STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106142	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Nursing and Rehab Center	15480 Max Leggett Parkway Jacksonville, FL 32218

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 - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on kitchen food service observations, staff interviews, facility document review, and facility policy and procedure review, the facility failed to follow proper sanitation and food handling practices to prevent the outbreak of foodborne illness, with the potential to affect all residents who consumed foods from the facility, by failing to label and date mark an open beverage found in the 400 hallways nourishment room. Additionally observed were open bundles of bread in the cook area storage bin. Food handling and sanitation are important in health care settings serving nursing home residents. Unsafe food handling practices represent a potential source of pathogen exposure.The findings include:During an observation of the 400 hallways nourishment room on 2/25/26 at 12:53 PM, an open 1.18-liter bottle of Starbucks Vanilla Latte with no date marking was observed. Licensed Practical Nurse (LPN) L was immediately notified and instructed to remove or properly label the item. (Photographic evidence obtained)On 2/26/26 at 1:02 PM, a re-inspection of the 400 hallways nourishment room revealed the same open, undated 1.18-liter bottle of Starbucks Vanilla Latte in the refrigerator. The item was discarded. (Photographic evidence obtained)During a follow-up observation in the kitchen on 2/26/26 at 2:42 PM< ten (10) open bundles of bread were observed in the cook area storage bin with no dates or labels. One (1) of 10 bundles contained visible mold. All 10 items were discarded. (Photographic evidence obtained)On 2/26/26 at 1:21 PM, Dietary Assistant Supervisor (DAS) M reported that kitchen staff were assigned daily to job #6 fill, check labeled items, and clean nourishment rooms, with DAS M responsible for ensuring task completion.On 2/26/26 at 2:42 PM, [NAME] I was asked what happened when bread was opened, used, and placed back on the shelf to store. [NAME] I replied, Tie the bag and store it for the next shift. On 2/26/26 at 2:50 PM, Certified Dietary Manager (CDM) K was asked what happened when staff opened bread, used it, and placed it back on the shelf. CDM K replied, Seal the bread and store it. Food opened and not used from dry storage should be sealed, labeled and dated. A review of the facility's policy and procedure titled Food Safety and Sanitation (dated 2019), revealed:Policy: All local, state and federal standards and regulations will be followed in order to assure a safe and sanitary food and nutrition services department. Procedure: 4 .all time and temperature control for safety (TCS) foods (including leftovers) should be labeled, covered, and dated when stored. When a food package is opened, the food item should be marked to indicate the open date. This date is used to determine when to discard the food. (Copy obtained)Reference: FDA Food Code 2022. https://www.fda.gov/media/184685/download?attachment; (Accessed on 3/9/2026)Annex 5 - C. Intervention Strategies for Achieving Long-term Compliance. 4. Establish First-In-First-Out (FIFO) Procedures. Page 555. Product rotation is important for both quality and safety reasons. First-In-First Out (FIFO) means that the first batch of product prepared and placed in storage should be the first one sold or used. Date marking foods as required by the Food Code facilitates the use of a FIFO procedure in refrigerated, ready-to-eat, TCS foods. The FIFO concept limits the potential for pathogen growth, encourages product rotation, and documents compliance with time/temperature requirements.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to implement interventions identified in the comprehensive care plan for two (Residents #31 and #3) of 32 residents in the total survey sample. Resident #31 had no floor mat at bedside as per the physician's order and her care plan. Resident #3 had no pillow supporting her left elbow as per the physician's order and her care plan. Failing to follow these residents' care plans could result in falls with injuries, worsening of pressure areas, increased pain, and overall functional decline. The findings include:1.A review of Resident #31's medical record revealed that she was admitted to the facility on [DATE]. Her diagnoses included spinal stenosis (narrowing of the spinal column spaces placing pressure on the nerves that travel through it), hemiplegia (paralysis of one vertical side of the body often causing trunk muscle control loss, including limpness or spasticity), polyneuropathy (widespread, simultaneous dysfunction of multiple peripheral nerves, often causing numbness, burning pain and muscle weakness, especially in the hands and feet), seizures, dementia and bipolar disorder.A review of the most recent Quarterly Minimum Data Set (MDS) assessment, dated 2/9/26, revealed a Brief Interview for Mental Status (BIMS) score of 4 out of 15 possible points, indicating severe cognitive impairment. Resident #31 was documented with a functional impairment of both upper and lower extremities on her right side.A review of the February 2026 Medication Administration Record (MAR) revealed an active physician's order, dated 4/10/2025, for Floor mats to right side of bedside. Check placement every shift.A review of the active comprehensive care plan (initiated 10/2/20) revealed a Focus Area indicating that the resident was identified as being at risk for falls related to impaired mobility, deconditioning, balance problems, muscle weakness, seizure disorder/epilepsy, medication side effects, and a history of CVA (stroke) with right-sided weakness. Interventions included: I will have a floor mat at right bedside per daughter's request. (initiated on 9/27/24, revised on 4/2/25).On 2/24/26 at 10:02 AM, the resident was observed lying in bed with the head of the bed (HOB) elevated. No floor mat was observed. (Photographic evidence obtained)On 2/24/26 at 2:01 PM, another observation revealed that the resident was in bed with her eyes closed. No floor mat was observed. (Photographic evidence obtained)On 2/25/26 at 9:54 AM, the resident was observed sitting in a wheelchair at the entrance of her room. No fall mats were observed in the room. (Photographic evidence obtained)On 2/26/26 at 2:20 PM, during an interview with Resident #31's assigned certified nursing assistant (CNA), CNA E, she stated she had been employed by the facility for five months. She confirmed that she provided care for the resident, but stated she was not aware that the resident was at risk for falls. She stated information about a resident's risk for falls could be found in the Kardex, but Resident #31 had not had a fall since she had been caring for her. CNA E stated she had never seen fall mats placed at the resident's bedside.On 2/26/26 at 1:03 PM during an interview with the Risk Manager, she confirmed, after reading aloud from Resident #31's Kardex, that Resident #31 should have fall mats on the right side of her bed. Upon entering the resident's room with the Risk Manager, she confirmed that there was no fall mat on the floor adjacent to the resident's bed. A staff member entered the resident's room with a floor mat at that time. 2.A review of Resident #3's medical record found that she was admitted to the facility on [DATE]. Her diagnoses included contracture (permanent tightening and shortening of muscles, tendons, skin, or joint capsules, usually caused by scarring, immobility or neurological conditions) of the left hand and both knees; osteoarthritis in her left elbow; dementia, pressure ulcer at the left elbow, and transient ischemic attack (TIA - temporary blockage of blood flow to the brain that causes stroke-like symptoms lasting from a few minutes to 24 hours.)A review of Resident #3's most recent Quarterly MDS assessment, dated 1/17/26, revealed that facility staff assessed the resident for mental status and found that short- and long-term memory were impaired, and the resident was unable to recall the season, the location of her room, staff names/faces or that (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she was in a nursing home. Her cognitive skills for daily decision making were documented as severely impaired. She was noted as dependent for all care needs with impairment to her upper and lower extremities on both sides.A review of the active comprehensive care plan revealed that the resident was identified as at risk for skin breakdown. The plan included an intervention for placement of an off-loading pillow under the resident's left elbow.On 2/23/26 at 11:34 AM, Resident #3 was observed in bed with her eyes closed. No pillow was observed under her left elbow.On 2/24/26 at 10:27 AM, the resident was observed in bed with her eyes closed. No pillow supporting the resident's left elbow was observed. The resident's left elbow had a bandage that was loose and was not adhering to her elbow wound. (Photographic evidence obtained)On 2/25/26 at 10:47 AM, Resident #3 was observed in bed with her eyes closed. A towel was observed under her left elbow, but no supportive pillow was observed. (Photographic evidence obtained)On 2/25/26 at 2:49 PM, during an interview with Licensed Practical Nurse (LPN) D, she stated she had been working at the facility for three to four years and had been a nurse for 30 years. She further stated a resident's functional status could be found in the Kardex. She conducted rounds every two hours. She reported that pressure injury interventions often involved turning and repositioning residents, conducting skin sweeps, off-loading and providing proper peri-care. She stated Resident #3 was not on her assignment. A review of the resident's February 2026 Treatment Administration Record (TAR) revealed that LPN D documented having performed the task of checking placement of the off-loading pillow under the resident's left elbow on 2/24/26. LPN D was made aware that her documentation on Resident #3's TAR had been reviewed. She stated she was helping another nurse yesterday. She further stated she did not know whether she documented on Resident #3 or not. She was asked if she was aware that the resident had a pressure ulcer; she confirmed that she was aware. LPN D was asked to check the resident's care plan as it related to the care and treatment of pressure injuries. She verbalized the interventions as she read them from the care plan. She was asked how often the off-loading pillow was supposed to be checked and she replied, every time you go into the room. She was accompanied to Resident #3's room to observe the resident. LPN D asked if this could be done the following day. She was informed that the observation should occur at this time. LPN D asked that she be given a few minutes and she walked away. She returned with the Risk Manager, and they were accompanied to Resident #3's room. In the room, LPN D checked the resident's left elbow and removed a towel that was rolled up underneath it. LPN D stated the towel was not supposed to be there and instead, a pillow was supposed to be supporting the resident's left elbow. The Risk Manager removed a yellow off-loading pillow from a chair in the corner of the resident's room and laid it on the resident's bed. The survey team then exited the room.On 2/25/26 at 3:07 PM during an interview with the Director of Nursing (DON), she stated when a staff member was assisting another staff member with residents, whoever was performing the task was responsible for documenting completion of the task; staff members should not sign off on tasks that were not done by them.