STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105664	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gainesville Health and Rehabilitation	4000 SW 20th Ave Gainesville, FL 32607

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, interview and record review the facility failed to promptly inform the resident representative when there was a change of condition and weight loss for 2, Resident #1 and #2, of 4 residents reviewed for changes in condition.Fiindings include: Review of Resident #1's admission record documented diagnosis that include dementia and other diseases classified elsewhere, mild, with mood disturbance, pain in left knee, pain in right knee, vitamin B deficiency unspecified, vitamin D deficiency unspecified, essential (primary) hypertension, anemia unspecified, type 2 diabetes mellitus without complications, hyperlipidemia unspecified, and hypothyroidism unspecified. Review of Resident #1's weights document on 10/6/2026 a weight of 106.2 pounds, on 11/3/2025 a weight of 105.4 pounds, on 12/2/2025 a weight of 99.6 pounds, on 1/3/2026 a weight of 95 pounds, on 2/20/2026 a weight of 92.8 pounds, and on 3/2/2026 a weight of 93.2 pounds. This is a significant weight loss of 12.24%. Review of Resident #1's nursing progress notes from October 1, 2025 through March 2, 2026, there are no notes documenting the resident representative or physician was notified of the change in condition of weight loss. During an interview on 3/11/2026 at 10:34 AM, Resident #1's representative stated, I have not been told about her weight loss or what they intend to do about it. No, I have not been told that she is seen by the dietician or what they plan to do. I should be told what they are doing for her. During an interview on 3/11/2026 at 12:15 PM, Staff A, Licensed Practical Nurse (LPN), stated, We did not communicate this to the doctor. We should call and discuss this (the residents weight loss) with her physician and her representative. I don't see that we have documented that we discussed this with her representative. I have not personally discussed this with her (Resident #1's representative) or her physician. Review of the policy and procedure titled, Change in Condition Process last review date of 01/2026 reads, Intent: The purpose of this policy is to ensure the facility promptly informs the resident, consults the residents physician, and notify, consistent with his or her authority, residents representatives when there is a change requiring notification. Procedure: The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Situations requiring notification include: 3. A need to alter treatment significantly, that is a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment. 4. Upon the identification of a change in condition in a resident the nurse will complete an evaluation of the resident status, and document findings on the SBER [Situation, Background, Assessment, Recommendation] Change in Condition in the resident electronic medical record. 2. Review of the admission record for Resident #2 documented diagnosis that include cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, cerebral infarction unspecified, peripheral vascular disease unspecified, history of falling, hyperlipidemia unspecified, essential primary hypertension, unspecified systolic congestive heart failure, retention of urine unspecified, pseudobulbar effect, vitamin D deficiency, major depressive disorder recurrent moderate, primary insomnia, bipolar disorder, benign prostatic hyperplasia without lower urinary tract symptoms, atherosclerosis of other arteries, other idiopathic peripheral autonomic neuropathy, vascular dementia unspecified severity without behavioral disturbance psychotic disturbance mood disturbance and (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anxiety and mild protein calorie malnutrition. Review of Resident #2's weights document a weight of 185.4 pounds on 10/3/2025 and a weight of 172.8 pounds on 12/2/2025 a weight of 168.2 pounds on 2/2/2026, and a weight of 163.1 pounds on 3/3/2026 indicating a 12.3% weight loss in 6 months. During an interview on 3/11/2026 at 10:27 AM the Registered Dietician (RD) stated, I am not responsible to call the family or physician and discuss weight loss, that would be the responsibility of the nurses. During an interview on 3/12/2026 at 9:15 AM the Director of Nursing (DON) stated, I do not see any family or doctor notifications that these residents had significant weight loss. I don't see any evidence that they did this. There should be documentation that the doctor and family were notified.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and record review the facility failed to provide housekeeping and maintenance services to provide a safe, clean, comfortable and homelike environment in 2 of 4 hallways reviewed for environment. Findings include: During the initial facility tour on 3/11/2026 at 8:45 AM, a strong urine odor was noted throughout the 200 and 300 hallways, including common areas. All rooms toured in the 300 hallway also had a pronounced urine odor. Resident beds were dry, and residents observed were clean and appropriately dressed, either in bed or seated in wheelchairs. In the 200 hallway, two rooms had floor grates with thick dust buildup, and several rooms had floors with dried, sticky residue. In the 300 hallway, the linen closet door vent had a heavy layer of dust. Several rooms had sticky floors with multiple dried stains, scuffed walls, and areas with missing paint. Many rooms also had significant dust accumulation and debris, including straws and cup lids, under the beds. The 300 hallway handrail had missing paint beneath the hand sanitizer dispenser; the underlying paint was wet to the touch and easily scraped off. Shower rooms in two hallways had thick brown substances in the corners that could be easily removed by hand. Three of the four hallways toured had missing or unsecured pieces of flooring that could be lifted without effort. One housekeeping closet was missing a doorknob. During a tour with the Nursing Home Administrator and the Director of Nursing on 3/11/2026 at 10:38 AM, they acknowledged the presence of a strong urine odor, sticky residue and dried stains on the floors, dust and debris under beds, and dust accumulation on vents and grates. They also acknowledged missing sections of flooring and areas where the flooring was not securely affixed. During an interview with the Assistant Maintenance Director on 3/11/2026 at 2:20 PM, he stated that the doorknob had come off on Monday and was removed for replacement. A needed part was missing, but it had been ordered and was expected to arrive that day. He also acknowledged that sections of the flooring were chipped or missing and that some areas were no longer properly adhered, noting that these issues should be repaired. During an interview on 3/11/2026 at 4:12 PM, the Nursing Home administrator stated, We should be cleaning regularly and making sure that rooms are getting deep cleanings done according to a schedule. The floors should be repaired. During an interview on 3/12/2026 at 8:26 AM, the Director of Nursing stated, I am responsible for the environment, and we have had some recent changes and have hired more housekeepers. We should not have dust and dirt on floors. We should be doing deep cleaning of rooms daily. We should have repairs done to the floors so that there are no areas where a wheel can get caught or a walker. Review of the policy and procedure titled, Physical Environment-Safe Environment, last approval date of 1/2026 reads, Intent: It is the policy of the facility to provide a safe environment in accordance with State and Federal regulations. Procedure: 2. The facility will maintain all essential mechanical, electrical and patient care equipment in safe operating condition. 5. The facility will provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. 7. The facility will maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner. 8. The facility will provide a safe, clean, comfortable, and home like environment, which allows the resident to use his or her personal belongings to the extent possible. 9. The facility will provide a housekeeping and maintenance services necessary to maintain a sanitary orderly and comfortable interior.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on interview and record review the facility failed to ensure that acceptable parameters of nutritional status were maintained when dietician assessment and recommendations were not followed to maintain body weight for 2, Resident #1 and #2, of 3 residents reviewed for weight loss. Findings include: Review of Resident #1's admission record documented diagnosis that include dementia and other diseases classified elsewhere, mild, with mood disturbance, pain in left knee, pain in right knee, vitamin B deficiency unspecified, vitamin D deficiency unspecified, essential (primary) hypertension, anemia unspecified, type 2 diabetes mellitus without complications, hyperlipidemia unspecified, and hypothyroidism unspecified. Review of Resident #1's weights documented on 10/6/2026 a weight of 106.2 pounds, on 11/3/2025 a weight of 105.4 pounds, on 12/2/2025 a weight of 99.6 pounds, on 1/3/2026 a weight of 95 pounds, on 2/20/2026 a weight of 92.8 pounds, and on 3/2/2026 a weight of 93.2 pounds. This was a significant weight loss of 12.24%. Review of Resident #1's dietary progress note, dated 2/4/2026, reads, Note Text: RD (Registered Dietician) Weight Note: On Regular diet and receives Milk Shake TID [Three times a day] (660 kcal [kilocalories]/18 gm[grams] Protein per day) & 120 mL[milliliters] Med Pass TID. Intake is variable and consumes 25-100% of meals. Per nurse, not accepting Med Pass, recommend d/c [discontinue]. WT [weight] Trends: 95# (BMI 14.4), 99.6# 12/2, 106.2# 10/3, 98.8# 7/1. Weight reflects significant loss of -10.5% X 3 month. Weight loss is likely r/t [related to] worsening Dementia; Recommend: consider Remeron to stimulate appetite. Encourage meals, snacks, supplements and PO [oral] fluids. Will continue to monitor intake, weight trends and adjust supplements accordingly. Consult RD PRN [as needed]. Review of Resident #1's active and discontinued orders from 2/4/2026 through 3/3/2026 documented no orders for Remeron to stimulate appetite. Review of Resident #1's dietary progress note, dated 3/3/2026, reads, Note Text: RD Weight Note: On Regular diet and receives Milk Shake TID (660 kcal/18 gm Protein per day) Intake is variable, somewhat improved and consumes 50-100% of meals. WT Trends: 93.2# 3/3 (BMI 14.2), 92.7# 2/20, 99.6# 12/2, 104.8# 9.2. Weight reflects significant loss of -11% X6 months. Weight loss is likely r/t worsening Dementia, mood d/o with depression features; Recommend: add Magic Cup BID @ L+S [lunch+supper] (580 kcal/18 gm Protein per day). Consider Remeron to stimulate appetite if no contraindication. No labs since last documentation. Encourage meals, snacks, supplements and PO fluids. Will continue to monitor intake, weight trends and adjust supplements accordingly. Consult RD PRN. Review of Resident #1's active and discontinued physician orders from 3/3/2026 through 3/11/2026 documented no physician orders for Remeron to stimulate appetite. During an interview on 3/11/2026 at 10:27 AM, the Registered Dietician (RD) stated, We having been monitoring her, I have made adjustments adding mighty shakes and med pass to increase her caloric intake mostly, she will not take these. I did recommend Remeron and don't know why it has not been ordered. I do not write the orders, I place the recommendations in a binder at the nurses station, and it is up to the nursing staff to convey this to the physician. I have spoken to the unit manager and DON (Director of Nursing) about this, they have not done it. The communication book does not have the recommendation acknowledged by the physician. It should have been done. We need to add this modality to see if we can have her increase her intake and begin to gain weight. She would be considered underweight at this time. I can't tell you why the recommendation has not been followed. I am not responsible to call the family or physician and discuss weight loss, that would be the responsibility of the nurses. During an interview on 3/11/2026 at 12:15 PM, Staff A, Licensed Practical Nurse (LPN), stated, We did not communicate this to the doctor [the dietician recommendation for Remeron]. I thought the dietician had the ability to write orders. We should have done this [notified the doctor of the weight loss and dietician recommendations] when the dietician first made the recommendation. We should call and discuss this with her [Resident #1's] physician and her representative. 2. Review of the admission record for Resident #2 documented diagnosis that include cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cerebral infarction unspecified, peripheral vascular disease unspecified, history of falling, hyperlipidemia unspecified, essential primary hypertension, unspecified systolic congestive heart failure, retention of urine unspecified, pseudobulbar effect, vitamin D deficiency, major depressive disorder recurrent moderate, primary insomnia, bipolar disorder, benign prostatic hyperplasia without lower urinary tract symptoms, atherosclerosis of other arteries, other idiopathic peripheral autonomic neuropathy, vascular dementia unspecified severity without behavioral disturbance psychotic disturbance mood disturbance and anxiety and mild protein calorie malnutrition. Review of Resident #2's weights document a weight of 185.4 pounds on 10/3/2025, a weight of 172.8 pounds on 12/2/2025, a weight of 168.2 pounds on 2/2/2026, and a weight of 163.1 pounds on 3/3/2026 indicating a 12.3 % weight loss in 6 months. Review of Resident #2's physician order dated 8/18/2025 read, Consult for in house dietician for weight loss. Review of Resident #2's dietary progress note, dated 12/24/2025, reads, Note Text: RD Weight Note: On Regular diet and receives Ensure Plus BID (two times a day) (700 kcal/26 gm Protein per day). Intake is variable and consumes 75-100% of meals, 25-75% at times. WT Trends: 172.8# (BMI 23.4), 186.6#, 186.5#, 197.8#. Weight reflects significant loss of -7.4% X1 month and -12.6% X6 months; Recommend increase Ensure Plus to TID (1050 kcal/39 gm Protein per day). No recent BMP [Basic metabolic profile] labs. Encourage meals, snacks, supplements and PO [oral] fluids. Will continue to monitor intake, weight trends and adjust supplements accordingly. Consult RD PRN. There are no additional Registered Dietician Assessments within Resident #2's medical records. During an interview on 3/11/2026 at 12:15 PM, the Registered Dietician stated, I have not seen him [Resident #2]. I was not aware of his continued weight loss. I do not have access to pull weight loss reports. The report I can pull is all weights not just a resident with a significant weight loss. He [Resident #2] does have a significant weight loss. I should have been seeing him. That is my note in December. I can't tell you why I did not see him again. I should have seen him again before now. During an interview on 3/12/2026 at 9:15 AM, the Director of Nursing (DON), stated, I can't tell you why there are no dietary reassessments on this resident [Resident #2] there should be. The dietician should have seen this resident and implemented additional treatments to prevent further weight loss. The nurses and unit managers should have notified the dietician of the continued weight loss. I don't see any evidence that they did this. Review of the policy and procedure titled , Nutritional management, last revision date of 4/27/2025, read, Policy: The facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of his or her overall condition. Compliance guidelines: 1. A systematic approach is used to optimize each resident's nutritional status: a. identifying and assessing each resident's nutritional status and risk factors. b. evaluating analyzing the assessment information. c. developing and consistently implementing pertinent approaches d. monitoring the effectiveness of interventions and revising them as necessary. 3. Evaluation/analysis: b. The dietician shall use data gathered from the nutritional assessment to estimate the resident's calorie, nutrient, and fluid needs and whether intake is adequate to meet those needs. Current standards of practice/formulas are used in calculating these estimates. 4. Care Plan implementation: b. Interventions will be individualized to address the specific needs of the resident. Examples include, but are not limited to: iii. Weight related interventions. 5. Monitoring/revision: d. The physician will be notified of: i. Significant changes in weight, intake, or nutritional status. ii. Lack of improvement toward goals.