

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: 105870	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Life Care Center of Citrus County		STREET ADDRESS, CITY, STATE, ZIP CODE 3325 W Jerwayne LN Lecanto, FL 34461	
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review the facility failed to maintain dignity for a resident who needed assistance with dining for 1 of 5 residents, Resident #6, reviewed for dining. Findings include: During an observation on 2/9/2026 at 11:52 AM Staff C, Certified Nursing Assistant (CNA) was seated bedside Resident #6 in a side-to-side position and was not facing the resident during the meal. Staff C was observed feeding Resident #6 over her shoulder rather than directly facing Resident #6. Between spoonfuls of food, Staff C picked up her cellphone resting it on her lap and was observed scrolling on the device. This occurred between each spoon feeding. There was no verbal interactions or engagement noted between Staff C and Resident #6 during the dining process. After completing the meal, Staff C stood up and exited the room with the meal tray. Review of Resident #6's Minimum Data Set titled Annual dated 12/24/2025 documented resident was dependent for eating. During an interview on 2/11/2026 at 12:50 PM Staff C, CNA, stated, I should not have had my phone out. I should have fed [Resident #6's name] paying attention and focusing on him. During an interview on 2/11/2026 at 1:36 PM Staff B Unit Manager/Licensed Practical Nurse stated, Staff should converse with residents and be focused completely on the resident making sure all dietary needs are met. Cell phones are not allowed in patient care areas. During an interview on 2/11/2026 at 1:40 PM the Director of Nursing stated, Staff should sit at eye level and provide sips of liquids in between the meal. The staff should be facing the resident and giving the resident one-to-one patient interaction. There should be no phones in the resident areas. Review of the facility policy and procedure titled Cell Phone Use with a last review date of 4/8/2025 read, Policy. The facility will ensure the appropriate usage of cell phones to safeguard patient privacy and to ensure the provision of high-quality patient care. Procedure: 1. Associates should refrain from using cell phones in patient care areas at all times.		

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	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to ensure each resident received an accurate assessment reflective of the resident status for 1 of 5 residents, Resident #65, reviewed for medication management. Findings include: Review of Resident #65's Minimum Data Set titled Modification of Quarterly/Medicare-5 Day dated 1/22/2026 read, N0300. Injections. Enter Days: 6. Record the number of days that injections of any type were received during the last 7 days or since admission/entry or reentry if less than 7 days. N0350. Insulin. Enter Days: 5. A. Insulin Injections. Record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days. Review of Resident #65's physician order dated 1/20/2026 read, Insulin Glargine Subcutaneous Solution Pen-Injector 100 Unit/ML [milliliter] (Insulin Glargine) inject 40 unit subcutaneously at bedtime for Diabetes. Review of Resident #65's physician order dated 1/20/2026 read, Novolog Solution 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale: if 0 - 200 = 0 units; 201 - 250 = 3 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 9 units; 401+ = 0 units Call MD [Medical Doctor], subcutaneously before meals and at bedtime for diabetes. Review of Resident #65's Medication Administration Record for the month of January 2026 documented only three days where the resident received an injection of insulin. During an interview on 2/11/2026 at 10:20 AM the Registered Nurse Minimum Data Set Coordinator stated, After reviewing [Resident #65's name] medication record for the look back period, the injections number was incorrect and needs to be modified. Review of the facility policy and procedure titled Resident Assessment Instrument and Care Plan Development with a review date of 8/29/2025 read, Policy: The facility will follow the procedures set forth in the Resident Assessment Instrument (RAI) User's Manual 3.0 when completing the MDS, Care Area Assessment, and Comprehensive Care Plan.		

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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 interview and record review the facility failed to ensure physician prescribed orders were followed for blood pressure medication for 1 of 9 residents, Resident #35, reviewed for medication management. Findings include: Review of Resident #35's physician order dated 2/3/2026 read, Clonidine HCl [Hydrochloride] Oral Tablet 0.1 MG [milligram] (Clonidine HCl) give 1 tablet by mouth every 8 hours as needed for SBP [systolic blood pressure] >150 mmHg [greater than 150] Notify MD [Medical Doctor] if ineffective. Review of Resident #35's blood pressure record for the month of February 2026 documented on 2/4/2026 at 0800 [8:00 AM] SBP was 159, on 2/6/2026 at 2000 [8:00PM] SBP was 158, and on 2/7/2026 at 2000 SBP was 163. Review of Resident #35's Medication Administration Record for the month of February 2026 did not document Clonidine 0.1mg as administered on 2/4/2026, 2/6/2026, and 2/7/2026 as order by the physician. Review of Resident #35's physician order dated 11/7/2025 read, Clonidine HCl Oral Tablet 0.1 mg (Clonidine HCl) give 1 tablet by mouth every 8 hours as needed for HTN [hypertension] give if SBP is 150 or above. Review of Resident #35's blood pressure record for the month of January 2026 documented on 1/2/2026 at 2000 [8:00 PM] SBP was 155, on 1/16/2026 at 2000 SBP was 160, and on 1/21/2026 at 2000 SBP was 161. Review of Resident #35's Medication Administration Record for the month of January 2026 did not document Clonidine 0.1mg as administered on 1/2/2026, 1/16/2026, and 1/21/2026 as ordered by the physician. During an interview on 2/11/2026 at 1:24 PM Staff D, Licensed Practical Nurse (LPN) stated, I do not remember having the medication [Clonidine] on her [Resident #35] MAR [medication administration record]. I don't remember, it has been some time. If it is not documented on the MAR as given, I probably did not give the medication. During an interview on 2/11/2026 at 1:29 PM Staff E, LPN, stated, I don't remember that day if she [Resident #35] had a prn [as needed] order for clonidine. I should have administered the medication. I don't remember that specific situation. During an interview on 2/11/2026 at 1:34 PM Staff F, LPN stated, I no longer work in that facility. [Resident #35's name] is familiar but I don't recall the resident having a prn order for Clonidine. During an interview on 2/11/2026 at 12:32 PM the Advance Practice Registered Nurse #1 stated, The resident has been stable, she has had elevated blood pressure but has not had to be sent out to the hospital. The staff are expected to follow parameters included in the MD orders. I have not gotten any calls from staff informing me the medication was not given per the parameters. During an interview on 2/12/2026 at 8:15 AM the Director of Nursing stated, Nurses need to follow the parameters and physician orders. Review of the facility policy and procedure titled Administration of Medications with a review date of 9/9/2025 read, Policy: The facility will ensure medications are administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on interview and record review the facility failed to ensure physician ordered parameters were followed for blood pressure medications resulting in the administration of unnecessary medications for 4 of 9 residents, Residents #19, #92, #35 and #17, reviewed for unnecessary medications. Findings include: 1. Review of Resident #19's admission record documented diagnosis to include displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with healing, encounter for other orthopedic aftercare, history of falling, essential (primary) hypertension, hyperlipidemia unspecified, gastroesophageal reflux disease without esophagitis, type 2 diabetes mellitus with diabetic neuropathy unspecified, and hypothyroidism unspecified. Review of Resident #19's physician order dated 4/29/2025 read, Metoprolol Tartrate Oral Tablet 25 MG [milligrams] (Metoprolol Tartrate) Give 1 tablet by mouth two times a day for HTN [hypertension] Hold for SBP [systolic blood pressure] less than 100 and HR [heart rate] < [less than] 60. Notify MD [Medical Doctor] if HR less than 50. Review of Resident #19's February Medication Administration Record (MAR) documented Metoprolol Tartare was administered on 2/6/2026 at 0800 (8:00 AM) with a heart rate of 57, at 1900 (7:00 PM) with a heart rate of 59, and on 2/7/2026 at 0800 with a Heart rate of 59. Review of Resident #19's MAR for January 2026 documented Metoprolol Tartare was administered on 1/1/2026 at 0800 with a heart rate of 51, at 1900 with a heart rate of 56, on 1/15/2026 at 0800 with a heart rate 52, on 1/19/2026 with a heart rate of 59, on 1/23/2026 at 0800 with a heart rate of 55, at 1900 with a heart rate of 55, on 1/26/2026 at 1900 with a heart rate of 58, and on 1/28/2026 at 1900 with a heart rate of 59. Review of Resident #19's MAR for December 2025 documented Metoprolol Tartare was administered on 12/20/2025 at 0800 with a heart rate of 59, on 12/27/2025 at 1900 with a heart rate of 58, on 12/31/2025 at 0800 with a heart rate of 51, and at 1900 with a heart rate of 51. During an interview on 2/11/2026 at 12:47 PM Staff I, Licensed Practical Nurse (LPN) stated, I should not have given that medication. I did administer it. I did not realize I shouldn't. I should have followed the doctor's orders. During an interview on 2/12/2026 at 8:40 AM Staff R, LPN stated, I should have held the medication. I should have followed the doctor's order. 2. Review of Resident #92's admission record documented diagnosis to include essential (primary) hypertension, hyperlipidemia unspecified, major depressive disorder single episode unspecified, unspecified dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, dizziness and giddiness, adult failure to thrive, wedge compression fracture of first lumbar vertebra, wedge compression fracture of third lumbar vertebra, disorder of thyroid, other specified persistent mood disorders, other specified anxiety disorder, primary insomnia, and unspecified protein calorie malnutrition. Review of Resident #92's physician order dated 5/22/2025 read, Lisinopril Oral Tablet 40 MG (Lisinopril) Give 1 tablet by mouth one time a day for HTN HOLD FOR SBP < 120. (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #92's MAR for December 2025 documented Lisinopril was administered at 0800 (8:00 AM) on 12/20/2025 with a blood pressure (B/P) of 114/46, on 12/17/2025 with a B/P of 116/50, on 12/19/2025 with a B/P of 114/60, and on 12/20/2025 with a B/P of 118/64. Review of Resident #92's MAR for January 2026 documented Lisinopril was administered at 0800 on 1/5/2026 with a B/P of 97/51 on 1/8/2026 with a B/P of 118/45, on 1/19/2026 with a B/P of 110/58, and on 1/23/2026 with a B/P of 112/56. Review of Resident #92's physician order dated 2/4/2026 read, Lisinopril Oral Tablet 40 MG (Lisinopril) Give 1 tablet by mouth one time a day for HTN [hypertension] Hold for SBP <110 or DBP [diastolic blood pressure] <90. Review of Resident #92's MAR for February 2026 documented Lisinopril was administered at 0800 on 2/5/2026 with a B/P of 114/52, on 2/6/2026 with a B/P of 114/52, on 2/7/2026 with a B/P of 145/84, on 2/9/2026 with a B/P of 142/62 and on 2/10/2026 with a B/P of 142/58. During an interview on 2/11/2026 at 9:45 AM Staff A, LPN stated, I did not see the diastolic blood pressure parameters and I did administer those [medication]. I should have followed the orders and held the medication. This order just changed and I didn't notice it. During an interview on 2/11/2026 at 9:00 AM the Director of Nursing (DON) stated, All physician orders should be followed for administering medications. The parameters should be followed. 3. Review of Resident #35's physician order dated 2/3/2026 read, Losartan Potassium Tablet 100 MG give 100 mg by mouth one time a day for HTN hold if SBP <100 or DBP < 90. Review of Resident #35's MAR for the month of February 2026 documented Losartan Potassium 100 mg was administered on 2/4/2026 at 0900 [9:00 AM] with a diastolic blood pressure of 68, on 2/5/2026 at 0900 with a diastolic blood pressure of 75, on 2/8/2026 at 0900 with a diastolic of 80, on 2/9/2026 at 0900 with a diastolic of 69, and on 2/11/2026 at 0900 with a diastolic of 63. Review of Resident #35's physician order dated 2/3/2026 read, Carvedilol Tablet 3.125 MG give 1 tablet by mouth two times a day for htn hold if SBP <100 or DBP <60 or HR [Heart Rate] <60. Review of Resident #35's MAR for the month of February 2026 documented Carvedilol 3.125 mg was administered on 2/9/2026 at 0800 [8:00AM] with a heart rate of 59 and at 2000 [8:00 PM] with a diastolic blood pressure of 58. Review of Resident #35's physician order dated 12/3/2025 read, Carvedilol Tablet 3.125mg give 1 tablet by mouth two times a day for htn hold if SBP <100 and/or apical pulse <60 bpm [beats per minute]. Review of Resident #35's MAR for the month of January 2026 documented Carvedilol 3.125 mg was administered on 1/1/2026 at 0800 with a pulse of 56, on 1/2/2026 at 2000 with a pulse of 58, on 1/19/2026 at 0800 with a pulse of 59, and on 1/24/2026 at 0800 with a pulse of 55. During an interview on 2/11/2026 at 10:13 AM Staff A, LPN, stated, We have always been told about the top number and the heart rate not to give if the top number is less than 110 or heart rate less than 60. I did not know when they put in orders for the bottom [diastolic] order parameters. If I do not give (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her blood pressure medication if the systolic is not less than 110 then her blood pressure will skyrocket. I want to talk to the provider about that order because she has high blood pressure if the medication is not given to her, her blood pressure goes up. If there is a check mark it means I have given the medication. We get so used to the residents, but I will be checking parameters. During an interview on 2/11/2026 at 1:24 PM Staff D, LPN, stated, A check mark documented on the medication record normally means that the medication was given. I don't remember it's been some time. If I marked it off, I probably gave the medication. During an interview on 2/11/2026 at 12:32 PM the Advance Practice Registered Nurse #1 stated, [Resident#35's name] has been stable she has had elevated blood pressure but has not had to be sent out to the hospital. The staff are expected to follow parameters included in the md [medical doctor] orders. I have not gotten any calls from staff informing me the medication was not given when out of the parameters. During an interview on 2/12/2026 at 8:15 AM the Director of Nursing stated, Nurses need to follow the parameters and nursing orders. 4. Review of Resident #17's admission record documented diagnosis that include cognitive communication deficit, dysarthria and anarthria, protein calorie malnutrition, pain in unspecified knee, chronic viral Hepatitis C, major depressive disorder, insomnia and lymphedema. Review of Resident #17's physician orders dated 1/20/2026 read, Metoprolol Tartrate Oral Tablet 50 MG (Metoprolol Tartrate) Give 1 tablet by mouth two times a day for HTN Hold for SBP 110 or below OR HR below 60 contact MD for HR below 50. Review of Resident #17's MAR for February 2026 documented Metoprolol was administered outside of physician ordered parameters on 02/01/2026 at 0800 (8:00 AM) HR 52, documented by LPN Staff K, on 02/01/2026 at 8:00 PM HR 58, documented by LPN Staff J, on 02/07/2026 at 8:00 AM HR 58, documented by LPN Staff Q, on 02/11/2026 at 8:00 PM BP 108/49 and HR 56, documented by LPN Staff P. During an interview on 2/12/2026 at 11:23 AM Staff K, LPN stated I do see in the MAR on 2/1/2026 at 8 AM that I signed and the HR was 52. The order stated hold if HR is less than 60 so I agree that the vitals are out of parameters. I should have notified the MD and at that time discussed the next protocol for the resident. I should have held the medication and made a progress note. During interview on 2/12/2026 at 9:02 AM Staff J, LPN stated, I did give [Resident #17's name] blood pressure medications out of parameter on 2/1/2026 at 8 PM, but I didn't look at any other months. I should have notified the MD that his pulse was under 60 and then the MD would have advised me further on the next step.		

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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. Based on observation, interview, and record review the facility failed to prevent the possible spread of infection and communicable diseases by failing to ensure staff used appropriate Personal Protective Equipment (PPE) for residents on enhanced barrier precautions and failing to perform hand hygiene. Findings include: 1. During an observation of medication administration on 2/12/2026 at 5:00 AM Staff I, Licensed Practical Nurse (LPN) did not perform hand hygiene, donned gloves, and assembled the supplies needed to complete an accucheck [a test to obtain blood sugar value results], removed the gloves and did not perform hand hygiene. Staff I, entered Resident #34's room, did not perform hand hygiene, donned gloves, and completed the accucheck. Staff I, LPN doffed the gloves, did not perform hand hygiene, and returned to the medication cart. Staff I did not perform hand hygiene, unlocked the medication cart, activated the computer, and removed insulin from the medication cart. Staff I, LPN entered Resident #34's room did not perform hand hygiene, did not don gloves, and administered the insulin via injection to Resident #34. Staff I, LPN washed her hands, exited the room, returned to the medication cart and began preparing medications for another resident. At 5:05 AM, Staff I, LPN unlocked the medication cart, activated and typed on the computer, did not perform hand hygiene, and prepared medications for Resident #35. Staff I entered Resident #35's room did not perform hand hygiene and administered the medications. Staff I did not perform hand hygiene, exited the resident's room, and returned to the medication cart. At 5:11 AM Staff I unlocked the medication cart, activated and typed on the computer, assembled the supplies to perform an accucheck, did not perform hand hygiene, and donned gloves. Staff I entered Resident #24's room, did not perform hand hygiene, completed the accucheck, doffed the gloves, did not perform hand hygiene, and returned to the medication cart. Staff I, LPN did not perform hand hygiene, unlocked the medication cart, activated and typed on the computer, and removed the insulin injection. Staff I returned to Resident #24's room performed hand hygiene, did not don gloves, and administered the insulin via injection to Resident #24. During an interview on 2/12/2026 at 5:18 AM Staff I, LPN stated, I didn't realize that I needed to put on gloves to give insulin. I should have used hand sanitizer more frequently. Review of Resident #82's admission record documented diagnosis that include atherosclerotic heart disease of native coronary artery without angina pectoris (chest pain), essential (primary) hypertension, hematuria (blood in the urine), unspecified, and obstructive and reflux uropathy, unspecified. Review of Resident #82's physician order dated 12/3/2025 read, Indwelling catheter to straight drainage. Size: 18 F [French] Bulb: 10 cc [cubic centimeters]. Change for infection, obstruction or when the closed system is compromised. Review of Resident #82's physician order dated 8/21/2025 read, Enhanced Barrier Precautions [infection control measure requiring staff to wear gowns and gloves during contact care, such as dressing, transferring, changing linens] r/t [related to] indwelling medical device. During an observation of urinary catheter care for Resident #82 on 2/12/2026 at 9:41 AM, Staff N, Certified Nursing Assistant (CNA) performed hand hygiene donned personal protective equipment (PPE) of a gown and gloves. Staff N, CNA assembled supplies and entered Resident #82's room placing the supplies on the overbed table. Staff N, CNA then exited Resident #82's room with the PPE on, went out to the supply room, obtained a plastic pad, and returned to Resident #82's room without (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changing the PPE of the gown and gloves. The plastic pad fell onto the floor and Staff CNA picked it up off the floor with gloved hands and placed the plastic pad under Resident #82. Staff N, CNA obtained wipes and provided catheter care wiping from front to back using one wipe each time and cleaning down the catheter. Staff N, CNA repositioned Resident #82, removed the gown and gloves, did not perform hand hygiene, and exited the room. During an interview on 2/12/2026 at 1:18 PM Staff N, Certified Nursing Assistant (CNA) stated, I would change a lot about that observation. I should have had everything ready, so I didn't leave the room with my gown and gloves on. I should have changed them. I shouldn't have picked up the plastic pad from off the floor and then done her catheter care. During an interview on 2/12/2026 at 1:21 PM the Director of Nursing (DON) stated, Staff should follow all infection control standards for enhanced barrier precautions and for changing PPE and gloves. They should perform hand hygiene when donning or doffing gloves. Review of the policy and procedure titled, Hand Hygiene with a last review date of 7/7/2025 read, Policy: The facility has adopted the CDC (Center for Disease Control) Core Infection Prevention and Control Practice for safe healthcare delivery in all settings for indications of hand hygiene that are generally consistent with the WHO (World Health Organization) 5 moments for hand hygiene. Procedure: 2. Associates perform hand hygiene (even if gloves are used) in the following situations: a. Before and after contact with the resident; b. After contact with blood, body fluids, or visibly contaminated surfaces; c. After contact with objects and surfaces in the resident's environment; d. After removing personal protective equipment (e.g., gloves, gown, eye protection facemask). 2. During an observation on 2/9/2026 at 10:39 AM Staff G, Certified Nursing Assistant (CNA) was changing Resident #74's bed linens. Staff G had donned gloves and no gown. Staff G wheeled Resident #74 to the shower room. Resident #74's door had an enhanced barrier precaution sign and personal protective equipment outside of the room door. During an observation on 2/9/2026 at 10:55 AM in the shower room, Staff G came around the corner of the curtain and was observed not wearing a protective gown while assisting Resident #74 with a shower. Review of Resident #74's physician order dated 12/22/2025 read, Enhanced Barrier Precautions Diagnosis: history of MDRO [Multidrug Resistant Organisms] every shift. During an observation on 2/9/2026 at 4:02 PM Staff G, CNA and Staff H, CNA, entered Resident #65's room. Resident #65's room door had an enhanced barrier precaution sign and personal protective equipment outside of the room. Staff G and Staff H were observed to go into the resident's room without donning a gown. When entry into the room was requested by this writer, Staff G CNA pulled the curtain back and stated patient care while disposing of a soiled brief. Staff G and Staff H were observed to be wearing gloves but no gowns. Review of Resident #65's physician orders dated 1/22/2026 read, Enhanced Barrier Precaution Diagnosis: MRSA [Methicillin-resistant Staphylococcus aureus] in nares every shift. During an interview on 2/11/2026 at 1:20 PM Staff H, CNA stated, I did not put a gown on because I was not aware that [Resident #65's name] had enhanced barrier precaution orders. (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105870	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Life Care Center of Citrus County		STREET ADDRESS, CITY, STATE, ZIP CODE 3325 W Jerwayne LN Lecanto, FL 34461	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/2026 at 10:14 AM Staff G, CNA stated, I was moving too fast and did not gown when helping [Resident 74's name]. I thought I had gowned for [Resident #65's name].		