STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106144	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apopka Health and Rehabilitation Center	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain sanitary conditions during dishwashing operations when the dishwasher was malfunctioning; and failed to ensure hot food was served at safe temperatures.Findings:1.On 1/26/26 at 10:02 AM, during the initial tour of the kitchen, the Certified Dietary Manager (CDM) demonstrated the process of dish sanitization by operating the commercial dishwasher. The temperature gauge reached a maximum of 120 degrees Fahrenheit (F), and he stated that in addition, they do a litmus paper check to ensure optimal sanitization with chlorine, at 50-100 parts per million (PPM). After about four attempts to check the sanitizer, there was no change in the color of the litmus paper, indicating the proper sanitizer solution level had been reached. The CDM verified the litmus paper was not expired, then proceeded to use another set of litmus paper strips. After two more attempts with the new litmus strips, there was still no change in the color of the strips to indicate the correct PPM of chlorine was present.A few minutes later, review of the dishwasher low temperature log sheet posted adjacent to the dishwasher revealed that for breakfast that day the temperature was documented as 120 degrees F and the sanitizer was 100 PPM. The entry had no initials to indicate who recorded the data. Dietary Aide A, assigned to the dishwashing task said he used the dishwasher earlier but did not use the test strips. He explained he knew this was an important step but could not say why he did not do it. Dietary Aide A said he did not document in the log. The CDM was unable to ascertain which staff documented the sanitizer was 100 PPM that morning because of the lack of initials. The CDM stated the log sheet was documented in error and crossed out the documented figures. The CDM acknowledged there was no way to determine whether the dishes were sanitized and directed staff to use disposable utensils for meals until the machine was fixed.On 1/27/26 at 9:57 AM, the CDM explained whenever the bucket with the chemical was changed, it caused air to build up and cause a clog. The CDM acknowledged the sanitizer was not at the required level, and that someone had documented in error that it was. The CDM said staff were supposed to report to him if the PPM of sanitizer was not within the required range.The facility's dishwasher log policy did not address the level of chemical sanitation required for a low temperature dish machine.2. On 1/28/26 at 11:35 AM, during the lunch meal service, the chicken orzo soup in the hot box was at 131 degrees F. The CDM acknowledged per accepted food safety standards, hot foods should be held at 135 degrees F of higher. On 1/29/26 at 10:39 AM, the CDM said the hot box was equipped with a heating element that measured about 175 to 180 degrees F. He explained maybe the soup was left on the counter too long before it was placed in the hot box. He said the cooking temperature was recorded at 213 degrees F, but said the temperature was not rechecked prior to placing it in the hot box. The CDM could not really say what caused the soup to be below the safe temperature for service. The CDM said he was the only one with the Safe Serve Certification in the kitchen.The facility's undated policy on cooking, holding and reheating temperatures for the hot foods service indicated all hot foods must be served at a temperature of at least 135 degrees F.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106144	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apopka Health and Rehabilitation Center	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)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely complete Comprehensive Minimum Data Set (MDS) Assessments for 2 of 6 residents reviewed for Resident Assessment, of a total of 56 residents, (#77, #162).Findings:1. Review of the medical record revealed resident #77, an [AGE] year-old female was admitted to the facility on [DATE] and re-admitted from an acute care hospital on 1/15/25 with diagnoses that included dementia, malnutrition, gastrostomy (feeding tube) status, convulsions, and abnormality of gait (walking) and mobility.Resident #77's most recent MDS Comprehensive Annual Assessment with an Assessment Reference Date (ARD) of 12/27/25 showed a completion date of 1/13/26, 3 days late.2. Review of the medical record revealed resident #162, a [AGE] year-old male was admitted to the facility from another nursing home on 9/05/23 with diagnoses that included gastrostomy status, seizures, encephalopathy (brain dysfunction), hemiplegia and hemiparesis (paralysis) after stroke, right lower leg pressure wound, major depressive disorder, dementia, malnutrition, contractures (muscle tightening/stiffening) of both knees, weakness, and aphasia (difficulty speaking/understanding speech)Resident #162's most recent MDS Comprehensive Annual Assessment with an ARD of 12/12/25 showed a completion date of 1/05/26, 10 days late.During a joint interview on 1/29/26 at 2:41 PM, with the MDS Director, MDS Coordinator, and Regional MDS, the MDS Director said the Resident Assessment Instrument (RAI) timelines were followed and the expectations were for timely completion by the due date, which was 14 days after the ARD. She checked the electronic records and acknowledged that residents #77 and #162's most recent Comprehensive Annual Assessments were completed late. The Registered Nurse (RN) relayed timely assessment completions were important so the Interdisciplinary Team (IDT) would recognize and act on any condition changes, declines, or concerns. She said assessments were tracked by a list and the IDT was reminded of due dates during daily meetings. She said the department was adequately staffed and the Regional MDS covered absences. She said delays occurred during the holidays and staff absences.Review of the facility's undated standards and guidelines for MDS' outlined that the RAI was a method for assessing functional capacity and needs, identification of problems and strengths, and intervention development for which results were used to develop, review, and revise individualized care plans. The policy noted the MDS Coordinator was responsible for tracking and monitoring due dates. The RAI Assessment Summary noted Comprehensive Annual Assessments were due every 366 days from previous Comprehensive Assessments and no later than 14 calendar days after the ARD date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106144	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apopka Health and Rehabilitation Center	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)
F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely complete Quarterly Minimum Data Set (MDS) Assessments for 4 of 6 residents reviewed for Resident Assessment, of a total of 56 residents, (#2, #127, #142, #151).Findings:1. Review of the medical record revealed resident #2, a [AGE] year-old male was admitted to the facility from an acute care hospital on 9/18/25 with diagnoses that included acute osteomyelitis (bone infection), absence of right toe(s), dysphagia (difficulty swallowing), type 2 diabetes mellitus, history of stroke, peripheral (arms/legs) vascular (veins/arteries) disease, abnormalities of gait (walking) and mobility, major depressive disorder, hypertension (high blood pressure), and unspecified fall.Resident #2's most recent MDS Quarterly Assessment with an Assessment Reference Date (ARD) of 12/26/25 showed a completion date of 1/12/26, 3 days late.2. Review of the medical record revealed resident #127, a [AGE] year-old male was admitted to the facility from an acute care hospital on 5/01/23 with diagnoses that included acute kidney failure, dementia with agitation, major depressive disorder, weakness, and right foot fracture on 7/22/24.Resident #127's most recent MDS Quarterly Assessment with an ARD of 12/28/25 showed a completion date of 1/12/26, 1 day late.3. Review of the medical record revealed resident #142, an [AGE] year-old male was admitted to the facility on [DATE] from an acute care hospital with diagnosis that included left hip fracture, encephalopathy (brain dysfunction), type 2 diabetes mellitus, coronary artery disease, abnormalities of gait and mobility, and weakness.Resident #142's most recent MDS Quarterly Assessment with an ARD of 12/26/25 showed a completion date of 1/12/26, 3 days late.4. Review of the medical record revealed resident #151, a [AGE] year old male was admitted to the facility on [DATE] and re-admitted from from an acute care hospital on [DATE] with diagnosis that included stroke, hemiplegia and hemiparesis (paralysis) on left dominant side after stroke, type 2 diabetes mellitus, anxiety disorder, depression, abnormalities of gait and mobility, and weakness.Resident #151's most recent MDS Quarterly Assessment with an ARD of 12/31/25 showed a completion date of 1/15/26, 1 day late.During a joint interview on 1/29/26 at 2:41 PM, with the MDS Director, MDS Coordinator, and Regional MDS, the MDS Director She said the Resident Assessment Instrument (RAI) timelines were followed and the expectations were for timely completion by the due date, which was 14 days after the ARD. She checked the electronic records and acknowledged that residents #2, #127, #142, and #151's most recent Quarterly Assessments were completed late. The Registered Nurse (RN) relayed timely assessment completions were important so the Interdisciplinary Team (IDT) would recognize and act on any condition changes, declines, or concerns. She said assessments were tracked by a list and the IDT was reminded of due dates during daily meetings. She said the department was adequately staffed and the Regional MDS covered absences. She said delays occurred during the holidays and staff absences.Review of the facility's undated standards and guidelines for MDS' outlined that the RAI was a method for assessing functional capacity and needs, identification of problems and strengths, and intervention development for which results were used to develop, review, and revise individualized care plans. The policy noted the MDS Coordinator was responsible for tracking and monitoring due dates. The RAI Assessment Summary noted Quarterly Assessments were due no later than 14 calendar days after the ARD date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106144	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apopka Health and Rehabilitation Center	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)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident with a positive Preadmission Screening and Resident Review (PASRR) level I who required a level II, was evaluated for required specialized services for 1 of 1 residents (#82) reviewed for mood and behavior out of a total sample of 56 residents.Findings:A Level I PASRR screen identified whether an individual applying for admission into a skilled nursing facility (SNF) had or was suspected of having a serious mental illness (SMI), intellectual disability (ID), or both. The Level II PASRR confirmed or ruled out an SMI, ID or both. It was an in-depth evaluation of the individual and a determination of the need for SNF services. If an SNF was the most integrated setting appropriate to meet the individual's long-term care needs, the Level II PASRR would also evaluate what specialized services, if any, would be recommended for the individual during their SNF stay, retrieved from(https://ahca.myflorida.com/medicaid/preadmission-screening-and-resident-review-process-pasrr).Resident #82 was admitted to the facility from an acute care hospital on 1/20/23 with diagnoses that included a history of cerebral infarction, bipolar disorder, seizures, generalized anxiety, and schizoaffective disorder.Review of resident #82's hospital records dated 4/17/24, revealed she had been admitted to the hospital from the facility due to a fall. The hospital records showed she had a history of head trauma, schizophrenia, bipolar disorder, depression, and dementia.Resident #82's most recent PASRR dated 6/24/25, revealed she was diagnosed with anxiety disorder, bipolar disorder, and schizoaffective disorder and required a level II PASRR evaluation due to serious mental illness. The level I evaluation had been completed by the Assistant Director of Nursing (ADON).Review of resident #82's Quarterly Minimal Data Set assessment dated [DATE], revealed she had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which was moderately impaired cognition.Review of the care plan for resident #82, revealed a care plan for behaviors initiated on 04/22/24, which showed she had behavior problems related to schizoaffective disorder, bipolar disorder and anxiety. She had episodes of severe confusion, forgetfulness, anxiousness, and agitation. Resident #82 also had a care plan for elopement and wandering, which was initiated on 06/23/23, and had interventions that included seeking a referral for mental health evaluation as needed. She had other behaviors such as shower refusals and mood problems related to depression, bipolar disorder, and schizoaffective disorder.On 1/27/26 at 11:04 AM, the level II PASSR for resident #82 was requested from ADON, who was responsible for PASRRs, but she did not provide it. Then on 01/28/26 at 11:00 AM, the ADON stated that there was no level II PASRR completed but that the psychiatrist had evaluated the resident on 01/26/26 and reviewed the level I PASSR. She provided this as an explanation for why the Level II PASRR was not obtained, however the level II was requested on 06/24/25 and the psychiatrist evaluation was completed seven months later. Review of resident #82's psychiatrist progress note dated 01/26/26 revealed the psychiatrist conducted a review of the resident's Level I PASRR and prior psychiatric provider's notes to reevaluate the accuracy of the diagnosis of schizoaffective disorder. The note concluded that the resident did not exhibit any signs or symptoms related to schizophrenia or schizoaffective disorder, so the records were updated to reflect that schizoaffective disorder had been resolved. However, the resident would continue to be treated for depression, bipolar disorder, and anxiety, which were still listed as SMI in the Level I PASRR, so a Level II PASRR was still required. Previous psychiatric notes dated 05/30/25, 11/11/25, and 12/24/25 were reviewed and these showed resident #82 was treated for schizoaffective disorder and behaviors.On 01/29/26 at 12:52 PM, the ADON stated she was the only staff member responsible for ensuring PASRRs were completed and submitted in a timely manner. She admitted the process for tracking the completion and accuracy of PASRRs had not been effective and that is why resident #82's Level II PASRR had been missed.Review of the facility's Policy and Procedures for PASRR dated 03/202, revealed it was the facility's policy to ensure all residents admitted to the facility (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106144	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apopka Health and Rehabilitation Center	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)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	received a PASRR screening in accordance with state and federal regulations. Staff responsible for the completion of the PASRR were to incorporate the recommendations from the PASRR level II determination and the PASRR evaluation report into the resident's assessment, care planning, and transitions of care. Furthermore, residents who presented with newly evident or possible serious mental disorder, intellectual disability, or a related condition were to be referred for a level II resident review upon a significant change in status assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106144	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apopka Health and Rehabilitation Center	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)
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 observation, interview, and record review, the facility failed to ensure medications were administered per physician orders and according to professional standards of practice for 1 of 56 residents reviewed for medication administration, (#71).Findings: Review of resident #71's medical record revealed she was admitted to the facility on [DATE] with diagnoses including type 2 diabetes, foot ulcer, neuropathy, skin infection, lower limb cellulitis, abnormality gate/mobility, and depression.The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented she had a Brief Interview for Mental Status (BIMs) score of 15 out of 15 that indicated she was cognitively intact.Review of resident #2's Medication Administration Record (MAR) for January 2026 revealed physician orders for the following medications: Voltaren External Gel 1 % (Diclofenac Sodium (Topical)) apply 4 grams to left hip topically three times a day for left hip pain do not apply more than 16 grams daily to any one affected joint, with an order date of 12/29/25.On 01/04/25 at 9:00 AM, 1:00 PM, 5:00 PM, and 1/13/26 6:00 AM, the MAR for Voltaren External Gel 1% Topical was noted to have an entry code of 9 which according to the facility MAR legend means other/see note with no documentation of why the medication was not administered. On 01/14/25 at 6:00 AM, the MAR for Voltaren External Gel 1% Topical was noted to have an entry code of 9 which according to the facility MAR legend means other/see note. The record did not have documentation stating why the medication was not administered. On 01/29/26 at 12:36 PM, the 200 Unit Manager explained a nursing note should be in place that corresponds to documentation of other on the MAR. She confirmed there was no documentation of the medications being administered or why they were not administered. She acknowledged that the process of medication administration is different for Voltaren External Gel 1% Topical as it is kept in the procedure cart instead of the medication cart.The facility's Medication Administration policy, reviewed on 01/18/2024, reads: It is the policy of the facility to provide care and services related to mediation administration in accordance with state requirements.The facility will have a staff member, who is licensed to administer medications, available to administer medication in accordance with a health care provider's order or prescription label.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106144	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apopka Health and Rehabilitation Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to use appropriate personal protective equipment (PPE) when providing high contact care to a resident per enhanced barrier precautions (EBP), for one of seven residents reviewed for infection control, of a total sample of 56 residents, (#194).Findings:Enhanced Barrier Precautions are an infection control intervention utilized by nursing homes to reduce transmission of multidrug-resistant organisms (MDROs). Enhanced Barrier Precautions involve use of PPE, for example, a gown and gloves, during high-contact resident care activities for residents known to be colonized or infected with a MDRO. EBP is also recommended for residents of nursing homes who are at increased risk of MDRO acquisition e.g., residents with wounds or indwelling medical devices, (retrieved on 2/06/26 from www.cdc.gov).Resident #194 was admitted to the facility on [DATE] with diagnoses that included sepsis, chronic viral hepatitis C, encephalopathy (brain dysfunction) and failure to thrive. admission records revealed resident #194 was admitted with a right chest port and a right pleural catheter.A chest port is a surgically implanted device that allows easy access to a vein for long term or frequent intravenous infusions. One in three people with implanted ports have complications, the most common is infection. Infection raises the risk of sepsis, a life-threatening bodily response to infection, (retrieved on 2/12/26 from myclevelandclinic.org).A pleural catheter is a soft tube inserted by a physician into the lung space to remove fluid that surrounds the lungs that can cause trouble breathing. Complications of a pleural catheter include infections (retrieved on 2/12/26 from thoracic.org). Review of the resident's care plan, initiated on 01/12/26, revealed the resident required EBP and staff were to follow precaution signage and protocol.On 1/28/26 at 10:32 AM, Occupational Therapist Assistant (OTA) D obtained resident #194's blood pressure as she was sitting up at the side of the bed. With the assistance of Physical Therapist Assistant (PTA) E, they both transferred the resident to a lying position by picking up her feet off the ground, then they boosted her up. Both staff members were observed wearing gloves but had not donned gowns. At that time, OTA D and PTA E acknowledged they were not wearing a gown over their clothes and explained they did not know resident #194 was on EBP. OTA D and PTA E acknowledged the EBP signage at the entrance of the resident's room, the EBP signage over her bed, as well as the PPE supplies at the entrance of the room. They both confirmed in addition to gloves, a gown should be worn when providing care to resident #194. They explained they missed it.On 1/29/26 at 10:28 AM, the Director of Nursing and the Assistant Director of Nursing acknowledged the breach of EBP by OTA D and PTA E when caring for resident #194 the previous day. The stated their expectation was for staff to wear the appropriate PPE to reduce the risk and spread of infections for residents on EBP.The facility did not provide a policy on Personal Protective Equipment.