STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106046	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terrace Healthcare & Rehabilitation Center	7207 SW 24th Ave Gainesville, FL 32608

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review, the facility failed to ensure care plan was revised for oxygen administration for 2 of 4 residents reviewed for respiratory care (Residents #71 and #116).Findings include:1) Review of Resident #116's physician order dated 2/10/2026 read, Oxygen at 5 liters/minute via nasal cannula with humidification when on concentrator. May be without humidification when on a tank every shift.During an observation on 3/17/2026 at 7:57 AM, Resident #116 was in bed, being administered oxygen at 4 liters per minute via nasal cannula, with an empty humidity bottle.Review of Resident #116's comprehensive care plan showed a focus for a potential for complications of respiratory distress related to chronic obstructive pulmonary disease and pneumonia, with the interventions that included administration of oxygen as ordered. There was no intervention to address adjustment of oxygen by the resident.During an interview on 3/19/2026 at 9:33 AM, Staff E, Licensed Practical Nurse (LPN), stated, He will adjust his oxygen levels as he sees fit. He has been using oxygen for a long time.2) Review of Resident #71's physician order dated 12/10/2025 read, Oxygen at 2 liters/minute via nasal cannula with humidification when on concentrator. May be without humidification when on a tank every shift.During an observation on 3/17/2026 at 8:17 AM, Resident #71 was in bed, with oxygen being administered at 4 liters per minute via a nasal cannula.During an observation on 3/18/2026 at 9:04 AM, Resident #71 was being administered oxygen at 4 liters per minute via nasal cannula. The oxygen concentrator was on the right side of the resident's bed outside of the resident's reach.Review of Resident #71's comprehensive care plan showed a focus for a potential for complications of respiratory distress related to rhinovirus and history of pneumonia, with the interventions that included administration of oxygen as ordered. There was no intervention for adjustment or removal of oxygen by Resident #71's representative.During an interview on 3/19/2026 at 9:33 AM, Staff E, Licensed Practical Nurse (LPN), stated, Her daughter will come in and adjust her oxygen. Sometimes she will actually remove it. We had educated her that this shouldn't happen, but she still does it anyway.Review of the facility policy and procedures titled Respiratory Care with the last approval date of 1/21/2026 read, Policy: It is the policy of this facility to provide respiratory care and safe oxygen administration to meet the needs of the residents. Procedure: 15. The use of oxygen, respiratory conditions/medications or trach [tracheostomy] needs should be reflected in the residents plan of care.

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review and interview, the facility failed to ensure residents on hospice received the care and services ordered by the hospice physician for 1 of 2 residents reviewed for hospice services (Resident #117) and failed to ensure residents received medications via gastrostomy tube consistent with standard of practice for 2 of 3 observations of medication administration via gastrostomy tube (Resident #151). Findings include: 1) Review of Resident #117's physician order dated 12/2/2025 read, [Name of the hospice] Hospice Services – [Name of the hospice] Hospice & Palliative Care. Review of Hospice-Skilled Nursing Facility Agreement between the facility and hospice, with an effective date of 11/6/2025, read Article II. Responsibilities of Hospice. 2.2 Professional Responsibility. Hospice shall be responsible for determining the appropriate course of hospice care, including the determination to change the level of services provided, including making arrangements for any necessary continuous care or hospice-related inpatient care in a participating Medicare/Medicaid facility as provided by 42 C.F.R. [Code of Federal Regulations] 418.108. 2.3 Patient Assessments. 2.5 (a) Coordination of Services. For each Hospice Patient in the Nursing Home, the Hospice Interdisciplinary Group shall (1) maintain responsibility for directing, coordinating, and supervising the Hospice Care and Hospice Services provided under this Agreement, (2) require all care and services provided to Hospice Patients shall be provided in accordance with the Hospice Plan of Care, based on all Hospice assessments of the patient and family needs. (b) Hospice Physician Services. Hospice Medical Director and Hospice Physicians (in conjunction with the Attending Physician) shall be responsible for providing Hospice Patients with medical services for the palliation and management of the terminal illness and conditions related to the terminal illness. Article V. Records. 5.1 Maintenance and Retention of Records. Nursing Home and Hospice shall each prepare and maintain complete and appropriate clinical records concerning each Hospice Patient in Nursing Home in accordance with prudent record keeping procedures, their own policies and procedures, applicable federal and State law and regulations, and applicable Medicare and Medicaid program guidelines. Review of Resident #117's Hospice Physician's Telephone/Verbal Order, signed by the Hospice Physician on 12/8/2025, read, Discontinue: Fleet enema, Citroma solution 1.745 gm [grams]/30 ml [milliliters], Aspirin 81 mg [milligrams], multivitamin, polyethylene glycol powder, Voltaren arthritis pain gel. New: Comfort Kit – Atropine 0.01% ophthalmic drops place 2 drops into mouth every 4 hours as needed for excessive secretions, Haloperidol liquid 2mg/ml give 0.5 ml by mouth every 4 hours as needed for agitation, Lorazepam liquid 2 mg/ml- give 0.25 ml by mouth every 4 hours as needed for anxiety, agitation, restlessness; morphine concentrate 20 mg/ml or 100 mg/sl [sublingual] give 0.2 sl by mouth every 2 hours as needed for non acute pain or dyspnea, ondansetron 4 mg give 1 tablet by mouth every 6 hours as needed for nausea and vomiting. Review of Resident #117's physician orders on 3/18/2026 showed the following orders: Fleet Enama, Insert 1 application rectally as needed for constipation if no results 1 day after suppository. Order Status: Active. Order Date: 10/06/2026; Citroma Solution 1.745 gm/30 ml (Magnesium Citrate), Give 296 ml by mouth as needed for constipation in AM [morning] if no results after enema. If no results within 1 hour of completion of bowel protocol, contact MD immediately for further orders. Order Status: Active. Order Date: 10/06/2024; Aspirin Oral Tablet Chewable 81 mg (Aspirin), Give 1 tablet (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by mouth one time a day related to unspecified osteoarthritis, unspecified site. Order Status: Active. Order Date: 10/07/2024; Multivitamin-Minerals Oral Tablet (Multiple Vitamins w/ [with] minerals), Give 1 tablet by mouth one time a day related to Vitamin Deficiency, unspecified. Order Status: Active. Order Date: 10/07/2024; Polyethylene Glycol Powder (Polyethylene Glycol 1450), Give 17 gram by mouth two times a day for Constipation. Order Status: Active. Order Date: 05/26/2025; Voltaren Arthritis Pain External Gel 1% *Diclofenac Sodium (Topical)), Apply to L [left] knee topically every 6 hours as needed for pain, Apply 4 gram. Order Status: Active. Order Date: 11/05/2025. Review of Resident #117's clinical records revealed a progress note authored by the Facility Physician on 1/5/2026 that showed the Facility Physician had addressed the continuation of the arthritis pain gel but failed to provide justification for continuation of other medications the Hospice Physician had ordered for discontinuation. Review of Resident #117's active physician orders on 3/18/2026 showed no order for the comfort kit medications ordered by the Hospice Physician. Review of Resident #117's physician progress notes showed no justification for not providing Resident #117 with the comfort kit medications ordered by the Hospice Physician. During an interview on 3/18/2026 beginning at 9:45 AM, the Director of Nursing confirmed the Hospice Physician's orders had not been implemented. She confirmed orders discontinued by the Hospice Physician were still in effect, the comfort kit medications ordered by the hospice physician had not been implemented, and Resident #117's Facility Physician had not provided justification in the clinical record for Resident 117's active medication regimen. During an interview on 3/18/2026 at 10:02 AM, the Facility Physician stated, I never saw that document [Hospice Physician's Telephone/Verbal Order]. I probably just wrote continue course. During an interview on 3/18/2026 beginning at 10:14 AM, Staff C, Licensed Practical Nurse/Unit Manager, stated, Honestly, can't say that I recall this [Hospice Physician's Verbal Order], but probably have seen it. I remember reviewing with [Name of the Facility Physician]. I remember this because of Haldol and Lorazepam. He did not want her to be snowed. He is particular about his patients, orders from outside are reviewed with him. I don't believe I did [document the conversation with him]. 2) Review of Resident #151's physician order dated 3/10/2026 read, Check tube residual to verify placement prior to administration of feeding, medication, and prior to flush. If residual is 100 ML [milliliters] or more, hold feeding and notify physician every shift. During an observation of medication administration for Resident #151 on 3/19/2026 at 5:05 AM, Staff C, Licensed Practical Nurse (LPN), assembled all supplies, performed hand hygiene, left the medication cart to get refrigerated medication, returned to the medication cart, performed hand hygiene and donned gown and gloves. Staff C did not attempt to verify gastrostomy tube placement by verifying gastric residual volume. Staff C did not flush the gastrostomy tube with water prior to administering medications. Staff C attached the syringe and provided liquid medications through the gastrostomy tube by pushing them in with the syringe instead of allowing gravity flow of medications. Resident #151 requested pain medication. Staff C removed gown and gloves and performed hand hygiene, and obtained pain medication. Staff C donned a new gown and gloves, and administered the medication without administering a water flush and checking for gastric residual volume. Staff C (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pushed the medication into the gastrostomy tube without allowing gravity flow of the medication. During an interview on 3/19/2026 at 5:50 AM, Staff C, LPN, stated, I should not have pushed the medication in. I should have let gravity flow it in. I should have checked to see if he had any residual volume before giving the medications. Review of the facility policy and procedure titled Medication Administration via Enteral Feeding Tube with the last review date of 1/21/2026 read, Policy: Medications shall be prepared and administered according to the following established guidelines. Licensed Staff shall not administer a drug that is inadequately dissolved (i.e., particulate matter still evident); that may clog the enteral feeding tube. Tube placement will be verified prior to the administration of a medication. The enteral tube will usually be flushed with 30-50 ml of water before and after medication administration and 5-10 ml water between medications administered, unless otherwise ordered by a physician. Procedure: 5. Verify feeding tube placement. 6. Flush feeding tube with a least 30-50 ml of warm water, or per physician orders to clear it of formula. Precautions: 2. Do Not administer drugs without flushing the tube before and after delivery.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on record review and interview, the facility failed to ensure acceptable parameters of nutritional status, specifically residents' body weight, were maintained for 1 of 7 residents reviewed for nutrition (Resident #68).Findings include:Review of Resident #68's Weights and Vitals Summary revealed the resident weighed 124.2 pounds on 10/16/2025 and 118.6 pounds on 11/6/2025, which shows a 4.51% weight loss. The resident weighed 109 pounds on 12/8/2025, which shows 8.09% weight loss from 11/6/2025. The resident weighed 111 pounds on 1/7/2026, 107 pounds on 2/5/2026, and 108.1 pounds on 3/16/2026. The resident had a 12.96% weight loss between 10/16/2025 and 3/16/2026.Review of Resident #68's SBAR (Situation, Background, Assessment, Recommendation) read, Situation. The change in condition, symptoms, or signs observed and evaluated is/are: Weight loss. This started on 01/06/2026. There was no documentation of notification of the Registered Dietitian.Review of Resident #68's dietary narrative note dated 1/16/2026 read, 88 y/o [year old] F [female] evaluated for a change in condition d/t [due to] weight loss . Resident is not currently receiving oral nutritional supplements. Weight hx [history] is admission wt [weight] of 124.2# [pounds] on 10/16/25, 11/6/25, 118.6# (-5.6%), 12/8/25 109# (-12.2), 1/7/26 111# (10.6%); percent weight loss compared to admission weight. No new labs currently available. Resident weight trend shows weight loss during the first 2 months in the facility . Continue to monitor and follow prn [as needed].Review of Resident #68's Nutritional Progress Note dated 2/16/2026 read, Resident is triggering for significant weight loss in 3 months of 9.8%/ 11.6# . Weight hx is admission wt of 124.2# on 10/16/25, 11/6/25 118.6# (-5.6%), 12/8/25 109# (-12.2), 1/7/26 111# (10.6%), 2/5/25 107#. Resident has gained 2# in January of 2026 compared to December 2025 and has now lost 4# compared to Jan '26 [January 2026] weight. Resident has referral (2/3/26) to gynecology d/t lump in lt (left) breast. Recommend house nutritional supplement BID [Twice a day]. Continue to monitor and follow prn.Review of Resident #68's Nutritional Progress Note dated 3/16/2026 read, Resident is triggering for weight loss trend. Resident is not currently receiving oral nutritional supplements. Recommend house nutritional supplement BID. Continue to monitor and follow prn.Review of Resident #68's physician orders from 10/15/2025 through 3/16/2026 revealed an order dated 3/16/2026 that read, House Nutritional Supplement two times a day for risk of malnutrition, Offer 120 ml [milliliter] BID. Document amount consumed. Further review showed no orders prior to 3/16/2026 for nutritional supplements or appetite stimulant medications.During an interview on 3/18/2026 at 12:10 PM Staff B, Licensed Practical Nurse (LPN), stated that if a resident had a significant weight loss, the expectation was to complete a Change in Condition form and notify the MD (medical doctor), the family, and the RD (Registered Dietitian). During an interview on 3/18/2026 at 12:53 PM, the RD stated, Staff routinely notify me for nutritional concerns with the residents, including weight loss. My process is to dig in the first working day after the 15th regarding resident weights and nutritional concerns, unless I am notified specifically about an issue. I entered supplements last month [for Resident #68]. I don't know where the disconnect was. Obviously with her downtrend, she needed to be on supplements. I evaluated her and ordered supplements in February and noticed on Monday [3/16/2026] that it didn't get started.During an interview on 3/18/2026 at 1:30 PM, Staff A, LPN, stated she called the RD on 1/6/2026 when she completed the change of condition form for Resident #68's weight loss, because she always called him. She thought she remembered Resident #68 being on a nutritional supplement, but she was not able to find that one had been ordered or given prior to 3/16/2026.During an interview on 3/18/2026 at 2:36 PM, the Director of Nursing (DON) stated, We enter weights monthly. We don't determine if weight loss is significant. We enter the weights and [name of the RD] lets us know if the weight loss is significant. The weights are done by restorative between the first and the seventh [of each month] and I enter the weights [in the medical record]. The unit manager spoke with the restorative CNA [Certified Nursing Assistant] who took [Resident #68's name] weight and knew she had lost weight. That's when she put in the change in the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition. We never put his [the RD's] orders in; we review the orders he puts in.During an interview on 3/18/2026 at 2:55 PM, Physician #1 stated he was sure he had talked to the nutritionist about a supplement [for Resident #68]. Maybe he could start her on [appetite] stimulants. He could have done something sooner about starting her on nutritional supplements or an appetite stimulant. Review of the facility policy and procedures titled Weights and Weight Loss with the last review date of 1/21/2026 read, Policy: It will be the practice of this facility to implement the following systems regarding weight documentation. Procedure: 5. Significant weight loss shall be addressed by the physician and/or RD through discussion with the resident and/or resident representative for known preferences and desires and development and implementation of interventions to attempt to address the weight loss.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medications were stored in a safe and secure manner.Findings include:During an observation on 3/16/2026 at 9:45 AM, there were three pills and two tablets on cup of medications on top of the medication cart. There was no staff present at the medication cart. Residents were going by the medication cart and staff members were at the desk. Staff D, Licensed Practical Nurse (LPN), returned to the medication cart at 9:52 AM.During an interview on 3/16/2026 at 9:53 AM, Staff D, LPN, stated, I should not have left those on the medication cart. I went to answer the telephone. I should have brought them with me.During an observation on 3/19/2026 at 5:10 AM, Staff C, LPN, went to the medication room, poured a refrigerated liquid medication, Gabapentin 22.5 milliliters, returned to the medication cart, and verified the order for the resident. Staff C removed 2.5 milliliters of the medication from the medication cup and left the remaining medication on the medication cart while Staff C administered gastrostomy tube medications. Staff C returned to the medication cart to prepare additional medications and placed the liquid Gabapentin into the top drawer of the medication cart. Staff C then went on to administer medications to three residents with the liquid medication left in the top drawer of the medication cart.During an interview on 3/19/2026 at 5:55 AM, Staff C, LPN, stated, I should have taken the Gabapentin back to the refrigerator when I realized that I had poured too much. I should not have left it on top of the medication cart or in the drawer. I should have brought it back.During an interview on 3/19/2026 at 8:30 AM, the Director of Nursing (DON) stated, Medications should not be left on the medication carts.Review of the facility policy and procedures titled Medication/Biological Storage with the last approval date of 1/21/2026 read, Policy: It will be the policy of this facility to store medications, drugs and biologicals in a safe, secure and orderly manner. Procedure: 1. Medications, drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received, unless otherwise necessary.