

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: 105962	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Life Care Center at Wells Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 355 Crossing Blvd Orange Park, FL 32073	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on kitchen food service observations, staff interviews, record review, and a review of the facility's policies and procedures, the facility failed to follow proper sanitation and food handling practices to prevent the outbreak of foodborne illness, with the potential to affect more than a limited number of residents who consumed foods from the facility's kitchen. The kitchen staff failed to log proper temperatures for the dish machine. Food handling and sanitation are important in health care settings serving nursing home residents. Unsafe food handling practices represent a potential source of pathogen exposure. The findings include: A tour of the kitchen was conducted on 09/08/2025 at 10:55 AM. During the tour, Dietary Aide A reported that the dish machine was a high-temperature dish machine. She ran the dish machine to test for appropriate wash and rinse temperatures with the following results: Wash: 110 degrees Fahrenheit (F) Rinse: 120 degrees F Wash: 118 degrees F Rinse: 122 degrees F Dietary Aide A was observed holding the test strip in open air inside the dishwasher tank to allow water to drip on the test strip. It was recommended that Dietary Aide A use a test strip on the ware to test for sanitation immediately after the final rinse was completed. For this reason, no sanitizer concentration was completed for the first dish machine test. After the second dish machine test, Dietary Aide A picked up a ware from the rack and poured water from the ware onto the test strip to test for the sanitizer concentration, and for this reason, no sanitizer concentration was completed for the second dish machine test. The dish machine water temperature and chlorine test strips used to measure the sanitizer concentration against the ware resulted in the following: Wash: 118 degrees F Rinse: 125 degrees F, 50-100 ppm (parts per million) Wash: 120 degrees F Rinse: 126 degrees F, 50-100 ppm A review of the dish machine temperature logs (Low Temperature Dish Machine) for January 2025 (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

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: 105962	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Life Care Center at Wells Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 355 Crossing Blvd Orange Park, FL 32073	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	through June 2025 (May 2025 was missing) revealed that for each day of the month at each meal (breakfast, lunch, and dinner, equaling 450 documentation opportunities), both the wash temperature and the rinse temperature were documented as 120 degrees F without deviation, and the rinse cycle test strips were documented as 100 ppm except as follows: January 2025: Dinner mealtime documentation was missing on 1/22/25 & 1/24/25. February 2025: Lunch mealtime documentation on 2/19 indicated a wash temperature of 130 degrees F. March 2025: Dinner mealtime documentation was missing on 3/15/25. All mealtime documentation was missing on 3/31/25. April 2025: Breakfast mealtime documentation on 4/11 indicated a wash temperature of 122 degrees F. June 2025: From 6/1/25 through 6/11/25, all mealtime documentation was missing except for the dinner meal on 6/3, the breakfast meal on 6/5, and the dinner meals on 6/9-10. For these exceptions, the wash temperature was documented as 120 degrees F. On 6/19, the breakfast mealtime rinse test strip was documented as 200 ppm and on 6/20, the rinse test strip was documented as 20 ppm. On 6/21/25, which was crossed out, each mealtime was documented with a wash/rinse temperature of 120 degrees F and a rinse test strip of 100 ppm. A review of the September 2025 dish machine temperature log from 9/1/25 through 9/11/25 (33 documentation opportunities), revealed a wash temperature of 120 degrees F and final rinse temperature of 120 degrees F, without deviation. An interview was conducted with Dietary Aide A on 9/11/2025 at 10:14 AM. She again reported that the dish machine was a high temperature machine. The same staff assigned to the dish machine was the staff responsible for documenting the dish machine temperatures on the log after each use. The dish machine was run and temperatures were logged three times daily. When asked how she knew what temperature to document on the log for the dish machine, she replied that she ran the dish machine 5-6 times to get the temperature up to 120 degrees F followed by immersing the test strip in the water. Staff were told to run the machine until it was 120 degrees F, so it was run until it was at least 120 degrees F. Dietary Aide A confirmed that she had received training on the dish machine and sanitation. An interview was conducted with Dietary Aide B on 9/11/2025 at 10:45 AM. When she was asked who was responsible for documenting on the dish machine temperature log, she replied that she did not document dish machine temperatures. She was assigned mostly in the prep area. The staff assigned to the dish machine were to document temperatures on the log. When she was asked how she knew what temperature to document on the log for the dish machine, she replied that the dish machine was run 4-5 times followed by checking the gauge to ensure it reached 120 degrees F. She confirmed that she received training on cleaning, sanitation and the dish machine. An interview was conducted with the Certified Dietary Manager (CDM) on 9/11/2025 at 10:57 AM. When she was asked how staff knew what temperature to document on the log for the dish machine, she replied, It's on the temperature log; it tells them what the temperature should be, and it is on the thermometer. They know the temperature has to be 120 degrees F. Dietary Aides are responsible for (continued on next page)		

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: 105962	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Life Care Center at Wells Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 355 Crossing Blvd Orange Park, FL 32073	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documenting the dish machine temperature logs after each shift, breakfast, lunch, and dinner. A review of the dish machine temperatures obtained from the test run with Dietary Aide A was shared with the CDM. After each test run the dish machine temperature changed/increased by 1-2 degrees. A review of the facility's policy and procedure titled Low Temp Dish Machine (revised 4/26/2023), revealed: 1. Dish machine will be used in accordance with the manufacturer's specifications. 2. The temperature and parts per million (PPM) of the sanitizer (50-100 ppm for chlorine) will be recorded on the Low Temperature Dish Machine Log a minimum of three times per day. (Copy obtained)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105962	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Life Care Center at Wells Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 355 Crossing Blvd Orange Park, FL 32073	
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 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 observations, interviews, record review, and a review of the facility's policies and procedures, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice for one (Resident #16) of 52 residents in the total survey sample. On 9/3/2025, Resident #16 was ordered a palm guard for his left hand except for hygiene/bathing, but he was not wearing it, and direct-care staff were not aware that he should be wearing it. This failure could result in the resident's functional decline. The findings include: During a tour of the facility on 9/9/2025 at 1:36 pm, Resident #16 was observed sitting in a wheelchair in the resident lounge near the nurses' station on the 400 hall. The resident's left hand was contracted and the nails on that hand were overgrown pressing into the resident's left palm. The resident was asked if he had a splint or assistive device for his left hand. He stood up from the wheelchair and began patting and pulling out his pockets with his right hand. Nothing was retrieved. The resident began murmuring that he didn't know what happened to it. He was asked what it was, but he did not respond. During the interview the resident began to display some confusion. He stated he had been in the facility for three years (per facility documentation the resident had only been in the facility for 18 days at the time of the interview) and that he was ready to go home. The resident stated he did not enjoy going to therapy downstairs (the facility is single-story). During a subsequent tour of the facility on 9/10/2025 at 1:55 pm, Resident #16 was observed in the resident lounge near the nurses' station on the 400 hall. The resident was again observed without a splint/device in his left hand. The nails on his left hand remained overgrown pressing into his left palm. A record review revealed that Resident #16 was admitted to the facility on [DATE]. His diagnoses included type II diabetes mellitus; hemiplegia/hemiparesis following cerebral infarction (stroke); dysarthria (speech disorder) following cerebral infarction; muscle weakness. His physician's orders included: Adaptive Device: Palm guard for L (left) hand except for hygiene/bathing 9/3/2025; Admit to Skilled Medicare A Services, SOC (start of care) 9/1/25 and Admit to skilled insurance services. (Photographic evidence obtained) Per the minimum data set (MDS) 5-Day assessment dated [DATE], Resident #16 scored 6 out of 15 possible points on the brief interview for mental status (BIMS) test, indicating severe cognitive impairment. He had functional impairment on one side of his upper/lower extremities. He required set-up/clean up assistance with eating and oral hygiene; partial/moderate assistance with showering/bathing; substantial/maximum assistance with toileting. He was assessed to be frequently incontinent of bladder and bowel. He received OT (occupational therapy) for 236 minutes within the last 7 days for 5 at least 15 minutes in the last 7 days starting on 8/23/2025; PT (physical therapy) 117 minutes within the last 7 days, 45 minutes of concurrent service (with another individual) 4 days a week at least 15 minutes within the last 7 days. His goal at the time of the assessment was to discharge back to the community with a discharge that was three or fewer months away. The resident's care plan was reviewed. Focuses included: At risk for breakdown in skin integrity initiated 8/26/2025 with interventions that included: weekly skin checks. The resident's care plan did (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105962	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Life Care Center at Wells Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 355 Crossing Blvd Orange Park, FL 32073	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not include a focus, goal or interventions for the ordered adaptive device. (Photographic evidence obtained) An interview was conducted on 9/10/2025 at 1:57 pm Licensed Practical Nurse (LPN) G, employed at the facility for three years. He stated he was somewhat familiar with Resident #16. He stated the resident was able to make his needs known. He referred to Resident #16 as alert and oriented x 3 (person, place, time) with left sided weakness due to a CVA (cerebrovascular accident & stroke). LPN G stated the resident did have some behaviors. He stated the resident's primary diagnosis was diabetes mellitus and that he was receiving a diabetic diet. He stated the resident's left side was affected by the infarction (stroke), and that the resident was in therapy to help him walk better. He stated he did not know if the resident had a splint, adding that he had not seen him with one. During the interview, Director of Rehabilitation (DOR) H, who was passing by, interjected, He has a palm guard. He only wears it in therapy. There's no order for it. On 9/10/2025 at 2:30 pm, Certified Nursing Assistant (CNA) I stated she had been employed at the facility for two months. She further stated she was familiar with Resident #16. She referred to him as sweet adding that he had moments when he got agitated and refused help. He wanted his independence. She stated she assisted the resident with walking, dressing on the left side because it was weaker, and toileting. She was asked if she knew if the resident had a splint/device. She stated she had seen him a week prior with a tan thing in his pocket. She had not seen it since that time, nor had she seen it when he went to therapy. She described the device as a tan furry thing like a glove to put around his hand to keep it open. She was asked who was responsible for ensuring the resident wore the device. she responded: They've never told me I needed to put it on. I'm not sure where it is. An interview was conducted on 9/10/2025 at 2:58 pm with Physical Therapist (PT). He stated that the evaluating PT determined the device that each resident received. He stated they determined what would be safe for the resident. If a resident had cognitive deficits, the device would not be left in their room. If a resident was cognitively intact and they demonstrated good safety awareness, they could keep the device in their room. The PT stated, We want them to be as independent as possible. He was asked who was responsible for monitoring the devices to ensure they were worn properly. He stated the treating therapist was responsible while a resident was in therapy, but when they were not in therapy, it was the responsibility of the CNAs and nurses. The PT stated the information on the assistive devices, how they functioned and what devices were to be used was located in the resident's plan of care (POC) in the computer on the wall. Therapy recommendations were also in the POC where the CNAs charted. He stated he was familiar with Resident #16. The resident was active on therapy caseload. He referred to him as a nice man, adding that he had had a stroke and that it was his second one. He stated since the resident had a second stroke, he had become more contracted and that it had also impacted his safety awareness. He was asked if the resident had any adaptive devices. The PT replied that he believed the resident had a hand splint. He stated it was to keep the hand open, to ensure that his fingernails did not dig into his skin, and that the skin did not break down because the hand was closed. The PT stated the Occupational Therapist (OT) would have additional information about the device, as they would have a care plan and goals for that evaluation. An interview was conducted on 9/10/2025 at 3:11 pm with OT K. She confirmed that she had performed the evaluation for Resident #16 but was not currently treating him. She stated the resident was on therapy for weakness, balance, and safety with his activities of daily living (ADLs). She confirmed that the resident had been given a palm guard for his left hand after observation of some skin breakdown in his hands. She stated the resident's nails were pretty long. She stated the treating therapist had been putting the device on and taking it off. The device was to be worn during the day, (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105962	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Life Care Center at Wells Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 355 Crossing Blvd Orange Park, FL 32073	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but it was to be removed for hygiene and bathing. The therapists were in the facility during the day and could monitor the device. She added that the resident was pretty contracted and those nails were digging into it (his palm). We have a PRN (as needed) therapist, so she would continue with the program. I know the CNAs are familiar with it and could probably put it on. An interview was conducted on 9/11/2025 at 11:37 am with Certified OT Assistant (COTA) L. She stated she was employed PRN and that the day prior to the interview was her first time working with Resident #16. She stated he did not have the palm guard during his therapy session. She confirmed that during his evaluation a palm guard was ordered. She stated the devices were onsite in the facility so the resident would have received it at that time. A review of the facility's policy and procedure titled Splints and Braces-Upper Extremity (issued 1/16/2024, reviewed 9/20/2024), revealed: The facility will provide splints and braces to upper extremities in accordance with professional standards of practice, as outlined by [NAME] through the procedure link below. The procedure stated: This facility will utilize the Lippincott procedures: Splints and braces, upper extremity which stated: Lippincott procedures Splints and braces, upper extremity Introduction: The use of a supportive and protective device designed for a patient's upper extremity, such as a sling, brace, or splint, helps provide support, facilitate functional use, reduce pain, maintain alignment, correct deformities, or provide protection for a healing injury. For use in immobilizing an acute injury, a splint or brace helps prevent further soft tissue, nerve or vascular damage while allowing for swelling and helping to reduce pain during healing. Use of upper extremity supportive and protective devices for such conditions as osteoarthritis, neurologic disorders, burns, dislocations, and fractures may involve the entire upper extremity or a single joint. (See upper extremity supportive and protective devices.) Hand and wrist devices: Static devices that support the hand can immobilize a joint; prevent deformity; reduce abnormal muscle tone; and reduce contractures in painful, spastic, or stiff distal interphalangeal joints, proximal interphalangeal joints, metacarpophalangeal joints, or carpometacarpal joints. A thumb spica splint can help prevent thumb movement and provide support when carpometacarpal joint arthritis is present or during recovery from an injury. A dynamic hand orthosis helps provide support while allowing corrective positioning of the hand and fingers to enable functional use of the hand; such dynamic devices can involve external supports, rubber bands, or elastic attachments. Also, use of dynamic devices at the wrist can augment the natural tenodesis action of the wrist when pairing wrist extension with finger flexion to achieve functional hand use (tenodesis splint). Hand, wrist, and forearm devices: (continued on next page)		

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: 105962	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Life Care Center at Wells Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 355 Crossing Blvd Orange Park, FL 32073	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Supports that span the hand, wrist, and forearm can treat tendonitis in the hand, forearm, or both; help maintain ROM (range of motion); or help prevent flexion contractures (resting hand splint). At the wrist, a cock- up splint can position the wrist in 15 to 30 degrees of wrist extension to reduce the risk of flexor tendon contracture. However, with carpal tunnel syndrome, placement of a splint or brace should be in a neutral wrist position to help avoid median nerve compression. Research seems to show that maximal symptom relief occurs within the first 2 weeks of wearing a splint, and full-time splint use yields better outcomes than wearing the splint only at night.		

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: 105962	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Life Care Center at Wells Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 355 Crossing Blvd Orange Park, FL 32073	
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 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. Based on record review and interview, the facility, that did not furnish in-house dialysis services, failed to enter into a contract with a dialysis provider to furnish dialysis services to one (Resident #54) of two residents receiving dialysis services, from a total survey sample of 52 residents. The findings include: A review of Resident #54's active physician's orders revealed: Dialysis patient: Receives dialysis at [provider name]. Do not take BP (blood pressure) on left arm with fistula/shunt; send to dialysis on one time a day every Mon, Wed, Fri for dialysis treatment. 10:30 chair time pickup via [transport service name] (08/13/2025). On 9/11/2025 (Thursday) at 2:42 PM, the Administrator confirmed that there was no contract with [the resident's dialysis provider]. On 9/11/2025 at 3:46 PM, a review of the dialysis communication forms verified that the resident attended [dialysis provider name, address and phone number] on Mondays, Wednesdays, and Fridays. First treatment: 8/13/2025 at 11:30 AM. A review of the facility's policy and procedure titled Dialysis (revised: 8/18/2022), revealed: Policy: Federal Regulations . Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice .		