

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106143	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
NAME OF PROVIDER OR SUPPLIER Middleburg Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1280 Henley Rd Middleburg, FL 32068	
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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review, interviews, and a review of facility documentation, the facility failed to send a copy of the notice of transfer or discharge (Discharge/Transfer Notice AHCA 3120-002 form) to the representative of the Office of the State Long-Term Care Ombudsman's office for four (Residents #126, #150, #151 and #152) of four residents reviewed for discharge requirements. The findings include: A review of the Discharge/Transfer Notice AHCA (Agency for Health Care Administration) 3120-002 Forms issued to Residents #126, #150, #151, and #152 revealed that the forms were incomplete. No date/time of notification was documented for when the notices were provided to the Long-Term Care Ombudsman's office. On 01/15/2026 at 9:47 AM, an interview with the Social Services Director (SSD) revealed that he was responsible for providing notification of transfer and discharge to the local state Ombudsman's office. He stated his process was to send the facility's monthly discharge and transfer list to the Ombudsman's office via fax within the first week of the month following the month the discharges occurred. He was shown the transfer and discharge AHCA 3120-002 forms provided to Residents #126, #150, #151, and #152 at discharge. He confirmed that the section where notice was given to the Local Long-Term Care Ombudsman Council on the AHCA 3120-002 form was blank. He confirmed that he did not send the actual forms to the Ombudsman's office; he only sent the facility's monthly admission/discharge list. On 01/15/2025 at 2:52 PM, an interview was conducted with the MDS (Minimum Data Set) Coordinator/Registered Nurse (RN), who confirmed that her department was responsible for issuing the discharge notifications to the residents, and the Social Services Department was responsible for informing the Long-Term Care Ombudsman's office. She could not confirm when the notifications of residents' transfers/discharges were being provided to the Ombudsman and was unaware of the requirement to send the actual transfer/discharge forms. A review of the facility's policy and procedure titled Discharge Planning Process (dated November 2025), revealed: Intent: It is the policy of the facility to assure that the discharge planning process is implemented in accordance with the State and Federal Regulations.		

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to honor a resident's right to make choices regarding accommodations to support safe bed mobility and positioning; specifically, failing to provide requested handrails in a timely manner for one (Resident #136) of 49 residents in the total survey sample. Failure to honor a resident's right to make choices about their care can result in physical injury or psychological distress. The findings include: On 01/13/2026 at 11:45 AM, Resident #136 was observed being pushed in her wheelchair by a staff member back to her room where her daughter was present. Resident #136 reported that she was admitted to the facility last week, and that upon admission, both she and her daughter had asked the Administrator directly for partial bedrails to assist her with positioning while she was in bed. The Administrator's response was that he would look into it, but they had not heard back about it yet. She further stated she was worried about hurting herself because the staff were asking her to grab onto the closet door handle and the side table to reposition herself. On 01/14/2026 at 11:41 AM, Resident #136 was observed seated in her wheelchair with a nasal cannula in place. She was dressed and eating her lunch. No bedrails were observed on her bed. Her daughter was present in the room and reported that she requested to speak with the Administrator yesterday (1/13) and was told he was out of his office. She left a note with the front desk personnel requesting to speak with him. She stated she overheard the Administrator in another resident's room and when he walked by Resident #136's room, she stopped him to ask about the bedrails for her mother's mobility. She stated his response was that he did not have time to address it right now. She stated he entered the room and asked about a telephone that was sitting on the floor but did not provide a response about the bedrails prior to leaving the room, so she planned on leaving another message for him with the front desk. On 01/14/2026 at 12:10 PM, an interview was conducted with Certified Nursing Assistant (CNA) P, who stated the residents with bedrails on their beds received them through the therapy department, and if she received a request for bedrails from a resident, she would notify the nurse. On 01/14/2026 at 12:36 PM, Resident #136's daughter was observed at the reception desk requesting to speak with the Administrator. As the Administrator was turning the corner away from the reception area, he was informed that a family member wanted to speak with him. He continued walking away without acknowledging the request. A medical record review for Resident #136 revealed that she was admitted to the facility for short-term rehabilitation services on 01/06/2026, with a discharge goal to return to the community. Her primary medical diagnosis was Rhabdomyolysis (a condition where damaged muscle tissue breaks down, releasing harmful substances into the bloodstream. Symptoms can include muscle pain and weakness). Additional listed medical diagnoses included generalized muscle weakness, anemia, peripheral vascular disease, and dependence on supplemental oxygen. A review of Resident #136's admission Minimum Data Set (MDS) assessment, dated 01/14/2026, revealed that she had clear speech, could make herself understood, and had the ability to understand others with a Brief Interview for Mental Status (BIMS) score of 14/15, indicating intact cognition. She was coded as requiring substantial/maximal assistance for rolling left and right, and partial to moderate assistance with sitting to lying and sitting to a standing position. No mental status changes, behavioral issues or refusal of care were noted. She was noted as using a rolling walker at home prior to admission and there were no limitations noted to her range of motion. A history of falls, muscle weakness and continuous oxygen use were noted. No bedrails were noted. There was no MDS question that asked the resident whether she would like bedrails for mobility assistance. There was no place on the MDS assessment to document this information. A review of the Physical Therapy Evaluation and Plan of Treatment was conducted for the certification time period of 1/7/2026 - 2/3/2026. The evaluation noted that the resident previously lived alone in a single-story home and was moderately independent (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with all functional mobility to include ambulating with a front-wheeled walker and driving. The following baseline information was documented as of 1/7/2026: Baseline: 30-second sit-to-stand - Patient is unable - Requires use of hands Baseline: Roll left to right - Partial/moderate assistance Baseline: Ambulation was not attempted due to medical conditions or safety concerns. Patient was admitted to the hospital on [DATE] for right lower back pain when moving her right leg. Patient now presents with a decline in strength, balance, endurance and safety awareness during bed mobility, transfers and ambulation. Precautions: Fall risk, anxious, self-limiting, Hoyer (mechanical lift) Prior Therapy: Yes, at hospital and inpatient rehab facility Prior Living: Patient resided in a private residence Prior Equipment: Front-wheeled walker, wheelchair, shower chair, grab bars, oxygen concentrator, portable oxygen Prior Cognitive Assistance: Independent Prior Device Use: Walker The evaluation indicated that the resident was previously independent with bed mobility, transfers and ambulation prior to hospitalization. History of Falls: The evaluation indicated that Resident #136 had fallen three times in the last year. Does the patient feel unsteady when standing? Yes. Does the patient worry about falling? Yes. Impaired lower extremity strength bilaterally (both legs) Decision making ability for routine activities: Independent A Request for Therapy Evaluation, dated 1/14/2026 (third day of the survey), was reviewed. The following information was included: The form's line for Nursing Assessment indicating that the resident had a recent change in the ability to _____ (line left blank) (ADL/functional activity) was not filled in; however, the Least restrictive devices for positioning was checked off with a handwritten entry stating, Mobility bar for bed. The therapist who authored the form wrote, Patient assessed for mobility bar for safety and improve indep. w/ADLs (independence with activities of daily living) Pt sup w/mobility bar. It was signed on 1/14/2026. (Copy obtained) On 1/15/2026 at 12:54 PM, during an interview with Licensed Practical Nurse (LPN) K/Unit Manager for the Short-Term Rehabilitation Unit, she stated residents with bedrails in place received them through an approval process with the therapy team who evaluated residents for their mobility needs and an assessment for use without harm. She further stated bedrails were then ordered, care planned and placed on the bed by the maintenance department staff. She denied being aware of any requests for bedrails made for Resident #136. On 01/15/2026 at 2:12 PM, an interview with Occupational Therapist (OT) F revealed that residents could have bedrails placed after being assessed by the nursing and therapy departments. The residents were evaluated for bed mobility during their initial evaluation when they asked about prior use of bedrails to determine the need. On 01/15/2026 at 2:36 PM, an interview was conducted with Physical Therapist (PT) D who completed Resident #136's Physical Therapy Evaluation and Plan of Treatment during the certification time period (1/7/2026 - 2/3/2026). PT D acknowledged that a request for bedrails was made by the resident for safety and positioning at the time of the evaluation on 1/7/2026, but she was denied because she did not use them at home. On 01/15/2026 at 3:27 PM, an interview with the Administrator was conducted. He was asked how residents and their family members were able to reach him and he replied, My contact information is available on my business cards, or through any of the managers or the receptionist. I have an open-door policy and can be contacted through email, voicemail, or staff directly, and when I'm not immediately available, I will call them back typically the same day or the next day. He was asked if he knew about Resident #136's request for bedrails. He said yes, he was notified the day after she was admitted to the facility, and he consulted with the Director of Nursing (DON), but he failed to follow up with the resident and family. He further stated, After the family member tracked me down in the hallway, I just had them installed today. This was something that just went by the wayside and I probably should've followed up sooner than I did, but the rails are in place now. (Nine days after the resident was admitted and requested the bedrails) A review of the facility's policy titled Resident Rights (dated December 2025), revealed on page 5, number 35 that, The resident has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interviews, the facility failed to provide the required beneficiary notices to two (Residents #150 and #151) of three residents reviewed for beneficiary notices, who remained in the facility following termination of their Medicare Part A services, placing them at risk of not receiving the required notice of rights and services and potential financial liability. The findings include: Record reviews for Residents #150 and #151 revealed that they remained in the facility following termination of their Medicare Part A services, and were not issued the Skilled Nursing Facility Advance Beneficiary Notices (SNF ABN), Forms CMS-10055, by the facility at the time Medicare A coverage ended; information that explained their potential financial liability for items or services that would no longer be covered by Medicare A. On 01/15/2026 at 9:47 AM, an interview with the Social Services Director (SSD) revealed that he was responsible for coordinating resident discharges; however, he was not responsible for issuing the Notice of Medicare Non-Coverage (NOMNC) or the SNF ABN notification, the MDS (Minimum Data Set) department was responsible. He stated he would follow up to explain the financial liability if the resident or family disagreed with the discharge. On 01/15/2026 at 2:52 PM, an interview was conducted with Licensed Practical Nurse (LPN) M who reported working in the MDS department for two years, and who confirmed that she was responsible for issuing the notices of discharge to residents discussed in the facility's weekly Patient Driven Payment Model (PDPM) meeting, where NOMNC and SNF ABN notifications were agreed upon. She confirmed that she was responsible for issuing the required SNF ABN notification to beneficiaries that explained potential financial liability, and she reported that when a resident disagreed with the NOMNC or wanted to make an appeal, she notified the Social Services department so they could explain the financial liability potential. She further stated she was unaware that a SNF ABN notification was required. On 1/15/2026 at 3:05 PM, an interview was conducted with the MDS Coordinator, who confirmed that she assisted LPN M with issuing the NOMNC notifications, and acknowledged the required SNF ABN notification was not being provided to beneficiaries as required. A review of the facility's policy titled Discharge Planning Process (dated November 2025), revealed: Intent: It is the policy of the facility to assure that the discharge planning process is implemented in accordance with the State and Federal Regulations. Procedure 2. The facility's discharge planning process will be consistent with the discharge rights set forth at 483.15 (b) as applicable. (Copy obtained)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that a resident with limited range of motion (ROM) received appropriate treatment and services to increase ROM and/or to prevent further decrease in ROM for one (Resident #66) of four residents reviewed for mobility/positioning, by failing to ensure daily placement of a physician-ordered hand splint. Failure to apply a physician-ordered splint/brace can result in worsening of a contracture, functional decline and increased pain. The findings include: On 01/12/2026 at 11:08 AM, Resident #66 was observed lying in bed with a sheet covering her up to her chin. She held the sheet with her left hand. When greeted, she smiled, shifted her upper body toward the left side of her bed and mumbled, hi. A dark blue colored brace was observed neatly folded on the nightstand located to the right side of her bed. She was asked if she wore the brace that was observed on her nightstand. She shook her head no and sighed before pulling her right arm from under the sheet with her left hand. The fingers on her right hand were stiff and curled toward her palm. She dropped her right hand down to her stomach and stated, see?. She was asked if she received assistance applying and removing her brace. She replied no and cradled her right hand with her left hand close to her chest and began rocking. On 01/14/2026 at 9:40 AM, a second observation was made of Resident #66. She was sitting upright in her bed with her breakfast tray covered on her bedside table. A family member was resting in a reclining chair in the corner of the room. When asked how she was feeling, she tilted her left hand back and forth to motion so/so. When asked if she had her brace on, she pulled her right arm out from under the covers with her left hand, dropped it to her stomach and cradled it with her left hand. The dark blue brace was observed on the nightstand in the same spot as it was on 01/12/2026 at 11:08 AM. The resident's family member reported that they visited her every day, all-day and they had not seen staff helping her with her brace in months. A record review conducted for Resident #66 revealed she was admitted to the facility on [DATE] with a primary diagnosis of hemiplegia/hemiparesis following a cerebral infarction (stroke) affecting her right side. Additional diagnoses included reduced mobility, muscle weakness, and chronic pain syndrome. The most recently completed Minimum Data Set (MDS) quarterly assessment, dated 09/05/2025, revealed that Resident #66 had adequate hearing, unclear speech/mumbled words, and her Brief Interview for Mental Status (BIMS) score was 06 out of 15 possible points, indicating severe cognitive impairment. No behaviors or rejection of care were documented. She was noted with upper impairment to one side (shoulder, elbow, wrist, hand) and for lower extremity impairment (hip, knee, ankle, foot). She used a wheelchair for mobility; she was dependent for toileting; she required substantial/maximal assistance with showering/bathing and upper body dressing. She was dependent on staff for lower body dressing. The Occupational Therapy start date was 08/14/2025. No range of motion or splint/brace assistance was documented. A review of the resident's active Physician's Orders revealed: Pt (patient) to have R (right) resting hand splint on 6-8 hrs. (hours) per day to decrease risk of contracture. RUE (right upper extremity (upper arm) skin checks to be performed before and after. Order date 03/20/2025, active. A review of the December 2025 Medication Administration Record (MAR) revealed that the physician's order for Resident #66 to have a right resting hand splint on 6-8 hours per day, in addition to skin checks before and after, was not listed. A review of the resident's active comprehensive care plan revealed no focus area for the right-hand contracture with splinting or the skin checks before and after use of the brace. On 01/14/2026 at 12:10 PM, an interview was conducted with Certified Nursing Assistant (CNA) P who confirmed that she worked with Resident #66 and was unaware of a splint or brace. On 01/15/2026 at 11:29 AM, CNA I reported that residents who had splints/braces were evaluated and assessed by therapy or a doctor, and then therapy would communicate to the CNAs. She further stated education was provided about when to apply the brace, the length of time it was to remain on, (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and the shift responsible for the application/removal of the brace. She added, We are responsible for placing them. She confirmed that she was familiar with Resident #66 and confirmed she had never seen a hand brace or splint on her. On 01/15/2026 at 12:15 PM, Licensed Practical Nurse (LPN) G reported her expectations for CNAs when rounding included obtaining vital signs, changing soiled briefs, checking skin condition, and reporting any changes to nursing. She was unable to confirm who was responsible for applying braces/splints, and said she was unaware of any of her assigned residents having a brace. If they did, it would be documented in their chart, and in the physician's orders. On 01/15/2026 at 2:05 PM, Occupational Therapist (OT) F reported that she had worked for the facility for five years, and her responsibilities included screening new admissions, completing assessments, and family and resident education. When she completed an evaluation, she did a full resident chart review, how they move, transfer and strengths. She made recommendations and goals were set related to ADLs to include bathing, dressing, and toileting. She confirmed that Resident #66 was not currently receiving therapy services, but she had worked with her when she was. OT F confirmed that there was an active order for a right resting hand splint and stated restorative nursing or the assigned CNA was expected to place the hand splint when the resident was not active in therapy. On 01/15/2025 at 3:11 PM, an interview was conducted with the MDS Coordinator/Registered Nurse (RN) and LPN E who was responsible for completing the assessments for all of the long-term care residents. LPN E confirmed that she completed the quarterly and annual assessments for Resident #66 and that completing her assessments was a challenge, but she asked yes and no questions, talked to the care team about any changes, and then updated the care plans. This last quarter she reported seeing no changes. LPN E was asked to review Resident #66's active physician's orders for any special devices. She confirmed that there was an active order for a right resting hand splint for 6-8 hours daily. She confirmed that the splint was missed on the quarterly MDS assessment completed on 09/05/2025, and that no comprehensive care plan was developed or implemented. A review of the facility's policy and procedure titled Activities of Daily Living (ADLs/Maintain Abilities) (dated January 2024), revealed: It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff across all shifts and departments, understand the principles of quality of life, and honor and support these principles. The policy interpretation and implementation indicated: 1. Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility will provide the necessary care and services to ensure that a resident's abilities of daily living do not diminish. 2. The facility will ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. 4. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.		

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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. Based on observations, interviews and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary environment and to help prevent the development and transmission of communicable diseases and infections for two (Residents #70 and #47) of nine residents observed during medication administration. RN B failed to perform hand hygiene as required while administering medications to more than one resident. The findings include: 1. During a medication administration observation on 01/14/2026 at 9:19 AM, Registered Nurse (RN) B began preparing medications for Resident #70. This included oral medications and eye drops. RN B wore gloves while preparing the medications and proceeded to Resident #70's room. The nurse entered Resident #70's room and did not perform hand hygiene. RN B placed the oral medications in the resident's palm at the resident's request and handed her a cup of water. Resident #70 swallowed her oral medications. While wearing the same pair of gloves, RN B proceeded to administer prescribed eye drops in both of Resident #70's eyes and handed her a paper towel. RN B removed the gloves, did not perform hand hygiene, and left the resident's room. 2. During continued observation of medication administration on 01/14/2026 at 9:24 AM, RN B, who had not performed hand hygiene after medicating Resident #70, donned a new pair of gloves. She began preparing the oral and transdermal medications for Resident #47. She placed the oral medications in a medication cup, placed Juven powder (therapeutic nutrition powder) in a water cup and added water to mix the powder with. RN B stirred the Juven powder with a spoon. She then removed the outer packaging from the ordered Nicotine Transdermal patch and wrote the date and her initials on the top of the patch. She proceeded to Resident #47's room. RN B entered Resident #47's room wearing the same pair of gloves and did not perform hand hygiene. While wearing the same pair of gloves, RN B proceeded to peel the backing off of the Nicotine Transdermal Patch and place the patch on the resident's left outer upper arm. Without removing the gloves or performing hand hygiene, RN B handed Resident #47 his oral medications. The resident swallowed his oral medications with water at the bedside. RN B then handed Resident #47 the cup of water with the Juven powder mixed in for the resident to consume and departed the room without performing hand hygiene. Upon returning to the medication cart, RN B removed the gloves and cleansed her hands with alcohol-based hand sanitizer. During an interview with RN B on 01/14/2026 at 9:30 AM regarding hand hygiene, she stated, We are supposed to wash our hands between residents. When asked if staff were supposed to perform hand hygiene upon entrance and exit of the resident's rooms, RN B stated, Well, we are supposed to do both. During an interview with the Director of Nursing (DON) on 01/14/2026 at 9:40 AM regarding Enhanced Barrier Precautions and Hand Hygiene during medication administration, the DON stated, We have a PIP [Performance Improvement Plan] on that and we just did training. A review of the facility's policy titled Hand Hygiene (dated April 2022), revealed: Policy Interpretation and Implementation: 2. Associates must perform appropriate handwashing procedures under the following conditions: d. before preparing or handling medications; f. before handling clean or soiled dressings, gauze pads, etc.; k. after removing gloves. A review of the facility's policy titled Infection Control-Transmission-Based Precautions (dated (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	August 2023), revealed: Procedure: 17. Enhanced Barrier Precautions will be implemented for residents with specific cases that do not require other types of transmission-based precautions but are associated with higher risks of transmission, a. Enhanced Barrier Precautions are to be implemented for residents with the following: ii. Residents with an indwelling medical device or a wound, regardless of infection or colonization status. A review of performance improvement documentation offered by the facility and dated with an initiation date of 10/15/2025, identified that Infection Control and Antibiotic Stewardship was being reviewed. Education with signature sheets, provided to the field office after the survey, indicated that handwashing education was provided on 10/15/2025 and 11/13/2025. RN B was not listed as having received handwashing education on either 10/15/2025 or 11/13/2025. Thirty-four handwashing competencies were provided to the field office after the survey. The Date line at the top of each form had been whited out. Twenty-six of thirty-four forms had a hand-written date entered on the date line of either 12/11 or 12/11/25. Eight forms were left with a blank date line after they were whited out. Four forms were incomplete. One form was missing the employee's signature, and two forms were missing a supervisor's signature. RN B was noted to have successfully completed a handwashing competency on 12/11/2025 per the competency forms. Handwashing audits provided to the field office after the survey were noted to have been completed by the Director of Nursing on 10/15, 10/16, 10/17, 10/20, 10/21 and 10/29/2025. RN B was not noted on any of the October 2025 audit forms. A handwashing audit dated 11/5/2025 and 11/19/2025 listed five staff members reviewed including RN B, who was noted as having performed hand hygiene appropriately. A handwashing audit dated 12/17/2025 and 12/31/2025 listed five residents reviewed, and an audit dated 1/7/2026 and 1/14/2026 listed five staff members reviewed including RN B, who was noted as having performed hand hygiene appropriately. On the same date, 1/14/2026, RN B was observed during medication administration, as described above, failing to wash her hands during medication administration for two residents. This indicated that the facility's performance improvement plan was ineffective.		