

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105809	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10676 MARVIN JONES BLVD PO BOX 4307, LIVE OAK, Florida, 32060	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A recertification survey was conducted at Good Samaritan Center on April 13, 2026 through April 16, 2026. The facility was not in compliance with Code of Federal Regulations (CFR) 42, Part 483, Requirements for Long Term Care Facilities.	F0000		
F0612 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to maintain kitchen equipment and environmental surfaces in a clean and sanitary condition for 1 of 1 kitchens observed, specifically related to the cleanliness of the kitchen floor, 3 out of 5 microwaves, and 3 out of 6 refrigerators, with the potential to affect all residents by increasing the risk of food contamination and infection.	F0812		

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 reverse for further 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 CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105809	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10676 MARVIN JONES BLVD PO BOX 4307, LIVE OAK, Florida, 32060	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0812 SS = E	<p>Continued from page 1</p> <p>Findings include:</p> <p>During an initial observation on 04/13/2026 beginning at 9:50 AM, in the kitchen, the floor was observed to be in an unsanitary condition, with accumulated food debris, grease buildup, and dried residue present under and around the food preparation and cooking equipment. In the Camelia Dining Room there was food spillage and residue present on the interior walls and bottom surface of the refrigerator and food debris present on the turnplate and interior surfaces of the microwave. In the Magnolia Nutrition Room there was food spillage and residue present on the interior walls and bottom surface of the refrigerator and food debris present on the turnplate and interior surfaces of the microwave. In Camelia Nutrition Room 1 there was food spillage and residue present on the interior walls and bottom surface of the refrigerator. In Camelia Nutrition Room 2 there was food debris present on the turnplate and interior surface of the microwave.</p> <p>During an observation on 04/15/2026 at 10:58 AM, the kitchen floor remained in an unsanitary condition with the presence of accumulated food debris, grease buildup, and dried residue under and around the food preparation and cooking equipment, indicating a failure to maintain ongoing sanitation practices.</p> <p>Review of the Dietary Services Policies and Procedures Manual, Section 7 – Sanitation and Infection Control: General Sanitation of Kitchen, last reviewed 08/26/2026, read, "The staff shall maintain the sanitation of the kitchen through compliance with a written comprehensive cleaning schedule."</p> <p>During an interview on 04/13/2026 at 11:02 AM, the Registered Dietician stated the cleanliness of the kitchen and nourishment rooms was not to expectations and required improvement.</p> <p>During an interview on 04/13/2026 at 10:15 AM, the Kitchen Manager stated the condition of the kitchen floor was not acceptable and required cleaning.</p> <p>During an interview on 04/16/2026 at 12:10 PM with the Administrator and DON, it was confirmed a Performance Improvement Plan (PIP) related to kitchen sanitation was initiated on 04/06/2026; however, no progress had been made prior to the survey, indicating ineffective implementation of corrective actions.</p>	F0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105809	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10676 MARVIN JONES BLVD PO BOX 4307, LIVE OAK, Florida, 32060	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0584 SS = D	<p>Safe/Clean/Comfortable/Homelike Environment</p> <p>CFR(s): 483.10(i)(1)-(7)</p> <p>§483.10(i) Safe Environment.</p> <p>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>The facility must provide-</p> <p>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.</p> <p>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to ensure residents had a clean,</p>	F0584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105809	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10676 MARVIN JONES BLVD PO BOX 4307, LIVE OAK, Florida, 32060	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0584 SS = D	<p>Continued from page 3 homelike environment for 1 of 3 units.</p> <p>Findings include:</p> <p>1) During an observation on 4/13/2026 at 9:55 AM of Resident #112's bathroom the lower wall surface and baseboard area were noted to be in poor repair. The wall adjacent to the floor showed visible discoloration/staining, peeling or damaged wall finish, and areas of cracked or deteriorated caulking/paint along the baseboard line. The baseboard was separated or poorly sealed in portions, creating gaps. [Photographic evidence obtained]</p> <p>Review of the facility maintenance log dated 3/20/2026 read, [Resident #112 room] repair base board.</p> <p>2) During an observation on 4/13/2026 at 10:25 AM of Resident #42's bathroom wall there was visible wall damage, peeling loose paint, gaps/holes, and staining. Sections were broken or missing. There was no baseboard present. [Photographic evidence obtained]</p> <p>Review of the facility maintenance log dated 2/17/2026 read, [Resident #42's name] bathroom wall.</p> <p>3) During an observation on 4/13/2026 at 10:45 AM there was a beige upholstered recliner next to the exit door to the patio in the memory care common living area. There was a resident sitting on the recliner. Both armrests showed torn areas with exposed underlying material.</p> <p>During an observation on 4/15/2026 at 4:20 PM the beige upholstered recliner next to the exit door to the patio in the memory care common living area was not occupied. The chair's seat cushion and armrest exhibited significant wear and deterioration. The surface material was cracked extensively across the seat area, with visible peeling and splitting of the upholstery. Both armrests showed torn areas with exposed underlying material.</p> <p>During an observation on 4/14/2026 at 9:34 AM there was a built-in cabinet unit located in the common living area of the memory care unit. The cabinet included drawers and door compartments; the front of one of the drawers was missing exposing unfinished wood.</p> <p>During an interview on 4/16/2026 at 8:52 AM the Administrator stated, "I observed it [the beige</p>	F0584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105809	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10676 MARVIN JONES BLVD PO BOX 4307, LIVE OAK, Florida, 32060	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0584 SS = D	<p>Continued from page 4 recliner in the memory care unit]. I cannot tell you the exact date. I am not as good about using the maintenance log. I am used to telling her [Maintenance Director] we need to replace this. I don't have a tracking of it. I would expect life safety issues to be immediate right away. If it's a maintenance issue she [Maintenance Director] has to prioritize."</p> <p>During an interview on 4/16/2026 at 9:34 AM the Director of Environmental Services and Plant Services stated, "I am aware of that [the cabinet door]. I would have to look at the maintenance log to know how long it has been like that. We are waiting for more dry wall that is why it has not been repaired [Resident #42's bathroom]. We are aware of that [the beige recliner in the memory care unit]. Usually there will be a blanket over the recliner to cover it. We purchase two at a time [recliners]. I am missing one of the maintenance guys and the new fellow has not been here that long. I give them the materials and the order. If it says completed [the repair], I go back and check if it was completed. I have not gone back to check those two rooms. [Resident #112's and Resident #42's rooms]."</p> <p>During an interview on 4/16/2026 at 9:34 AM the Director of Environmental Services and Plant Services confirmed the built in cabinet in the memory care unit was missing the front cover, the beige recliner had tears in the seat and both arm rests, and [Resident #112's and Resident #42's] bathroom dry wall and base boards were in need of repair.</p> <p>Review of the facility policy and procedure titled "Homelike Environment" with a last review date of 8/26/2025 read, "Policy Statement: Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible."</p>	F0584		
F0645 SS = D	<p>PASARR Screening for MD & ID</p> <p>CFR(s): 483.20(k)(1)-(3)</p> <p>§483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.</p> <p>§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:</p> <p>(i) Mental disorder as defined in paragraph (k)(3)(f) of this section, unless the State mental health authority</p>	F0645		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105809	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10676 MARVIN JONES BLVD PO BOX 4307, LIVE OAK, Florida, 32060	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0645 SS = D	<p>Continued from page 5 has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services; or</p> <p>(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.</p> <p>§483.20(k)(2) Exceptions. For purposes of this section-</p> <p>(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.</p> <p>(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-</p> <p>(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,</p> <p>(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and</p> <p>(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.</p>	F0645		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105809	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10676 MARVIN JONES BLVD PO BOX 4307, LIVE OAK, Florida, 32060	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0645 SS = D	<p>Continued from page 6</p> <p>§483.20(k)(3) Definition. For purposes of this section-</p> <p>(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).</p> <p>(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure the completion of the Preadmission Screening and Resident Review (PASRR) prior to admission for a resident's serious mental disorder for 1 of 6 residents, Resident #2, reviewed for PASRR.</p> <p>Findings include:</p> <p>1) Review of Resident #2's admission record documented the resident was admitted originally admitted on 3/5/2025 with diagnoses to include panic disorder (onset date of 2/7/2020) and hallucinations (onset date of 4/6/2021).</p> <p>Review of Resident #2's Preadmission Screening Resident Review form dated 3/4/2025 did not document a diagnosis of hallucinations or panic disorder.</p> <p>Review of Resident #2's patient summary dated 3/3/2025 documented hallucinations as a confirmed diagnosis.</p> <p>Review of Resident #2's [Name of psychiatric provider] note dated 3/6/2025 read, "Dx [Diagnosis]: Z: panic disorder (episodic paroxysmal anxiety) without agoraphobia-F41.0 Staff to monitor, document and report worsening symptoms of anxiety symptoms: excessive worry, not able to control worry, restless/agitation, being easily fatigued, poor concentration, irritability, muscle tension, sleep disturbance, and panic attacks 3: hallucinations, unspecified - R44.3 Increase Seroquel 50 mg [milligrams] BID [twice a day]."</p> <p>Review of Resident #2's physician order dated 3/6/2025 read, "Seroquel 50 mg Tablet (Quetiapine) 50 mg by mouth twice daily for hallucinations, unspecified.</p>	F0645		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105809	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10676 MARVIN JONES BLVD PO BOX 4307, LIVE OAK, Florida, 32060	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0645 SS = D	<p>Continued from page 7</p> <p>Signed by: [Medical Doctor #1]: "Last Dose 4/15/2026)."</p> <p>During an interview on 4/16/2026 at 9:19 AM the Administrator stated, "[Resident #2's name] Level I PASSAR needs to be updated."</p> <p>Review of the facility policy and procedure titled "Admission Criteria" with a review date of 8/26/2025 read, "7. All new admissions and readmission are screened for mental disorders (MD), intellectual disabilities (ID), or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. a. The facility conducts a Level I PASARR screen for all potential admission, regardless of payer source, to determine if the individual meets the criteria for MD, ID, or RD."</p>	F0645		
F0689 SS = D	<p>Free of Accident Hazards/Supervision/Devices</p> <p>CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents.</p> <p>The facility must ensure that -</p> <p>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible for 2 of 7 dietary service areas observed by failing to secure hazardous chemicals in areas not intended for resident use but accessible to residents, with the potential to affect all residents, increasing the risk of accidental ingestion, inhalation, and/or skin and eye exposure to harmful substances.</p> <p>Findings include:</p> <p>During an observation on 04/13/2026 at 10:11 AM, in the unsecured Dogwood Nourishment Room, two chemicals were observed stored in an unlocked lower cabinet, Odoban Deodorizer and Disinfectant and Aero Assault II Insecticide Aerosol. The nourishment room was located adjacent to the Dogwood residents' common living area, where</p>	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105809	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10676 MARVIN JONES BLVD PO BOX 4307, LIVE OAK, Florida, 32060	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = D	<p>Continued from page 8</p> <p>eight residents were present at the time of the observation. Although not intended for resident use, the nourishment room was not secured and lacked a locking mechanism or other access controls, allowing residents the opportunity to inadvertently enter and access the chemicals.</p> <p>Review of Safety Data Sheet (SDS) information for Odoban Deodorizer and Disinfectant documented the product presents potential hazards, including skin and eye irritation, and indicates the product should be stored securely to prevent unintended exposure to vulnerable individuals.</p> <p>Review of Safety Data Sheet (SDS) information for Aero Assault II Insecticide Aerosol documented the product presents potential hazards, including inhalation toxicity and flammability, and includes instructions to avoid exposure and ensure safe storage to prevent access and potential harm to vulnerable individuals.</p> <p>During an observation on 04/13/2026 at 11:00 AM, in the café nourishment area, seven chemicals were observed stored in an unlocked lower cabinet, Fabuloso Multipurpose Cleaner, Clorox Bleach Germicidal Wipes, Odoban Deodorizer and Disinfectant, Micro-Kill Bleach Germicidal Wipes, Clorox Healthcare Hydrogen Peroxide Cleaner Disinfectant Wipes, clear spray bottle labeled "Delimer", and clear spray bottle labeled "Vinegar and Water Window Cleaner." The cabinet was located in a nourishment area within the dining room accessible to residents walking through the area or eating in the dining room, creating the opportunity for inadvertent access to hazardous chemicals.</p> <p>Review of Safety Data Sheet (SDS) information for Fabuloso Multipurpose Cleaner documented the product may cause eye and skin irritation and should be handled and stored securely to prevent unintended exposure.</p> <p>Review of Safety Data Sheet (SDS) information for Clorox Bleach Germicidal Wipes documented the product contains sodium hypochlorite and may cause skin irritation, eye damage, and respiratory irritation if inhaled, and should be stored securely to prevent exposure.</p> <p>Review of Safety Data Sheet (SDS) information for Odoban Deodorizer and Disinfectant documented the product presents potential hazards including skin and eye irritation and should be stored securely to prevent unintended exposure.</p>	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105809	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10676 MARVIN JONES BLVD PO BOX 4307, LIVE OAK, Florida, 32060	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = D	<p>Continued from page 9</p> <p>Review of Safety Data Sheet (SDS) information for Micro-Kill Bleach Germicidal Wipes documented the product contains bleach-based disinfectant agents and may cause irritation to the skin, eyes, and respiratory tract, and should be handled and stored securely to prevent exposure.</p> <p>Review of Safety Data Sheet (SDS) information for Clorox Healthcare Hydrogen Peroxide Cleaner Disinfectant Wipes documented the product contains hydrogen peroxide and may cause eye and skin irritation and should be stored securely in accordance with safety precautions to prevent unintended exposure.</p> <p>Review of Safety Data Sheet (SDS) information for the clear spray bottle labeled "Delimer" documented the product is an acidic cleaning agent that may cause skin burns, eye damage, and respiratory irritation depending on concentration, and should be clearly labeled and stored securely to prevent exposure.</p> <p>Review of Safety Data Sheet (SDS) information for the clear spray bottle labeled "Vinegar and Water Window Cleaner" documented the product may cause mild eye and skin irritation and should be appropriately labeled and stored securely to prevent unintended exposure.</p> <p>During an interview on 04/13/2026 at 11:00 AM, the Dietician stated all chemicals are expected to be kept in locked and secure locations to reduce the risk of exposure to residents.</p> <p>During an interview on 04/13/2026 at 11:04 AM, the Administrator stated all chemicals are expected to be locked and secured to ensure resident safety.</p>	F0689		
F0757 SS = D	<p>Drug Regimen is Free from Unnecessary Drugs</p> <p>CFR(s): 483.45(d)(1)-(6)</p> <p>§483.45(d) Unnecessary Drugs-General.</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-</p> <p>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or</p> <p>§483.45(d)(2) For excessive duration; or</p>	F0757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105809	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10676 MARVIN JONES BLVD PO BOX 4307, LIVE OAK, Florida, 32060	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0757 SS = D	<p>Continued from page 10</p> <p>§483.45(d)(3) Without adequate monitoring; or</p> <p>§483.45(d)(4) Without adequate indications for its use; or</p> <p>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and record review the facility failed to ensure physician ordered parameters were followed for blood pressure medications for 2 of 6 residents, Residents #73 and #46, reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>1) Review of Resident #73's admission record documents diagnosis to include essential primary hypertension, anemia unspecified, depression unspecified, hyperlipidemia unspecified, essential tremor, vitamin B12 deficiency anemia unspecified, history of falling, hypothyroidism unspecified, overactive bladder, generalized anxiety disorder, insomnia unspecified, personal history of healed traumatic fracture, and mild cognitive impairment of uncertain etiology.</p> <p>Review of Resident #73's physician order dated 9/16/2025 read, "Metoprolol tartare 25 mg [milligram] tablet 1/2 tablet=12.5 mg by mouth twice a day daily for essential primary hypertension hold for HR [heart rate] < 65 or SPBP [systolic blood pressure] < 100."</p> <p>Review of Resident #73's Medication Administration Record [MAR] for March 2026 documented metoprolol tartare 12.5 mg by mouth was administered at 0800 [8:00 AM] on 3/13/2026 with a heart rate of 61, on 3/30/2026 with a heart rate of 63, and at 2000 [8:00 PM] on 3/21/2026 with a heart rate of 64, on 3/22/2026 with a heart rate of 63, on 3/23/2026 with a heart rate of 64 and on 3/27/2026 with a heart rate of 58.</p> <p>Review of Resident #73's MAR for April 2026 documented metoprolol tartare 12.5 mg by mouth was administered at 0800 on 4/10/2026 with a heart</p>	F0757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105809	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10676 MARVIN JONES BLVD PO BOX 4307, LIVE OAK, Florida, 32060	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0757 SS = D	<p>Continued from page 11</p> <p>rate of 61, at 2000 on 4/1/2026 with a heart rate of 58, on 4/2/2026 with a heart rate of 62, and on 4/10/2026 with a heart rate of 60.</p> <p>During an interview on 4/15/2026 at 10:37 AM Staff N, Licensed Practical Nurse (LPN) stated, "I did administer that metoprolol. Honestly, most of the time it's written for a heart rate of 60. But I should not have administered it. I should have followed the order and held it."</p> <p>During an interview on 4/15/2026 at 1:03 PM Staff F, Registered Nurse (RN) stated, "I did administer his medications outside of parameters and should not have."</p> <p>During an interview on 4/15/2026 at 1:44 PM the Director of Nursing (DON) stated, "They [licensed nurses] should have followed the physician orders for the parameters. They should not have given the medication."</p> <p>Review of the policy and procedure titled "Administering Medications" last approval date of 8/26/2025 read, "Policy Statement: Medications are administered in a safe and timely manner as prescribed by nurses at the Good Samaritan Center. Policy Interpretation and Implementation: 4. Medications are administered in accordance with prescriber orders, including any required time frame. 11. The following information is checked/verified for each resident prior to administering medications: b. Vital signs, as necessary."</p> <p>2) Review of Resident #46's physician order dated 10/22/2025 documented, "Hydralazine 10 mg, give 10 mg by mouth every 8 hours; hold if systolic blood pressure is greater than 115."</p> <p>Review of Resident #46's Medication Administration Record (MAR) for March and April 2026 documented hydralazine was administered outside of the physician-ordered parameters on 03/04/2026 at 2:00 PM, blood pressure was 112/73; medication administered by Staff I, RN, on 04/01/2026 at 2:00 PM, blood pressure was 108/62; medication administered by Staff I, RN, on 04/07/2026 at 2:00 PM, blood pressure was 108/66; medication administered by Staff I, RN, and on 04/08/2026 at 2:00 PM, blood pressure was 104/58; medication administered by Staff I, RN.</p> <p>During an interview on 04/16/2026 at 10:37 AM, the Director of Nursing (DON) stated, "It is the expectation that nurses administer medications in accordance with physician orders, including</p>	F0757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105809	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10676 MARVIN JONES BLVD PO BOX 4307, LIVE OAK, Florida, 32060	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0757 SS = D	Continued from page 12 adhering to ordered parameters."	F0757		
F0761 SS = D	<p>Label/Store Drugs and Biologicals</p> <p>CFR(s): 483.45(g)(h)(1)(2)</p> <p>§483.45(g) Labeling of Drugs and Biologicals</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals used in the facility were stored and labeled in accordance with accepted professional principles in 2 of 3 units.</p> <p>Findings include:</p> <p>1) During an observation on 04/13/2026 at 11:28 AM, in Resident #6's room, one white oval tablet was observed in a medication cup on the resident's bedside table.</p> <p>During an interview on 04/13/2026 at 11:28 AM Resident #6 stated the tablet was metformin.</p> <p>Review of the physician order dated 01/27/2025 documented, "Metformin 1000 mg tablet – 1000 mg by mouth twice daily for type 2 diabetes mellitus</p>	F0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105809	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10676 MARVIN JONES BLVD PO BOX 4307, LIVE OAK, Florida, 32060	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0761 SS = D	<p>Continued from page 13 with hyperglycemia."</p> <p>During an interview on 04/13/2026 at 11:31 AM, Staff J, RN, stated, "Medications should not be left at a resident's bedside."</p> <p>During an interview on 04/16/2026 at 10:37 AM, the DON stated, "When administering medications, nursing staff are expected to remain with the resident until all medications are taken and should not leave medications unattended at the bedside."</p> <p>2) During an observation on 4/13/2026 at 10:30 AM Resident #25 was not in her room. On top of her bedside table there was a zinc oxide ointment. [Photographic evidence obtained]</p> <p>During an interview on 4/13/2026 at 10:57 AM Staff A, Licensed Practical Nurse (LPN) stated, "That [zinc oxide ointment] should not be there."</p> <p>3) During an observation on 4/13/2026 at 10:34 AM Resident #86 was not in her room. There were three ampules of ipratropium albuterol at bedside next to a nebulizer machine.</p> <p>Review of Resident #86's physician order dated 2/14/2024 read, "Ipratropium 0.5 mg-albuterol 3 mg (inhalation every 6 hours as needed for SOB [short of breath]/Wheeze."</p> <p>During an interview on 4/13/2026 at 10:58 AM Staff A, LPN, stated, "That [ipratropium albuterol] should not be in her [Resident #86's] room."</p> <p>During an interview on 4/13/2026 at 12:57 PM the Director of Nursing stated, "Medication should not be left unattended at bedside. [Resident #6's name] would not be able to self-administer metformin that is not one of the medications we would allow self-administration here in the facility."</p> <p>Review of the facility policy and procedure titled "Medication Labeling and Storage" with a last review date of 8/26/2025 read, "Policy statement: The Good Samaritan Center stores all medications and biologicals according to the manufacturer's recommendations in locked compartments under proper temperatures, humidity and light controls. Only authorized nursing and pharmacy personnel have access to keys."</p>	F0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105809	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10676 MARVIN JONES BLVD PO BOX 4307, LIVE OAK, Florida, 32060	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0867 SS = D	<p>QAPI/QAA Improvement Activities</p> <p>CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii)</p> <p>§483.75(c) Program feedback, data systems and monitoring.</p> <p>A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:</p> <p>§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.</p> <p>§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators.</p> <p>§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.</p> <p>§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.</p> <p>§483.75(d) Program systematic analysis and systemic action.</p> <p>§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.</p>	F0867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105809	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10676 MARVIN JONES BLVD PO BOX 4307, LIVE OAK, Florida, 32060	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0867 SS = D	<p>Continued from page 15</p> <p>§483.75(d)(2) The facility will develop and implement policies addressing:</p> <p>(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;</p> <p>(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and</p> <p>(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.</p> <p>§483.75(e) Program activities.</p> <p>§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.</p> <p>§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.</p> <p>§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.</p> <p>§483.75(g) Quality assessment and assurance.</p> <p>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body,</p>	F0867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105809	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10676 MARVIN JONES BLVD PO BOX 4307, LIVE OAK, Florida, 32060	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0867 SS = D	<p>Continued from page 16 or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:</p> <p>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;</p> <p>(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to ensure full and effective implementation of the facility's developed performance improvement plan to correct the facility's identified quality deficiencies for kitchen sanitation.</p> <p>Findings include:</p> <p>During an initial observation on 04/13/2026 beginning at 9:50 AM, in the kitchen, the floor was observed to be in an unsanitary condition, with accumulated food debris, grease buildup, and dried residue present under and around the food preparation and cooking equipment. In the Camelia Dining Room there was food spillage and residue present on the interior walls and bottom surface of the refrigerator and food debris present on the turnplate and interior surfaces of the microwave. In the Magnolia Nutrition Room there was food spillage and residue present on the interior walls and bottom surface of the refrigerator and food debris present on the turnplate and interior surfaces of the microwave. In Camelia Nutrition Room 1 there was food spillage and residue present on the interior walls and bottom surface of the refrigerator. In Camelia Nutrition Room 2 there was food debris present on the turnplate and interior surface of the microwave.</p> <p>During an observation on 04/15/2026 at 10:58 AM, the kitchen floor remained in an unsanitary condition with the presence of accumulated food debris, grease buildup, and dried residue under and around the food preparation and cooking equipment, indicating a failure to maintain ongoing sanitation practices.</p> <p>During an interview on 04/13/2026 at 11:02 AM, the</p>	F0867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105809	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10676 MARVIN JONES BLVD PO BOX 4307, LIVE OAK, Florida, 32060	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0867 SS = D	<p>Continued from page 17</p> <p>Registered Dietician stated the cleanliness of the kitchen and nourishment rooms was not to expectations and required improvement.</p> <p>During an interview on 04/13/2026 at 10:15 AM, the Kitchen Manager stated the condition of the kitchen floor was not acceptable and required cleaning.</p> <p>During an interview on 04/16/2026 at 12:10 PM with the Administrator and DON, it was confirmed a Performance Improvement Plan (PIP) related to kitchen sanitation was initiated on 04/06/2026; however, no progress had been made prior to the survey.</p> <p>Review of the Dietary Services Policies and Procedures Manual, Section 7 – Sanitation and Infection Control: General Sanitation of Kitchen, last reviewed 08/26/2026, read, "The staff shall maintain the sanitation of the kitchen through compliance with a written comprehensive cleaning schedule."</p> <p>Review of the facility QAPI [Quality Assurance Performance Improvement]-Dietary Kitchen Sanitation and Regulatory Compliance initiated 4/6/2026 read, "Through the rounding process, ongoing concerns regarding kitchen sanitation have been identified. Plan: Provide additional training and performance improvement plan to Dietary Director with specific goals to include: Expected Performance Standards: Maintain full compliance with all dietary and sanitation regulations. Ensure inspection readiness with no repeat deficiencies. Maintain staffing schedule with adequate shift coverage. Implement scheduling app.</p> <p>Review/Understand Florida Statutes (Labor Laws) Keep food cost within approved budget. Utilize order guides. Upload invoices. Community coffee orders should be online or in email so it can be tracked. Complete required documentation accurately and on time. Ensure staff receive appropriate training and on going education. Texture Modification (Minced & Moist, Soft & Bite Sized) Appropriate usage of Simply Thick. Respond to communication from colleagues. Maintain a 40+ hour per week schedule. Communicate hours worked and planned time off.</p> <p>Additional Action Plan: Conduct weekly sanitation and infection control audits. Hold Dietary Manager accountable for assigned audits, checking daily logs and reporting identified concerns. Review past deficiencies and implement ongoing corrective actions. Create schedule 2 weeks in advance. Implement app. Reduce overtime. Track weekly inventory and reduce waste. Accountability schedule: Weekly communication with NHA [Nursing Home Administrator] and with Dietician to review</p>	F0867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105809	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10676 MARVIN JONES BLVD PO BOX 4307, LIVE OAK, Florida, 32060	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0867 SS = D	<p>Continued from page 18 progress. 30 day review to assess improvements. Final 60 day evaluation. Consequences of Not Meeting Expectations. Failure to demonstrate consistent and sustained improvement in the areas outlined above may result in further disciplinary action, up to and including termination of employment."</p> <p>Review of Performance Improvement Plan (PIP). Employee Name: [Dietary Director's name]. Job Title: Dietary Director. Department: Dietary /Food Service. Date Initiated: April 6, 2026. Purpose: This Performance Improvement Plan is being implemented to address concerns related to department oversight, regulatory compliance, and operational effectiveness within the dietary department. The goal is to provide clear expectations and support to help achieve consistent performance standards. Areas of Concern: Inconsistent compliance with food safety regulations. Department of Health and internal audits reveal inappropriate food safety and storage. Continue to observe personal drinks and other items in serving areas. Food items continue to not be appropriately labeled, dated and rotated. Serving spoiled/molded food. Lack of overall follow up on deficiencies identified from internal audits including infection control observations. Scheduling concerns leading to coverage issues. Scheduling app not implemented. Lack of adherence to Florida Statute (Labor Laws) for scheduling guidelines. Inventory management concerns resulting in food cost overages. Community coffee order- Lack of documentation and follow up. Consistent department trainings, educations, and disciplinary actions are not occurring. Weekly rounding reports (for Joint Commission POC [Plan of Correction]) not being completed. Lack of response to emails from NHA, Dietician and other IDT [Interdisciplinary Team] members. Menus- changes and corrections submitted by Dietician have not been implemented. Financial Accountability-Invoices are not consistently being added to One Drive folder. Time and Attendance - not consistently working 40 hours per week and not consistently submitting time off request in advance in writing. Expected Performance Standards: Maintain full compliance with all dietary and sanitation regulations. Ensure inspection readiness with no repeat deficiencies. Maintain staffing schedules with adequate shift coverage. Implement scheduling app. Review/Understand Florida Statutes (Labor Laws). Keep food cost within approved budget. Utilize order guides. Upload invoices. Community coffee orders should be online or in email so it can be tracked. Ensure staff receive appropriate training and on-going education. Texture</p>	F0867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105809	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10676 MARVIN JONES BLVD PO BOX 4307, LIVE OAK, Florida, 32060	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0867 SS = D	<p>Continued from page 19 Modification (Minced & Moist, Soft & Bite Sized) Appropriate usage of Simply Thick. Respond to communication from colleagues. Maintain a 40+ hour per week schedule. Communicate hours worked and planned time off. Additional Action Plan: Conduct weekly sanitation and infection control audits. Hold Dietary Manager accountable for assigned audits, checking daily logs and reporting identified concerns. Review past deficiencies and implement ongoing corrective actions. Create schedule 2 weeks in advance. Implement app. Reduce overtime. Track weekly inventory and reduce waste. Accountability schedule: Weekly documentation with NHA and with Dietician to review progress. 30 day review to assess improvements. Final 60-day evaluation. Consequences of Not Meeting Expectations. Failure to demonstrate consistent and sustained improvement in the areas outlined above may result in further disciplinary action, up to and including termination of employment. Acknowledgement. I acknowledge that I have reviewed the Performance Improvement Plan and understand the expectations outlined. Employee Signature [Dietary Manager Signature] dated 4/6/26. Dietician/Manager Signature/Date: [Dietician Signature] dated 4/6/26. NHA Signature/Date: [Administrator's Signature] dated 4/6/26.</p> <p>During an interview on 4/16/2026 at 8:37 AM the Administrator stated, "We have a performance improvement plan regarding the dietary staff issue and that will probably be escalated. On 4/6/2026 we implemented a PIP regarding the staff member. If it is a one off observation you kind of deal with it and provide education and a corrective action. If a trend is identified it is taken to QAPI."</p> <p>During an interview on 4/16/2026 at 8:37 AM with the Administrator a request was made for additional information regarding education and audits related to the PIP.</p> <p>During an interview on 4/16/2026 at 1:10 PM the Administrator stated, "Concerns were first identified on March 15, 2026. Then on April 1st we had a DOH [Department of Health] inspection. The issue is identified through rounding and identified concerns. DOH visit was the trigger, concerns were not addressed and we put in a performance improvement plan in place. As the DOH is doing the walk through they say concerns. Again, to me the PIP is implemented once we realize that our normal process is not followed. Part of the process is to audit and correct things we find in real time. We became aware of the issue by auditing and not seeing corrections. Audits show minimal</p>	F0867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105809	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10676 MARVIN JONES BLVD PO BOX 4307, LIVE OAK, Florida, 32060	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0867 SS = D	<p>Continued from page 20 improvements [audits were not provided]. Minimal improvement was sustained. These are the kinds of rounds done and communication. I would go back in and ensure that it was fixed. I don't necessarily have evidence that it was fixed. From my perspective it is never perfect, but when you start seeing the same things over and over that's when we initiated a formal process. Maybe this weekly rounding process is part of the quality assurance process. We were not seeing improvement that is why we initiated a formal improvement plan." As of 4/16/2026 at 1:10 PM no additional documentation was provided.</p> <p>Review of the facility 2025-2026 Quality Assurance & Performance Improvement (QAPI) Plan for Good Samaritan Center At Advent Christian Village read, "Guiding Principles: Guiding principle #4: QAPI focuses on systems and processes, rather than individuals. The emphasis is on identifying system gaps rather than on blaming individuals. Guiding principles #6: GSC [Good Samaritan Center] sets goals for performance and measures progress toward those goals. Scope: Housekeeping. We provide and ensure that all health and sanitation requirements are met through regular cleaning, disinfection, and sanitation of all aspects of the building."</p> <p>Review of the facility policy and procedure titled "Quality Assurance and Performance Improvement (QAPI) Program" with a last review date 8/26/2025 read, "Policy Statement: This facility shall develop, implement, and maintain an ongoing, facility-wide, data driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents. Policy Interpretation and Implementation: The objectives of the QAPI program are to: 1. provide a means to measure current and potential indicators for outcomes of care and quality of life. 2. Provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators. 3. Reinforce and build upon effective systems and process related to the delivery of quality care and services 4. establish systems through which to monitor and evaluate corrective actions. Implementation: 2. The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include: a. tracking and measuring performance; b. establishing goals and thresholds for performance measurement; c. identifying and prioritizing quality deficiencies; d. systematically analyzing underlying causes of performance improvement activities; and f. monitoring or evaluating the effectiveness of</p>	F0867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105809	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10676 MARVIN JONES BLVD PO BOX 4307, LIVE OAK, Florida, 32060	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0867 SS = D	Continued from page 21 corrective actions/performance improvement activities and revising as needed.*	F0867		