

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER Apopka Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2001 Alston Bay Blvd Apopka, FL 32703	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify resident guardian of missing dentures for 1 of 1 residents reviewed for dental, of a total sample of 56 residents, (# 139). Findings: Resident #139 was admitted to the facility on [DATE] with diagnoses to include dementia with behavioral disturbances. Review of the resident's electronic medical record revealed a court determination of the resident's total incapacity dated 10/26/23 related to her diagnosis of Dementia and showing signs of a lack of awareness. On 8/8/24 the court appointed a legal guardian of person and property of resident #139. The admission Record included resident # 139's court appointed legal guardian's name with her associated telephone number and email address. Review of resident's inventory list dated 7/29/24 indicated the resident had upper dentures listed with her belongings. Review of the resident's clinical record revealed a monthly summary progress note on 1/19/26 at 8:05 PM, that stated the resident wears dentures or partials. On 1/27/25 at 12:24 PM, resident #139 was noted in the dining room for lunch. She was noted to not have her dentures in. On 1/28/26 at 3:40 PM, a phone interview with resident #139's legal guardian revealed she was unaware of the resident's missing dentures. She confirmed that the facility never notified her that they were missing at any point. On 1/29/26 at 10:05 AM, the Executive Director stated that sometimes the residents dentures go missing for a few weeks before they turn up again. She stated the staff think resident # 139's dentures have been missing for approximately 3 weeks. She confirmed that she was unaware of the resident's missing dentures before this week during survey. The Executive Director stated they have a dentist who comes to the facility and will determine if the resident is still a candidate for dentures. The facility will determine at that time if reimbursement is necessary. She confirmed that the resident's legal guardian was not notified of the missing dentures since typically they turn up again. Review of the facility policy titled Notification of Changes with no revision date states that when a resident is deemed incapacity the resident's representative would be notified and they would make any decision that need to be made.</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 106144
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