STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105756	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Hilliard	3756 W Third St Hilliard, FL 32046

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 - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on food service observations, staff interviews, and a review of the facility's policies and procedures, the facility failed to follow proper sanitation and food handling practices to prevent the outbreak of foodborne illness, by failing to ensure food items were properly labeled and dated in the main kitchen. This deficient practice prevents staff from determining the appropriate use by date and increases the risk of pathogen exposure to all residents who consume foods from the facility's kitchen.The findings include:On 04/20/2026 at 10:33 AM, an observation of the dry storage room revealed one opened box of cabbage, one opened box of zucchini, one opened box of potatoes, one opened box of sweet potatoes, one opened box of bananas, one open crate of onions, and one opened bag of pasta with no label or date. Observations of the reach-in freezer in the cook area revealed one opened bag of French fries, one opened bag of cauliflower, and one opened bag of biscuits with no labels or dates. (photographic evidence obtained)On 04/22/2026 at 11:19 AM, another observation of the dry storage room revealed the same opened boxes of potatoes, sweet potatoes, bananas, crate of onions, and bag of pasta with no labels or dates. The same observations were made of the reach-in freezer in the cook area of one opened bag of French fries, one opened bag of cauliflower, and one opened bag of biscuits with no labels or dates. (photographic evidence obtained)On 04/23/2026 at 1:21 PM, an interview with Dietary Aide G revealed that food items taken out/opened but not completely used, were to be put back, dated and discarded after three days of the written date.On 04/23/2026 at 1:28 PM, an interview with Dietary Aide H revealed that the facility's procedure for date marking food entailed sealing used items, dating them for two days, and after two days the items were discarded.On 4/23/2026 at 1:33 PM, an interview with [NAME] I revealed that when a food item was used and placed back where it came from without a date, it had to be discarded because the staff did not know when the item was opened or how long it had been sitting there.On 04/23/2026 at 1:41 PM, during an interview with Certified Dietary Manager (CDM) J, he confirmed that all dietary staff were responsible for dating and labelling food items. He stated when items were received, they were marked with the date received. Once opened, used or unused products that were placed back in the dry storage, refrigerator or freezer should have an open date and a use-by date that was two days after the opened date. Perishable items should have the use-by date indicating two days after the opened date, and should be discarded on the third day. Reference: FDA Food Code 2022. https://www.fda.gov/media/184685/download?attachment; (Accessed on 4/21/2026) Annex 5 - C. Intervention Strategies for Achieving Long-term Compliance. 4. Establish First-In-First-Out (FIFO) Procedures. Page 555. Product rotation is important for both quality and safety reasons. First-In-First Out (FIFO) means that the first batch of product prepared and placed in storage should be the first one sold or used. Date marking foods as required by the Food Code facilitates the use of a FIFO procedure in refrigerated, ready-to-eat, TCS foods. The FIFO concept limits the potential for pathogen growth, encourages product rotation, and documents compliance with time/temperature requirements. A review of the facility's policy and procedure titled Food Safety and Sanitation (dated 2023), revealed:Food is stored and maintained in a clean, safe and sanitary manner following federal, state and local guidelines to minimize contamination and bacterial growth. Receiving: .5 The First In, First (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Out (FIFO) method is used in food storage or according to state regulation. 6 Food is labeled with the date received if not already indicated on the item. Dry Storage: .2 Opened packages of food are resealed tightly to prevent contamination of the food item and ?use by date' will be used when applicable. 8. Foods not safe for consumption or the safety of the food is in question will be removed from storage.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, interviews, and a review of the facility's policies and procedures, the facility failed to provide transfer/discharge notification to the Long-Term Care (LTC) Ombudsman's office for seven (Residents #129, #127, #48, #8, #91, #98 and #135) of 21 residents reviewed for transfer/discharge. Appropriate notification to the LTC Ombudsman's office provides added protection to residents from being inappropriately transferred or discharged . It provides residents with access to an advocate who can inform them of their options and rights, and it ensures that the LTC Ombudsman's office is aware of facility practices and activities related to transfers and discharges. The findings include:1.A review of Resident #129's medical record revealed an admission date of 02/26/2026 with diagnoses including fracture of the superior rim of the right pubis, subsequent encounter for fracture healing.A review of the resident's active care plans revealed a focus area indicating a short stay with a discharge plan to return home with her spouse once her rehabilitation was completed (03/06/2026).A review of the progress notes revealed that Resident #129 had a planned discharge home on [DATE].A review of the Minimum Data Set (MDS) dated [DATE] revealed a Discharge/Return Not Anticipated assessment was completed.Further review of the record revealed that the facility completed a discharge summary, recapitulation, and discharge disposition on 03/20/2026. Resident #129's electronic medical record (EMR) did not contain a Nursing Home Transfer/Discharge Notice (CMS (Centers for Medicare and Medicaid Services) Form 3120) or evidence of notification of the LTC Ombudsman's office.2.A review of Resident #127's medical record revealed an admission date of 01/28/2026 with diagnoses including unspecified Intracranial Injury without loss of consciousness. The resident was transferred on 03/13/2026 to an acute care hospital for evaluation. The EMR did not contain a Nursing Home Transfer/Discharge Notice (CMS Form 3120) or evidence of notification of the LTC Ombudsman's office.3.A review of Resident #48's medical record revealed an admission date of 12/04/2025 with diagnoses including metabolic encephalopathy. The resident was transferred to an acute care hospital for evaluation on 03/27/2026. The EMR did not contain a Nursing Home Transfer/Discharge Notice (CMS Form 3120) or evidence of notification of the LTC Ombudsman's office.4.A review of Resident #8's medical record revealed an admission date of 08/26/2025 with diagnoses including hemiplegia (total to near total paralysis) and hemiparesis (muscular weakness) following cerebral infarction (stroke) affecting the resident's left non-dominant side. Resident #8 was transferred to an acute care hospital for evaluation on 03/22/2026. The EMR did not contain a Nursing Home Transfer/Discharge Notice (CMS Form 3120) or evidence of notification of the LTC Ombudsman's office.5.A review of Resident #91's medical record revealed an admission date of 12/08/2025 with diagnoses including sepsis (systemic infection). Resident #91 was transferred to an acute care hospital for evaluation on 03/20/2026. The EMR did not contain the Nursing Home Transfer/Discharge Notice (CMS Form 3120) or evidence of notification of the LTC Ombudsman's office.6.A review of Resident #98's medical record revealed an admission date of 07/18/2025 with diagnoses including congestive heart failure (CHF). Resident #98 was transferred to an acute care hospital for evaluation on 03/03/2026. The EMR did not contain a Nursing Home Transfer/Discharge Notice (CMS Form 3120) or evidence of notification of the LTC Ombudsman's office.7.A review of Resident #135's medical record revealed an admission date of 02/13/2026 with diagnoses including nonrheumatic aortic valve stenosis. The resident was discharged home on [DATE]. The EMR did not contain the Nursing Home Transfer/Discharge Notice (CMS Form 3120) or evidence of notification of the LTC Ombudsman's office.On 04/22/2026 at 1:33 PM, an interview was conducted with the Administrator. She was asked who was responsible for sending the Nursing Home Transfer/Discharge Notice (CMS Form 3120) to the LTC Ombudsman's office when a resident was transferred or discharged . She stated the responsibility fell on the Social Services Director. She was (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	asked how often the LTC Ombudsman's office was notified of facility transfers/discharges. She stated, I'm not sure about that; I'll need to get back to you.On 04/22/2026 at 1:43 PM, an interview was conducted with Social Services Director (SSD) D, who confirmed that the LTC Ombudsman's office was notified of transferred/discharged residents monthly by the end of the month via certified mail. She confirmed that she had not sent the transfer/discharge notices to the LTC Ombudsman's office for the month of March 2026. She explained that the facility's Case Manager usually mailed the notices to the LTC Ombudsman's office monthly, but that she had not been employed by the facility since February 2026, and furthermore, she was unaware of where the certified mail receipts were kept. She was asked if she had knowledge of the regulation concerning transfer/discharge notification to the LTC Ombudsman's office. She replied, Not off the top of my head. She was asked where the transfer/discharge notifications were stored after the residents were discharged . She confirmed that copies of the notices were kept in her office in a file. She was asked to provide the files for review.On 04/22/2026 at 3:05 PM, the Administrator provided the Nursing Home Transfer and Discharge Notices (CMS Form 3120) for 21 residents who were discharged /transferred in March 2026. Resident #129 was not included. The Administrator confirmed that she had emailed the nursing home transfer/discharge notices for March 2026 to the LTC Ombudsman's office on 04/22/2026 (the date of this interview).On 04/22/2026 at 4:48 PM, an email was received from the LTC Ombudsman confirming that their office had not received any transfer/discharge notices from this facility for March 2026 until today, 04/22/2026.A review of the facility's policy and procedure titled Notice of Transfers and Discharges (revised 02/17/2026), revealed:The facility will notify the resident and the resident's representative(s), and Office of the State Long-Term Care (LTC) Ombudsman of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. This written notification from the facility includes the following:4. The facility must maintain evidence that the notice was sent to the Ombudsman. While Ombudsman Programs vary from state to state, facilities should know the process for Ombudsman notification in their state. 6. For any other types of discharges, the facility must provide notice of discharge to the resident and resident representative along with a copy of the notice of the State LTC Ombudsman at least 30 days prior to discharge or as soon as possible. The copy of the notice must be sent at the same time notice is provided to the resident and or the resident representative.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, record reviews, interviews and a review of facility policies and procedures, the facility failed to ensure that residents who needed respiratory care, were provided such care, consistent with professional standards of practice, by failing to ensure that oxygen was administered at the ordered flow rate for four (Residents #95, #115, #119 and #6) of 10 residents reviewed for oxygen therapy. The findings include: 1.On 04/20/2026 at 1:10 PM, an observation of Resident #95's oxygen concentrator revealed an oxygen flow rate of 3 liters per minute (LPM). (photographic evidence obtained) On 04/22/2026 at 10:09 AM, another observation was made of Resident #95 in her wheelchair receiving oxygen from a portable oxygen tank at a flow rate of 3 LPM. (photographic evidence obtained) A review of Resident #95's medical record revealed an admission date of 03/29/2026 with diagnoses including chronic obstructive pulmonary disease (COPD) and shortness of breath (SOB). A review of the resident's Comprehensive Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 possible points, indicating moderate cognitive impairment. On 04/22/2026 at 10:05 AM, an interview with Resident #95 revealed she was not aware of what her oxygen flow rate setting should be. A review of the resident's active care plans revealed a focus area for Shortness of Breath related to COPD. The care plan interventions included: Oxygen at 1 LPM via nasal cannula as needed for shortness of breath. A review of the physician's orders revealed an active order for oxygen at 1 LPM per nasal cannula, as needed, with a start date of 3/30/2026. On 04/23/2026 at 10:46 AM, in an interview with Licensed Practical Nurse (LPN) K, she stated Resident #95's oxygen flow rate was ordered for 2 LPM as of 04/23/2026 and stated it was the responsibility of the certified nursing assistant (CNA) to report oxygen flow rate settings to the nurse; only a nurse could adjust oxygen flow rate settings. LPN K stated if the physician's orders for PRN (as needed) oxygen settings did not contain parameters, oxygen was to be administered when a resident was experiencing shortness of breath, or when oxygen saturation levels were below 90%. 2.On 04/21/2026 at 10:18 AM, Resident #115 was observed lying in bed wearing her nasal cannula with oxygen infusing at 2.5 LPM. (photographic evidence obtained) A review of Resident #115's medical record revealed an active oxygen order for oxygen at 2 LPM continuously via nasal cannula. Further review of the record revealed the most recent admission date of 10/08/2025 with an initial admission date on 05/14/2021. Resident #115's diagnoses included emphysema and heart failure. A review of the resident's Annual MDS assessment, dated 02/12/2026, revealed that Resident #115 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	received oxygen therapy and had a BIMS score of 3 out of 15 possible points, indicating severe cognitive impairment. A review of Resident #115's active care plans revealed a focus area for Risk for Complications with Breathing/Wheezing related to heart failure, emphysema and seasonal allergic rhinitis. Another focus area for History of Pneumonia with continuous oxygen ordered at 2 LPM via nasal cannula related to emphysema was noted. 3.On 04/20/2026 at 12:41 PM, Resident #119 was observed sitting in bed wearing her nasal cannula with oxygen infusing at 3 LPM. (photographic evidence obtained) On 04/21/2026 at 10:41 AM, Resident #119 was observed lying in bed with her oxygen running at a flow rate of 1.5 LPM. She was not wearing her nasal cannula. At 12:38 PM, she was observed sitting up in bed. She was not wearing her nasal cannula and stated, I take it out sometimes. (photographic evidence obtained) On 04/22/2026 at 2:29 PM, Resident #119 was observed lying in bed removing her nasal cannula. Her oxygen was running at a flow rate of 1.5 LPM. (photographic evidence obtained) On 04/23/2026 at 8:54 AM, Resident #119 was observed in bed with her nasal cannula hanging from her right ear (not positioned in her nose). The oxygen concentrator was running. When she was asked if she removed her nasal cannula herself, she replied, yes. When she was asked if nursing was aware that she was removing her nasal cannula, she replied, yes. A review of the resident's active physician's orders revealed an order for oxygen at 2 LPM via nasal cannula as needed (1/20/2026). A review of the resident's medical record revealed the most recent admission date of 09/22/2025 with an initial admission date of 10/08/2022. The resident's diagnoses included chronic congestive heart failure (CHF). A review of the Quarterly MDS assessment, dated 03/13/2026, revealed the resident received oxygen therapy and had a BIMS score of 3 out of 15 possible points, indicating severe cognitive impairment. A review of the active care plans revealed focus areas for Risk for Shortness of Breath related to CHF and anemia. Interventions included administration of oxygen at 2 LPM as needed for shortness of breath. On 04/23/2026 at 9:55 AM, RN K observed Resident #119 with her nasal cannula hanging from her ear and asked the resident, May I put your oxygen back on? Resident #119 agreed and RN K placed the nasal cannula back in her nose and exited the room without verifying the oxygen flow rate. RN K was accompanied to her medication cart, and she confirmed that Resident #119's oxygen flow rate was ordered at 2 LPM via nasal cannula as needed. She stated nursing provided ongoing monitoring of residents' oxygen therapy and ensured residents received oxygen at the flow rates ordered by their physicians'. Correct oxygen flow rate settings were identified by reviewing the physicians' orders and were communicated from one nurse to the next during change-of-shift report. When RN K was asked if Resident #119 made changes to her own oxygen flow rate, RN K replied, No, she is not able to, but she is able to take off the nasal cannula at times. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/16/2026 at 2:37 PM, a Health Status note revealed that Resident #119 was reviewed in an Interdisciplinary Team meeting. Resident continues to use oxygen of 2 liters via nasal cannula as needed and nebulizer treatments as needed due to the diagnosis of shortness of breath/cough/congestion. The resident's Medication Administration Record for April 2026 identified oxygen was provided as ordered by the physician. 4.On 04/20/2026 at 10:50 AM, Resident #6 was observed in bed with oxygen infusing at 3 LPM via nasal cannula. (photographic evidence obtained) When he was asked if he knew what his flow rate should be, he replied, Two liters. A review of the resident's medical record revealed an active physician's order dated 10/10/2025 for oxygen at 2 LPM via nasal cannula as needed for shortness of breath related to Chronic Obstructive Pulmonary Disease (COPD). On 04/21/2026 at 10:16 AM, the resident was observed with oxygen infusing at 3 LPM via nasal cannula. (photographic evidence obtained) On 04/21/2026 at 10:21 AM, Licensed Practical Nurse (LPN) A was observed standing at the doorway of the resident's room with her medication cart, preparing medication. She was asked to verify the resident's oxygen flow rate, and she stated, 3 LPM. She was asked to check the resident's physician's order for oxygen. After reviewing the physician's order, she stated the resident was supposed to be receiving oxygen at 2 LPM via nasal cannula as needed for shortness of breath. A review of Resident #6's medical record revealed an admission date of 11/25/2023 with diagnosis including Chronic Obstructive Pulmonary Disease (COPD). A review of the Quarterly MDS assessment with an assessment reference date (ARD) of 04/02/2026, revealed a BIMS score of 15 out of 15 possible points, indicating intact cognition. The MDS revealed the resident exhibited shortness of breath (SOB) with exertion and received oxygen therapy. A review of the resident's care plans revealed a focus area for Risk for Shortness of Breath related to Congestive Heart Failure (CHF), Anemia and COPD as of 10/23/2025. Care plan Interventions included oxygen at 2LPM via nasal cannula as needed for shortness of breath (04/09/2025). On 04/22/2026 at 10:32 AM further review of the resident's medical record revealed that the Nurse Practitioner was notified on 04/21/2026 at 11:55 AM of the resident's current oxygen flow rate and no new orders were received. The resident was to continue on 2 LPM as needed (PRN). A review of the facility's policy and procedure titled Oxygen Administration (Infection Control, Safety, & Storage) (Revised 03/03/2026), revealed: Policy: To ensure oxygen is administered and stored safely within the facility or in an outside storage area.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews, record review ,and a review of the facility's policies and procedures, the facility failed to ensure that its medication error rate was not 5% or greater. There were 26 opportunities for error with two errors identified, resulting in an error rate of 7% and involving two (Residents #6 and #99) of five residents observed during medication administration.The findings include:On 04/21/2026 at 11:13 AM, Licensed Practical Nurse (LPN) A was observed preparing medications for Resident #6. She administered Refresh Tears Ophthalmic Solution, 1 drop in each eye. She was asked to compare the current physician's order with the dose she had just administered. She confirmed the current order was for Refresh Tears Ophthalmic Solution, instill 2 drops in each eye.On 04/22/2026 at 10:13 AM, Registered Nurse (RN) F was observed preparing medications for Resident #99. She prepared Sertraline Hydrochloride (HCL)100 milligram (mg), 1 tablet. She was asked to compare the dose she prepared with the current physician's order. She confirmed that the order was written for Sertraline HCL 100 mg, 2 tablets. A review of the facility's policy and procedure titled Administration of Medications (revised 02/13/2023, reviewed 09/09/2025), revealed:Policy:The facility will ensure medications are administered safely and appropriately per physician's order to address residents' diagnoses and signs and symptoms.Medication Error:This means the observed or identified preparation or administration of medications or biologicals which is not in accordance with:The prescriber's order.