STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106135	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dolphin Pointe Health Care Center	5355 Dolphin Point Blvd Jacksonville, FL 32211

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations of kitchen food preparation and storage areas and interviews with staff, the facility failed to adhere to acceptable food storage practices to prevent food contamination or foodborne illness by failing to ensure opened foods were sealed, labeled and dated, and food preparation and storage equipment was clean and sanitary. Food storage and kitchen sanitation is important in health care settings serving nursing home residents. Unsafe food handling practices present a potential source of pathogen exposure and has the potential to affect all residents who consumed foods from the facility, An initial tour of the kitchen was conducted with the Certified Dietary Manager (CDM) on 1/26/26 at 2:15 PM. Inspection of the commercial ice machine's ice chute cover revealed an a 2-inch square area covered with wet, dark matter resembling biological growth such as mildew. Condensation had formed on the surface of the cover, which could drip into the ice below. When the CDM wiped the matter with a paper towel-covered finger, the matter easily wiped off. Seemingly puzzled, he explained the machine was cleaned weekly. The heat-on-demand plate base (an insulated base designed to fit under plates and maintain food temperatures) warmer next to the tray line service area had a white powdery, tacky substance on the horizontal surfaces. When wiped with a finger, the powdery substance wiped away. The same powdery matter was observed on the bottom of the plate warmer bases. The CDM acknowledged the substance and suggested it could be cleaned. The deep fryer basket still held two fries from a prior meal and food crumbs and debris was observed where the oil line met the fryer walls. Reach-in freezer #2 held multiple boxes of frozen food. One box was unsealed and had an open plastic bag of frozen omelets inside. The bag was not dated, and the omelets were exposed to air. The CDM acknowledged the finding and suggested the contents could have been stored in zipper lock baggies. The walk-in refrigerator's floor had approximately 1/4 inch of pooled water on one side. The pipe coming out of the bottom of the fan's housing was covered in condensation and dripping onto two boxes of chocolate muffins. The CDM acknowledged the findings and removed the boxes from the shelf. When he did, water poured off of the boxes and spilled onto the floor. Inside, the boxed muffins were sitting in water. The CDM recognized the pipe coming out of the fan housing had been bent, assuming it may have been hit by a box as dietary staff stored the items. The fan blades and both protective fan grilles had a buildup of dark feathery matter resembling dust. In a subsequent visit to the kitchen on 1/29/26 at 11:51 AM, the CDM requested a second inspection of the ice machine, explaining he had removed the chute cover and cleaned it. Upon reinspection of the interior of the chute, a much larger amount of the dark buildup was noted on the vertical sides and corner of the ice chute, covering a surface area of approximately 8 to 10 square inches. The CDM suggested the area was stained, not soiled, and wiped it with a rag. The substance wiped off with a rag and scraped off with a fingernail. (Photographic evidence was obtained) The CDM acknowledged the condition of the ice machine despite efforts to clean it. When asked who was responsible for cleaning the machine, he said he was.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, it was determined that the facility failed to ensure residents who were dependent on staff for grooming and personal care received necessary assistance with activities of daily living (ADLs), specifically related to fingernail and toenail trimming and cleaning, for four of six residents reviewed for ADLs (Residents #76, #116, #67, and #45).The findings include: 1. On 1/27/26 at 10:40am, Resident #76 was observed with elongated fingernails on her right hand with brown debris noted under each fingernail. The resident stated she likes her fingernails long and she likes to get them painted. They were not observed to be painted or polished. She was asked if staff clean under her fingernails. She stated no but they should. Her left hand was observed contracted and she stated she can't really open that hand. Unable to observe left hand fingernails. (Photographic evidence obtained.) On 1/28/26 at 10:05am, Resident #76 was observed awake in her bed. Her right-hand fingernails were observed elongated, as observed yesterday with brown debris observed under each fingernail. She stated no one has cleaned under her nails. Her left hand was observed contracted with fingers to palm. She was asked if she has any pain in her left hand and stated no. She was asked if she could open her fingers at all and stated no. Her left fingers were observed flat against her left palm, and the fingernails were observed elongated and dusky in color. On 1/29/26 at 12:00pm, Resident #76 was observed lying in her bed, awake. She was observed to have a hand splint on her left hand. The fingernails on her left hand were observed to be elongated with dark brown debris under the nails. (Photographic evidence obtained.) Her right hand was observed with each fingernail elongated with brown debris under each nail. She was asked if any staff had come in to clean or trim her fingernails and she stated no. A review of the medical record for Resident #76 revealed: A Minimum Data Set (MDS) quarterly evaluation dated 11/2/25 revealed Section C (Cognitive Patterns) Brief Interview for Mental Status (BIMS) was conducted, and the resulting score was 11. A score of 8-12 indicates the resident assessed is moderately cognitively impaired.Section of E (Behavior) of the same assessment on the same date revealed Resident #76 did not have any behavioral symptoms, which included no rejection of care, as documented specifically in Section E 0800.A review of the comprehensive person-centered care plan for Resident #76 revealed: Focus (1/27/24, revised 3/15/24) The resident has an ADL self-care performance deficit related to impaired mobility, impaired cognition.Interventions/Tasks (1/27/24) Provide the amount of assistance/supervision that is needed. 2. On 1/28/26 at 10:00am, Resident #116 was observed in her room, awake and sitting up in her bed, dressed for the day. Her fingernails were observed to be elongated on both hands, with some filed and jagged. She was asked if she prefers to keep her fingernails long. She stated no, not at all. When asked if staff trim her fingernails, she stated no one here has ever trimmed her fingernails and expressed her desire to have that done. She stated her daughter had to do it once when she was here. (Photographic evidence obtained.) On 1/29/26 at 12:15pm, Resident #116 was observed sitting up in her bed, awake and dressed for the day. Her fingernails were observed untrimmed, as observed yesterday. She stated no one has trimmed her fingernails since she has been here except for her daughter. A review of the medical record for Resident #116 revealed: A Minimum Data Set (MDS) quarterly evaluation dated 1/20/26 revealed Section C (Cognitive Patterns) Brief Interview for Mental Status (BIMS) was conducted, and the resulting score was 15. A score of 13-15 indicates the resident assessed is cognitively intact. Section of E (Behavior) of the same assessment on the same date revealed Resident #116 did not have any behavioral symptoms, which included no rejection of care, as documented specifically in Section E 0800.A review of the comprehensive person-centered care plan for Resident #116 revealed: Focus (1/14/26, revised 1/14/26) The resident has an ADL self-care performance deficit related to left side hemiparesis due to Cerebral Vascular Accident.Interventions/Tasks (1/14/26) Provide the amount of assistance/supervision that is needed.Focus: (1/14/26) The resident has Diabetes Mellitus.No (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Goals/Interventions related to fingernail care in person-centered care plan for focus of Diabetes Mellitus. 3. On 1/27/26 at 10:30am, Resident #67 was observed awake, dressed for day, and lying in her bed. She presented as non-verbal and did not answer any questions, including simple yes/no questions. She was observed with elongated fingernails on both hands with brown debris observed under each fingernail. (Photographic evidence obtained.) On 1/28/26 at 9:45am, Resident #67 was observed awake, dressed for the day, lying in her bed. Her fingernails were observed on both hands to be elongated with brown debris observed under each fingernail. A review of the medical record for Resident #67 revealed: A Minimum Data Set (MDS) annual evaluation dated 10/21/25 revealed Section C (Cognitive Patterns) Brief Interview for Mental Status (BIMS) was conducted, and the resulting score was 00. A score of 00 indicates the resident assessed is severely cognitively impaired.Section of E (Behavior) of the same assessment on the same date revealed Resident #67 did not have any behavioral symptoms, which included no rejection of care, as documented specifically in Section E 0800.A review of the comprehensive person-centered care plan for Resident #67 revealed: Focus (9/11/23, revised 1/25/26) The resident has an ADL self-care performance deficit related to muscle weakness and disease process.Interventions/Tasks (9/11/23) Provide the amount of assistance/supervision that is needed. Personal hygiene: the resident requires x1 staff assistance with personal hygiene. 4. On 1/26/26 at 2:50pm, Resident #45 was observed lying in bed, eyes closed. She did not open eyes to her name being called. Her feet were observed uncovered. Both first toenails on each foot were observed to be elongated, thick, and yellow in color. Each of the other toenails on both feet were observed to be longer than the toe. On 1/27/26 at 4:15pm, Resident #45 was observed up in her wheelchair, in her room. She was smiling and pleasant. She was able to state her name and was able to say she was in a nursing home. She was asked if her toenails were elongated and stated yes. She was asked if she could remove her slippers, which she did. The toenails were observed as they were yesterday, with her first (big) toenail on each foot observed to be elongated, thick, and yellow in color. Each of the other toenails on both feet were observed to be longer than the toe. (Photographic evidence obtained.)She was asked if she was a diabetic and stated yes. She was asked if she had been seen by a foot doctor over the past few months and stated she didn't think so. On 1/29/26 at 11:50am, Resident #45 was observed sitting up in her room, dressed for the day. She was asked if anyone had been in to trim her toenails. She stated no. She removed her slippers which revealed elongated toenails on each toe. She stated they really need to be trimmed. A review of the medical record for Resident #45 revealed: A Minimum Data Set (MDS) quarterly evaluation dated 10/17/25 revealed Section C (Cognitive Patterns) Brief Interview for Mental Status (BIMS) was conducted, and the resulting score was 03. A score of 00-07 indicates the resident assessed is severely cognitively impaired.Section of E (Behavior) of the same assessment on the same date revealed Resident #45 did not have any behavioral symptoms, which included no rejection of care, as documented specifically in Section E 0800.A review of the comprehensive person-centered care plan for Resident #45 revealed: Focus (8/5/24, revised 11/5/24) The resident has an ADL self-care performance deficit related to impaired mobility.Interventions/Tasks (8/5/24) Provide the amount of assistance/supervision that is needed.Focus: (8/5/24) The resident has Diabetes Mellitus.No Goals/Interventions related to foot/toenail care in person-centered care plan for focus of Diabetes Mellitus.Further review of the medical record for Resident #45 revealed one visit by a podiatrist (a foot doctor) which was dated 9/3/25. The report notes a history of diabetes. The assessment on this report revealed:Assessment: Nail dystrophy [abnormal, thickened, or damaged nails]Provider Plan: Trimming of dystrophic nails 2-4 bilaterallyAssessment: Tinea Unguium [a fungal infection of the toenails] Provider Plan: After consent, the patient was seen and examined for foot care and for elongated toenails that a non-professional could not treat as it would be considered hazardous to the patient. The therapeutic management is direct toward prevention of pain and the control of complications. Foot exam performed. The patient meets criteria for at-risk foot care with two Class B findings- absent posterior tibial pulses and three advanced trophic changes: thickened nails, shiny (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	skin, and absent pedal hair growth and two Class C findings- edema [swelling] and neuropathy [loss of feeling]. After consent, fungal nails 1 bilateral were debrided extensively utilizing a nail [NAME] [a type of nail clipper used for hard or thick nails] and Dremel [a small electric tool used to file and smooth nails] with reduction in length and girth to the patient's tolerance. I discussed with patient proper foot care. Regular podiatric care is recommended for this patient. On 1/29/26 at 12:40pm, during an interview with Employee A, a certified nursing assistant (CNA), she was asked who cleans and trims residents' fingernails. She stated the CNAs do that if the residents are not diabetic. She was asked how often this type of care is provided and she stated it's done as needed. She was asked if there is any type of schedule for providing fingernail care and stated there's no specific schedule. She was asked what the process is if a resident refuses this type of care. She stated we notify the nurse and then document the refusal. She was asked where she would document the refusal of this type of care. She stated in the computer, the Point of Care system, and on the bath/shower sheet. She was asked if she was caring for Resident #67 today and stated yes. She was asked if she had provided care for this resident's fingernails today for either cleaning under the nails or trimming them. She stated she provided her care, but didn't notice her fingernails. She was asked to observe Resident #67's fingernails. Upon making her own observation of Resident #67's fingernails, she confirmed they were long and need to be cleaned. She stated sometimes when CNAs switch units, that can fall off and might not get done. On 1/29/26 at 12:50pm, during an interview with Employee B, a CNA, she was asked who cleans and trims residents' fingernails. She stated, Well, we can clean them, but we can't clip their nails. Only the nurses can clip the resident's fingernails. She was asked what the process is if a resident refuses to have their fingernails cleaned. She stated they let the nurse know. She was asked if she documents when a resident refuses to have care completed for cleaning their fingernails. She stated yes and they have a Point of Care in the computer for documentation. She was asked if she was caring for Resident #76 today and stated yes. She was asked to observe Resident #76's fingernails. Upon making her own observation of Resident #76's fingernails, she was asked if she saw the brown debris under the resident's fingernails and she said yes. She was asked if cleaning the debris under a resident's fingernails was an expectation while providing Activity of Daily Living (ADL) care and she stated yes. On 1/29/26 at 1:00pm, Employee C, a licensed practical nurse (LPN) stated, I just spoke to Employee B, (a CNA) and I wanted to clarify about the fingernail care for you and follow up on what she told you. CNAs can clean and trim the resident's fingernails, as long as they are not diabetic or it's not contradicted for another reason. Activities staff also provides manicures as an activity and they can clean under the nails and polish the nails. On 1/29/26 at 1:10pm, during an interview with Employee D, an LPN and Unit Manager, she was asked what the expectation was for residents' fingernail care for cleaning and trimming the fingernails. She stated the CNAs are supposed to do them every Sunday, because there are no showers scheduled on Sundays. She stated the podiatrist comes in every Friday for toenails. The CNAs do not trim the diabetic resident's fingernails. She was asked who trims the diabetic resident's fingernails. She stated the nurses should do that. She was asked how often that should be done and she stated as needed. She was asked who cleans under the diabetic residents' fingernails and stated the CNAs can clean under the fingernails. She stated the CNAs should clean under the residents' fingernails when they notice it needs to be done, and they should check and do that with the morning ADL care. Activity staff will also clean, file, and cut resident fingernails on spa days, when they do manicures, and they will polish the fingernails. On 1/30/26 at 12:35pm, during an interview with the Director of Nursing (DON), she confirmed the facility does not have a policy regarding ADLs, including fingernail or toenail care. She was asked how often diabetic residents should be seen by a podiatrist for toenail care and trimming. She stated she was not sure, and the facility did not have a policy. She was asked to confirm if the last time Resident #45, a diabetic resident, had her toenails trimmed by the podiatrist was on 9/3/25. She was not sure, and stated they were looking to see if she has any other documentation. That was the only podiatry report that was found.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observations, interviews, and record review, it was determined that the facility failed to ensure residents' rights to self-administer medications was consistently assessed and safely implemented, as evidenced by the failure to complete required self-medication assessments and to ensure medications approved for self-administration were securely stored for three of three residents reviewed (Residents #116, #80, and #37). The findings include: 1. On 1/27/26 at 4:30pm, during an interview with Resident #116, she stated she has always had her eye drops and Flonase nasal spray left for her at the bedside per her request and stated yesterday afternoon staff took them away and said she couldn't have then in her room. She stated she wants her eye drops and nasal spray in her room, and that she has always administered them herself. On 1/28/26 at 10:00am, a Flonase nasal spray box and Artificial Tears box were observed on bedside table of Resident #116. She stated the staff gave them back to her. The boxes were observed to be empty, and she stated she put the medications into her small, zippered makeup bag, which was observed on her bedside table. On 1/29/26 at 12:15pm, during an interview with Resident #116, she was asked if she still had her Flonase nasal spray and Artificial Tears in her room. She stated yes, I have them in my pouch. She unzipped a cloth pouch that was on her bedside table and showed it contained a bottle of Flonase nasal spray and a bottle of Artificial Tears. She was asked if she has anywhere to lock them up to keep them secure. She stated no. She was asked if her nightstand has a locking drawer. She stated she didn't know, but couldn't reach it if it did. Her bedside nightstand was observed to have a key in the bottom drawer. She confirmed she does not use that drawer to store anything and wouldn't be able to reach it. A review of the medical record for Resident #116 revealed: A Minimum Data Set (MDS) quarterly evaluation dated 1/20/26 revealed Section C (Cognitive Patterns) Brief Interview for Mental Status (BIMS) was conducted, and the resulting score was 15. A score of 13-15 indicates the resident assessed is cognitively intact. Section of E (Behavior) of the same assessment on the same date revealed Resident #116 did not have any behavioral symptoms. A review of the Self-Administration of Medication Evaluation completed for Resident #116, dated 1/20/26, revealed the resident was assessed for self-administration of Fluticasone Propionate Suspension 50 micrograms per actuation 2 spray per nostril daily for allergic rhinitis (this medication is also known as Flonase Nasal Spray) and Artificial Tears 1 drop in both eyes two times a day for dry eyes. Part 7 of the evaluation stated: The resident can appropriately demonstrate secure storage of medications kept in room with completely capable checked off. A review of the comprehensive person-centered care plan for Resident #116 revealed: Focus (1/21/26, revised 1/22/26) The resident has a physician's order for unsupervised self-administration of the following medications: Fluticasone Propionate Suspension 50 micrograms per actuation; Artificial Tears Ophthalmic Solution 1%.Interventions/Tasks (1/21/26) May keep medication at bedside as ordered. 2. On 1/28/26 at 9:30am, a bottle of Refresh eye drops was observed on bedside table of Resident #80. She stated they are her eyes drops, and she that they aren't allowed to keep prescription medications in the room, but those are over the counter, so they allow her to keep those there. On 1/29/26 at 11:55am, a bottle of Refresh eye drops was observed on the bedside table of Resident #80. Resident #80 stated she uses them maybe once a week or so for dry eyes. She was asked if any staff had evaluated her use of the eye drops to ensure she could instill them properly. She stated no. She was asked where she stores the bottle of eye drops. She stated right there, where you see them, on her table. On 1/29/26 at 12:06pm, during a medication pass observation, Employee E, a licensed practical nurse (LPN) was observed to pass medications to Resident #80. Employee E was asked if he knew about the bottle of Refresh Eye Drops on the resident's bedside table. He stated those are used for dry eyes and irritation, and thought she used them every 12 hours as needed.Employee E was asked if the resident has an order to self-medicate these eye drops. He stated she should. He was asked if he could check and stated yes. Upon reviewing the resident's orders, he didn't see an order on the Medication (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admission Record (MAR), but thought she had an as needed order for the eye drops. He confirmed the resident did not have an order to self-medicate the eye drops because she didn't have an order for the eye drops. He was asked what the process is for a resident to self-medicate medications. He stated if a resident requests to self-medicate any of their medications we would assess them for safe administration and safe storage and let the doctor know the resident is requesting to self-administer. He was asked what safe storage means for self-administered medications. He stated the medications should be locked in the bedside table drawer. A review of the medical record for Resident #80 revealed: A Minimum Data Set (MDS) quarterly evaluation dated 11/25/25 revealed Section C (Cognitive Patterns) Brief Interview for Mental Status (BIMS) was conducted, and the resulting score was 15. A score of 13-15 indicates the resident assessed is cognitively intact. Section of E (Behavior) of the same assessment on the same date revealed Resident #80 did not have any behavioral symptoms. A review of the medical record for Resident #80 did not reveal a Self-Administration of Medication Evaluation was completed. A review of the comprehensive person-centered care plan for Resident #80 did not reveal a focus related to self-administration of medications. 3. On 1/29/26 at 9:20am, during medication pass, Employee F, a licensed practical nurse (LPN) was observed preparing medications for Resident #37. Upon completion of administering the medications to Resident #37, Employee F was asked about the order Resident #37 had listed which read: Breo Ellipta Inhalation Aerosol Powder Breath Activated 50-25 MCG/INH (Fluticasone Furoate-Vilanterol): 1 inhalation inhale orally one time a day for ANTIASTHMATIC AND BRONCHODILATOR AGENTS unsupervised self-administration. Rinse mouth with water and spit.(Breo Ellipta Inhalation Aerosol Powder Breath Activated 50-25 MCG/INH (Fluticasone Furoate-Vilanterol) is a prescription inhaled medication used to help control breathing problems such as asthma or chronic lung disease by keeping the airways open). Employee F stated yes, the resident took that medication earlier this morning. She was asked how she knew the resident had taken the medication and stated she watched her take it earlier. She was asked where the resident stores the medication and stated it's locked in her bedside drawer; she has the key. On 1/30/26 at 9:54am, during an interview with Employee N, a licensed practical nurse (LPN), she was asked if Resident #37 self-administers any of her medications. Upon checking the MAR, she stated yes, she self-medicates her Breo inhaler. She stated see the medication is in green, that indicates a resident self-administers the medication. She was asked how she ensures a resident self-administered a medication if the order indicates that and stated there's nothing to sign. They have to pass a test to ensure they can safely self-administer. She was asked how she knows the medication was taken and stated she asks the resident. If she says no, the nurse will remind her to take it. She was asked where the resident stores her inhaler and stated she was not sure. She was asked if Resident #37 had taken her morning medications today and stated not yet because she's in therapy right now. On 1/30/26 at 10:30am, during an interview with Resident #37, she was asked if she self-administers any of her medications. She stated, Yes, I have my Breo inhaler. They weren't bringing it on time, so I wanted to keep it in my room. I talked to the Administrator, and he said it was ok. She was asked where she stores it and she said in her locked bedside table drawer. A review of the medical record for Resident #37 revealed: A Minimum Data Set (MDS) annual evaluation dated 10/22/25 revealed Section C (Cognitive Patterns) Brief Interview for Mental Status (BIMS) was conducted, and the resulting score was 15. A score of 13-15 indicates the resident assessed is cognitively intact. Section of E (Behavior) of the same assessment on the same date revealed Resident #37 did not have any behavioral symptoms. A review of the Self-Administration of Medication Evaluation completed for Resident #37, dated 1/27/26, revealed the resident was assessed for self-administration of Nystatin Powder 100,000 unit/gram Apply to groin abdominal folds topically every shift for redness and Anti-Diarrheal Solution (Loperamide) with no instructions on the assessment. The assessment did not reveal Resident #37 was assessed for self-administration of Breo Ellipta Inhalation Aerosol Powder Breath Activated 50-25 micrograms/inhalation. A review of the comprehensive person-centered care plan for Resident #37 (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed: Focus: (1/20/25, revised 1/28/26) The resident has a physician's order for self-administration of the following medications: Refresh Plus Ophthalmic Solution, Anti-Diarrheal Oral Solution (Loperamide HCl), Nystatin Powder 100,000 UNIT/GRAMGoal: The resident will demonstrate the ability to take medications at the correct dose, route, time, frequency and for the right reason. Resident able to verbalize of side effects to report.Interventions: Assess resident's ability to safely self-administer medications specified on admission/re-admission, quarterly, with change in medication orders and with significant changes in condition. May keep medication at bedside as ordered. Review medication self-administration with the resident as needed to reassess abilities. A review of this care plan did not reveal any reference to self-administration of Breo Ellipta Inhalation Aerosol Powder Breath Activated 50-25 micrograms/inhalation. On 1/30/26 at 12:42pm, during an interview with the Director of Nursing (DON), she was asked if Resident #37 had been assessed for self-administration of her Breo inhaler. She stated no, she doesn't have an assessment for that medication. She was asked if Resident #80 had been assessed for self-administration of Artificial Tears. She stated she was assessed for that today. She was asked to confirm Resident #80 was only assessed for self-medication as of today, and not at any other previous date during her stay at the facility. She stated that was correct. She was asked if Resident #116 had been evaluated for self-administration of her Flonase and artificial tears and stated yes. She was asked where and/or how residents with self-administration medication orders store their medication in their rooms. She stated they would store them at bedside; they have a locked drawer to store them in after use. She was asked if the expectation was that the self-administered medications be stored in a locked drawer. She stated that's what we expect them to do. She was asked if she was aware Resident #116 was not securing her self-administered medications securely and stated no. A review of the facility policy titled Self-Administration of Medications (undated) revealed:Purpose: To respect the wishes of competent residents to self-administer prescribed medications.To provide evaluation process to determine if a resident is capable of self-administration. Procedure: 1. If a resident desires to participate in self-administration, the interdisciplinary team will assess the competence of the resident to participate by completing a Self-Administration of Medication Evaluation. 2. The nurse will interview the resident to determine their ability to identify, prepare, and administer medications. 3. The nurse will obtain a physician's order for each resident conduction self-administration of medications. 4. The nurse will educate the resident regarding reaction and side effects of the medication. 5. Nurses will evaluate compliance of self-administration and record self-administered medications as indicated. A review of the facility policy titled Medication Storage (undated) revealed: Best Practice Guidelines:Medication carts and storage rooms should be locked. This policy did not address the specifics of securing self-administered medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106135	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on observation, interviews and record reviews the facility failed to ensure staff followed policy and procedure for reporting and investigating allegations of abuse for one of one resident sampled for abuse (Resident #38) and failed to ensure staff participated in annual training on abuse, neglect and exploitation for two of 10 staff members reviewed (Staff members J, and the Assistant Director of Nursing).The findings include: 1. On 01/26/26 at approximately 2:25 PM, an observation was made of Resident #38 who was standing in the doorway of her room. The resident stated, Someone just tried to hurt me and They came into my room. At this time, staff member J, Dietary Aide, was observed in the hallway and was told by the surveyor what the resident had said. Staff member J entered the resident's room and assisted the resident back to her bed. On 1/26/26 at approximately 3:27 PM, an interview was conducted with Staff member I, Licensed Practical Nurse (LPN), who was assigned to care for Resident #38, during which she was asked if she had been informed of the resident's report of someone trying to hurt her to which she responded, No. At this time she walked down the hall toward the resident's room and stated she would report it to management. She was observed to enter the resident's room. A review of the medical record for Resident #38 revealed she had care plans for self-care deficient related to senile degeneration, weakness and impaired cognition. She also had concerns with anxiety, depression, and insomnia with a history of wandering around the unit and not recalling receiving meals/food and forgetting to use her walker. She had impaired cognitive function/dementia with a Brief Interview for Mental Status (BIMS) of 2 out of 15 indicating severely impaired cognition. The review failed to reveal nursing documentation of the incident with Resident #38 on 1/26/26 or on 1/27/26. On 1/27/26 at 3:11 PM, an interview was conducted in the facility's conference room with the Assistant Director of Nursing (ADON) and the Director of Nursing (DON). The ADON stated that staff member, I, LPN had reported to her the incident with Resident #38 on 1/26/26, but she did not follow up because staff member I stated the resident did not remember saying that someone had tried to hurt her. She confirmed that Resident #38 had issues with memory and had a BIMS indicating severe cognitive impairment. She was asked if a resident cannot remember an incident does it mean she does not have to investigate the concern to which she offered that she should have investigated further and should have reported it to the DON. At this time the DON stated she was unaware of the allegation until this interview and that she should have been told immediately so she could report it to the administrator and start the investigation. On 01/28/2026 at 11:28 AM, an interview was conducted with the DON in the facility's conference room regarding the investigation related to the allegation made by Resident #38. During the interview the DON stated she obtained statements from staff member J, staff member I, and the ADON. The DON read each of the three staff statements out loud. After reading from the documents, she confirmed that the statements did not include a date of the incident, dates in which staff were notified of the concern or the date the ADON was notified of the issue. She stated these dates could be added at a later time after the investigation was completed. A review of the Interview Record for an interview conducted by the DON with staff member J stated, Telephone Interview conducted with (staff member J), regarding (resident #38). (Staff member J) states she was walking on unit 6 hall. She saw surveyor in hallway. Saw (resident #38) but did not hear her make comment someone tried to hurt me (resident #38) need help back to room. Escorted resident who sat herself in bed. Could not assist because not a CNA. The statement did not include a date of the incident or if the staff member reported the concern to anyone. A review of the Interview Record for an interview conducted by the DON with staff member I, dated 1/27/26 states, Interview conducted with (Staff member I, LPN) in regards to (Resident #38). Nurse stated that surveyor informed her that (Resident #38) stated that someone tried to hurt her. Nurse immediately went to resident and interviewed resident, did not recall statement. Nurse reported to ADON. The statement did not include a date of the incident or the date the ADON was informed of the concern. A review of the Interview Record for an interview conducted by the DON with the ADON on (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/27/26 states, Interviewed (ADON), regarding (resident #38). (ADON) stated that she was at the desk on unit 5 when (staff member I, LPN) reported to her that (resident #38) stated that someone tried to hurt her. Nurse stated that she interview [sic] the resident and did not recall making statement The statement did not include a date of the incident or the date the ADON was informed of the concern. On 01/29/26 at approximately 12:34 PM, an interview conducted with the Unit Manger (UM) who stated that Resident #38 is confused, and sun-downs (a worsening of confusion, agitation, anxiety or other behaviors changes that often occurs in people with dementia in the late afternoon and evening as the sun sets) around 5 or 6 in the evening. The UM reported that the resident usually sits outside her room, is up pretty much all night and wanders around the unit. She verified that the resident has had outbursts in the past which are better now. The UM stated she was not aware of the resident making false accusations, stating that the resident was never alert and oriented, but can have a conversation with you but won't remember having it. If she was saying someone hurt her she would report it to the abuse coordinator who is the Administrator and would not ignore it, just because she is confused you would still need to report it for them to investigate. She would document this in a progress note as well. It is her expectation that the nurses would do the same. She would follow the same process if it was a family member or visitors reported this concern and would conduct an investigation. 2. Review of the employee file for the ADON with a date of hire of 2/9/23 revealed she had abuse and neglect training on 1/20/26. Review of the employee file for staff member J, dietary aide had a date of hire 6/13/23 with abuse and neglect training conducted on 1/29/26.On 1/30/26 at approximately 11:35 AM, an interview was conducted with the Certified Dietary Manager (CDM) who stated all employees go through new employee orientation and get abuse and neglect training at that time. He stated that dietary staff should report concerns to him - all concerns but if they have a concern involving a resident they can report it to the nurse but they should also tell him. He stated that he has not been informed of any concerns by staff member J in the last week or so. On 1/30/26 at approximately 11:46 AM, an interview was conducted with the Staff Development Coordinator during which she stated that all employees go to new employee orientation in which abuse and neglect is reviewed verbally and there is a video they watch. They take a test before and after reviewing a video regarding abuse. They also have discussions about what is abuse to include verbal, physical and sexual abuse. She brought the new employee orientation folder for staff member J from 2023 which included a training on abuse upon hire in 2023 and from 1/29/26. She stated they keep the most current training in the folder and said the older ones go into a box. She said she would try and find the others. No additional documents were provided by the time of survey exit. Review of the Position Description for the Assistant Director of Nursing (ADON) signed by the ADON on 11/22/24, revealed, Safety Awareness: Follows safety program guidelines; immediately reports accidents and incidents to supervisors; The essential job duties include, Assist with overall supervision of the Nursing Department and provides guidance to the Nursing staff. Assist the Director of Nursing in directing and developing the nursing department to ensure the delivery of high-quality care and services in accordance with all laws, regulations and Company guidelines and makes recommendations to the DON. Assesses resident care needs and makes recommendations to the DON regarding the nursing department's ability to meet those needs. Performs daily rounds within the nursing department to effectively monitor residents and ensure that nursing needs have been met as outlined in the care plans. Review of the facility policy titled Resident Mistreatment, Abuse and Neglect Prohibition revealed the purpose, and personal possessions of every resident. Each facility has systems, procedures and a program of employee training and supervision in place to foster dignified treatment, respect and compassion for residents. Any form of mistreatment of any resident including but not limited to abuse, neglect, injuries of unknown origin and misappropriation of resident property is strictly prohibited. All allegations of mistreatment, abuse, neglect, injuries of unknown origin and misappropriation of resident property are to be reported immediately and investigated by the Administrator, Risk Manager or designee. Under the section for Training the policy states, Upon (continued on next page)

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	106135	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hire, annually, and additionally if determined appropriate by the facility management, each employee will be trained on the following topics: included in the list was, Resident Mistreatment, Neglect and Abuse Prohibition Guidelines; Appropriate interventions to deal with aggressive and/or potentially dangerous behaviors; What constitutes mistreatment, abuse, neglect, unreasonable confinement, injuries of unknown origin and misappropriation of resident property; How to recognize signs of burnout, frustration and stress that may lead to abuse; Employee responsibilities as a mandated reported.; How staff should report their knowledge of allegations without fear of reprisal. Employees are expected to review the educational material carefully and attend all training sessions. The policy defines mental abuse, includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation. Verbal abuse is defined, the use or oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within their hearing distance regardless of their age, ability to comprehend, or disability. Mandatory reported includes any person who has assumed full or intermittent responsibility for care or custody of an elderly person, whether or not that person receives compensation, such as administrators, supervisors, and any licensed staff of a facility that provides care or services for elderly adults or any care custodian, health practitioner, clergy member or employee of a county adult protection services agency or local law enforcement agency. Mandatory reporting is a legal obligation for mandated reports to formally report suspected, believed, or witnessed abuse, neglect or mistreatment of residents in accordance with state and federal laws. Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Under the section titled Prevention states, Each facility is required to identify, correct, and intervene in situations where abuse, neglect and/or misappropriation of resident property are likely to occur, or are suspected to have occurred. Under the heading Investigation states, Each facility will thoroughly investigate injuries of unknown origin and any suspected or alleged abuse, neglect, misappropriation of resident property in accordance with federal and state regulations. The electronic incident report and investigation system forms should be completed for all incidents of suspected or alleged mistreatment, abuse, neglect, misappropriation of resident property and for injuries of unknown origin

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	106135	A. Building B. Wing	01/30/2026

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure accurate medical records were reflective of residents' care for one of one resident (Resident #155) observed with edema and ordered to wear compression stockings (snug knee-high socks that provide pressure to the legs, ankles, and feet to improve circulation, reduce swelling, and prevent blood clots), out of a total of 45 residents in the sample. An observation conducted of Resident #155 on 1/27/26 at 10:29 AM found her barefoot and in bed. During an interview at this time, she was asked if she had any socks available to wear. Resident #155 answered, Yes, but they are over there. (pointing across the room to a pair of slippers) No socks or stockings were observed in the vicinity. Resident #155 was able to provide a detailed medical history leading up to her transfer to this facility. During an observation on 1/28/26 at 2:47 PM, Resident #155 was sitting on the side of her bed barefoot. Some mild edema (swelling caused by an accumulation of fluids) was noted to her ankles. When asked about being barefoot, she explained she did not like to wear shoes. When she was first admitted to the facility, they tried some vibrating things on her legs (described intermittent compression devices which are used to stimulate the legs by mimicking walking and prevent blood clots), but she hated them and told staff to get them off. She has not worn them since. When asked if she wore compression stockings, she said she had not. On 1/29/2026 at 11:33 AM, Resident #155 was observed in the beauty parlor getting a haircut. Mild edema was noted to her right ankle. She had on slippers, but no socks or stockings. During a second observation this day at 2:13 PM, Resident #155 was once again observed without socks or stockings. In a final interview at this time, she insisted she had no awareness of any compression stockings. A record review revealed Resident #155 was admitted on [DATE]. Per her comprehensive minimum data set (MDS) assessment dated [DATE], she had a brief interview for mental status (BIMS) score of 13, reflecting she was cognitively intact. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD- a progressive lung disease), cancer, schizophrenia and medically complex conditions. A psychiatric progress note dated 1/22/26 reflects Resident #155 was pleasant and conversant. She described a detailed medical history to the practitioner, and although she had a diagnosis of schizophrenia, had no presenting symptoms and was not on psychotropic medication. Resident #155 presented with fair short-term memory, normal long-term memory, an appropriate fund of knowledge, logical thought processes, and intact associations. The practitioner noted Resident #155 was compliant with medical care and treatment. Photographic evidence was obtained. Resident #155 had a physician's order dated 1/23/26 for [Brand name] hose (compression stockings) knee high on in the AM (morning), remove in the PM (afternoon/evening), every day and evening shift for prevention. Review of the corresponding treatment administration record (TAR) revealed two different lines for nurses to document the use of the hose, specifically, ON for the Day shift, and OFF on the Evening shift. On 1/23/26 the hose were signed OFF on the evening shift. The hose had been signed off by nursing staff for both the day shift as ON and the evening shift as OFF on 1/24/26, 1/25/26, 1/26/26, 1/27/26, 1/28/26 and 1/29/26. (Photographic evidence obtained) Further review of the record revealed no corresponding nursing or exception notes indicating Resident #155 had refused or removed her physician's ordered stockings, and no record of reporting non-compliance with their use to the prescribing physician. An interview was conducted with Employee K, Registered Nurse, on 1/29/2026 at 2:13 PM. She explained Resident #155 did wear compression stockings but had asked her to remove them this morning. When asked what time Employee K removed the stockings, she said, About 2 (PM). When advised Resident #155 was in the beauty parlor without her hose at 11:33 am, Employee K hesitated, then said Resident #155 could remove them herself. Any refusals to wear the stockings would be noted on the TAR. An interview was conducted with Employee L, Certified Nursing Assistant (CNA), on 1/29/2026 at 2:21 (continued on next page)

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	106135	A. Building B. Wing	01/30/2026

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM. He confirmed he was assigned to Resident #155. When asked about the compression stockings, he stated he had seen her in those a while ago but couldn't recall when. He could not recall seeing them on recently. Employee L confirmed the CNAs can apply compression hose; nurses usually give them to the CNAs to put on the resident. An interview was conducted with the Director of Nursing on 1/30/26 at 10:51 AM. She said she heard Resident #155 was removing her physician's ordered hose. She was asked if resident refusals were expected to be noted on the TAR. The DON said she wasn't sure. When advised Resident #155 was observed for 3 days without the hose and denied their existence, the DON acknowledged nurses were signing the TAR that the stockings were applied as ordered, instead of noting refusals or removal. Review of the facility's clinical guidance manual's subject Elastic Stockings CCHC0608, no date) revealed the purpose of the stockings is to prevent formation of deep vein thrombosis (blood clots) and potential pulmonary embolism (sudden blockage in the lung artery that usually results from a blood clot travelling from the legs), provide support for, and aid return of circulation from lower extremities. Procedures directed to apply the stockings per the plan of care and ensure they were worn in bed and during ambulation to provide continuous therapy. The application of stockings should be documented in the resident electronic record. (Photographic evidence was obtained)