STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105927	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountains Rehabilitation at Mill Cove	9960 Atrium Way Jacksonville, FL 32225

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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 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 observations, interviews and record review, the facility failed to store and label food items in a manner to prevent foodborne illness and maintain sanitary conditions, by failing to appropriately date mark food items in the dry storage area and nourishment rooms. This deficient practice had the potential to affect all residents who receive food and nourishment items prepared and/or stored by the facility.The findings include:During the initial kitchen tour on 2/8/26 at 11:30 AM, the following was observed: A dessert was plated on the walk-in refrigerator's shelving unit, which was wrapped but was not date marked. (Photographic evidence obtained)An observation of the 800 Wing nourishment room on 2/9/26 at 8:44 AM revealed that seven of 13 sandwiches in the refrigerator were not date-marked, and foods brought in from outside the facility were without dates. (Photographic evidence obtained)On 2/9/26 at 8:44 AM, a follow-up observation was conducted with the Certified Dietary Manager (CDM), in which he confirmed that there were seven sandwiches without date markings. In an interview at the time of the observation, the CDM stated the sandwiches were from the kitchen and should have been dated. He removed the sandwiches and discarded the items that were not labeled. He explained that the kitchen staff were responsible for date marking items from the kitchen and removing items from the kitchen that were older than three days and not labeled in the nourishment rooms.During a second kitchen observation on 2/10/26 at 11:04 AM, the following was observed in the dry storage room: An opened half full container of peanut butter without date marking. (Photographic evidence obtained) Lead [NAME] I observed the surveyor obtain a photograph of the peanut butter jar, then she removed the item from the shelf and was overheard asking the kitchen staff who put this in there without a date. During an interview on 2/10/26 at 11:35 AM, Lead [NAME] I stated whoever opened the items in the dry storage room was responsible for dating them. During an interview on 2/11/26 at 9:27 AM with Dietary Aide G, he stated certified nursing assistants (CNAs) were responsible for cleaning nourishment rooms and discarding food. He further stated everyone was responsible for date marking in the kitchen.A review of the facility's policy titled Food Storage - Dry Goods (dated 1/27/26), revealed:The Dining Services Director or designee ensures that the storage will be neat, arranged for easy identification, and date marked as appropriate.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide documentation to confirm that each resident was informed before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate for three (Residents #49, #998 and #999) of three residents whose Beneficiary Notices were reviewed. The findings include:On [DATE] at 11:57 AM, an entrance conference was conducted with the Administrator. At this time, he was given the Beneficiary Notice form and asked to provide a list of residents discharged within the last six months.On [DATE] at 3:40 PM, the survey team was provided with the completed Beneficiary Notice forms. The Administrator was advised that the Beneficiary Notice forms contained inaccurate information. He was advised that the list contained residents who were discharged to the hospital, other skilled nursing facilities and/or who had expired. He was referred to the instructions on the form which instructed to exclude beneficiaries who received Medicare Part B benefits only, were covered under Medicare Advantage insurance, expired, or were transferred to an acute care facility or another SNF (skilled nursing facility) during the sample date range. The form's instructions were highlighted for easy visibility.On [DATE] at 8:40 AM, the survey team received what the facility presented as the corrected Beneficiary Notice forms. The documentation remained inaccurate. At 10:05 AM, the survey team advised the Administrator of the inaccuracies. Again, the forms and instructions were reviewed. The instructions were highlighted on the new forms for easy visibility, and the Administrator was asked to provide accurate information based on the instructions that were highlighted. On [DATE] at 12:58 PM, the facility provided the Beneficiary Notice forms. The information provided by the facility was incomplete. Residents who remained in the facility during the designated period were not listed on the forms.On [DATE] at 4:04 PM, the Administrator was advised that the forms provided this day at 12:58 PM were also inaccurate. He was shown that there were no residents listed as remained in facility. He replied, and there definitely should be. He stated he would have the information corrected and would return it to the survey team on the following day ([DATE]).During an interview on [DATE] at 9:41AM, the Administrator was asked whether or not the Beneficiary Notice Review forms were available for review. He stated the facility was unable to access the information electronically; it would have to be done manually. He did not provide any further explanation.An interview was conducted on [DATE] at 10:23 AM with the Director of Nursing (DON). He provided all of the previous lists along with a separate list for residents who remained in the facility. Three residents were randomly selected from the lists provided, one resident who went home and two residents who remained in the facility. The names of the selected residents were written on three separate Beneficiary Notice Review forms and given to the DON. He was asked to have the forms completed and returned to the survey team. On [DATE] at 3:28 PM, the Administrator was asked to provide the three selected resident Beneficiary Notice Review forms. He stated he did not know what the surveyor was referring to but would check on the request.On [DATE] at 3:41PM, the Business Office Manager (BOM) approached the survey team. She did not have the three selected resident Beneficiary Notice Review forms. She stated she was given the forms and was told to file them. When asked about her tenure with the facility, she stated she had been employed as the BOM for 3.5 years. She was asked if she had knowledge of the Beneficiary Notice requirement for the facility's annual survey. She stated she did not recall completing this task on the last annual survey. She stated she was responsible for the Advance Beneficiary Notice (ABN) forms and that it was the responsibility of the Social Services Director to complete the Notice of Medicare Non-coverage (NOMNC). She stated she would consult with the SSD for more information. She asked if the forms needed to be completed, adding that she did not know if she should write on them.On [DATE] at 10:47AM, the facility provided the three selected resident Beneficiary Notice Review forms to the (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	survey team. A review of the information revealed that the forms still contained inaccurate information. One of the three residents, who the facility stated remained in the facility, had been discharged . Only one of the residents requested remained in the facility, Resident #49. No additional attempts were made after the survey team identified that inaccuracies remained in the documentation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on record review, interviews and a review of facility policies and procedures, the facility failed to maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections, by failing to monitor and track infections properly between August 2025 and February 2026. This failure can contribute to preventable diseases spreading rapidly, resulting in widespread resident illness with potentially fatal outcomes.The findings include:A review of the facility's infection control tracking information on 2/11/26 with the Director of Nursing (DON) revealed that no tracking was available for August 2025 through November 2025 or for January 2026. During an interview on 2/11/26 at 2:30 PM, the DON stated, Since [previous Infection Preventionist] left, I've been keeping up with it. When asked where the missing data was, the DON replied, I have like four binders; I just have to find it.A review of the facility's infection control tracking information on 2/12/26 at 9:30 AM revealed that antibiotic records generated from the electronic health record for August 2025 to present (2/12/26) revealed that they were generated on 2/8/26 and 2/11/26 during the time of the survey. (Photographic evidence obtained)During an interview on 2/12/26 at 10:00 AM regarding the infection control tracking information, the DON stated, I thought people were keeping track of it and I just ended up with all these papers. A review of the facility's policy titled Infection Prevention Control Program - Core Practices (reviewed 5/2025), revealed: C. Surveillance: a. Routine monitoring through use of audits and surveillance will be conducted to determine compliance with infection prevention and control policies and procedures. Surveillance tools will be used for recognizing the occurrence of infections, recording the number of infections and frequency, detecting outbreaks and epidemics, monitoring employee infections, and detecting unusual pathogens (e.g., C difficile, MDROs) with infection control implications. Surveillance is designed to identify possible communicable diseases and infections before they can be spread to other residents in the facility and procedures for reporting possible incidents of communicable diseases or infections.

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its admissions policy for one (Resident #5) of six residents reviewed for admission agreements.The findings include:A review of Resident #5's record revealed no admission agreement present for his admission on [DATE] or his readmission following hospitalization on 11/21/25.Further review of the record verified an initial admission date of 9/26/25 with the most recent admission on [DATE]. During an interview on 2/11/26 at 9:10 AM, the Admissions Director (AD) stated, I didn't start until November [2025], but I did talk to him [Resident #5] one time about it. When the AD was asked where she documented her conversation with the resident, she stated, I didn't document it anywhere.A review of the facility's policy titled Admissions Process - IDT (Interdisciplinary Team) (revised 1/27/26, previously revised 7/1/23 and 3/1/22) revealed:It is the policy of this facility to follow a consistent and complete process for admission of a resident into the facility.Procedure:4. The facility will follow policies for the admission process for residents, and through the administrator, will be responsible for the development of and adherence to procedures implementing the policies.5. The facility may choose to develop an orientation packet specific to their facility to assist with some of the aspects of the resident's orientation to the facility.7. The full admission assessment process will be completed within five (5) days.The policy did not specify who was responsible for reviewing the admission agreement with the residents. The policy did not specifically address the admission agreement. A review of the Facility Admissions Director Position Description (effective 10/3/2018), revealed:Duties and Responsibilities: Administrative Functions: Provide, review, and explain to the resident and/or guardian admission paperwork and policies.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interviews and record review, the facility failed to develop and implement a comprehensive, person-centered care plan that reflected the resident's individualized needs for one of (Resident #10) of 21 residents whose care plans were reviewed. Resident #10 had no care plan addressing his vision problems and although he had been referred to an ophthalmologist more than once in 2024 (January and May) for cataract surgery, the facility did not follow through until February of 2025. An interview with the resident revealed this negatively affected his mood and he felt trapped. The findings include: An interview was conducted on 2/09/2026 at 11:23 AM with Resident #10. During the interview the resident became visibly upset and in a raised voice stated he was blind and they (facility staff) were not helping him. He further stated he had cataracts and was supposed to have surgery a year ago and still had not had that. He stated he had insurance and other funds to pay for the surgery, but the facility was not assisting him with arranging for it. He said his loss of vision impacted his mood and made him feel trapped. He did not feel that the facility staff cared about his wellbeing; they only wanted his money. A review of the resident's medical record revealed an admission date of 10/23/2023. His diagnoses included cerebral infarction (stroke), AFIB (Atrial Fibrillation – rapid, irregular heartbeat), urinary retention, hypertension (HTN – high blood pressure) and morbid obesity. His active physician's orders included: May have podiatry, dental, audiology, ophthalmology and psychiatric/psychology services as needed (10/24/2023). A review of the resident's Annual minimum data set (MDS) assessment, dated 9/25/2024, revealed that Resident #10 scored 15 out of 15 possible points on his Brief Interview for Mental Status (BIMS), indicating intact cognition. His vision was noted as severely impaired. He displayed little interest or pleasure in doing things and felt down, depressed, or hopeless 7-11 days of the assessment reference period. He required supervision/touch assistance with tub/shower transfers and was independent with all other Activities of Daily Living (ADLs). Per his most recent Quarterly MDS assessment, dated 11/24/2025, revealed a BIMS score of 13/15, indicating intact cognition. His vision was noted as impaired. He had no recorded mood/behavior issues and was independent with all ADLs. Resident #10's active care plan was reviewed. Focus Areas included: I have mood and behavior changes. My behaviors include refusal of the following: showering/assistance with ADLs/fingernail cutting/toenails [Resident #10] is on antiplatelet/anticoagulant therapy related to AFIB, anticoagulant and history of CVA (cerebrovascular accident – stroke) and his health status [Resident #10] is at risk for falls related to the use of medication, pain, cardiac disease and his health status. The Care Plan did not address the resident's impaired vision. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the resident's record revealed that he had been seen by a vision service provider multiple times in the facility. Per the provider's consultation forms: 1/31/24 - Referred to ophthalmologist for cataract surgery; visit Dx H25.13 age related nuclear cataract bilateral. 5/21/24 - Referred to ophthalmologist for cataract surgery additional note: Referred last visit and nothing has been done, no glasses ordered; no readers assigned; visit Dx H25.13 age related nuclear cataract bilateral. Exam 5/22/24: Chief complaint decreased vision; orientation to time and place: WNL (within normal limits); Mood and Affect: WNL; visit Dx H25.13 age related nuclear cataract bilateral. 2/20/25 - Referred to ophthalmologist for cataract surgery visit Dx H25.13 age related nuclear cataract bilateral. A review of the resident's progress notes revealed: 5/21/24 - Late Entry: Patient examined by Optometrist on 5/21/24. see uploaded exam by documents 2/20/25 - Late Entry: Patient examined by Optometrist on 2/20/25. See uploaded exam by documents. An interview was conducted on 2/10/26 at 2:23 PM with Licensed Practical Nurse (LPN) D who stated he was familiar with Resident #10. He said he was unsure of whether or not the resident was legally blind, but he knew the resident could not see. LPN D stated the resident was moved from the rehabilitation side of the facility to the long-term care unit. He stated the resident could manage and did not ask for a lot. His biggest complaint is that he can't see. He said the staff kept the resident's room dark because he couldn't tolerate too much brightness, and during medication administration, the resident requested that the pill cup be placed on his table within his reach so that he could pick it up. The resident would then shake the cup to determine whether or not he was receiving the correct amount of medication. An interview was conducted on 2/10/26 at 3:17 PM with Certified Nursing Assistant (CNA) B who stated she had been employed by the facility for more than 15 years and she was familiar with Resident #10. She stated he complained about pain and that he could not see well; he was supposed to have cataract surgery. An interview was conducted on 2/11/26 at 11:23 Am with Unit Clerk K who stated she had been employed by the facility for four years. Initially, she was CNA who worked as needed and after a year she transitioned to the Unit Clerk position. She was asked to describe her role as it related to resident care. She stated when the resident was admitted from the hospital, she introduced herself. She checked the hospital transfer form, what the form documented as having been done while the resident was hospitalized and the next steps to take while at the skilled nursing facility. She stated if the resident was alert and oriented, she asked them about any follow-up appointments they may have. She did a follow-up with the provider to schedule any appointments and transportation required. She was responsible for scheduling the dental and vision appointments with third-party providers. She said she was notified of needed appointments by residents, providers and at times, by the resident's family. Unit Clerk K said she was familiar with Resident #10. He had not had any appointments (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scheduled within the last two months. She said that a couple of months ago, he had an appointment to check his eyes but he decided that he wasn't going. She stated she kept an email for the residents who went out for appointments. She was asked to provide documentation of the scheduled appointment and the resident's refusal to go. She stated she was not sure if there was any documentation of this, adding that the nurse should be documenting that information. She stated Resident #10 was declining and he had been asking to go to the eye doctor but then refused to go. Again, she could not provide documentation verifying this. An interview was conducted on 2/11/26 at 1:27 PM with the Social Services Director (SSD). She stated she had been employed by the facility for four years. She worked as the Social Services Assistant for two years and had been the SSD for two years. She stated the Unit Manager was responsible for setting up transportation when residents were scheduled for appointments outside of the facility. She was shown the documentation for the three visits referring Resident #10 for cataract surgery. She stated she was not sure why an appointment was not set up. She stated for the 5/21/24 visit, she believed there may have been a payer source change; however, she could not verify this. She stated she uploaded the visit notes and nursing, and everyone, should be viewing them. She stated the vision service provider came in quarterly and if a resident was referred out, the Unit Clerk was responsible for scheduling the appointment.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on observation, interview, and record review, the facility failed to ensure that one (Resident #10) of 2 residents reviewed for vision abilities/status from a total survey sample of 21 residents, received proper treatment and assistance in making appointments and arranging for transportation to and from the office of a practitioner specializing in the treatment of vision impairment or the office of a professional specializing in the provision of vision assistive devices to maintain vision abilities. The findings include:An interview was conducted on 2/09/2026 at 11:23 AM with Resident #10. During the interview the resident became visibly upset and in a raised voice stated he was blind and they (facility staff) were not helping him. He further stated he had cataracts and was supposed to have surgery a year ago and still had not had that. He stated he had insurance and other funds to pay for the surgery, but the facility was not assisting him with arranging for it. He said his loss of vision impacted his mood and made him feel trapped. He did not feel that the facility staff cared about his wellbeing; they only wanted his money.A review of the resident's medical record revealed an admission date of 10/23/2023. His diagnoses included cerebral infarction (stroke), AFIB (Atrial Fibrillation - rapid, irregular heartbeat), urinary retention, hypertension (HTN - high blood pressure) and morbid obesity. His active physician's orders included: May have podiatry, dental, audiology, ophthalmology and psychiatric/psychology services as needed (10/24/2023).A review of the resident's Annual minimum data set (MDS) assessment, dated 9/25/2024, revealed that Resident #10 scored 15 out of 15 possible points on his Brief Interview for Mental Status (BIMS), indicating intact cognition. His vision was noted as severely impaired. He displayed little interest or pleasure in doing things and felt down, depressed, or hopeless 7-11 days of the assessment reference period. He required supervision/touch assistance with tub/shower transfers and was independent with all other Activities of Daily Living (ADLs). A review of his most recent Quarterly MDS assessment, dated 11/24/2025, revealed a BIMS score of 13/15, indicating intact cognition. His vision was noted as impaired. He had no recorded mood/behavior issues and was independent with all ADLs. Resident #10's active care plan was reviewed. Focus Areas included: I have mood and behavior changes. My behaviors include refusal of the following: showering/assistance with ADLs/fingernail cutting/toenails [Resident #10] is on antiplatelet/anticoagulant therapy related to AFIB, anticoagulant and history of CVA (cerebrovascular accident - stroke) and his health status [Resident #10] is at risk for falls related to the use of medication, pain, cardiac disease and his health status.The Care Plan did not address the resident's impaired vision.Further review of the resident's record revealed that he had been seen by a vision service provider multiple times in the facility. Per the provider's consultation forms:1/31/24 - Referred to ophthalmologist for cataract surgery; visit Dx H25.13 age related nuclear cataract bilateral. 5/21/24 - Referred to ophthalmologist for cataract surgery additional note: Referred last visit and nothing has been done, no glasses ordered; no readers assigned; visit Dx H25.13 age related nuclear cataract bilateral. Exam 5/22/24: Chief complaint decreased vision; orientation to time and place: WNL (within normal limits); Mood and Affect: WNL; visit Dx H25.13 age related nuclear cataract bilateral. 2/20/25 - Referred to ophthalmologist for cataract surgery visit Dx H25.13 age related nuclear cataract bilateral. A review of the resident's progress notes revealed:5/21/24 - Late Entry: Patient examined by Optometrist on 5/21/24. see uploaded exam by documents2/20/25 - Late Entry: Patient examined by Optometrist on 2/20/25. See uploaded exam by documents.An interview was conducted on 2/10/26 at 2:23 PM with Licensed Practical Nurse (LPN) D who stated he was familiar with Resident #10. He said he was unsure of whether or not the resident was legally blind, but he knew the resident could not see. LPN D stated the resident was moved from the rehabilitation side of the facility to the long-term care unit. He stated the resident could manage and did not ask for a lot. His biggest complaint is that he can't see. He said the staff kept the resident's room dark because he couldn't tolerate too much brightness, and during medication administration, the resident requested that the pill cup be placed on his table within (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his reach so that he could pick it up. The resident would then shake the cup to determine whether or not he was receiving the correct amount of medication.An interview was conducted on 2/10/26 at 3:17 PM with Certified Nursing Assistant (CNA) B who stated she had been employed by the facility for more than 15 years and she was familiar with Resident #10. She stated he complained about pain and that he could not see well; he was supposed to have cataract surgery.An interview was conducted on 2/11/26 at 11:23 Am with Unit Clerk K who stated she had been employed by the facility for four years. Initially, she was CNA who worked as needed and after a year she transitioned to the Unit Clerk position. She was asked to describe her role as it related to resident care. She stated when the resident was admitted from the hospital, she introduced herself. She checked the hospital transfer form, what the form documented as having been done while the resident was hospitalized and the next steps to take while at the skilled nursing facility. She stated if the resident was alert and oriented, she asked them about any follow-up appointments they may have. She did a follow-up with the provider to schedule any appointments and transportation required. She was responsible for scheduling the dental and vision appointments with third-party providers. She said she was notified of needed appointments by residents, providers and at times, by the resident's family. Unit Clerk K said she was familiar with Resident #10. He had not had any appointments scheduled within the last two months. She said that a couple of months ago, he had an appointment to check his eyes, but he decided that he wasn't going. She stated she kept an email for the residents who went out for appointments. She was asked to provide documentation of the scheduled appointment and the resident's refusal to go. She stated she was not sure if there was any documentation of this, adding that the nurse should be documenting that information. She stated Resident #10 was declining and he had been asking to go to the eye doctor but then refused to go. Again, she could not provide documentation verifying this.An interview was conducted on 2/11/26 at 1:27 PM with the Social Services Director (SSD). She stated she had been employed by the facility for four years. She worked as the Social Services Assistant for two years and had been the SSD for two years. She stated the Unit Manager was responsible for setting up transportation when residents were scheduled for appointments outside of the facility. She was shown the documentation for the three visits referring Resident #10 for cataract surgery. She stated she was not sure why an appointment was not set up. She stated for the 5/21/24 visit, she believed there may have been a payer source change; however, she could not verify this. She stated she uploaded the visit notes and nursing, and everyone, should be viewing them. She stated the vision service provider came in quarterly and if a resident was referred out, the Unit Clerk was responsible for scheduling the appointment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105927	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountains Rehabilitation at Mill Cove	9960 Atrium Way Jacksonville, FL 32225

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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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure that 1) It posted daily, at the beginning of each shift, the facility name, current date, the total number and the actual hours worked by registered nurses, licensed practical nurses, and certified nursing assistants per shift, as well as the resident census on two (2/8/26 and 2/9/26) of five days during the recertification survey.The findings include:During a tour of the facility conducted on 2/8/26 from 11:00 AM - 12:00 PM, no staffing information was posted. A clear frame with no staffing information was observed hanging on a wall next to the reception desk. A whiteboard near the south wing of the facility with staffing posted was dated 2/6/26. (Photographic evidence obtained) During the tour it was observed that all resident rooms had whiteboards next to each bed with spaces to list the current date, current shift and the assigned nurse and certified nursing assistant (CNA) for that shift. Seven of the boards observed had not been updated with the current date. One was dated 1/18/26(room [ROOM NUMBER]), three were dated 1/28/26 (room [ROOM NUMBER]), one was dated 2/2/26, one was dated 2/6/26 (room [ROOM NUMBER]), and another was undated and did not list the name of the assigned nurse or CAN (room [ROOM NUMBER]). (Photographic evidence obtained)During a tour of the facility on 2/9/26 at 9:01 AM, the Daily Staffing posted at the entrance of the facility near the nurses' station was dated Sunday, 2/8/26. An interview was conducted with the Director of Nursing (DON) on 2/11/26 at 4:21PM. He was asked who was responsible for posting the facility's daily staffing. He stated previously the staffing coordinator was responsible for this task; however, that individual was no longer employed with the facility and that as of 2/6/26, the task had become his responsibility. He stated he should not have been assigned this task and was only filling in until they hired another staffing coordinator. He was made aware of the concerns with the posted staffing and was shown the photographic evidence. He acknowledged that the staffing had not been posted, and he acknowledged the incorrect/missing dates on the boards in the residents' rooms. He stated the nurses were responsible for updating the staffing on the unit and the CNAs were responsible for updating the boards in the residents' rooms. This should be done at the beginning of each shift. The Administrator was present during the interview. He stated the information should have been corrected by the nurses and/or the CNAs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105927	A. Building B. Wing	02/12/2026

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observations, interviews and a review if facility policies and procedures, the facility failed to maintain its equipment in safe operating condition, by failing to ensure lint was promptly removed from facility dryers. Leaving lint in a dryer trap creates a severe fire hazard, as accumulated lint easily ignites from the heating element, potentially causing a fire that can place staff, residents and other facility occupants in danger. It also restricts airflow, which can lead to overheating. The findings include:An observation in the laundry room on 2/11/26 at 9:30 AM revealed that the lint removal log had not been completed for 7:00 AM or 9:00 AM.An observation in the laundry room on 2/11/26 at 9:35 AM revealed that the lint trap in the first dryer was covered with a thick layer of white fluffy material.During an interview with Laundry Assistant A on 2/11/26 at 9:40 AM, she stated, We clean it [lint trap] out after every load. When asked if it had been cleaned this morning, she nodded her head yes. When asked why there was a layer of what appeared to be lint in the trap of the dryer, she replied, I don't know how to answer that.During an interview on 2/11/26 at 9:45 AM regarding the laundry room's lint removal log and lint trap concerns, the interim Housekeeping Director stated, I don't know, I'm the Maintenance Director.During an interview on 2/12/26 at 9:30 AM regarding the laundry room's lint removal log and lint trap concerns, the Administrator stated, I'd have to look at the policy, but if it says after every load, then I expect them to do it after every load and document it.A review of the facility's policy titled Dryers/Lint Catcher (reviewed 1/2026), revealed: Lint Catch/Screens: Lint Catchers should be cleaned after each load.