STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105621	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Campus Rehabilitation and Nursing Center	700 N Palmetto St Leesburg, FL 34748

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure medications were secure when unattended, failed to label medications, and failed to discard expired medications. Findings include: 1. During an observation on 4/19/2026 at 9:10 AM of Resident #44's room there were unsecured medications at bedside. The medications consisted of four cups of crushed pills, one cup of clear liquid, and one clear vial of medication. During an interview on 4/22/2026 at 8:45 AM Staff A, Registered Nurse (RN) stated, The medication at bed side are the morning meds. I couldn't tell you each medication. They are part of the med pass, and the vial is the eye drops. Review of Resident #44's medication administration record (MAR) documented the morning medications at the bedside as aspirin chewable 81mg (milligram), cyanocobalamin 1000 mcg (micrograms), escitalopram oxalate oral solution 5 mg/5ml (milliliters), ferrous sulfate 325 mg, lisinopril 20 mg, acidophilus lactobacillus oral capsule, cyclosporine ophthalmic emulsion 0.05 %, oxybutynin 5 mg, hydralazine 50 mg, and carbidopa-levodopa 25-100 mg. 2. During an observation of medication cart #1 on 4/19/2026 at 10:35 AM there was one Lantus insulin with an expiration date of 4/16/2026, one Novolog insulin with an expiration date of 4/16/2026, and four capsules in a medication cup, not in the original pharmacy packaging and unlabeled. During an interview on 4/19/2026 at 10:36 AM Staff C, Licensed Practical Nurse (LPN) stated, The insulin is expired and shouldn't be in the cart. Those are fish oil. They should be in their container. They are not labeled. It should not be like that. 3. During an observation of medication cart #2 on 4/19/2026 at 10:40 AM there was one Novolog insulin with an expiration date of 2/26/2026, one glargine insulin with an open date of 3/1/2026 [expires 28 days after being opened], one Novolog insulin with an open date of 3/1/2026 [expires 28 days after it is first opened], one glargine with an expiration date of 4/15/2026, and one unopened Novolog insulin with pharmacy instructions to refrigerate until opened [to maintain maximum potency and stability to ensure effectiveness]. During an interview on 4/19/2026 at 10:43 AM Staff B, LPN stated, They [the medications] are expired and shouldn't be on the cart. That is not opened [Novolog insulin], it should not be on the (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cart. 4. During an observation of medication cart #3 on 4/19/2026 at 10:45 AM there were two opened glargine insulins with no open dates [critical to track the 28-day expiration period] and one Novolog insulin with no open date. During an interview on 4/19/2026 at 10:50 AM Staff A, Registered Nurse (RN) stated, They [the medications) should have the dates on them of when they were opened. 4. During the medication administration observation on 4/20/2026 at 8:14 AM of Staff, I, LPN, when the medication cart was opened for Staff I to start preparation for medication administration there was a medication cup that containing a small white pill and a tan colored pill in the drawer. The medications were not in the original pharmacy packaging, and the medication cup was not labeled. During an interview on 4/20/2026 at 8:15 AM Staff I, LPN stated, I do not know what these are. They should not be in the medication cart. We cannot pre pour medications or leave them in the cart without labeling them. During an interview on 4/20/2026 at 1:30 PM the Director of Nursing (DON) stated, All meds [medications] should be labeled when they are opened. We should not have any medications at bedside, and we should have all meds on the cart labeled. Review of the policy and procedure titled, Medication/Biological Storage with a last approval date of 1/13/2026 read, Policy: It will be the policy of this facility to store medications, drugs, biologicals in a safe, secure and orderly manner. Procedure: 1. Medications, drugs, and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received, unless otherwise necessary. 2. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner. 4. The facility shall not use discontinued, outdated or deteriorated medications, drugs or biologicals.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food was properly stored in 1 of 3 nourishment rooms (West Unit nourishment room) and failed to ensure food was prepared and/or served in a sanitary manner. Findings include: During an observation on 04/19/2026 at 11:37 AM, the Director of Food and Nutritional Services was wearing gloves and plating meal trays from the steam table for lunch. The Director of Food and Nutritional Services walked to the microwave, removed the glove from her right hand, pushed a button on the microwave with her right hand, and removed a container from the microwave. The Director of Food and Nutritional Services did not perform hand hygiene, walked back to the tray line, and put a new glove on her right hand and continued plating food. During an observation on 04/19/2026 at 11:38 AM, the Director of Food and Nutritional Services was observed handing plates of food to Staff E, Dietary Aide, who was not wearing gloves. Staff E, Dietary Aide was observed handing plates of food to Staff D, Dietary Aide, who was also not wearing gloves. Staff D, Dietary aide was observed with the bare thumb of his right hand touching the inner food contact surface of the plate, touching the mashed potatoes on the plate. Staff D then shook off his hand and placed the plate of food onto a tray, covered the plate, and placed the tray onto the tray cart. During an interview on 04/21/2026 at 10:00 AM, the Director of Food and Nutritional Services stated, If [Staff D, Dietary Aide's name] touched the food with his bare hand, he should have handed the plate back, and had a new, fresh plate of food made.During an interview on 04/21/2026 at 10:01 AM, The Director of Food and Nutritional Services stated, I did not need to do hand hygiene when I took the food out of the microwave because I was just continuing to do the same task, and I did not touch the food with my hands.During an observation on 04/19/2026 at 10:52 AM, an opened container of Med Pass was observed in the [NAME] Unit nourishment room refrigerator. The container of Med Pass was approximately 3/4 empty and did not have an opened date. The container of Med Pass read, After open, consume product within 4 days if properly refrigerated.During an interview on 04/19/2026 at 11:02 AM, the Director of Nursing stated, That Med Pass should have an opened date on it.Review of the policy and procedure titled, Food and Nutrition Services Policy with a last reviewed date of 01/13/2026 read, Policy: The facility shall provide each resident with a nourishing, well-balanced diet that meets daily nutritional and special dietary needs, prepared and served under sanitary conditions and in accordance with professional standards for food safety. B. Food Storage. 4. Foods shall be: Dated and labeled upon receipt/opening. C. Food Preparation 1. Staff shall perform proper hand hygiene before and during food preparation. 2. Gloves shall be used appropriately and changed between tasks.Review the of policy and procedure titled, Meal Distribution with a last reviewed date of 01/13/2026 read, Policy: It is the policy of this facility that meals are transported to the dining locations in a manner that ensures proper temperature maintenance, protects against contamination, and are delivered in a timely and accurate manner. 5. Proper food handling techniques to prevent contamination and temperature maintenance will be used during meal delivery and at point of service dining.Review of the policy and procedure titled Hand Hygiene last approval date of 1/13/2026 read, Policy: The facility considers hand hygiene the primary means to prevent the spread of infections. Procedure: 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 5, Use an alcohol based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. before and after coming into direct contact with residents. c. before and after handling medications; e. before and after handling an invasive device (e.g. urinary catheter, IV access devices. 6. Hand hygiene is the final step after removing and disposing of personal protective equipment. 7. The use of gloves does not replace hand washing/hand hygiene, integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to maintain the facility interior in a sanitary and orderly manner for 3 of 3 medication storage rooms.Findings include:During an observation on 4/19/2026 at 10:51 AM with Staff A, Registered Nurse (RN) of medication room [ROOM NUMBER], the sink had a very thick brown substance on it covering the entire sink basin which was sticky to the touch. There were multiple pieces of paper and medication caps in the sink. There were bags and paper towels on the floor, and the floor had a sticky residue when walking on the floor.During an interview on 4/19/2026 at 10:51 AM Staff A, RN stated, The sink is filthy and there are multiple things in the sink. The floor is dirty and sticky. I don't know the last time it was cleaned.During an observation on 4/19/2026 at 11:20 AM of medication room [ROOM NUMBER], the Director of Nursing (DON) verified there was a brown sticky substance on the sink with multiple papers and medications caps in the sink basin, the floor contained bags, papers and a sticky residue when walking on the floor.During an observation on 4/19/2026 at 11:25 AM of medication room [ROOM NUMBER] with the DON the sink had a brown residue and on the floor were multiple items of paper and medication caps.During an observation on 4/19/2026 at 11:30 AM of medication room [ROOM NUMBER] there was a plastic bag over the sink handles, and the basin was dirty and rusty. The floor was not clean, there were many items on the floor, and the floor was sticky while walking on it.During an interview on 4/19/2026 at 11:31 AM the DON stated, The medication rooms are not clean, the sinks are dirty and need cleaning. There is trash on the floors, and the floors need to be cleaned. Medication room [ROOM NUMBER] has a non-working sink and staff would not be able to wash their hands while in the medication room. I do not know why they [the medication rooms] were not being cleaned, they should be.During an interview on 4/22/2026 at 06:30 AM the Environmental Services Director stated, The rooms [medication rooms] have not been being cleaned regularly. They are in need of deep cleaning. They [the medications rooms] were not on a routine cleaning schedule and should have been.Review of the policy and procedure titled Environmental Services Cleaning Guidelines with a last approval date of 1/13/2026 read, Policy: It is the policy of this facility that the workplace will be maintained in a clean and sanitary condition with a written schedule of cleaning and decontamination based on area of the facility, type of surface to be cleaned, type of soil present and tasks being performed in the area. Procedure: Horizontal surfaces:1. Surfaces such as table tops, window ledges, bedside stands, counters, sinks, tubs, shower floors, toilet seats, floors, and all other surfaces will be cleaned daily using EPA approved hospital grade disinfectant-detergent solution. 2. These surfaces will also be cleaned as needed when spills or soiling occur. Schedule of Cleaning: 1/A cleaning schedule and the employee responsible for these tasks are to be maintained by the Housekeeping Supervisor. Hand washing Facilities: 1. Hand washing sinks will be cleaned and checked daily for adequate function and supplies. Review of the policy and procedure titled, Medication/Biological Storage with a last approval date of 1/13/2026 read, Policy: It will be the policy of this facility to store medications, drugs, biologicals in a safe, secure and orderly manner. Procedure: 1. Medications, drugs, and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received, unless otherwise necessary. 2. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner. 4. The facility shall not use discontinued, outdated or deteriorated medications, drugs or biologicals.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a required Level 2 Preadmission Screening and Resident Review (PASARR) was completed for 1 of 3 residents, Resident #86, reviewed for PASARR. Findings include:Review of Resident #86's medical record documented the resident was admitted into the facility on [DATE]. Dated 02/18/2026 a Level I PASARR was completed related to the resident having a new medical diagnosis of Brief Psychotic Disorder. The Level I PASARR indicated a Level 2 PASARR should be completed. The record did not contain a Level 2 PASARR.During an interview on 04/21/2026 at 9:15 AM, the Director of Nursing stated, I will get with social services and let you know about the PASARR.During an interview on 04/21/2026 at 11:33 AM the Director of Social Services stated, [Resident #86's name's] level 2 PASARR is in the process of being completed. We had attempted to finish it, and submitted it, and [name of the healthcare management partner] closed it.Review of the policy and procedure titled, Role of Admissions and Social Services in PASARR reviewed 01/13/2026 read, Policy: The facility will ensure each resident in a nursing facility is screened for a mental disorder (MD) or intellectual disability (ID) prior to admission and that individuals identified with MD or ID are evaluated and receive care and services in the most integrated setting appropriate to their needs by coordinating with the appropriate, State-designated authority. The facility will ensure that individuals with a mental disorder or intellectual disabilities continue to receive the care and services they need in the most appropriate setting, when a significant change in their status occurs. IV. Resident Review: 1. The facility Social Service Director/Credentialed user will complete a referral for Level II resident review evaluation for individuals previously identified by PASARR to have a mental disorder, intellectual disability, or a related condition who experience a significant change. 2. Referring all Level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for Level II Resident Review upon a significant change is status assessment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to ensure the implementation of resident care plans for 3 of 6 residents, Residents #86, #73, and #23, reviewed for care plans. Findings include: 1) During an observation on 04/20/2026 at 8:25 AM, Resident #86 was sitting up in bed sleeping with the overbed table in front of her. There were no floor mats on the sides of the bed. Review of Resident #86's care plan dated 04/16/2026 read, Focus: [Resident #86's name] is at risk for falls and/or fall related injury r/t [related to]: generalized weakness, limited endurance, impaired balance, has a hx [history] of falls, has poor safety awareness, has impaired vision, receives psychotropic meds, use of antiplatelet. Interventions: 1/24/26 bilateral floor mats for safety. During an observation on 04/21/2026 at 9:18 AM, Resident #86 was sitting up in bed. The resident was adequately groomed and dressed appropriately for the time of day and the weather. There were no floor mats beside the bed. During an interview on 04/21/2026 at 9:21 AM, Staff F, LPN [Licensed Practical Nurse] stated, To prevent falls for [Resident #86's name], we do every two hour checks on her and supervise her. I don't think she is care planned for floor mats. During an interview on 04/21/2026 at 9:48 AM, the Director of Nursing stated, [Resident #86's name] is supposed to have bilateral floor mats for safety. Review of the policy and procedure titled, Comprehensive Assessments and Care Plans reviewed 01/13/2026 read, Standard: It will be the standard of this facility to make a comprehensive assessment of a resident's needs, strengths, goals, life history, and preferences, using the resident assessment instrument (RAI) specified by CMS. Guidelines: 8. The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at 483.10(c)(2) and 483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. 11. The services provided or arranged by the facility, as outlined by the comprehensive care plan, will be provided by qualified persons in accordance with each resident's written plan of care and will also be culturally-competent and trauma- informed. 2) Review of Resident #73 admission record documented diagnosis to include chronic obstructive pulmonary disease (COPD), unspecified, chronic pulmonary edema, dependence on supplemental oxygen, chronic kidney disease, unspecified, chronic diastolic (congestive) heart failure, major depressive disorder, gastro-esophageal reflux disease without esophagitis, hyperlipidemia, unspecified, chronic pulmonary embolism, essential (primary) hypertension, chronic embolism and thrombosis of other specified veins. Review of Resident #73 physician orders dated 1/16/2026 read, Continuous O2 [oxygen] at 2L-3L [liters]/MIN [minute] via NC [nasal cannula] q [every] shift to maintain O2 greater than 93% every shift. Review of Resident #73's comprehensive care plan read, [Resident #73's name] has a potential for (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	complications of respiratory distress r/t [related to] dx [diagnosis of] COPD, hx [history of] CHF [congestive heart failure], hx COVID [Coronavirus Disease]. Interventions: O2 sats [saturations] as ordered. Administer O2 as ordered. During an interview on 4/20/2026 at 1:40 PM Staff J, LPN stated, At times the resident or staff can bump the concentrator, and it will be very sensitive. During an interview on 4/22/2026 at 7:25 AM the Director of Nursing (DON) stated, We should always follow the care plan interventions and have the oxygen running correctly. 3) Review of Resident #23's admission record documented diagnosis to include metabolic encephalopathy, acute on chronic diastolic (congestive) heart failure, brief psychotic disorder, chronic kidney disease, stage 3 unspecified, chronic obstructive pulmonary disease with (acute) exacerbation, chronic respiratory failure with hypoxia, hyperlipidemia, unspecified, hypertensive heart disease with heart failure, iron deficiency anemia, major depressive disorder, recurrent, mild, obstructive sleep apnea (adult) (pediatric), other seizures, other specified anxiety disorders, other symptoms and signs involving cognitive functions following nontraumatic intracerebral hemorrhage, paroxysmal atrial fibrillation, presence of cardiac pacemaker, sick sinus syndrome, sick sinus syndrome and type 2 diabetes mellitus without complications. Review of Resident #23's physician orders dated 4/14/2026 read, Oxygen at 5 liters/minute via nasal cannula, continuously. During an observation on 4/19/2026 at 12:20 PM Resident #23 was on 4 liters of oxygen via nasal cannula. Review of Resident #23 comprehensive care plan read, Problem: [Resident #23's name] has potential for complications r/t an alteration in cardiac function d/t dx of: CHF, hx of MI [myocardial infarction – heart attack] , hyperlipidemia, coronary angioplasty, dx of heart disease. Interventions: O2 sats as ordered. Administer O2 as ordered. During an interview on 4/22/2026 at 7:25 AM the DON stated, We should always follow the care plan interventions and have the oxygen running correctly.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure midline catheter intravenous medication administration was completed according to professional standards of practice for 1 of 2 residents, Resident #16, reviewed with a midline catheters. Findings include:Review of Resident #16's admission record documented diagnosis to include cellulitis, unspecified, other bacterial infections of unspecified site and lymphedema not elsewhere classified.Review of Resident #16's physician order dated 4/14/2026 read, Cefepime HCL [hydrochloride] Intravenous Solution Reconstituted 2 GM (grams), use 2 gram intravenously every 12 hours for cellulitis for 14 days. During an observation of medication administration on 4/22/2026 at 9:39 AM Staff A, Registered Nurse (RN) assembled supplies to administer Cefepime intravenously and entered Resident#16's room. Resident #16 was observed with a left single lumen midline catheter needleless connector that was resting in contact with the resident's arm. Staff A, RN did not scrub the hub of the needleless connector, and attached a 10 milliliter normal saline syringe to the needleless connector. Staff A, RN did not attempt to verify the placement of the midline catheter by assessing for blood return and did not use the push pause method (used to verify patency) when injecting the normal saline quickly in a smooth motion into the midline catheter.During an interview on 4/22/2026 at 9:50 AM Staff A, RN stated, I should have tried to verify placement and didn't. I did not use the push pause method to give it [the normal saline flush]. During an interview on 4/22/2026 at 9:54 AM the Director of Nursing stated, She [the RN] should have attempted to verify line placement before administering meds [medications] and should have used the push pause method when flushing the line. Review of the policy and procedure titled Intermittent Infusion with a last approval date of 1/13/2026 read, Purpose: To provide guidelines and procedures for intermittent infusion parameters. Procedure: 16: Vigorously cleanse the needleless connector with alcohol. Allow to air dry. 17. Maintaining asepsis, attach flush syringe to needleless connector. Verify venous access patency.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review the facility failed to document in the medical record rationales for the pharmacy recommendations for 1 of 5 residents, Resident #31, reviewed for unnecessary medications. Findings include:Review of Resident #31's admission record documented diagnosis to include cerebrovascular disease unspecified cerebral atherosclerosis, chronic obstructive pulmonary disease unspecified, type 2 diabetes mellitus without complications, schizoaffective disorder bipolar type, morbid severe obesity due to excess calories, pseudobulbar effect, chronic pain syndrome, unspecified dementia unspecified severity without behavioral disturbance psychotic disturbance mood disturbance and anxiety, Barrett's esophagus with dysplasia, bipolar disorder, post-traumatic stress disorder unspecified, obstructive sleep apnea adult, legal blindness, opioid dependence in remission, personal history of malignant neoplasm of prostate, major depressive disorder recurrent moderate, other specified anxiety disorders, bipolar disorder recurrent episode mixed and moderate, other specified persistent mood disorders, opioid abuse uncomplicated, anxiety disorder unspecified, depression unspecified, acute and chronic respiratory failure with hypercapnia, acute kidney failure unspecified and encounter for palliative care, hypertensive heart disease without heart failure, unspecified convulsions, metabolic encephalopathy.Review of Resident #31's pharmacy recommendation dated 3/29/2026 read, PRN [as needed] lorazepam [Ativan] IM [intramuscular] has been limited to 14 days, however the order continues to lack defined behavioral parameters and clear criteria for IM use in a resident already receiving scheduled lorazepam. Recommendation: Please consider: Defining specific behavioral parameters (e.g., severe agitation, risk to self/others, non-redirectable behaviors. Provider response: Continue IM Ativan. Behavioral recommendations were not added.Review of Resident #31's pharmacy recommendation dated 9/12/2025 read, Medications: lorazepam 0.5 mg po [by mouth] tid [three times a day] + Trazodone 100 mg po tid + Seroquel 200 mg po tid + oxcarbazepine 300 mg po tid. Could we attempt a dose reduction at this time to verify this resident is on the lowest dose if not please indicate response below. The response read, psych there was no signature or date to indicate when this was written.Review of Resident #31's pharmacy recommendation dated 6/11/2025 read, This resident is receiving 2 medications with very similar therapeutic activity: 1. Seroquel 100 milligram PO TID, 2. Seroquel 50 milligram tablet give 75 milligram PO TID suggest discontinuing one of these medications and adjusting the dose of the other if necessary. There was no response documented to the recommendation. There was a provider signature dated 6/24/25.During an interview on 4/21/2026 at 2:30 PM the Director of Nursing (DON) stated, I'm not sure who that signature belongs to. There are no responses to the recommendations and there should be. The nurse practitioners or doctors should provide the rationale and agree or disagree with the recommendations. A request was made for policy and procedures for pharmacy recommendations. None were provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to prevent the possible spread of infection when not performing hand hygiene and/or maintaining enhanced barrier precautions for 4 of 7 observations of medication administration. Findings include:1) During an observation of medication administration on 4/20/2026 at 8:17 AM Staff I, Licensed Practical Nurse (LPN) did not perform hand hygiene and poured medications into a medication cup for Resident #86, entered Resident #86's room, did not perform hand hygiene, donned gloves and attempted to administer medications. Resident #86 spit out the medications into Staff I's gloved hand. Staff I, LPN doffed the gloves, did not perform hand hygiene, donned new gloves and administered Resident #86's eye drops. 2) During an observation of medication administration on 4/20/2026 at 8:31 AM Staff I, LPN returned to medication cart, retrieved keys from a uniform pocket, unlocked the medication cart, activated and typed on the computer. Staff I, LPN did not perform hand hygiene and began preparing Resident #34's medications, entered the resident's room, did not perform hand hygiene, and administered the medications.3) During an observation of medication administration on 4/20/2026 at 8:37 AM Staff I, LPN returned to the medication cart, retrieved keys from a uniform pocket, unlocked the cart, activated and typed on the keyboard. Staff I, LPN did not perform hand hygiene and poured medications for Resident #9, entered the resident's room, did not perform hand hygiene, donned gloves, and administered the medications. Staff I, LPN doffed the gloves, did not perform hygiene, and returned to the medication cart.During an interview on 4/20/2026 at 8:50 AM Staff I, LPN stated, Oh I didn't realize that I didn't perform hand hygiene. I should have done that.4) During an observation of medication administration on 4/22/2026 at 9:39 AM Staff A, Registered Nurse (RN) was observed in a resident's room completing medication administration. Staff A did not perform hand hygiene prior to exiting the resident's room and returned to the medication cart to prepare medications for another resident. Staff A, RN retrieved keys from a uniform pocket, unlocked the medication cart, activated and typed on the computer. Staff A, RN did not perform hand hygiene, donned gloves, and entered Resident #16's room without donning a gown. Resident #16's left single lumen midline catheter needleless connector was in contact with Resident #16's arm. Resident #16 moved their arm and the needleless connector came in contact with the resident's wheelchair arm. Staff A, RN did not cleanse the needleless connector with alcohol, did not check for the catheter's placement, attached a 10-milliliter syringe of normal saline to the needless connector, and administered the medication. Staff A, RN let go of the needleless connector which came in direct contact with the resident's arm and wheelchair arm. Staff A, RN then attached the IV (intravenous) tubing without cleansing the needleless connector with alcohol, attached the IV medication, and activated the IV pump for the infusion.During an interview on 4/22/2026 at 9:50 AM Staff A, RN stated, I only had gloves on. I should have had on a gown. He is on enhanced barrier precautions. I did not clean the hub before I did the normal saline. I should have tried to verify placement and didn't. I did not use the push pause method [a flushing technique used to verify IV patency and proper placement] to give it [medication] and I should have cleaned it again after I flushed and before I hung the antibiotic.During an interview on 4/22/2026 at 9:54 AM the Director of Nursing stated, She [the nurse] should have worn a gown, she should have cleaned the hub [needleless connector] with alcohol, she should have attempted to verify line placement before administering meds and should have used the push pause method when flushing the line.Review of the policy and procedure titled Intermittent Infusion last approval date of 1/13/2026 read, Purpose: To provide guidelines and procedures for intermittent infusion parameters. Procedure: 16: Vigorously cleanse the needleless connector with alcohol. Allow to air dry. 17. Maintaining asepsis, attach flush syringe to needleless connector. Verify venous access patency. Review of the policy and procedure titled Hand Hygiene last approval date of 1/13/2026 read, Policy: The facility considers hand hygiene the primary means to prevent the spread of infections. Procedure: 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105621	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Campus Rehabilitation and Nursing Center	700 N Palmetto St Leesburg, FL 34748

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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	residents, and visitors. 5, Use an alcohol based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. before and after coming into direct contact with residents. c. before and after handling medications; e. before and after handling an invasive device (e.g. urinary catheter, IV access devices. 6. Hand hygiene is the final step after removing and disposing of personal protective equipment. 7. The use of gloves does not replace hand washing/hand hygiene, integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. Review of the policy and procedure titled Enhanced Barrier Precautions [EBP] with a last approval date of 1/13/2026 read, Policy: It will be the policy of this facility to implement enhanced barrier precautions for preventing transmission of novel or targeted multidrug-resistant organisms. Procedure: 2. Initiation of Enhanced Barrier Precautions: b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds and/or indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy, ventilator, etc.) regardless of MDRO [multidrug resistant organisms] colonization status. 4. For residents whom EBP are indicated, EBP is employed when performing the following high contact resident care activities: g. Device care or use: central line.