STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105693	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charming Lakes Rehab	2020 W Lake Parker Dr Lakeland, FL 33805

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to provide dining in a manner to preserve the dignity for 3 of 33 residents in the final sample, Residents #11, 14 and 9. The findings included:The facility’s policy, “Resident Rights – Right to Respect, Dignity and to have Personal Property” with a reference date of 04/01/22, did not address dignity during dining. 1. Resident #11 was admitted to the facility on [DATE]. According to the resident’s most recent complete assessment, a Significant Change Minimum Data Set (MDS), with a reference date of 05/21/25, Resident #14 had a Brief Interview for Mental Status (BIMS) score of 12, indicating that Resident #14 was moderately cognitively impaired. The assessment documented that the resident required partial/moderate assistance for eating. Resident #14’s diagnoses at the time of the assessment included: Arthritis, Parkinson’s disease, Seizure disorder, muscle weakness, Dysphagia. Resident #14’s care plan for Activities of Daily Living (ADLs) documented, “Resident has an ADL self-care performance deficit related to weakness, impaired mobility, tremors/Parkinson’s disease Date Initiated: 05/14/2024 Revision on: 06/04/2024 The goal of the care plan was documented as, “The resident will maintain or improve current level of function in ADLs through the review date. Date Initiated: 05/14/2024 Revision on: 06/04/2025 Target Date: 11/19/2025. Interventions to the care plan included: • EATING: The resident needs partial/mod assist of 1 when having tremors Date Initiated: 06/04/2024 During an observation of breakfast served to the residents in their rooms, on 08/20/25 at 8:33 AM, Resident #14 was sitting in a wheelchair on the left side of the resident’s bed facing the wall at the head of the bed. Staff N, CNA was noted to be assisting the resident by standing behind him and feeding him from over his right shoulder. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #11 was admitted to the facility on [DATE]. According to the resident’s most recent complete assessment, a Significant Change MDS with a reference date of 08/10/25, Resident #11 was not assessed for cognition due to ‘resident is rarely/never understood’. The assessment documented that the resident required substantial/maximal assistance for eating. Resident #11’s diagnoses at the time of the assessment included: Gastro-esophageal reflux disease (GERD), Arthritis, Osteoarthritis, Aphasia, Seizure disorder, Dysphagia. Resident #11’s care plan for ADLs documented, “Resident has an ADL self-care performance deficit r/t Impaired balance, weakness, cognitive and communication deficit, traumatic brain injury, Cerebrovascular accident (CVA) subdural hematoma, contractures risk for decline in function. Date Initiated: 04/10/2023 Revision on: 08/21/2025. The goal of the care plan was documented as, “The resident will maintain or improve current level of function in ADLs through the review date. Date Initiated: 04/10/2023 Revision on: 08/18/2025 Target Date: 11/19/2025. Interventions to the care plan included: • EATING: The resident needs substantial/max assist x1. can feed self finger foods Date Initiated: 04/10/2023. During an observation of breakfast served to the residents in their rooms, on 08/20/25 at 8:33 AM, Resident #11 was positioned in a wheelchair at the resident’s left side of the bed with breakfast on an overbed table, while Staff O, CNA was standing over and to the resident’s left side to feed the resident. At the time of the observations of Resident #14 and Resident #11 being assisted by staff, Staff P, Licensed Practical Nurse/Unit Manager (LPN/UM), was asked to join the surveyor to make the observations. Staff P acknowledged the concerns at the time of the observations. 3. Record review for Resident #9 revealed the resident was originally admitted to the facility on [DATE] with a most recent readmission on [DATE] with diagnoses which included: Sequelae of Cerebral Infarction, Dysphagia, Dementia, Type 2 Diabetes Mellitus with Diabetic Polyneuropathy. Review of the Minimum Data Set (MDS) for Resident #9 dated 07/11/25 revealed in section C a Brief Interview for Mental Status (BIMS) score of 99, indicating that she was rarely/never understood. Review of section GG revealed Resident #9 was dependent on staff assistance for eating. During a lunch dining observation conducted on 08/21/25 at 1:02 PM, in the 200-unit hallway, it was noted Staff I, Certified Nursing Assistant (CNA) was in Resident #9’s room assisting with her lunch meal. Staff I was observed standing over Resident #9 while feeding the resident. Further observation of the room revealed an empty chair in the room by the window. At 1:13 PM, an interview was conducted with Staff I, who stated she has worked at the facility for 5 years. When asked if she should be standing to assist with meals, Staff I appeared confused, unsure of what to say and then asked the surveyor if she should sit or stand to assist with meals. Staff I was then asked again what the protocol is when a resident requires assistance with feeding. She then stated that she should sit because the resident might feel rushed to finish the meal. Then Staff I acknowledged that she was standing over Resident #9 while assisting with lunch and that was not per protocol.

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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 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to provide ADL care for fingernails for 3 residents, (Resident #68, Resident #6, and Resident #1), who were sampled for ADLs. The failure to provide ADL care caused harm to 1 Resident, (Resident #68). The findings included: A review of the facility’s policy for Activities of Daily Living (ADLs) effective 04/01/2022, revealed the purpose was to ensure all residents’ needs were met in a manner that promoted their quality of life and preferences. The procedure section included that the facility would provide residents with the appropriate treatment and services to maintain hygiene. This included bathing, dressing, grooming, and oral care. 1.A record review revealed that Resident #68 was admitted to the facility on [DATE]. His diagnoses included Cerebral Infarction, Dementia, and Spastic Hemiplegia unspecified side The minimum data set (MDS) quarterly assessment dated [DATE] revealed he had severe cognitive impairment, and he was dependent on assistance for personal hygiene. Resident #68’s plan of care last revised on 02/03/25 noted that he had an activity of daily living, self-care performance deficit, that was related to a recent stroke, impaired mobility, and impaired communication. One documented intervention was to monitor, document, and report to the Doctor any changes or potential for improvement. During an observation on 08/18/25 at 2:32 PM, Resident #68 lied on his back with his head elevated in his bed. His hands were visible and most of his fingernails were approximately ¾ inch long. Dark brown/black sediment was on the middle fingernail of his right hand, and under the fingernail of the thumb on his left hand. On 08/19/25 at 4:00 PM the fingernails were observed again. The left hand was contracted. Four fingernails were visible, and they were all approximately the same length, ¾ inch long. The end of the pinky nail was not visible. Photographic evidence was obtained. When the resident was asked if he liked his fingernails long, he moved his head from the left to the right, which indicated he did not want long fingernails. An interview with Staff F, (a Licensed Practical Nurse), on 08/20/25 at 10:55 AM revealed that Resident #68 used to receive treatments for his left hand after it had been bleeding and leaking. When Staff F was asked to evaluate the condition of Resident #68’s fingernails, she touched Resident #68’s hand and attempted to turn the hand into a position for inspection. Resident #68 began to shake, and he pulled his hand away. Staff F said that his fingernails needed to be clipped. When asked who was responsible for clipping fingernails, Staff F said that the podiatrist came out to clip nails. She added that she tried to clip his fingernails a few weeks ago with the clippers from the activities room, and those nail clippers didn’t work. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	During a later interview with Staff F on 08/20/25 at 2:49 PM, when asked to locate documentation in the medical record about her attempt to cut Resident #68’s fingernails, Staff F could not find any documentation to support her statement. When asked how she followed up on the discovery about Resident #68’s injured hand, Staff F said that Staff G, the Nurse Practitioner (NP), came and viewed Resident #68’s fingernails she ordered Bactrim, an antibiotic tablet for his infection to the left big toe and to the left hand on 08/20/25. She also ordered a treatment to clean his hand with saline solution and to apply Nystatin Powder two times a day for 14 days on 08/20/25. Staff F said that “the nail was pretty much deep into the palm of his hand.” When asked if she thought that this hand injury could have been prevented, Staff F said with proper hand and nail care the injury could have been prevented. An interview later that day with Resident #68 at 4:19 PM revealed that his left hand was painful and that he wanted his nails to be cut. During an interview with the Activities Director (AD) on 08/20/25 at 2:58 PM, the AD said that the podiatrist only cut toenails. She said that fingernail care was performed by the nursing department and by the activities department. She added that nursing did the cutting. During a phone Interview on 08/20/25 at 4:20 PM, Staff G, (a Nurse Practitioner), said she performed her usual rounds earlier that morning. She said she reviewed Resident #68’s chronic systems which included medications, gastrostomy tube, and left big toe wound, and then she left the room. Staff G explained that Staff F told her Resident #68 had a problem with his left hand so they went into his room together. She said that they looked at the resident’s hand and saw that his fingernail dug into the palm of his left hand. The Nurse Practitioner said that she told the nurse to follow up and cut his fingernails. On 08/20/25 at 5:15 PM an interview was conducted with Staff S, (a CNA), who stated that Resident #68 was one of the residents in her assignment. She said Resident #68 did not talk; He communicated by nodding yes or no. She stated since the resident had Diabetes, she did not trim his fingernails or his toe nails. She stated the foot doctor trims toe nails and the nurses will trim his finger nails. She stated that at times Resident #68 touched his feces. She then stated that the nurse was aware Resident #68 had those behaviors. During an interview with the Administrator and DON on 08/21/25 at 4:17 PM, the DON said that they first found out about the hand injury on 08/20/25. A record review performed on 08/21/25 revealed that the most recent completed skin evaluation tool was completed on 08/06/25. It showed Resident #68 had an open area to left great toe. The surveyor's concern for the resident's long nails and injury to the palm of his hand was not identified until after the surveyor brought it to the attention of the LPN. The skin evaluation tool that was noted “in progress”, and dated 08/20/25, listed skin impairment to resident's left toe. It had no mention of the resident's fingernails or injury to his hand. 2. A record review revealed that Resident #6 was admitted to the facility on [DATE]. Her diagnoses included Muscle Weakness, and Type 2 Diabetes Mellitus. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	A Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 had a Brief Interview for Mental Status score of 13, which indicated that she was cognitively intact. This same MDS assessment documented that Resident #6 was dependent on assistance with personal hygiene. Her plan of care last revised on 07/14/25 noted that she had an ADL self-care performance deficit, and she required partial to moderate assistance with ADLs related to personal hygiene. During an observation on 08/18/2025 at approximately 3:00 PM, Resident #6 was lying in bed with her hands on top of the blanket. Her nails were very long. When asked if she liked her nails that long, Resident #6 said no. During an observation on 08/19/25 at 3:20 PM, Resident #6 was in bed with her hands crossed on top of her abdomen. There were 5 visible fingernails with lengths one half to three quarters of an inch past her fingertips. The nail portion above the fingertip had brown, black sediment underneath the nail. Brown/black sediment was also on the perimeter, top portion of some nails. During an interview with Staff J, (a CNA) on 08/20/2025 at 5:37 PM, the CNA said that she can not cut nails of any resident who was diagnosed with diabetes. She said that she did not report to a nurse manager the need for the resident's nails to be cut. In addition, the CNA said that her fingernails needed to be cleaned. Outside of the resident’s room, the CNA said that this resident was known to put her fingers in her feces. 3. A record review revealed that Resident #1 was admitted to the facility on [DATE]. Her medical history included the Need for Assistance with Personal Care, and Type 2 Diabetes Mellitus. A review of the Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #1 had a Brief Interview for Mental Status of 8, which indicated that she had cognitive impairment. A record review of Resident #1’s plan of care noted that her ADL self-care performance deficit was related to weakness, impaired mobility, some cognitive loss, and the loss of dexterity in her fingers. A listed intervention specified she needed maximum assistance for personal hygiene. During an observation on 08/20/25 at approximately 6:45 PM, Resident #1 was in her bed watching television. Her nails were long and the second digit of her left hand was pressing into the palm of her hand. Her fingers were contracted. [NAME] crusted looking patches of skin were on her palm. Red polish was on the upper half of her nails. There was no hand appliance on at that time. During an observation on 08/21/2025 at 9:17 AM, Resident #1 was in her bed and she was wearing an appliance on her left hand. Staff I removed the hand appliance and photographic evidence was obtained. The resident was asked if she wanted her fingernails cut and she said yes. Staff I was asked whose responsibility it was to clip the resident’s nails. Staff I said that she had cut them before, and that recently when she looked for the clippers she couldn’t find them. 4. During the tour on 08/18/25 at 11:58 AM, an interview was conducted with Resident #31’s spouse. He stated he has filed several grievances regarding care and for Resident #31 to get assistance to eat during meals. He is very concerned that his wife is not being encouraged to eat and drink by the staff. He stated that the facility mentioned the staff has been educated to assist his wife to eat. He stated he comes to visit every day and does help her with the meals; however, he is not sure if anyone is assisting when he is not at the facility. He also stated that Resident #31 appears thinner to him and dehydrated, she’s blind and has a hard time feeding herself. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Record review documented Resident #31 was admitted on [DATE] with diagnoses to include Sequelae of Cerebral Infarction, Malignant Neoplasm of Colon, Adult Failure to Thrive, Generalized Muscle Weakness, Cognitive Communication Deficit. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed that Resident #31 had a Brief Interview for Mental Status (BIMS) score of 09, indicating moderately cognitively impaired. Review of Section GG revealed that Resident #31 required setup or clean-up assistance for eating. Record review of the July Concern Log (Grievances) documented Resident #31’s spouse filed a grievance on 07/31/25 requesting assistance while eating for Resident #31. Further review of the Complaint/Grievance Report revealed the above grievance was resolved with education and the results were verbally communicated to family, who expressed satisfaction on 08/01/25. Record review of Resident #31 weight summary documented the following weights: 07/26/25 19:35 157.0 Lbs. 08/04/25 07:47 152.4 Lbs. 08/04/25 08:04 152.4 Lbs. 08/11/25 10:16 150.4 Lbs. During a breakfast dining observation on 08/19/25 at 8:13 AM, Resident #31 was in bed with the head of the bed raised and the breakfast tray in front of her on the over bed table. Breakfast consisted of scrambled eggs, hashbrown and oatmeal, 4oz container of milk (with a straw) and a foam cup of water with a lid and no straw. There were no staff in the room and Resident #31 was not eating anything on her breakfast tray. Continued observation at 8:22 AM did not show any staff in the room assisting Resident #31 with her meal which was100% untouched. At this time, an interview was conducted with Resident #31, who stated the food at the facility is okay and then grabbed the water foam cup and attempted to drink however was unable to since it had a lid and no straw. She then placed the foam cup back on the tray without drinking water. At 8:30 AM, the breakfast tray was taken out of the room. On 08/21/25 at 8:17 AM another breakfast observation was conducted for Resident #31, and no breakfast tray was observed in the room. Staff L, Certified Nursing Assistant (CNA) was asked to see Resident #31’s tray. Staff L removed the tray from the meal cart and noted that Resident #31 had eaten about 50% of her breakfast. She stated that she assisted the resident with her meal this morning. Staff L also stated that Resident #31 sometimes eats and sometimes does not, she needs encouragement.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to follow orders for fluid restrictions for 1 of 1 resident reviewed for Dialysis, Resident #3. The findings included:The facility's policy, 'Fluid Restrictions' with a reference date of 05/2014 and a revision date of 09/2017, documented: A fluid restriction will be implemented only as part of a therapeutic diet prescription. The policy did not address fluids provided by staff for hydration. Resident #3 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, a Quarterly Minimum Data Set (MDS), Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. The assessment documented that Resident #15 required supervision or touching assistance for eating. Resident #3's diagnoses at the time of the assessment included: Hypertension, Peripheral Vascular disease (PVD), Diabetes Melitus, Psychotic disorder, Cerebral infarction, Muscle weakness, Dependence on Renal dialysis, Hypothyroidism. Resident #3's orders included;FLUID RESTRICTION - 1500 CC / day 720 ML by dietary, 260 ML 7-3, 260 ML 3-11, 260 ML 11-7 - every shift for nutrition 260 ml per shift by nursing - 07/07/25Resident #3's care plan for dehydration documented, The resident has dehydration risk for fluid restrictions, infections, diuretic use Date Initiated: 07/08/2025 Revision on: 8/18/2025. The goal of the care plan was documented as, The resident will be free of symptoms of dehydration and maintain moist mucous membranes, good skin turgor. Date Initiated: 07/08/2025 Target Date: 10/13/2025. Interventions to the care plan included: Monitor/document/report PRN any s/sx of dehydration. Date Initiated: 07/08/2025 Notify Physician if: Persistent symptoms of diarrhea, nausea/vomiting unresolved past 48 hours; persistent output exceeding intake past 48 hours; abnormal lab. Date Initiated: 07/08/2025 Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Date Initiated: 07/08/2025. Resident #3's care plan for nutrition documented, Resident has nutritional problem or potential nutritional problem related to End Stage Renal Disease, constipation, Hypertension, Peripheral vascular disease, Hypothyroidism, Gastroesophageal reflux disease, Chronic kidney disease, Cerebral infarction, Respiratory failure, Adjustment disorder, Hyperkalemia, eats out of facility, dialysis, fluid restrictions, history of non-compliance to diet, history of readmission, history of appetite stimulant use, Refused renal diet. Date Initiated: 05/30/2025 Revision on: 07/08/2025. Interventions to the care plan included: Fluid restrictions as ordered Date Initiated: 07/08/2025 Provide, serve diet as ordered. Monitor intake and record with each meal. Date Initiated: 04/17/2025. On 08/19/2025 at 11:22 AM Resident #3 was noted to be not in her room. At the time of the observation, there was a 20 ounce foam cup approximately 1/3 full of fluid (water) on her overbed table to the resident's left side of the bed. During an interview, on 08/19/25 at 11:35, with Resident #3, when asked about being aware of the fluid restrictions, Resident #3 stated, I have to watch my water intake because of the dialysis. If I get too much I would have to go to the hospital and get some taken off. When asked about the water on the overbed table, Resident #3 replied, I didn't drink it, I spilled some of it. It is for the middle of the night. On 08/20/25 at 8:30 AM, Resident #3 was not in her room. At the time of the observation, Resident #3's breakfast was on her overbed table and there was a 20 ounce Styrofoam cup of fluid (water) on the nightstand to the resident's left side of the bed. During an interview, on 08/20/25 at 3:15 PM, with Staff A, LPN, when asked about hydration provided to the residents, Staff A stated that 11-7 shift refreshes the fluids at the end of their shift and when they start doing coffee for breakfast they will be refilled. During an interview, on 08/21/25 at 6:50 AM, with Staff Q, CNA, when asked about providing fluids to Resident #3 during her shift (11PM to 7 AM), Staff Q replied, I never give her fluids. The nurse told me that she is on fluid restrictions, so I don't provide water at her bedside. Staff Q further stated that she worked on Monday night (08/18/25) and last night (Wednesday, 08/20/25). During an interview, on 08/21/25 at 6:53 AM with Staff P, LPN/Unit Manager, when the concern was brought to her attention, Staff P stated, she is noncompliant with her fluid restrictions. She has been educated about the risk, but if she gets her own from outside, we can't stop her. When asked about the risk associated with being noncompliant with the restrictions, Staff P stated, She is on dialysis, so they would have to remove more fluid because her kidneys would not be able to process the extra fluids. She could get swollen, she could have congestive heart failure, she can get fluid in her lungs.

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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. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide nutrition via enteral feedings per physician orders for 1 of 3 residents (Resident #68), reviewed for enteral feeding. This had the potential to affect 3 residents who were dependent on enteral feeding for nutrition. The findings included:The facility's policy on Enteral Feeding and Nutrition, effective 04/01/22, was to ensure adequate parameters of nutrition and hydration status through the provision of physician ordered enteral feedings. It specified that the physician orders for enteral nutrition were based on recommendations of the Registered Dietitian. A record review revealed that Resident #68 was admitted to the facility on [DATE]. His diagnoses included Cerebral Infarction, Dementia, Dysphagia following Cerebral Infarction, and Gastrostomy Status. The minimum data set (MDS) quarterly assessment dated [DATE] revealed he had severe cognitive impairment, and he received enteral feeding exclusively, also known as tube feeding, to meet his needs for nutrition. Resident #68's most recent weight was 116.2 lbs. His Body Mass Index was 18.2. This indicated that Resident #68 was underweight. A record review of Resident #68's care plan last revised on 11/26/2024, revealed a focus on tube feeding that was related to his diagnosis Dysphagia (difficulty swallowing). The quarterly assessment completed by the Registered Dietitian on 08/06/25 noted that Resident #68 was at risk for malnutrition and tube feeding complications; She calculated that the resident required 1800 Calories to be administered each day. This included 1240 milliliters of water that was a component in the 1500 milliliters of Glucerna 1.2 Cal formula. A doctor's order dated 11/26/24 was for an NPO (nothing by mouth) diet. A doctor's order dated 11/26/24 specified to administer Glucerna 1.2 Cal at a rate of 75 milliliters per hour for 20 hours. On at 2pm, off at 10am; until 1500ml infused. Another order for enteral feeding of Glucerna 1.2 dated 02/27/25 said to administer Glucerna 1.2 via PEG (percutaneous endoscopic gastrostomy) to run at 75 milliliters per hour via pump for 20 hours. Total volume to be infused 1500 milliliters/24 hours. Up at 2:00 PM and down at 10 AM. May stop for care and ADLs. There were 2 orders for enteral feeding. An observation of Resident #68 on 08/18/2025 at 12:10 PM during the initial screening process, revealed that the resident had physical signs of malnutrition. He was in bed wearing a loosely tied hospital gown. The enteral feeding pump was off. Severely depressed muscles in between the clavicle bones on his left shoulder were visible. Later that day, on 08/18/25 at 2:32 PM, the pump was on, and the resident's enteral feeding was in progress at 75 milliliters per hour. The 1000 milliliter plastic bottle appeared to be full. The hand-written date on the label was 08/18/25 and the time written on the label said was 2:00 PM. Approximately 50 milliliters was administered. The EntraFlo Pump digital display showed 49 milliliters was delivered since the pump was started (approximately 2:00 PM). Photographic Evidence Provided. An observation of Resident #68's enteral feeding on 08/19/25 at 10:07 AM revealed that the pump was turned off. The turn off time was scheduled at 10:00 AM. The 1000 milliliter bottle had dark black graduated lines printed along the right edge of the large rectangular label, revealed that the bottle still had approximately 800 milliliters left in the bottle. The date on the bottle was 08/19/25 and the start time was listed 4:00 A.M. Photographic Evidence Obtained. An observation of the digital readout of the amount of Glucerna 1.2 Cal that was delivered showed 1324 milliliters. This number was displayed 15 minutes prior to the shut off time. Considering there was 950 milliliters left in the bottle dated 08/18/25, 2:00 PM the difference is 374 milliliters that was delivered from the bottle dated 08/19/25 4:00 AM. A 1000 milliliter bottle minus 374 milliliters leaves 626 milliliters. There were 800 milliliters left in the bottle. The digital readout did not correlate with the observed amount of formula that was left in the bottle. A complete feeding of 1500 milliliters would have left 500 milliliters in the bottle after the 1000 milliliter bottle dated 08/18/25 was finished, and a new 1000 milliliter bottle was started. In the 20-hour feeding from 2:00 PM on 08/18/25, to 10:00 AM on 08/19/25, Resident #68 received approximately 300 milliliters too little formula. Photographic Evidence Obtained. During an observation of the enteral feeding pump connected to Resident #68 on 08/19/25 at 3:30 PM, the digital readout on the EntraFlo pump said 1324 milliliters was delivered. At 3:30 PM Resident #68 received 120 milliliters from the bottle of Glucerna 1.2 that was scheduled to start at 2:00 PM. Approximately 680 milliliters remained in the bottle of Glucerna that was dated 08/19/25, 4:00 AM. Photographic Evidence Obtained. During an observation of the enteral feeding pump connected to Resident #68 on 08/20/25 at 9:45 AM. The tube feeding was in progress at 75 milliliters per hour. The digital readout showed that 518 milliliters was delivered to the resident. The bottle of Glucerna 1.2 had a handwritten date 08/20/25, and time 2:00 AM. Approximately 600 milliliters remained in the bottle. If

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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. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice for 1 of 1 sampled resident for respiratory care (Resident #24). The findings included:Review of the facility's policy titled, Tracheostomy Care with an effective date of 04/01/22 included in part the following: General Guidelines -Aseptic technique must be used: During cleaning and sterilization of reusable tracheostomy tubes. A mask and eyewear must be worn if splashes, spraying of blood or body fluids is likely to occur when performing this procedure. Clean the Removable Inner Cannula-Maintaining sterile field, pour equal parts hydrogen peroxide and normal Saline in one compartment of opened kit. Pour normal saline in another compartment. Put on sterile gloves. Secure the outer neck plate with non-dominate hand. Remove and discard gloves into appropriate receptacle. Wash hands and put on fresh gloves. Record review for Resident #24 revealed the resident was admitted to the facility on [DATE] with readmissions on 07/04/25 and 08/01/25, with diagnoses that included in part the following: Diffuse Traumatic Brain Injury and Tracheostomy Status. The Minimum Data Set, dated [DATE] documented in Section C a Brief Interview of Mental Status score of 15 indicating a cognitive response. Review of the Physician's Orders for Resident #24 revealed in part the following orders:An order dated 06/19/24 to change trach collar every night shift and was discontinued 07/02/25.An order dated 06/19/24 to change trach inner cannula every day. Trach size:4UN65H inner cannula #4IC65 every night shift related to Tracheostomy Status and was discontinued on 07/02/25.An order dated 08/01/25 to change trach collar every night shift every 3 days.An order dated 08/06/25 to change trach inner cannula every day. Trach inner cannula size 4UN65H every night shift.In summary the resident did not have orders to change trach collar or to change trach inner cannula from 07/04/25 to 07/30/25 while the resident was in the facility. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for Resident #24 from 07/04/25 to 07/30/25 revealed there was no documentation of trach care. Review of the Progress Notes for Resident #24 from 07/04/25 to 07/30/25 revealed there was no documentation of trach care. Review of the Care Plan for Resident #24 dated 03/27/24 with a focus on the resident has a tracheostomy, resident puts his hands on tracheostomy frequently. The goals were for the resident to have minimal signs/symptoms of infection and for the resident to have clear and equal breath sounds bilaterally through the review date. The interventions included in part the following: Ensure that trach ties are secured at all times. Suction as necessary. On 08/18/25 at 12:42 PM an observation was made of Resident #24 who has a trach collar in place with suction set up at bedside. During an interview conducted on 08/18/25 at 12:45 PM with Resident #24 who was asked if staff perform trach care, he said they usually do it every day but not always. He said the nurse that he has today is good about doing it when she is working. On 08/20/25 at 12:15 PM an observation of tracheostomy care for Resident #24 performed by Staff A Licensed Practical Nurse (LPN) who was assisted by Staff B Licensed Practical Nurse/Wound Care Nurse (LPN/WCN). During the observation Staff A LPN performed suctioning, tracheostomy care that included: removing, cleaning and replacing outer cannula, replacing disposable inner cannula, removing and replacing trach ties. During the observation neither nurse wore any eye protection. Staff A LPN did apply sterile gloves but touched a plastic cover with both sterile gloved hands and touched the tip of the suction tubing prior to performing suctioning. During the suctioning a large mucus plug came out of the resident. Staff B LPN/WCN consistently had to give direction to Staff A LPN during all parts of the procedure including set up, suctioning, removing and cleaning outer cannula, replacing disposable inner cannula and replacing the trach ties. Staff A LPN continued to touch several items on the sterile field with contaminated sterile gloves and with non-sterile gloves. Staff A LPN cleaned the outer cannula and replaced the disposable inner canula with non-sterile gloves. During an interview conducted on 08/20/25 at 12:57 PM with Staff B LPN/WCN who was asked about Staff A LPN's performance of tracheostomy care for Resident #24, she said it was not good. Staff B LPN/WCN admitted he did not maintain a sterile field or use sterile technique while performing the procedures involved in tracheostomy care. During an interview conducted on 08/20/25 at 1:10 PM with Staff A LPN who was asked about his performance of tracheostomy care, he said he saw Staff B LPN/WCN in the hall on his way to this interview and knew it was not good. When asked about maintaining a sterile field maintaining a sterile gloved hand during the procedure, he admitted he did not. When asked about eye protection, he admitted that neither

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to provide pharmaceutical services, including procedures that assure the accurate dispensing, and administering of all drugs for, 7 of 9 residents reviewed for controlled substances (Residents #7, #104, #32, #14, #48, #69, and #85) and failed to establish a system of records of all controlled drugs to ensure discontinued controlled medications are removed from the medication carts for 2 of 9 residents reviewed for controlled medications (Residents #104 and #14). The findings included: 1. During an interview conducted on 08/19/25 at 9:51 AM with the Director of Nursing (DON) who was asked about medications, the DON stated all meds are secured at all times. When asked about what happens to controlled medications for residents who discharged or sent to the hospital, the DON stated the nurse on the med cart will remove the medication and give it to her. The DON said she is always on the floor daily and always asks nurses if they have any discontinued medications they need to give to her. Once she has the controlled medication that is discontinued or no longer in use, she stores them in her office in a locked file cabinet and they are destroyed with two people including herself and the Administrator or the Consultant Pharmacist. If it is her and the Administrator, the Consultant Pharmacist will sign off on the destruction of the medication and they keep a log of the destroyed medications. When asked if they audit the med carts to ensure controlled medications no longer in use or for residents no longer in the facility, she said she or the Consultant Pharmacist will periodically check the carts. On 08/20/25 at 4:00 PM a review of a south unit med cart for the 500 hall was performed with Staff D Licensed Practical Nurse (LPN) who had a medication cup with 11 pills in the top drawer. Review of the controlled meds and the Medication Monitoring/Control Record for the following residents revealed the following: Resident #48 Hydromorphone 2mg (23) was signed off on the Medication Monitoring/Control Record on 08/20/25 at 6:28 AM and not signed off on the Medication Administration Record (MAR). This was confirmed by Staff D LPN. Resident #14 Tramadol 50mg the resident had two Medication Monitoring/Control Records for the same medication, with one record showing the resident as given the medication on 08/17/25 at 1:30 AM however the medication was not documented on the MAR as the medication was discontinued on 08/12/25. During an interview conducted on 08/20/25 at 4:02 PM with Staff D LPN who was asked about the pills in the cup, she said she did not pull the pills. She said they must have been in the cart from the previous nurse. When asked what time she took over the med cart, she said it was at 7:00 AM this morning. When asked when a controlled medication is taken out to give to a resident where is this documented, she said it should be documented on the Medication Monitoring/Control Record and on the MAR. When asked about when the controlled medications are discontinued or the resident has been discharged or transferred out of the facility what is done with the controlled medications, she said they leave them in the cart until someone comes to pick them up. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/21/25 at 10:40 AM a review of a south unit med cart for the 600 hall was performed with Staff E Licensed Practical Nurse (LPN). Review of the controlled meds and the Medication Monitoring/Control Record for the following residents revealed the following: Resident #32 Tramadol Hcl 50mg (8) the Medication Monitoring/Control Record documented the medication was signed out seven times (07/25/25, 07/27/25, 07/28/25, 07/29/25, 07/31/25, 08/03/25, and 08/05/25) and none of these days the medication was signed out on the MAR. Resident #104 Alprazolam 0.5mg (6) the Medication Monitoring/Control Record documented the medication was signed out 4 times (07/25/25, 07/26/25, 0728/25, and 07/29/25) and none of these days the medication was signed out on the MAR. The medication had in fact been discontinued on 03/05/25 but had remained in the med cart. Resident #7 Fentanyl patch 50mcg (2) the Medication Monitoring/Control Record documented the medication was documented as signed out on 08/16/25 but was not documented on the MAR as administered. During an interview conducted on 08/21/25 at 11:00 AM with Staff E LPN who stated when a controlled medication is removed from the cart to be given to resident she will document the medication removal on the Medication Monitoring/Control Record and document the medication administration on the resident's MAR. Staff E LPN acknowledged Resident #32's Tramadol 50mg was not documented on the MAR but signed out on the Medication Monitoring/Control Record (07/25/25, 07/27/25, 07/28/25, 07/29/25, 07/31/25, 08/03/25, and 08/05/25). Staff E LPN also acknowledged Resident #104 Alprazolam 0.5mg was discontinued on 03/05/25 and had been documented as signed out on the Medication Monitoring/Control Record on 07/25/25, 07/26/25, 07/28/25, and 07/29/25 but not documented on the MAR as being administered on those dates. Staff E LPN acknowledged for Resident #7 the Fentanyl patch 50mcg (2) the Medication Monitoring/Control Record documented the medication was documented as signed out on 08/16/25 but was not documented on the MAR as administered. Record review for Resident #48 revealed the resident was originally admitted to the facility on [DATE] with most recent readmission on [DATE] with diagnoses that included in part the following: Fibromyalgia, Generalized Anxiety Disorder. The Minimum Data Set (MDS) dated [DATE] documented in Section C a Brief Interview of Mental Status (BIMS) score of 15 indicating a cognitive response. a. Review of Physician’s Orders for Resident #48 revealed an order dated 06/18/25 for Hydromorphone HCl Oral Tablet 2 MG give 1 tablet by mouth every 6 hours as needed. b. Record review for Resident #104 revealed the resident was originally admitted to the facility on [DATE] with most recent readmission on [DATE] with diagnoses that included in part the following: Mood Disorder Due to Known Physiological Condition with Mixed Features and Generalized Anxiety Disorder. The MDS dated [DATE] documented in Section C a BIMS score of 15 indicating a cognitive response. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Physician’s Orders for Resident #104 revealed an order dated 02/19/25 for Alprazolam Tablet 0.5 MG give 1 tablet by mouth every 12 hours as needed for Anxiety for 14 Days was discontinued on 03/05/25. c. Record review for Resident #7 revealed the resident was originally admitted to the facility on [DATE] with the most recent readmission to the facility on [DATE] with diagnoses that included in part the following: Multiple Sclerosis and Other Chronic Pain. The MDS dated [DATE] documented in Section C a BIMS score of 15 indicating a cognitive response. Review of the Physician’s Orders for Resident #7 revealed an order dated 06/27/25 for Fentanyl Patch 72 Hour 50 MCG/HR apply 1 patch transdermal every 72 hours for pain Rotate Site and remove per schedule. d. Record review for Resident #32 revealed the resident was originally admitted to the facility on [DATE] with the most recent readmission on [DATE] with diagnoses that included in part the following: Cerebal Palsy and Rheumatoid Arthritis. The MDS dated [DATE] documented in Section C a BIMS score of 13 indicating a cognitive response. Review of the Physician’s Orders for Resident #32 revealed an order dated 12/19/24 for Tramadol HCl Tablet 50 MG give 1 tablet by mouth every 12 hours as needed for pain. e. Record review for Resident #14 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Parkinsons Disease and Other Polyosteoarthritis. The MDS dated [DATE] documented in Section C a BIMS score of 12 indicating a moderate cognitive response. Review of the Physician’s Orders for Resident #14 revealed an order dated 08/15/24 for Tramadol HCl Tablet 50 MG give 1 tablet by mouth every 8 hours as needed and was discontinued on 08/12/25. 2. Record review for Resident #69 revealed an admission to the facility on [DATE] with diagnoses to include Hemiplegia and Hemiparesis following Cerebral Infarction, Type 2 Diabetes Mellitus, Radiculopathy. Review of Resident #69’s Physician Orders dated 05/28/25 documented “Percocet (Oxycodone with Acetaminophen) 5-325 milligrams (mg) give one tablet every 4 hours as needed for pain (a controlled substance for pain)”. On 08/20/25 at 5:22 PM a medication storage observation was held on the North wing of the facility in which a controlled substance reconciliation was conducted for Resident #69. The medication monitoring/control record sheet documented Oxycod/APAP (Percocet) 5-325 mg was removed from the controlled substance locked box on 08/20/25 at 0042 (12:42 AM), 0822 (8:22 AM), and at 16:36 (4:36 PM). However, a review of the August Medication Administration Record (MAR) documented that Resident #69 was administered Percocet 5-325 mg tablet on 08/20/25 at 0822 and 1637; no entry was documented Resident #69 was administered the controlled substance on 08/20/25 at 0042. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Record review for Resident #85 revealed the resident was originally admitted to the facility on [DATE] with a most recent readmission on [DATE] with diagnoses included: Diabetes Mellitus due to Underlying condition with Diabetic Neuropathy, Generalized Muscle Weakness, Complete Traumatic Amputation at Level Between Knee and Ankle. Review of Resident #85’s Physician Orders dated 07/12/25 documented Tramadol (a controlled substance for pain) 50 mg, give one tablet every 6 hours as needed for moderate and severe pain. On 08/20/25 at 5:22 PM a medication storage observation was held on the North wing of the facility in which a controlled substance reconciliation was conducted for Resident #85. The medication monitoring/control record sheet documented Tramadol 50 mg was removed from the controlled substance locked box on 08/12/25 at 1855 (6:55 PM), and on 08/16/25 (unable to read the time). The next recorded date that the medication was removed from the locked box was on 08/19/25. Record review of the August MAR documented Resident #85 was never administered Tramadol 50 mg on 08/12/25; and the medication was administered twice on 08/16/25 at 0950 (9:50 AM) and at 1746 (5:46 PM). Further review revealed Resident #85 was administered Tramadol 50 mg on 08/17/25 at 1204 (12:04 PM), which was not documented as administered in Resident #85’s MAR.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure adequate monitoring of behaviors and side effects for residents on psychotropic medications for 3 of 5 residents reviewed for unnecessary medications (Residents #24, #2, #3). The findings included:Review of the facility’s policy titled, “Antipsychotic Medication Use” with an effective date of 04/02/22 included in part the following: Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the Attending Physician. 1. Record review for Resident #2 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Urinary Tract Infection, Dementia, and Psychotic Disorder with Hallucinations Due to Known Physiological Condition. The Minimum Data Set, dated [DATE] documented in Section C a Brief Interview of Mental Status score of 3 indicating severe cognitive impairment. Review of the Physician’s Orders for Resident #2 revealed in part the following: An order dated 07/25/25 for Donepezil HCl Tablet 10 MG Give 0.5 tablet by mouth one time a day. An order dated 07/25/25 for Memantine HCl Tablet 10 MG Give 1 tablet by mouth at bedtime. An order dated 07/25/25 for Behaviors – Monitor for the Following: Sad Affect, Continuous crying, seems withdrawn, Mood Changes Document: \'N\' if none of the above observed. \'Y\' if any of the above was observed, select chart code \'Other\/ See Nurses Notes\' and progress note findings every shift agitation (Active). An order dated 07/25/25 for Behaviors – Monitor for the following: Restlessness (Agitation), Hitting, Increase in Complaints, Spitting, Cussing, Racial Slurs, Elopement, Psychosis, Aggression, Refusing Care, Angry. Document: \'N\' if none of the above observed. \'Y\' if any of the above was observed, select chart code \'Other\/ See Nurses Notes\' and progress note findings every shift An order dated 07/25/25 for Side Effects 1)Tardive dyskinesia 2)Hypotension 3)Sedation\/Drowsiness 4)Increased falls\/dizziness 4)Appetite changes\/weight change 5)Headache 6)Insomnia 7)Weakness 8)Visual Disturbances 9)Gastrointestinal disturbances 10)Other: see progress notes every shift for monitoring. Put in corresponding code. An order dated 07/26/25 for Antipsychotic Medication – Monitor for Dry Mouth, Constipation, Blurred Vision, Disorientation/Confusion, Difficulty Urinating, Hypotension, Dark Urine, Yellow Skin, Nausea/Vomiting, Lethargy, Drooling, Extrapyramidal Symptoms (Tremors, Disturbed Gait, Increased Agitation, Restlessness, Involuntary Movement of Mouth of Tongue). Document: \'Y\' if monitored and none of the above observed. \'N\' if monitored and any of the above was observed, select chart code \'Other\/ See Nurses Notes\' and progress note findings every day shift. An order dated 08/01/25 for Brexpiprazole (Rexulti)Oral Tablet 2 MG Give 1 tablet by mouth at bedtime. An order dated 08/02/25 for Mirtazapine Tablet 7.5 MG Give 1 tablet by mouth at bedtime. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration Record (MAR) for Resident #2 documented for side effects a code of “0” which has no indication according to the order. Review of the MAR for Resident #2 documented for behaviors was just a check mark not a “Y” or “N” to indicate if the resident had behaviors or not. Review of the Care Plan for Resident #2 dated 07/25/25 with a focus on the resident is on antipsychotic therapy at risk for side effects. The goal was for the resident to be/remain free of antipsychotic drug related complications. The interventions included in part the following: Monitor behavioral symptoms and side effects. During an interview conducted on 08/21/25 at 10:40 AM with Staff E Licensed Practical Nurse (LPN) who was asked about monitoring side effects and behaviors for psychotropic medications, she said they document in the MAR under the order. When asked about Resident #2 she acknowledged the documentation was not clear if the resident had side effects or behaviors. When asked about Resident #24 she acknowledged there were no orders for monitoring behaviors or side effects. During an interview conducted on 08/21/25 at 11:20 AM with Staff A Licensed Practical Nurse (LPN) who was asked about monitoring side effects and behaviors for psychotropic medications, she said they document in the MAR under the order. When asked about Resident #2 he acknowledged the documentation was not clear if the resident had side effects or behaviors. When asked about Resident #24 he acknowledged there were no orders for monitoring behaviors or side effects. 2 Record review for Resident #24 revealed the resident was admitted to the facility on [DATE], transferred to the hospital on [DATE] and returned to the facility on [DATE], and went out to the hospital again on 07/30/25 and returned to the facility on [DATE], with diagnoses that included in part the following: Diffuse Traumatic Brain Injury and Tracheostomy Status. The Minimum Data Set, dated [DATE] documented in Section C a Brief Interview of Mental Status score of 15 indicating a cognitive response. Review of the Physician’s Orders for Resident #24 revealed in part the following orders: An order dated 07/04/25 for Lorazepam Tablet 0.5 MG give 1 tablet by mouth two times a day. An order dated 07/10/25 for Duloxetine HCl Capsule Delayed Release Particles 30 MG give 2 capsule by mouth two times a day. In summary there were no orders to monitor behaviors or side effects for resident receiving psychotropic medications. Review of the MAR for Resident #24 from 08/01/25 to 08/17/25 revealed there was no documentation of monitoring behaviors or side effects. Review of Nursing Progress Notes for Resident #24 from 08/01/25 to 08/17/25 revealed there was no documentation of monitoring behaviors or side effects. (continued on next page)

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	105693	A. Building B. Wing	08/21/2025

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Charming Lakes Rehab	2020 W Lake Parker Dr Lakeland, FL 33805

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan for Resident #24 dated 04/15/24 with a focus on the resident uses psychotropic medications antidepressant at risk for side effects. The goal was for the resident to be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date. The interventions included in part the following: Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift. Monitor/document/report PRN any adverse reactions of Psychotropic medications. 3. Record review for Resident #3 revealed the resident was originally admitted to the facility on [DATE] with a most recent readmission on [DATE] with diagnoses included: Adjustment Disorder with Mixed Disturbance of Emotions And Conduct; Unspecified Psychosis not due to a Substance or Known Physiological Condition; Major Depressive Disorder, Recurrent, Moderate; Mood Disorder due to Known Physiological Condition with Mixed Features; Generalized Anxiety Disorder. Review of Section C of the MDS dated [DATE] revealed that Resident #3 had a BIMS score of 15, which indicated that she was cognitively intact. Review of Resident #3’s Physician Orders dated 06/11/25 documented Divalproex Sodium 250 milligrams (ml) give 4 tablets by mouth at bedtime for anticonvulsant (a psychotropic medication used for mood disorder and anxiety).” Review of Resident #3’s Physician Orders dated 07/23/25 documented “Paroxetine HCl 20 mg, give 1 tablet by mouth one time a day for depression (a psychotropic medication)”. “Olanzapine 5 mg give 1 tablet by mouth at bedtime for psychotic disorder” and “Olanzapine 2.5 mg give 1 tablet by mouth one time a day for depression related to Unspecified Psychosis not due to A Substance or Known Physiological Condition (an antipsychotic medication). Review of Resident #3’s Physician Orders dated 07/30/25 documented “0-no behavior, 1-agitation, 2- combative, 3-verbally inappropriate, 4-sexually inappropriate, 5-crying, 6-calling out, 7-screaming, 8-hallucinations, 9-delusions, 10-resists care, 11-socially inappropriate, 12-other see progress notes, every shift for <type the medication class>”. Further review of Resident #3’s Physician Orders revealed no orders to monitor side effects of the above psychotropic and antipsychotic medications. Review of the provider psych notes documented that on 07/23/25 Resident #3 was seen by Psych Health Associates for medication review and the provider recommended for Resident #3 to be monitor closely for side effects, sedation, or increase confusion; and a gradual dose reduction is not clinically indicated at this time due to the resident’s current psychiatric instability and ongoing needs for therapeutic support. Record review of the July and August Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed Resident #3 was administered all her medications, however, was not monitored for side effects for the psychotropic and antipsychotic medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to secure medications at all times during 2 of 4 medication pass observations (Residents #73 and #45), failed to secure medications at all times for over the counter medications in 1 of 2 unit manager's offices (unit manager for south), and failed to store medications according to facility policy for 1 of 3 medication carts reviewed for medication storage (Med Cart 500 Hall). The findings included:Review of the facility's policy titled, Medication Storage with no date included in part the following: 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 the Florida Department of Health guidelines. With the exception of Emergency Drug Kits, all medications will be stored in a locked cabinet, cart or room that is accessible only to authorized personnel. Expired, discontinued and/or contaminated medications will be removed from the medication storage areas and disposed of in accordance with the facility policy 1. During an interview conducted on [DATE] at 10:30 AM with Staff P Licensed Practical Nurse/Unit Manager (LPN/UM) in her office when an observation was made of approximately 36 bottles of over the counter medications and 1 enema solution were located on an open bookshelf in her office. When asked when she leaves her office does she lock the door, she replied no she just shuts the door. When asked about the approximate 36 bottles of medication and 1 enema solution located on an open bookshelf in her office, she said they were in the office when she moved into the office about a week or so ago. She added the medications were removed from the medication carts due to nurses marking a date on the medications and that is not their policy. When asked if the medications should be secured at all times she said yes, from now on I will lock my door when I leave my office. 2. On [DATE] at 4:00 PM a review of a south unit medication cart for the 500 hall was performed with Staff D Licensed Practical Nurse (LPN) who had a medication cup with 11 pills in the top drawer. During an interview conducted on [DATE] at 4:02 PM with Staff D LPN who was asked about the pills in the cup, she said she did not pull the pills. She said they must have been in the cart from the previous nurse. When asked what time she took over the med cart, she said it was at 7:00 AM this morning. During an interview conducted on [DATE] at 9:51 AM with the Director of Nursing (DON) who was asked about medications, the DON stated all medications are secured at all times. 3. During a medication pass observation for Resident #73 on [DATE] at 9:00 AM performed by Staff A Licensed Practical Nurse (LPN), he left 2 oral medications (gabapentin 300 MG, and Saccharomyces boulardii Capsule 250 MG) and 1 intravenous medication (Cefepime HCl Intravenous Solution 2 GM/100ML) on the overbed table in front of the resident, out of his sight when the LPN went to put on a gown and gloves before administering the intravenous antibiotic.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, policy review, and record review, the facility failed to provide pureed foods in appropriate consistency for 3 residents (Resident #30, Resident #78, Resident #76) on Dysphagia Puree texture diets and for one resident (Resident #108) who was on a diet with an order for nectar thickened fluids. This had the potential to affect 27 residents who were on mechanically altered diets. The findings included:A review of the policy on the Levels of the National Dysphagia Diet from the Nutrition Care Manual dated 2019 described the pureed diet as a homogenous, pudding-like consistency without particles, The General Guidelines for Thickened Liquids stated that all liquids should be thickened to the proper consistency, including soups, water, oral supplements, and all other beverages. 1.A record review revealed that Resident #30 was admitted to the facility on [DATE] with diagnoses that included Dysphagia (difficulty swallowing), Dementia, Muscle Weakness, and Lack of Coordination. A Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed that Resident #30 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated that she had severe cognitive impairment. This MDS assessment revealed that she received a mechanically altered diet. A review of the medical records showed that Resident #30's diet order dated 02/07/25 was for a regular diet, with Dysphagia Puree texture, and Nectar thickened fluids. A record review revealed that Resident #78 was admitted to the facility on [DATE]. Her diagnoses included Multiple Sclerosis, Muscle Weakness, and Dysphagia, Oral Phase. Review of the Minimum Data Set (MDS) 5-day assessment dated [DATE] revealed that Resident #78 had a Brief Interview for Mental Status of 12, which indicated that she had moderate cognitive impairment. This assessment also documented that Resident #78 was on a mechanically altered diet. A record review revealed that Resident #76 was admitted to the facility on [DATE]. His diagnoses included Cerebral Infarction, Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominant Side, and Unspecified Dementia. The Minimum Data Set (MDS) significant change assessment dated [DATE] showed that Resident #76 was cognitively impaired. His most recent weight was 112 lbs on 08/12/25, and his Body Mass Index (BMI) was 16.5. This indicated he was severely underweight. His diet order dated 08/01/24 was for a Regular diet, with Dysphagia Puree texture, and Nectar thickened fluids. During an observation 08/19/25 at 5:10 PM Resident #30 was in the dining room. She received a plate of pureed foods. The pureed rice was lumpy. On 08/19/25 at 6:17 PM Resident #76 was receiving assistance with feeding while he was in bed. The pureed food was lumpy. The resident coughed several times. Photographic evidence obtained. When the surveyor entered the kitchen to examine the pureed foods, there were no pureed leftovers to examine. During observations on 08/20/25 at 12:36 PM, Resident #30, Resident #78, and Resident #76 were served plates of pureed foods. The pureed meat entree, and the pureed bread appeared lumpy. During an interview with the Kitchen Manager on 08/20/25 at 12:40 PM, a plate of pureed foods was requested. The Kitchen Account Manager and the surveyor tasted the pureed bread and the pureed meat. The pureed bread looked lumpy but it tasted smooth. The Kitchen Account Manager said the pureed meat could be smoother. It had sand like particles in it and it was not a homogenous texture. When the Kitchen Account Manager was shown photos from the dinner meal served on 08/19/25, she was asked if the rice appeared to be of a unified texture. The Kitchen Account Manager said that the pureed rice did not appear to be a uniform texture. 2.A record review of Resident #108 revealed that he was admitted on [DATE]. His diagnoses included Chronic Obstructive Pulmonary Disease, Muscle Weakness, Dementia, and Dysphagia, Oropharyngeal Phase. The Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #108 had a Brief Interview for Mental Status (BIMS) of 06, which indicated that he had severe cognitive impairment. This MDS assessment documented that Resident #108 was on a mechanically altered diet. His diet order dated 03/21/24 was for a Regular diet, with Dysphagia Advanced texture, and Nectar thickened fluids (consistency). During an observation on 08/19/25 at 5:51 PM in the resident's room, Resident #108 had a cup of thin coffee in a mug on his meal tray, and a large styrofoam cup of regular consistency water with a straw in it. The meal ticket on the tray said that he was to be served Nectar thick fluids. Photographic Evidence Obtained. During an interview with Staff K , (a CNA), on 08/19/25 at 6:00 PM, when asked if the water in the Styrofoam cup was regular thin water, Staff K answered yes. When asked if the coffee was regular texture, Staff K said that she thought thickener was added to the liquid and that it was too thin. She got more thickener to add to the coffee. She noticed that there was thickener on the bottom of the cup that was not mixed in thoroughly. Photographic evidence of a

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure that potentially hazardous foods were held and reheated in a manner to prevent the growth of pathogens that cause foodborne illness and in a manner consistent with professional standards for food safety for 1 of 33 residents in the final sample, Resident #3. The findings included: The facility's policy, 'Food: Preparation', with a reference date of 05/2014 and a revision date of 09/2027, did not address reheating potentially hazardous foods (PHF) from a resident's meal. Resident #3 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, a Quarterly Minimum Data Set (MDS), Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. The assessment documented that Resident #15 required supervision or touching assistance for eating. Resident #3's diagnoses at the time of the assessment included: Diabetes Melitus, Seizure disorder, Depression, Cerebral infarction, Muscle weakness, Need for assistance with personal care, Lack of coordination, Dependence on Renal dialysis. Resident #3's orders included:Hemodialysis every Monday, Wednesday, and Friday in house - 07/15/25. During an observation of breakfast served to the residents in their rooms, on 08/20/25 at 8:30 AM, Resident #3 was noted to be out of the room, while her breakfast tray - including scrambled eggs, toast, a half pint carton of milk, and a cup of orange juice - was noted to be on her overbed table. During an interview, on 08/20/25 at 8:33 AM, with Staff D, LPN (Licensed Practical Nurse), when asked about the resident's whereabouts, Staff D stated that the resident was at dialysis. When asked about the breakfast meal being left on the resident's overbed table, Staff D replied, They leave it there and they warm it when she gets back in the pantry (referring to the Certified Nursing Assistants (CNAs)). During an interview, on 08/20/25 at 9:01 AM, with Staff O, CNA, when asked how long Resident #3's dialysis treatments were, Staff O replied, She goes from 7:30 AM to 9:30 AM or so, no more than 2 hours. When asked about reheating the resident's breakfast, Staff O stated that she takes the meal to the pantry and heats it in the microwave in the unit pantry. When asked about the process for reheating potentially hazardous foods in a microwave, Staff O led this surveyor to the unit pantry and referred to a sign that was posted on the cabinet that instructed the staff in the following manner: Temperature limits for warming food:Potentially hazardous food = 135 F (degrees Fahrenheit)Poultry and stuffed meats = 165 FPork = 145 FRare roast beef = 130 Staff O then stated that she re-heats foods to 135 F. when asked about taking the temperature of the food, Staff O then began looking in the cabinets and drawers for the thermometer that was found in a drawer under the microwave. During an interview, on 08/20/25 at 9:07 AM, with Staff R, CNA, when asked about reheating food for the residents, Staff R stated that he uses the microwave oven that is in the unit pantry. Staff R led this surveyor to the unit pantry. Staff R was asked how to determine that the foods were reheated safely and Staff R stated that he takes the temperature. When asked what temperature to cook the food to, Staff R replied, 100-something. When asked about taking the temperature, Staff R stated that he uses a thermometer. Staff R then began looking in the cabinets and drawers, including the drawer that the thermometer was stored in, and struggled to find the thermometer. During an interview, on 08/20/25 at approximately 9:15 AM, the Food Service Manager was made aware of the concerns related to staff reheating potentially hazardous foods in a microwave oven and agreed that the instructions provided to the staff were inaccurate. The Food Service Manager stated that staff would be educated about reheating potentially hazardous foods.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observations, and interviews, the facility failed to dispose of garbage and refuse appropriately. The findings included: Upon arriving to the facility, on 08/18/25 at 8:25 AM, it was noted that the trash dumpster appeared to be overflowing and there was an accumulation of trash and debris on the ground around the dumpster. At the time of the observation, the Director of Nursing (DON) was outside. Upon entering the facility, on 08/18/25 at 8:30 AM, the surveyor explained the concern to the DON to which the DON acknowledged. On 08/19/25 at approximately 8:00 AM, the dumpster area was visible through a window at the end of the 500 unit. It was noted that the accumulation of trash and refuse had not been cleaned up.