STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106070	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desoto Health and Rehab	475 Nursing Home Dr Arcadia, FL 34266

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 0791 Level of Harm - Actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, interviews and record review, the facility failed to arrange routine and emergency dental services to meet the needs and address the dental pain of 1 (Resident #8) of 3 residents reviewed for dental services.The findings included:Review of the facility Resident Rights policy (last revised December 2016) noted Federal and state laws guarantee certain basic rights to all residents in this facility. These rights include the resident's right to: communication with and access to people and services, both inside and outside the facility.Review of the facility Dental Services policy (last revised December 2016) noted routine and emergency dental care services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care . Routine and 24-hour emergency dental services are provided to our residents through: a contract agreement with a licensed dentist that comes to our facility monthly, referral to the resident's personal dentist, referral to community dentists, or referral to other health care organizations that provide dental services . Social services representatives will assist residents with appointments, transportation arrangements, and for reimbursement of dental services under the state plan, if eligible. On 2/24/26 at 10:42 a.m., during an interview, Resident #8 said he had been having dental issues for a while. He's been asking to see the dentist but he is unable to get in a wheelchair. He's asked for the dentist to come to the facility but no one has ever seen him. A long, yellow, hard and pointy object, approximately 1 inch long was observed in a medicine cup at the resident's bedside. Resident #8 said, Oh that's my tooth. He said he's had a loose tooth for a while and a piece of bacon got stuck in it this morning. Resident #8 said he got tired of it and ripped it out.Review of the clinical record for Resident #8 revealed an admission date of 8/16/2019. Diagnoses included Hemiplegia (Paralysis of one side of the body) affecting the left side and dysphagia (Difficulty swallowing).Review of the Brief Interview for Mental Status dated 1/5/26 revealed Resident #8 scored 15, indicating intact cognition.Resident #8's care plan last revised 1/16/26 noted that the resident was at risk for dental/oral problems due to broken/missing teeth. Interventions included monitor/document/report as needed any s/sx (signs or symptoms) of oral/dental problems including teeth missing, loose, broken, decayed, dental consult as needed, notify physician of any changes .Review of a progress note dated 10/15/25 at 1:45 p.m., noted, Resident c/o (complaining of) loose tooth, Social worker informed.Review of a progress note dated 11/23/25 at 2:38 p.m., noted, Resident c/o dental pain states he has a loose tooth to bottom left side. Resident given tramadol at his request for pain.The clinical record lacked documentation of a dental consultation, or dental notes. The provider's notes from October 2025 had no documentation of dental concerns for Resident #8.On 2/24/26 at 12:10 p.m., in an interview, Resident #8 said he's been telling the facility just about every day that his left lower tooth was bothering him. It made it hard to eat and could not chew his food. He said the facility told him he had to go out to see the dentist. He said he's never refused to go to the dentist but he is unable to get in a wheelchair due to pain and contractures (fixed bend of a joint). Resident #8 said the tooth had been loose for a while so he just pulled it out.On 2/24/26 at 12:18 p.m., in an interview, Licensed Practical Nurse (LPN) Staff A said she was nurse assigned to Resident #8 and saw the resident's tooth at bedside. LPN Staff A said the resident told her he had bacon stuck in the loose tooth so he pulled the tooth himself. LPN Staff A said Resident #8's tooth has been loose (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 0791 Level of Harm - Actual harm Residents Affected - Few	prior to today but he will not go out to the dentist.On 2/24/26 at 1:02 p.m., in an interview, Unit Manager Staff B said when there are dental concerns, they usually notify the resident's Primary Care Physician and Social Services. Unit Manager Staff B said Resident #8 has requested to see a dentist prior to today, but he won't go to an outside dentist because he can't get into a wheelchair. She said getting into the wheelchair causes Resident #8 to be uncomfortable and in pain. Unit Manager Staff B said Social Services was notified on 2/19/26 of Resident #8's dental concerns.On 2/24/26 at 1:11 p.m., in an interview, the Social Services Director said she found out about Resident #8's loose tooth a week ago. She said that there is a free basic dental program that can be requested which would cover basic dental care such as checkups, cleanings and an exam but the issue is that Resident #8 can't get out of bed to go to the dentist. Upon reviewing the notes dated 10/15/25 and 11/23/25 in which Resident #8 complained of dental issues, she said she did not know what happened.On 2/25/26 at 10:43 a.m., in an interview, the Social Services Director said she was unable to locate any dental requests or records for Resident #8.On 2/25/26 at 1:30 p.m., in an interview, the Social Services Director said the facility in-house dental company responded and confirmed they have never seen Resident #8.On 2/25/26 at 1:38 p.m., in an interview, the Director of Nursing (DON) said that if a dental issue is identified, they need to reach out to social services. The DON said they complete an application to see if the resident qualifies for dental services. The DON said Resident #8 won't get into a wheelchair to go to a dentist outside of the facility. She said the issue was reported last week. The DON verified that the progress notes dated 10/15/25 and 11/23/25 documented that Resident #8 complained of dental issues. She said the expectation is to notify the physician and document it in the resident's medical record. The DON confirmed that a dental consultation was never obtained for Resident #8.

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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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on record review and interview, the facility failed to have an arbitration agreement that explicitly grants the resident the right to rescind the agreement within 30 calendar days of signing it. This has the potential to affect all residents residing in the facility.The findings included: Review of the facility's arbitration agreement revealed that Each party to this agreement shall have three (3) business days from execution of this agreement to cancel the agreement by notifying the other party in writing, by certified mail return receipt or retractable overnight delivery, of its desire to cancel. Residents #35, #47 and #42 were sampled from the facility provided list of new admissions who had signed the arbitration agreement. During an interview on 2/26/26 at 8:50 a.m., Resident #35 said she was familiar with arbitration due to being in and out of facilities. Resident #35 was unable to say how long she has to rescind the arbitration agreement. During an interview 2/26/26 at 8:57 a.m., Resident #47 said he was explained the arbitration process when he entered the facility. Resident #47 was unable to explain how long he has to rescind the arbitration agreement. During an interview on 2/26/26 at 9:02 a.m., Resident #42 said she has no knowledge related to the facility arbitration process. During an interview on 2/25/26 at 3:18 p.m., the Social Services Director said she explains the arbitration process to the residents upon admission before they sign it. The Social Services Director verified that the facility's arbitration agreement did not explicitly grant the resident or his/her representative the right to rescind the agreement within 30 calendar days of signing it.The Social Services Director confirmed the facility's arbitration agreement stated that each party to this agreement shall have three (3) business days from execution of this agreement to cancel the agreement.During an interview on 2/25/26 at 3:25 p.m., the Director of Nursing (DON) was unable to show where the facility arbitration agreement stated that the residents have 30 calendar days to rescind the agreement. The DON confirmed the arbitration agreement stated there were 3 business days to rescind the agreement.During an interview on 2/26/26 at 8:03 a.m., the Nursing Home Administrator confirmed the arbitration agreement did not have a 30-calender day rescind period.

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide a neutral and fair arbitration process and agree to arbitrator and venue. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to have an arbitration agreement that provides the selection of a venue that it convenient for both parties when there is a dispute. This has the potential to affect all residents residing in the facility.The findings included:Review of the facility's arbitration agreement revealed, Venue: In the event that any litigation arises under, or in any manner in relation to this agreement, whether ex contractor, or ex delicto, the venue of same shall lie exclusively in [NAME] County, Florida and no other location.Residents #35, #47 and #42 were sampled for review from the facility provided list of newly admitted residents who signed the arbitration agreement.During an interview on 2/26/26 at 8:50 a.m. Resident #35 said she is familiar with arbitration due to being in and out of facilities. Resident #35 was unable to explain the facility arbitration process.During an interview 2/26/26 at 8:57 a.m. Resident #47 said he was explained the arbitration process when he entered the facility. Resident #47 said arbitration is when they use a mutual party to resolve issues at the facility. Resident #47 was unable to explain any other details related to arbitration.During an interview on 2/26/26 at 9:02 a.m. Resident #42 said she has no knowledge related to the facility arbitration process. Resident #42 said she is unable to explain what arbitration is.During an interview on 2/25/26 at 3:18 p.m. the Social Services Director said she explains the arbitration process to the residents upon admission before they sign it. The Social Services Director confirmed the arbitration agreement said the venue was only in [NAME] County, Florida and no other location.During an interview on 2/25/26 at 3:25 p.m., the Director of Nursing (DON) was unable to show where the facility arbitration agreement stated that the residents have a right to a neutral venue. The DON confirmed the arbitration agreement said the venue was only in [NAME] County, Florida and no other location.During an interview on 2/26/26 at 8:03 a.m., the Nursing Home Administrator confirmed the arbitration agreement said the venue was only in [NAME] County, Florida and no other location.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, facility policy review, staff, resident, and resident representative interviews, the facility failed to ensure dignity during dining for 18 of 22 residents observed in the dining room during meals. The findings included:Review of the facility provided Policy for Resident Rights revised March 2021 statement revealed, Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a dignified existence; be treated with respect, kindness, and dignity; self-determination; be supported by the facility in exercising his or her rights; exercise his or her rights without interference, coercion, discrimination or reprisal from the facility; be informed about his or her rights and responsibility.On 2/23/26 at 11:43 a.m., 22 residents were observed sitting at tables in the dining room during the lunch meal. A staff member was observed going from resident to resident and applying a long clothing protector to approximately 18 residents without their request or permission. An unidentified female resident stated, I guess I am a messy eater.On 2/24/26 at 11:39 a.m., 22 residents were observed in the dining room during the lunch meal. A staff member was observed placing a clothing protector at each table setting. The staff member then went from resident to resident and applied a clothing protector without the resident's request or permission.On 2/24/26 at 12:20 p.m., in an interview, Resident #59 said she did not like having the clothing protector. She said, It makes me feel like an old lady.On 2/24/26 at 12:22 p.m., Resident #9 was observed in the dining room, wearing a clothing protector. Resident #9 was not able to answer interview questions. In an interview, Resident #9's sister said she visits four days a week and everyone in the dining room gets a clothes protector. She said she does not see staff asking residents if they would like to wear a clothing protector. The resident's sister said it would be upsetting if she was at a restaurant and someone walked up and applied a clothing protector without her permission.On 2/24/26 at 1:30 p.m., in an interview, Certified Nursing Assistant (CNA) Staff G said she has been employed at the facility for a year and a few months. When asked about applying clothing protectors to all residents during dining, she stated, We usually put it on everyone unless they refuse but most don't refuse. She said they do not ask the residents if they want to wear a clothing protector or not.On 2/25/26 at 2:50 p.m., in an interview, the Director of Nursing (DON) said that staff should be asking the residents before applying a clothing protector. She said that it was not right to apply the clothing protector without asking the resident first. She said she would not like it if someone put a bib on her without asking.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on record review, review of facility's policy and procedure, and interviews, the facility failed to ensure ongoing communication and collaboration with the dialysis center for 1 (Resident #5) of 2 residents reviewed for dialysis.The findings included:Review of the facility's undated policy and procedure for Dialysis Residents revealed the purpose was, To establish standardized clinical pathways for residents receiving dialysis services to ensure safe, coordinated, and high-quality care in compliance with federal and Florida state regulations . Dialysis Coordination . Communication with Dialysis Provider. Share clinical updates. Document dialysis treatment summaries. Participate in interdisciplinary care meetings.Review of the facility provided communication form used to coordinate with the dialysis center revealed a section to be completed by the Charge Nurse prior to dialysis which included vital signs, examination of shunt site, pain, concerns, time of last meal, fluid restrictions and amount. A section to be completed by a Dialysis Center Representative included pre-dialysis weight, vital signs, monitor shunt site, concerns, amount of meal eaten, supplement consumed, lab results, and follow-up orders. The last section to be completed by the Charge Nurse after dialysis included examine shunt site, location, dressing, pain, and concerns.Review of the clinical record for Resident #5 revealed an admission date of 5/22/25. Diagnoses included hemiplegia (paralysis of one side of the body), end-stage renal disease, and dependence on renal dialysis.Review of the care plan with a target date of 4/10/26 revealed that Resident #5's dialysis schedule was on Monday, Wednesday and Friday.On 2/24/26 at 1:43 p.m., in an interview, Resident #5 said she goes to dialysis on Monday, Wednesday and Friday. She said the facility does not give her a binder with the communication forms to take to dialysis.On 2/24/26 at 2:52pm in an interview, Licensed Practical Nurse (LPN) Staff E said she takes the resident's vital signs before she goes to dialysis but has not been filling out the communication form since the dialysis center never sends the form back to the facility. When asked about how the facility informed the dialysis center of changes to the resident's status, LPN Staff E said, I do not know how to answer that. She said she would assume the resident would tell them if there was a change in condition. LPN Staff E said Unit Manager Staff F calls the dialysis center to request the communication form to be faxed to the facility.On 2/24/26 at 3:01 p.m., in an interview, Unit Manager Staff F said the nurse should complete and send the communication form with the resident to dialysis. The dialysis center should complete their section and return the form with the resident. Unit Manager Staff F said it was hit or miss if the dialysis center returns the form. She said the dialysis center and the facility usually communicate via telephone but that communication was not documented.On 2/26/26 at 10:33 a.m., the facility provided two dialysis communication forms for Resident #5 for 11/24/25 and 1/15/26. The forms were incomplete. In an interview, Unit Manager Staff F verified there was no documentation of coordination with the dialysis center for Resident #5 from November 2025 through February 24, 2026. She said that somewhere along the line the dialysis communication binder went missing and it fell through the crack.On 2/26/26 at 10: 53 a.m., in an interview, the Director of Nursing (DON) said the Dialysis Communication Form should be sent with the resident to each dialysis session. She said the Dialysis Communication Form should come back completed by the dialysis center. The DON verified there was no documentation for the period November 2025 through February 24, 2026.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of facility's policy and procedure, and interviews, the facility failed to provide nail care necessary to maintain good personal hygiene for 1(Resident #8) of 3 dependent residents reviewed for nail care.The findings included:Review of the facility Activities of Daily Living (ADL) policy revised December 2016 revealed, It is the policy of [NAME] Health and Rehab to ensure all residents receive needed assistance with Activities of Daily Living (ADLs) in a manner that promotes independence, dignity, and the highest practicable level of physical, emotional, and psychosocial well-being, consistent with state and federal long-term regulations.Dressing/Grooming . Support grooming tasks (hair care, shaving, nail care) per resident preference . All DDL care must be documented in the resident record . documentation must be completed by the end of each shift for nursing services and included in the ongoing care record.On 2/24/26 at 10:42 a.m., Resident #8 was observed in bed. The resident's left hand was contracted (fixed bend of joint preventing extension) with all fingers curled inward in a tight fist. The resident's left index was protruding from the fist, and the left index jagged fingernail extended approximately 2 inches from the fingertip.In an interview during the observation, Resident #8 said he was not able to extend the fingers of his left hand and was not able to trim his fingernails. He said the staff trim his nails, except his left hand fingernails. Resident #8 said when he asks staff to trim his left hand fingernails, they say that they needed a special tool and would tell someone. Resident #8 said he did not remember the last time they trimmed the fingernails on his left hand. Record review for Resident #8 showed an admission date of 8/16/2019. Diagnoses included cerebral infarction (a blockage of brain blood vessels leading to inadequate oxygenation of the brain), Hemiplegia (paralysis of one side of the body) affecting the left side and dysphagia (difficulty swallowing).Review of the Brief Interview for Mental Status dated 1/5/26 revealed Resident #8 scored 15, indicating intact cognition.Review of Quarterly Minimum Data Set (MDS) assessment with an assessment reference date of 12/1/25 noted that Resident #8 required substantial/maximal assistance with personal hygiene. Review of Resident #8's Care Plan revealed that the resident had an ADL self-care deficit and needed assistance with all his ADL tasks. The interventions as of 2/28/2020 included to check the resident's nail length, clean and trim them on bath day and as necessary. Staff was to report any changes to the nurse.On 2/25/26 at 11:06 a.m., in an interview CNA Staff C said residents fingernails are trimmed twice a week, on shower days. She said nail care is documented on the shower sheets placed in the shower book. CNA Staff C said that refusals were also documented in the shower sheets. CNA Staff C verified that Resident #8's left index fingernail extended approximately 2 inches from the tip of the fingers. She said the resident's fingernail should be trimmed or filed down. On 2/25/26 at 11:35 a.m., in an interview CNA Staff D said that CNAs trim residents' fingernails. She said that nail care is provided as needed and documented on the resident's shower sheet. Upon observation of Resident #8's left index fingernail, CNA Staff D said the resident's nail was too long and should be trimmed. On 2/25/26 at 11:41 a.m., in an interview Unit Manager Staff B said that CNAs or nurses trim residents' fingernails. She said that nail care was offered twice a week during showers and documented on the shower sheet. Unit Manager Staff B said refusal of nail care was also documented on the shower sheet. When shown Resident #8's left index fingernail, she said it should be trimmed.Review of the shower sheets for January and February 2026 revealed that on 1/15/26, 1/22/26, 1/24/26, 1/29/26 and 2/7/26, Resident #8 received a shower but no nail care was provided.The shower sheets for 1/3/26, 1/17/26, 1/31/26 and 2/21/26 documented that nail care was provided to Resident #8.On 2/25/26 at 1:38 p.m., in an interview, the Director of Nursing (DON) said residents' nails should be trimmed as needed, as requested and offered with showers. The DON said nail care should be documented on the shower sheet. The DON said refusals of nail care should be documented on the shower sheet. The DON said her expectation was that (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refusals of nail care or the reason why nail care was not done needs to be documented and reported to the nurse. The DON reviewed the shower sheets and verified the documentation that on 2/21/26, nail care was provided to Resident #8. Upon observation of Resident #8's left index finger, the DON verified that the fingernail extended approximately 2 inches from the fingertip and said that the nail did not grow that long since 2/21/26. She said the resident's fingernail should have been trimmed.