STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105638	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parklands Care Center and Rehab	1000 SW 16th Ave Gainesville, FL 32601

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all residents were free from the use of a physical restraints for 1 of 3 residents, Resident #28, reviewed for resident rights.Findings include:During an observation on 04/27/2026 at 10:17 AM, Resident #28 was observed sitting in a wheelchair with a seatbelt buckled; the resident is noted to have bilateral hand contractures.During a subsequent observation on 04/29/2026 at 11:08 AM, Resident #28 was observed sitting in the hallway in her personal wheelchair with a lap belt in place.Review of Resident #28's clinical record documented diagnoses to include unspecified sequelae of cerebrovascular infarction, unspecified dementia, essential hypertension, unspecified protein-calorie malnutrition, multiple contractures, history of falls, and major depressive disorder.Review of the Determination of Capacity form dated 10/28/2020 documented Resident #28 lacks capacity to make medical decisions.Review of the Minimum Data Set (MDS) Quarterly Nursing Comprehensive Evaluation dated 04/06/2026 documented Resident #28 did not have enabler devices or restraints in place. Review of the MDS assessment dated [DATE], Section P, revealed no documentation of restraints.Review of Resident #28's Kardex [a quick reference to provide immediate, updated overview of resident needs] did not have documentation of the resident having a seatbelt or lap belt restraint.Review of Resident #28's medical record progress notes revealed no documentation regarding the use of a seatbelt or lap belt.Review of Resident #28's physician orders did not reveal an order for the use of a seatbelt or lap belt.During an interview on 04/28/2026 at 3:00 PM, Staff L, LPN (Licensed Practical Nurse) stated the wheelchair was a personal wheelchair and that the facility does not utilize the seatbelt.During an interview on 04/29/2026 at 11:54 AM, the [NAME] President of Clinical Operations stated the resident should not have a belt [seatbelt/lap belt].During an interview on 04/29/2026 at 12:00 PM, the Director of Rehabilitation, stated the wheelchair was specifically made for the resident and the belt was part of the manufacturer design. He verified there was no place for a seatbelt, the family had not been contacted regarding use of the belt, and it was not care planned.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure Minimum Data Set [MDS} assessments were accurate for 4 of 10 residents, Residents #3, #9, #28, and #62, reviewed for assessments. Findings include: 1) Review of Resident #3's Minimum Date Set (MDS) titled Quarterly dated 3/4/2026 Section I Active Diagnosis did not have psychiatric/mood disorders documented. Review of Resident #3's psychiatry subsequent note dated 1/5/2026 read, Chief Complaint: psychosis, mood, depression, and dementia. Review of Resident #3's psychiatry subsequent note dated 2/19/2026 read, Chief Complaint: Psychosis, mood disorder, depression, and dementia. Review of Resident #3's physician order dated 2/12/2026 read, Depakote [a medication used to treat certain types of psychosis] Oral Tablet delayed release 500 mg [milligrams] (Divalproex Sodium) give 500 mg by mouth two times a day for mood stabilization. During an interview on 4/29/2026 at 10:10 AM Staff F, Registered Nurse Minimum Data Set Coordinator stated, [Resident #3's name] psychiatric diagnoses are not listed in his MDS. It was not captured in the MDS. 2) During an observation on 4/27/2026 at 12:31 PM Resident #9 was eating independently in his room. The meal served had a mechanical soft consistency and thicken juice. During an observation on 4/28/2026 at 8:07 AM Resident #9 was eating in his room independently. The diet served was a mechanically soft meal which included eggs, toast, ground sausage, thicken juice and oatmeal. Review of Resident #9's physician order dated 11/5/2025 read, Consistent Carbohydrate diet. Mechanical Soft texture, nectar consistency for fortified food. Review of Resident #9's MDS titled Quarterly dated 3/3/2026 Section K Swallowing/Nutritional Status did not document the resident was on a mechanically altered therapeutic diet. During an interview on 4/29/2026 at approximately 1:35 PM the Dietary Manager stated, [Resident #9's name] MDS section K needs to be corrected to reflect his current diet. Review of the facility policy and procedure titled MDS Assessments with a last review date of 12/16/2025 read, Policy: It will be the policy of this facility to complete MDS assessments in accordance with the RAI [Resident Assessment Instrument] manual guidelines. 3) During an observation on 4/27/2026 at 10:17 AM Resident #28 was seen sitting in her wheelchair in the hallway with a lap belt clasped over her trunk. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/29/2026 at 11:08 AM Resident #28 was seen sitting in her wheelchair in the hallway with a lap belt clasped over her trunk. Review of Resident #28 Minimum Data Set titled Quarterly dated 4/6/2026 Section P Restraints and Alarms Subsection Physical Restraints there was no documentation of a trunk restraint being used. During an interview on 4/29/2026 at 11:05 AM Staff H, MDS Staff stated Section N should be documented to reflect usage of the lap belt. 4) Review of Resident #62's pertinent medical diagnosis read, Type 2 Diabetes Mellites with autonomic polyneuropathy. Review of Resident #62's physician order dated 1/17/2025 read, Lantus SoloStar, Inject 20 unit subcutaneously at bedtime related to type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy. Review of Resident #62's physician order dated 3/18/2026 read, NovoLOG, Inject subcutaneously before meals and at bedtime for diabetes mellitus, per sliding scale (SS). Review of Resident #62 Minimum Data Set (MDS) Quarterly dated 4/11/2026 Section N Medication, Subsection High-risk Drug Classes: Use and Indication did not have hypoglycemic coded [the code used for prescribed insulin use]. During an interview on 4/29/2026 at 11:05 AM Staff H, MDS Staff stated that Section N in the MDS dated [DATE] was coded incorrectly.

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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 residents with newly evident or known diagnosis of serious mental disorders have a coordinated Preadmission Screening and Resident Review (PASRR) for 5 of 10 residents, Residents # 106, #14, #9, #40, and #12, reviewed for PASRR. Findings include: 1) Review of Resident #106's medical record documented diagnosis to include major depressive disorder recurrent mild dated 2/9/2026. Review of Resident #106's Preadmission Screening Resident Review (PASRR) was dated 11/6/2025 did not have a diagnosis of major depressive disorder documented. Review of Psychological evaluation notes dated 2/18/2026 documented DX [diagnosis]: F33.0 Major Depressive Disorder Recurrent Mild. Review of Resident #106's physician order dated 2/10/2026 read, Remeron oral tablet 30 mg [milligrams] (Mirtazapine) give one table at bedtime for major depressive disorder. Review of Resident #106's medication administration record (MAR) dated April 2026 read, Remeron [a medication used to treat major depressive disorder] oral tablet 30 mg (Mirtazapine) give one tablet at bedtime for (Major Depressive Disorder). During an interview on 4/28/2026 at 2:05 PM, the Social Services Director stated, I was not aware that behavior changes had to be updated on the Preadmission Screening and Resident Review. During interview on 4/29/2026 at 2:35 PM, the Clinical Operations and Director of Nursing (DON) stated, Preadmission Screening and Resident Review and care plans should be reviewed and/or completed within 72 hours of admission. Review of the facility policy and procedure titled, P&P [Policy and Procedure] Role of Admissions and Social Services in PASRR with an issue date of 4/1/2022 and last review date of 12/16/2025 read, Policy: The Facility will see each resident in a nursing facility is screened for a mental disorder (MD) or intellectually 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 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 settings when a significate change in their status occurs. 2) Review of Resident #9's State of Florida Agency for Health Care Administration Preadmission Screening and Resident Review (PASRR) dated 8/27/2025 did not document mental illness. Review of Resident #9 psychiatry subsequent note dated 2/26/2026 read, Chief Complaint: Depression. Reason for encounter: Today, I saw the patient for medication management as patient has active psychiatric diagnosis, is in the facility setting, and last psychiatric visit was 12 or more weeks ago. History of Presenting Illness: This is a [Resident #9's age] patient with past psychiatric (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	history of depression. Today, I saw the patient for medication management as patient has no symptoms of depression. Patient is eating and sleeping decently. Patient is not on any psych meds. The current diagnoses are being managed by non-pharmacological interventions. Plan of Action: The patient is not on any active psychiatric medications to be continued. Diagnoses Rationale and Justifications: Adjustment disorder with depressed mood: The history suggests that patient's depressed mood is secondary to underlying stressors This appears to be situational, and most likely will improve with time along with ongoing emotional support. Review of Resident #9's Psychosocial Evaluation dated 4/10/2026 read, Dx: Major depressive disorder, recurrent moderate. Reason for referral: Depression, social isolation, staff concern regarding possible decline in mental health. Session Summary: Provider met with [Resident #9's name] to address depressive symptoms as well as social isolation. Review of Resident #9's Supportive Care Psychological Services progress note dated 4/17/2026 read, Dx: Major depressive disorder, recurrent, moderate. Symptoms: Psychological: Depression, helplessness, hopelessness. During an interview on 4/30/2026 at 10:12 AM the Social Services Director stated, I submitted a resident review for him. Psych was not communicating with me when there were changes and new diagnosis added for the patient. I would not be aware that a review of the PASRR needed to be submitted. If psych does not tell me there is a new diagnosis I would not know to add it to the care plan as a focus. Review of Resident #9's Hospital Discharge summary dated [DATE] read, Diagnosis: Developmental delay. Review of Resident #9's provider note dated 9/11/2025 read, History of present illness: This is a [Resident #9's age and gender] with a history of developmental delay and diabetes who is admitted to Parklands Care Center for rehabilitation; skill nursing care. During an interview on 4/30/2026 at 11:20 AM the Psychiatric Mental Health Nurse Practitioner stated, [Resident #9's name] has been seen once before by me and he has more like a temporary adjustment disorder with minimal depression. He was diagnosed with adjustment disorder with depressed mood. He is on no medication at this time. It was a new diagnosis after his admission. I do a post rounding log and email it to the Social Services Director, the Director of Nursing, and MDS [Minimum Data Set]. I might have missed it. During an interview on 4/30/2026 at 11:33 AM the Director of Nursing stated, All the diagnosis should have been updated on the PASSR for [Resident #9's name]. 3) Review of Resident #14's State of Florida Agency for Health Care Administration Preadmission Screening and Resident Review (PASRR) dated 8/7/2024 did not document mental illness. Review of Resident #14's pertinent medical diagnosis include adjustment disorder with depressed mood, major depressive disorder and bipolar disorder. Review of Resident #14's psychology subsequent note dated 8/28/2024 read, DX: Major depressive disorder, recurrent, mild. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #14's psychology subsequent note dated 10/1/2024 read, DX: Bipolar disorder, current episode mixed, moderate. During an interview on 4/30/2026 at 11:33 AM the Director of Nursing stated, All the diagnosis should have been updated on the PASSR for [Resident #14's name]. Review of Resident #40's PASRR dated 3/18/2026 documented there were no diagnoses checked pertaining to mental illness or suspected mental illness. Review of Resident #40's Psychosocial Evaluation dated 3/20/2026 documented her diagnosis as, major depressive disorder, recurrent, moderate. The reason for the referral was documented as depression. The Session Summary read, Provider met with [Resident #40's name] to complete assessment due to recent admission to facility. Although [Resident #40's name] understood why she was at the facility she had difficulty articulating what had happened. She is alert, but oriented only to self and the town that she lives in. She is delayed in many of her thoughts and does not appear to have capacity of benefit of services. There are no recommendations made at this time. Review of a Balanced Wellbeing Psychiatry Evaluation Note dated 3/18/2026 read, The history of presenting illness: Past psychiatric history of depression and anxiety. 4) Review of Resident #40's Census Data revealed she was admitted on [DATE] with medical diagnoses that included fracture of other parts of pelvis, subsequent encounter for fracture with routine healing; unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety; major depressive disorder, recurrent, moderate Review of Resident #40's most recent MDS (Minimum Data Set) Assessment, a Modification of Medicare - 5 Day dated 4/05/2026 documented her BIMS (Brief Inventory of Mental Status) Score as 10 out of 15 which indicated she had some cognitive impairment. She had diagnoses that included Non-Alzheimer's Dementia and Depression (other than bipolar). During an interview on 4/28/2026 at 2:05 PM the Social Services Director confirmed that she had not included any mental health diagnoses on the Level I PASSR for Resident #40. During an interview on 4/30/2026 at 11:33 AM the DON (Director of Nursing) stated, All the diagnoses should have been included on the PASSR for [Resident #40's name]. 5) Review of Resident #12's Documents revealed her Level I PASRR dated 7/30/2025 did not identify any mental illness or suspected mental illness and included negative documentation of dementia being a primary or secondary diagnosis. During an interview on 4/28/2026 at 2:05 PM the Social Services Director stated that Resident #12 had been admitted from home, and her daughter did not provide a lot of information. The Admissions Department was responsible for obtaining previous medical records. She completes the level I PASSARs for residents who are admitted without one. She would review medical records for information on diagnoses and treatments relevant to include in the PASSAR. She confirmed that she had not include any mental health diagnoses for Resident #12. During an interview on 4/29/2026 at approximately 12:30 PM the Admissions and Marketing Director stated that if a resident were admitted from a referral from a community physician, she would contact (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	them for an H&P (History and Physical) and a med (medication) list. The PASSAR would be completed in-house. Resident #12 came from home. She had been at [name of a skilled nursing facility] in [NAME] and had been discharged home from that facility. During an interview on 4/29/2026 at 2:25 PM the DON and VP (Vice President) of Clinical Operations stated that PASRRs and care plans should be screened for accuracy and/or completed within 72 hours of admission. Review of the Progress Note dated 7/09/2025 from Resident #12's PCP (Primary Care Physician) documented diagnoses to include cognitive impairment and dementia. The section titled History of Present Illness, read, The patient is a [AGE] year old Caucasian/White female who is followed for depressive symptoms. The patient's mood has been worsening but the patient denies any suicidal ideation. Review of Resident #12's Progress Note dated 7/17/2025 read, History of present illness: This is a 70 y.o. (year old) female with a history of depression who is admitted to [name of the facility] for rehabilitation; skilled nursing care. Past Medical History: Manic depressive disorder (CMS-HCC: 59). Plan: Diagnoses and all orders for this visit: Cognitive impairment - Comments: Suspect major neurocognitive disorder; Obvious memory deficits; Requires assistance with ADLs/IADLs (Activities of Daily Living/ Instrumental Activities of Daily Living (complex daily tasks necessary for independent community living) Review of the policy and procedure titled Role of Admissions and Social Services in PASRR, with the last review date of 12/16/2025 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 session 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. State Designated Authority: Individuals with serious mental illness, intellectual disability, or a related condition have special protections under state and federal law to ensure that long-term services and supports are provided in the right setting to meet their needs. According to state regulation, nursing facilities and hospitals in Florida are also delegated to complete PASRR Level 1 screenings. Level 1 screeners must be an MSW [Master of Social Work], LCSW [Licensed Clinical Social Worker], LMHC [Licensed Mental Health Counselor], RN [Registered Nurse], ARNP [Advanced Registered Nurse Practitioner], a psychologist, or a physician.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement comprehensive care plans for 3 of 10 residents, Residents #9, #40, and Resident #28 sampled for care plans.Findings include: 1) Review of Resident #9 psychiatry subsequent note dated 2/26/2026 read, Chief Complaint: Depression. Reason for encounter: Today, I saw the patient for medication management as patient has active psychiatric diagnosis, is in the facility setting, and last psychiatric visit was 12 or more weeks ago. History of Presenting Illness: This is a [Resident #9's age] patient with past psychiatric history of depression. Today, I saw the patient for medication management as patient has no symptoms of depression. Patient is eating and sleeping decently. Patient is not on any psych meds. The current diagnoses are being managed by non-pharmacological interventions. Plan of Action: The patient is not on any active psychiatric medications to be continued. Diagnoses Rationale and Justifications: Adjustment disorder with depressed mood: The history suggests that patient's depressed mood is secondary to underlying stressors This appears to be situational, and most likely will improve with time along with ongoing emotional support. Review of Resident #9's Psychosocial Evaluation dated 4/10/2026 read, Dx: Major depressive disorder, recurrent moderate. Reason for referral: Depression, social isolation, staff concern regarding possible decline in mental health. Session Summary: Provider met with [Resident #9's name] to address depressive symptoms as well as social isolation. Review of Resident #9's Supportive Care Psychological Services progress note dated 4/17/2026 read, Dx: Major depressive disorder, recurrent, moderate. Symptoms: Psychological: Depression, helplessness, hopelessness. Review of Resident #9 care plan did not include a focus of adjustment mood disorder or depression. During an interview on 4/30/2026 at 10:12 AM the Social Services Director stated, I submitted a resident review for him. Psych was not communicating with me when there were changes and new diagnosis added for the patient. I would not be aware that a review of the PASRR needed to be submitted. If psych does not tell me there is a new diagnosis I would not know to add it to the care plan as a focus. During an interview on 4/30/2026 at 11:20 AM the Psychiatric Mental Health Nurse Practitioner stated, [Resident #9's name] has been seen once before by me and he has more like a temporary adjustment disorder with minimal depression. He was diagnosed with adjustment disorder with depressed mood. I do a post rounding log and email it to the Social Services Director, the Director of Nursing and MDS [Minimum Data Set]. I might have missed it. They should care plan the resident for depression. During an interview on 4/30/2026 at 11:33 AM with the Director of Nursing stated, All the diagnosis should have been updated for [Resident #9's name] along with his care plan. 2) Review of Resident #40's Census Data revealed she was admitted on [DATE] with medical diagnoses that included fracture of other parts of pelvis, subsequent encounter for fracture with routine healing; unspecified dementia, unspecified severity, without behavioral disturbance, psychotic (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disturbance, mood disturbance, and anxiety; major depressive disorder, recurrent, moderate Review of Resident #40's most recent MDS (Minimum Data Set) Assessment, a Modification of Medicare - 5 Day dated 4/05/2026 documented her BIMS (Brief Inventory of Mental Status) Score as 10 out of 15 which indicated she had some cognitive impairment. She received antidepressant, opioid, and anticonvulsant medications that were documented as high-risk medications. She had diagnoses that included Non-Alzheimer's Dementia and Depression (other than bipolar). Review of Resident #40's care plan did not include a focus of dementia or major depressive disorder Review of Resident #40's Psychosocial Evaluation dated 3/20/2026 documented her diagnosis as, major depressive disorder, recurrent, moderate. The reason for the referral was documented as depression. The Session Summary read, Provider met with [Resident #40's name] to complete assessment due to recent admission to facility. Although [Resident #40's name] understood why she was at the facility she had difficulty articulating what had happened. She is alert, but oriented only to self and the town that she lives in. She is delayed in many of her thoughts and does not appear to have capacity or benefit of services. There are no recommendations made at this time. Review of a [name of the psychiatric group] Evaluation Note dated 3/18/2026 read, The history of presenting illness: Past psychiatric history of depression and anxiety. During an interview on 4/29/2026 at approximately 2:10 PM the Social Services Director stated that MDS (Minimum Data Set [department/staff]) enters the diagnoses and she reviews them. The development of care plan areas for mental health depended on psych (psychiatry/psychology) notes and behaviors. For Resident #40 with diagnoses of dementia and major depressive disorder on admission, she should have implemented a cognition care plan. She confirmed that Resident #40 did not have a cognition care plan [focus area]. During an interview on 4/29/2026 at 2:25 PM the DON and VP (Vice President) of Clinical Operations stated that PASRRs and care plans should be screened for accuracy and/or completed within 72 hours of admission. Review of the policy and procedure titled, Comprehensive Assessments and Care Plans, last reviewed on 12/16/2025 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 (Centers for Medicare and Medicaid Services). The assessment will include at least the following: cognitive patterns; Mood and behavior patterns; Psychological well-being. Guidelines: 7. The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care period the baseline care plan will be developed within 48 hours of a resident's admission. 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 timeframe to meet resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. 3) During an observation on 04/27/2026 at 10:17 AM, Resident #28 was observed sitting in a wheelchair with a seatbelt buckled; the resident is noted to have bilateral hand contractures. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a subsequent observation on 04/29/2026 at 11:08 AM, Resident #28 was observed sitting in the hallway in her personal wheelchair with a lap belt in place. Review of Resident #28's clinical record documented diagnoses to include unspecified sequelae of cerebrovascular infarction, unspecified dementia, essential hypertension, unspecified protein-calorie malnutrition, multiple contractures, history of falls, and major depressive disorder. Review of the Determination of Capacity form dated 10/28/2020 documented Resident #28 lacks capacity to make medical decisions. Review of the Minimum Data Set (MDS) Quarterly Nursing Comprehensive Evaluation dated 04/06/2026 documented Resident #28 did not have enabler devices or restraints in place. Review of the MDS assessment dated [DATE], Section P, revealed no documentation of restraints. Review of Resident #28's care plan did not show a focus for the use of a lap belt/seat belt. Review of Resident #28's Kardex [a quick reference to provide immediate, updated overview of resident needs] did not have documentation of the resident having a seatbelt or lap belt restraint. Review of Resident #28's medical record progress notes revealed no documentation regarding the use of a seatbelt or lap belt. Review of Resident #28's physician orders did not reveal an order for the use of a seatbelt or lap belt. During an interview on 04/28/2026 at 3:00 PM, Staff L, LPN (Licensed Practical Nurse) stated the wheelchair was a personal wheelchair and that the facility does not utilize the seatbelt. During an interview on 04/29/2026 at 11:54 AM, the [NAME] President of Clinical Operations stated the resident should not have a belt [seatbelt/lap belt]. During an interview on 04/29/2026 at 12:00 PM, the Director of Rehabilitation, stated the wheelchair was specifically made for the resident and the belt was part of the manufacturer design. He verified there was no place for a seatbelt, the family had not been contacted regarding use of the belt, and it was not care planned.

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Parklands Care Center and Rehab	1000 SW 16th Ave Gainesville, FL 32601

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review the facility failed to review and revise the comprehensive care plan for 3 of 7 residents, Residents #57, #62, and #93, reviewed for revised care plans. Findings include: 1) Review of Resident #57 Quarterly Nursing Comprehensive Evaluation dated 1/24/2026 read, 7. Smoking Evaluation: resident may smoke independently or with set up. Review of Resident #57 care plan initiated on 3/11/2026 read, [Resident #57's name] desires to smoke. Resident has been assessed as able to smoke: with supervision d/t [do to] poor safety awareness. During an interview on 4/29/2026 at 9:56 AM Staff G, Certified Nursing Assistant (CNA) stated, [Resident #57's name] is consider a safe smoker. He is able to keep materials with him except the lighters. I always light the cigarettes for all residents to be safe, but if he [Resident #57] had a lighter he could light the cigarettes himself. During an interview on 4/29/2026 at 10:15 AM Staff H, Licensed Practical Nurse (LPN) Minimum Data Set Coordinator stated, [Resident #57 's name] care plan needs to be updated, he is considered a safe smoker. During an interview on 4/29/2026 at 10:53 AM the Director of Nursing (DON) stated, Based on last assessment he [Resident #57] is alert and competent. Last one is [smoking assessment] a safe smoker. I would expect them to revise the care plan. Review of the facility policy and procedure titled Comprehensive Assessment and Care Plans with a last review date 12/16/2026 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:10 The plan of care reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessment. 2) Review of Resident #62's physician order dated 11/27/2018 read, Full Code. Review of Resident #62's care plan revealed a focus that read, [Resident #62's name] has expressed the following wishes regarding code status and has the following advanced directives in place: Health Care Surrogate, is capable of making informed consent regarding their health care decisions, is a DNR [Do Not Resuscitate]. Date Initiated: 11/19/2024 Revision on: 11/19/2024. During an interview on 4/29/2026 at 11:00 AM the Social Services Director stated, The care plan is incorrect and will need changes to reflect the accurate code status. 3) Review of Resident #93's Do Not Resistate (DNR) Form dated 9/3/2025 stated the resident was a DNR. Review of Resident #93's care plan revealed a focus that read, [Resident #93's name] has expressed (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the following wishes regarding code status and has the following advanced directives in place: is Full Code, incapacitated with HCP [health care provider] pending. Date Initiated: 10/04/2021 Revision on: 01/04/2022. During an interview on 4/29/2026 at 1:24 PM the Social Services Director stated, The care plan is incorrect and does not reflect the current code status.

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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. Based on observation, interview and record review, the facility failed to ensure the physician was notified when a skin tear was identified for 1 of 3 residents, Resident #57, a low blood sugar value and physicians' ordered insulin not being administered for 2 of 6 residents, Residents #6 and #102. Findings include:1) During an observation on 04/27/2026 10:13 AM Resident #57 was sitting in bed there was gauze with tape over the resident's right hand with dried dark matter and a band aide with dry blood on the side of outer part of the resident's right hand. There was no date on the dressings.During an interview on 4/27/2026 at 10:13 AM Resident #57 stated, They put the band aide on his Friday [4/24/2026] they need to change it. During an observation on 4/27/2026 at 12:24 PM Resident #57 was in the room. There was a band aide on the outer part of the resident's right hand with dried dark matter.During an observation on 4/28/2026 at 9:13 AM Resident #57 was lying in bed there was a band aide on the outer side of the resident's right had with dried dark matter.During an interview on 4/28/2026 at 9:13 AM Resident #57 stated, They had not changed the band aide. I got a skin tear from the door of the smoking patio.Review of Resident #57 physician ordered did not document wound care orders for the right hand. Review of Resident #57 progress notes did not document information regarding a skin tear located on the right hand. During an interview on 4/28/2026 at 1:30 PM Staff I, Licensed Practical Nurse stated, He [Resident #57] gets skin tears all the time. Normally we will do an incident report, and we will do our part. I am not sure what happened, he told me he cut it with the door. I cannot tell you what it is it had dry blood. He had no orders in place.During an interview on 4/28/2026 at 2:33 PM the Wound Care Nurse stated, I just saw his skin tear and put orders in the system for wound care. An incident report needs to be completed and explain what happened. MD [medical doctor] and family will be notified. There are orders we can use for skin tears. That is what we would put in place until the wound care doctor sees the resident. I ordered xeroform and med honey. There should always be an order for wound care.During an interview on 4/29/2026 at 10:43 AM the Director of Nursing (DON) stated, Once it's been [skin tear] observed and there is a skin impairment there should be a progress note that documents what happened and that the provider was notified. Once you observe the nurses should follow the process. Notify family, MD, obtain treatment and do the incident report. There is a section which populates in the progress note. The incident report was put in place on 4/28 [2026]. Wound care should always have an order.Review of the facility policy and procedure titled Identification of Skin Condition Changes with a last review date of 12/16/2025 read, Policy: It is the policy of this facility that the facility monitors the skin integrity of the residents for changes in condition. Procedure: 3. the nurse should document the newly identified skin area and provide first aid or receive physician orders as are appropriate. 4. Notification of the physician and responsible party should occur when a newly developed skin condition is identified. Residents with minor recurrent skin conditions that are known to the physician, responsible party and staff as a part of their usual condition, do not require recurrent notification provided it is in agreement with the physician's and facility's resident plan of care.2) During an interview on 4/27/2026 at approximately 9:30 AM Resident #6 stated that he refused his long-acting insulin over the weekend because his blood sugar was 21. It had been low a couple times previously, but never that low. Review of Resident #6's Physician Orders dated 3/05/2026 read, Novolog Injection Solution 100 unit/ml [milliliters] (Insulin Aspart) Inject 15 unit subcutaneously with meals for DM [Diabetes Mellites] Give within 15 minutes of eating The physician order did not show parameters for the medication administration.Review of Resident #6's MAR (Medication Administration Record) from 3/01/2026 through 4/28/2026 for Novolog Injection documented 4 - held per parameters on 3/10/26 at 12:00 PM, 3/11/2026 at 12:00 PM and 3/17/2026 at 7:15 AM.During an interview on 4/30/2026 at 9:50 AM Staff E, LPN (Licensed Practical Nurse) stated that she had held Resident #6's insulin on 3/10 and 3/11 [2026] because he was low [low blood sugar] and she didn't want him to bottom out. She should have called the doctor.During an interview on 4/30/2026 at 11:26 AM the Director of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing (DON) stated that the expectation was if a nurse held a medication based on the resident's lab values they should follow up with the physician, explain the values and clarify whether to hold the medication.3) During an interview on 4/27/2026 at 4:31 PM Resident #102 stated that she often refused her insulin because she was not taking insulin at home and does not like to have her finger pricked so often for blood sugar checks. Review of Resident #102's physician order on the Medication Administration Record for March 2026 read, Humulin 70/30 KwikPen (70/30) 100 unit/ml suspension pen-injector, inject 15 unit subcutaneously at bedtime for DM documented at 9:00 PM Resident #102 refused the medication on 3/01/2026, 3/07/2026, 3/08/2026, 3/14/2026, 3/16/2026, 3/23/2026, 3/24/2026, 3/25/2026, 3/27/2026, 3/28/2026, 3/29/2026, and 3/30/2026.Review of Resident #102's physician order on the MAR for March 2026 read, Humulin 70/30 KwikPen (70/30) 100 unit/ml suspension pen-injector, inject 20 unit subcutaneously in the morning for DM documented at 6:00 AM Resident #102 refused the medication on 3/1/2026 and 3/5/2026.Review of Resident #102's physician order on the MAR for March 2026 read, Humulin 70/30 KwikPen (70/30) 100 unit/ml suspension pen-injector, inject 23 unit subcutaneously in the morning for DM documented at 6:00 AM Resident #102 refused the medication on 3/7/2026, 3/8/2026, 3/9/2026, 3/11/2026, 3/12/2026, 3/13/2026, 3/15-30/2026.Review of Resident #102's physician order on the Medication Administration Record for April 2026 read, Humulin 70/30 KwikPen (70/30) 100 unit/ml suspension pen-injector, inject 15 unit subcutaneously at bedtime for DM documented at 9:00 PM Resident #102 refused the medication on 4/3/2026, 4/5/2026, 4/7/2026, 4/11-14/2026, and 4/19-21/2026.Review of Resident #102's physician order on the MAR for April 2026 read, Humulin 70/30 KwikPen (70/30) 100 unit/ml suspension pen-injector, inject 23 unit subcutaneously in the morning for DM documented at 6:00 AM Resident #102 refused the medication on 4/1/2026-4/4/2026 and 4/6/2026 - 4/15/2026.Review of Resident #102's Progress Notes from 3/01/2026 through 4/27/2026 there was nothing documented regarding notification to provider of refusal of medications.During an interview on 4/29/2026 at approximately 11:30 AM the DON stated that if a resident refused medications multiple times, she expected the nurse to notify the physician.During an interview on 4/29/2026 at 4:39 PM, Physician #1 stated that he did not recall receiving any calls regarding Resident #102. If he was aware that a resident refused medication multiple times, he would consider changing the medication. With insulin it was difficult unless the resident's blood sugar was well controlled.During an interview on 4/29/2026 at 5:11 PM Staff A, LPN stated that Resident #102 often refused her medications. He should have made a note and documented that he notified the MD (Medical Doctor).During an interview on 4/29/2026 at 5:15 PM the VP (Vice President) of Clinical Operations stated that the expectation was that the nurses should call the MD every time a resident refused medication.

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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. Based on interview and record review the facility failed to ensure residents were free of unnecessary medications for 3 of 6 residents, Residents #8, #28, and #74, reviewed for medications.Findings include: 1) Review of Resident #8's physician orders dated 1/30/2026 read, Cozaar oral tablet 100 mg [milligrams] (Losartan Potassium) Give 1 tablet by mouth one time a day related to essential (primary) hypertension. Hold for SBP (systolic blood pressure) less than 110 or HR (heart rate) less than 60 Review of the Resident #8's MAR from 3/01/2026 through 4/28/2026 documented Cozaar oral tablet 100 mg (Losartan Potassium) Give 1 tablet by mouth one time a day related to essential (primary) hypertension. Hold for SBP less than 110 or HR less than 60 -Start Date 01/31/2026 0900 -D/C Date 04/29/2026 2122 (9:22 PM). There was documentation of administration on 3/14/2026 with a heart rate (HR) of 58; administration on 4/06/2026 with a HR of 58; 4/08/2026 with a HR of 53; on 4/16/2026 with a HR of 59; and administration on 4/22/2026 with a HR of 58. During an interview on 4/30/2026 at 12:15 PM Staff D, LPN (Licensed Practical Nurse) stated that if a vital sign for Resident #8 was outside of an ordered parameter she should not have given her the Cozaar. She should have made a note and clarified it with the provider. She did check all of her own vitals and didn't rely on the ones taken by the CNAs (Certified Nursing Assistant). During an interview on 4/30/2026 at 11:26 AM the Director of Nursing (DON) stated that the expectation was for the nurses to follow up with the MD (Medical Doctor) to explain a resident's vital signs and to clarify if a medication was to be given outside of the parameters ordered. During an interview on 4/29/2026 at 4:39 PM Physician #1 stated that he did not remember the nurses reaching out about Resident #8's heart rate being outside of the ordered parameter for administration of her Cozaar. During an interview on 4/29/2026 at 6:09 PM APRN (Advanced Practice Registered Nurse) #1 stated that she did not recall getting a call regarding Resident #8's heart rate or her Cozaar administration parameters. Review of Resident #8's Progress Notes from 3/01/2026 through 4/27/2026 revealed there was no documentation of notification to a provider or confirmation of administration for her Cozaar. 2) Review of Resident #28's physician order dated 8/6/2025 read, Amlodipine Besylate oral tablet 5 mg [milligrams] (Amlodipine Besylate), Give 1 tablet by mouth one time a day for HTN [hypertension] please hold if systolic BP [blood pressure] is less than 120. Hold for diastolic BP less than 60. Review of Resident #28's physician order dated 4/7/2026 read, Metoprolol Tartrate Tablet 100 mg, Give 0.5 tablet by mouth two times a day related to essential (primary) hypertension, please hold if systolic bp less than 120 or if HR [heart rate] is less than 70. Review of Resident #28's Medication Administration Record (MAR) for April 2026 documented Amlodipine Besylate was administered out of parameters at 9:00 AM on 4/7/26 - 113/71, 4/8/26 – 110/67, 4/14/26 – 118/76, 4/22/26 – 119/64, and 4/27/26 – 112.65. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #28's Medication Administration Record (MAR) for April 2026 documented Metoprolol Tartrate was administered out of parameters at 9:00 AM on 4/1/26 – HR 60, 4/6/26 – HR 65, 4/7/26 – BP 113/71, 4/8/26 – BP 110/67, 4/12/26 – HR 68, 4/14/26 – BP 118/76, 4/18/26 – HR 69, 4/19/26 – HR 60, 4/22/26 – BP 119/64, and 4/27/26 – BP 112/65. Administered at 5:00 PM on 4/1/26 – HR 64, 4/9/26 – BP 112/69 and HR 68. During an interview on 4/29/2026 at 2:55 PM with Staff E, LPN stated that she did not administer the medications outside parameters what she did was accidently document the wrong blood pressure. She stated that when she administered the medication the blood pressure was within parameters for the order. During an interview on 4/29/2026 at 2:58 PM with DON stated that she would have expected her nursing staff to administer medication according to the physician order. 3) Review of Resident #74's physician orders dated 2/12/2026 read, Insulin Aspart FlexPen 100 unit/ml [milliliters] solution pen-injector Inject as per sliding scale: 151-200 = 2 units, 201-250 = 4 units, 251 – 300 = 6 units, 301 – 350 = 8 units, 351 – 400 = 10 units subcutaneously before meals and at bedtime for DM [diabetes mellitus]. Review of Resident #74's physician orders dated 2/12/2026 read, Insulin Aspart FlexPen 100 Unit/ML [milliliters] Solution pen-injector Inject 9 units subcutaneously before meals for DM [diabetes mellitus] hold for BS [blood sugar] under 151. Review of Resident #74's Medication Administration Record (MAR) for the months of March and April 2026 for Insulin Aspart sliding scale documented the insulin was administered as ordered by the physician. Review of Resident #74's MAR for March 2026 for the physician ordered Insulin Aspart FlexPen inject 9 units before meals for DM Hold for BS under 151 and with review of the Schedule for Mar (March) 2026 blood sugar values documented Insulin Aspart was administered per the initialing of the licensed nurse on 3/7/2026 at 11:30 BS 132, 3/16/2026 at 11:30 BS 121, 3/19/2026 at 11:30 BS was 137, 3/25/2026 at 11:30 BS was 96, 3/26/2026 at 11:30 BS was 96. Review of Resident #74's MAR for April 2026 for the physician ordered Insulin Aspart FlexPen inject 9 units before meals for DM Hold for BS under 151 and with review of the Schedule for April 2026 blood sugar values documented Insulin Aspart was administered per the initialing of the licensed nurse on 4/1/2026 at 1630 [4:30 PM] BS 139, 4/2/2026 at 11:30 BS 110, 4/4/2026 at 11:30 BS 131, 4/9/2026 at 1630 BS 125, 4/11/2026 at 11:30 BS 103, and 4/25/2026 at 11:30 BS 125. During an interview on 4/29/2026 at 11:32 AM with Staff I Licensed Practical Nurse (LPN) stated, I do not really recall, but normally I will hold her [Resident #74's] insulin if it is below her parameters because I know it needs to be held if under the 151. It might have been an error while I was checking off the medications. During an interview on 4/29/2026 at 2:12 PM Staff M, Registered Nurse stated, That was a missed documentation. She [Resident #74] is a brittle diabetic I would not give her insulin if it is [blood sugar value] below the parameter. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/2026 at 10:08 AM the Director of Nursing stated, Nurses are to follow orders as written. Review of the facility policy and procedure titled Charting and Documentation with a last review date of 12/16/2025 read, Policy: It is the policy of this facility that services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's clinical record as needed. Procedure: 1. Observations, medications administered, services performed, ect., should be documented in the resident's clinical records.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 drugs and biologicals used in the facility were stored and labeled in accordance with accepted professional principles for 1 of 4 medication carts and 1 of 4 hallways reviewed for unattended medication and labeling.Findings include: 1) During an observation on 4/27/2026 at 9:37 AM Resident #24 was sitting in his wheelchair, there was a clear plastic medication cup with a white cream that was not labeled at the side from where the resident was sitting. [Photographic evidence obtained] During an interview on 4/27/2026 at 9:37 AM Resident #24 stated, That's for my bottom [pointing at the white cream in the medication cup.] I put it on myself. 2) During an observation on 4/27/2026 at 9:43 AM Resident #15 was sitting up in bed, on her bedside table there was zinc oxide ointment. [Photographic evidence obtained] During an interview on 4/27/2026 at 9:43 AM Resident #15 stated, I buy the cream and the staff put it on for me. 3) During an observation on 4/27/2026 at 10:18 AM Resident #13 was lying in bed. An enteral feeding formula was running at 60 milliliters per minute. The bag containing the enteral feeding formula was dated 4/27 and timed at 0900 (9:00 AM). The enteral feeding bag was not labeled with the name of the formula it contained. [Photographic evidence obtained] During an interview on 4/29/2026 at 11:11 AM the Director of Nursing stated, Medication should not be left unattended and enteral feeding bags should be labeled with the formula's name. During an interview on 4/30/2026 at approximately 9:00 AM the [NAME] President Of Clinical Operations stated, We do not have a policy and procedure for labeling but labeling is a standard of care. Review of the facility policy and procedure titled Medication/Biological Storage with a last review date of 12/16/2025 read, Policy: It will be the policy of this facility to store medications, drugs and biological in a safe, secured and orderly manner. Procedures: 4. The facility shall not use discontinued, outdated or deteriorated medications, drugs or biologicals. 7. Compartments (Including, but not limited to, drawers, cabinets, rooms, refrigerators carts and boxes) containing medications, drugs and biological shall be locked when not in use and trays or carts used to transport such items shall not be left unlocked if out of nurse's view. 4) During an observation on 4/28/2026 at 5:44 PM the East Long medication cart was reviewed. In one drawer of the cart an open plastic bag was observed. The label on the bag read, [Resident #14's name], Methyl PR Ace Inj 80MG/ML, [Methylprednisolone Acetate Injection 80 milligrams/milliliter]. A potent, steroid medication] and Disp [dispense]: 08/25/2025; Orig [original order date]: 08/25/2025; Stop: 09/01/2025. (Photographic evidence obtained) During an interview on 4/28/2026 at 5:45 PM Staff N, LPN stated that the medication for Resident (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#14 was not administered by the nurses. It was for the physician to inject for his fingers. She confirmed the medication was past the labeled expiration/discard date and should have been discarded. During an interview on 4/30/2026 at approximately 9:00 AM the [NAME] President of Clinical Operations stated that they did not have a policy for medication labeling, but labeling was a standard of care.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 is properly and safely stored, labeled, and dated in 2 of 2 nourishment rooms. Findings Include: During an observation on 4/27/26 at 9:25 AM of the [NAME] Wing nourishment room, there was a Salisbury steak frozen meal in the freezer that was not labeled or dated. During interview on 4/27/26 at 9:28 AM with the Certified Dietary Manager, stated that the foods should be labeled and dated.During an observation 4/27/26 at 9:40 AM of the East Wing nourishment room, there were three packages of smoked vegan turkey packaged meats, a frozen falafel, and an open box of frozen cheese pizza not labeled or dated in the freezer.During interview on 4/27/26 at 9:45 AM the Certified Dietary Manager stated that the foods should be labeled and dated.Review of the policy and procedures titled: Foods Brought in From the Outside reviewed 12/16/25, read, It will be the policy of this facility to provide safe and sanitary storage, handling, and consumption of all food including food and beverages brought to residents by family and other visitors. Procedure: Label containers with food item name and date received. Any item noted to be without a label and/or date will be discarded.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105638	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parklands Care Center and Rehab	1000 SW 16th Ave Gainesville, FL 32601

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record review the facility to ensure complete and accurate records for 2 of 5 residents, Residents #40 and #62, reviewed for medical record documentation. Findings include: During an observation on 4/27/2026 at approximately 10:00 AM Resident #40 was sitting up in bed dressed in a hospital gown. She was clean and well groomed. A bordered gauze dressing was observed on her left wrist dated 4/24. During an interview on 4/27/2026 at approximately 10:00 AM Resident #40 stated she was unsure of what happened with her wrist, but the nurse had put a dressing on it. Review of Resident #40's physician's order did not show an order for wound care to the resident's left wrist. Review of Resident #40's Progress Notes documented a Health Status Note dated 4/24/2026 that read, Note Text: resident observed sitting in chair directly across from nurses station scratching left forearm, open area was noted. Resident stated its itching, and left forearm cleansed with wound cleanser, xerofoam and border gauze dressing applied. MD (Medical Doctor) notified 1758 (5:38 PM), (daughter's name) notified 1759. Order placed for xerofoam and border gauze dressing During an interview on 4/29/2026 at 8:25 AM Staff B, LPN stated that she had seen Resident #40 scratching her arm. She called the doctor and got an order to clean it and put on a dressing. She also called Resident #40's family to notify them. She knew it was important to put an order in the computer for the wound care, and she thought she had put the order in, but maybe she forgot. During an interview on 4/29/2026 at 12:55 PM the Director of Nursing (DON) stated the expectation would be for the nurse who got the wound care order on Friday would have put it in the system. 2) Review of Resident #62's physician order dated 2/5/2021 read, Systane Gel, Instill 1 drop in both eyes two times a day for dry eyes unsupervised self-administration. Review of Resident #62's Medication Administration Record for April 2026 documented daily documentation of SA (self-administration) for Systane Gel. Review of Resident #62's Quarterly Nursing Comprehensive Evaluation dated 4/11/2026 read, Section:14. Medication administration- 3a. Resident does NOT wish to self-administer medication or treatments. During an interview on 4/29/2026 at 10:00 AM with Resident #62 stated that the eye drops are in the nurses' cart. During an interview on 4/29/2026 at 2:50 PM the Director of Nursing stated that when she reviewed the order that had the resident self-administer the eyedrops it was incorrectly put into the computer the administration area when placing a medication order the clinician administration is right above the self-administration button and it was inadvertently hit instead of the clinician button. Her (continued on next page)

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	105638	A. Building B. Wing	04/30/2026

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expectations would be that the nursing staff would have questioned and seek clarification of the order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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, interview, and record review the facility failed to ensure a safe, sanitary environment to prevent the possible spread of infection in the handling, storing, and processing of soiled linens and residents' clothing in the laundry room.Findings include:An observation was conducted on 4/29/2026 beginning approximately at 4:55 PM with the Housekeeping Supervisor and the Maintenance Director of the laundry room. During the tour of the laundry room the door separating the soiled utility room and the washing machine area was propped open with two plastic bins. The soiled room contained multiple bags of soiled linen. One bin was observed partially filled; a large volume of soiled linen, including bedding and pillowcases, was noted piled unsecured on top of the containers rather than contained within closed, leak-proof bags or covered receptacles. The door in the washing machine area leading to the dryer room area was open. In the dryer area there was a yellow rolling linen cart, articles of clothing were observed draped over the exterior side of the cart, with portions hanging down the side. A blue piece of clothing on a hanger was directly on the floor in close proximity to the clean linen cart. The clothing on the linen cart was not covered. There was a plastic shelving unit with multiple linens, towels, and clothing items stored in an unorganized manner. Several bags of laundry or linen were on the floor. A large quilted linen item was draped over and not fully contained. A broom was leaning against the shelving unit, with the broom head resting on the floor near the quilted linen. [Photographic evidence obtained]During an interview on 4/29/2026 at 4:58 PM the Housekeeping Supervisor stated, The doors from the soiled room should not be left opened. The technician was sorting the items, and I do not know why she left it [the door to the soiled utility room] open. The clothes and the linen in the soiled room should be covered. We are a bit backed up due to one of our washers being down. The items in the clean area should not be left uncovered and should not be on the floor. They will need to be washed again.During an observation on 4/29/2026 at 5:15 PM with the Administrator of the laundry room, the door to the soiled utility room continued to be open. The soiled linen continued to be not bagged. The door from the washer area to the dryer area was open and the dryer room was observed to have the yellow cart with clothing draped over the exterior of the cart, with portions hanging down the side. The blue clothing item on the hanger continued to be on the floor next to the linen cart. The shelving unit continued to have towels and clothing items stored in an unorganized manner. Several bags of laundry or linen remained on the floor, and the quilted linen continued to be draped near the broom's head.During an interview on 4/29/2026 at 5:16 PM the Administrator verified the areas of concern. Review of the facility policy and procedure titled Laundry Service with a last review date of 12/16/2025 read, Policy: It will be the policy of this facility to provide laundry services in accordance with resident preference while maintaining infection control techniques. Procedure: 3. Staff will maintain infection control techniques while handling both dirty and clean laundry and linen. 4. Dirty and clean laundry will be maintained in separate areas in the laundry room. 5. Facility linens will be bagged and be placed in soiled utility rooms for transport to the laundry room.