

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105652	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Palatka Center for Rehabilitation and Healing		STREET ADDRESS, CITY, STATE, ZIP CODE 110 Kay Larkin Dr Palatka, FL 32177	
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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Minimum Data Set (MDS) assessments were complete and accurate for 8 of 15 residents, Residents #2, #3, #8, #9, #112, #73, #139, and #153, reviewed Minimum Data Set assessments. Findings include: 1) Review of Resident #2's physician order dated 4/2/2026 read, Olanzapine Oral Tablet 5 MG [Milligram] (Olanzapine) give 1 tablet by mouth at bedtime for schizophrenia. Review of Resident #2 Medication Administration Record for the month of April 2026 documented the resident was administered Olanzapine for schizophrenia for the look back period of 4/2/2026 through 4/8/2026. Review of Resident #2's MDS titled Medicare 5 Day dated 4/8/2026, under Section I &ndash; Active Diagnoses, schizophrenia was not documented. During an interview on 7/15/2026 at 11:03 AM the MDS Registered Nurse (RN) Lead stated, [Resident #2's name] assessment is missing the diagnosis of schizophrenia. 2) Review of Resident #8 physician order dated 6/23/2026 read, Amoxicillin-Pot Clavulanate 875-125 MG [milligrams] give 1 tablet by mouth every 12 hours for bacterial infection for 7 Days. Review of Resident #8's Medication Administration Record (MAR) for the month of June 2026 documented resident was administered Amoxicillin-Pot Clavulanate for the look back period of 6/23/2026 through 6/27/2026. Review of Resident #8's physician order dated 6/25/2026 read, Sulfamethoxazole Trimethoprim Tablet 800-160 MG give 1 tablet by mouth every 12 hours for UTI [urinary tract infection] for 7 days Review of Resident #8 Medication Administration Record for the month of June 2026 documented the resident was administered Sulfamethoxazole Trimethoprim for the look back period of 6/25/2026 through 6/27/2026. Review of Resident #8's lab results for Urinalysis w/Micro, Reflex to Urine Culture/Urine Culture documented a collection date of 6/19/2026 and a reported date of 6/25/2026. The report read, Result: Klebsiella pneumoniae, Escherichia coli, and Acinetobacter baumannii [bacterial infections]. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #8's MDS titled Quarterly dated 7/5/2026 under Section I - Active Diagnoses UTI was not documented in the last 30 day look back. During an interview on 7/15/2026 at 10:22 AM the MDS RN (Registered Nurse) Lead, stated, The UTI diagnosis was not put in [coded in the assessment]. 3) Review of Resident #139's (Name of psychiatry provider) note dated 4/9/2026 read, Chief Complaint: Mood disorder, PTSD [post-traumatic stress disorder], depression, anxiety, TD [Tardive dyskinesia] and opioid abuse. Diagnoses Rationale and Justifications: PTSD (Post Traumatic Stress Disorder): The history suggests that this patient has suffered from significant trauma resulting in nightmares, flashbacks, and hypervigilance in the past. The symptoms have caused significant distress and functional impairment to the patient. The symptoms have lasted for more than one month and have occurred without any substance use or organic brain pathology. Review of Resident #139's MDS titled Annual dated 4/15/2026 under Section I - Active Diagnoses, PTSD was not documented as an active diagnosis. During an interview on 7/15/2026 at 10:37 AM the MDS Coordinator stated the diagnosis should have been documented. Review of the facility policy and procedure titled Accuracy of Resident Assessment Policy with a last review date of 1/20/2026 read, Policy Statement: The facility ensures that all resident assessments, including the Minimum Data Set (MDS) are accurate, complete and reflective of the resident's status in accordance with federal regulations under F641. 4) Review of Resident #153's physician orders as documented on the Medication Administration Record (MAR) for the month of April 2026 showed the resident was administered Remeron (used to treat major depressive disorders), Eliquis (use to stop dangerous blood clots from forming), and Lasix (used to treat fluid retention). Review of Resident #153's MDS dated [DATE] documented under Section N, High-Risk Drug Classes for antidepressant was coded as No, for anticoagulant (used to stop blood from clotting) was coded as No, and diuretic (used to treat fluid retention), was coded as No. During an interview on 07/15/2026 at 3:40 PM, the MDS Coordinator reviewed the MDS assessment dated [DATE] and acknowledged the identified sections had been coded incorrectly. 5) Review of the physician's orders for Resident #73 dated 06/19/2026 documented an order for Metoprolol Succinate Extended-Release 25 mg by mouth daily for hypertension and an order for Atorvastatin 40 mg by mouth at bedtime for hyperlipidemia. Review of Resident #73's history and physical dated 06/23/2026 documented a past medical history significant for hyperlipidemia. Review of Resident #73's nursing progress notes dated 06/29/2026 and 06/30/2026 documented (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure wound care dressing changes were provided per physicians' orders for 4 of 7 residents, Resident #49, #58, #132, and #161 reviewed for skin conditions and failed to apply compression stockings per they physician order for 1 of 3 residents, Resident #150 reviewed for edema. Findings include: 1) During an observation on 7/13/2026 at 9:56 AM Resident #161 was lying in bed. There was a wound dressing on the resident's left ankle. The wound dressing was dated 7/11. [photographic evidence obtained] During an observation on 7/14/2026 at 9:00 AM Resident #161 was lying in bed. The resident had a wound dressing to the left ankle that was dated 7/11/2026. During an interview on 7/14/2026 at 9:00 AM Resident #161, stated, They have not changed my dressing, and I need them to change it. Review of Resident #161's physician order dated 7/7/2026 read, Apply betadine to left ankle and cover with [sic] Tegaderm every day shift. During an interview on 7/15/2026 at 9:09 AM Staff E, Licensed Practical Nurse (LPN), stated [Resident #161's name] has orders to change the dressing every day. If the wound doctor rounds, they will do the dressing if not the cart nurse is responsible. I did not change the dressing on Monday [7/13]. I do not remember seeing the dressing order. During an observation on 7/15/2026 at 9:09 AM with Staff E, LPN, Staff E, confirm the wound dressing was dated 7/11/2026. 2) During an observation on 7/13/2026 at 10:55 AM Resident #132 was lying in bed. There was a wound dressing to the resident's left arm. The wound dressing was not dated and had dark dried drainage on the lower right side of the dressing. The dressing was not dated or initial. [Photographic evidence obtained] During an interview on 7/13/2026 at 10:55 AM Resident #132 stated, I have a skin tear on my arm and had sutures removed from my leg. They did dressing changes on Saturday [7/11/2026]. During an observation on 7/14/2026 at 9:06 AM Resident #132 was lying in bed. A wound dressing was observed to the resident's left arm. The wound dressing was not dated and had dark dried drainage on the lower right side of the dressing. The dressing was not dated or initial. [Photographic evidence obtained] During an interview on 7/14/2026 at 9:06 AM Resident #132 stated, The nurses have not changed the dressing on my arm or leg. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #49's Care Plan documented Focus &ndash; [Resident #49's name] is at Risk for Impaired Skin integrity. Interventions included: Evaluate skin; Provide skin care per facility guidelines and PRN (a needed). Focus - The resident has a Skin Tear/potential for skin tear of the right arm above wrist. Interventions included - 7/6/26 Offer nail care as needed to reduce risk of scratching or injury from picking at skin. Focus &ndash; [Resident #49's name] has potential/actual impairment to skin integrity r/t (related to) peripheral vascular disease, chronic kidney disease, State 3. Interventions included &ndash; Treatment as ordered (see MD [medical doctor] order for most current order). Review of Resident #49's physician orders dated 7/08/2026 read, Cleanse lower right forearm with wound cleanser, pat dry, apply dry dressing. Cleans right hand (between thumb and index finger) with wound cleanser, pat dry, apply dry dressing every shift for Skin tears. During an interview on 7/15/2026 at approximately 10:00 AM the DON (Director of Nursing) stated that the expectation was that ordered treatments were to be administered, which included wound care, dressing changes, and treatments or procedures. During an interview on 7/16/2026 at 1:08 PM Staff B, LPN stated that she had worked with Resident #49 on the night shift on 7/12/2026. She was not sure whether she provided wound care or a new dressing for him. During an interview on 7/16/2026 at 3:00 PM Staff C, LPN stated that she had worked with Resident #49 over the past weekend. She believed she had provided wound care and applied a dressing on Saturday night but not on Sunday. She did not use plain gauze, she always used Coban and it would have been purple or blue. 4) During an observation on 7/13/2026 at 10:29 AM, Resident #58 had a wound dressing on the resident's left upper arm. The wound dressing was dated 7/11/2026. During an interview on 7/13/2026 at 10:29 AM, Resident #58 stated that they had left the tape on her arm too long and it had pulled her skin off. They were changing the dressing every 2 days. Review of Resident #58's medical record documented the resident was admitted on [DATE] with medical diagnoses that included fracture of superior rim of left pubis, subsequent encounter for fracture with routine healing (primary) Review of Resident #58's most recent quarterly assessment dated [DATE] documented her BIMS Score as 13 out of 15 which indicated she was cognitively intact. Review of Resident #58's care plan documented: Focus - Risk for Impaired Skin Integrity. Interventions included &ndash; Provide skin care per facility guidelines and PRN (as needed). Focus &ndash; The resident has a skin tear of left upper arm. Interventions included - Treatment as ordered (See MD order for most current order). Review of Resident #58's physician orders dated 6/23/2026 read, Skin tear to left upper arm: Cleanse (continued on next page)		

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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 securely stored when unattended for 2 of 4 hallways. Findings include: 1) During an observation on 7/13/2026 at 9:31 AM Resident #53 was sitting in her room. On top of the resident's nightstand there was a medication cup with a white cream. During an interview on 7/13/2026 at 9:31 AM Resident #53 stated, The nurses give me that cream so I can apply it to my hands and feet it has lidocaine. I use it for my neuropathy pain. During an interview on 7/13/2026 at 1:23 PM Staff E, Licensed Practical Nurse (LPN) stated, [Resident #53's name] is not able to self-administer medication. Normally she will rub the cream herself, but the nurse has to be there with her. 2) During an observation on 7/13/2026 at 10:20 AM Resident #8 was lying in bed with eyes closed. There was an antibiotic ointment on top of the cabinet in the room. During an interview on 7/13/2026 at 1:25 PM Staff J, Unit Manager Registered Nurse (RN) stated, [Resident #8's name] is not able to self-administer the ointment, it is for his wound. The ointment should not be left in his room. 3) During an observation on 7/14/2026 at 8:08 AM Resident #50 was sitting up in bed there was a clear medication cup containing medications on top of the bedside table. During an interview on 7/14/2026 at 8:08 AM Resident #50 stated, I normally drink my medications with coffee. I am waiting for breakfast. During an interview on 7/14/2026 at 8:11 AM Staff D, LPN, stated, [Resident #50's name] is not able to self-administer medication. I thought he had taken all his medications before leaving the room. During an interview on 7/15/2026 at 9:40 AM the Director of Nursing stated, Nurses should ensure residents consume medications, no medication should be left unattended. Review of the policy and procedure titled, Medication Storage with a last review date of 1/20/2026 read, Policy: Medications will be stored in a manner that maintains the integrity of the product and ensures the safety of the residents and is in accordance with FL [Florida] Department of Health guidelines. Procedure: A. With the exception of Emergency Drug Kits, all medication will be stored in a locked cabinet, cart or medication room that is accessible only to authorized personnel, as defined by facility policy. 4) During an observation of Resident #159's room on 07/13/2026 at 9:13AM a bottle of Equate eye drops was on the bedside table. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of Resident #159's room on 07/14/2026 at 2:23PM, the resident was sitting in wheelchair in the room. On the bedside table was a bottle of Equate Eye Drops. (Photographic evidence obtained) During interview with Resident #159 on 07/15/2026 at 12:55 PM, the resident stated, The eyedrops. I have used them for a long time. I used to have the name brand ones, but they got too expensive and I use the generic now. They work just as well. I want them in my room I never know when I am going to need them for my dry eyes. During an interview with the Director of Nursing (DON) on 07/14/2026 at 2:30PM, the DON stated an evaluation for self-administration must be done for a resident to be able to have medications available at bedside. Review of Resident #159's physician orders did not show an order the resident was safe to self-administer medications. Review of Resident #159's medical record showed the record did not contain an evaluation for the self-administration of medications. 5) During an observation of Resident #162's room on 07/14/2026 at 8:30 AM, in the shared bathroom were medicine cups of unidentified creams and powder on the counter and in a grey basin placed on the counter. (Photographic evidence obtained) During an interview with Resident #162 on 07/14/2026 at 8:31AM, the resident stated they have been treating me for a fungal infection, and the cream is applied when I am getting cleaned up in the bathroom or I can put it on myself where and when my rash is bothering me. Review of Resident #162's physician orders dated 07/01/2026 read, Nystatin Cream 100000 UNIT/GM Apply to abdominal area bilateral topically every shift for fungal rash for 14 days, Nystatin External Cream 100000 UNIT/GM apply to bilateral breast topically every shift for rash for 14 days, and Nystatin Cream 100000 UNIT/GM apply to bilateral under arms topically every shift for fungal rash for 14 days.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed ensure residents' records were complete and accurate for 5 of 7 residents, Residents #49, #58, #132, #161, and #150, reviewed for documentation. Findings include: 1) During an observation on 7/13/2026 at 9:56 AM Resident #161 had a wound dressing on the resident's left ankle. The wound dressing was dated 7/11. [Photographic evidence obtained] During an observation on 7/14/2026 at 9:00 AM Resident #161 had a wound dressing on the resident's left ankle. The wound dressing was dated 7/11. During an interview on 7/14/2026 at 9:00 AM Resident #161, stated, They have not changed my dressing and I need them to change it. Review of Resident #161's physician order dated 7/7/2026 read, Apply betadine to left ankle and cover with {sic} tegaderm every day shift. Review of Resident Treatment Record for the month of July for dressing changes of to the left ankle documented dressing changes were completed on 7/12/2026, 7/13/2026, and 7/14/2026. During an interview on 7/15/2026 at 9:09 AM Staff E, Licensed Practical Nurse (LPN), stated [Resident #161's name] has orders to change the dressing every day. If the wound doctor rounds, they will do the dressing if not the cart nurse is responsible. I did not change the dressing on Monday [7/13]. I do not remember seeing the dressing order. I do not know why it would have a check mark. During an observation on 7/15/2026 at 9:09 AM with Staff E, LPN, Staff E, LPN confirmed the wound dressing was dated 7/11/2026. During an interview on 7/16/2026 at 10:23 AM Staff F, Registered Nurse (RN) stated, A check mark would mean the treatment was completed. I might have misread what it said or got confused with the area. 2) During an observation on 7/13/2026 at 10:55 AM Resident #132 was lying in bed. There was a wound dressing to the resident's left arm. The wound dressing was not dated and dark dried drainage on the lower right side of the dressing. The dressing was not dated or initialed. [Photographic evidence obtained] During an interview on 7/13/2026 at 10:55 AM Resident #132 stated, I have a skin tear on my arm and had sutures removed from my leg. They did the wound dressing changes on Saturday (7/11/2026). During an observation on 7/14/2026 at 9:06 AM Resident #132 was lying in bed. There was a wound dressing on the resident's left arm that was not dated and had dark dried drainage on the lower right (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	side of the dressing. The dressing was not dated or initialed. [Photographic evidence obtained] During an interview on 7/14/2026 at 9:06 AM Resident #132 stated, The nurses have not changed the dressing on my arm or leg. Review of Resident #132 physician order dated 4/21/2026 read, Cleanse skin tear to left arm with wound wash; pat dry; apply TAO [triple antibiotic ointment] and a dry dressing every day shift. Review of Resident #132 Medication Administration Record for the month of July 2026 documented left arm skin tear wound care was completed on 7/12/2026, 7/13/2026, and 7/14/2026. During an interview on 7/15/2026 at 9:50 AM Staff G, Licensed Practical Nurse stated, Yesterday the wound care team rounded, and they are the ones who do the wound care on Tuesday. I did not do her wound care yesterday it should have been the wound care team or the wound care nurse that was just hired. The dressings should be dated and initialed and the dressing should have been changed. During an observation on 7/15/2026 at 9:50 AM with Staff G, LPN, Staff G, LPN confirmed the wound dressing on the resident's left arm was not dated and was soiled and the wound dressing to the resident's right foot was dated 7/11/2026. [Photographic evidence obtained] During an interview on 7/15/2026 at 9:48 AM the Director of Nursing stated, A check mark means the wound dressing was completed. I would expect staff to document accurately. Review of the facility policy and procedure titled, Skin Care and Wound Management with a last review date of 1/20/2026 read, Policy: The facility will manage wound care based upon current standards of practice. Procedure: 3. The treatment order will be documented on the Treatment Administration Record. Review of the facility policy and procedure titled, Clinical Documentation with a last review date of 1/20/2026 read, Purpose: The facility clinical staff will document the provision of care and services according to nursing standards and regulatory requirements. When completed, documentation will accurately reflect the clinical care and other services provided to the resident and ensure that the appropriate information is available to all interdisciplinary the members. 3) During an observation on 7/13/2026 at approximately 11:00 AM, Resident #49 was sitting up in bed. He was dressed in street clothes, and his wife was sitting with him. Resident #49 had a gauze wound dressing on his left wrist with a reddish-brown substance observed. The dressing had a date of 7/11. During an interview on 7/13/2026 at approximately 11:00 AM, Resident #49 stated that he had asked to have his nails trimmed and that he scratched himself. Resident #49's wife confirmed that he had scratched himself, and said his bandage was changed Saturday. Review of Resident #49's care plan documented Focus &ndash; [Resident #49's name] is at Risk for Impaired Skin Integrity. Interventions included - Evaluate skin; Provide skin care per facility guidelines and PRN (as needed). Focus - The resident has a Skin Tear/potential for skin tear of the right arm (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	above wrist. Focus & [Resident #49's name] has potential/actual impairment to skin integrity r/t (related to) peripheral vascular disease, chronic kidney disease, Stage 3. Interventions included & Treatment as ordered (see MD (medical doctor) order for most current order) Review of Resident #49's physician orders dated 7/08/2026 read, Cleanse lower right forearm with wound cleanser, pat dry, apply dry dressing. Cleanse right hand (between thumb and index finger) with wound cleanser, pat dry, apply dry dressing every shift for skin tears Review of Resident #49's MAR/TAR (Medication Administration Record/Treatment Administration Record) from 7/07/2026 through 7/15/2026 read, Cleanse lower right forearm with wound cleanser, pat dry, apply dry dressing. Cleans right hand (between thumb and index finger) with wound cleanser, pat dry, apply dry dressing. every shift for skin tears. There was documentation of wound care and dressing changes each shift, three times daily, on 7/11/2026, 7/12/2026, and 7/13/2026. During an observation on 7/13/2026 at approximately 3:00 PM Resident #49 was lying in bed with his eyes closed. He had a gauze wound dressing on his left lower forearm/wrist that was dated 7/11. During an interview on 7/16/2026 at 1:08 PM Staff B, LPN stated that she had worked with Resident #49 on the night shift on 7/12/2026. She was not sure whether she provided wound care or a new dressing for him. If a medication or treatment was signed off on the MAR/TAR, it meant that I did it. During an interview on 7/16/2026 at 3:00 PM Staff C, LPN stated that she had worked with Resident #49 over the past weekend. She believed she had provided wound care and applied a dressing on Saturday night but not on Sunday. She did not use plain gauze for a dressing on the wrist. 4) During an observation on 7/13/2026 at 10:29 AM, Resident #58 had a wound dressing on to the left upper arm. The wound dressing was dated 7/11/2026. During an interview on 7/13/2026 at 10:29 AM, Resident #58 stated that they were changing the dressing every 2 days. Review of Resident #58's care plan read, Focus: for Impaired Skin Integrity. Interventions included & Provide skin care per facility guidelines and PRN (as needed). Focus & The resident has a skin tear of left upper arm. Interventions included - Treatment as ordered (See MD order for most current order) Review of Resident #58's physician orders dated 6/23/2026 read, Skin tear to left upper arm: Cleanse with wound cleanser, pat dry, apply Medi honey, cover with silicone bordered foam dressing until healed every day shift Review of Resident #58's MAR/TAR from 6/01/2026 documented an entry that read, Skin tear to left upper arm: Cleanse with wound cleanser, pat dry, apply Medi honey, cover with silicone bordered foam dressing until healed every day shift. There was documentation of daily treatment as ordered from 6/24/2026 through 7/14/2026, with the exception of documentation of resident refusal on 7/02/2026. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5) During an observation on 7/13/2026 at approximately 10:30 AM Resident #150 was sitting in his wheelchair beside his bed with the television on. He was dressed in street clothes and was wearing non-slip socks. During an interview on 7/13/2026 at approximately 10:30 AM Resident #150 stated, I can't get anyone to put on my compression socks. It's been about three days. My cardiologist told me I should wear them [the compression socks] every day. Review of Resident #150's MDS, a quarterly assessment dated [DATE] documented his BIMS Score as 12 out of 15 which indicated he had some mild cognitive impairment. He required partial to moderate assistance for bathing and putting on/taking off footwear. Review of Resident #150's care plan documented Focus - Risk for Impaired Skin Integrity. Interventions - Apply knee high compression socks during day. Remove at night. Focus - The resident is on diuretic therapy r/t (related to) edema/swelling. Review of Resident #150's physician order read, Apply knee high compression socks during day. Remove at night one time a day for circulation remove at night. Review of Resident #150's physician order read, Remove knee high compression socking {sp.} at night in the evening for edema. Review of Resident #150's MAR/TAR from 7/01/2026 through 7/16/2026 read, Apply knee high compression socks during day. Remove at night one time a day for circulation remove at night. There was documentation of application of the compression socks daily. During an observation on 7/14/2026 at 4:39 PM Resident #150 was sitting in his wheelchair. He was dressed in street clothes and wearing non-slip socks. During an interview on 7/15/2026 at approximately 10:00 AM the Director of Nursing stated that a check mark on a resident's MAR/TAR indicated the medication or treatment was administered. The expectation was that nurses accurately document what they did. If there was a question about the order, the nurse is expected to get clarification from the provider. During an interview on 7/15/2026 at 2:35 PM Staff G, LPN stated, a check mark on the MAR or TAR meant completed (medication or treatment administered). If there was an error or could not be completed after it was documented, the nurse has to go back in and strike it (the check mark) out. If there was a question about an order, the nurse is supposed to contact the DON and confirm the order with the doctor. Based on what the doctor said, the nurse would change or leave the order. During an observation on 7/16/2026 at 12:15 PM Resident #150 was assisted out of his bed into his wheelchair. He was dressed in street clothes and non-slip socks. A pair of knee-high compression socks/stockings were laying on the dresser in Resident #150's room. (Photographic evidence obtained) (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/16/2026 at 12:20 PM Resident #150 stated that it had been days since anyone had assisted him to put on his compression socks. He was not able to put them on or take them off by himself. During an interview on 7/16/2026 at 12:25 PM Staff H, CNA stated that she regularly worked with Resident #150. She had not put his compression socks on today. She did not remove the compression socks, and he could not remove them himself. 6) Review of Resident #7's physician order dated 5/01/2026 read, Novolog Flex Pen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart): Inject subcutaneously three times a day for Diabetes - Inject as per sliding scale: if 0 - 150 = 0 units if blood sugar reads less than 70, initiate hypoglycemic protocol and notify MD [Medical Doctor]; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 8units; 301 - 350 = 10 units if blood sugar reads greater than 350 give 10 units and notify MD, subcutaneously three times a day for Diabetes Review of Resident #7's MAR/TAR from 5/01/2026 through 5/31/2026 read, NovoLog Flex Pen Subcutaneous Solution Pen-injector 100 UNIT/ML Inject as per sliding scale: if 0 - 150 = 0 units if blood sugar reads less than 70, initiate hypoglycemic protocol and notify MD; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 8units; 301 - 350 = 10 units if blood sugar read greater than 350 give 10 units and notify MD, subcutaneously three times a day for Diabetes. Dated 5/16/2026, 5/18/2026, 5/22/2026, 5/27/2026 5/31/2026 at 0600 [6:00 AM] and 5/12/2026, 5/13/2026, 5/16-18/2026, 5/21/2026, 5/22/2026, 5/26/2026, and 5/27/2026 at 2200 [10:00 PM] blood sugar results were in the range requiring insulin coverage per the physician. Documented for the administration was a 9 (Other/See Nurse Note). Review of Resident #7's nurse progress notes from 5/01/2026 through 5/31/2026 showed there were no notes documenting why the physician order was not followed for the administration of insulin. Review of Resident #7's MAR/TAR from 6/01/2026 through 6/30/2026 read, NovoLog Flex Pen Subcutaneous Solution Pen-injector 100 UNIT/ML Inject as per sliding scale: if 0 - 150 = 0 units if blood sugar reads less than 70, initiate hypoglycemic protocol and notify MD; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 8units; 301 - 350 = 10 units if blood sugar read greater than 350 give 10 units and notify MD, subcutaneously three times a day for Diabetes. Dated 6/6/2026, 6/7/2026 at 0600 and 6/1/2026, 6/6/2026, and 6/7/2026 at 2200 blood sugar results were in the range requiring insulin coverage per the physician. Documented for the administration was a 9 (Other/See Nurse Note). Review of Resident #7's Progress Notes from 6/01/2026 through 6/30/2026 showed there were no notes documenting why the physician order was not followed for the administration of insulin. During an interview on 7/15/2026 at approximately 10:00 AM the Director of Nursing stated the expectation is ordered treatments are to be administered. For residents with sliding scale insulin, the dosage of insulin needs to be documented on the MAR. If the resident did not require insulin coverage, a numeric chart code could be documented to indicate that no coverage was needed or administered. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/15/2026 at approximately 3:00 PM the Director of Nursing stated after reviewing Resident #7's chart, she could not determine what doses of insulin, if any, were administered for the 19 occurrences of a chart code of 9 between 5/01/2026 and 6/30/2026. During an interview on 7/16/2026 at approximately 12:00 PM Staff K, LPN stated, there was not a reason to use the numeric code 9, but if it was used, a note should be written. During an interview on 7/16/2026 at 3:00 PM Staff C, LPN stated that during May and June she had not been following proper documentation procedures when documenting on Resident #7's sliding scale insulin order. Review of the policy and procedure titled, Medication Administration General Guidelines with the last review date of 1/20/2026 read, Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Procedure: A. Preparation 4) Five Rights - Right resident, right drug, right dose, right route and the right time, are applied for each medication being administered. A triple check of these five rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away. D. Documentation (including electronic) 1) The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. Review of the policy and procedure titled, Wound Care and Dressings Change, Dry/Clean, with the last review date of 1/20/2026 read, Purpose: The purpose of this procedure is to provide guidelines for the application of dry, clean dressings. Documentation: The following information should be recorded in the resident's medical record, treatment sheet or designated wound form: 1. The date and time the dressing was changed. 2. The name and title (or initials) of the individual changing the dressing. 5. If the resident refused the treatment, the reason for refusal and the resident's response to the explanation of the risks of refusing the procedure, the benefits of accepting and available alternatives. Document family and physician notification of refusal. Reporting. 2. Report other information in accordance with facility policy and professional standards of practice.		

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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 interview and record review the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) and Level II PASRR were completed when a mental illness was identified for 2 of 3 residents, Resident #2 and #136, review for PASRR screening. Findings include: 1) Review of Resident #2's State of Florida Agency for Health Care Administration Preadmission Screening and Resident Review (PASRR) dated 4/2/2026 read, Section I: PASSR Screen Decision-Making. A. MI [Mental Illness] or Suspected MI: Schizophrenia and substance abuse. Section III: PASSR Screen Provisional admission or Hospital Discharge Exemption: Individual may be admitted to an Nursing Facility (check one of the following): Hospital Discharge Exemption. The individual is being admitted under 30 day discharge exemption. If the individual's stay is anticipated to exceed 30 days, the NF must notify the Level I screener on the 25th day of stay and the Level II evaluation must be completed no later than the 40th day of admission on or before (date): [blank]. The resident continues to reside in the facility. Review of Resident #2's medical record did not document a PASRR Level II screening having been completed. Review of Resident #2 Discharge summary dated [DATE] read, Hospital Course to date: significant history of schizophrenia. During an interview on 7/15/2026 at 12:26 PM with the Director of Social Services stated, [Resident #2's name] PASSR was not clear and we did not have the history. We got the history later on. We told psych and they were going to let me know and I never got told and life went on. We should have looked at it better. A Level II PASSR was not completed and needed to be completed. 2) Review of Resident #136's State of Florida Agency for Health Care Administration Preadmission Screening and Resident Review dated 5/5/2026 did no document depression. Review of Resident #136's admission record documented the resident was admitted on [DATE] and readmitted on [DATE] with diagnosis including but not limited to major depression disorder [onset date 6/4/2026]. Review of Resident #136's [Name of psychiatric provider] note dated 5/7/2026 read, Chief Complaint: Depression. History of Presenting Illness: As per collected information, new admission psychiatric assessment completed with patient presenting for evaluation following report of cancer diagnosis. Patient appeared withdrawn during encounter, frequently avoiding eye contact and turning away when spoken to, with affect appearing, mildly depressed and constricted. Patient is not on any psych meds. Diagnoses Rationale and Justifications: Adjustment disorder with depressed mood: The history suggest that the patient's depressed mood is secondary to the underlying stressors. Review of Resident #136's [Name of psychiatric provider] note dated 6/18/2026 read, Chief Complaint: Depression and insomnia. Patient reports benefiting from medication. Current dose of Mirtazapine [used to treat major depressive disorder] is managing depression. Diagnoses Rationale and Justifications: MDD [major depressive disorder], Recurrent: The history suggests that this patient has suffered from episode of depression lasting for more than 2 weeks. The symptoms have caused significant distress and functional impairment to the patient, and they have occurred without any underlying substance use or organic brain pathology. Review of Resident #136's physician order dated 7/8/2026 read, Mirtazapine Tablet 7.5 MG [milligram] give 1 tablet by mouth at bedtime for mmd. During an interview on 7/15/2026 at 12:35 PM the Director of Social Services stated, MDS [Minimum Data Set] nor Psych notified us of a change in diagnosis. [Resident #136's name] PASSR should have been reviewed due to the new diagnosis given of depression. During an interview on 7/16/2026 at 12:00 PM the Administrator stated, We had a change in social services and two newer people in admissions in the past six months. What we had in place (continued on next page)		

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Centers for Medicare & Medicaid Services

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NAME OF PROVIDER OR SUPPLIER Palatka Center for Rehabilitation and Healing		STREET ADDRESS, CITY, STATE, ZIP CODE 110 Kay Larkin Dr Palatka, FL 32177	
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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prior was our admission Director and our Social Services Director both looked at PASSRs. I think the system broke when we had the change in admission, social service department, the Director of Nursing and psych. Review of the facility policy and procedure titled Pre-admission Screening and Resident Review (PASRR) with a last review date of 1/20/2026 read, Overview: The purpose of PASRR is to ensure individuals who are being considered for placement in Nursing Facility are evaluated for serious mental illness and/or intellectual disability and are offered the most integrated setting appropriate for their long term care needs (including determining whether a Nursing Facility is appropriate).		

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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 interview and record review the facility failed to develop and implement a comprehensive care plan for 1 of 3 residents, Resident #139, reviewed for behavioral management. Findings include: Review of Resident #139's [Name of psychiatric provider] note dated 4/9/2026 read, Chief Complaint: Mood disorder, PTSD [Post Traumatic Stress Disorder], depression, anxiety, TD [Tardive dyskinesia] and opioid abuse. Diagnoses Rationale and Justifications: PTSD (Post Traumatic Stress Disorder): The history suggests that this patient has suffered from significant trauma resulting in nightmares, flashbacks, and hypervigilance in the past. The symptoms have caused significant distress and functional impairment to the patient. The symptoms have lasted for more than one month and have occurred without any substance use or organic brain pathology. Review of Resident #139's [Name of psychiatric provider] note dated 7/9/2026 read, Chief Complaint: Mood disorder, PTSD, depression, anxiety, TD and opioid abuse. Diagnoses Rationale and Justifications: PTSD (Post Traumatic Stress Disorder): The history suggests that this patient has suffered from significant trauma resulting in nightmares, flashbacks, and hypervigilance in the past. The symptoms have caused significant distress and functional impairment to the patient. The symptoms have lasted for more than one month and have occurred without any substance use or organic brain pathology. Triggers: Perceived helplessness. Review of Resident #139's care plan did not have a focus area for PTSD. During an interview on 7/15/2026 at 10:26 AM the Minimum Data Set (MDS) Registered Nurse Lead stated, [Resident #139's name] care plan does not include PTSD, just depression and anxiety. During an interview on 7/16/2026 at 1:21 PM the Director of Nursing stated, [Resident #139's name] care plan does not include PTSD and in should have been included. Review of the policy and procedure titled, Resident Assessment Instrument [RAI] Comprehensive Care Plan Policy with a last review date of 1/20/2026 read, Purpose: To ensure that each resident in the facility receives individualized and appropriate care based on a thorough assessment using the Resident Assessment Instrument (RAI), and to comply with state and federal regulations. Policy Statement: The facility will utilize the RAI process to assess residents' needs, develop individualized care plans, and ensure the delivery of quality care. This process will involve interdisciplinary team members and be revised to reflect resident condition changes.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review the facility failed to ensure the flushing of a gastric tube after the administration of a bolus feeding for 1of 4 residents, Resident #136, reviewed for enteral tube management.Findings include:During an observation on 7/15/2026 at 12:04 PM Staff G, Licensed Practical Nurse (LPN) entered Resident #136's room. Staff G donned gloves but did not don a gown. Staff G administered 50 ml [milliliters] of water to flush Resident #136's gastric tube followed by 250 ml of Glucerna 1.5. Staff G finished the administration of the bolus feeding and did not flush the gastric tube after administering the bolus feed.During an interview on 7/15/2026 at 12:12 PM Staff G, LPN stated, Usually I only flush before to clean out the gastric tube not after. The order did not say to flush after.Review of Resident #136's physician orders dated 7/8/2026 read, Enteral Feed Order every 8 hours Enteral: Bolus Feeding - Glucerna 1.5 per G-TUBE [gastrostomy tube] via bolus. 250 mL every 8hrs, FLUSH with 50ML of H2O [water] BEFORE AND AFTER EVERY BOLUS to provide 1125 KCALS [kilocalorie]/ [per] 24 hours.During an interview on 7/15/2026 at 1:36 PM the Director of Nursing stated, Nursing staff should review orders and flush gastric tubes before and after the administration of a bolus feeding.During an interview on 7/16/2926 at 9:26 AM the Registered Dietitian when ask if Resident #136 was at risk of dehydration stated, Not necessarily, [Resident #136's name] is on a oral diet. The nurses should flush before and after the bolus it is the protocol to do it.Review of the policy and procedure titled, Feeding Tube with a last review date of 1/20/2026 read, Purpose. The purpose of this procedure is to provide guidelines for the safe administration of tube feeding. Procedure: Feeding Administration: i. Draw up thirty (30) to sixty (60) cc tap water. Flush feeding tube with water.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review the facility failed to ensure respiratory care for oxygen administration and/or humidification per physician orders for 2 of 6, Resident #48 and #147, and failed to obtain a physician order for the use of a continuous positive airway pressure machine for 1 of 3 residents, Resident #84, reviewed for respiratory services. Findings include: 1) During an observation on 07/13/2026 at 9:28 AM Resident #48 was lying in bed oxygen was administered at 4 liters with humidification attached. During an observation on 7/14/2026 at 9:01 AM Resident #48 was lying in bed with eyes closed oxygen was administered via nasal cannula at 2 liters per minute with humidification. [Photographic evidence obtained] Review of Resident #48 physician order dated 6/15/2026 read, Oxygen @ 4 L/Min [at 4 liters per minute] continuous inhalation via NC [nasal cannula] every shift. There was no order documented in the record for the use of humidification. During an interview on 7/15/2026 at 9:13 AM Staff E, Licensed Practical Nurse (LPN) stated, [Resident #48's name] does not a humidifier ordered. I am not sure if it should be part of the order. Her [Resident #48's] order is for 4 liters we should be checking the flow rate every shift. During an interview on 7/15/2026 at 9:53 AM the Director of Nursing stated, Nurses are to check the flow rate throughout the shift to make sure it is accurate. I will have to review the policy to see if a humidifier needs to have orders. During an interview on 7/16/2026 at 10:19 AM Staff F, Registered Nurse stated, [Resident #48's name] has never changed her flow rate. If a resident's oxygen is making her nose dry or having nose bleeds, we will do oxygen with humidification. We would call the provider to let them know and make a note in the system. During an interview on 7/16/2026 at 1:21 PM the Director of Nursing stated, If a resident has a dry nose or has discomfort, I would expect the nurses to notify the provider of need for treatment and document it. Review of the facility policy and procedure titled Oxygen Administration with a last review date of 1/20/2026 read, Purpose: The purpose of this procedure is to provide guidelines for oxygen administration. Procedure: 9. Turn on the oxygen. Start the flow of oxygen at the prescribed rate. 2) During an observation on 07/13/2026 at 9:45 AM Resident #147 was lying in bed with oxygen being administered via nasal cannula at 3 liters per minute. During an observation on 07/13/2026 at 2:29 PM Resident #147 was lying in bed with oxygen being administered via nasal cannula at 3 liters per minute. [Photographic evidence obtained]. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 07/14/2026 at 8:50 AM Resident #147 was lying in bed with oxygen being administered via nasal cannula at 3 liters per minute. [Photographic evidence obtained]. During an observation on 07/14/2026 at 9:10 AM Resident #147 was lying in bed with oxygen being administered via nasal cannula at 3 liters per minute. [Photographic evidence obtained]. Review of Resident #147 physician's order dated 06/26/26 read, Oxygen @ 2L [liters]/Min [minute] continuous inhalation via NC [nasal cannula] every shift. During an interview on 7/15/2026 at 9:08 AM, Staff E, Licensed Practical Nurse (LPN), confirmed Resident #147's active oxygen order is for a 2 liter per minute flow rate. She stated, We're supposed to check oxygen flow rate every day for accuracy. During an observation on 7/15/2026 at 9:08 AM with Staff E, LPN, Staff E observed Resident #147's flow rate and confirmed the flow rate was at 3 liters per minute and stated, The flow rate is wrong. During an interview on 07/15/26 at 09:53 AM, the Director of Nursing stated, Nurses are to check the flow rate throughout the shift to make sure it is accurate. Review of the policy and procedure titled, Oxygen Administration with a last review date of 1/20/2026 read, Purpose: The purpose of this procedure is to provide guidelines for oxygen administration. Procedure: 9. Turn on the oxygen. Start the flow of oxygen at the prescribed rate. 3) During an observation of Resident #84's room on 07/13/2026 at 10:43 AM, the Resident had an oxygen concentrator not in use in the corner of the room. There was a white nebulizer treatment machine and a black Continuous Positive Airway Pressure(C-PAP) machine on the bedside table. The mask was stored and dated in a patient belongings bag. During an observation on 07/15/2026 11:37 AM of Resident #84's room a C-PAP and a nebulizer machine were on the nightstand with the tubing in a bag. During an interview on 7/15/2026 at 11:37 AM Resident #84 stated I have used a C-Pap for so long I can't even remember when I started. I have had that one here with me since day one. It came from my house. During an interview on 07/15/2026 at 12:43 PM Staff L, Licensed Practical Nurse (LPN stated, An order is needed for a C-PAP, If there is no order, we would go to the medical records from admission and see if the hospital has information on the setting and see when the last sleep study was done. We do supply C-PAP machines. During an interview on 07/15/2026 at 2:45 PM the Director of Nursing stated, If the Resident needs a C-PAP machine the nurse should call the Doctor for an order. Review of Resident #84's medical record documented diagnosis to include: COPD (Chronic Obstructive Pulmonary Disease) and heart failure. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #84's physician order dated 07/05/2026 read, Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML [milligram/milliliter] 1 vial inhale orally every 8 hours as needed for wheezing related to chronic obstructive pulmonary disease, unspecified. There was no physician order in the record for a C-PAP machine. Review of Resident #84's Nursing Progress Notes Daily Medicare/Managed Care Note on 7/11/26 by Staff K, LPN read, Respiratory Devices: None of the above. Review of Resident #84's MDS (Minimum Data Set) Medicare 5 Day dated 06/30/2026 under Section O, did not have documentation for the use of a C-PAP machine. Review of Resident #84's care plan read, Focus: [Resident #84's name] has COPD. Goal: The resident will be free of s/sx [signs/symptoms] of respiratory infections through review date. Intervention: Encourage to elevate head of bed while in bed to assist with breathing and prevent episodes of shortness of breath when lying flat. CPAP on at HS [hour of sleep], setting as ordered. Give aerosol or bronchodilators as ordered. Monitor/document any side effects and effectiveness. Head of bed elevated as tolerated to prevent SOB [shortness of breath] while lying flat. Observe for s/s of acute respiratory insufficiency: Anxiety, Confusion, Restlessness, SOB at rest, Cyanosis, Somnolence. Review of the policy and procedure titled, Skilled Nursing-Use of CPAP/BIPAP/APAP [continuous positive airway pressure/ bilevel positive airway pressure, automatic positive airway pressure] last revision date 01/20/2026. Guidelines for use: MD [Medical Doctor] Orders: Obtain MD order that includes the following: Specifies what type of machine is required (CPAP, BIPAP, APAP). Contains the specific pressure. If machine is from home (May continue home settings). Diagnosis. For cleaning mask and tubing instructions. Care and Maintenance: All machines have at least one filter, located at the back of the machine at the air intake. Washable foam filters should be cleaned as soon as they are discolored or at least weekly.		

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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 physician orders were followed related to the pharmacy Psychoactive Medication Use Recommendations for the monthly drug regimen review for 1 of 5 residents, Resident #49, reviewed for unnecessary medications. Findings include: Review of the Psychoactive Medication Use Recommendations document for Resident #49 dated 6/23/2026 read, Currently receiving Trazodone which can increase risk of drowsiness and falls. Per clinical record, with recent falls. Please evaluate, consider tapering dose or implementing alternative treatment, if necessary. The physician response was documented as Agree; Will do; D/ C [discontinue]. Review of Resident #49's physician orders dated 6/22/2026 read, Trazodone HCl Oral Tablet 50 MG [milligrams] (Trazodone HCl): Give 25 mg by mouth at bedtime related to major depressive disorder, recurrent, moderate (F33.1) Review of Resident #49's MAR (Medication Administration Record) from 6/23/2026 through 7/15/2026 documented that Trazadone was administered daily at bedtime per the initialing of the MAR by the licensed nurse. During an interview on 7/16/2026 at 9:50 AM the DON (Director of Nursing) stated the Medication Regimen Review (MRR) process was that the pharmacist's recommendations were presented to the providers and were reviewed by the MD or NP (Medical Doctor or Nurse Practitioner). Any changes or orders were then entered [into the electronic medical record (EMR)] by the Unit Managers. The expectation was that the providers' orders would be entered and followed. During an interview on 7/16/2026 at 11:15 AM Physician #1 stated he and the nurse practitioners were routinely addressing the recommendations made by the pharmacists. The expectation was that when he or a nurse practitioner wrote a medication order, it was to be followed. Review of the policy and procedure titled, [Name of Pharmacy] - Drug Regimen Review, with the last review date of 1/20/2026 read, Policy: In accordance with State and Federal regulations, the consultant pharmacist will review each resident's clinical chart monthly. Apparent irregularities will be reported in writing to the Director of Nursing, Medical Director, Attending Physician and Administrator. The facility shall follow up of {sp.} Consultant Pharmacist recommendations to ensure all residents maintain the highest practical level of functioning. Purpose: To ensure drug and medication regimen reviews are completed, received and reviewed by appropriate personnel in a timely manner. Procedure: 2. Recommendations and apparent irregularities will be reported timely to ensure the safe and appropriate medication utilization to meet the individual needs of the residents.		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on interview and record review the facility failed to ensure laboratory specimens as ordered by the physician were collected for 2 of 4 residents, Resident #3 and #48, reviewed for laboratory services. Findings include: Review of Resident #48's physician order dated 7/7/2026 read, Ferritin, Folate, Iron, TIBC [Total Iron-Binding Capacity], and % SAT [saturation] waiting to be sent one time only related to Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation. Review of Resident #48's medical record for lab results the record did not contain lab results for the physician ordered labs dated 7/7/2026. During an interview on 7/16/2026 at 9:07 AM the Director of Nursing stated, [Resident #48's name] labs did not get drawn. The facility did not do a requisition form. Review of Resident #3's physician's order dated 06/30/2026 read, Urinalysis w/Micro [with microscopic], Refl {sic} to Urine Culture - ** SCHEDULED 6/30/2026; Auto-Send 6/30/2026 12:00 AM ** one time only. Review of Resident #3's medical record for labs results the record did not contain lab results for the physician ordered labs dated 06/30/2026. During an interview on 7/16/2026 at 1:21 PM the Director of Nursing stated, [Resident #3's name] urinalysis was not completed. During an interview on 7/16/2026 at 11:50 the [Name of lab providing services to the facility] representative stated, [Resident #48's name] did not have labs drawn on 7/7/2026. Last labs are on 6/6/2026 which was a CBC [Complete Blood Count], CMP [Comprehensive Metabolic Panel], TSH [Thyroid-stimulating hormone], B12 [vitamin B12], and Vitamin D. [Resident #3's name] does not have a urinalysis collected. The last labs for [Resident #3's name] were on 6/29/2026 which were CBC and CMP. Review of the facility policy and procedure titled, Laboratory Test/Diagnostic Procedures: Communicating the results with a last review date of 1/20/2026 read, Procedure: 2. All other lab or diagnostic procedure orders received are documented in PCC when received. The designated nurse is responsible for completing the lab requisition or verifying the diagnostic procedure appointment has been made as part of noting the order. The order lab is logged on the lab log sheet found in front of each date in the binder.		

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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 prevent the possible spread of infection during wound care and the administration of gastrointestinal tube feeding. Findings include: 1) During an observation of wound care on 07/15/2026 at 2:30 PM, Staff A, Licensed Practical Nurse (LPN) performed hand hygiene, and donned a gown and clean gloves. The LPN set up wound care supplies on a sheet of tin foil and placed supplies on Resident #6's bedside table, doffed the gloves, performed hand hygiene, and applied clean gloves. The LPN cleansed the resident's coccyx wound with wound cleanser, patted the area dry with gauze, did not remove the soiled gloves, did not perform hand hygiene, or don clean gloves, and packed the wound with mupirocin, Santyl, and calcium alginate, placed a silicone foam dressing over the wound, then completed hand hygiene. During an interview on 07/15/2026 at 2:45 PM, Staff A, LPN stated that she was not aware that she needed to wash her hands and change her gloves between cleaning the wound and applying the new wound dressings. During an interview on 07/15/2026 at 3:15 PM, the Director of Nursing stated that the nurse should have washed her hands and changed her gloves after cleaning the resident's wound, before applying a new dressing. Review of policy and procedure titled, Handwashing/Hand Hygiene reviewed 01/20/2026 read, The facility considers hand hygiene the primary means to prevent the spread of infections. 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: g. Before handling clean or soiled dressings, gauze pads, etc.; h. Before moving from a contaminated body site to a clean body site during resident care. 2) During an observation on 7/15/2026 at 12:04 PM Staff G, Licensed Practical Nurse, entered Resident #136's room. Staff G donned gloves but did not don a gown. Resident #136's room door had an enhanced barrier sign. Staff G administered 50 ml [milliliters] of water to flush the gastric tube followed by 250 ML of Glucerna 1.5. Staff G finished the administration and did not flush the tubing after administering the bolus feed. During an interview on 7/15/2026 at 1:36 PM the Director of Nursing stated, Staff should have donned a gown to provide a bolus feeding via the feeding tube. During an interview on 7/15/2026 at 3:02 PM the Assistant Director of Nursing/Infection Preventionist stated, When a resident is on enhanced barrier precautions staff should don gloves and a gown to provide direct care. During an interview on 7/15/2026 at 4:29 PM with Staff G, LPN, stated, I should have donned a gown to provide care to [Resident #136's name]. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy and procedure titled, Enhanced Barrier Precautions with a last review date of 1/20/2026 read, Policy Statement: Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs). Policy Interpretation and Implementation 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, ect).		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review the facility failed to ensure the residents' health record showed the residents either received the pneumococcal immunization for 1 of 5 residents, Resident #43 reviewed for immunization. Findings include: Review of Resident #43's vaccination records showed a pneumococcal immunization consent signed on 8/25/2025 accepting to receive the pneumococcal vaccine. Review of Resident #43's immunization report did not document Resident #43 was administered a pneumococcal vaccine. During an interview on 7/16/2026 at 1:21 PM the Director of Nursing stated, [Resident #43's name] did not receive the pneumococcal vaccination. Review of the policy and procedure titled, Pneumococcal Vaccine with a last review date of 1/20/2026 read, Policy Statement. All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Policy Interpretation and Implementation. 4. Pneumococcal vaccines will be administered to residents (unless medically contraindicated, already given, or refused) per our facility's physician-approved pneumococcal vaccination protocol.		