STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106042	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Freedom Square Health Care Center	10801 Johnson Blvd Seminole, FL 33772

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 interviews and record review, the facility failed to provide treatment related to respiratory complications to one resident (#2) out of three residents sampled. On 2/10/2026 at 5:55 p.m. Resident #2 began to experience increased mucous production, increased phlegm, and coughing as a result of his illness. On 2/11/2026 at 2:35 a.m. Resident #2 was found to have no pulse and not breathing. Findings Included:An interview was conducted on 2/17/26 at 1:07 p.m. with the Resident Representative (RR) for Resident #2. The RR stated having had several conversations with the facility nursing staff regarding Resident #2's treatment plan after radiation therapy to the esophagus. The RR stated the conversations included the side effects of the radiation therapy which included thick secretion that would need to be coughed up or suctioned to clear the air way. The RR stated the family hired a sitter to be with Resident #2. The RR stated the sitter informed her Resident #2 was throwing up phlegm. The RR stated she requested the sitter to notify the nursing staff at the facility. The RR said on 2/10/26, around 10:48 p.m., the nurse called and informed her the bolus tube feeding could not be administer at 6:00 p.m. or 8:00 p.m. because Resident #2 was coughing and choking. She stated the nurse informed her she had contacted the doctor who ordered intravenous (IV) fluids, chest x-ray, and an x-ray to check for intestinal blockage. She stated The nurse was more concerned about the bolus tube feed than the coughing and choking. The RR stated she reiterated the thick secretions being a side effect of the radiation therapy and asked the nurse if they are able to suction Resident #2. The RR stated the nurse assured her suctioning was available, although Resident #2 had not needed to be suctioned due to Resident #2 being able to clear the secretions. The RR stated the next phone call she received was Staff B, Registered Nurse (RN) informing her Resident #2 had passed away. The RR stated upon arriving to the facility asking Staff B, RN if Resident #2 had been suctioned. Staff B, RN told me that he had not suctioned Resident #2. An interview was conducted on 2/18/26 at 11:06 a.m. with Staff A, Certified Nursing Assistant (CNA). Staff A said she was assigned Resident #2 from 11 p.m. on 2/10/26 to 7 a.m. on 2/11/26. She said when she came in at 11:00 p.m. Resident #2 was acting like himself and around 12:00 a.m. she and Staff B, Registered Nurse (RN) put a brief on him and helped him into bed. Staff A said just before 1:00 a.m. she saw Staff B, RN walking fast down the hall and he asked if I could go watch Resident #2. Staff A said when she got to Resident #2's room he was lying in bed unresponsive. She said the resident was breathing and sounded like something was stuck in his throat. She said the resident then started making a gargling sound in his throat. Staff A said the nurse had left the room and she did not know what to do. Staff A said she never saw Staff B, RN or anyone else try to suction Resident #2 to clear his airway and the oxygen was never applied to the resident. Staff A said when Staff B, RN came back to the room, Staff C, RN; Staff D, CNA; and Staff E, CNA were with him. Staff A said when Staff A came back to the room Resident #2 still had a pulse and was breathing but had a lot of foam coming out of his mouth. Staff A said Resident #2 was a Do Not Resuscitate (DNR) (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

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	and took his last breath.Review of admission Records showed Resident #2 was admitted on [DATE] with diagnoses including malignant neoplasm of esophagus, gastrostomy status, adult failure to thrive, Alzheimer's disease, and dysphagia.Review of Resident #2's 12/13/25 Minimum Data Set (MDS), Section C, Cognitive Patterns, showed a Brief Interview for Mental Status (BIMS) score of 2, which indicated severely impaired cognition.Review of Resident #2's physician orders showed:-NPO [nothing my mouth] diet. Dated 1/10/26.-Do Not Resuscitate. Dated 1/10/26.Review of Resident #2's progress notes showed:-2/10/26 5:55 p.m.Resident experiencing increased mucus production/phlegm. Resident also has increased coughing. percutaneous endoscopic gastrostomy (PEG) tube feeding held. Called and reported to doctor. Received new orders for an immediate (STAT) chest x-ray 2 view, STAT kidney, ureter, and bladder x-ray, STAT complete blood count and comprehensive metabolic panel, duo-neb inhaler one now and as needed (PRN) every (q) 6hrs, and Tessalon pearls 200 mg q 8hrs as needed for cough via PEG tube.Change in Condition/Situation, Background, Appearance, Review/Recommendation (SBAR) completed.-2/10/26 10:12 p.m.Call placed to on call provider requesting to send resident to hospital at which time on call practitioner stated not to send, but to administer IV fluids and await lab and diagnostics. After speaking with on call, Resident Representative (RR) was made aware of nursing concerns regarding missed bolus feeds and respiratory status, agrees with practitioner on call to stay in facility as opposed to hospitalization and that resident is completing his radiation treatments and would rather him not go out to the hospital, but to be monitored and await result, as increased mucus insertion was a common side effect among radiation treatment. IV fluid orders carried out, resident is stable responsive and alert at time of IV placement. Head of bed elevated call light within reach.- 2/10/26 10:27 p.m.Call placed to on call for primary care provider (PCP) regarding continued concerns about increased mucous, phlegm production, and coughing. Head of bed (HOB) elevated, resident effectively coughing secretions into basin. Per on call, IV fluids normal saline (NS) 0.9% via peripheral intravenous (IV) 100 cubic centimeters(cc)/hour (hr.) x 1 liter (L). Report STAT lab and diagnostics as soon as possible (ASAP) when available. Productive cough noted, self-expectorating secretions into basin. Frequent monitoring by staff. HOB elevated, call light within reach.- 2/10/26 10:37 p.m. Spoke to RR regarding Resident #2's condition, clinical update provided regarding concerns r/t increased mucous and cough. Made aware of new orders for IV and NS. Reported that diagnostics had been completed, awaiting results. Made aware that resident did not tolerate 6:00 p.m. and 10:00 p.m. bolus feeding due to (d/t) severe cough. Continued monitoring, HOB elevated, basin and call light in reach.- 2/11/26 12:09 a.m.Peripheral IV started to right (Rt) hand, tolerated well, patent, good blood return. IV NS 0.9% at 100 cc/hr started. IV site covered with sleeve dressing. HOB elevated. Call light within reach.- 2/11/2026 02:17 2320H IV NS 0.9% started @ 100cc/hr. running well. noted skin tear on his left forearm approx. 4 cleanse with NS and covered with allevyn. 12:50 a.m. [Staff B, RN] saw resident standing on the side of his bed. increasing restlessness. sweating and diaphoretic. Vital signs (VS) blood pressure (Bp) 156/117, heart rate (HR) 103, temperature (T) low, oxygen (o2) saturation (sat) 45%. Nebulizer breathing treatment (Tx) administered and try to call doctor but unable to contact. 911 activated. Came back to room with oxygen the resident is no longer breathing.-2/11/26 2:35 a.m.1:00 a.m. the resident had no pulse and no breathing. Ambulance arrived. He passed away.An interview was conducted on 2/18/26 at 2:39 p.m. with Staff E, CNA. Staff E said on 2/11/26 she saw Staff B, RN running to get oxygen out of the clean utility room so she went to Resident #2's room. Staff E said the night before she cared for Resident #2 and he did not have any issues. Staff E said when she got to Resident #2's room on 2/11/26 just before 1:00 a.m., he had oxygen tubing but it was not hooked up to oxygen. She said Staff B, RN had the staff help try to sit the resident up and pull (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	him up in bed. Staff E said the resident was very pale, sweating, hot, and had shallow breathing. She said Resident #2 was not coughing. She said Staff B, RN never got oxygen hooked up to the resident even though he was still breathing. Staff E said the staff were like deer in the headlights. An interview was conducted on 2/18/26 at 1:57 p.m. with Staff B, RN. Staff B said he was the assigned nurse for Resident #2 starting at 11:00 p.m. on 2/10/26. He said a little bit before 1:00 a.m. on 2/11/26 Resident #2 was standing by his bed without a brief on and Staff A, CNA helped him get a brief on the resident and get him back in bed. Staff B said after a little bit he went back to the room and Resident #2 had shortness of breath (SOB) so he went and got a nebulizer treatment to administer to the resident. Staff B said he also tried to call the doctor but did not get him. He said he went back to Resident #2's room but did not listen to his lungs because he could hear that he had crackling but the resident was not coughing. Staff B said he checked Resident #2's VS and he had high blood pressure and low oxygen saturation, so he left the room to call 911 and get oxygen. Staff B said he did not call for help from the room, but when he left the room he saw Staff A, CNA and asked her to go watch the resident. He said he was going to get oxygen from the clean utility room and when he came back other staff came with him to the room. He said he did not know what they did then, but he was not able to get oxygen on the resident and Resident #2 took his last breaths. Staff B said he had a nasal cannula but there was no oxygen or suction machine in the resident's room. Staff B said he did not grab the code cart that has oxygen, oxygen masks and suction on it because Resident #2 was a Do Not Resuscitate. An interview was conducted on 2/18/26 at 1:45 p.m. with the Respiratory Therapist (RT). The RT said he had not seen Resident #2 but staff were supposed to call him if something goes wrong with a resident and respiratory therapy might be needed. He said he should be contacted if there are any questions or problems with residents. The RT said if a resident had gurgling sounds or sounded like something was stuck in their throat, you would think the nurse would have suctioned them and placed them on oxygen. The RT said even residents on hospice would be suctioned in that case. As far as giving the resident a nebulizer he said, that is not going to help a whole lot. The RT said that is the type of education he does in the building. He said the nurses were not using their resources.An interview was conducted on 2/17/26 at 3:30 p.m. with the Director of Nursing (DON). The DON said Staff B, RN's timeline of the events did not line up and his note looked like it was documented after the fact in a frantic manor. The DON said she would have expected Staff B, RN to have stayed with the resident and not left the resident with the CNA. She said she did not understand why the nurse did not get the code cart, suction the resident and apply oxygen, which is what the nurse should have done. The DON said if the nurse grabbed the code cart he would have had everything he needed in front of him (i.e. oxygen, oxygen mask, suction, etc.). She said the cart is not only used for codes, it has all the emergency supplies.Review of the facility's Respiratory Protocol, undated showed:When the resident is exhibiting any of the following: rapid breathing, shortness of breath, wheezing, use of accessory muscles, or decreased O2 saturation (under 92% unless previously documented as resident normal).IMMEDIATELY Check airway to make sure nothing is obstructing air flow (clear airway if needed: *Check for any PRN medications to be utilized for relevant symptoms (bronchodilators to be administered through nebulizers or inhalers) and Notify [company name] Respiratory [phone numbers]RESPIRATORY DISTRESS-Check resident airway (clear if needed)-Obtain crash cart -place non-rebreather mask on resident attached to O2 -suction (if needed)-Call Physician-Call 911 if unable to stabilize resident.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to follow the prescribed diet for two (Resident #2 and #6) of three residents sampled. Findings included: Durning an interview on 2/17/26 at 1:07 p.m. Resident #2's resident representative (RR) said on three different occasions when visiting staff were attempting to give Resident #2 fluids or food. RR stated Resident #2 was not to have anything by mouth. A review of Resident #2's medical record revealed an admission date of 12/9/25 and readmission on [DATE] with the following diagnosis to include but not limited to: malignant neoplasm of esophagus; dysphagia; and dementia. A review of Resident #2's Minimum Data Set (MDS) dated [DATE] revealed a brief interview for mental status (BIMS) score of 2, meaning resident had significant cognitive impairment. A review of Resident #2's physician orders revealed an order dated 12/9/25 for Resident #2 to have nothing by mouth (NPO). Review of the grievance log for December 2025 revealed Resident #2's family had filed grievances on 12/25/25 regarding resident receiving a meal tray. The grievance showed the meal tray was mistakenly given to Resident #2, was not Resident #2's tray as Resident #2 did not receive a tray. Staff were educated. Review of the grievance log for January 2026 revealed Resident #2's family filing a grievance on 1/14/26 regarding Resident #2 receiving a meal tray, again. The grievance showed staff re-educated on verifying meal tray tickets upon delivery of tray to resident. During an interview on 2/17/26 at 3:30 p.m. the Social Service Director (SSD) stated the grievances were filed by Resident #2's family and confirmed Resident #2 had received trays on both occasions. On 2/18/26 at 11:24 a.m. Resident #6 was observed being served the lunch meal in the resident's room. The tray had a small can of ginger ale and the resident's meal. Resident #6 was up and sitting in the wheelchair with the over the bed table. The tray was placed on the over the bed table. Next to the tray were three cans of unopened ginger ale and one open. Staff F, Certified Nursing Assistant (CNA) entered the room and placed a cup of hot chocolate onto Resident 6's tray. Staff F, CNA stated Resident #6 can have what he wants. Staff F, CNA stated he gets enough, when asked about if Resident #6 was on fluid restrictions. A review of Resident #6's medical record revealed an admission date of 12/3/25 with the following diagnosis to include but not limited to: end stage renal disease (ESRD) with dependence on renal dialysis, type 2 diabetes mellitus with diabetic chronic kidney disease, chronic hepatitis, and dementia without behavioral disturbance. A review of Resident #6's MDS dated [DATE] revealed a BIMS of 5, meaning resident had significant cognitive impairment. No behaviors were exhibited in the look back period. Resident #6 was able to complete eating and mobility after being set up with assistance and was on a therapeutic diet. A review of Resident #6's physician orders revealed an order dated 12/3/25 for 1000 milliliter (ml) fluid restriction per 24 hours, Nursing 400 ml (7a-3p - 240 ml, 3p-11p - 100 ml, 11p-7a 60 ml), Dietary 600 ml (120 ml at breakfast, 240 ml at lunch and dinner) related to ESRD, nursing to document amount consumed. A review of Resident #6's medical record did not reveal any notification to the physician or family of Resident #6's noncompliance with fluid restrictions. During an interview on 2/18/26 at 11:47 a.m. Staff G, CNA stated the computer system and tray ticket informs the staff of knowing if a resident is on a specific diet or fluid restrictions and of course, you can always ask the nurse. Staff G, CNA stated being the assigned CNA for Resident #6 and he can have what he likes with his meals just nothing in between. During an interview on 2/18/26 at 2:17 p.m. Staff H, Registered Nurse (RN) stated there would be a physician order for fluid restrictions. If a resident is non-compliant the physician and family would need to be notified. During an interview on 2/18/26 at 3:30 p.m. the Registered Dietitian (RD) stated residents should receive the diets as (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordered by the physician. Resident #6 was on dialysis and was on fluid restrictions. The RD stated knowing the resident is non-compliant with fluid intake and has not spoken with dialysis center, the physician nor the family. During an interview on 2/18/26 at 3:18 p.m. the Director of Nursing (DON) stated the expectation is for residents to receive the diets as ordered by the physician and for notification to be made if necessary regarding non-compliance. Review of the facility policy titled Therapeutic and Mechanically-Altered Diets not dated revealed: Policy: It is the policy of the community to provide therapeutic and mechanically altered diets as ordered by the attending physician. Food will be designed in a form to meet individuals' needs and support optimal nutritional status. Procedure: . Tray tickets identify diet orders to ensure the resident receives a diet as order. Response to therapeutic or mechanically-altered diet by the Dietary Manager or Resident Dietitian. When a resident refuses to comply with the therapeutic diet, negative consequences of noncompliance will be explained. If the resident continues to refuse adherence, the Charge Nurse will be notified and the physician will be contacted for possible diet liberalization.