STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106077	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Moosehaven	1701 Park Avenue 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, record review and review of the facility's policy and procedure titled Care Plans, Comprehensive Person-Centered (revised March 2022), the facility failed to develop and implement a comprehensive person-centered care plan that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and included the resident's goals, desired outcomes, and preferences for the use of psychotropic medications, for one (Resident #6) of six residents reviewed for unnecessary medication administration, from a total of 22 residents in the sample. This failure has the potential to result in unmet therapeutic goals, adverse drug events, unnecessary medication use, and reduced quality of life.The findings include: On 6/3/2026 at 8:57 AM, Resident #6 was observed sitting in his reclining chair in the corner of his room with a blanket draped over his lap. The television was off and he was looking out the window. He reported feeling okay. He said he had good days and bad days. He reported being independent with his activities of daily living (ADLs), requiring minimal assistance from staff, and said he received his medications but could not name them all or what they were treating. A review of Resident #6's medical record revealed an admission date of 9/11/2024. His medical diagnoses included type 2 diabetes mellitus, major depressive disorder, insomnia and anxiety disorder. A review of the resident's active physician's orders included: Wellbutrin XL Oral Tablet Extended Release 24 Hour 300 mg (Bupropion HCL), Give 1 tablet by mouth one time a day for depression, 6/4/2026 start date. Citalopram Hydrobromide Oral Tablet 20 mg (Citalopram Hydrobromide), Give 1 tablet by mouth one time a day for depression, ordered 11/27/2025. Trazodone HCL Oral Tablet 50 mg (Trazodone HCl), Give 1 tablet by mouth at bedtime for depression, ordered 6/4/2025.A review of the most recent annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 5/5/2026, revealed a Brief Interview for Mental Status (BIMS) score of 08 out of 15 possible points, indicating moderate cognitive impairment. Diagnoses included anxiety and depression (other than bipolar). Antidepressant medication was administered over the look-back period, the Psychotropic Drug Use Care Area was triggered, and the Psychotropic Drug Use Care Planning Decision was coded as yes.A review of the resident's active Comprehensive Care Plan revealed no care plans in place addressing the resident's active diagnoses of depression, anxiety or insomnia, and there was no care plan in place for the use of antidepressant medications or monitoring for adverse side effects related to the daily use of the medications. A review of the most recent behavioral health progress note, provided by the Social Services Director (SSD), and titled, Balanced Wellbeing Psychiatry Subsequent Note with date of service 5/20/2026 from the provider, stated the resident was, Depressed and feeling down. We are monitoring symptoms and behaviors, with medication regimen Citalopram, Wellbutrin along with Trazodone as augmentation strategy for depression. On 6/3/2026 at 11:35 AM, a second observation of Resident #6 was made. He was seated in the same place as he was during the observation made on 6/3/2026 at 8:57 AM. He was in his reclining chair, the television was off, and he was looking out the window. He stated the facility had too many activities going on, and he didn't like that; he enjoyed being alone. On 6/5/2026 at 11:25 AM, an interview was conducted with the SSD, who reported working at the facility in her current role for the last six years. She stated she was (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible for completing the MDS assessment sections for cognitive patterns, mood and behaviors, for each resident. She was also responsible for developing and implementing comprehensive care plans for mood, behavior and cognitive functioning when a resident triggered in those areas. Psychiatry and psychology visits occurred weekly, and if there were changes, she or the MDS Coordinator updated the resident's care plan. She stated, The care plan is implemented as soon as a concern is identified. Depression should go into a care plan as soon as there is an indication. That would include monitoring for signs and symptoms, and the use of medications. She stated she was familiar with Resident #6 and confirmed there was no active care plan developed or implemented for his diagnosis of depression. She said she added a care plan for depression today, 6/5/2026. On 6/5/2026 at 3:06 PM, a joint interview was conducted with the Administrator and the Director of Nursing (DON). They stated the facility currently had no corrective action plans in place. They stated until today, they were unaware that Resident #6 did not have a comprehensive care plan in place for his diagnosis and treatment of depression. The DON stated, I don't know how that got missed. Knowledge of our residents should make us more accurate not less accurate. A review of the facility's policy and procedure titled Care Plans, Comprehensive Person-Centered (Policy Version 2.0 -H5MAPL0110, Revised March 2022), revealed: STATEMENT: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. INTERPRETATION: 1) The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2) The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 7) The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 8) Services provided for or arranged by the facility and outlined in the comprehensive care plan are: a. provided by qualified persons.