

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: 105630	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2025
NAME OF PROVIDER OR SUPPLIER Vicar's Landing Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1003 York Road Ponte Vedra Beach, FL 32082	
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on kitchen food service observations, staff interviews, and facility policy and procedure review, the facility failed to follow proper sanitation and food handling practices to prevent the outbreak of foodborne illness, with the potential to affect more than a limited number of residents who consumed foods from the facility, by failing to seal and date mark open food used for resident consumption in the dietary service area. Food handling and sanitation is important in health care settings serving nursing home residents. Unsafe food handling practices represent a potential source of pathogen exposure. The findings include: A follow-up tour of the kitchen was conducted on 07/30/2025 at 11:16 AM. During the tour, no date markings were observed on one open bottle of Simply Thick Easy Mix in the [NAME] Unit nourishment room, one open bottle of Simply Thick Easy Mix in the Assisted Dining Room, or on two open bottles of alcohol-removed wine in the Cambridge Unit refrigerator. (Photographic evidence obtained) During an interview on 07/30/2025 at 1:39 PM with Dining Server B, she explained that the facility's policy related to date marking food items was to add the open and expiration date to open foods. During an interview on 07/30/2025 at 1:46 PM with Dining Server C, she stated food items that were opened, used, and placed back in the refrigerator or freezer were to be sealed, labeled and dated. During an interview on 07/30/2025 at 2:07 PM with Dietary Supervisor D, he explained that the facility's policy related to date marking food items was to add the open and use-by date. During an interview on 07/30/2025 at 2:15 PM, the Certified Dietary Manager (CDM) confirmed that the kitchen staff used labels on open food items to add the date opened, used-by date, and initial. A review of the facility's policy and procedure titled Food Labeling Policy (dated 10/17/2022), revealed: It is the policy of this facility to ensure that all food items stored, prepared, or served within the Health Center comply with Federal, state, and local food safety regulations. All opened food items in the facility, including those in dietary service areas and at nursing unit refrigerators must be properly labeled to ensure food safety.		

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and facility policy and procedure review, the facility failed to ensure that residents who needed respiratory care received oxygen therapy as ordered for one (Resident #4) of 23 residents receiving oxygen therapy in a total survey sample of 26 residents. The findings include: On 7/28/2025, at 12:47 PM, Resident #4 was observed in her room in a chair beside her bed in a hospital gown. She was receiving oxygen via nasal cannula. She reported she received oxygen at a flow rate of two liters per minute (2 L/min). The oxygen concentrator was in her bathroom, not within arm's reach of the resident, and was set at 3 L/min. (Photographic evidence obtained) On 7/29/2025, at 12:13 PM, Resident #4 was observed in her room in a chair beside her bed in a hospital gown. She was receiving oxygen via nasal cannula. The oxygen concentrator was in her bathroom and was set at 3 L/min. (Photographic evidence obtained) A review of Resident #4's medical record revealed active physician's orders for oxygen therapy: Continuous oxygen via nasal cannula at 2L/min every shift for hypoxia (dated 3/7/2025). Oxygen bubbler and tubing need to be changed every week, write date and initials when changed, remove old bubbler and tubing (dated 3/9/2025), and oxygen in use card to be place by residents and door and checked - verified by nurse every shift for oxygen safety (dated 3/7/2025). Other orders included albuterol sulfate inhalation nebulization solution (2.5 mg/3ml - milligrams per milliliter) 0.083% (dated 3/7/2025) and morphine sulfate (concentrate) oral solution 20 mg/ml (morphine sulfate), give 0.25 ml by mouth every four hours as needed for shortness of breath/non-acute, moderate to severe pain SL (dated 7/9/2025). (Copy obtained) Further review of the medical record revealed that Resident #4 was readmitted to the facility on [DATE] with an initial admission date on 9/16/2023. Her primary diagnoses included: Acute respiratory failure with hypoxia, shortness of breath, chronic obstructive pulmonary disease (COPD), unspecified; and obstructive sleep apnea. A review of the Quarterly Minimum Data Set (MDS) assessment, dated 06/25/2025, revealed the resident was receiving hospice care, required oxygen therapy, and had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 possible points, indicating moderate cognitive impairment. Resident #4 was independent with eating and required supervisory or touching assistance for toilet transfers. A review of the care plan, focus and goals related to oxygen therapy included altered respiratory status/difficulty breathing related to congestive heart failure (CHF), sleep apnea, and COPD. Interventions included oxygen settings: oxygen via nasal prongs (cannula) at 2L/min, administer medication/puffers as ordered, monitor for effectiveness and side effects, and set-up or clean-up assistance. A review of the resident's oxygen saturations from 7/1/2025 - 7/29/2025 revealed a range of 93-98% (oxygen via nasal canula), on 7/15/2025: 94% (room air), and on 7/22/2025: 98% (room air). The resident's Medication Administration Record (MAR) for July 2025 was initialed for continuous oxygen via nasal cannula at 2 L/min every shift for hypoxia and oxygen bubbler and tubing need to be changed every week, write date and initials when changed, remove old bubbler and tubing, as ordered by physician. (Copy obtained) On 7/29/2025 at 3:46 PM, Licensed Practical Nurse (LPN) A confirmed that Resident #4's oxygen setting was set at 3L/min and stated the oxygen order was for 2 L/min. The LPN also confirmed there was no bubbler/humidifier on the oxygen concentrator. Nurses provide ongoing monitoring of the resident's oxygen therapy. Nursing is responsible for assuring that the resident is receiving the correct oxygen flow rate as ordered. Correct oxygen settings are identified through reports and by checking the order. Nurse staff on the night shift are responsible for changing the resident's oxygen tubing every Sunday. Correct settings are communicated from one staff person to another through shift reports. The LPN stated in the past Resident #4 would turn the concentrator on and off when leaving her room, but she had not turned off the machine in a while. Sometimes Resident #4 took off the nasal cannula; she was reminded to put it back on with no problem. On 7/30/2025 at 10:27 AM, the Director of Nursing (DON) confirmed that correct oxygen flow rate settings were (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified by checking the orders and the Medication Administration Record and Treatment Administration Record. Residents who sometimes moved the dial were educated on the importance of maintaining oxygen at the correct setting. A review of the facility's policy and procedure titled Oxygen Administration (revised on 1/2025), revealed: Oxygen is administered to residents who need it, consistent with professional standards of practice, comprehensive person-centered care plans, and the residents' goals and preferences. Policy Explanation and Compliance Guidelines: 1. Oxygen is administered under orders of a physician, except in the case of an emergency. In such cases, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control. 2. Staff shall notify the physician of any changes in the resident's condition, including changes in vital signs, oxygen concentration, or evidence of complications associated with the use of oxygen. (Copy obtained)		