

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106126	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2026
NAME OF PROVIDER OR SUPPLIER Lake City Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 298 SW Prosperity Place Lake City, FL 32024	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the dietary department failed to store, prepare, and serve food in a sanitary manner for the resident for 1 of 2 observations of the kitchen. Findings include: During an initial tour of the kitchen on 8/9/2026 at 9:10AM with Staff S [NAME] there was a pitcher of lemonade that was placed on top of the ice machine and a bowl of oatmeal placed on top of the serving area for plates. A clear bag of sausage links was placed on top of a plastic cart. The package was not dated or labeled. During an interview on 8/9/2026 at 9:13 AM with Staff S [NAME] stated, Sausage package was opened yesterday it should have been dated and stored in the refrigerator when not in use. During an observation on 8/9/2026 at 9:16 AM with Staff S [NAME] the walk in refrigerator had a plastic container with aluminum foiled covering the container which was inside another pan with ice. The aluminum foiled had labeled chicken but no date. The chicken was stored in the second shelf on top of the potatoes. During an interview on 8/9/2026 at 9:17 AM with Staff S [NAME] stated, This chicken will be used tomorrow. It should have been stored in the bottom shelf and it should have been dated before being stored in the refrigerator. During an observation on 8/9/2026 at 9:35 AM with Staff T Lead [NAME] of [NAME] Hall refrigerator did not have a thermometer. During an interview on 8/9/2026 at 9:35 am with Staff T Lead [NAME] confirm no thermometer could be located inside of the refrigerator and would need to get one to place inside the refrigerator. During an observation on 8/11/2026 at 11:30 AM Staff T Lead [NAME] was observed grabbing small bowls touching the inside of the bowl where food would be store. Staff T was observed multiple times during meal serving grabbing at times five bowls at a time and placing her hand inside the last bowl on the bottom row. Then serving carrots in the bowls. Staff U [NAME] was observed preparing grill cheese sandwiches she was observed using the spatula and touching the grilled cheese sandwich with her gloved hand to flip the bread over. Staff T Lead [NAME] asked Staff U [NAME] to hand her a bowl. Staff U [NAME] without changing her gloves or performing hand hygiene return to flipping the grill cheese using her hands and the spatula. Staff U [NAME] was observed putting away cheese in a cooler across where she was preparing the grill cheese and without hand hygiene or changing her gloves return to the station and using her gloved hands grabbed the grill cheese sandwich and put them into a container. During an interview on 8/11/2026 at 1:20 PM with the Assistant Dietary Manager stated, The lemonade should have been stored in the cooler and not left on top of the ice maker, sausages should be put back in the freezers when the staff were done with them inside a ziplock bag and it should have been labeled and dated. The chicken should be dated and stored in the bottom rack. The potatoes should have been store in the second shelf and the chicken on the bottom shelf. Refrigerator should have a thermometer inside. I checked Friday and it was one upfront not sure what happened over the weekend. Staff should have grab the bowl by the outside (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	never touching the inside of the blow. Staff should have washed hands and change gloves when handling food. Review of the facility policy and procedure titled Dating and Labeling Policy with a last review date 1/20/2026 read, Policy: Kitchen will assure food safety by maintaining proper dates and labels to all goods and ready to eat food products. Procedure: 2. Label products in storage with date the package was opened.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to notify residents' physicians and/or Resident Representatives for three (Resident #2, Resident #37 and Resident #28) of ten residents reviewed for skin issues, one (Resident #11) of three reviewed for ADL (Activities of Daily Living) care, and one (Resident #30) of three reviewed for accidents. Findings include: During an observation on 8/09/2026 at 10:26 AM Resident #37 was lying in bed on her left side. There was a bandage on her lower right forearm dated 8/7. During an interview on 8/09/2026 at 1:22 PM Resident #37's daughter/Responsible Party stated that she had noticed the bandage on her mother's arm. She presumed it was a skin tear. The facility had not notified her of the injury. During an interview on 8/10/2026 at 1:55 PM Staff B, LPN stated that if a resident had a new skin issue, such as a skin tear, she would assess the resident and try to determine what had happened. If there had been a witness to an event, she would obtain a witness statement. She would notify the family and notify the physician and get wound care orders. If the Wound Care provider needed to see the resident, she would notify them. Review of Resident #37's face sheet revealed she was admitted on [DATE] with medical diagnoses that included metabolic encephalopathy (primary); dysphagia, oropharyngeal phase; weakness; unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; aphasia; extended spectrum beta lactamase (ESBL) resistance; cognitive communication deficit; hypoglycemia, unspecified Review of Resident #37's Physicians' Orders revealed an order dated 8/04/2026 read, Skin tear: Cleanse area to bilateral arms with wound cleanser, apply TAO (triple-antibiotic ointment) to site and cover bordered gauze QOD (every other day) until healed. every day shift every other day for skin tear Review of Resident #37's Physicians' Orders revealed an order dated 6/21/2026 that read, Wound care: Right Wrist- cleanse with wound cleanser. Apply TAO to wound bed. Place non-adherent dressing to wound bed and wrap with rolled gauze. Daily and as needed every day shift for Skin Tear Review of Resident #37's Progress Notes from 6/1/2026 through 8/10/2026 revealed no documentation regarding notification to a provider or the Resident Representative regarding Resident #37's wounds/dressings. Review of Resident #37's most recent MDS Assessment, a quarterly assessment dated [DATE] documented no BIMS (Brief Inventory of Mental Status) Score. She required substantial/maximal assistance or was dependent on staff for all self-care activities. (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #37's Care Plan revealed the following: Focus - The resident has potential impairment to skin integrity r/t (related to) fragile skin, incontinence, limited mobility / LLE (left lower extremity) Interventions included - Follow facility protocols for treatment of injury. Focus - The resident has a Skin Tear of bilateral arms. Interventions included - If skin tear occurs, treat per facility protocol and notify MD (medical doctor), family. During an interview on 8/11/2026 at 11:26 AM Physician #1 stated that he could not recall receiving a call regarding Resident #37 having a wound. Education may be needed for the nurses regarding wound care and provider notification. If the Wound Care Nurse or a Staff Nurse had received an order for wound care, they should have documented the assessment and the conversation. During an interview on 8/11/2026 at approximately 12:00 PM Staff R, RN stated that if a resident had a skin tear or wound with any bleeding, she would treat it right away to stop the bleeding and document her assessment and the care provided. She would inform the doctor, the Unit Manager and the DON. The family would be notified as well. During an interview on 8/11/2026 at 2:24 PM Physician #1 stated that Best Practice for new or worsening wounds would be for the nurse to assess the issue, contact the provider and discuss and confirm an order. As the Medical Director, he was available if other providers could not be reached. During an interview on 8/11/2026 at 1:05 PM Staff A, RN - Wound Care Nurse stated that she had assessed Resident #37 on 8/04/2026 and discovered that she had wounds on her bilateral forearms with dressings already in place. She had removed the dressings, cleaned the wounds, and applied new dressings. She had entered the wound care orders in the computer. She did not write a progress note or contact a provider to report her findings or confirm the wound care order. She did not contact Resident #37's family regarding the wounds. During an interview on 8/11/2026 at 1:23 PM the DON (Director of Nursing) stated that the Wound Care Nurse was expected to notify family and a provider if she identified a new or worsening wound. The Wound Care Nurse or Staff Nurse was expected to contact a provider for any wound care orders. 2) Review of Resident #2's Physicians' Orders from 8/01/2026 through 8/11/2026 revealed an order dated 8/04/2026 that read, Skin Tear: Cleanse skin with wound cleanser of choice. Apply TAO to open area to left lateral ankle and apply non adherent or silicone dressing until healed every day shift for wound care The order was entered by Staff A, RN as a verbal order from Physician #2 on 8/04/2026 at 9:55 AM. Review of Resident #2's Progress Notes from 8/01/2026 through 8/11/2026 revealed there was no documentation regarding a skin tear, notification to family or provider, or treatment orders for wound care. Review of Resident #2's Care Plan revealed the following: Focus - The resident has potential for impairment to skin integrity. Interventions included - Follow facility protocols for treatment of injury. Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs and symptoms) of infection, maceration etc. to MD (medical doctor). Focus -The resident (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	has a Skin Tear r/t fragile skin. Left lateral ankle/left lower leg. Interventions included - If skin tear occurs, treat per facility protocol and notify MD, family. Review of Resident #2's face sheet shows Resident was admitted to the facility on [DATE] with medical diagnosis of encounter for other orthopedic aftercare. Additional diagnoses included: Weakness, difficulty in walking, chronic obstructive pulmonary disease, excoriation (skin-picking) disorder, subsequent encounter for closed fracture with routine healing, generalized anxiety disorder, major depressive disorder, recurrent, heart failure, and post-traumatic stress disorder. Review of Resident #2's MDS (Minimum Data Set) assessment dated [DATE] documented her BIMS (Brief Inventory of Mental Status) Score as 15 out of 15 which indicated she was cognitively intact. During an observation on 8/09/2026 at 10:55 AM Resident #2 was sitting up in bed. There was a gauze bordered dressing to resident's left lower extremity which was dated 8/08. During an interview on 8/09/2026 at 11:00 AM Resident #2 stated that the wound nurse changed the dressing on her left lower leg on Wednesday and said she would be back on Friday. During an interview on 8/11/2026 at approximately 2:45 PM Physician #2 stated that he did not remember receiving a call regarding Resident #2's wound(s). Review of the policy and procedure titled Documentation, with the last review date of 1/20/2026 read, Policy: Each resident's medical record shall contain an accurate representation of actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Documentation: The following information should be recorded in the resident's clinical record: Abnormal observation from the skin inspection performed such as: edema, redness, drainage, discoloration, and/or other new skin changes. 3) During an observation on 8/09/2026 at 9:35 AM Resident #11 had small red papules on his face and his skin was dry and flakey. Dry skin flakes were observed on the front of his hospital gown. During an interview on 8/10/2026 at 1:55 PM Staff B, LPN stated that if a resident refused a shower or bath, the CNA (Certified Nursing Assistant) was supposed to make 3 attempts to convince the resident to have a shower/bath. The nurse should also check on the resident as to why they refused bathing and to try to convince them to take a bath. She would notify Resident #11's son if the resident refused a bath or shower. During an interview on 8/10/2026 at 1:50 PM Staff V, CNA stated that Resident #11 had refused a bed bath earlier in the day. The process when a resident refused a bath was to document it and try to get the resident to sign that they had refused. When she attempted to have Resident #11 sign the refusal, he had first indicated that he was not able to sign and then that he was not able to read the document. She had not gone back a second time to try to convince him to take a bath. She documented the refusal on a shower sheet, but was not sure if there was documentation in the electronic medical record also. (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/10/2026 at 2:00 PM Resident #11 stated that he often preferred a bed bath to a shower. He did not refuse baths. During an interview on 8/10/2026 at approximately 4:00 PM the DON (Director of Nursing) stated that the expectation was for the CNAs to offer residents ADL care - a shower or bath, multiple times. If the resident refused, they were to notify the nurse and document it. If the resident refused a shower or bath multiple times, it should be offered on the next shift. If the resident still refused, the Resident's Representative and the physician should be notified. Review of Resident #11's Care Plan revealed the following: Focus - The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) limited mobility, weakness, dementia, adult failure to thrive. Interventions included - BATHING/SHOWERING: The resident requires assist x1 staff and as necessary. Review of Resident #11's Shower/Bath Sheets from 7/01/2026 through 8/10/2026 revealed there were no documents for 7/01/2026, 7/08/2026, 7/10/2026, 7/13/2026, 7/15/2026, 7/22/2026, 7/24/2026, 7/29/2026, 7/31/2026, 8/03/2026, or 8/05/2026. Review of Resident #11's Task List documentation for ADL - Bathing from 7/01/2026 through 8/10/2026 revealed documentation of Resident #11 refused a bath or a shower on 7/01/2026, 7/03/2026, 7/10/2026, 7/15/2026, and 8/07/2026. Review of Resident #11's Progress Notes from 7/01/2026 through 8/11/2026 revealed that there was no documentation regarding notification to Resident #11's physician or Resident Representative regarding Resident #11's refusal of ADL care/Shower or Bath. Review of the policy and procedure, titled ADL Care and Services, with the last review date of 1/20/2026 read, Standard: Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Guideline: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Procedure 7. The resident has the right to refuse any and all ADL care. The refusal of care will be documented in the resident's medical record with appropriate notification including the physician and resident representative. 4)During an observation on 08/09/2026 at 11:05 AM, Resident #28 was lying in bed. There was a gauze dressing to Resident's right wrist, which was dated 08/06/2026. Review of Resident #28's nursing note authored by Staff F, LPN dated 08/06/2026 read, [Certified Nursing Assistant's name] noticed resident had a new skin tear to right wrist (top) and was bleeding this am. Nurse notified, assessed area. Bleeding stopped ,area cleaned and dressed. Review of Resident #28's progress notes showed there was no documentation that the provider was notified of Resident #28's skin tear to the right wrist. (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/11/2026 at 8:20 AM Staff A, RN wound care nurse stated, [Resident #28's name] does not have any wounds to my knowledge. Staff are supposed to write any new wounds in the wound care book, so I am notified to go and assess the resident. During an interview on 08/11/2026 at 9:45 AM the Director of Nursing stated that Staff F, LPN should have notified the provider and obtained orders for wound care. 5)During an interview on 08/10/2026 at 9:00 AM, Resident #30's daughter stated, The nurses at the facility don't call me half the time when my Mother falls. I have to find out through the hospice nurses. Review of Resident #30's change in condition note dated 03/06/2026 read, Indicate type of change in condition: Skin. 1. The change in condition, symptoms, or signs observed and evaluated is/are: skin tear. 2. This started on: 03/06/2026. 8. Name of Family/Health Care Agent Notified: [Unit Manager's name]. Date and time notified: 03/06/2026 18:50 [6:50 PM]. Review of Resident #30's change in condition note dated 03/07/2026 read, Indicate type of change in condition: Fall. This started on: 03/07/2026. Name of Family/Healthcare Agent Notified: DON [Director of Nursing]. Date and time notified: 03/07/2026 06:00 [6:00 AM]. Review of Resident #30's nursing progress note dated 03/07/2026 read, CNA notified writer that resident was on the floor in the bathroom. Upon entering the room resident was lying on the floor in the bathroom. Resident was assessed and assisted back into wheelchair. Resident with skin tear to left elbow. DON notified. Plan of care ongoing. Review of Resident #30's change in condition note dated 05/29/2026 read, The change in condition, symptoms, or signs observed and evaluated is/are: Fall. This started on 05/29/2026. 4. Name of Family Member/Responsible Party Notified: [name of hospice]. Date/Time notified: 05/29/2026 11:00. Review of Resident #30's change in condition note dated 07/02/2026 read, The change in condition, symptoms, or signs observed and evaluated is/are: Fall. This started on 07/02/2026. 4. Name of Family Member/Responsible Party Notified: [name of hospice]. Date/Time notified: 07/02/2026 19:10 [7:10 PM]. During an interview on 08/11/2026 at 11:05 AM, the Director of Nursing stated that the family should have been notified for Resident #30's falls. The expectation is for staff to notify the family for changes in condition. Review of policy and procedure titled, Clinical- Change of Resident Condition reviewed 01/20/2026 read, Purpose: To identify changes in Resident condition and communicate the changes to the provider and/or other employees to implement interventions to potentially prevent decline in status and possible re-hospitalization, understanding that not all conditions and declines in medical status are preventable. 4. The provider will be notified of the Resident change in condition with evaluation findings and supporting data (pain evaluation, skin inspection, vital signs, pain level, oxygen saturation, and/or accu-check blood sugar). 8. The resident's family/legal representative should be notified of the change in condition and the current/modified treatment plan as indicated.		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. Based on interview and record review the facility failed to encode and transmit the resident discharge assessment for 1 of 4 residents, Resident #9, reviewed for minimum data set [MDS] completion. Findings include: Review of Resident #9's EXCEL- SNF(Skilled Nursing Facility) to Hospital Transfer form documented the resident was discharged on 7/15/2026. Review of Resident #9's Minimum Data Set (MDS) assessments did not document a Discharge MDS Assessment for 7/15/2026. During an interview on 8/11/2026 at 8:11 AM, Staff K, Regional MDS Coordinator, stated, [Resident #9's name] 's MDS was not updated because the Facility MDS representative just missed it and the facility does not have a policy they just go by RAI.		

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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 the facility failed to develop and implement a comprehensive care plan for 1 (Resident #6) of 2 residents reviewed for dialysis and 1 (Resident #18) of 3 residents reviewed for urinary catheter devices. Findings include: 1) Review of Resident #6 's care plan initiated on 5/21/2026 interventions read, provide, serve diet as ordered. Monitor intake and record q [every] meal. Review of Resident #6's Task ADL [activities of daily living] Eating and Meal Percentage did not document meal intake percentage for 7/16/2026, 7/17/2026, 7/18/2026, 7/23/2026, 7/25/2026, 7/30/2026, 8/1/2026, 8/3/2026, 8/4/2026, 8/6/2026. Review of Resident #6's physician order dated 5/20/2026 read, Renal diet Regular texture, Regular/Thin Liquids consistency, 1000ml [milliliters] fluid restriction. During an interview on 8/12/2026 at 12:22 PM, Staff H, Certified Nursing Assistant, stated, When [Resident #6's Name] comes back from dialysis we will get him something to eat for lunch. We are to record the meal intake after every meal in point click care. During an interview on 8/12/2026 at 12:30 PM with the Director of Nursing stated, [Resident #6's Name] will come back from dialysis and will have lunch in the facility. Normally we will get him a new tray or a chef salad. He normally gets a chef salad. The staff should record the intake of whatever it is given to him and what is eaten. 2.) Review of Resident #18 Care Plan initiated 06/07/2026 did not include Resident provides self-care of suprapubic catheter. During observation on 08/09/2026 at 9:55AM Resident #18's Foley bag was hanging from the bedside frame, and attachment nozzle was exposed/uncapped and lying on bed. During an interview on 08/09/2026 at 10:00AM, Staff P, LPN, stated [Resident #18's Name] switches to the leg bag himself. He is very independent. The tip should be covered. During an interview with Resident #18 on 08/10/2026 at 9:01AM reported he wears the bigger bag at night and puts the leg bag on in the morning himself. He stated, I am [Age of Resident #18] years old I have been taking care of myself all my life. During an interview with the ADON (Assistant Director of Nursing) Infection Control Nurse on 08/11/2026 at 12:35PM, she stated each time a new leg bag is opened it comes with a blue cap. It does need to be covered when he switches it and leaves it on the bed. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with Staff Q, LPN (licensed practical nurse) MDS (Minimum Data Set) on 08/12/2026 at 2:21 PM, she stated a Resident should be Care Planned for self-management of foley after nursing has evaluated and educated the Resident. Review of Resident #18's MDS (Minimum Data Set) 06/07/2026 Annual Section H documented Indwelling catheter Foley. Review of Resident #18's physician orders read, Suprapubic (flexible tube placed directly into your bladder through a small cut in your lower abdomen to drain urine) catheter care every shift every shift 12/12/2025. Review of the facility policy and procedure titled Clinical-Care Plan with a last review date of 1/20/2026 read, Purpose: To ensure the development and implementation of a comprehensive, person-centered care plan that includes measurable objectives and interventions to meet the resident's physical, psychosocial and functional needs.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services that met professional standards for two (Resident #37 and Resident #2) of ten reviewed for skin issues and one (Resident #43) of three reviewed for feeding tube management. Findings include: During an observation on 8/09/2026 at 10:26 AM Resident #37 was lying in bed on her left side. There was a bandage on her lower right forearm dated 8/7. During an interview on 8/09/2026 at 1:22 PM Resident #37's daughter/Responsible Party stated that she had noticed the bandage on her mother's arm. She presumed it was a skin tear. The facility had not notified her of the injury. During an interview on 8/10/2026 at 1:55 PM Staff B, LPN stated that if a resident had a new skin issue, such as a skin tear, she would assess the resident and try to determine what had happened. If there had been a witness to an event, she would obtain a witness statement. She would notify the family and notify the physician and get wound care orders. If the Wound Care provider needed to see the resident, she would notify them. Review of Resident #37's face sheet revealed she was admitted on [DATE] with medical diagnoses that included metabolic encephalopathy (primary); dysphagia, oropharyngeal phase; weakness; unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; aphasia; extended spectrum beta lactamase (ESBL) resistance; cognitive communication deficit; and hypoglycemia, unspecified. Review of Resident #37's Physicians' Orders revealed an order dated 8/04/2026 read, Skin tear: Cleanse area to bilateral arms with wound cleanser, apply TAO (triple-antibiotic ointment) to site and cover bordered gauze QOD (every other day) until healed. every day shift every other day for skin tear. The order was documented as being entered on 8/03/2026 by Staff A, RN as a verbal order from Physician #1. Review of Resident #37's Physicians' Orders revealed an order dated 6/21/2026 that read, Wound care: Right Wrist- cleanse with wound cleanser. Apply TAO to wound bed. Place non-adherent dressing to wound bed and wrap with rolled gauze. Daily and as needed every day shift for Skin Tear. Review of Resident #37's Progress Notes revealed a Nursing Progress Note dated 6/17/2026 read, CNA was getting resident up for the day when she noted a quarter size skin tear to her right wrist. Nurse notified, small amount of bleeding noted. Area cleaned with wound cleaner and then dressing applied. Resident noted no pain to area and no distress noted. Review of Resident #37's Progress Notes from 6/1/2026 through 8/10/2026 revealed no documentation regarding notification to a provider or the Resident Representative regarding Resident #37's wounds/dressings. Review of Resident #37's most recent MDS Assessment, a quarterly assessment dated [DATE] documented no BIMS (Brief Inventory of Mental Status) Score. She required substantial/maximal assistance or was dependent on staff for all self-care activities. She was at risk for pressure ulcers or injuries. She did not have any pressure ulcers/injuries or wounds. She was not receiving wound care. Review of Resident #37's Care Plan revealed the following: Focus - The resident has potential impairment to skin integrity r/t (related to) fragile skin, incontinence, limited mobility / LLE (left lower extremity) Interventions included - Follow facility protocols for treatment of injury. Focus - The resident has a Skin Tear of bilateral arms. Interventions included - If skin tear occurs, treat per facility protocol and notify MD (medical doctor), family. Review of Resident #37's MAR/TAR (Medication Administration Record/Treatment Administration Record) from 8/01/2026 through 8/11/2026 revealed an entry that read, Skin tear: Cleanse area to bilateral arms with wound cleanser, apply TAO (triple antibiotic ointment) to site and cover bordered gauze QOD (every other day) until healed. every day shift every other day for skin tear -Start Date 08/05/2026 0700 (7:00 AM) There was documentation of wound (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Lake City Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 298 SW Prosperity Place Lake City, FL 32024	
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care and application of dressing on 8/05/2026, 8/07/2026, and 8/09/2026. Review of Resident #37's MAR/TAR from 6/01/2026 through 7/31/2026 revealed an entry that read, Wound care: Right Wrist- cleanse with wound cleanser. Apply TAO to wound bed. Place non-adherent dressing to wound bed and wrap with rolled gauze. Daily and as needed every day shift for Skin Tear -Start Date 06/22/2026 0700 -D/C (discontinue) Date 07/08/2026 0839 (8:39 AM) There was documentation of wound care and application of a dressing once daily from 6/22/2026 through 6/29/2026 and 7/01/2026 through 7/07/2026. During an interview on 8/11/2026 at 11:26 AM, Physician #1 stated that he could not recall receiving a call regarding [Resident #37's Name] having a wound. Education may be needed for the nurses regarding wound care and provider notification. If the Wound Care Nurse or a Staff Nurse had received an order for wound care, they should have documented the assessment and the conversation. During an interview on 8/11/2026 at approximately 12:00 PM Staff R, RN stated that if a resident had a skin tear or wound with any bleeding, she would treat it right away to stop the bleeding and document her assessment and the care provided. She would inform the doctor, the Unit Manager and the DON. The family was notified as well. During an interview on 8/11/2026 at 2:24 PM Physician #1 stated that the Wound Care Nurse or Staff Nurses should not enter orders for wound care without confirming the order with a provider. Best Practice would be for the nurse to assess the issue, contact the provider and discuss and confirm an order. As the Medical Director, he was available if other providers could not be reached. During an interview on 8/11/2026 at 3:02 PM, APRN #1 stated that off the top of her head she had not received any calls regarding wounds or treatment orders for [Resident #37's Name] or [Resident #2's Name]. If a resident required wound care and/or required a Wound Care consult, the nurse should contact a provider for an order. During an interview on 8/11/2026 at 1:05 PM Staff A, RN - Wound Care Nurse stated that she had assessed [Resident #37's Name] on 8/04/2026 and discovered that she had wounds on her bilateral forearms with dressings already in place. She had removed the dressings, cleaned the wounds, and applied new dressings. She had entered the wound care orders in the computer. She did not write a progress note or contact a provider to report her findings or confirm the wound care order. She did not contact Resident #37's family regarding the wounds. She routinely addressed wounds and entered orders if they were not already in place or she updated the orders if indicated. During an interview on 8/11/2026 at 1:23 PM, the DON (Director of Nursing) stated that the Wound Care Nurse was expected to notify family and a provider if she identified a new or worsening wound. The facility did not have any standing orders or protocols for wound care or wound care dressings. The Wound Care Nurse or Staff Nurse was expected to contact a provider for any wound care orders. During an interview on 8/11/2026 at 5:28 PM, Staff A, RN - Wound Care Nurse stated that she entered the wound care orders under the name of the resident's PCP (Primary Care Physician), not the Wound Care APRN (Advanced Practice Nurse Practitioner)/Provider. 2) Review of Resident #2's Physicians' Orders from 8/01/2026 through 8/11/2026 revealed an order dated 8/04/2026 that read, Skin Tear: Cleanse skin with wound cleanser of choice. Apply TAO to open area to left lateral ankle and apply non adherent or silicone dressing until healed every day shift for wound care The order was entered by Staff A, RN as a verbal order from Physician #2 on 8/04/2026 at 9:55 AM. Review of Resident #2's Progress Notes from 8/01/2026 through 8/11/2026 revealed there was no documentation regarding a skin tear, notification to family or provider, or treatment orders for wound care. Review of Resident #2's MAR/TAR from 8/01/2026 through 8/11/2026 revealed an entry that read, Skin Tear: Cleanse skin with wound cleanser of choice. Apply TAO to open area to left lateral ankle and apply non adherent or silicone dressing until healed. every day shift for wound care -Start Date 08/05/2026 0700 There was documentation of wound care and dressing application once daily from 8/05/2026 through 8/11/2026. Review of (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2's Care Plan revealed the following, Focus - The resident has potential for impairment to skin integrity. Interventions included - Follow facility protocols for treatment of injury. Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs and symptoms) of infection, maceration etc. to MD (medical doctor). Focus -The resident has a Skin Tear r/t (related to) fragile skin. Left lateral ankle/left lower leg. Interventions included - If skin tear occurs, treat per facility protocol and notify MD (medical doctor), family. Review of Resident #2's face sheet shows Resident was admitted to the facility on [DATE] with medical diagnosis of encounter for other orthopedic aftercare. Additional diagnoses, but not limited to included: Weakness, difficulty in walking, chronic obstructive pulmonary disease, excoriation (skin-picking) disorder, subsequent encounter for closed fracture with routine healing, generalized anxiety disorder, major depressive disorder, recurrent, heart failure, and post-traumatic stress disorder. Review of Resident #2's MDS (Minimum Data Set) assessment dated [DATE] documented her BIMS (Brief Inventory of Mental Status) Score as 15 out of 15 which indicated she was cognitively intact. During an observation on 8/09/2026 at 10:55 AM Resident #2 was sitting up in bed. There was a gauze bordered dressing to resident's left lower extremity which was dated 8/08. During an interview on 8/09/2026 at 11:00 AM Resident #2 stated that the wound nurse changed the dressing on her left lower leg on Wednesday and said she would be back on Friday. When the wound nurse came back on Friday she told her that it was fine, that one changed it on Thursday because it only needed to be done three times per week. During an interview on 8/11/2026 at approximately 2:45 PM, Physician #2 stated that he did not remember receiving a call regarding Resident #2's wound(s). It was appropriate for a nurse, after assessing a wound, to make a recommendation for wound care treatment, but they should leave it to the practitioner to make the final treatment decision. Review of the policy and procedure titled Clean/Dry Dressing, with the last review date of 1/20/2026 read, Purpose: To provide guidelines for the application/removal and change of a dry/clean dressing. Procedure: Verify the provider's order for this treatment. Review of the policy and procedure titled Documentation, with the last review date of 1/20/2026 read, Policy: Each resident's medical record shall contain an accurate representation of actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Policy explanation and compliance guidelines: 1) Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 2) Documentation shall be completed at the time of service but no later than the shift in which the assessment, observation, or care service occurred. 3) During an observation on 8/09/2026 at 9:23 AM Resident #43 was sitting up in bed. There was not a feeding pump or any supplies for enteral feeding observed. During an interview on 8/09/2026 at 9:23 AM, Resident #43 stated that she had passed out in the hospital and woke up with a feeding tube. She did not like it. She was taking her medications and Glucerna by mouth and nothing was going through the feeding tube. Review of Resident #43's MAR (Medication Administration Record) revealed documentation of Glucerna being administered enterally four times daily. Review of Resident #43's face sheet revealed she was admitted on [DATE] with medical diagnoses that included nontraumatic intracerebral hemorrhage, intraventricular (primary); unspecified sequelae of cerebral infarction; cerebral edema; type 2 diabetes mellitus without complications; morbid (severe) obesity due to excess calories; paroxysmal atrial fibrillation; gastrostomy status; hypertensive heart disease without heart failure; retention of urine, unspecified; hypothyroidism, unspecified. Review of Resident #43's Physicians' Orders revealed an order dated 7/20/2026 that read, Consistent Carbohydrates (CCD) diet; Regular texture, Regular/Thin Liquids consistency. Review of Resident (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#43's Physicians' Orders revealed an order dated 7/10/2026 read, after meals and at bedtime Flush 90mL's of H2O after each bolus feeding, and after meals and at bedtime Bolus 237mL of Glucerna 1.5 when less than 75% eaten at meals Review of Resident #43's Task List documentation from 7/10/2026 through 8/10/2026 related to percentage of meals eaten for the past 30 days revealed 11 instances of Resident #43 consuming less than 76% of a meal and 6 instances of Resident #43 refusing a meal. Review of Resident #43's MAR/TAR from 6/01/2026 through 8/09/2026 revealed an entry that read, Enteral Feed Order: after meals and at bedtime Bolus 237mL of Glucerna 1.5 when less than 75% eaten at meals Start Date-07/10/2026 1800 There was documentation of administration four times daily 8/01/2026 through 8/08/2026, twice on 7/10/2026, four times daily from 7/11/2026 through 7/26/2026, two times on 7/27/2026, three times on 7/28/2026, and four times on 7/29/2026 and 7/30/2026, and three times on 7/31/2026. Review of Resident #43's Progress Notes revealed a Nutrition Note dated 7/09/2026 that read, Resident receives Glucerna 1.5 56 ml's /hr. x 20 hrs. (milliliters per hour times 20 hours) via feeding tube, per pump. Tube flushed with 42 ml's H2O/hr. x 20 hrs. Resident receives CCD (controlled carbohydrate diet), Mech. (mechanical) Soft diet, intake varies, approximate 60% average meals eaten, per meal intake record. Weight 231#, above IBWR120# +/- 10%. BMI 39.6. Skin issue R buttock. Current labs unavailable for review. Assessed nutritional needs: Kcals 1682 25 Kcals/Kg. adj.wt., Pro.67 1 gm/Kg. adj. wt., Fluid 1 ml/Kcal. Recommend Glucerna 1.5 56 ml's/hr. x 20 hrs be discontinued. Recommend H2O flush 42 ml's/hr. x 20 hrs be discontinued. Recommend Glucerna 1.5 237 ml's bolus when <75% meals eaten. Recommend tube be flushed with 90 ml's H2O before and after each bolus feeding. Monitor intake/weight/skin issue/tolerance to bolus feedings and H2O flushes with intervention PRN. Review of Resident #43's most recent MDS Assessment, an end of Part A assessment dated [DATE] documented her BIMS Score as 15 out of 15 which indicated she was cognitively intact. She required supervision or touching assistance for eating. She had a feeding tube; she required a mechanically altered diet; she required a therapeutic diet. Review of Resident #43's care plan documented, Focus - The resident requires tube feeding. Interventions included - The resident is dependent with tube feeding and water flushes. See MD (Medical Doctor) orders for current feeding orders., The resident has nutritional problem r/t (related to) DYSPHAGIA, GASTRO-ESOPHAGEAL REFLUX, DMII, CVA Interventions included - Provide, serve diet as ordered. Monitor intake and record q (every) meal. RD (Registered Dietitian) to evaluate and make diet change recommendations PRN (as needed). During an interview on 8/10/2026 at approximately 1:30 PM Staff B, LPN stated that residents who had G tubes, but were able to take medications and/or food and fluids orally and were being tapered off of their tube feedings, she would confirm with the CNAs the percentage of meals consumed. She would either check with the CNAs or confirm the documentation in PCC (the electronic medical record). If the resident was consuming over the required amount for a week, she would contact the provider to recommend having the G-tube removed. During an interview at approximately 9:15 AM Staff B, LPN stated that related to Resident #43's ordered enteral feedings, for the majority of the time she would ask Resident #43 how much of her meal she had eaten to know whether she required the ordered Glucerna. Resident #43 would drink the Glucerna, so she would administer it orally [versus the order route of enterally]. During an interview on 8/11/2026 at 9:50 AM the DON (Director of Nursing) stated that medications and feedings were expected to be documented by the route they were being administered. If the order was for enteral administration the feeding should be given enterally, not orally. If the resident preferred to take the feeding orally, the physician should be notified, and the order should be updated. During an interview on 8/11/2026 at 2:45 PM the RD (Registered Dietitian) stated that she had recommended bolus feeding with a flush before and after the bolus if she was not (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	eating 75% of her meals. Glucerna was a safety measure to make sure Resident #43 got enough nutrition and did not lose weight. She had ordered it as an enteral bolus because some residents did not want to drink that much and it would be for their comfort. If the resident wanted to drink the Glucerna that would be better. She was not aware that Resident #43 was drinking the Glucerna, no one had contacted her. If the resident wanted the feeding tube removed, she would discuss it with the physician. Review of the policy and procedure titled, Medication Administration, with the last review date of 1/20/2026 read, Purpose: To administer medications as per provider's order in accordance with regulatory guidelines and practice standards. Policy: Licensed or qualified personnel shall administer medication per their licensure scope of practice following the providers order. Guidelines for medication administration: Read orders to ensure the information is clear and accurate. Clarify questions with the Charge Nurse or the provider as needed. Observe the rights of medication administration - right resident, right medicine, right time, right dose, write route, write documentation.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interview, observation, and record review, the facility failed to ensure assistance with activities of daily living (ADLs) for haircuts for 1 of 3 residents, Resident #7 reviewed for ADL care. Findings include: During an observation on 8/09/2026 at 10:16 AM Resident #7 was resting in bed. Resident #7's hair extended beyond his ears. During an interview on 8/09/2026 at 10:16 AM Resident #7 stated, I would like to get a haircut. They have never offered to do that for me. Review of Resident #7 Care Plan dated 6/16/2026 documented, Focus: The resident has an ADL self-care performance deficit r/t weakness, limited mobility, confusion, compression fracture, h/o falls. During an interview on 8/11/2026 at 9:30 AM Director of Nursing stated that the facility does not have anything in writing stating that [Resident #7's name] has been receiving or refusing the haircuts. Reviewed Policy and Procedure: Clinical Activities of Daily Living (ADL's) Effective Date 4/1/2022 Revision Date 11/11/2025 states Purpose: To ensure resident's needs are met in a manner that promotes their quality of life, resident rights, preferences, and independence. Procedure: 2. The facility shall provide care and services for the following activities of daily living as needed based on the individual care plan of each resident: A. Hygiene: bathing, dressing, grooming, and oral care		

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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 interview, observation and record review, the facility failed to ensure physician orders and facility policy were followed for wound care for 3 of 10 residents reviewed for wounds (Resident #113, Resident #21 and Resident #28). Findings Include: 1) During an observation on 08/09/2026 at 11:05 AM, Resident #28 was lying in bed. There was a gauze dressing to Resident's right wrist, which was dated 08/06/2026. Review of Resident #28's nursing note, authored by Staff F, LPN (Licensed Practical Nurse) dated 08/06/2026 read, [Certified Nursing Assistant's name] noticed resident had a new skin tear to right wrist (top) and was bleeding this am. Nurse notified assessed area. Bleeding stopped area cleaned and dressed. Review of Resident #28's physician orders revealed there were no orders for wound care to the right wrist. During an interview on 08/11/2026 at 8:20 AM Staff A, RN (Registered Nurse) wound care nurse stated, [Resident #28's name] does not have any wounds to my knowledge. When a resident gets a skin tear, the nurse should take care of the skin tear, recover the skin back over, cleanse it, and dress it. They should notify the physician, the family, and put new orders in. During an interview on 08/11/2026 at 9:45 AM the Director of Nursing (DON) stated that [Resident #28's Name] does not have orders for wound care to right wrist. The DON stated that Staff F, LPN should have notified the provider and obtained orders for wound care. 2.) During observation of Resident #21 on 08/09/2026 at 10:10AM Resident had an island dressing on Right knee with no date or initials. During an interview with DON on 08/11/2026 at 8:20 AM stated, Yes, I expect the dressings to be dated. We have a full-time wound care nurse. During an interview with the Wound Care Nurse, Staff A, RN (registered nurse) on 08/11/2026 at 9:33AM it is her practice to date and initial every dressing change. She works Monday thru Friday and the nurse on the cart is responsible to do the daily dressing changes on the weekends and the PRN dressing changes. Review of Treatment Administration Record for August 2026 read, Treatment as follows: R knee surgical site cleanse with wound cleanser, apply long island dressing. every day shift for Wound Care Observe changes in drainage, pain, or s/sx (signs/symptoms) of infection. Notify Provider as appropriate 07/30/2026. Review of facility Policy and Procedure titled, Clinical-Clean/Dry Dressing, last revision 01/20/2026 (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	read, Purpose: To provide guidelines for the application/removal and change of a dry/clean dressing. Procedure, Affix and prepare tape/label with date and initials. 3)During an observation on 8/9/2026 at 12:34 PM Resident #113 was lying in bed there was a dressing dated 8/6 and a white pain patch on her left arm dated 8/6/2026. Review of Resident #113 's physician order dated 8/1/2026 read, Cleanse left arm with wound cleanser and apply xeroform and honey gel and place border gauze everyday shift for skin tear. Review of Resident of Resident #113's physician order dated 8/1/2026 read, Aspercreme Lidocaine Patch 4% (Lidocaine) apply to left shoulder topically Morning/Night for Apply to left hip and remove at bedtime. During an interview on 8/11/2026 at 9:35 AM Staff A Wound Care Nurse stated, I cover skin tears. Over the weekend the cart nurse will have the knowledge to treat them. I was not familiar with [Resident #113's name] skin tear wound dressing orders. I have a wound log on every unit. Monday I round on every unit for follow up the information is not always convene to me. I will see the nurse and she sometimes will tell me and then it should be put in into the system and make sure I round. Normally change every day or every other day depending on the severity. I eye it depending on drainage if superficial could be treated every other day. I myself need to be aware and if I am not I have no way of knowing if its not on my wound log. I would not have the Knowledge to know it needs to be changed out. Wound care should be done as order. This is one I was not familiar with. During an interview on 8/11/2026 at 10:15 AM with the Director of Nursing stated, Dressings and treatments should be done however ordered. A check mark in the treatment record means completed. Nurses are to accurately document care provided. During an interview on 8/11/2026 at approximately 3:15 PM with Staff B Licensed Practical (LPN), stated, Her [Resident #113's name] patch should be removed every day and put a new one. Review of the facility policy and procedure titled Clinical-Clean/Dry Dressing with a last review date of 1/20/2026 read, Verify the provider's order for this treatment.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review the facility failed to provide treatment and services for the care of one out of five residents reviewed for indwelling urinary catheter. Findings Include: During observation of Resident #60 on 08/09/2026 at 9:15 AM Foley tubing had cream colored sediment residing along length of the tubing. During observation of Resident #60 on 08/11/2026 at 10:21AM Foley line sediment was observed to be unchanged in appearance with cream colored sediment along the length of the tubing. During an interview with Staff N, CNA on 08/11/2026 10:31 AM she stated Hospice comes on Fridays. If I noticed something wrong with his foley when I was emptying it I would let the nurse know. During interview via phone with Haven Hospice Director of Clinical Operation, on 08/11/2026 at 11:53AM stated, Our last visit was 08/07/2026. The aid documented that she performed bath, shampoo, shave and emptied the foley. If they found anything new or the Resident made any complaints or had a request the aid would let the RN(registered nurse) for Hospice know and the floor nurse after care was provided. During an interview with the ADON(Assistant Director of Nursing) Infection Control Nurse on 08/11/2026 at 12:30PM she stated that [Resident #60's Name] foley catheter tubing should be changed from the way it looks. The problem is he does not have a formal order for changing the tubing every 30 days right now it is just PRN (pro re nata). During interview with DON (Director of Nursing) on 08/12/2026 1:53 PM she stated a PRN foley change would need to be done if there was leakage, blockage or it had sediment that could not be flushed out. Review of Resident #60's Physician Orders revealed ,Foley Care every shift 06/15/2026. Urinary Catheter: Irrigate with 60cc (cubic centimeters) normal saline for blockage, increased sediment, or decreased output. every 6 hours as needed Notify physician of any abnormal observation from baseline 05/22/2026. Review of facility Policy and Procedure, titled, Clinical-Indwelling Urinary Catheter, Last revised on 01/20/2026 read, Purpose: To minimize complications associated with indwelling urinary catheter use. Procedure: 5. Changing indwelling catheters or drainage [NAME] routinely and at fixed intervals is not recommended. Rather, it is suggested to change catheters and drainage based based on clinical indications, obstruction, or when the closed system is compromised at the discretion of the medical provider. 8. Observe the resident routinely for complications related to urinary catheter use. Report new complications to the provider as indicated.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview and record review the facility failed to complete dialysis communication sheet for 1 (Resident #6) of 2 residents reviewed for dialysis. Findings include: Review of Resident #6 physician order dated 5/20/2026 read, Dialysis Treatment Center Name: [Name and Phone Number of Third Party Dialysis Provider] Days/Schedule: TU/TH/SA [Tuesday/Thursday/Saturday] Pick up time:0700 Chair Time:0730 Transport via Wheelchair every day shift every Tue, Thu, Sat for Dialysis Information. Review of Resident #6 Dialysis Communication Forms facility to complete upon resident's return from dialysis section was not completed on 8/8/2026, 8/6/2026, 8/4/2026, 8/1/2026, and 7/28/2026. No other communication sheets were provided prior to 7/28/2026. During an interview on 8/11/2026 at 12:50 PM Staff G Licensed Practical Nurse (LPN) stated, We do an assessment for him [Resident #6] and fill out the communication sheets for him before he goes to dialysis and upon return. During an interview on 8/12/2026 at 8:32 AM Director of Nursing (DON) stated, I expect the staff to complete the communication sheets completely. when asked about the progress notes stated it would be on the communication sheet. No other communications sheets provided. During an interview on 8/12/2026 at 9:42 AM with the DON stated no other communication sheets provided. During an interview on 8/12/2026 at 11:10 AM with Staff D, LPN, stated, Normally we will fill out the dialysis book before leaving and upon his [Resident #6] return we would have to take his vitals and fill out the dialysis communication book. Review of the facility policy and procedure titled Clinical Dialysis Management with a last review date 1/20/2026 read, 2. Facility personnel will provide information that is useful or necessary for the care of the resident to the dialysis center as needed.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and record review the facility failed to maintain the exterior waste properly. Finding include: During an observation on 8/9/2026 at 9:41 AM of the exterior dumpster area with Staff T the lid of dumpster was open. Inside there were clear plastic bags. Next to the dumpster there is a grease trap that had dark buildup and liquid pooling outward from the base of the grease container across the concrete pad. There was loose debris, trash fragments, paper clutter accumulated directly around the base. During an interview on 8/9/2026 at 9:41 AM with Staff T Lead [NAME] stated, Dumpster lid should be closed at all times. I am not sure who is responsible for cleaning the grease trap. During an interview on 8/11/2026 at 1:20 PM with Assistant Dietary Manager stated, The garbage container lid should always be closed. The grease trap I do not know who maintains it no one has ever told us to clean it. During an interview on 8/11/2026 at 2:16 PM with the Administrator stated, The dumpster lid should be closed at all times. I will go look at the grease trap and speak to maintenance. During an interview on 8/11/2026 at 3:12 PM with Maintenance Director stated, The area needs to be clean looks like it has some sort of spillage. Review of the facility policy and procedure titled Dietary Department Dumpster and Trash Management Policy with a last review date 1/20/2026 read, Purpose: To ensure safe, sanitary, and regulatory-compliant handling and disposal of all dietary waste in accordance with infection control standards and guidelines from Centers for Medicare & Medicaid Services, Occupational Safety and Health Administration, and Centers for Disease Control and Prevention. Policy Statement: All dietary waste must be handled, stored, and disposed of in a manner that prevents contamination, odors, pest infestation, and safety hazards for residents, staff, and visitors. Procedures: 4. Dumpster Use: Dumpster lids must remain closed at all times when not in use. 5. Cleaning & Sanitation. Dumpster areas must be: Clean and free of debris. Washed down routinely (recommended weekly or as needed). Immediate cleanup for: spills, leaks, loose trash. 9. Compliance & Monitoring: Dietary Manager or designee will: Conduct routine inspections of the dumpster area. Ensure compliance with sanitation standards. Deficiencies will require immediate corrective action.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview and record review, the facility failed to ensure complete and accurate documentation in the medical record for activities of daily living care for 1 of 3 residents reviewed (Resident #11), and documentation on the treatment administration record for 3 of 10 residents reviewed for skin conditions (Resident #113, Resident #21, Resident #3). Findings Include: 1) Review of Resident #3's physician order dated 06/20/2026 read, Wound Care: RLE [right lower extremity]- cleanse with wound cleanser. Apply A&D ointment to peri wound. ABD [abdominal] pad to wound bed. Wrap with Ace bandage. Daily and as needed. every day shift for Weeping. Review of Resident #3's TAR (Treatment Administration Record) for July 2026 showed wound care for right lower extremity was not documented on July 10, 2026, July 12, 2026, July 21, 2026 and July 30, 2026. Review of Resident #3's physician order dated 07/07/2026 read, Wound Care: LLE [left lower extremity] (outer) Cleanse with wound cleanser. Apply ointment to peri wound. Collagen sheet to wound bed secure with ABD pad. Wrap with Ace bandage. QOD [every other day] and as needed. Review of Resident #3's TAR for July 2026 showed wound care for left lower extremity was not documented on July 10, 2026 and July 12, 2026. During an interview on 08/12/2026 at 9:03 AM, Staff L, LPN [licensed practical nurse] stated, I completed the wound care, I am not sure why it didn't get documented. 2.) During observation of Resident #21 on 08/09/2026 at 10:10AM Resident had no compression socks on bilateral lower extremities. During an interview with DON on 08/11/2026 at 2:10PM stated, All Doctors orders are expected to be carried out and refusals charted. Review of Resident #21's Physician Orders documented, Compression stockings to BLE every day shift 07/22/2026. 3) During an observation on 8/9/2026 at 12:34 PM Resident #113 was lying in bed there was a dressing dated 8/6 and the patch on her left arm dated 8/6/2026. Review of Resident #113's physician order dated 8/1/2026 read, Cleanse left arm with wound cleanser and apply xeroform and honey gel and place border gauze everyday shift for skin tear. Review of Resident #113 Treatment Administration Record for the month of August 2026 documented dressing was completed on 8/8/2026. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident of Resident #113's physician order dated 8/1/2026 read, Aspercreme Lidocaine Patch 4% (Lidocaine) apply to left shoulder topically Morning/Night for Apply to left hip and remove at bedtime. Review of Resident #113 's Treatment Administration Record for the month of August 2026 documented patches were applied and removed on 8/7/2026 and 8/8/2026. During an interview on 8/11/2026 at 9:35 AM Staff A Wound Care Nurse stated, I cover skin tears. Over the weekend the cart nurse will have the knowledge to treat them. I was not familiar with [Resident #113's name] skin tear wound dressing orders. I have a wound log on every unit. Monday I round on every unit for follow up the information is not always convene to me. I will see the nurse and she sometimes will tell me and then it should be put in into the system and make sure I round. Normally change every day or every other day depending on the severity. I eye it depending on drainage if superficial could be treated every other day. I myself need to be aware and if I am not I have no way of knowing if its not on my wound log. I would not have the Knowledge to know it needs to be changed out. Wound care should be done as order. This is one I was not familiar with. During an interview on 8/11/2026 at 10:15 AM with the Director of Nursing (DON) dressing should be done however order. A check mark in the MAR means completed. Nurses are to accurately document care provided. During an interview on 8/11/2026 at approximately 3:15 PM with Staff B Licensed Practical (LPN), stated, That night I took the patch off her shoulder. I don't know. During an interview on 8/12/2026 at 8:41 AM with Staff I, LPN, stated, I do not recall. A check mark means it was completed. 4.) During an observation on 8/09/2026 at 9:35 AM Resident #11 had small red papules on his face and his skin was dry and flakey. Dry flakes of skin were observed on the front of his hospital gown. Review of Resident #11's Shower/Bath Sheets from 7/01/2026 through 8/10/2026 revealed there were no documents for 7/01/2026, 7/08/2026, 7/10/2026, 7/13/2026, 7/15/2026, 7/22/2026, 7/24/2026, 7/29/2026, 7/31/2026, 8/03/2026, or 8/05/2026. Review of Resident #11's Task List documentation for ADL - Bathing from 7/01/2026 through 8/10/2026 revealed documentation inconsistent with documentation on the printed Shower/Bath Sheets on 7/03/2026, 8/07/2026, and 8/10/2026. There was documentation of Resident #11 refused a bath or a shower on 7/01/2026, 7/03/2026, 7/10/2026, 7/15/2026, and 8/07/2026. There was nothing documented on 7/08/2026 or 8/10/2026. Review of Resident #11's Progress Notes from 7/01/2026 through 8/11/2026 revealed that there was no documentation regarding notification to Resident #11's physician or Resident Representative regarding Resident #11's refusal of ADL care/Shower or Bath. During an interview on 8/10/2026 at 1:55 PM Staff B, LPN stated that if a resident refused a shower (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or bath, the CNA was supposed to make 3 attempts to convince the resident to have a shower/bath and document the outcome. The nurse should also check on the resident as to why they refused bathing and to try to convince them to take a bath. The nurse was supposed to sign the shower sheet. During an interview on 8/10/2026 at 1:50 PM Staff V, CNA stated that [Resident #11's Name] had refused a bed bath earlier in the day. The process when a resident refused a bath was to document it and try to get the resident to sign that they had refused. When she attempted to have [Resident #11's name] sign the refusal, he had first indicated that he was not able to sign and then that he was not able to read the document. She had not gone back a second time to try to convince him to take a bath. She documented the refusal on a shower sheet but was not sure if there was documentation in the electronic medical record also. During an interview on 8/10/2026 at 2:00 PM Resident #11 stated that he often preferred a bed bath to a shower. He did not refuse baths. During an interview on 8/10/2026 at approximately 4:00 PM the DON (Director of Nursing) stated that the expectation was for the CNAs (Certified Nursing Assistants) to offer residents ADL care - a shower or bath, multiple times. If the resident refused, they were to notify the nurse and document it. The documentation on the Shower Sheets should match what was documented in [the electronic medical record]. Review of the policy and procedure titled, ADL Care and Services, with the last review date of 1/20/2026 read, Standard: Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Guideline: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Review of the policy and procedure titled, Documentation, with the last review date of 1/20/2026 read, Policy: Each resident's medical record shall contain an accurate representation of actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Policy explanation and compliance guidelines: 1) Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 2) Documentation shall be completed at the time of service but no later than the shift in which the assessment, observation, or care service occurred. 6) Contradictory information may be clarified by a new entry in the medical record. a. Date and time the entry. b. Provide sufficient details to support that the current information is accurate. c. Sign each entry with the name and credentials.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to perform hand hygiene for 1 (Resident #115) of 10 residents reviewed for skin conditions, failed to perform hand hygiene for 1 (Resident #35) of 9 medication observations, failed to donned appropriate personal protective equipment for 2 (Resident #35 and Resident #92) of 4 residents review for enhanced barrier precautions, and failed to clean medical equipment and perform hand hygiene during dining. Findings include: 1) During an observation on 8/9/2026 at 11:24 AM Staff J Certified Nursing Assistant grabbed a pink tumbler from Resident #20's table and filled with the tumbler with apple juice. Staff J returned to the table and placed down the tumbler. Staff J return to the drink cart and poured cranberry juice and delivered the cup to Resident #20. Staff J without hand hygiene proceed to the next table and asked Resident #26 whom was accompanied by his wife and Resident # 72 what they would like to drink. Staff J return to the drink cart and poured drinks. Staff V ,CNA assisted Staff J ,CNA to deliver drinks to the table. Staff J without performing hand hygiene proceed to Resident #52's table and served him cream in his coffee cup. 2)During an observation on 8/11/2026 at 9:19 AM, Staff A Wound Care Nurse and the Assistant Director of Nursing (ADON) were standing at the treatment cart. Staff A removed her gloves to don gown and without hand hygiene donned a gown and a new pair of gloves to prepare the supplies needed. Staff A Wound Care Nurse entered Resident #115's room, adjusted the bed using the bed remote. Staff A using the same gloves removed the dressing on Resident #115 's right groin area. Staff A then removed the gloves and without hand hygiene donned a new set of gloves. Staff A cleaned the wound and removed the gloves. Staff A did not perform hand hygiene and don new pair of gloves. Staff A packed the wound and changed gloves without performing hand hygiene, donned new gloves and applied a new dressing. During an interview on 8/11/2026 at 9:30 AM with the ADON stated, More hand hygiene should have been done in between glove changes. During an interview on 8/11/2026 at 9:46 AM with Staff A Wound Care Nurse stated, I should have done hand hygiene in between changing my gloves. During an interview on 8/12/2026 at 9:42 AM with the Director of Nursing stated, Staff should perform hand hygiene every time she changes her gloves. The staff should perform hand hygiene in between each resident interaction. 3) During the observation of the preparation of oral medications on 8/11/2026 at 9:04 AM, a multivitamin tablet was dropped onto the top of the medication cart. Staff B, LPN put on gloves, without performing hand hygiene, picked up the medication and placed it in the medication cup. Staff B, LPN removed and discarded her gloves without performing hand hygiene. She added additional oral (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications to the pill cup and proceeded to administer the medications to Resident #35. 4) During an observation on 8/11/2026 at 9:34 AM Staff B, LPN (Licensed Practical Nurse), obtained Resident #8's blood pressure without cleaning the blood pressure cuff that was previously used on another resident. She failed to perform hand hygiene after obtaining the blood pressure/before preparing and administering oral medications. During an interview on 8/11/2026 at approximately 10:00 AM Staff B, LPN stated that the top of the medication cart was not a clean surface and she should have discarded the multivitamin that dropped onto the top of the medication cart. She believed the policy for cleaning resident-care equipment was to clean it between residents. She confirmed that she had used the blood pressure cuff on another resident prior to taking Resident #8's blood pressure and had not cleaned it in between. During an interview on 8/11/2026 at 9:50 AM the DON (Director of Nursing) stated the expectation for nurses administering medications was that if a pill was dropped on top of the medication cart it should be discarded. Hand hygiene was required before preparing medications for administration, and after administration to each resident. Equipment, such as blood pressure cuffs, were to be cleaned after each use/between residents. 5) During an observation on 8/11/2026 at 8:55 AM Staff C, LPN disconnected Resident #92's IV line, attached a syringe of 10ml of normal saline, flushed the line, removed the syringe and attached a new cap. She was not wearing a gown during the procedure. During an interview on 8/11/2026 at approximately 1:10 PM Staff C, LPN stated that Enhanced Barrier Precautions (EBP) applied to residents with IVs. The EBP were to provide an extra layer of protection for the residents. When providing direct care for residents on EBP, staff were to use gowns, gloves, and sometimes a mask. During an observation on 8/12/2026 at 7:35 AM Staff D, LPN accessed Resident #92's PICC (peripherally inserted central catheter) line, located in her right upper arm. She flushed with 10 milliliters of normal saline and attached the intravenous antibiotic infusion. She was not wearing a gown during the procedure. During an interview on 8/12/2026 at 7:40 AM Staff D, LPN stated that Enhanced Barrier Precautions (EBP) were to protect residents from multidrug-resistant organisms. For residents who were on EBP, staff were supposed to wear personal protective equipment (PPE) when performing direct care. She should have worn a gown when she was administering Resident #92's IV antibiotics because Resident #92 was on EBP. During an interview on 8/11/2026 at 11:05 AM the DON stated that when residents were on EBP the staff needed to wear appropriate PPE, at least a gown and gloves, when providing direct care, which would include administering or discontinuing IV medications or flushing a PICC line. Review of Resident #92's Physician Order revealed an order dated 7/31/2026 that read, Enhanced Barrier Precautions &dash; PICC line every shift (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6) During an observation on 8/12/2026 at 9:20 AM Staff E, RT (Respiratory Therapist) performed tracheostomy care for Resident #73. She donned a pair of gloves and a mask. She removed her gloves after setting up the supplies and donned a clean pair. She did not wear a gown during the procedure. During an interview on 8/12/2026 at 9:27 AM Staff E, RT stated that she did not wear a gown while providing tracheostomy care for Resident #73. She did not believe she was required to wear a gown unless she was performing deep suctioning. During an interview on 8/12/2026 at 9:32 AM the DON stated that the expectation for a resident on EBP was that all staff would wear a gown, gloves, and a mask if indicated, while performing direct patient care. For Resident #73, while receiving tracheostomy care, staff should wear a gown, gloves, and a mask. Review of Resident #73's Physicians' Orders revealed an order dated 3/12/2026 read, Enhanced Barrier Precautions-[NAME] tube (a soft, flexible silicone device placed into a neck stoma after a person has their larynx (voice box) removed) every shift Review of the facility policy and procedure titled Hand Hygiene with a last review date 1/20/2026 read, Purpose: This facility requires employees to use a acceptable infection control practices which includes hand hygiene when it is indicated. Hand hygiene is a general term that applies to washing hands with water and either plain soap or thoroughly applying an alcohol-based hand rub (ABHR). Procedure: Situations that require hand hygiene include, but not limited to: Before and after direct resident contact. After removing gloves or aprons. Review of the facility policy and procedure titled Clinical-Clean/Dry Dressing with a last review date 1/20/2026 read, Perform hand hygiene. Review of the Policy and Procedure titled Enhanced Barrier Precautions (EBP) with the last review date of 1/20/2026 read, Purpose: To ensure compliance with regulations and practice standards in the facility's effort to decrease transmission of multidrug-resistant organisms (MDRO). Definitions: Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms by utilizing Person Protective Equipment (PPE) during high contact resident care activities. Procedure: 1. Enhanced Barrier Precautions (EBP) are used for resident with any of the following: b. Wounds and/or indwelling medical devices even if the resident is not known to be colonized with MDRO. 6. Indwelling Medical Devices include the following: a. Central lines d. Tracheostomies 9. Appropriate PPE for EBP would include: a. Gown b. Gloves 10. Employees should wear appropriate PPE when performing the following duties for residents requiring EBP: j. Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator. Review of the policy and procedure titled, Infection Control & Clinical Equipment Cleaning, with the last review date of 1/20/2026 read, Standard: Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA bloodborne pathogens standard. Guideline: 2. Non-critical resident-care items are those that come in contact with intact skin but not mucous membranes. A. Non-critical resident-care items include bedpans, blood pressure cuffs, crutches and (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	computers. B. Most non-critical reusable items can be decontaminated where they are used (as opposed to being transported to a central processing location). 3. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment). 5. Durable medical equipment (DME) is cleaned and disinfected before re-use by another resident. Review of the policy and procedure titled, linical &ndash; Medication Administration, with the last review date of 1/20/2026 read, Purpose: To administer medications as per provider's orders and in accordance with regulatory guidelines practice standards. Preparation: E.) The top of the medication cart should be kept free of any hazardous material including medications. Infection Control: A.) Perform hand hygiene prior to beginning med pass; after direct contact with a resident or if hands become visibly soiled; before and after administering meds. C.) Avoid touching medications with hands.		