

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105743	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2025
NAME OF PROVIDER OR SUPPLIER Fleet Landing		STREET ADDRESS, CITY, STATE, ZIP CODE One Fleet Landing Blvd Atlantic Beach, FL 32233	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, staff and resident interviews, medical record review, and facility policy and procedure review, the facility failed to ensure that two (Residents #31 and #32) of two residents reviewed for activities of daily living (ADLs), from a total survey sample of 21 residents, received necessary services to maintain good grooming and hygiene, specifically fingernail care, when they were unable to complete ADLs independently. The findings include: 1. On 07/21/2025 at 11:40 am, Resident #31 was observed lying in bed. Her fingernails on both hands were elongated with brown debris under each of the nails. The resident was asked if she preferred her nails long. She stated, No, I like them trimmed. (Photographic evidence obtained) On 07/22/2025 at 8:30 am, Resident #31 was observed lying in bed with her eyes closed. She opened her eyes when she was greeted. Her fingernails were elongated with brown debris underneath. A review of Resident #31's Minimum Data Set (MDS) assessment, dated 04/14/2025, revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15 possible points, indicating moderate cognitive impairment. The resident was documented as dependent for self-care of personal hygiene. Further review of the MDS revealed that Resident #31 had no behaviors documented, including refusal of care. A review of Resident #31's person-centered care plan revealed: Focus: (12/31/24, revised 4/17/25) (Resident #31) has ADL self-care deficit performance related to dementia and other medical co-morbidities. Goal: (Resident #31) will maintain current level of function in ADLs through the review date. Interventions: Bathing/Showering: Check nail length and trim and clean on bath day and as necessary. Personal Hygiene: The resident requires supervision with personal hygiene. Resident #31 was not care-planned for behaviors or refusal of care. 2. On 07/21/2025 at 11:38 am, Resident #32 was observed sitting up at the side of his bed. His fingernails on both hands were untrimmed. His right ring fingernail and his left middle, ring, and pinky fingernails were jagged. All of his fingernails had brown debris under them. (Photographic evidence obtained) On 07/22/2025 at 8:28 am, Resident #32 was observed lying in bed with his eyes closed. He opened his eyes when he was greeted and sat up on the edge of the bed to eat his breakfast. Fingernails on both hands were untrimmed. His right ring fingernail and his left middle, ring, and pinky fingernails were jagged. All of his fingernails had brown debris under them. A review of Resident #32's MDS assessment, dated 04/07/2025, revealed a BIMS score of 2 out of 15 possible points, indicating severely impaired cognition. The resident was documented as requiring partial to moderate assistance for self-care and supervision or touching assistance for personal hygiene. No behaviors were documented, including refusal of care. A review of the resident's person-centered care plan revealed: Focus: (12/31/24) (Resident #32) has ADL self-care deficit performance related to dementia and other medical co-morbidities. Goal: (Resident #32) will maintain current level of function in ADLs through the review date. Interventions: Bathing/Showering: Check nail length and trim and clean on bath day and as necessary. Personal Hygiene: The resident requires supervision with personal hygiene. Resident #32 was not care-planned for behaviors or refusal of care. On 07/22/2025 at 2:30 pm, during an interview with Certified Nursing Assistant A, she was asked if she was caring for Residents #31 and #32. She replied, Yes. When she was asked who was responsible for cleaning and trimming the residents' fingernails, she replied that it was an Activities event. They do nails on Saturdays; they file and buff them. She was asked who trimmed the residents' (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fingernails. She replied, We, the CNAs are not allowed to do that. The nurses trim the nails. She was asked how she cleaned residents' fingernails. She stated, I don't like to use the orange sticks; I'll use a washcloth to try to clean under the nails. She was asked to observe Residents #31 and #32's fingernails. She observed both residents' fingernails and confirmed they both had debris under their nails. She stated some of Resident #32's fingernails were jagged and unkempt and Resident #31's fingernails were elongated with debris under the nails. Resident #31 was under hospice care. I think they try to clean her nails but sometimes she refuses. On 07/22/2025 at 2:40 pm during an interview with Licensed Practical Nurse (LPN) B, she was asked if she was caring for Residents #31 and #32. She stated she was. She was asked who was responsible for cleaning and trimming residents' fingernails. She stated, Well, mostly the nurses do fingernails when nails are observed to be long. The CNAs can't trim the diabetics' fingernails; only nursing can do those. Activities, I think, can file nails; I'm not sure if they can trim them. She was asked if there was a schedule for fingernail care. She stated, No, there's no schedule. She was asked to observe Residents #31 and #32's fingernails. She observed Resident #32's fingernails and confirmed that some of his nails were long and jagged with debris under them. She stated, They shouldn't be jagged because he could scratch his skin. She observed Resident #31's fingernails and confirmed that they were elongated with debris under them. LPN B stated, Sometimes she refuses to have them cut, so we try to file them. She was asked what nursing did if a resident refused to have personal care provided. She stated, We should document the behavior and let the doctor know. She was asked where she had documented this resident's refusal of fingernail care. She stated she had not documented it. She was asked which doctor she had notified. She stated she had not notified the doctor. On 07/22/2025 at 3:00 pm, during a second interview with LPN B, she stated, I found out that Activities staff can only file nails, they can't trim them. We don't have specific orders for fingernail care; we just check them as part of our regular care and assessment. Anyone, nurses and CNAs can file the nails, and they should be cleaned on shower days and also as needed, but trimming the fingernails is only nursing. She was asked how often Residents #31 and #32 were scheduled for showers. She replied, Twice a week. On 07/22/2025 at 3:10 pm during an interview with the Director of Nursing (DON), she was asked what the expectation was for residents' fingernail care, including cleaning under fingernails and trimming them. She stated this was a part of their daily hygiene. It's very important for staff to communicate with the residents for their needs. The bath expectation is three times a week, but they do refuse sometimes. Refusals should be documented. Nails should be cleaned and trimmed at that time, on shower days. She was asked who was permitted to trim and clean the residents' fingernails. She stated, The CNAs and the nurses, except CNAs cannot trim diabetics' fingernails. She was asked if a resident refused this care, was it documented. She stated it should be documented in their POC (plan of care) system, and they should be care planned for it. A review of the facility's policy and procedure titled Activities of Daily Living (ADLs) (Effective 3/1/23, Revised 5/21/25) revealed: Policy: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following ADLs: 1. Bathing, dressing, grooming, and oral care. Policy Explanation and Compliance Guidelines: 3. A resident who is unable to carry out ADLs will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, staff and resident interviews, medical record review, and facility policy and procedure review, the facility failed to ensure that the resident environment remained free of accident hazards for one (Resident #32) of two residents reviewed for accident hazards, from a total survey sample of 21 residents. The findings include: On 07/21/20 25 at 11:41am, a tube of Voltaren Arthritis Pain (diclofenac sodium) topical gel 1% was observed in the bathroom on a side table, next to the toilet of Resident #32. (Photographic evidence obtained) An interview was attempted with Resident #32 at that time; however, he was unable to answer any questions related to the Voltaren tube observed. On 07/21/2025 at 8:26 am, a tube of Voltaren Arthritis Pain (diclofenac sodium) topical gel 1% was observed in the bathroom on a side table, next to the toilet of Resident #32. (Photographic evidence obtained) On 07/22/2025 at 2:22 pm, Resident #32 was observed in his bathroom by himself. He stated he had just finished and was observed walking out of his bathroom by himself to his bed. A tube of Voltaren Arthritis Pain (diclofenac sodium) topical gel 1% was observed in the bathroom on a side table. (Photographic evidence obtained) A review of Resident #32's medical record revealed diagnoses including unspecified dementia and unspecified glaucoma. A review of the quarterly Minimum Data Set (MDS) assessment, dated 04/07/2025, revealed that Resident #32 had a Brief Interview for Mental Status (BIMS) score of 2 out of 15 possible points, indicating severely impaired cognitive function. A review of Resident #32's active physician's orders revealed no order for Voltaren Arthritis Pain (diclofenac sodium) topical gel 1%. The tube observed in his bathroom had an expiration date of August 2023. A review of the resident-centered care plan revealed: Focus: (12/31/24) (Resident #32) has impaired cognitive function/dementia or impaired thought processes. Goal: (Resident #32) will be able to communicate basic needs on a daily basis through the review date. Interventions: The resident needs assistance with all decision making. Focus (1/9/25) (Resident #32) has impaired visual function related to Glaucoma. Goal: (Resident #32) will maintain optimal quality of life within limitations imposed by visual function through the review date. Interventions: Tell the resident where you are placing their items; be consistent. The resident is able to see objects in the room. On 07/22/2025 at 2:30 pm during an interview with Certified Nursing Assistant (CNA) A, she was asked if she was caring for Resident #32. She replied that she was. She was asked if he was expected to be in the bathroom by himself. She stated, No, he should have staff with him. She was asked about the tube of Volteran gel in his bathroom which was observed during this interview. She stated, Oh, I think their niece brought that in when they moved here. She was asked who applied the gel to the resident. She stated, I don't know, I've never used it. On 07/22/2025 at 2:40 pm during an interview with Licensed Practical Nurse (LPN) B, she was asked if she was caring for Resident #32. She replied that she was. She was asked if she knew whose tube of Volteran gel was in Resident #32's bathroom, which was observed in the bathroom during this interview. She stated, I'm not sure. I don't think either he or his wife have an order for that. They have a niece. She may have brought it in. She was asked if it should be in the bathroom unattended. She stated, No, it should be labeled and kept locked in the treatment cart. She picked the tube up and stated, It's old. The expiration date is August 2023. I didn't even see it there, and I filled up their briefs in their bathroom this morning. On 07/22/2025 at 3:10 pm during an interview with the Director of Nursing (DON), she was asked what the expectation was for medications being stored in residents' rooms/bathrooms. She stated, They are not allowed to have medication in rooms unless they have an order for self-medication. She was asked if Resident #32 had orders for self-administration of medication. She said no. She was asked if she was aware that there was a tube of Volteran gel in Resident #32's bathroom. She stated it should not have been there. We are going to issue a memo about families bringing in things like that and even cough drops. We have been checking rooms recently for these things. A review of a facility's policy and procedure titled Medication Storage (Effective 03/01/2023, Revised 05/01/2025) revealed: It is (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturers' recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms.)		