STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105980	A. Building B. Wing	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Center for Rehabilitation and Healing	11411 Armsdale Road Jacksonville, FL 32218

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and a review of facility policies and procedures, the facility failed to ensure that the resident environment was as free of accident hazards as was possible for one (Resident #47) of 31 sampled residents. The findings include: On 09/29/2025 at 1:11 PM, an aerosol can of Lysol disinfectant spray was observed located on Resident #47's bedside table. (Photographic evidence obtained) On 09/30/2025 at 11:23 AM, the resident was observed sitting up in a chair in his room with his spouse and daughter visiting. The resident's daughter was asked if she was aware of the can of Lysol that was now located on the resident's sink and where it came from. She stated, It belongs to him; we leave it here to spray his room at times. She was asked if the staff was aware of the Lysol, and whether or not any family teaching had been provided about environmental safety and storing aerosol sprays and other items that should not be left in a resident's room. She stated, No, they've never said anything about it. On 10/01/2025 at 10:35 AM, an aerosol can of Lysol disinfectant spray was observed located on the resident's sink. (Photographic evidence obtained) A review of Resident #47's record revealed an admission date of 12/12/2023 with diagnoses including hypertension, other specified disorders of the brain, occlusion and stenosis of the right carotid artery, dysphagia following cerebral infarction, Parkinson's disease, and a need for assistance with personal care. A review of the resident's Quarterly MDS (minimum data set) assessment, dated 9/19/2025, revealed a BIMS (brief interview for mental status) score of 02 out of 15 possible points, indicating severe cognitive impairment. The resident required set-up or clean-up assistance for eating, he was dependent on staff assistance for toileting, he was independent with bed mobility, and he required partial/moderate assistance with transfers. On 10/01/2025 at 12:54 PM, a review of the resident's active Care Plan revealed the following Focus Areas: The resident has an ADL (Activities of Daily Living) Self-Care Performance Deficit r/t (related to) a diagnosis of Parkinsonism. Date Initiated: 12/16/2023, Revision on: 12/16/2023. [Resident #47] has a Behavior Problem. He likes to put himself on the floor and crawl around. He resists care, refuses medication and has agitation. Date Initiated: 09/09/2024, Revision on: (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/30/2025. The resident has Impaired Cognitive Function/Dementia or Impaired Thought Processes r/t a diagnosis of dementia. Date Initiated: 12/16/2023, Revision on: 12/16/2023. A review of the resident's active physician's orders revealed: Ativan (anxiolytic) Injection Solution 2 milligrams/milliliter, Inject 0.5 milliliters intramuscularly every 12 hours as needed for severe anxiety for 14 Days (9/20/25-10/4/25) Sertraline (antidepressant) Oral Tablet 50 mg (milligrams), 1 tablet by mouth in the morning for depression 9/16/25 Clonazepam (long-acting tranquilizer) Oral Tablet Disintegrating 0.25 mg,1 tablet by mouth three times a day for anxiety 9/9/2025, and Buspirone (anxiolytic) Oral Tablet 30 mg, give 1 tablet by mouth two times a day for anxiety 5/28/25. On 10/02/2025 at 1:03 PM, an interview was conducted with Certified Nursing Assistant (CNA) B, who was asked how often she made resident rounds during her shift. She stated, every two hours. She was asked how she ensured the safety of the resident's environment. She replied, I make the bed, hang up clothes, and empty the trash. She was asked if the facility had a policy for the use of aerosol spray cans in resident care areas. She stated, They can't really have spray cans in their rooms. She was asked if she had received any training on restrictions of aerosol spray cans in the facility. She stated, yes. She was asked what she had been instructed to do if she observed aerosol spray cans in resident care areas. She replied, We take them out of their rooms and bring them to the nurses' station, and they discard them. On 10/02/2025 at 1:31 PM, an interview was conducted with Registered Nurse (RN) A, who was asked how often she conducted rounds on the residents. She replied, every two hours. She was asked how she maintained the residents' room environment. She stated, I clean up clutter, throw away things they don't need, or pick up paper off the floor. When she was asked if the facility had a policy for aerosol spray cans in resident care areas, she replied, yes. She was asked what she'd been instructed to do if she observed aerosol spray cans in resident care areas. She stated, We know to provide education to the resident and/or family that we can't allow those items because they are a hazard, and we remove them. On 10/02/2025 at 3:40 PM, an interview was conducted with Licensed Practical Nurse (LPN) C, who confirmed that she was the nurse assigned to Resident #47 during the evening shift on 10/1/25 and 10/2/25. She was asked how often she made rounds on her residents. She replied, I try to do it every two hours, but sometimes it's according to what's going on with the patients. Sometimes a resident may need more care, and I may not be able to keep my rounds to every two hours. She was asked how she maintained the residents' room environment. She stated, I might clean the bedside table and get things prepared for the meal. I also make sure fall interventions and call lights are in place. She was asked if the facility had a policy for aerosol spray cans in resident care areas. She stated, Yes, we have a book that outlines what they should and should not have. She was asked what she had been instructed to do if she observed aerosol spray cans in resident care areas. She stated she would first provide education and the facility policy to show them that the item had to be checked out by maintenance to make sure it was safe and to determine whether they had an MSDS (material safety (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	data sheet) allowing them to have it. On 10/02/2025 at 3:43 PM, LPN C was accompanied to room [ROOM NUMBER] (Resident #47's room). The nurse acknowledged the aerosol can of Lysol disinfectant that was still located on the resident's sink. She was asked if she identified the spray while she was working yesterday. She apologized for not observing the spray yesterday and stated, We try to catch things like this. She removed the can of Lysol from the room. On 10/02/2025 at 4:24 PM, an interview was conducted with the Director of Nursing (DON), who was asked if the staff received any training or education about resident safety as it pertained to aerosol spray cans in resident care areas. She stated, Yes they have, and the families have been told many times not to bring in cans of spray. She did not provide evidence of resident/family teaching about the prohibition of aerosol spray cans in resident care areas. She was asked what the staff had been trained to do if they observe aerosol spray cans in resident care areas. She replied, They know to remove it and educate the resident or family on why it's not safe to have it. A review of the facility's OSHA-Safety Data Sheet (SDS - 3 pages), revealed: A current SDS will be obtained and kept on file for each hazardous chemical stored or used on our premises. A review of the facility's policy on Environmental Services - Safe Environment (3 pages), revealed: In accordance with resident rights the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her own personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. Environment refers to any environment in the facility that is frequented by residents and visitors, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas.

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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. **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 who needed oxygen therapy received oxygen therapy as ordered for one (Resident #31) of 13 residents receiving oxygen therapy. The findings include: On 09/30/2025 at 11:19 AM, Resident #31 was observed lying in bed wearing a nasal cannula. She reported that she was doing well and had no concerns. She further stated she received 2 liters of oxygen, and the facility's food was great. The oxygen concentrator beside the resident's bed was out of her reach and was set with an oxygen flow rate of 2 liters per minute (2L/min). (Photographic evidence obtained) A review of Resident #31's active oxygen orders revealed: Oxygen: Nasal cannula ear cushions/padding every shift for pressure reduction (3/26/2025) Oxygen at 3 L/min continuous inhalation via nasal cannula every shift (3/26/2025) Oxygen saturation every shift (3/26/2025) Head of bed elevated per resident's request to prevent shortness of breath while lying flat every shift (3/26/2025) Oxygen tubing, cannula/mask change weekly and as needed one time a day every Saturday (8/2/2025). Other orders included: CPAP 8 cm H20 with 2L oxygen to be worn at bedtime for CPAP (3/27/2025) CPAP 12 cm H20 with sleep and as needed, may adjust settings as needed for compliance every shift for sleep apnea , apply CPAP every night with sleep and as needed naps (7/4/2025) Resident will have respiratory rate, lung sounds and oxygen saturation evaluation. Lung Sounds: C=Clear D=Diminished RA-Rales RH=Ronchi A=Absent Ask resident if experiencing nausea every shift notify DON (Director of Nursing) for temperature > 99.2 (3/25/2025). Further review of Resident #31's medical record revealed an admission date of 6/12/2024 with an initial admission date on 4/19/2018. The resident's primary diagnoses included acute and chronic respiratory failure with hypoxia. A review of the resident's End of PPS (Prospective Payment System) Part A Stay MDS (Minimum Data Set) assessment dated [DATE] revealed oxygen therapy, continuous, noninvasive mechanical ventilator, and CPAP. Resident #31 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 possible points, indicating severe cognitive impairment. The resident required partial/moderate assistance for eating, and toilet transfers were not attempted due to medical condition or safety concerns. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the active Care Plan focus and goals revealed: The resident has a diagnosis of Asthma/ Chronic Obstructive Pulmonary Disease (Date Initiated: 06/19/2025) and oxygen therapy (Date Initiated: 07/10/2025 with Revision on: 07/10/2025). Interventions included providing oxygen per MD (physician) order. Monitor oxygen saturation as per MD order Date Initiated: 06/19/2025 with Revision on: 06/19/2025); and Oxygen Settings: Oxygen at 3 L/min continuous inhalation via nasal cannula per MD orders (Date Initiated: 07/10/2025 with Revision on: 07/10/2025). (Copy obtained) A review of the resident's September and October 2025 Medication Administration Record (MAR) revealed that nursing was signing off as having administered oxygen at 3 L/Min continuous inhalation via nasal cannula every shift. (Copy obtained) On 10/2/2025 at 10:28 AM, Resident #31 was observed lying in bed awake, wearing her nasal cannula when Licensed Practical Nurse (LPN) E verified that the oxygen flow rate on the resident's oxygen concentrator that was located next to the head of the resident's bed and out of her reach was set at 2 L/min. LPN E further verified the resident's oxygen order in the electronic medical record, stating the resident had two orders: continuous and at bedtime. The certified nursing assistants (CNAs), when completing vital signs, and the nurses provided ongoing monitoring of residents' oxygen therapy. Nurses ensured residents receiving oxygen therapy received oxygen at the correct flow rate as per the physicians' orders. Nurses on the night shift were responsible for changing residents' oxygen tubing. Correct oxygen settings were identified during follow ups and by reviewing the physicians' orders. Correct flow rate settings were communicated from one staff person to another during walking rounds at change of shift. When LPN E was asked if the resident changed her own oxygen flow rate, the nurse replied, no. When asked if the resident ever refused oxygen therapy, LPN E replied, no. On 10/2/2025 at 11:53 AM, the Director of Nursing confirmed that correct oxygen flow rate settings were identified by reviewing the physicians' orders. She stated nursing could adjust a resident's oxygen flow rate as necessary if the resident was in distress. Then the nurse would notify the physician of the concern and flow rate adjustment made and to request a new order. A review of the facility's policy and procedure titled Nursing - Oxygen Administration (undated), revealed: Purpose: The purpose of this procedure is to provide guidelines for oxygen administration. Procedure . 11. Adjust the delivery device so that it is comfortable to the residents and the proper flow of oxygen is being administered. (Copy obtained)