STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105626	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chautauqua Springs Health Center	785 S 2nd Street Defuniak Springs, FL 32435

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure wound care services were provided for 1 of 5 residents sampled for wound care (Resident #160).The findings included:An interview was conducted with Resident #160's daughter on 6/25/26 at 10:00 AM. She explained that her mother was receiving home hospice services and was admitted to the facility on [DATE] for a 5-day respite care stay. She further explained the plan was for the facility to provide comfort measures for Resident #160's pain and anxiety along with physician ordered wound care. She stated she spoke with a nurse and found out Resident #160 had not received wound care since her admission. As a result of this concerns, the daughter made the decision to take Resident #160 home that day instead of having her stay at the facility until 6/27/26 as planned.Review of Resident #160's medical record confirmed she was admitted to the facility on [DATE]. Resident #160 had a medical history significant for lung cancer, type 2 diabetes, pulmonary hypertension, Chronic Obstructive Pulmonary Disease, and anxiety.Review Resident #160's Physician's orders revealed there were active orders for wound care. These orders included the following: Right Hip-cleanse open area with normal saline, sure prep peri-wound, apply calcium alginate and cover with dry dressing every day shift, dated entered 6/22/26, start date 6/23/26; and Coccyx-cleanse open area with normal saline, sure prep peri-wound, apply calcium alginate and cover with dry dressing, every day shift, dated entered 6/22/26, start date 6/23/26.Review of Resident #160's Treatment Administration Record (TAR) revealed staff did not document that wound care was performed for Resident #160 on 6/23/26 or 6/24/26. Review of Resident #160's Plan of Care revealed there were no focus interventions related to Resident #160's wounds on the coccyx or hip. An interview was conducted with the facility's Director of Nursing (DON) on 6/25/26 at 11:34 AM. The DON stated Staff A, Licensed Practical Nurse (LPN) was assigned to care for Resident #160 on 6/23/26 and 6/24/26 and that she should have performed the resident's wound care on those days.An interview was conducted with Staff E, LPN and Wound Care Nurse on 6/25/26 at 12:17 PM. Staff E explained she normally performed wound care on Wednesdays at the facility. She stated she received a note in the morning on 6/25/26 that Resident #160 had something on her hip but further stated she did not perform wound care on Resident #160 because she was a new resident and she needed time to learn about the resident before she could perform the ordered wound care. Staff E confirmed she is not the only nurse who performs wound care but rather any nurse who is assigned to a resident requiring wound care if responsible for performing the task. She further stated she had Resident#160 on her list of residents to see that day. An interview was conducted with Staff A, LPN on 6/25/26 at 12:36 PM. Staff A stated she was assigned to care for Resident #160 on 6/23/26 and 6/24/26. She was aware that Resident #160 was admitted to the facility for respite care and that the plan was for the staff to provide medication for pain and anxiety and wound care according to the physician's orders. She stated she did not get around to do [Resident #160's] wound care on Tuesday and Wednesday. She further stated she did not perform the wound care because she was prioritizing safety and medication administration.An interview was conducted with Staff G, LPN on 6/25/26 at 2:56 PM. Staff G stated she received report on her residents from the night shift nurse, Staff H, LPN, at around 6:45 AM on 6/25/26. She stated she did (continued on next page)

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

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not know Resident #160 had orders for wound care.An interview was conducted with Staff D, LPN and Unit Manager on 6/25/26 at 4:14 PM. Staff D confirmed Resident #160 was admitted to the facility on [DATE] and that her family had brought in the respite care medications from home. Staff D explained that she had previously assisted Resident #160 to the bed from wheelchair. Staff D recalled that Resident #160 was weak but was able to stand and pivot transfer to the bed. Staff D stated she had replaced Resident #160's wound care dressings on 6/22/26. Staff D, LPN stated Resident #160 had no concerns the last two days. Staff D stated, as a unit manager, I am not sure the reason wound care was not done the last two days, because if something was not done, the expectation was to communicate it to the next shift.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, staff and resident interviews, and record reviews, the facility failed to ensure the resident environment remained free of accident hazards for 2 of 43 residents observed for accident hazards (Resident #103 & #129).The findings included:An observation was conducted of Residents #103 and #129 in their shared room on 6/23/26 at 2:50 PM. At this time, a roach-like insect was observed running under a case of bottled waters and other personal belongings on Resident #129's side of the room. Upon seeing this insect, Resident #129 propelled herself out of the room to speak to the Maintenance Assistant about the insect. The Maintenance Assistant entered the residents' room with a pump sprayer and began spraying an unknown substance around the edges of the room at the baseboards and where the insect was seen running near the resident's personal belongings and water bottles. When asked if the facility normally sprayed for insects with residents in their rooms, Resident #129 said, Yeah, they always do it when we are in the room. An interview was conducted with the facility Maintenance Assistant on 6/25/26 at 11:03 AM. When asked whether he sprays chemicals in resident's rooms while the residents are present in the rooms, he stated, I usually do not spray with people in the room. [The residents] sent a work order in and saw the bugs and wanted it taken care of, so I sprayed the room at that time. He went on to state that this is a chemical that is diluted with water and is immediately non-hazardous when it dries. He agreed he probably should have asked the residents to exit the room until the solution dried.An interview was conducted with the facility Maintenance Director on 6/25/26 at 11:20 AM. He provided the information for the spray used, which was Talstar Professional Insecticide, with an active ingredient of Bifenthrin (which is a synthetic form of Pyrethoid) (photographic evidence obtained). The Maintenance Director stated the residents should not be present in any room while spraying this chemical. He confirmed Resident #103 and #129 should have been escorted out of the room until the solution dried. According to the National Poison Control website (https://www.poison.org/articles/pyrethroids), this chemical should not come into contact with skin and, if spraying indoors, should be in a well-ventilated room to avoid inhalation of the spray. Inhalation, contact with skin, or swallowing pyrethroids are ways pyrethroids can enter the body . They can cause irritation and allergic reactions, while high levels can cause more serious symptoms. Some spray formulations contain volatile hydrocarbon solvents or pressurized propellants which can also cause toxicity, especially if inhaled.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, and facility policy review, facility staff failed to ensure proper protective measures were used for 1 of 1 resident sampled for contact isolation (Resident #158).The findings included:An observation was conducted on 6/24/26 at 8:40 AM of contact isolation signage present on Resident #158's room door. There was Personal Protective Equipment (PPE) in front of the room including isolation gowns, gloves and masks.Review of Resident #158's medical record revealed Resident #158 was admitted to the facility on [DATE] with medical diagnoses including Extended Spectrum Beta Lactamase (ESBL) resistance (a condition which makes a person resistant to antibiotic treatments). Physician orders included Contact Isolation for 10 days related to ESBL, dated 6/18/26. The care plan included diagnoses of Urinary Tract Infection (UTI) due to ESBL with antibiotic treatment through 6/29/26 with interventions including contact isolation precautions as ordered. An observation was conducted on 6/24/26 at 8:45 AM of Staff A, Licensed Practical Nurse (LPN) entering Resident #158's room with a medication cup. Staff B, Certified Nurse Assistant (CNA), was already inside the room assisting Resident #158. While donning gloves, Staff B asked Staff A to help assist with repositioning the resident. Staff A donned gloves without washing her hands. Neither staff member donned isolation gowns. Staff A and Staff B proceeded to assist Resident #158 with repositioning.An interview was conducted with Staff A, LPN on 6/24/26 at 8:55 AM, following the observation. She confirmed she was aware of Resident #158's Contact Isolation precautions but stated she did not have contact with Resident #158's urine. When asked to explain the facility's Contact Isolation protocol, Staff A stated Contact Isolation did not require wearing a mask but further stated staff should be donning an isolation gown before entering a room and should remove the gown before exiting. She acknowledged that she and Staff B did not wear isolation gowns when they were in Resident #158's room. When asked about hand washing, Staff A stated she only washed her hands after removing her gloves. An interview was conducted with Staff C, Registered Nurse (RN) on 6/24/26 at 3:35 PM. Staff C confirmed she was the facility's Infectious Preventionist. Staff C stated when a resident was on Contact Isolation, the facility would place the Contact Isolation signage on the resident's room door and would make PPE available to the staff. She further stated the staff should wear a gown upon entering the room and should wash their hands before donning and after removing their gloves. Review of the facility's policy titled Isolation Precautions (revised June 2025) was conducted. The policy stated, Contact precautions: must be implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or patient-care items in the resident's environment. Wear gloves when entering room. Wear a gown when entering the room if you anticipate that your clothing will have substantial contact with the patient, environmental surfaces, or items in the patient's room, or if the resident is incontinent, has diarrhea, an ileostomy, a colostomy, or wound drainage not contained by a dressing.Review of the facility's policy titled Hand Hygiene (revised 3/1/25) was conducted. The policy stated, The use of gloves did not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.