

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: 105658	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER Solaris Healthcare Lake Zephyr		STREET ADDRESS, CITY, STATE, ZIP CODE 38250 A Ave Zephyrhills, FL 33542	
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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure a grievance process was followed for one resident (#5) of three residents sampled for grievances. Findings Included: Review of Resident #5's medical record revealed the resident was re-admitted to the facility on [DATE]. The medical diagnosis of the resident included: concussion with loss of consciousness status unknown, subsequent encounter trauma fall with laceration 3 centimeters with hematoma, major depressive disorder, recurrent, moderate, and adjustment disorder with anxiety. Review of Resident #5's Minimum Data Set (MDS), revealed the resident had a Brief Interview Mental Status (BIMS), score of 13 out of 15, indicating the resident's cognition was intact. During an interview at 9:54 a.m. on 11/24/2025 Staff C, Certified Nursing Assistant (CNA) stated once or twice a resident had complained of being kept awake by another resident's behavior. Staff C stated staff could file a grievance on behalf of residents. During an interview at 10:22 a.m. on 11/24/2025 Resident #5 reported having had 2 roommates who walked around at night and hit the resident's bed. Resident #5 stated the nurses had tried to control them and the facility had not offered a room change. The facility did not talk to the resident about the situation. Resident #5 reported losing sleep due to previous roommates keeping the resident awake. The resident reported the situation regarding roommates to nurses and aides. Review of the 2025 grievance log for the months of September, October, and November, revealed no grievances submitted for Resident #5, related to roommate disturbances. During an interview at 1:14 p.m. on 11/24/2025, the Social Services Director (SSD) stated they had no knowledge of Resident #5 having issues with roommate disturbances. The SSD stated if staff brought attention to the SSD about Resident 5's concerns, a room change would have been performed, for Resident #5. During an interview at 1:45 p.m. on 11/24/2025, Staff C CNA explained having been told about Resident #5's roommate, who was causing disturbances that kept Resident #5 from sleeping. Staff C stated they alerted the nurse, however, was unable to recall which nurse was notified. Staff C stated if a resident expressed concerns regarding disturbances from a roommate, Staff C would tell a nurse, place a grievance, and ask social services to speak with the resident. During an interview at 1:53 on 11/24/2025 , Staff D Licensed Practical Nurse (LPN) Unit Manager stated if a resident made a complaint known to staff, the staff would attempt to resolve the resident's (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concern. Staff D stated if there was no resolution, then social services would be notified. During an interview at 3:16 p.m. on 11/24/2025, the Nursing Home Administrator (NHA) stated when residents complain of disturbances from roommates, the expectation was for the staff to attempt to resolve the situation. The NHA stated grievances are for more detailed concerns like missing items. The NHA was not aware of Resident #5's complaint of roommate disturbance keeping Resident #5 awake. The NHA stated the expectations of the CNA, was to notify the nurse and if unresolved to continue the chain of command to social services. A policy titled: Filling Grievances and Complaints, with a review date of 01/2024, revealed: Policy Statement Our facility will help residents, their representatives, other interested family members, or resident advocates file grievances or complaints when such requests are made. Policy Interpretation and Implementation 1. Any resident, representative, family member, or appointed advocate may file a grievance or complaint concerning treatment, medical care, behavior of other residents, staff members, theft of property, etc., without fear of threat or reprisal in any form. 2. Upon admission, residents are provided with written information on how to file a grievance or complaint. A copy of our grievance/complaint procedures is posted on the center bulletin board. 3. Grievances and/or complaints may be submitted orally or in writing. 4. The Administrator has delegated the responsibility of grievance and/or complaint investigation to the Grievance Officer. 5. Upon receipt of a grievance and/or complaint, the Grievance Officer will investigate the allegations and submit a written report of such findings to the Administrator within five (5) working days of receiving the grievance and/or complaint. 6. The Administrator will review the findings with the person investigating the complaint to determine what corrective actions, if any, need to be taken. 7. The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. A written summary of the investigation will also be provided to the resident, and a copy will be maintained in the grievance log. 8. Should the resident not be satisfied with the result of the investigation, or the recommended actions, he or she may file a written complaint to the office of the local ombudsman or to the state survey and certification agency. (Note: Address and telephone numbers of these agencies are posted on the center bulletin board.)		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews the facility failed to provide adequate and appropriate health care for one (#2) of three sampled residents as evidence by not obtaining a urinalysis with culture and sensitivity as ordered by the physician and not monitoring a surgical site for signs of infection, drainage, and/or a clean intact dressing. Findings included: Review of Resident #2s admission Record showed the resident was admitted on [DATE] from an acute care facility and discharged on 7/15/25. The record revealed a primary diagnosis of aftercare following joint replacement surgery and included diagnoses of presence of right artificial hip joint and presence of left artificial knee joint. Review of Resident #2s Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form (Agency for Healthcare Administration (AHCA) form 3008), dated 7/1/25 form revealed the resident was status post (s/p) anterior approach hip replacement, was receiving post-operative (op) antibiotic(s) prophylactically, and had a right hip surgical incision. The comments revealed Right (RT) hip dressing change N/A post-op day #7, Follow up (F/U) with (name of physician) in 2 week (wk). Review of Resident #2s Clinical admission progress note dated 7/2/25 showed the resident was admitted with constant stabbing, aching, sharp pain in the right hip. The skin evaluation showed a right hip disarticulation - amputation site surgical wound and a right iliac crest redness with red and bleeding surface or granulation tissue. The resident was alert and oriented x3 (person, place, and time). Review of Resident #2s Nurses Note effective 7/2/25 reported Resident has bilateral bruising on the arms/redness on abdominal folds (applied skin barrier cream), redness on coccyx area (applied skin barrier cream), bilateral heels are red (applied skin prep), right (rt) hip surgical wound that is covered by doctor's covering (to not be removed). Review of Resident #2s progress notes showed the Social Worker had spoken with a family member on 7/4/25. The note revealed the family member was concerned with the resident's confusion since surgery, had reported the resident had a long history of urinary tract infections (UTI), and would like to speak with nursing. Review of Resident #2s progress notes revealed a note written by nursing staff on 7/4/25 to address a family members concerns of the patient being more confused. The nurse informed the family member the resident was taking an antibiotic prophylactic after surgery and educated on such symptoms after surgery. Review of Resident #2s Advanced Practitioner Registered Nurse (APRN) encounter note on 7/7/25 revealed the plan was for staff to Monitor for surgical incision for signs/symptoms (s/s) of infection, bleeding, (and) dehiscence, Altered Mental Status (AMS), (and) Check UA C&S. The note revealed the resident's skin was warm and dry, right groin incision clean, dry, and intact (CDI) with abnormal extremity pin prick test. The note was signed by APRN on 7/9/25. Review of a Nurses Note effective 7/8/25 at 11:50 a.m. showed the Nurse Practitioner (NP) completed rounds with patient and ordered urinalysis culture and sensitivity (UA, C&S) for increased confusion. Review of Resident #2s Nurses Note effective 7/8/25 revealed order was signed on {Electronic Medical Record} for collecting ua {urinalysis} c/s, resident already on antibiotic (abt) for UTI. Review of Resident #2s Laboratory results did not include information regarding the provider's ordered urinalysis. Review of Resident #2s July Medication Administration Record (MAR) revealed the resident received Cefadroxil 500 milligram (mg) one capsule by mouth every morning and at bedtime for post op prophylaxis for 7 days, 7/3 - 7/9/25. The MAR did not include documentation of staff monitoring the resident's surgical site and/or dressing. Review of Resident #2s July Treatment Administration Record (TAR) revealed an order dated 7/8/25 for a Urine Culture and Sensitivity urine analysis one time only, specify (clean catch, urinary catheter, straight cath) one time only for increased confusion for 1 day. The order was signed off as administered on 7/8/25. The TAR did not include documentation of staff monitoring the resident's surgical site and/or dressing. Review of Resident #2s Skilled Nursing Note dated 7/4/25 showed the resident's Skin is not intact, previously identified area of skin breakdown. Resident has wounds. with no comment related to the right lower extremity surgical incision. Review of Resident (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#2's Skilled Nursing Note, dated 7/5/25 showed the resident's Skin is not intact, previously identified area of skin breakdown. Resident has wounds. with no comment related to the right lower extremity surgical incision. Review of Resident #2's Skilled Nursing Note, dated 7/6/25. showed the resident's Skin is intact with no comment related to the right lower extremity surgical incision. Review of Resident #2's Skilled Nursing Note, dated 7/6/25 showed the resident's Skin is intact with no comment related to the right lower extremity surgical incision. Review of Resident #2's Skilled Nursing Note, dated 7/8/25 showed the resident's Skin is intact with no comment related to the right lower extremity surgical incision. Review of Resident #2's Skilled Nursing Note, dated 7/9/25 showed the resident's Skin is intact with no comment related to the right lower extremity surgical incision. Review of Resident #2's Skilled Nursing Note, dated 7/9/25 showed the resident's Skin is intact with no comment related to the right lower extremity surgical incision. Review of Resident #2s primary care physician (PCP) encounter note on 7/10/25 showed the plan was for staff to Monitor for surgical incision for signs/symptoms (s/s) of infection, bleeding, (and) dehiscence, Altered Mental Status (AMS), (and) Check UA C&S. The physical exam of the skin revealed Warm and dry, right groin incision clean, dry and intact (CDI). Review of Resident #2s APRN encounter note, dated 7/11/25 the skin inspection showed warm and dry, with a right groin incision and was CDI. The plan was for staff to Monitor for surgical incision for signs/symptoms (s/s) of infection, bleeding, (and) dehiscence, Altered Mental Status (AMS), (and) Check UA C&S. Review of Resident #2s Skilled Nurses Note on 7/12/25 revealed Skin is intact with no further comments regarding surgical incision site and/or dressing. Review of Resident #2s Skilled Nurses Note on 7/13/25 showed the resident's Skin is intact with no further comment regarding surgical incision site or dressing. Review of Resident #2s Minimum Data Set, 7/9/25 showed the resident scored 4 of 15 on Brief Interview of Mental Status (BIMS) indicating a severely cognition impairment. The MDS showed the resident had a pressure ulcer/injury, a scar over bony prominence or a non-removable dressing/device with no surgical wound. During an interview at 2:19 p.m. on 11/24/25 the Director of Nursing (DON) stated if a provider orders a UA C&S the orders are put in, if the provider puts in ordered we carry out the orders, obtain the urine, have preliminary results within 24 hours and culture (results) within 72 hours, send preliminary results to the provider and the provider may choose to treat or wait for the sensitivity (culture). The DON reported staff are to document communication with the physician and if there were any new orders. A review was conducted with the DON of Resident #2s Cefadroxil order and the DON stated the antibiotic was not ordered for a UTI. The laboratory results for the resident were reviewed and the DON confirmed not seeing urinalysis results. Review of the urinalysis order showed a Licensed Practical Nurse (LPN) had entered the order on 7/8/25 and if the resident refused or urine was not obtained there should be a note reporting the physician had been notified and if the resident was already on an antibiotic staff were to call provider with directions because the antibiotic may mask the organism. On 11/24/25 at 3:08 p.m. the DON reported the UA had not been collected. During an interview at 4:00 p.m. on 11/24/25 the DON reviewed Resident #2s AHCA form 3008 and stated the order would be clarified (Right (RT) hip dressing change N/A post-op day #7) usually surgical dressings are left in place until follow up but staff are to monitor for excess drainage, redness, and to ensure the dressing was intact. Review with the DON of the resident's MAR and TAR did not show staff were monitoring the area. Review of the policy - Specimen Collection, reviewed 12/10/2024, showed: 1. The Physician will identify, in order diagnostic and lab testing based on diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for test. 3. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility. The Review by Nursing Staff showed: 2. The person who has to communicate results to a physician will review and be prepared to discuss the following (to the extent that such information is available): a. The individual's current condition in any recent changes in status, including vital signs and mental status. b. Major diagnosis, allergies, pertinent current medications, other recent pertinent lab work, actions already taken to address results and treat the resident, impertinent aspects of advanced (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	directives (for example, limitations on testing and treatment); e. Any concerns or issues the physician will expected to address upon receiving the results. Review of the section, Determining the Reason for Testing revealed: 1. If the results do not meet their proceeding criteria for immediate notification, then the nursing staff will review why the test was obtained, as well as the residents current clinical status including the presence of any signs and symptoms. a. If the resident has signs and symptoms of acute illness or condition change and he/ she is not stable or improving, or there are no previous results for comparison, then the nurse will notify the physician promptly to discuss the situation, including a description of relevant clinical findings as well as the test results. b. If the individual is stable or improving in the results do not warrant immediate notification, then the nursing staff may notify the physician routinely (for example, a stable individual with slightly abnormal follow up test results, or low or therapeutic drug blood levels). Review of Test Results showed The resident's attending physician will be notified of the results of diagnostic test. Review of policy - Skin and Wound Management, policy and procedure review 12/10/2024, revealed staff would examine the skin of a new admission for ulcerations or alterations in skin. The policy was specific towards Pressure/Injury(s)/Skin breakdown and not towards surgical wounds as discussed with the DON. A policy related to management of surgical wounds was not provided.		