STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105705	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Port Square Health Center	701 Lake Port Blvd Leesburg, FL 34748

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure resident assessments were completed accurately to reflect the resident's status for 4 (Resident #4, #6, #8 and, #15) of 9 residents reviewed. Based on observation, interview and record review the facility failed to ensure resident assessments were completed accurately to reflect the resident's status for 4 (Resident #4, #6, #8 and #15) of 9 residents reviewed. Findings include: During an observation on 6/8/2026 at 10:28 AM, Resident #8 was sitting in her wheelchair self-propelling in her room. There were no observations of restraints. During an interview on 6/8/2026 at 10:28 AM, Resident #8 stated, I have no concerns with my care and do not use any restraints. During an observation on 6/9/2026 at 2:14 PM, Resident #8 was sitting in activity room participating in activities in a wheelchair. No restraints observed at this time. Review of Resident #8's physician orders did not document orders for restraints. Review of Resident #8's Minimum Data Set (MDS) titled Quarterly dated 5/8/2026 read, Section P Restraints and Alarms: chair prevents rising. 1. Used less than daily. During an interview on 6/10/2026 at 8:42 AM, Staff B Licensed Practical Nurse (LPN) stated, [Resident #8's name] does not have any restraints. There is no seat belt or anything that would prevent her from getting out of her wheelchair. During an interview on 6/10/2026 at 9:35 AM, the MDS Coordinator stated, [Resident #8's name] does not use any restraints. No restraints in the building are used. I will update that section. During an interview on 6/10/2026 at 11:43AM, the Director of Nursing stated, We do not use any kind of restraints. Review of Resident #4's Minimum Data Set titled Quarterly dated 5/23/2026 read, Section N Medications: Antibiotics. No. Review of Resident #4's physician order dated 5/15/2026 read, Mupirocin External Ointment 2% (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Mupirocin) apply to L [left] pointer and L mid [middle]. Fing [finger] topically two times a day for fungal rash for 7 Days left pointer and left middle finger. Review of Resident #4's Medication Administration Record for the month of May 2026 documented Mupirocin External Ointment 2% administered from 5/16/2026 through 5/22/2026. During an interview on 6/10/2026 at 9:29 AM, the MDS Coordinator stated, [Resident #4's name] assessment does say no for antibiotic use in the section. Mupirocin is considered an antibiotic. I will correct it. During an interview on 6/11/2026 at 8:13 AM with the Director of Nursing stated, The facility follows the RAI [Resident Assessment Instrument]. During observation on 06/09/2026 at 3:00PM, Resident #15 and her daughter were seated outside on front patio of facility. Resident was wearing a black sling on left arm. During interview on 06/10/2026 at 8:05AM, Resident #15 stated that she had hernia surgery in 2010 and has been dealing with the surgical site since then. During interview on 06/10/2026 at 8:51 AM, the MDS Coordinator stated, Section GG No impairment of upper and lower extremity is wrong, as she came in with a diagnosis of Left arm fracture. Yes, it is incorrect and I will have to change it. Section I does not have a diagnosis of Schizophrenia listed, and it is on her diagnosis. Section M Skin Issues with none listed is because she came in and the staging was still to be determined as of 05/21/2026 as to what it was to classified as. The hernia I have listed; she is getting wound care for. I see she is able to have ointments and dressings. It was that the etiology was not available for me at that time. I would have to go to the Resident and look at it myself to see how to classify it. During interview on 06/10/2026 at 11:47 AM, Wound Care Nurse stated, [Resident #15's Name]'s wound is an old hernia operation draining from her abdomen. I put an ABD and dry dressing on it. Review of Resident #15's admission record dated 05/20/2026, reads, Diagnosis: Primary Admitting 05/20/2026 Unspecified Fracture of Shaft of Humerus Left Arm, Ventral Hernia, and Schizophrenia. Review of Resident #15's MDS dated [DATE] reads, Section GG Functional Limitation in Range of Motion- Upper extremity and Lower Extremity Coded 0 No Impairment, Section I Active Diagnosis: Renal Insufficiency, Thyroid Disorder, Osteoporosis, Non-Alzheimer's Dementia, Seizure Disorder, Bipolar Disorder, Chronic Obstructive Pulmonary Disease, Unspecified Fracture of Shaft of Humerus, Left Arm, Repeated Falls, Cognitive Communication Deficit, Age Related Debility, Enterococcus as the Cause of Disease, Ventral Hernia, Section M Skin Conditions Unhealed Pressure Ulcers/ Injuries Code 0 No. Review of Resident #15's Physician Order dated 05/22/2026 reads, Wound care: Abdomen - Cleanse with NS (normal saline), Pat Dry, apply calcium alginate, skin prep surrounding tissue, apply ABD (Abdominal) pad, and silicone bordered dressing. every day and evening shift for wound Care AND every 8 hours as needed for If wet, soiled, dissolved. Review of Skin and Wound Progress Note dated 05/21/2026 from [Name of Wound Care Providers], Staff L, NP (nurse Practitioner) read, She has a closed fracture of the left humerus. Wound care (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	consulted for evaluation and treatment of wounds. [Resident #15's Name] has a large weeping hernia on her abdomen that wound care will be following. Etiology to be determined and will collaborate with PCP (Primary Care Physician) regarding management moving forward. Review of Resident #6's admission record reads, Diagnosis: Onset Date 05/11/2026 Personal history of Transient Ischemic Attack (Tia), and Cerebral Infarction Without Residual. Review of Resident #6's Medical Doctor Progress Note, dated 05/12/2026 reads, Hemorrhagic stroke on 4/14 presented expressive aphasia during dialysis, CT (Computed tomography) head showed attenuation of left parietal region with focal hemorrhage +lytic lesion on right parietal calvarium. Review of Resident #6's MDS dated [DATE] Section I Active diagnoses does not include TIA or Cerebral Infarction. During interview on 06/10/2026 at 8:44 AM, the MDS coordinator stated, [Resident #6's Name] has a diagnosis of TIA (transient ischemic attack) and a history of stroke with no residual from his hospital paperwork. I will need to add it on to Section I.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure assessments were updated following documentation of a new diagnosis for 2 Residents (Resident #4 and #9) out of 5 residents sampled for preadmission screening and resident reviews (PASARR). Findings include:Review of Resident #9's admission record shows resident was admitted on [DATE] and readmitted on [DATE] with diagnosis including but not limited to Brief psychotic disorder [onset date 11/14/2025] and major depressive disorder [onset date 3/17/2026].Review of Resident #9's State of Florida Agency for Health Care Administration Preadmission Screening and Resident Review (PASSR) dated 11/11/2025 did not document mental illness.Review of Resident #9's physician orders dated 11/18/2026 read, Quetiapine Fumarate Oral Tablet 25 MG [milligram] give 1 tablet by mouth at bedtime for Brief Psychosis for agitation and sedation.Review of Resident #9's [Name of Psychology Provider] admission Note dated 11/26/2026 reads, History of Present Illness: He was referred for psychotherapy services due to concerns of adjustment difficulties. [Resident #9's name] reported periods of mild anxiety related to current situation and being away from home. Sx [signs] have been present since health decline. Problem List Brief Psychotic Disorder active 11/18/2025, adjustment disorder active 12/02/2025.Review of Resident #9's physician orders dated 12/10/2025 read, Trazadone HCl Oral Tablet give 25 mg [milligram] by mouth at bedtime for insomnia related to depression.Review of Resident #9's [Name of Psychology Provider] Progress note dated 3/17/2026 read, Problem List: Adjustment Disorder active 12/2/2025. Major Depressive Disorder, recurrent, mild active 3/17/2026. Delusional disorders active 3/17/2026.During an interview on 6/11/2026 at 9:20 AM, the Director of Nursing stated, In March we were monitoring him [Resident #9], he was having a hard time because he found out his cancer had come back.Review of Resident #4's admission record shows resident was admitted on [DATE] and readmitted on [DATE] with diagnosis including but not limited to major depressive disorder [onset date 11/7/2025] and anxiety disorder [onset date 11/7/2025].Review of Resident #4's State of Florida Agency for Health Care Administration Preadmission Screening and Resident Review (PASRR) dated 10/24/2025 did not document any mental illness.Review of Resident #4's [Name of Behavioral Science Provider] progress note dated 11/18/2025 read, The patient is a [age of Resident #4] year old female with a past psychiatric hx [history] of depression. Assessment/Plan: Major Depressive Disorder, Recurrent, Unspecified.Review of Resident #4's [Name of Behavioral Science Provider] progress note dated 1/7/2026 read, Treatment Plan: Encounter was requested by staff due to concerns in condition, overall decline and limiting behaviors.Review of Resident #4's physician order dated 2/18/2026 read, Escitalopram Oxalate Oral Tablet 5 MG give 1 tablet by mouth one time a day for Depression monitor for s/s of isolation and sadness. During an interview on 6/10/2026 at 10:57 AM, Social Services Assistant stated, Both PASSRs [Resident #4 and Resident #9] need to be updated.During an interview on 6/10/2026 at 11:43 AM, the Director of Nursing stated, Psych gives Social Services a list of all patients that were seen and they also sit in the meetings where we discuss changes and the residents.Review of the facility policy and procedure titled Psychotropic Medication Use with a last review date of 1/22/2026 read, Policy Interpretation and Implementation. Assessment and Evaluation of the Resident. 1. When determining whether to initiate, modify, or discontinue medication therapy, the interdisciplinary team conducts and documents an evaluation of the resident. The evaluation includes the resident's: f. the state PASSAR evaluation.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview and record review the facility failed to administer correct dosage amount of medication to 1 (Resident #9) of 6 residents reviewed for medication administration and failed to provide intravenous device care as per nursing standards for 1 (Resident#15) of 2 residents reviewed for intravenous infusions. Findings include: During an observation on 6/10/2026 at 8:10 AM Staff B, Licensed Practical Nurse (LPN) was pouring medication for Resident #9. Staff B, LPN, poured one tablet of Methotrexate Sodium 2.5 mg into the medication cup. When Staff B, LPN was finished pouring all medications, Staff B entered Resident 9's room and administered the medications. Staff B, LPN then exited Resident #9's room and signed off on all the medications. Review of Resident #9 physician order dated 2/09/2026 read, Methotrexate Sodium Oral Tablet 2.5 MG [milligram] (Methotrexate Sodium) give 6 tablet by mouth one time a day every Wed [Wednesday] for rheumatoid arthritis 6 X 2.5 mg=15mg. During an interview on 6/10/2026 at 12: 25 PM, Staff B, LPN, stated, I should have given him [Resident #9] 6 tablets to make 15mg not just one tablet. I will have to call the provider to let him know and let the DON [Director of Nursing] know. During an interview on 6/10/2026 at 1:10 PM, the Director of Nursing stated, The nurse came to me and told me what happen. I told her to call the provider and let the patient know. Providers order a one-time dose for the missing amount. The nurse was nervous. During an interview on 6/11/2026 at 9:50 AM, the Director of Nursing stated, Nurses are to review orders and compare the medication cards to the orders in the system. Pharmacy will come and do medication observations and have not had any concerns. The pharmacy has not verbalized any concerns with [Resident #9's Name] medication not being given when they review the medication carts or when refilling medication. Review of the facility policy and procedure titled Administering Medications with a last review date of 1/22/2026 read, Policy Statement. Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: 4. Medications are administered in accordance with prescriber orders, including any required time frame. During an observation on 06/08/2026 at 9:30 AM, Resident #15's Midline dressing was dated 5/30/2026 on upper inner right arm. Skins visibly purple at insertion site with dry blood on foam circle around line under clear dressing. (photographic evidence obtained). IV (Intravenous) pump with empty bag of ordered antibiotics in room. During observation on 06/09/2026 at 9:22AM, Resident #15 did not have a Midline in place or dressing located on the upper inner right arm. A purple colored mark was still present on skin The IV pump was not in the room. During interview on 06/11/2026 at 11:38 AM, the Medical Director stated, A line is to be removed immediately after the last dose of antibiotic has been given. It is a verbal order over the phone (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	usually. During interview on 06/11/2026 at 12:03 PM, the DON stated, The dressings are to be changed weekly it is typically done on Thursday, so we have a second pair of eyes on it because wound care is done on Tuesday and Thursday. The process to remove the midline is at the end of the treatment we get an order for the midline to be removed or obtain labs if ordered then flush it and remove it. After a verbal order is obtained it is to be put into PCC (point click care) by the end of their shift. Review of Resident #15's Nursing Progress Note Dated 06/07/2026 by Staff K, LPN (licensed practical nurse) reads, Normal Saline Flush Solution 0.9 %- Use 10 ml intravenously every shift for Midline Flush Bandage dry/intact with no s/s of infection/infiltration. Flushed with no resistance. Review of Resident #15's Physician Order dated 06/08/2026 reads, Review of Late Entry Nursing Progress Note Verbal order per MD to pull IV line as tx was complete. IV line pulled with no issues, Review of Resident #15's Physician Orders dated 06/02/2026, Reads, Change catheter site dressing one time a day every Thur (sic) for dressing change catheter securement device AND every 8 hours as needed for Dressing change catheter securement device., Observe midline site with intermittent therapy or when not in use for s/sx of infiltration/extravasation, redness, swelling and pain. every shift for monitor IV site, Normal Saline Flush Solution 0.9 % (Sodium Chloride Flush) Use 10 ml(milliliters) intravenously every shift for Midline Flush, ceftriaxone Sodium Intravenous Solution Reconstituted 1 GM(gram) Use 1 Gram intravenously one time a day for UTI(Urinary tract infection) until 06/06/2026, Sodium Chloride Solution 0.9% Use 125ml/hr (milliliters/hour) intravenously every evening shift for run for 2 liters for 1 day 05/30/2026, midline to be placed per (Medical Doctor). Review of facility policy titled, Policy for Peripheral and Midline IV Dressing Changes, last updated 01/22/2026, reads, 4. Change dressing if it becomes damp, loosened, or visibly soiled and at least every 7 days for TSM (transparent semi-permeable membrane) Dressing.

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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. Based on observation, interview and record review the facility failed to provide nutritional supplements as order for 1 (Resident #12) of 6 residents reviewed for nutritional services. Findings include:During an observation on 6/8/2026 at 12:03 PM, Resident #12 was having lunch in her room. The meal tray contained soup, iced tea, noodles, brussels sprouts, peaches, and chicken. There was no nutritional treat observed. [photographic evidence obtained]During an interview on 6/8/2026 at 12:03 PM, Resident #12 stated, I do not get any additional nutrition treat. Nothing that is frozen. During an observation on 6/9/2026 at 12:48 PM, Resident #12 eating in her room. The tray contained iced tea, dessert, rice, vegetables, and pork. There was no frozen nutritional treat on the meal tray. [photographic evidence obtained]Review of Resident #12's physician order dated 11/26/2025 read, Frozen nutritional treat with Lunch and dinner two times a day for at risk for malnutrition.Review of Resident #12's medical record shows documented weights on 5/23/2026 187.4 lbs [pounds], 4/13/2026 194.6 lbs, 2/22/2026 189.8 lbs, and on 11/30/2026 196.1 lbs. Review of Resident #12's Dietary/Nutrition Evaluation dated 6/4/2026, reads, Weight history. Wt [weight] stable. C. Nutritional Approaches current nutritional supplements. Yes. magic cup bid [twice a day].During an interview on 6/10/2026 at 11:25 AM, Staff B, Licensed Practical Nurse (LPN), stated, Normally the frozen nutritional treat comes on the tray form the kitchen. I was not aware she [Resident #12] did not get her nutritional treat for lunch.During an interview on 6/10/2026 at 11:32 AM, Staff E Certified Nursing Assistant (CNA), stated, I cannot recall if [Resident #12's name] gets a frozen nutritional treat. If she did it would come from the kitchen we do not have them in the refrigerator.During an interview on 6/10/2026 at 11:33AM, Staff F, CNA, stated, No, [Resident #12's name] did not have a frozen treat on her treat for lunch yesterday. That I know of she does not get them.During an interview on 6/10/2026 at 3:01 PM, the Registered Dietician (RD) stated, I came in this week. Normally the RD puts in the orders in the system and then will fill out a communication sheet that goes to the kitchen. [Resident #12's name] frozen nutritional treat was not communicated with the [kitchen program] and was not showing up in the meal ticket.During an interview on 6/10/2026 at 3:06 PM, the Kitchen Manager stated, Nursing will normally write a communication form from nursing. If I get that [new orders in the communication sheet] I make the change but if I don't get it, I cannot make the change. Some how this one got overlooked. Nursing directly give it to me. It will show up on the ticket. The frozen nutritional treats will aways come from the kitchen on the meal tray. No one came to me to ask me for a frozen treat these past few days that I can recall. During an interview on 6/11/2026 at 6:21 AM with the Director of Nursing stat, The CDM walked out on Friday and he is the one that typically pull the order in and make sure that everything is on the tray.Review of the facility policy and procedure titled, Supplemental Feeding with a last review date of 1/22/2026 read, Policy: It is the policy of the community to provide nutritive supplements as appropriate for residents with weight loss or when other nutrition risk factors are identified. Procedures: 1. Nutritive Supplements will be given when ordered by the physician.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review the facility failed to ensure the oxygen delivery rate was specified for 1 resident, Resident #11, and failed to ensure nebulizer equipment was properly stored for 1 resident, Resident #85, of 3 residents reviewed for respiratory care. Findings include: During an observation on 6/9/2026 at 8:12 AM, Resident #11 was semi reclined in his bed in his room. Resident #11 was being administered oxygen from a concentrator via nasal cannula at 2 liters per minute. Review of Resident #11's care plan, initiated 1/2/2026, revealed Resident #11 was at risk for complications related to sleep apnea secondary to the need for continuous positive airway pressure with a history of refusing the continuous positive airway pressure. Resident #11's respiratory care plan interventions included oxygen as needed to Promote lung expansion and improve air exchange by positioning with proper body alignment (if tolerated, head at 45 degrees). Review of Resident #11's physician's orders showed Resident #11 had physician orders that included O2 [Oxygen]: Clean oxygen filters every night shift every 4 weeks on Mon [Monday] for Maintenance, O2 [Oxygen]: Change nebulizer mask and tubing every night shift every Mon [Monday] for Infection control, Respiratory Orders: Oxygen PRN [as needed] night (Resident uses O2 [Oxygen] at night for sleep apnea, he does not like MASK for CPAP) every night shift for Sleep Apnea Resident uses O2 [Oxygen] at night for sleep apnea, he does not like MASK for CPAP. Review of Resident #11's clinical records failed to reveal a physician's order that established an ordered delivery rate for Resident #11's oxygen. During an interview on 6/10/2026 at 8:58 AM, Staff A, Licensed Practical Nurse, confirmed Resident #11's clinical records failed to reveal a physician's order that established an ordered delivery rate for Resident #11's oxygen. Staff A reported Resident #11 used the oxygen overnight typically and sometimes during the day. She reported Resident #11's oxygen delivery rate was set by facility nurses and Resident #11 did not set the oxygen delivery rate. During an interview on 6/10/2026 at 9:52 AM, the Director of Nursing agreed residents' oxygen delivery rates should be included in the residents' clinical record as a physician's order. During an observation on 6/8/2026 at 9:41 AM, Resident #85 was sitting in her wheelchair. There was a nebulizer mask lying on top of the nightstand that was not bagged. [photographic evidence obtained] During an observation on 6/8/2026 at 12:06 PM Resident #85 was lying in bed with her eyes closed. There was a nebulizer mask lying on top of the nightstand that was not bagged. Review of Resident #85's physician orders dated 6/7/2026 read, Levalbuterol HCl 0.63 MG [milligram] /3ML [milliliter] Nebulization solution Give 1 vial by mouth every 8 hours for sob [shortness of breath]. Review of Resident #85's physician orders dated 6/7/2026 read, Ipratropium-Albuterol Inhalation (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 3 ml inhale orally every 6 hours as needed for SOB. During an interview on 6/10/2026 at 10:34 AM, Staff J, Licensed Practical Nurse [LPN] stated, Nebulizer mask and oxygen tubing should be stored in a bag when not in use. During an interview on 6/10/2026 at 10:40 AM, the Director of Nursing stated, The nebulizer mask and tubing should be stored in a bag that is dated when not in used. Review of the facility policy and procedure titled Departmental (Respiratory Therapy)-Prevention of Infection with a last review date 1/22/2026 read, Purpose: The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. Steps in the Procedure. 8. Keep the oxygen cannula and tubing used PRN in a plastic bag, when not in use. Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol: 7. Store the circuit in plastic bag, marked with date and resident's name between uses.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review the facility failed to follow standards of medication storage for 2 out of 6 halls reviewed for unattended medication.Findings include: During an observation on 6/8/2026 at 9:15 AM Resident #86 was lying in bed. Resident #86's wife was at bedside. There was a clear medication cup with cream inside. Medication cup was not labeled. There were two normal saline flush syringes on top on nightstand. During an interview on 6/8/2026 at 2:11 PM, Staff I Licensed Practical Nurse (LPN) stated, I am not aware of any cream or normal saline flushes. I have not done any of it. During an interview on 6/8/2026 at 2:13 PM, Resident #86's Representative stated, The staff came in and applied the cream when the changed him [Resident #86]. During an interview on 6/8/2026 at 2:16 PM, Staff G Certified Nursing Assistant (CNA) stated, The wound care nurse gave me the cream this morning; I left it in his [Resident #86] room and when I came back I applied it. During an observation on 6/8/2026 at 10:25 AM Resident #38 was lying in bed. There was a clear medication cup at bedside with a spoon and cream. [photographic evidence obtained] During an interview on 6/8/2026 at 10:25 AM, Resident #38 stated that staff will apply the cream to him when they change him. During an interview on 6/8/2026 at 2:20 PM, Staff H, CNA confirmed there was a clear medication cup with a spoon at Resident #38 bedside nightstand. Staff H reported it is cream to apply when he is changed but should not have been left at bedside. During an interview on 6/8/2026 at 2:21 PM, Staff B, LPN, stated, [Resident #38's name] does not have an order to self-administer medication. During an interview on 6/11/2026 at 6:22 AM, the Director of Nursing stated, [Residents #86 and #38's name] did not have orders to self-administer medications. The medication should not be left unattended at bedside. Review of the facility policy and procedure titled Medication Labeling and Storage with a last review date of 1/22/2026 read, Policy Statement. The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105705	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Port Square Health Center	701 Lake Port Blvd Leesburg, FL 34748

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to ensure food was stored in a safe manner in the main kitchen and in 1 of 2 nourishment rooms. Findings include: During the initial tour of the main facility kitchen on 6/8/2026 at 9:38 AM, there was no thermometer in the walk-in freezer. During an interview on 6/8/2026 beginning at 9:38 AM, the Kitchen Manager agreed there was no stand-alone thermometer in the walk-in freezer. During an observations on 6/8/2026 beginning at 9:48 AM, the thermometer in the 300 Hall nourishment room freezer registered 30 Fahrenheit degrees. There were 7 thawed ice cream bars stored in the 300 Hall nourishment room freezer. During interview on 6/8/2026 beginning at 9:48 AM, the Kitchen Manager reported the thermometer in the 300 Hall nourishment room freezer registered 30 degrees Fahrenheit. She agreed the ice cream bars stored in the 300 Hall nourishment room freezer were thawed. Review of the policy titled Food & Beverage Standards of Excellence, last reviewed 1/22/2026, read 5. Food will be purchased, stored, prepared and served in a sanitary manner.Proper food temperature .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105705	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Port Square Health Center	701 Lake Port Blvd Leesburg, FL 34748

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation and interview the facility failed to ensure garbage and refuse was disposed of properly.Findings include: On 6/8/2026 at 9:51 AM, there was a large dumpster with no lid that contained exposed filled household style plastic garbage bags. The plastic garbage bags were not secured from pests or wildlife. There was 1 small dumpster in the area. The left side top lid of the small dumpster was open exposing the contents of the dumpster to pests and wildlife.During an interview on 6/8/2026 beginning at 9:51 AM, the Kitchen Manager reported the large dumpster with no lid should not contain garbage. She acknowledged the left side top lid of the small dumpster was open exposing the contents of the dumpster to pests and wildlife.During interview on 6/9/2026 at 9:09 AM, the Interim Certified Dietary Manager reported the large dumpster was a construction dumpster and should not contain facility trash. Review of the facility policy titled Sanitization, last reviewed 1/22/2026, read, All kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects.14. Garbage and refuse containers are in good condition, without leaks, and waste is properly contained in dumpsters/compactors with lids (or otherwise covered).15. Areas used for garbage disposal are free from odors and waste fats, and maintained to prevent pests.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105705	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Port Square Health Center	701 Lake Port Blvd Leesburg, FL 34748

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review the facility failed to document therapy sessions for 1 (Resident #38) out of 2 residents reviewed for rehabilitation services.Finding includes:During an interview on 6/9/2026 at 8:24 AM Resident #38 stated , I want to know if I am going to have therapy today. The guy who does my physical therapy has been on vacation and I have not gotten therapy in weeks.Review of Resident #38 physician order dated 4/21/2026 read, PT [physical therapy] recertification order for PT TX [treatment] QD [everyday]1 X/WK [week] x 60 days for thera ex, thera activity, Gait training, PT. /CG ed. TX DX R53. 1 one time for 60 Days.Review of Resident #38 Service Log Matrix for the Month of May 2026 there is no documentation for 5/19/2026 visit.Review of Resident #38 Service Log Matrix for the Month of April 2026 there is no documentation for 4/14/2026 and 4/28/2026 visits.During an interview on 6/10/2026 at 10:18 AM with the Director of Therapy stated, He[Resident #38] did missed on April 14. There is no documentation. He is on the assignment board for functional maintenance. The therapist is in Thailand and cannot communicate with me to see what happen. For whatever reason if he [Resident #38] refused or not feeling well it is not documented. On April 28 he is on case load assignment board that the therapist gets daily. For whatever reason it is not documented why he did not receive the therapy session. It is Pro bono and been on it since last July 2024. On May 19 he is on the assignment board but no documentation of visit. He really doesn't like to get out of bed a lot that could be the reason. If we cannot do it on Tuesday we will move it a day. The therapist should have documented the reasons why therapy session was not completed that day.During an interview on 6/10/2026 at 11:25 AM with Staff B Licensed Practical Nurse (LPN) stated, He [Resident #38] is usually pretty go about going to therapy. He goes every Tuesday and he is pretty go about going. He has not verbalized that he has missed therapy. They are good at providing therapy to the residents.During an interview on 6/10/2026 at 2:44 PM with the Director of Therapy stated, I spoke to [Resident #38's name and he remembers being sick on those particular days that are missing.During an interview on 6/10/2026 at 2:47 PM Resident #38 stated he has missed therapy once or twice due to him not feeling well. Stated his therapist has been sick once and they send someone and then the other time he was sick and did not have therapy due to this.Review of the facility policy and procedure titled Documentation Requirements with a last review date of 1/22/2026 read, Policy: It is company policy that documentation of a resident's care will be maintained in a complete, timely and orderly fashion.