STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105793	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Oaks Nursing and Rehab Center	2225 Knox McRae Dr Titusville, FL 32780

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, and interview, the facility failed to provide a homelike environment for all residents who ate their meals in the west wing dining area, by serving the resident's meals on serving trays at the table in an institutional manner.Findings:On 2/22/26 at 12:56 PM, during meal observation on the west wing, 5 residents were observed seated at the tables in the dining area. Each resident was noted to have a serving tray on the table in front of them which contained the lunch meal. The plates, cups, bowls and eating utensils remained on the tray and were not removed from the tray at the table.On 2/23/26 at 1:00 PM, during meal observation on the west wing, 7 residents were observed seated in the dining areas. Staff were observed as they served meals to residents on serving trays. Staff placed the trays on the table in front of each resident but did not remove items from the tray. A family member visiting one of the residents in the room was observed as she removed the items from the serving tray in front of the resident and placed them on the table in front of the resident. Staff continued with meal service and did not remove items from any of the serving trays. On 2/24/26 at 12:49 PM, during meal observation on the west wing, 4 residents were seated in the dining area. Three different staff members were observed as they served the lunch meal on serving trays. The trays were placed on the table in front of each resident but items were not removed from the tray. On 2/24/26 at 1:00 PM, the Administrator was rounding on the west wing and observed the residents and staff in the dining area. He agreed the items on the trays should have been removed and placed on the table in front of the residents. He stated they talked about it a couple of weeks ago but it had obviously not been followed. The Administrator explained it was his expectation that staff provide a home-like environment for residents eating in each dining area. The facility was unable to provide a policy regarding homelike environment in facility dining areas.

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to conduct medication self-administration assessment to ensure safety for 3 of 5 residents reviewed for choices out of a total sample of 34 residents, (#31, #55, #75).Findings 1Resident #31 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, dementia, congestive heart failure and chronic kidney disease.Review of the medical record showed the Minimum Data Set (MDS) Quarterly assessment with assessment reference date (ARD) of 1/16/26 revealed resident # 31 had a Brief Interview for Mental Status (BIMS) Score of 14 out of 15 which indicated she was cognitively intact. The MDS also revealed that the resident's vision was adequate and she wore corrective lenses.Physician's orders included Refresh Tears Ophthalmic Solution 0.5 % (Carboxymethylcellulose Sodium (Ophthalmic)) and nurses were directed to instill 2 drops in both eyes two times a day for dry eyes.On 2/22/26 at 12:19 PM, resident #31 was observed in bed, pleasant, alert and oriented. There were three boxes of artificial tears on her bedside table, and she said she applied it by herself twice a day.On 2/22/26 at 12:21 PM, the assigned nurse LPN A was made aware of artificial tears eyedrops found at resident's bedside and she immediately removed the bottles and placed them on the medication cart to review. She acknowledged that there were no orders for self-administration of the eyedrops nor was the self-administration assessment done on resident #31. LPN A said she did not notice the eyedrops on the bedside table and that she worked weekends and was not aware of the resident self-administering the eyedrops.Findings 2Resident #55 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus, unspecified asthma, primary open angle glaucoma, left eye severe stage, primary open angle glaucoma right eye moderate stage, dry eye syndrome of bilateral lacrimal glands.Review of the medical record showed the Minimum Data Set (MDS) Quarterly assessment with assessment reference date (ARD) of 12/3/25 revealed resident #55 had a Brief Interview for Mental Status (BIMS) Score of 15 out of 15 which indicated she was cognitively intact. The MDS also revealed that the resident's vision was impaired and she wore corrective lenses.Resident #55's plan of care revealed that she had impaired vision function related to glaucoma, blind in left eye with appropriate interventions to maintain optimal quality of life within limitation imposed by visual function.Physican's orders for eyedrops included Combigan Ophthalmic Solution 0.2-0.5 % (Brimonidine Tartrate-Timolol Maleate) and nurses were directed to instill 1 drop in right eye one time a day; cyclosporine ophthalmic Emulsion 0.05 % (Cyclosporine (Ophthalmic)) and nurses were directed to instill 1 drop in both eyes two times a day; Lumigan Ophthalmic Solution 0.01 % (Bimatoprost) and nurses were directed to instill 1 drop in right eye in the evening and wait 5mins between each eye drop administration. There was also a physician's order for Fluticasone Propionate Nasal Suspension 50 MCG/ACT (Fluticasone Propionate (Nasal)) 1 dose in each nostril as needed for allergic rhinitis daily as needed.On 2/22/26 at 12:12 PM, resident #55 was observed in her wheelchair and was alert and oriented. There was a bottle of cyclosporine eye drops, and a bottle of fluticasone nasal spray found on her bedside table. The resident said she administered eye drops twice daily and the nasal spray as needed by herself. The assigned nurse LPN A verified the eye drops, and the nasal spray was from the facility's pharmacy Omnicare by the label. She acknowledged that the medications could not have been brought in by the family. LPN A also acknowledged there were no orders nor assessments for the resident to self-administer medications and she removed them from the bedside table and placed them in the medication cart. Again, she said she had not noticed them before.Findings 3Resident #75 was admitted to the facility on [DATE] with diagnoses that included parkinsonism, chronic pain, Bell's Palsy, cortical age-related cataract bilateral and major depressive disorder.Review of the medical record showed the Minimum Data Set (MDS) Annual assessment with assessment reference date (ARD) of 11/20/25 revealed resident #75 had a Brief Interview for Mental Status (BIMS) Score of 15 out of 15 which indicated she was cognitively intact. The MDS also (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed that the resident's vision was adequate and she wore corrective lenses.On 2/22/26 at 12:49 PM, resident #75 was up in bed, alert and oriented. There was a bottle of Normal Saline nasal spray on her bedside table. Resident #75 said that she used the nasal spray whenever she felt congested and it helped her. The dates on the bottle showed it was opened on November 2025 with an expiration date of February 2026. The assigned nurse LPN A was made aware, verified the expiration dates and removed it from the resident. LPN A also confirmed there were no physician's orders for the nasal spray and acknowledged there was no assessment for self-administration of medications for resident #75. LPN A said she was not aware of resident #75 using the nasal spray ad did not notice it on her bedside table.On 2/22/26 at 1:00 PM, the East Wing Unit Manager was made aware of the three residents who were self-administering ophthalmic and nasal medications, and he explained that in order for residents to self-administer medications, they needed an assessment and physician orders to do so. He acknowledged that eyedrops and nasal sprays should not have been left at the bedside for residents to self-administer without the proper orders and assessments.On 2/24/26 at 3:20 PM, the director of nursing said that her expectation was not to have medications at the bedside for residents to self-administer unless they have that assessment done.The facility's policy on Self Administration of Medication revised August 2023, states To allow the resident and or legal representative of the resident the right to self-administer medication when it has been deemed by the interdisciplinary team that it is clinically appropriate. The resident may only self-administer medications after the interdisciplinary team has determined which medications may be self-administered.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement resident-directed care and treatment consistent with the resident's physician orders for removal of a central venous catheter for 1 of 2 residents reviewed for intravenous lines and for 1 of 2 residents reviewed for limited range of motion, of a total sample of 34 residents, (#6,#70).Findings: 1.On 2/22/26 at 11:43 AM resident #6 was observed sitting in her wheelchair in her room. Resident was noted to have a single lumen midline to her right upper arm with a date of 2/20/26 on the dressing. Resident #6 was admitted to the facility on [DATE] with diagnoses including dislocation of internal right hip prosthesis, infection following a procedure, and non-pressure chronic ulcer. Review of Infectious Disease note 2/20/26 revealed that on 2/3/26 the resident was assessed and her left buttocks wound was noted to be red and a foul smell. An order was given for culture and sensitivity of left buttock wound which was positive for Proteus mirabilis Extended-Spectrum Beta-Lactamases (ESBL). ESBL are enzymes produced by certain bacteria that make them resistant to a variety of commonly used antibiotics (retrieved on 2/27/26 https://www.cdc.gov/esbl-producing-enterobacterales/about/index.html). She was then started on Meropenem 500 milligrams (mg) every 8 hours for 7 days intravenously. On 2/16/26, the order was given to discontinue the intravenous line. Further review of the note, revealed on 2/19/26 Infectious Disease gave another order to discontinue the intravenous line since the resident was no longer receiving intravenous antibiotics and was instead on oral antibiotics, Review of a progress note on 2/16/26 revealed that the Infectious Disease Nurse Practitioner was at facility and gave an order to discontinue the midline IV as antibiotic therapy was completed. A review of physician orders revealed no order to remove the midline from 2/16/26 Review of physician orders revealed an order on 2/20/26 to remove midline IV with a completed date of 2/21/26 at 3:59 PM. Review of the electronic treatment administration record (ETAR) revealed no documentation for 2/20/26 and 2/21/26. On 2/22/26 at 11:50 AM, Weekend Supervisor A acknowledged that resident #6's midline was still in place and had not been removed. She stated that on 2/20/26 she attempted to remove the resident's midline, but the resident was unavailable as she was in therapy. Weekend Supervisor A assumed the next shift would remove the midline. Review of resident #6's therapy scheduled for the month of February revealed that on 2/20/26 the resident had 45 minutes of Physical Therapy (PT) and 30 minutes of Occupational Therapy (OT). On 2/21/26, the resident received no therapy services On 2/25/26 at 10:27 AM, the Director of Nursing (DON) acknowledged that a resident being in therapy was not an excuse for not removing the midline. If the resident was unavailable during day shift, the expectation would be for the following shift to remove the midline. She also verified that the expectation is that when the physician gives an order it should be followed. The DON did not have an explanation as to why the nurse who received the order to remove the midline on the 16th did not add (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	it to the resident's order sheet. 2.Resident #70 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, aphasia following cerebral infarction and unspecified dementia. Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed resident #70 was cognitively impaired with a brief interview for mental status score (BIMS) of 3 out of 15 and she also had impairment on one side of her upper extremity. Physician orders included a resting hand splint to right wrist/hand to patient's tolerance to promote skin/joint integrity. Review of resident #70's plan of care showed that the resident had alteration in musculoskeletal status cerebral vascular accident with right sides weakness initiated 9/23/24 and interventions included resting hand splint to right wrist/hand to patient tolerance to promote skin/joint integrity initiated on 11/12/24. On 2/23/24 at 10:30 AM, resident #70 was observed without the splint on her right hand. On 2/22/26 at 1:30 PM, resident #70 was observed sitting up in her wheelchair in the East Wing common area and she was not wearing a splint. Her daughter and son-in-law were visiting at the time and were asked if the resident wore a splint on her right hand. They explained that they rarely saw her with it on. They continued to explain that they had inquired about it as well as the possibility of her starting therapy again but had not heard anything back. On 2/24/26 at 3:38 PM, the Rehab Director said that resident #70 was referred to therapy by nursing yesterday and would now be on services. She said that the evaluation is still in progress. The Rehab Director explained that the last time the resident was on their services was 10/21/25 and had received restorative services but was no longer on it. She verified the order for the right resting hand splint to patient tolerance. She explained that they provided education to the staff regarding the schedule, how to apply the splint, and that it helped to maintain skin/joint integrity. She continued to explain that once the resident is off from services, nursing is responsible for applying the splint/brace and that the Unit Manager (UM) would oversee it. The Rehab Director could not answer why the order was not seen on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR). On 2/24/26 4:10 PM, the assigned Certified Nursing Assistant (CNA) C said that resident #70 refused the splint at times, and that she did not like to wear it. On 2/24/26 at 4:25 PM, the East Wing UM verified the order for the splint and stated that the CNAs would apply the splint. He confirmed that the order was not on resident #70's TAR nor was it shown on the CNAs tasks in Point of Care (POC). The only place it was found was on the resident's Kardex (which is used by the CNA). He stated there could have been an error when the order was entered because the order did not specify a time of day or for how long the brace should be applied. When he was asked about resident's refusal to wear the splint and where that would be documented, he confirmed there was no refusal documented. On 2/25/26 at 11:57 AM, the Director of Nursing said that the expectation would be that physician orders were followed and that the order for the splint should have been on the TAR so that nurses could check it off as applied or not. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Physician Orders revised 8/2023 states that orders given by a physician and accepted by a licensed nurse should be documented on the physician order sheet, and physician's orders are obtained to provide a clear direction in the care of the resident.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to supervise a catheter drainage bag per infection control standards, to prevent contamination and the spread of infection for 1 of 1 resident reviewed for a bladder catheter of a sample of 34 residents. Findings:Resident #14 was admitted to the facility 1/30/26 with diagnoses of congestive heart failure, atrial fibrillation, urinary retention, peripheral vascular disease, right femoral embolism, & chronic kidney disease. On 2/22/26 at 10:35 AM, resident #14 was asleep in his chair, his catheter bag on the ground. At 12:12 PM he sat in his chair, and the urine collection bag was on the floor. The Quarterly Minimum Data Set (MDS) dated [DATE], revealed that resident #14 was cognitively intact, used a walker with minimal supervision, and needed moderate assistance for activities of daily living. The resident's care plan from 12/20/25 contained a goal of decreased risk of signs and symptoms of a urinary tract infection (UTI) and other complications related to the catheter. One of the interventions was position or secure tubing to prevent traumatic removal. On 2/22/26 at 12:15 PM, Unit Manager Nurse B commented that the drainage bag should be hooked to the chair. She put on gloves, picked the bag off the ground, and attached it to the resident's wheelchair. The LPN added that the bag should not be on the ground due to infection control. On 2/24/26 at 12:28 PM, CNA F stated that a catheter bag should be hung underneath the bottom of a chair, or a rail. If she saw a drainage bag on the ground, for the sake of infection control, she would pick it up and hang it. On 2/24/26 at 12:42 PM, LPN E remarked she would wear gloves, pick a urine bag up off the ground, hang it up, and make sure it had a privacy bag. She said it does not belong on the ground due to contamination. On 2/24/26 at 1:40 PM, the Director of Nursing (DON) explained that a catheter bag should be placed below bladder level and hung from the bed or wheelchair. She concluded it should not be on the floor, and if there were no place to hang it then it should be moved into a basin. Review of the Catheter Care and Services policy revised 6/2024 read, the intent for the center [is] to ensure that a resident receives the appropriate care. to prevent urinary tract infections. It also stipulated, Do not rest the catheter bag on the floor.