

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105805	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Radiant Nursing and Rehab at Palatka		STREET ADDRESS, CITY, STATE, ZIP CODE 501 S Palm Ave Palatka, FL 32177	
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 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, record review, and interview the facility failed to ensure a physician's order was obtained to administer oxygen therapy per standard of practice for 1 of 3 residents, Resident #12, reviewed for respiratory care. Findings include: Review of Resident #12's clinical record documented an admission date of 5/3/2026 with diagnosis including but not limited to chronic obstructive pulmonary disease (block airflow in the lungs), heart failure (failure of heart to pump blood), and dependence on supplemental oxygen, During an observation on 6/15/2026 at 11:49 AM Resident #12 was lying in bed with oxygen being administered at 4 liter/minute via nasal cannula. During an interview on 6/15/2026 at 11:49 AM Resident #12 stated, I don't know the rate. I think it [oxygen] should be at 2 [liter/minute]. Review of the physician orders for Resident #12 documents no orders for oxygen. Review of the MDS (Minimum data set) dated 5/8/2026 section O- C1. A. On admission Oxygen therapy, Yes and B while a resident, yes. Review of Resident #12's care plan read, The resident has oxygen therapy related to ineffective gas exchange. Give medications as ordered by physician. During an interview on 6/16/2026 at 1:58 PM the Director of Nursing (DON) stated, She [Resident #12] is on oxygen. I don't know why there is no order. During the interview the DON reviewed Resident #12's physician orders and verified there is no order for oxygen in the record. The DON stated, The physician orders have to be written and followed. Review of the policy and procedure titled Documentation of Medication Administration with a last review date of 1/6/2026 read, Policy Statement: A medication administration record is used to document all medications administered. Policy Interpretation and Implementation: 1. A nurse or certified medication aide (where applicable) documents all medications administered to each resident on the resident's medication administration record (MAR). 3. Documentation of medication administration includes, as a minimum: h. resident response to the medication, if applicable (e.g., PRN, pain medication, etc.) Review of the policy and procedure titled Oxygen Administration and Documentation Policy and Procedure with a last review date of 1/6/2026 read, Purpose: To establish guidelines for the safe administration, monitoring, and documentation of oxygen therapy in accordance with physician orders, accepted standards of nursing practice, federal and state regulations, and resident-centered care principals. Policy: Oxygen shall be administered only upon the order of a licensed practitioner authorized to prescribe treatment. Oxygen therapy shall be administered, monitored, and documented by licensed nursing personnel in accordance with physician orders, facility policy, manufacturer recommendations, and applicable federal and state regulations. Oxygen is considered a medication and shall be treated with the same standards of accuracy, accountability, and documentation as all prescribed medications and treatments. Responsible Staff: The following personnel are responsible for implementation of this policy: Registered Nurse (RN); Licensed Practical Nurse (LPN); Respiratory Therapist (if applicable); Certified Nursing Assistant (CNA) for observation and reporting only.		

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to document oxygen administration on the medication administration record per policy and procedure for 2 of 3 residents, Resident #6 and #33, reviewed for respiratory care. Findings include: 1) During an observation on 6/15/2026 at approximately 11:00 AM Resident #6 was lying in bed. She was wearing a nasal canula that was attached to an oxygen concentrator administering oxygen at 2 liters per min (2L/Min). During an observation on 6/16/2026 at 12:00 PM Resident #6 was sitting up on the side of her bed. The nurse was at her bedside observing Resident #6 taking medications. Resident #6 was wearing a nasal canula attached to an oxygen concentrator administering oxygen at 2L/Min. During an interview on 6/16/2026 at 12:00 PM Resident #6 stated that she had a history of COPD (Chronic Obstructive Pulmonary Disease). She needed oxygen; it has been a life saver. Review of Resident #6's Census Data documented the resident was admitted on [DATE] with medical diagnoses to include chronic obstructive pulmonary disease, unspecified; heart failure, unspecified. Review of the physician's order for Resident #6 read, O2 (oxygen) via nasal prongs @ (at) 2 L PRN (2 liters per minute as needed) &ndash; May remove adlib (as much as one desires). During an interview on 6/16/2026 at 4:00 PM the ADM (Administrator) and ADON (Assistant Director of Nursing) stated since oxygen was ordered similarly to a medication, they would refer to the medication administration policy for guidance. During an interview on 6/17/2026 at 9:45 AM Resident #6 stated She puts on and takes off the oxygen herself. The nurse checks the rate once a week when they change the tubing. During an interview on 6/17/2026 at 9:50 AM Staff A, RN (Registered Nurse) stated that for a resident with a PRN (as needed) oxygen order the expectation was to document when the resident was wearing oxygen, what their oxygen saturation level was, and why they were wearing the oxygen (what symptoms they are having). Resident #6 should have her oxygen documented on her MAR. During an interview on 6/17/2026 at 10:30 AM the ADON stated that residents were to have their vital signs checked and documented every shift; their oxygen saturation level required the nurse to document whether the resident was receiving oxygen. If a resident was wearing oxygen the nurse was expected to check their O2 sat (oxygen saturation level), check the rate of administration (of the oxygen) and confirm that it is the correct rate, and document it on the resident's MAR. Review of Resident #6's Vital Sign form for the period of 4/01/2026 through 6/16/2026 documented multiple instances of oxygen saturation levels. Review of Resident #6's MAR/TAR (Medication Administration Record/Treatment Administration Record) for the period of 4/01/2026 through 6/16/2026 did not provide documentation of the administration of oxygen. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) During an observation on 06/15/2026 at 10:25 PM, an oxygen concentrator with nasal cannula tubing attached was observed in Resident #33's room. At the time of the observation, Resident #33 was not being administered oxygen. During an interview on 06/18/2026 at 9:42 AM, Staff B stated, He wears oxygen at night mostly. During an interview on 06/18/2026 at 9:44 AM, Resident #33 stated, I wear oxygen at night to help me breathe. Review of Resident #33's physician orders dated 01/07/2026 revealed an order for Oxygen at 2 liters per minute via nasal cannula PRN, may remove ad lib for ADLs [activities of daily living]. Review of Resident #33's oxygen saturation documentation dated 06/13/2026 at 11:21 AM documented an oxygen saturation of 97% with documentation indicating oxygen was being administered via nasal cannula. Review of Resident #33's oxygen saturation documentation dated 06/16/2026 at 3:33 AM revealed an oxygen saturation of 95% with documentation indicating oxygen was being administered via nasal cannula. Review of Resident #33's June 2026 Medication Administration Record (MAR) revealed no documentation of oxygen administration despite documentation elsewhere in the clinical record indicating oxygen was administered. Review of the policy and procedure titled Documentation of Medication Administration with a last review date of 1/6/2026 read, Policy Statement: A medication administration record is used to document all medications administered. Policy Interpretation and Implementation: 1. A nurse or certified medication aide (where applicable) documents all medications administered to each resident on the resident's medication administration record (MAR). 3. Documentation of medication administration includes, as a minimum: h. resident response to the medication, if applicable (e.g., PRN, pain medication, etc.) Review of the policy and procedure titled Oxygen Administration and Documentation Policy and Procedure with a last review date of 1/6/2026 read, Purpose: To establish guidelines for the safe administration, monitoring, and documentation of oxygen therapy in accordance with physician orders, accepted standards of nursing practice, federal and state regulations, and resident-centered care principals. Policy: Oxygen shall be administered only upon the order of a licensed practitioner authorized to prescribe treatment. Oxygen therapy shall be administered, monitored, and documented by licensed nursing personnel in accordance with physician orders, facility policy, manufacturer recommendations, and applicable federal and state regulations. Oxygen is considered a medication and shall be treated with the same standards of accuracy, accountability, and documentation as all prescribed medications and treatments. Responsible Staff: The following personnel are responsible for implementation of this policy: Registered Nurse (RN); Licensed Practical Nurse (LPN); Respiratory Therapist (if applicable); Certified Nursing Assistant (CNA) for observation and reporting only.		