times daily for behavior. Further review of the orders, progress notes and medication administration record revealed no active monitoring for what behaviors were occurring, what non-pharmacological interventions were offered when exhibiting those behaviors or any side-effects observed for any of the psychoactive medications she was receiving. An interview was conducted with the DON on 12/04/2025 at 5:35 PM. She was asked if nursing staff monitored residents for behaviors, interventions and side effects for psychotropic medications. She said yes, that was expected. She was asked for Resident #77's behavior monitoring. She departed the room and returned with a CNA task list that showed when behaviors were occurring but did not include any additional monitoring. She acknowledged the finding and departed again to look but did not return. During a second interview at approximately 6:30 PM, the DON acknowledged that Resident #77 had no active behavior monitoring, as required.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105547	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Flagler Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Dr Carter Boulevard Bunnell, FL 32110	
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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observations and interviews with dietary staff, the facility failed to ensure the area surrounding the commercial trash dumpsters was clean and free of debris, and that all waste was contained inside the receptacle. The findings include: As part of the initial tour of the kitchen with the Director of Dietary Services (DDS) on 12/01/2025 AM at 10:20 AM, the commercial dumpsters behind the building were inspected. The grassy and wooded area around and behind the dumpsters was observed with scattered debris including used and inverted blue medical gloves, paper, plastic bottles, baggies and cup lids, a foam to-go food container, a cup and other food containers. The DDS acknowledged the scattered trash but stated she was not sure who was responsible for cleaning it up. She wasn't sure who was responsible for maintaining the dumpster area. During another visit to the dumpster area with the visiting DDS from a sister facility on 12/04/2025 at 10:32 AM, the dumpster area was found in the same condition as during the 12/01/2025 observation at 10:20 AM, with trash strewn about. He stated he had not been advised of the observation and condition of the dumpsters on Monday. He confirmed the condition of the area and stated he would have maintenance clean it up.		

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff followed Enhanced Barrier Precaution (EBP) requirements for Personal Protective Equipment (PPE) use during high-contact resident care activities for one (Resident #30) of three residents sampled for review of Enhanced Barrier Precautions. The findings include: On 12/03/25 at 12:54 PM, an observation was made of the Wound Care Nurse who was providing care to Resident #30's left shoulder wound. The Wound Care Nurse was assisted by Certified Nursing Assistant (CNA) J, who assisted with turning the resident. A blue dressing was noted on the resident's left shoulder that was dated 12/01/25. At this time the Wound Care Nurse stated she had changed the dressing yesterday (12/02/25) but had gotten the date wrong on the dressing. Neither the nurse nor the CNA wore PPE as directed on the EBP notice on the outside of the resident's room. A supply bin with PPE was noted on the exterior of the room. (Photographic evidence obtained) On 12/03/25 at 1:10 PM, an interview was conducted with the Wound Care Nurse immediately after the completion of the wound care for Resident #30. She was asked about the EBP stop sign notice hanging on the door frame of the resident's room. She stated she should have worn a gown; she just forgot. On 12/03/25 at 1:19 PM, a joint interview and observation was conducted with CNA L and CNA J. They were observed in the resident's room together repositioning the resident and pulling him up in the bed after the completion of the wound care. During this observation, neither CNA was noted wearing PPE. As they exited the room they were asked about PPE and they both stated they should have worn a gown since they were touching the resident. CNA L stated she was not aware that the resident was on EBP until just now. On 12/03/25 at 1:57 PM, an interview was conducted with the Director of Nursing (DON) who was asked about EBP expectations. She stated EBP were used for residents with colostomies, catheters, wounds, and PICC (peripherally inserted central catheter) or IV (intravenous) lines, etc. If staff were not touching the resident, then they did not have don PPE; however, if they were providing care they were expected to wear PPE such as gowns and gloves. A review of Resident #30's medical record revealed he was admitted to the facility on [DATE]. On the Medical Certification for Medicaid Long-Term Care Services and resident Transfer form 3008 he had a primary diagnosis of sepsis and a history of MRSA (methicillin-resistant Staphylococcus aureus) of the left shoulder wound and required contact isolation. He was receiving antibiotics for MRSA/Strep Group A (a bacterium that can cause a variety of mild to severe illness). A review of the Enhanced Barrier Precautions Stop Sign outside of Resident #30's room revealed, EVERYONE MUST: Clean their hands, including before entering and when leaving the room. and PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing Briefs or assisting with toileting, Device care or use; Central Line, urinary catheter, feeding tube, tracheostomy; Wound Care: any skin opening requiring a dressing. A review of the facility's policy and procedure titled Standards and Guidelines, Enhanced Barrier Precautions (last revised 5/28/24), revealed: The policy defines EBP refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Under item 9 Appropriate PPE for EBP would include a. Gown b. Gloves. Item 10 Employees should wear appropriate PPE when performing the following duties for residents requiring EBP i. wound care. Item 15 states EBP should remain in place for the duration of the resident's stay or until the resolution of the wound or discontinuing the medical device.		