STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105638	A. Building B. Wing	08/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parklands Care Center and Rehab	1000 SW 16th Ave Gainesville, FL 32601

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 22428 Based on observation and interview, the facility failed to ensure a safe and sanitary homelike environment due to failure to maintain the washer lint tray and clean residents' bedroom (Photographic Evidence Obtained). Findings: 1. During an observation on 8/16/2021 at approximately 1:00 PM of the facility laundry room with Staff K and L, Laundry Aides (LA), it showed the LAs pulled the lower shield from the front of the dryer lint trap. There was a profuse amount of lint, too much lint to quantify in fistfuls. The lint spread across the total inside floor of the lint catching area at about one inch thickness. It covered the mesh screen hanging down from underneath the actual dryer drum. Review of the facility policy titled, Lint, last reviewed on 12/28/2020, reads, All lint screens must be cleaned and brushed every hour and every single load. During an interview on 8/16/2021 at 1:05 PM with Staff K and L, Laundry Aides, they stated, We remove all of the lint every shift. They could not provide a log of the removal. They did not answer when asked if the amount of lint observed was safe. They stated the amount of lint currently on the floor of the lint catching area was appropriate. The lint hanging in the mesh screen was not lint and were not able to state what the substance was. They denied proper training or knowledge of appropriate amounts, removal of lint, and documenting the removal. During an interview on 8/18/2021 at approximately 2:30 PM, the Laundry Supervisor verified the amount of lint found exceeded what was safe. 2. During an observation on 8/18/2021 beginning at 11:00 AM, Staff M, Housekeeper, was conducting room cleaning for Residents #15, #17, and #19, who all reside in the same room located on the 100 Hall. There were three beds in the room. Staff M began the process by sweeping the floor. She did not move the overbed tables or trash cans. She swept around them missing a package wrapper that was on the floor next to Bed C. She began mopping the floor. She did not move the bedside tables or the trash cans. She put the mop on the cart and the mop head in a bag and stated she was finished with the room and going on break. She did not empty the trash cans. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Deep Cleaning Rooms, last reviewed 12/28/2020, reads, Move dressers, beds, clean and mop under them. Hit window seals and tops of closets, Deep clean bathrooms, check curtains and hit sinks and mirrors that's a daily, clean bed frames top and bottom and top of lights and tvs, clean off bed remotes and bottom rails, make sure room is free of dust and corner to corner is clean. During an observation of Residents #15, #17, and #19's room with the Housekeeping Supervisor on 8/18/2021 at approximately 11:45 AM, it showed the room had dark, dried drip marks on the floor, the overbed table for Beds B and C had dirt and debris on them with snacks and other personal items. During an interview on 8/18/2021 at approximately 12:00 PM, the Housekeeping Supervisor verified Staff M should have cleaned all of the frequently touched surfaces and the room sink of Residents #15, #17, and #19 before cleaning the floor. He stated the staff were all trained the floor is the last item to clean. He denied they clean the floors then come back and clean the other areas in the rooms. He stated when she finished the floor the room should be considered completed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 34769 Based on observation, interview, and review of the policies and procedures, the facility failed to ensure resident rights to be free from neglect by failing to ensure structures and processes were in place to prevent the likelihood of harm due to respiratory smoke inhalation, burns from fire, and death by failure to have a functioning fire alarm system that would alert the monitoring company and the fire department in case of smoke and/or fire, and failed to implement a fire watch for 109 of 109 residents, which consist of two residents who are bedfast, 70 requiring extensive assistance for ambulation, 32 ambulate with assistance or assistive device, and five are independently ambulatory. Findings: During an observation on 8/17/2021 at 11:35 AM, while conducting a tour of the facility, in the Therapy room/fire alarm control panel area the control panel indicated a trouble mode. The control panel trouble light (orange) was illuminated, and the control panel was silent. The control panel was illuminated, but the panel was not sounding an audible noise to indicate the trouble mode. During an observation on 8/17/2021 at 2:05 PM the fire alarm system dialer was tested by unplugging the control panel battery (one of the two ways that the dialer unit can be tested). After waiting ten minutes for an audible/visual signal on the panel and a phone call from the monitoring company, the audible/visual signal nor the call from the monitoring company happened. During an observation on 8/17/2021 at 2:15 PM of the annunciator panel (secondary fire alarm panel) located in the main lobby showed the trouble light was also illuminated (orange). Review of the [Company's Name] fire alarm system service invoice report dated 9/3/2020 reads: Trouble shot panel and found all of loop 2 in trouble. Panel is bad and needs to be replaced. Review of the [Company's Name] fire alarm system service inspection and testing form dated 1/14/2021 at 8:30 AM reads Discrepancy list: Dialer trouble module 01-017, Loop 2 all devices communication error. Review of the [Company's Name] fire alarm system service inspection and testing form dated 6/10/2021 at 10:00 AM reads Discrepancy List: Dialer unplugged and not working. Loop #2 failed to function. See initiating device sheets for devices that failed to function. Need to be on fire watch. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 8/20/2021 at 10:15 AM the facility Administrator stated, I knew approximately in September 2020 that the control panel needed to be replaced, but I was not aware that we needed to be on fire watch. We did get a service call back in September 2020, but the Maintenance Director did not tell me that we needed to be on a fire watch. I am responsible for the building. My Maintenance Director spoke to the Fire Marshall, and he told me that he said that the pull station would still work, and we did not need to be on fire watch. I do not know the date he spoke with him. I think it was sometime in June after the 6/10/2021 inspection. I do not think any contact was made with the Fire Marshall prior to that. I do not have that in writing. I do not have any electronic mail from the Fire Marshall, and I do not have any documentation that the Fire Marshall was contacted. We do have a policy that states in the event of the fire system failure we will initiate a fire watch, that we should notify the fire department and the agency [Agency for Health Care Administration]. We did not begin a fire watch and we did not call the fire department or AHCA [Agency for Health Care Administration]. I was supposed to initiate a fire watch according to our policies and procedures. I was supposed to alert the Fire Marshall and notify the agency. I did not reach out to the Fire Marshall and verify the information provided to me by the Maintenance Director. We began training and the fire watch on 8/17/2021. We educated all staff on the fire watch. I'm not sure how many staff were trained. Staff are assigned to complete fire watch on each unit. We did not identify the number of residents that might be affected, we just noted that no residents were affected. During a telephone interview on 08/20/21 at 11:00 AM, the President/CEO (Chief Executive Officer) of the monitoring company stated, The fire system that serves Loop 2 of the building is not functioning and none of the pull stations will dial the fire department and get them to the building. When we were there in January 2021, we recommended they provide a fire watch. We had been to the facility back in September 2020 or October 2020 and recommended a complete replacement of the system as Loop 2 was not functioning then. That would mean that pull stations would not dial the fire department. The dialer itself is not functioning and that would not dial the fire department. During a follow up telephone interview on 08/20/21 at 11:19 AM the service invoice report dated 9/3/2020 was read to the President/CEO of the monitoring company. It read as follows: Trouble shot panel and found all of Loop 2 in trouble. Panel is bad and needs to be replaced. The President/CEO stated, That means that Loop 2 was not working at all and needed to be replaced. The facility was told that they needed to be on fire watch at that time. During an interview on 8/20/2021 at 11:25 AM Staff A, Licensed Practical Nurse (LPN) stated, In case of a fire I would pull the fire alarm and start to evacuate the residents. We wouldn't need to call 911, pulling the alarm gets the fire department here. We are on fire watch, but the alarms still work. I am doing fire watch so every 30 minutes I tour the unit. I am giving residents medications; I am on the medication cart also. During an interview on 8/20/2021 at 11:30 AM Staff R, LPN, stated, If there was a fire, I would pull the fire alarm and start closing doors and if I found the fire, I would rescue the resident, close the door, and get the extinguisher. I would not need to call 911, pulling the fire pull would do that. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 8/20/2021 at 11:35 AM Staff S, LPN stated, I am on fire watch today. I look in all the rooms every one-half hour. I am also working the medication cart. If I smelled smoke, I would rescue the resident and pull the nearest fire alarm station. I would do the RACE [Rescue, Alarm, Confine, Extinguish] procedure and when I got the fire extinguisher, I would follow PASS [Pull, Aim, Squeeze, Sweep] procedure. I don't need to call 911, pulling the fire alarm does that. I would need to rescue the residents or make sure they are safe. During an interview on 8/20/2021 at 11:40 AM Staff T, Certified Nursing Assistant (CNA), stated, If there was a fire, I would pull the fire alarm and start to close doors after I got the resident out of their room. We have been on fire watch this week. I did not know that the fire alarm doesn't work and didn't know I needed to call 911 to get the fire department. I'm used to calling if the nurses need the ambulance, but I didn't know that. During an interview on 8/20/2021 at 11:45 AM Staff U, CNA stated, We have been on fire watch, the nurses are assigned to do that, I don't. I would pull the fire alarm and start to close doors and get the residents safe. I don't have to call 911; just pull the alarm. I did not know that we needed to call 911 too. During an interview on 8/20/2021 at 11:49 AM Staff V, CNA, stated, We did get training that we are on fire watch, and someone has to go into every room every 30 minutes. I think the nurses are doing that. I would pull the fire alarm and close the doors of the patients' rooms if there was a fire. I don't think that I need to call 911. I just would pull the fire alarm and get the fire extinguisher. During an interview on 8/20/2021 at 11:58 AM Staff W, LPN stated, I am on fire watch, so I am supposed to check the rooms for smells of smoke. If I smell any smoke; I would pull the fire alarm, start the rescue of the residents, close the doors to residents' rooms, and rescue the resident where the fire was. I am on the medication cart today. I am working and doing the fire watch. During an interview on 8/20/2021 at 12:05 PM Staff B, LPN stated, If I smelled smoke, I would pull the fire alarm and start the RACE procedure. We are on fire watch, that means that I have to round every 30 minutes in every room and sign the sheet. I am doing patient care and working the med cart also. I don't have to call 911 unless I want Emergency Medical Services. I did not know that there was any problem with the fire alarms until they started the fire watch. During an interview on 8/20/2021 at 12:15 PM Staff X, Dietary Aide stated, If I smelled smoke, I would pull the fire alarm and let my boss know. We are on fire watch but I'm not doing anything on that. I don't know what to do and I would just take direction from anyone in charge as to what to do. I don't know why we are on fire watch. During an interview on 8/20/2021 at 12:20 PM, Human Resources stated, We are on fire watch. I am not assigned to do that. We were trained that we need to be on fire watch in case of a fire. I would pull the fire alarm and page Code Red overhead. I wouldn't need to call 911. During an interview on 8/20/2021 at 12:25 PM Staff Y, Housekeeper stated, If I saw a fire, I would pull the fire alarm. I have not had any training and I don't know what a fire watch is. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 8/20/2021 at 12:30 PM Staff Z, Physical Therapy Assistant (PTA), stated, If I smelled smoke, I would find the fire station and pull it and then I would start the RACE/PASS process. I have not had any training that told me the fire alarms weren't working. They did say we are on fire watch, but I am not involved in the fire watch. During an interview on 8/20/2022 at 12:40 PM, the Assistant Director of Nursing, Registered Nurse stated, We are on fire watch currently, so staff are assigned to do it every 30 minutes. They look through every room. They are assigned to other duties, the nurses are assigned to the cart, giving meds and on fire watch. The fire pull stations are working so in the event of a fire we would pull them, and the fire department would come. During an interview on 8/20/2021 at 12:49 PM with Staff Q, CNA stated, In case of a fire I would pull the alarm and start to close doors and get the residents out if I needed to. The fire pull would call the fire department so I would not need to. I think we are on fire watch, but I don't do that, the nurses are. During an interview on 8/20/21 at 1:00 PM, Staff AA, CNA stated Of course I would pull the fire alarm and then I would start to close the doors and do anything else I was told. I don't know why we are on fire watch, but I am not doing it, the nurses are. When you pull the fire alarm it automatically calls the fire department so I would not call 911. During an interview on 8/20/21 at 1:05 PM, Staff E, CNA stated, If I smelled smoked, I would pull the fire alarm then rescue the resident. The fire alarm pull calls the fire department. We are on fire watch, that means rooms are checked every 30 minutes. When we pull the fire alarm, we do not need to call 911. During a follow up interview on 08/20/21 at 2:18 PM the Administrator stated, I was aware that the panel needed to be replaced and I was not sure what the report meant. Residents were possibly at risk for injury while the loop was not functional. Residents were possibly at risk for injury when we did not have the fire alarm system and they are possibly still at risk that is why we are getting a security company. During an interview on 08/20/21 at 3:10 PM, the Director of Nursing (DON) stated, I was not aware of any problems with the fire alarm system until a few days ago. We did not provide any training related to the fire alarms before a few days ago. It is conceivable that residents were at risk since the fire alarm system was broken. I was trained on the fire watch process and the training involved the policy. We should not have staff doing anything more than fire watch if that is what our policy says, so it is conceivable that residents are still at risk of harm. We should have known the seriousness of this before the survey started. This was not brought up in QAPI [Quality Assurance Performance Improvement]. I do not recall ever hearing that the fire pulls did not work and would not get the fire department. In an emergency staff would pull the fire alarm and start RACE [Rescue, Alarm, Confine, Extinguish] and PASS [Pull, Aim, Squeeze, Sweep] procedures. I'm not sure if they would have called 911. I would hope so, but in an emergency of a fire I just can't say. During an interview on 08/20/21 at 3:19 PM, the Maintenance Assistant stated, I did know that we needed to have the fire alarm panel replaced. I have never notified the Fire Marshal about any of this. I have never heard that we had to be on fire watch until you all came in. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 08/20/21 at 4:08 PM, the Regional Director of Plant Operations stated, We have completed testing of the alarms today and verified that the system was not alerting the fire department. We verified this with the monitoring company that the alarms we tested did not connect to the fire department. I was not aware of the extent of the malfunction and would have started fire watch immediately. All residents, staff, and visitors are at risk of injury if a fire had started, and staff did not understand that they needed to call 911 to get the fire department to respond. I was not aware that staff were doing their normal job duties and being assigned to fire watch. They should not be. Review of the training provided by the facility titled, Fire Watch dated 8/17/21 revealed 32 out of 145 staff attended the training totaling 22% of all staff. Review of the training titled Fire Watch/Call 911 dated 8/20/21 revealed 24 out of 145 staff attended the training totaling 38% of all staff. Sixty three percent (63%) of staff remained untrained in Fire Watch procedures. Review of the policy titled Abuse Protection and Response Policy, undated, last reviewed on 12/28/20, reads, Policy: Abuse, as hereafter defined, will not be tolerated by anyone, including staff, patients, volunteers, family members or legal guardians, friends or any other individuals. The health center Administrator is responsible for assuring that patient safety, including freedom from risk of abuse, holds the highest priority. Definitions - Neglect: is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the Policy Number 13.04.07, titled Fire Watch, with an issue date of 3/18, last review on 12/28/2020, reads, Standards: Fire Watch: Guidelines: In the event of a failure of the fire alarm system, sprinkler system, the facility will initiate a fire watch. Guidelines: 1. Notify the local fire department and document instructions. 2. Notify the Agency through the area office. 3. Assess the extent of the condition and effect corrective action, with a documented time frame. If corrective action will take more than 4 hours, do the following: Implement a contingency plan to the facility fire plan containing: a description of the problem, specifically what the system is not doing that it normally does, and the projected correction time frame. All staff on shifts involved shall have documented in-service and drilling for the contingency. Begin a documented fire watch, until the system is restored. Persons used for fire watch will not be assigned to any other duty and must be trained in what to look for, what to do, and be able to expeditiously contact the fire department. 4. Maintenance Director will initiate 'fire watch'. If the maintenance director is not in the facility, the manager on duty or the charge nurse will initiate the 'fire watch'. Until staff (not on duty) or other contracted agency can be called to carry out the 'fire watch'. 5. The fire watch person will conduct a tour of the facility every 15 minutes. This tour will include checking each resident room, offices, closets, storage, common areas and mechanical rooms for signs of smoke, fire smoke, or fire hazards. Smoke from under a door, feel the door and handle for heat, if any exist, they will need to sound the alarm and call fire dept. 6. Announcements will be made to staff reminding them that the fire alarm or sprinkler is not working. 7. In the event if a fire watch person or any person discovers a fire in progress or smoke indicating fire, he/she will contact 911 and then the point of contact person (i.e. maintenance director or manager on duty or charge nurse) and report the fire to him/her. The fire watch person will stay at the scene and try to contain and/or extinguish the fire. 8. The point of contact will immediately call 911 (local fire department) and then announce over the facility intercom CODE RED (area of fire, i.e. RM 53). CODE RED (area of fire, i.e. RM 53), CODE RED (area of fire, i.e. RM 53). The point of contact person will ensure that the RACE procedure is followed. 9. The fire watch will continue until the fire alarm panel or sprinkler system is restored and tested in the presence of the Maintenance Director or Administrator. The fire department and local area office will be notified of the stand down of the fire watch. 10. In the event that there is a phone system failure in the facility, cell phones are available for the employee doing fire watch to be able to dial '911' in case of emergency. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the policy titled Fire Watch, revised in August 2018, last reviewed on 12/28/2020, reads, Policy statement: Fire watch procedures will be initiated if the fire alarm system fails. Policy interpretation and Implementation: 1. The purpose of the Fire Watch is to serve as a plan of correction should the fire alarm system fail to work properly to provide continuous facility wide fire detection and alarm capabilities. 2. A fire alarm system should include, but is not limited to, fire alarm panel, smoke or heat detection system, sprinkler system and for department notification system. 3. Fire alarm outages can occur during construction, renovation, electrical storms, component/system failure or unplanned events that eliminate a portion of or all of the fire alarm system. Emergency Procedure-Fire Watch. 1. Contact the Administrator, Director of Nursing, and Maintenance Director when any problems are encountered with the fire alarm system. 2. Contact the fire alarm company if the maintenance director or other responsible party is unable to correct the problem. 3. Notify the Fire Department and State Regulatory/Licensure Agency that the fire alarm system is not working correctly and that fire watch procedures are in place until the system is restored. 4. Report to the Incident Command Post for instruction. If warranted, based on the potential severity of the system failure, activate the ICS (Incident Command System) to manage the incident. The most qualified staff member (in regard to the Incident Command system) on duty at the time assumes the Incident Commander position. 5. Initiate fire watch tours throughout the facility. Fire watch tours occur at one-half hour intervals, 24 hours a day and consist of periodic walking tour of the entire facility by one or more assigned and trained staff. a. The fire watch staff monitors the facility through direct observation of all rooms, including resident rooms, mechanical and electrical rooms, kitchen laundry, etc. for all possible signs of fire. b. The fire watch staff documents fire watch tours with findings noting date, time and staff initials. c. The fire watch staff consists of personnel solely dedicated to the fire watch with no other facility related activities or events. 8. Do not terminate the Fire Watch until all fire protection equipment is in normal operating condition and upon authority of the Administrator/Incident commander or designee. Under the section title, Emergency Procedure - Fire reads, Utilize the Fire Procedure in the event of an actual fire, smoke condition, or smell of smoke in the facility. 1. Activate the R-A-C-E response as soon as there is discovery of a fire or potential fire situation with the building. DO NOT PANIC. The documentation for A reads, ALARM: Activate the building's fire alarm system by pulling the nearest manual pull station. Announce CODE RED and the fire location over the loudspeaker-repeat.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41334 Based on observation, interview, and record review, the facility failed to develop and implement a person-centered care plan for nutrition related to intentional weight loss for 1 of 4 residents, Resident #59, and 3 of 4 residents, Residents #33, #34, and #50, for respiratory care, out of a total sample of 46 residents. Findings: 1. Review of Resident #34's medical record revealed the resident was admitted with a diagnosis of chronic obstructive pulmonary disease (COPD), obstructive sleep apnea (a sleep related breathing disorder), and morbid obesity with alveolar hypoventilation (an increase in carbon dioxide levels in the blood). On 8/16/2021 at 10:37 AM, Resident #34 was observed sitting in his wheelchair being administered oxygen at 1.5 liters per minute (l/m). Resident #33's CPAP (Continuous Positive Airway Pressure) mask was observed on the nightstand. The CPAP mask was dated 7/1/2021. It was not in a bag and the tubing that connects to the oxygen was observed on the floor. On 8/17/2021 at 1:03 PM, Resident #34 was observed sitting in his wheelchair in his room. His CPAP Mask remained on his nightstand, labeled 7/1/2021, with the tubing that connects the mask to the oxygen on the floor and the mask was not in a bag. A review of Resident #34's care plan reads,[Resident #34's Name] is at risk for complications of respiratory distress r/t [related to] diagnosis of COPD and sleep apnea: administer O2 [oxygen] as ordered, store respiratory equipment in infection control bag when not in use, change every week and PRN [as needed]. Review of Resident #34's physician orders dated 1/27/2021 reads, Resident to wear Autopap [a machine that delivers a stream of oxygenated air into the airways through a mask and a tube] at night due to COPD and SOB [Shortness of breath]. During an interview on 8/17/2021 at 1:55 PM with Staff N, Licensed Practical Nurse (LPN), she stated, The CPAP mask should not be just sitting on the nightstand and should be in a bag and the connection tubing should not be on the floor and should be in a bag also. The CPAP tubing and mask is labeled 7/1/2021 and gets changed once a month. It should have been changed. 2. Review of Resident #33's medical records revealed the resident was admitted to the facility with a diagnosis of chronic obstructive pulmonary disease, diabetes mellitus, hypertension, and congestive heart failure (a condition where the heart does not pump blood as well as it should). Review of Resident #33's physician orders dated 3/8/2021 reads, Apply O2 at 4L [liters] via nasal cannula to maintain saturations greater than 90%. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105638	A. Building B. Wing	08/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parklands Care Center and Rehab	1000 SW 16th Ave Gainesville, FL 32601

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/16/21 at 10:48 AM, Resident #33 was observed resting in bed with oxygen being administered at 5 liters per minute via nasal cannula. On 8/17/21 at 8:43 AM, Resident #33 was observed resting in bed with oxygen being administered at 5 liters per minute via nasal cannula. On 8/17/21 at 1:32 PM, Resident #33 was observed in bed being administered oxygen at 5 Liters per minute via nasal cannula. Review of Resident #33's care plan reads, [Resident #33's name] has a potential for complications of respiratory distress related to CHF (congestive heart failure), obstructive sleep apnea, COPD: Administer O2 as ordered. During an interview on 08/17/21 at 2:07 PM with Staff N, LPN, she stated, The oxygen is not on the correct amount. She can't reach the oxygen, so I don't know how they were changed to 5 liters. 3. Review of Resident #50's medical records revealed the resident was admitted to the facility with a diagnosis of cerebral infarction (a stroke), chronic obstructive pulmonary disease, chronic kidney disease, dementia, hypertension, and heart failure, Review of Resident #50's physician orders dated 6/11/2021 reads O2 at 2 LPM [liters per minute] via NC [nasal cannula] to maintain oxygen level over 90%. On 08/17/21 at 8:58 AM, Resident #50 was observed in bed being administered oxygen at 4 liters per minute. On 08/17/21 at 2:21 PM, Resident #50 was observed in bed being administered oxygen at 4 liters per minute. Review of Resident #50's care plan reads, [Resident #50's name] has a potential for complications of respiratory distress r/t dx [diagnosis] of COPD: administer O2 as ordered. During an interview on 08/17/21 at 2:22 PM with Staff N, LPN, she stated, The oxygen concentrator is at 4 liters per minute, it is not on the correct amount. During an interview on 8/18/2021 at 3:30 PM, the Director of Nursing (DON) stated, I expect that physician orders are followed when administering oxygen, that the nurses view it to determine if it is set as ordered. I expect that any respiratory equipment be placed in a bag for protection, and it would not be placed on a nightstand. If a resident takes their CPAP or oxygen off themselves when staff see it out of a bag that they put it away in a bag. When tubing falls on the floor, all the equipment gets changed. I think that we change the masks every month and the tubing for CPAP machines. Review of the policy and procedure titled 2001 Med-pass, revised in October 2010, last reviewed on 12/28/2020, reads, Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 34769 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Review of Resident #59's medical record documented the resident was admitted on [DATE] with diagnosis that include chronic obstructive pulmonary disease, moderate protein calorie malnutrition, anemia, malignant neoplasm of endometrium, vitamin B12 deficiency anemia, vitamin D deficiency, essential primary hypertension, and gastro esophageal reflux disease without esophagitis. During an interview on 8/17/21 at 12:13 PM, the resident stated she had lost 100 pounds and she didn't feel hungry. Review of Resident #59 weights were documented as 5/5/21: 208.0, 4/21/21: 217.6, 4/15/21: 213.8, 3/7/21: 221.4, 2/1/21: 232.4, and 11/4/20: 260.4. The resident's weight loss was 20.89% for the six-month period from 11/4/2020 to 5/5/2021; 11.36% for the three-month period from 2/1/21 to 5/5/21; and 3.65% for one-month period from 4/15/2020 and on 5/5/2021. There are no current weights available. Review of Resident #59's Minimum Data Set (MDS), Annual Comprehensive assessment dated [DATE] revealed the resident is 71 inches in height, 208 pounds, has not lost more than 10% in the last 6 months, and is not on a prescribed weight loss program. The resident is not on a mechanically altered diet or therapeutic diet. Review of the dietary progress notes dated 4/23/21 reads, [Resident #59's Name] requested information about losing weight to improve her health. She would like to lose another 50 pounds (#) (she has already lost 68# over the last 2 years by cutting back on high calorie foods). Stated she is a vegetarian but eats chicken and turkey and requests a hamburger for evening meal when available. Preferred food list provided to food service. Review of the dietary progress notes dated 5/23/21 reads, Weight summary: CBW (current body weight) 208# down 52.4# x 180 days. Weight loss intentional and desirable. Review of the nursing progress notes dated 7/1/21 reads, IDT (Interdisciplinary team) met today for care plan review meeting. Resident did not attend; family did not respond to mailed care plan invitation. Resident's plan of care including medications, labs, ADL (Activities of Daily Living) functioning, advance directives, nutrition including participation with activities were reviewed and discussed during the meeting. Remains here for long term care. Nursing reports refuses medications. Therapy continues with PT [Physical therapy] 5 times a week and excellent progress. Quarterly and PRN [as needed] screens. Participates with activities of choice and online classes to further her education and interacts with staff and other residents. Weight she has lost and wants to lose weight. She weighs weekly and continues with good intake. Condition remains stable including ADL [activities of daily living] functioning. Primary care provider involved in the development of the plan of care. Care plan remains current or updated for resident needs. During an interview on 8/18/21 at 10:02 AM, the Registered Dietitian confirmed the last nutritional assessment completed on Resident #59 was in June 2020. She stated there was no care plan for intentional weight loss and there were no physician's orders for a prescribed weight loss plan. She agreed there was no safe weight loss plan in place for the resident. She stated, We should have a care plan meeting; the physician should know about desire to lose weight and document his recommendations. We should document a plan with rate of weight loss with a prescribed meal plan. The RD voiced a concern of the resident being at risk for malnutrition without a prescribed diet/meal plan. She confirmed that the facility has not honored the resident's food preferences (requested salads and fruit plates) and diet by sending her pureed meat. (continued on next page)

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	105638	A. Building B. Wing	08/20/2021

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/18/21 at 10:50 AM, the Director of Nursing confirmed Resident #59 wants to lose weight. There was no prescribed weight reducing diet for the resident. She confirmed there was no developed or implemented care plan for intentional weight loss. The resident has had a weight loss between November 2020 and May 2021 of 20%. During an interview on 8/18/21 at 3:45 PM, Staff H, Licensed Practical Nurse, MDS Coordinator, confirmed that the annual MDS dated [DATE] is inaccurate because it does not reflect the significant weight loss of 20%. The MDS does not reflect the desired wishes of the resident to lose weight. She confirmed that there was no care plan for intentional weight loss.

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	105638	A. Building B. Wing	08/20/2021

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 15234 Based on record review and interview, the facility failed to revise and update the comprehensive care plan for 1 of 6 residents, Resident #12, reviewed for nutrition in a total sample of 46 residents. Findings: Record review of Resident #12's clinical record revealed a progress note written by the Registered Dietician on 07/21/2021 that documented Resident #12 was seen by speech therapy who recommended Resident #12 be provided a mechanical soft texture with nectar consistency. The progress note documented the recommendation Resident #12's bolus tube feeding be discontinued and his therapeutic mechanically altered diet be continued. Record review of Resident #12's physician's orders revealed diet orders mechanical soft texture, nectar consistency (Start Date: 07/20/21) and mechanical soft texture, nectar consistency, double portions of meat on each tray (Start Date: 08/16/2021). Record review of Resident #12's care plan (Date Initiated: 05/26/2021. Revision Date: 07/14/2021 and 08/17/2021 revealed care plan documentation that Resident #12 was at risk for complications associated with enteral feedings due to diagnoses of dysphagia, was nothing by mouth, and received enteral feeding to meet his nutritional and hydration needs. Resident #12's care plan documented nutritional interventions that included verify tube feeding placement as ordered, check enteral feeding residuals as ordered, administer enteral feeding and flushes as ordered and observe for tolerance and observe for complications related to enteral feeding, aspiration, dehydration. During an interview on 08/17/2021 at 2:25 PM, Staff H, Licensed Practical Nurse/ Minimum Data Set confirmed, Resident #12 no longer received enteral feedings. She confirmed his diet order had been upgraded to mechanical soft texture on 07/20/21. Staff H stated that Resident #12's care plan should have been updated by the facility dietary department within a couple of days following his diet upgrade.

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	105638	A. Building B. Wing	08/20/2021

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22428 Based on observation, record review, and interview, the facility failed to ensure each resident's environment remains as free of accident hazards as is possible for 4 of 12 residents, Residents #53, #63, #69, and #254, in a total sample of 46 residents (Photographic Evidence Obtained). Findings: 1. During a tour of the facility on 8/17/2021 beginning at approximately 10:00 AM with the Maintenance Supervisor, it showed the electronic air pump for the mattress to Resident #54's bed was observed to have a set of wires that was to be encased in a dark thick plastic that was attached to the pump and the electrical wall outlet. The dark thick plastic covering the wires had moved or worn away from the multiple wires attached directly to air pump at the foot of the resident's bed. The pump was attached to the wooden foot board of the bed even with the mattress and the resident's feet. It provided air to inflate the entirety of the resident's mattress. The Resident was observed to be laying on the mattress while the pump with the exposed wires was engaged. Review of Resident #54's record revealed he has a physician's order dated 7/7/21 for the air pump and mattress. Review of the 8/1/2021 Nursing Assessment revealed Resident #54 is incontinent of bowel and has an abscess in the mid back region along the vertebrae. The assessment noted he required assistance with some of his activities of daily living. During an interview on 8/17/2021 at 12:30 PM, Resident #54 stated he is scared of the wires coming apart. 2. During an observation of Resident #63's bed on 8/17/2021 at approximately 10:10 AM with the Maintenance Supervisor, the electric pump wires attached to the air mattress were missing the protective covering as they attached to the pump on the resident's bed. The pump was engaged, and the resident was in the bed. Review of Resident #63's record revealed a physician's order dated 9/23/2020 which provided for application of a LAL [Low Air Loss] Pressure Relief mattress to bed prophylactically. Review of the nursing assessment dated [DATE] noted he required assistance with all of his activities of daily living. 3. During an observation of Resident #69's bed on 8/17/2021 at approximately 10:25 AM with the Maintenance Supervisor, the electric pump wires attached to the air mattress were missing the protective covering as they attached to the pump on the resident's bed. The pump was engaged, and the resident was in the bed. Review of Resident #69's record revealed a physician's order dated 6/18/2020 which provided the use of a LAL mattress every shift for prophylaxis. (continued on next page)

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	105638	A. Building B. Wing	08/20/2021

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing assessment dated [DATE] noted assistance was required with all activities of daily living and is incontinent of bowel and bladder. During an interview on 8/17/2021 at approximately 10:20 AM, Resident #69 stated she needed a safe mattress because she is not ambulatory. She stated she had a pressure sore in the past. 4. During an observation of Resident #254's bed on 8/17/2021 at approximately 10:15 AM with the Maintenance Supervisor, the electric pump wires attached to the air mattress were missing the protective covering as they attached to the pump on the resident's bed. The wires were wrapped in black electrical tape where the plastic covering was worn away. The pump was engaged, and the resident was in the bed. Review of Resident #254 record revealed a physician's order dated 7/27/2021 which provided the use of a pressure relief mattress. It read, float heels, turn and reposition for comfort as needed. During an interview on 8/17/2021 at approximately 10:20 AM, Resident #254 stated he wanted a mattress which was safe because he needs the relief. During an interview on 8/17/2021 at 10:30 AM, the Maintenance Supervisor verified the four beds were missing the protective covering over the electric wiring for the pumps on their beds. They usually replace the pumps when the wires become worn out. He had no information regarding the pump with the worn wires which someone wrapped in black electrical tape which was peeling. A request was made for copies of the inspections for bed safety, none were provided. Review of the facility policy titled Bed Safety, last reviewed on 12/28/20, revealed the following directives 2. c. Ensure when bed system components are worn and need to be replaced, components meet manufacturer specifications. 3. The maintenance department shall provide a copy of the inspections to the Administrator.

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	105638	A. Building B. Wing	08/20/2021

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15234 Based on observation, interview, and record review, the facility failed to ensure 4 of 6 residents reviewed for nutrition status, Residents #12, #57, #59, and #91, maintained acceptable parameters of nutritional status or offered the prescribed therapeutic diets. Findings: 1. Record review of Resident #12's clinical record revealed a progress note written by the Registered Dietician on 07/23/2021 that documented Spoke with Dialysis Registered Dietician (RD). RD requesting double portions of meat on trays. Communicated to Dietary staff. Record review of Resident #12's physician's orders revealed the diet order mechanical soft texture, nectar consistency, double portions of meat on each tray. (Start Date: 08/16/2021). An observation of the morning meal was completed on 08/17/2021 beginning at 8:25 AM. The tray cart was delivered to Resident #12's residential hallway. There was no morning meal for Resident #12 included on the meal tray cart delivered to Resident #12's residential hallway. During interview on 08/17/2021 at 8:29 AM, Staff E, CNA (Certified Nursing Assistant), confirmed Resident #12 had not received a morning meal. On 08/17/2021 at 8:31 AM, Staff I, Dietary Aide (DA), brought Resident #12's morning meal to the residential hallway. Resident #12's morning meal tray was observed not to include double meat portions as ordered by the physician. During an interview on 08/17/2021 at 8:31 AM, Staff I, DA, stated Resident #12's meal ticket documented Resident #12 should receive a regular portion of meat; it does not document Resident #12 should receive a double portion of meat. On 08/17/2021 beginning at 12:35 PM, an observation of Resident #12's midday meal showed Resident #12 was served a single portion, a 4-ounce portion of ham, with his meal. Record review of Resident #12's meal ticket for the lunch meal on 08/17/2021 showed Resident #12 was provided a 4-ounce portion of meat with his lunch meal. During an interview on 08/17/21 beginning at 11:54 AM, Staff J, LPN (Licensed Practical Nurse), stated that Resident #12's diet had been changed to include double meat portions on 08/16/2021. She stated that a nurse should complete a dietary communication form and forward the communication form to the kitchen if the physician changes a resident's diet order. She confirmed no one had completed the dietary communication form and forwarded the form to the kitchen after Resident #12's diet order had been revised to include double meat. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105638	A. Building B. Wing	08/20/2021

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 08/18/2021 at 8:17 AM, the facility Registered Dietician stated that Resident #12's diet order had changed after the dialysis center had recommended double meat portions following receipt of Resident #12's lab results. She stated that increased protein would benefit Resident #12 by increasing his albumin level and confirmed that a 4 ounce portion was a single serving of meat and an 8 ounce portion was a double portion of a meat. 44571 2. Review of Resident #57's medical record documented this is a [AGE] year-old female admitted to the facility with diagnosis to include hemiplegia and hemiparesis, vitamin D deficiency, congestive heart failure, type 2 dialysis, severe protein malnutrition, hyperlipidemia, major depressive disorder, and schizophrenia. Review of the physician orders revealed an order for a meal tray with a regular diet with mechanical soft texture and a Magic Cup for lunch and dinner. Glucerna 1.5 @ [at] 60 milliliters/hour times 10 hours with 40 milliliters h20 [water] flush from 12 pm to 8 am, and a 2nd order of Jevity if Glucerna not available @ 95 milliliters/hour for 12 hours and free water flush @ 70 milliliters/hour for 12 hours. An observation was made on 8/16/2021 at approximately 11:30 AM of the lunch trays being delivered to the residents. Resident #57 had a tray with pureed foods and a tray ticket with pureed foods listed. An interview was conducted on 8/16/2021 at approximately 11:45 AM with the Registered Dietician (RD) regarding the physician diet order for Resident #57. The RD stated that the resident should be receiving a mechanical soft diet which would be ground meats. The RD confirmed the existing tray card ticket showed a pureed diet is being sent to the Resident. An observation was made on 08/17/21 at 12:35 PM of the meal trays as they were being passed. A meal tray was observed sitting on top of the meal cart and Staff Q, CNA, was tearing the meal ticket in half and placing back on the tray for Resident #57. During an interview on 08/17/21 at 12:35 PM with Staff Q, CNA, when asked whether the Resident #57 had been discharged or sent out of facility, Staff Q stated that the resident would not eat anything. An interview was conducted with Resident #57 on 08/17/21 at 10:03 AM regarding her meal intake. The Resident stated that she eats her meals when they bring them. She received a tray for supper on 8/16/21 and it was good. When asked about her lunch meal, the resident stated she did not get one but would have probably eaten it. (continued on next page)

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	105638	A. Building B. Wing	08/20/2021

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #57's Point of Care Response History for Eating Meal Percentage for the period of 7/19/2021 through 8/16/2021 failed to reveal complete documentation of the amount of the meal consumed by Resident #57 for each meal. The history documented 7/19/2021 not applicable checked. 7/20/2021 tube feeding checked for breakfast and lunch and 0-25% for dinner. 7/21/2021 not applicable, tube feeding, and 25-50% for dinner. 7/22/2021 not applicable, and two entries of tube feeding. 7/23/2021 not applicable, and two entries of tube feeding. 7/24/2021 not applicable, resident refused and not applicable. 7/25/2021 the three entries read non-applicable. 7/26/2021 non-applicable and two entries of tube feeding. 7/27/2021 non-applicable, lunch 25-50%, and tube feeding. 7/28/2021 non-applicable and two entries resident refused. 7/29/2021 non applicable, lunch 0-25%, and tube feeding. 7/30/2021 shows two entries of resident not available and two entries of non-applicable. 7/31/2021 shows three entries of tube feeding only. 8/01/2021 shows two entries of tube feeding only. 8/02/2021 shows not applicable and two entries of resident refused. 8/03/2021 shows one entry for the day of not applicable. 8/04/2021 shows three entries of tube feeding. 8/05/2021 shows NPO (nothing by mouth) and two entries of tube feeding only. 8/06/2021 shows NPO and two entries of tube feeding only. 8/07/2021 shows two entries of tube feeding only. 8/08/2021 shows one entry for the day of non applicable. 8/09/2021 shows tube feeding and two entries of Resident refused. 8/10/2021 shows NPO and two entries of resident refused. 8/11/2021 shows not applicable and two entries of resident refused. 8/12/2021 shows one entry for the day of not applicable. 8/13/2021 shows one entry for the day of not applicable. 8/14/2021 shows two entries of tube feeding. 8/15/2021 shows three entries of tube feeding only. 8/16/2021 shows one entry non applicable and two resident refused. An interview was conducted on 08/18/21 at 07:37 AM with the Registered Dietician, (RD) concerning the Residents weight loss. The RD confirmed that the meal intake should be documented to allow for calculations and monitoring for daily caloric intake. The RD confirmed that documentation was not completed accurately with only 2-3 days of meal intake noted on the task tab of the medical record for the months of June, July, and August of 2021. An interview was conducted on 8/18/2021 at 11:10 AM with Staff F, Assistant Dietary Manager, regarding the physician ordered diet. Staff F stated that the tray tickets should match what nursing entered in the electronic chart. Staff F confirmed that the tray ticket for Resident #57 showed the resident was to receive a pureed diet. An observation was made on 8/18/2021 at approximately 8:00 AM of the breakfast meal trays being delivered to the residents. Resident #57 had a tray with pureed foods and a tray ticket with pureed foods listed. Review of Resident #57's weight record reavealed 149.4 pounds on 01/02/2021, 133.8 pounds on 04/16/2021, 133.2 pounds on 06/04/2021, and 125.6 pounds on 07/01/2021. The resident had a total weight loss of 15.93% over a six-month period, 6.13% weight loss over a 90-day period, and a 5.71% weight loss over the last 30 days. Review of the policy titled Guidelines for Charting and Documentation, dated April 2012, reads, Guidelines: document the diet, appetite, food consumption, eating habits, assistance needed and where, diet normally consumed, weight variations, hydration status, fluid intake, tolerance of tube feeding, etc. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105638	A. Building B. Wing	08/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	34769 3. Review of Resident #59's medical record documented the resident was admitted on [DATE] with diagnosis that include chronic obstructive pulmonary disease, moderate protein calorie malnutrition, anemia, malignant neoplasm of endometrium, vitamin B12 deficiency anemia, vitamin D deficiency, essential primary hypertension, and gastro esophageal reflux disease without esophagitis. During an interview on 08/16/21 at 10:23 AM, Resident #59 stated that she prefers salads, cottage cheese, fruit, mostly vegetarian type foods. During an observation on 08/16/21 at 1:08 PM, Resident #59 was served the following for lunch: Roast beef, buttered noodles with gravy, buttered peas, ginger ale, and pineapple. The lunch ticket reads, Regular diet, no restrictions. Herb baked chicken, egg noodles, green peas, vegetable salad, ginger ale. Allergies: Fish (fin fish), shellfish, tuna fish, seafood/fish entrees. Note: Likes Diet Ginger Ale & Iced Tea. Send Cottage Cheese & Fruit Plate each meal. Soup every meal. During an interview on 08/16/21 at 01:08 PM, Resident #59 confirmed she did not get a salad or cottage cheese/fruit plate as per request. She confirmed she did not receive the chicken and stated, that happens here a lot. During an interview on 8/16/21 at 8:03 AM, Staff O, Certified Nursing Assistant (CNA), stated, Right now if the resident states that they don't want what is on their plate, we just serve what comes out of the kitchen. During an observation on 8/17/21 at 8:10 AM, Resident #59 was served the following for breakfast: orange juice, coffee, scrambled eggs, blueberry muffin, sausage patty, frosted flakes, 2% milk. The meal ticket reads, Regular diet, no restrictions, orange juice, scrambled eggs, slivered green onions, blueberry muffin, oatmeal, whole milk, hot tea/hot coffee, creamer, salt & pepper, sugar. Allergies: Fish (fin fish), shellfish, tuna fish, seafood/fish entrees. Note: No biscuit, no gravy, no cranberry juice. Scrambled eggs, sausage and cold cereal, add coffee to tray, 2% milk. Resident consumed frosted flakes and orange juice. No other breakfast items were consumed. During an interview on 8/17/21 at 12:13 PM, the resident stated she had lost 100 pounds and she didn't feel hungry. During an observation on 8/17/21 at 12:30 PM, Resident #59 was served the following for lunch: pureed ham, sauerkraut, roasted red potatoes, whole wheat roll, lemon pudding, diet ginger ale. The meal ticket reads, Regular diet, no restrictions, roasted red potatoes, braised red cabbage, garden vegetable salad, ginger ale soda. Allergies: Fish (fin fish), shellfish, tuna fish, seafood/fish entrees. Note: Likes Diet Ginger Ale & Iced Tea. Send Cottage Cheese & Fruit Plate each meal. Soup every meal. Resident did not eat any of the lunch items that were provided on the tray. During an observation on 08/18/21 at 8:10 AM, Resident #59 was served the following for breakfast: orange juice, scrambled egg, biscuit, grits, 2% milk, hot tea/hot coffee, creamer, salt & pepper, sugar. The meal ticket reads, Regular diet, no restrictions, orange juice, scrambled egg, biscuit, grits, whole milk, hot tea/hot coffee, creamer, salt & pepper, sugar. Allergies: Fish (fin fish), shellfish, tuna fish, seafood/fish entrees. Note: No biscuit, no gravy, no cranberry juice. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105638	A. Building B. Wing	08/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parklands Care Center and Rehab	1000 SW 16th Ave Gainesville, FL 32601

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #59 weights were documented as 5/5/21: 208.0, 4/21/21: 217.6, 4/15/21: 213.8, 3/7/21: 221.4, 2/1/21: 232.4, and 11/4/20: 260.4. The resident's weight loss was 20.89% for the six-month period from 11/4/2020 to 5/5/2021; 11.36% for the three-month period from 2/1/21 to 5/5/21; and 3.65% for one-month period from 4/15/2020 and on 5/5/2021. There are no current weights available. Review of the physician's orders for Resident #59 dated 6/16/21 reads Regular diet, regular texture, thin consistency, for prophylaxis. Review of Resident #59's Minimum Data Set (MDS), Annual Comprehensive assessment dated [DATE] revealed the resident is 71 inches in height, 208 pounds, has not lost more than 10% in the last 6 months, and is not on a prescribed weight loss program. The resident is not on a mechanically altered diet or therapeutic diet. Review of the dietary progress notes dated 4/23/21 reads, [Resident #59's Name] requested information about losing weight to improve her health. She would like to lose another 50 pounds (#) (she has already lost 68# over the last 2 years by cutting back on high calorie foods). Stated she is a vegetarian but eats chicken and turkey and requests a hamburger for evening meal when available. Preferred food list provided to food service. Review of the dietary progress notes dated 5/23/21 reads, Weight summary: CBW (current body weight) 208# down 52.4# x 180 days. Weight loss intentional and desirable. Review of the nursing progress notes dated 7/1/21 reads, IDT (Interdisciplinary team) met today for care plan review meeting. Resident did not attend; family did not respond to mailed care plan invitation. Resident's plan of care including medications, labs, ADL (Activities of Daily Living) functioning, advance directives, nutrition including participation with activities were reviewed and discussed during the meeting. Remains here for long term care. Nursing reports refuses medications. Therapy continues with PT [Physical therapy] 5 times a week and excellent progress. Quarterly and PRN [as needed] screens. Participates with activities of choice and online classes to further her education and interacts with staff and other residents. Weight she has lost and wants to lose weight. She weighs weekly and continues with good intake. Condition remains stable including ADL [activities of daily living] functioning. Primary care provider involved in the development of the plan of care. Care plan remains current or updated for resident needs. During an interview on 8/18/21 at 8:00 AM, the Assistant Director of Nursing (ADON), stated that the resident's meal ticket comes with their tray, the CNA should check the ticket for diet and compare to the meal and communicate with the kitchen if the tray is wrong. During an interview on 8/18/21 at 10:02 AM, the Registered Dietitian confirmed the last nutritional assessment completed on Resident #59 was in June 2020. She stated there was no care plan for intentional weight loss and there were no physician's orders for a prescribed weight loss plan. She agreed there was no safe weight loss plan in place for the resident. She stated, We should have a care plan meeting; the physician should know about desire to lose weight and document his recommendations. We should document a plan with rate of weight loss with a prescribed meal plan. The RD voiced a concern of the resident being at risk for malnutrition without a prescribed diet/meal plan. She confirmed that the facility has not honored the resident's food preferences (requested salads and fruit plates) and diet by sending her pureed meat. (continued on next page)

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	105638	A. Building B. Wing	08/20/2021

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/18/21 at 10:35 AM, the Assistant Dietary Director, confirmed the dietary department did not follow the resident's diet or preferences. She confirmed the resident did not receive baked chicken for lunch at 8/16/21 and the resident received pureed ham for lunch on 8/17/21. She confirmed that garden salads and cottage cheese with fruit was not provided per the resident's request. During an interview on 8/18/21 at 10:50 AM, the Director of Nursing confirmed Resident #59 wants to lose weight. There was no prescribed weight reducing diet for the resident. She confirmed there was no developed or implemented care plan for intentional weight loss. There was no physicians order for a prescribed weight reducing diet. There was no current weight for the resident and that all weights have been suspended due to COVID-19 (Coronavirus Disease - 2019). The last weight for the resident was 5/5/21. The resident has had a weight loss between November 2020 and May 2021 of 20%. During an interview on 8/18/21 at 3:45 PM, Staff H, Licensed Practical Nurse, MDS Coordinator, confirmed that the annual MDS dated [DATE] is inaccurate because it does not reflect the significant weight loss of 20%. The MDS does not reflect the desired wishes of the resident to lose weight. She confirmed that there was no care plan for intentional weight loss. Review of the physician notes from the visit dated 8/2/21 revealed the resident was evaluated for abnormal labs, obesity and weight loss targets. Patient is motivated and is restricting her calories and it was advised and recommended to keep up with her dietary and lifestyle changes to lower the weight and increase the mobility. The patient has occasional pain, selective eating, sometime refusal of medications. Plan: obesity. Patient has had high weight and BMI in the range of 38 and in January 2020 weight was 276 pounds and most recent weight recorded in the system on 5/5/2021 is 208 which is promising. I have advised patient and communicate with staff that for the patient's height of 71 inches, her weight target is to be 179 pounds or lower up to 133 pounds. Also recommended to have most recent weight recorded. During an interview on 8/18/21 at 3:00 PM, the DON stated that following the physicians visit related she weighs weekly and continues with good intake. Condition remains stable including ADL functioning. Primary care provider involved in the development of the plan of care. Care plan remains current or updated for resident needs. 4. Review of Resident #91's medical records revealed the resident was admitted on [DATE] with diagnosis that include periprosthetic fracture around internal prosthetic left hip joint, aftercare following joint replacement surgery, and unspecified protein-calorie malnutrition. During an observation on 8/16/21 at 10:57 AM, Resident #91 was observed in bed. The head of the bed was slightly elevated. The resident was alert and pleasant. During an observation on 08/17/21 at 07:55 AM, Resident #91 was observed to be served bacon strip, scrambled eggs, blueberry muffin, cheese grits, orange juice and whole milk. Resident consumed 100% of meal and requested another blueberry muffin. The resident's meal ticket reads, Mechanical soft, no restrictions. Orange juice, scrambled eggs, shaved green onions, buttered blueberry muffin, oatmeal, whole milk, hot coffee/or tea, creamer, salt, pepper, sugar, ground sausage patty. (continued on next page)

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	105638	A. Building B. Wing	08/20/2021

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/17/21 at 8:20 AM, Staff O, CNA, stated resident consumed 100% of meal and was on her way to get him another blueberry muffin. She confirmed that he did eat his bacon, she did not deliver his tray. He was not supposed to get bacon. He is on a mechanical soft diet. Review of the physician's order dated 7/19/21 reads, Regular diet, mechanical soft texture, thin consistency per resident request due to missing teeth. Review of the MDS, comprehensive 5-day assessment dated [DATE] for Resident #91 revealed the resident is receiving a mechanically altered diet. During an interview on 08/18/21 at 10:02 AM, the Registered Dietitian confirmed that Resident #91 is on a mechanical soft diet. He should not have bacon as that is a risk. She is unsure why the substitution was made as the ticket read ground sausage. During an interview on 08/18/21 at 10:34 AM, Staff F, Assistant Dietary Manager, confirmed that bacon was sent out to Resident #91. She stated that was dangerous that he could choke on the wrong texture. She confirmed he is mechanical soft diet. During an interview on 08/18/21 at 10:50 AM, the Director of Nursing confirmed Resident #91 is on a mechanical soft diet and did not get the correct ordered diet. She stated he should not have been served bacon. He should have received ground sausage for breakfast as stated on the tray ticket. Review of the policy titled Therapeutic Diets, dated October 2019, last reviewed on 12/28/20, reads, Policy Statement. It is the Center policy to ensure that all residents have a diet order, including regular, therapeutic, and texture modified, prescribed by the attending physician, physician extender, or credentialed practitioner in accordance with applicable regulatory guidelines. Definitions. Therapeutic diet is defined as a diet ordered by a physician or delegated registered or licensed dietitian as part of the treatment for a disease or clinical condition, to eliminate or decrease specific nutrients in the diet (e.g. sodium), or to increase specific nutrients in the diet (e.g. potassium), or to provide food that a resident is able to eat (e. g. mechanically altered diet). Mechanically altered diet means one in which the texture of the diet is altered. When the texture is modified, the type of texture must be specific and part of the physicians' or delegated registered or licensed dietitian's order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105638	A. Building B. Wing	08/20/2021

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41334 Based on observation, interview, and record review, the facility failed to ensure respiratory care services were provided consistent with professional standards of practice for oxygen administration and care of respiratory care equipment for 4 of 4 residents reviewed for respiratory care, Residents #33, #34, #50, and #47, out of a total 18 residents in the facility receiving respiratory care. Findings: 1. Review of Resident #34's medical record revealed the resident was admitted with a diagnosis of chronic obstructive pulmonary disease (COPD), obstructive sleep apnea (a sleep related breathing disorder), and morbid obesity with alveolar hypoventilation (an increase in carbon dioxide levels in the blood). Review of Resident #34's physician orders dated 1/27/2021 reads, Resident to wear Autopap [a machine that delivers a stream of oxygenated air into the airways through a mask and a tube] at night due to COPD and SOB [Shortness of breath]. On 8/16/2021 at 10:37 AM, Resident #34 was observed sitting in his wheelchair being administered oxygen at 1.5 liters per minute (l/m). Resident #33's CPAP (Continuous Positive Airway Pressure) mask was observed on the nightstand. The CPAP mask was dated 7/1/2021. It was not in a bag and the tubing that connects to the oxygen was observed on the floor. On 8/17/2021 at 1:03 PM, Resident #34 was observed sitting in his wheelchair in his room. His CPAP Mask remained on his nightstand, labeled 7/1/2021, with the tubing that connects the mask to the oxygen on the floor and the mask was not in a bag. A review of Resident #34's care plan reads,[Resident #34's Name] is at risk for complications of respiratory distress r/t [related to] diagnosis of COPD and sleep apnea: administer O2 [oxygen] as ordered, store respiratory equipment in infection control bag when not in use, change every week and PRN [as needed]. During an interview on 8/17/2021 at 1:55 PM with Staff N, Licensed Practical Nurse (LPN), she stated, The CPAP mask should not be just sitting on the nightstand and should be in a bag and the connection tubing should not be on the floor and should be in a bag also. The CPAP tubing and mask is labeled 7/1/2021 and gets changed once a month. It should have been changed. 2. Review of Resident #33's medical records revealed the resident was admitted to the facility with a diagnosis of chronic obstructive pulmonary disease, diabetes mellitus, hypertension, and congestive heart failure (a condition where the heart does not pump blood as well as it should). Review of Resident #33's physician orders dated 12/01/2020 reads, Bipap Auto [devices for sleep apnea treatment that use two separate pressure settings for inhale and exhale] at bedtime and as needed. (continued on next page)

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	105638	A. Building B. Wing	08/20/2021

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #33's physician orders dated 3/8/2021 reads, Apply O2 at 4L [liters] via nasal cannula to maintain saturations greater than 90%. On 8/16/21 at 10:48 AM, Resident #33 was observed resting in bed with oxygen being administered at 5 liters per minute via nasal cannula. On 8/17/21 at 8:43 AM, Resident #33 was observed resting in bed with oxygen being administered at 5 liters per minute via nasal cannula. On 8/17/21 at 1:32 PM, Resident #33 was observed in bed being administered oxygen at 5 Liters per minute via nasal cannula. Review of Resident #33's care plan reads, [Resident #33's name] has a potential for complications of respiratory distress related to CHF (congestive heart failure), obstructive sleep apnea, COPD: Administer O2 as ordered. Bipap treatment as ordered/encourage her to wear it at all times. During an interview on 08/17/21 at 2:07 PM with Staff N, LPN, she stated, The oxygen is not on the correct amount. She can't reach the oxygen, so I don't know how they were changed to 5 liters. The CPAP mask should not be on the nightstand without being in a bag. 3. Review of Resident #50's medical records revealed the resident was admitted to the facility with a diagnosis of cerebral infarction (a stroke), chronic obstructive pulmonary disease, chronic kidney disease, dementia, hypertension, and heart failure, Review of Resident #50's physician orders dated 6/11/2021 reads O2 at 2 LPM [liters per minute] via NC [nasal cannula] to maintain oxygen level over 90%. On 08/17/21 at 8:58 AM, Resident #50 was observed in bed being administered oxygen at 4 liters per minute. On 08/17/21 at 2:21 PM, Resident #50 was observed in bed being administered oxygen at 4 liters per minute. Review of Resident #50's care plan reads, [Resident #50's name] has a potential for complications of respiratory distress r/t dx [diagnosis] of COPD: administer O2 as ordered. During an interview on 08/17/21 at 2:22 PM, Staff N, LPN, stated, The oxygen concentrator is at 4 liters per minute, it is not on the correct amount. During an interview on 8/18/2021 at 3:30 PM, the Director of Nursing (DON) stated, I expect that physician orders are followed when administering oxygen, that the nurses view it to determine if it is set as ordered. I expect that any respiratory equipment be placed in a bag for protection, and it would not be placed on a nightstand. If a resident takes their CPAP or oxygen off themselves when staff see it out of a bag that they put it away in a bag. When tubing falls on the floor, all the equipment gets changed. I think that we change the masks every month and the tubing for CPAP machines. (continued on next page)

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	105638	A. Building B. Wing	08/20/2021

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy and procedure titled, 2001 Med-pass, revised in October 2010, last reviewed on 12/28/2020 reads, Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 34769 4. Review of Resident #47's admission record revealed the resident was admitted to the facility on [DATE] with diagnosis that include acute and chronic respiratory failure with hypoxia and chronic obstructive pulmonary disease (COPD) with acute exacerbation. On 08/16/21 at 11:46 AM, Resident #47 was observed sitting on the side of his bed working on a lap top computer. The resident was, alert, awake, and pleasant. The resident was observed being administered oxygen via a nasal cannula attached to a concentrator at 3.5 liters per minute (l/m). On 08/17/21 at 03:20 PM, Resident #47 was observed lying in bed, alert, awake and pleasant. The resident was observed being administered oxygen via a nasal cannula attached to a concentrator at 3.5 l/m. Review of the physician orders dated 6/18/2021 read, Continuous O2 at 3L/MIN [3 liters per minute] via NC [nasal cannula] q [every] shift. During an interview on 08/17/21 at 3:32 PM, Staff A, LPN, confirmed Resident #47 was being administered oxygen via a nasal cannula attached to a concentrator being administered at 3.5 l/m. Staff A stated that he monitors the concentrators in the morning during medication pass. Review of Resident #47's comprehensive care plan dated 4/6/21 revealed Resident #47 has a potential for complications related to active infection as follows: COPD/respiratory infection with a goal to be free of infection. Interventions: Administer O2 as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105638	A. Building B. Wing	08/20/2021

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41334 Based on observation, interview, and record review the facility failed to ensure that all drugs and biologicals used in the facility were stored and labeled in accordance with current professional standards in 5 of 5 medication carts reviewed for medication labeling and storage. Findings: During an observation conducted on 8/16/21 at 9:18 AM with Staff A, Licensed Practical Nurse (LPN) of the 100 hallway medication cart there was one opened Lantus insulin pen with no date opened or expiration date, and one opened Levemir insulin pen with no date opened or expiration date. During an interview on 8/16/2021 at 9:25 AM, Staff A, LPN, stated, Insulin should be labeled with the date they were opened and the expiration date. During an observation conducted on 8/16/2021 at 9:30 AM with Staff B, LPN of the second medication cart on the 100 hallway, there was one opened bottle of Lubricant eye drops with no date opened or expiration date, one Victoza pen that was not opened with a refrigerate until opened pharmacy label on the packaging, and one unopened bottle of latanoprost eye drops with a refrigerate until opened sticker on the pharmacy packaging. During an interview on 8/16/2021 at 9:55 AM, Staff B, LPN, stated, All eye drops should be labeled with the date they are opened. Any medication that is labeled refrigerate until opened should not be on the cart until we are ready to use them. During an observation on 8/16/2021 at 10:30 AM with Staff C, LPN on the 200 Hallway there was one vial of Benadryl 50 mg/ml (milligrams/milliliter) vial which contained approximately one-half of a milliliter with no resident identifier and no date opened or expiration date, one opened tube of bacitracin ointment with no resident identifier or date opened, and one cup with nine capsules that were orange and brown not in the original pharmacy container. During an interview on 8/16/2021 at 10:40 AM, Staff C, LPN, stated, All medication vials should be in the original pharmacy package with the name of the resident, and the dates they are opened. The medication in the cup should not be on the cart, the capsules should be in the pharmacy bottle and not in a cup. During an observation on 8/16/2021 at 11:30 AM of the medication cart on 200 [NAME] with Staff D, LPN there was one Lantus Insulin flex pen with no date opened or expiration date and one multi dose vial of Lidocaine 1% with no resident identifier, no date opened, and no expiration date. During an observation on 8/16/2021 at 11:45 AM of the second medication cart on 200 [NAME] with Staff D, LPN there was one bottle of Latanoprost eye drops with no date opened or expiration date. (continued on next page)

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	105638	A. Building B. Wing	08/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/16/2021 at 11:58 AM, Staff D, LPN, stated, All insulin and the lidocaine should have a date they are opened, eye drops need the date they are opened also. During an interview on 8/18/2021 at 3:40 PM, the Director of Nursing (DON) stated, I expect that all staff will label medications when they are opened, maintain the proper temperature if they need refrigeration, and that they keep all medication in the original pharmacy containers and not place any in cups. Review of the policy titled Labeling of Medication Containers 2001 Med-Pass, revised in April 2007, with a last review date of 12/28/2020, reads, Policy Statement: All medications maintained in the facility shall be properly labeled in accordance with current state and federal regulations. Policy interpretation and Implementation: 3. Labels for individual drug containers shall include all necessary information such as: d. The name, strength and quantity of the drug. h. The expiration date when applicable. 4. Labels for each floor stack medications shall include all necessary information, such as: a. The name and strength of the drug. 8. Medications may not be transferred between containers. Review of the policy titled Storage of Medications 2001 Med-Pass, revised in April 2007, last reviewed on 12/28/2020, reads, Policy statement: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy interpretation and implementation: 1. Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received. 9. Medications requiring refrigeration must be stored in the refrigerator located in the drug room at the nurses station or other secured location.

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	105638	A. Building B. Wing	08/20/2021

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 44571 Based on record review and interview, the facility failed to ensure a qualified director of food and nutritional services provided oversight to the daily operations of the facility dietary services. Findings: Record review of the facility personal roster revealed Staff F (Date of Hire 01/03/2005) was employed and designated as a dietary aide. An interview was conducted on 8/17/2021 with Staff F who stated she was the Assistant Dietary Manager (ADM). Staff F stated that the facility does not have a Director of Food Service or Certified Dietary Manager (CDM) at this time. Staff F stated that the last CDM resigned effective June 30, 2021. Staff F confirmed that she does not have any credentials, management training or experience as a director of food and nutritional services. An interview was conducted with the Administrator on 8/18/21 at 9:02 AM regarding a director of food and nutritional services. The Administrator stated that the facility does not have a dietary director.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105638	A. Building B. Wing	08/20/2021

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44571 Based on observation, interview and record review, the facility failed to ensure proper temperatures were maintained for safe food storage. Findings: An observation was made during the initial walk through of the kitchen on 8/16/2021 at 9:23 AM with Staff G, Cook, who confirmed there was no internal thermometer in the reach-in refrigerator or the reach-in freezer. An interview was conducted on 8/16/2021 at 9:25 AM with Staff G, Cook who stated, the reach-in refrigerator or freezer did not have an internal thermometer to monitor temperatures of food being stored in either of the two units. Staff G stated an internal thermometer should be in the refrigerator and freezer. An interview was conducted on 8/17/2021 at 8:15 AM with Staff F, the Assistant Dietary Manager, (ADM) regarding placement of thermometers to monitor temperatures. The ADM agreed that thermometers are required to be placed in the refrigerator and freezer to monitor safe temperatures of food. Review of the policy and procedures titled, Food Storage: Cold was conducted on 8/18/21 at 8:15 AM. The policy stated that the Dining Services Director/Cook(s) ensures that an accurate thermometer will be kept in each refrigerator and freezer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105638	A. Building B. Wing	08/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parklands Care Center and Rehab	1000 SW 16th Ave Gainesville, FL 32601

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 34769 Based on interview, record review, and policy and procedure review, the facility Administration failed to effectively and efficiently attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident by not assuming full responsibility for the day to day operations of the facility ensuring the safety for the 109 residents when deficiencies were identified of the non-functioning fire alarm system necessary to alert the monitoring company and the fire department in case of fire and not implementing a fire watch. Findings: During an interview on 8/20/2021 at 10:15 AM the facility Administrator stated, I knew approximately in September 2020 that the control panel needed to be replaced, but I was not aware that we needed to be on fire watch. We did get a service call back in September 2020, but the Maintenance Director did not tell me that we needed to be on a fire watch. I am responsible for the building. My Maintenance Director spoke to the Fire Marshall, and he told me that he said that the pull station would still work, and we did not need to be on fire watch. I do not know the date he spoke with him. I think it was sometime in June after the 6/10/2021 inspection. I do not think any contact was made with the Fire Marshall prior to that. I do not have that in writing. I do not have any electronic mail from the Fire Marshall, and I do not have any documentation that the Fire Marshall was contacted. We do have a policy that states in the event of the fire system failure we will initiate a fire watch, that we should notify the fire department and the agency [Agency for Health Care Administration]. We did not begin a fire watch and we did not call the fire department or AHCA [Agency for Health Care Administration]. I was supposed to initiate a fire watch according to our policies and procedures. I was supposed to alert the Fire Marshall and notify the agency. I did not reach out to the Fire Marshall and verify the information provided to me by the Maintenance Director. We began training and the fire watch on 8/17/2021. We educated all staff on the fire watch. I'm not sure how many staff were trained. Staff are assigned to complete fire watch on each unit. We did not identify the number of residents that might be affected, we just noted that no residents were affected. This was not brought to the Quality Assurance and Performance Improvement committee (QAPI) and no plan of action or correction was started. I really just found out the seriousness of this on Tuesday. I have not had a QAPI emergency meeting yet, it is going to happen, but it hasn't yet. We were getting bids for the repairs, I just didn't think that it was this serious. I did not know that the fire alarm pull stations are not working. I did not follow the policy for QAPI and did not call an emergency meeting. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the Administrator Job Description dated 2/1/2013 reads Purpose of Your Job Position. The primary purpose of your position is to direct the day-to-day functions of the Facility in accordance with current federal, state and local standards guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times. Delegation of Authority. As Administrator you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties. Duties and Responsibilities. Administrative Functions. Plan, develop, organize, implement, evaluate, and direct the Facility's programs and activities in accordance with guidelines issued by the VP [Vice President] of Operations. Develop and maintain written policies and procedures and professional standards of practice that govern the operation of the Facility. Assist department directors in the development, use, and implementation of departmental policies and procedures and professional standards of practice. Committee Functions. Assist the Quality Assurance And Assessment Committee in developing and implementing appropriate plans of action to correct identified quality deficiencies. Safety and Sanitation. Ensure that all Facility personnel, residents, visitors, etc., follow established safety regulations, to include fire protection and prevention, smoking regulations, infection control, etc. Equipment and Supply Functions. Ensure that the Facility is maintained in a clean and safe manner for resident comfort and convenience by assuring that necessary equipment and supplies are maintained to perform such duties and services. The job description is signed by the Administrator. Review of the [Company's Name] fire alarm system service invoice report dated 9/3/2020 reads: Trouble shot panel and found all of loop 2 in trouble. Panel is bad and needs to be replaced. Review of the [Company's Name] fire alarm system service inspection and testing form dated 1/14/2021 at 8:30 AM reads Discrepancy list: Dialer trouble module 01-017, Loop 2 all devices communication error. Review of the [Company's Name] fire alarm system service inspection and testing form dated 6/10/2021 at 10:00 AM reads Discrepancy List: Dialer unplugged and not working. Loop #2 failed to function. See initiating device sheets for devices that failed to function. Need to be on fire watch. During a telephone interview on 08/20/21 at 11:00 AM, the President/CEO (Chief Executive Officer) of the monitoring company stated, The fire system that serves Loop 2 of the building is not functioning and none of the pull stations will dial the fire department and get them to the building. When we were there in January 2021, we recommended they provide a fire watch. We had been to the facility back in September 2020 or October 2020 and recommended a complete replacement of the system as Loop 2 was not functioning then. That would mean that pull stations would not dial the fire department. The dialer itself is not functioning and that would not dial the fire department. During a follow up telephone interview on 08/20/21 at 11:19 AM the service invoice report dated 9/3/2020 was read to the President/CEO of the monitoring company. It read as follows: Trouble shot panel and found all of Loop 2 in trouble. Panel is bad and needs to be replaced. The President/CEO stated, That means that Loop 2 was not working at all and needed to be replaced. The facility was told that they needed to be on fire watch at that time. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a follow up interview on 08/20/21 at 02:18 PM the Administrator stated, I was aware that the panel needed to be replaced and I was not sure what the report meant. Residents were possibly at risk for injury while the loop was not functional. Residents were possibly at risk for injury when we did not have the fire alarm system and they are possibly still at risk that is why we are getting a security company. During an interview on 08/20/21 at 3:10 PM, the Director of Nursing (DON) stated, I was not aware of any problems with the fire alarm system until a few days ago. We did not provide any training related to the fire alarms before a few days ago. It is conceivable that residents were at risk since the fire alarm system was broken. I was trained on the fire watch process and the training involved the policy. We should not have staff doing anything more than fire watch if that is what our policy says, so it is conceivable that residents are still at risk of harm. We should have known the seriousness of this before the survey started. This was not brought up in QAPI [Quality Assurance Performance Improvement]. I do not recall ever hearing that the fire pulls did not work and would not get the fire department. In an emergency staff would pull the fire alarm and start RACE [Rescue, Alarm, Confine, Extinguish] and PASS [Pull, Aim, Squeeze, Sweep] procedures. I'm not sure if they would have called 911. I would hope so, but in an emergency of a fire I just can't say. Review of the Director of Nursing Services Job Description dated 12/5/2018 reads Purpose of Your Job Position. The primary purpose of your position is to plan, organize, develop, and direct the overall operation of our Nursing Service Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern our Facility and as may be directed by the Administrator to ensure that the highest degree of quality care is maintained at all times. Duties and Responsibilities. Administrative Functions. Assist in developing and implementing appropriate plans of action to correct identified deficiencies. Safety and Sanitation: Assist in developing safety standards for the nursing service department. Ensure that the department's policy and procedure manuals identify safety precautions and equipment to use when performing tasks that could result in bodily injury. Develop, implement and maintain a procedure for reporting hazardous conditions or equipment. Job description was signed on 1/10/19 by the Director of Nursing Services. During an interview on 08/20/21 at 3:19 PM, the Maintenance Assistant stated, I did know that we needed to have the fire alarm panel replaced. I have never notified the Fire Marshal about any of this. I have never heard that we had to be on fire watch until you all came in. During an interview on 08/20/21 at 4:08 PM, the Regional Director of Plant Operations stated, We have completed testing of the alarms today and verified that the system was not alerting the fire department. We verified this with the monitoring company that the alarms we tested did not connect to the fire department. I was not aware of the extent of the malfunction and would have started fire watch immediately. All residents, staff, and visitors are at risk of injury if a fire had started, and staff did not understand that they needed to call 911 to get the fire department to respond. I was not aware that staff were doing their normal job duties and being assigned to fire watch. They should not be. (continued on next page)

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	105638	A. Building B. Wing	08/20/2021

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the Maintenance Supervisor Job Description dated 5/20/2005 reads Purpose of Your Job Position. The primary purpose of your position is to plan, organize, develop, and direct the overall operation of the Maintenance Department in accordance with current federal, state, and local standards guidelines, and regulations governing our Facility and as may be directed by the Administrator, to assure that out Facility is maintained in a clean, safe, and comfortable manner. Duties and Responsibilities. Plan, develop, organize, implement, evaluate, and direct the Maintenance Department, its programs and activities. Assume the administrative authority, responsibility, and accountability of directing the Maintenance Department. Make written oral reports and recommendations to the Administrator, as necessary or required, concerning the operation of the Maintenance Department. Keep abreast of economic conditions or situations and recommend to the Administrator adjustments in maintenance services that assure the continued ability to provide a clean, safe and comfortable environment. Committee Functions. Serve on various committees of the Facility (i.e. Infection Control, Safety, QA, etc.) and provide written or oral reports of maintenance services and activities as required by the committee's guidelines or direction. Evaluate and implement recommendations from established committees. Safety and Sanitation. Supervise safety and fire protection and prevention programs by inspecting work areas and equipment at least weekly. Ensure that maintenance personnel follow established safety regulations in the use of equipment and supplies at all times. Ensure that all supplies, equipment, etc. are maintained to provide a safe and comfortable environment. Promptly report equipment or Facility damage to the Administrator. Equipment and Supply Functions. Recommend to the Administrator the equipment and supply needs of the department. Make periodic rounds to check equipment and to assure the necessary equipment is available and working properly. Job description was signed on 2/14/15 by the Maintenance Director. Review of the training provided by the facility titled, Fire Watch dated 8/17/21 revealed 32 out of 145 staff attended the training totaling 22% of all staff. Review of the training titled Fire Watch/Call 911 dated 8/20/21 revealed 24 out of 145 staff attended the training totaling 38% of all staff. Sixty three percent (63%) of staff remained untrained in Fire Watch procedures. Review of the policy titled Quality Assurance and Performance Improvement (QAPI) Committee, dated July 2016, last reviewed 12/28/20 reads Policy Statement. This facility shall establish and maintain a Quality Assurance and Performance Improvement (QAPI) Committee that oversees the implementation of the QAPI Program. Policy Interpretation and Implementation. 1. The Administrator shall delegate the necessary authority for the QAPI committee to establish, maintain and oversee the QAPI program. 2 . The primary goals of the QAPI Committee are to: 1. Establish, maintain , and oversee facility systems and processes to support the delivery of quality of care and services. Review of the policy titled Abuse Protection and Response Policy, undated, last reviewed on 12/28/20, reads, The health center Administrator is responsible for assuring that patient safety, including freedom from risk of abuse, holds the highest priority. Definitions. Neglect: is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. (continued on next page)

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	105638	A. Building B. Wing	08/20/2021

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the Policy Number 13.04.07, titled Fire Watch, with an issue date of 3/18, last review on 12/28/2020, reads, Standards: Fire Watch: Guidelines: In the event of a failure of the fire alarm system, sprinkler system, the facility will initiate a fire watch. Guidelines: 1. Notify the local fire department and document instructions. 2. Notify the Agency through the area office. 3. Assess the extent of the condition and effect corrective action, with a documented time frame. If corrective action will take more than 4 hours, do the following: Implement a contingency plan to the facility fire plan containing: a description of the problem, specifically what the system is not doing that it normally does, and the projected correction time frame. All staff on shifts involved shall have documented in-service and drilling for the contingency. Begin a documented fire watch, until the system is restored. Persons used for fire watch will not be assigned to any other duty and must be trained in what to look for, what to do, and be able to expeditiously contact the fire department. 4. Maintenance Director will initiate 'fire watch'. If the maintenance director is not in the facility, the manager on duty or the charge nurse will initiate the 'fire watch'. Until staff (not on duty) or other contracted agency can be called to carry out the 'fire watch'. 5. The fire watch person will conduct a tour of the facility every 15 minutes. This tour will include checking each resident room, offices, closets, storage, common areas and mechanical rooms for signs of smoke, fire smoke, or fire hazards. Smoke from under a door, feel the door and handle for heat, if any exist, they will need to sound the alarm and call fire dept. 6. Announcements will be made to staff reminding them that the fire alarm or sprinkler is not working. 7. In the event if a fire watch person or any person discovers a fire in progress or smoke indicating fire, he/she will contact 911 and then the point of contact person (i.e. maintenance director or manager on duty or charge nurse) and report the fire to him/her. The fire watch person will stay at the scene and try to contain and/or extinguish the fire. 8. The point of contact will immediately call 911 (local fire department) and then announce over the facility intercom CODE RED (area of fire, i.e. RM 53). CODE RED (area of fire, i.e. RM 53), CODE RED (area of fire, i.e. RM 53). The point of contact person will ensure that the RACE procedure is followed. 9. The fire watch will continue until the fire alarm panel or sprinkler system is restored and tested in the presence of the Maintenance Director or Administrator. The fire department and local area office will be notified of the stand down of the fire watch. 10. In the event that there is a phone system failure in the facility, cell phones are available for the employee doing fire watch to be able to dial '911' in case of emergency. (continued on next page)

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	105638	A. Building B. Wing	08/20/2021

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the policy titled Fire Watch, revised in August 2018, last reviewed on 12/28/2020, reads, Policy statement: Fire watch procedures will be initiated if the fire alarm system fails. Policy interpretation and Implementation: 1. The purpose of the Fire Watch is to serve as a plan of correction should the fire alarm system fail to work properly to provide continuous facility wide fire detection and alarm capabilities. 2. A fire alarm system should include, but is not limited to, fire alarm panel, smoke or heat detection system, sprinkler system and for department notification system. 3. Fire alarm outages can occur during construction, renovation, electrical storms, component/system failure or unplanned events that eliminate a portion of or all of the fire alarm system. Emergency Procedure-Fire Watch. 1. Contact the Administrator, Director of Nursing, and Maintenance Director when any problems are encountered with the fire alarm system. 2. Contact the fire alarm company if the maintenance director or other responsible party is unable to correct the problem. 3. Notify the Fire Department and State Regulatory/Licensure Agency that the fire alarm system is not working correctly and that fire watch procedures are in place until the system is restored. 4. Report to the Incident Command Post for instruction. If warranted, based on the potential severity of the system failure, activate the ICS (Incident Command System) to manage the incident. The most qualified staff member (in regard to the Incident Command system) on duty at the time assumes the Incident Commander position. 5. Initiate fire watch tours throughout the facility. Fire watch tours occur at one-half hour intervals, 24 hours a day and consist of periodic walking tour of the entire facility by one or more assigned and trained staff. a. The fire watch staff monitors the facility through direct observation of all rooms, including resident rooms, mechanical and electrical rooms, kitchen laundry, etc. for all possible signs of fire. b. The fire watch staff documents fire watch tours with findings noting date, time and staff initials. c. The fire watch staff consists of personnel solely dedicated to the fire watch with no other facility related activities or events. 8. Do not terminate the Fire Watch until all fire protection equipment is in normal operating condition and upon authority of the Administrator/Incident commander or designee.

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	105638	A. Building B. Wing	08/20/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 34769 Based on observation, staff interview, and policy and procedure review, the quality assessment and assurance committee failed to develop and implement appropriate plans of action to correct the identified quality deficiencies of the nonfunctioning fire alarm system that is necessary to alert the monitoring company and the fire department in case of fire, and failed to implement a fire watch. Findings: During an observation on 8/17/2021 at 11:35 AM, while conducting a tour of the facility, in the Therapy room/fire alarm control panel area the control panel indicated a trouble mode. The control panel trouble light (orange) was illuminated, and the control panel was silent. The control panel was illuminated, but the panel was not sounding an audible noise to indicate the trouble mode. During an observation on 8/17/2021 at 2:05 PM the fire alarm system dialer was tested by unplugging the control panel battery (one of the two ways that the dialer unit can be tested). After waiting ten minutes for an audible/visual signal on the panel and a phone call from the monitoring company, the audible/visual signal nor the call from the monitoring company happened. During an observation on 8/17/2021 at 2:15 PM of the annunciator panel (secondary fire alarm panel) located in the main lobby showed the trouble light was also illuminated (orange). Review of the [Company's Name] fire alarm system service invoice report dated 9/3/2020 reads: Trouble shot panel and found all of loop 2 in trouble. Panel is bad and needs to be replaced. Review of the [Company's Name] fire alarm system service inspection and testing form dated 1/14/2021 at 8:30 AM reads Discrepancy list: Dialer trouble module 01-017, Loop 2 all devices communication error. Review of the [Company's Name] fire alarm system service inspection and testing form dated 6/10/2021 at 10:00 AM reads Discrepancy List: Dialer unplugged and not working. Loop #2 failed to function. See initiating device sheets for devices that failed to function. Need to be on fire watch. During an interview on 8/20/2021 at 10:15 AM the facility Administrator stated, I knew approximately in September 2020 that the control panel needed to be replaced, but I was not aware that we needed to be on fire watch. We did get a service call back in September 2020, but the Maintenance Director did not tell me that we needed to be on a fire watch. I am responsible for the building. This was not brought to the Quality Assurance and Performance Improvement committee (QAPI) and no plan of action or correction was started. I really just found out the seriousness of this on Tuesday. I have not had a QAPI emergency meeting yet, it is going to happen, but it hasn't yet. We were getting bids for the repairs. I just didn't think that it was this serious. I did not know that the fire alarm pull stations are not working. I did not follow the policy for QAPI and did not call an emergency meeting. (continued on next page)

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	105638	A. Building B. Wing	08/20/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a telephone interview on 08/20/21 at 11:00 AM, the President/CEO (Chief Executive Officer) of the monitoring company stated, The fire system that serves Loop 2 of the building is not functioning and none of the pull stations will dial the fire department and get them to the building. When we were there in January 2021, we recommended they provide a fire watch. We had been to the facility back in September 2020 or October 2020 and recommended a complete replacement of the system as Loop 2 was not functioning then. That would mean that pull stations would not dial the fire department. The dialer itself is not functioning and that would not dial the fire department. During a follow up telephone interview on 08/20/21 at 11:19 AM the service invoice report dated 9/3/2020 was read to the President/CEO of the monitoring company. It read as follows: Trouble shot panel and found all of Loop 2 in trouble. Panel is bad and needs to be replaced. The President/CEO stated, That means that Loop 2 was not working at all and needed to be replaced. The facility was told that they needed to be on fire watch at that time. During an interview on 08/20/21 at 02:47 PM, the Medical Director stated, We meet every quarter and had a QAPI meeting two months ago, we did not talk about fire alarms. I was not aware that there was anything wrong with the fire alarms. When we meet, we get updates related to any problems that there have been and any new concerns there are. I know the maintenance department reports every QAPI meeting, but I do not recall ever being told the fire alarms did not work. That is about all I can tell you. During an interview on 8/20/2021 at 4:08 PM, the Regional Director of Plant Operations stated, We have completed testing of the alarms today and verified that the system was not alerting the fire department. We verified this with the monitoring company that the alarms we tested did not connect to the fire department. I was not aware of the extent of the malfunction and would have started fire watch immediately. All residents, staff, and visitors are at risk of injury if a fire had started, and staff did not understand that they needed to call 911 to get the fire department to respond. I was not aware that staff were doing their normal job duties and being assigned to fire watch. They should not be. During an interview on 8/20/2021 at 3:10 PM, the Director of Nursing (DON) stated, I was not aware of any problems with the fire alarm system until a few days ago. We did not provide any training related to the fire alarms before a few days ago. It is conceivable that residents were at risk since the fire alarm system was broken. I was trained on the fire watch process and the training involved the policy. We should not have staff doing anything more than fire watch if that is what our policy says, so it is conceivable that residents are still at risk of harm. We should have known the seriousness of this before the survey started. I do not recall ever hearing that the fire pulls did not work and would not get the fire department. In an emergency staff would pull the fire alarm and start RACE [Rescue, Alarm, Confine, Extinguish] and PASS [Pull, Aim, Squeeze, Sweep] procedures. I'm not sure if they would have called 911. I would hope so, but in an emergency of a fire, I just can't say. This was not brought up in QAPI. Review of the policy titled Abuse Protection and Response Policy, undated, last reviewed on 12/28/20, reads, The health center Administrator is responsible for assuring that patient safety, including freedom from risk of abuse, holds the highest priority. Policy: Trends of investigative findings will be analyzed and addressed by the QA (Quality Assurance) and Risk Management committee process. (continued on next page)

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	105638	A. Building B. Wing	08/20/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the policy titled, Quality Assurance and Performance Improvement (QAPI) Committee, dated July 2016, last reviewed 12/28/20 reads Policy Statement. This facility shall establish and maintain a Quality Assurance and Performance Improvement (QAPI) Committee that oversees the implementation of the QAPI Program. Policy Interpretation and Implementation. 1. The Administrator shall delegate the necessary authority for the QAPI committee to establish, maintain and oversee the QAPI program. 2. The committee shall be a standing committee of the facility and shall report to the Administrator and Governing board (body). Goals of the Committee. The primary goals of the QAPI Committee are to: 1. Establish, maintain, and oversee facility systems and processes to support the delivery of quality of care and services. 2. Promote the consistent use of facility systems and processes during provision of care and services. 3. Help identify actual or potential negative outcomes relative to resident care and resolve them appropriately. 4. Support the root cause analysis to help identify where patterns of negative outcomes point to underlying systemic problems. 5. Help departments, consultants and ancillary services implement systems to correct potential and actual issues of quality of care. 6. Coordinate the development, implementation, monitoring and evaluation of performance improvement projects to achieve specific goals. 7. Coordinate and facilitate communication regarding the delivery of quality resident care within and among departments and services and between facility staff, residents, and family members. Committee Authority: 8. The QAPI committee advises the Administrator and owner and/or governing/board (body). Committee meetings. 1. The committee will meet monthly at an appointed time. 2. Special meetings may be called by the coordinator as needed to address issues that cannot be held until the next regularly scheduled meeting. Committee Audit Process. 2. The QAPI committee shall help various departments/committees/disciplines/individuals develop and implement plans of correction and monitoring approaches. These plans and approaches should include specific time frames for implementation and follow up. 3. The committee shall track the progress of any active plans of correction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105638	A. Building B. Wing	08/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parklands Care Center and Rehab	1000 SW 16th Ave Gainesville, FL 32601

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 - Many	Provide and implement an infection prevention and control program. 41334 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program to help prevent the possible development and transmission of communicable diseases and infections by not performing hand hygiene during medication administration. Findings: On 8/18/2021 at 4:10 PM, Staff P, Licensed Practical Nurse (LPN), was observed at the medication cart pouring medications. The LPN entered Resident #102's room. He did not perform hand hygiene when he entered the room. He administered the medications and returned to the medication cart without performing hand hygiene. On 8/18/2021 at 4:15 PM, Staff P, LPN, poured medications for Resident #91 without performing hand hygiene, entered the resident's room and administered the medications. He left the room and returned to the medication cart. He did not perform hand hygiene and began preparing medications for another resident. On 8/18/2021 at 4:27 PM, Staff P, LPN, poured medications for Resident #87 without performing hand hygiene. Staff P entered the resident's room without performing hand hygiene, went to the resident's bedside, administered the medications, and left the room. Staff P did not perform hand hygiene, and returned to the medication cart to prepare medications for another resident. On 8/18/2021 at 4:32 PM, Staff P, LPN, began to pour Resident #3's medications without performing hand hygiene. Staff P entered the resident's room and administered the oral medications without performing hand hygiene. The LPN donned gloves and performed an accucheck without performing hand hygiene. He removed the gloves, performed hand hygiene, and donned new gloves. He administered artificial tears, removed the gloves, went to medication cart, drew up insulin into a syringe, donned gloves without performing hand hygiene, and administered the insulin. Staff P doffed the gloves and returned to cart without performing hand hygiene. On 8/18/2021 at 4:42 PM, Staff P, LPN, began to pour medications for Resident #36 without performing hand hygiene. Staff P did not perform hand hygiene when entering the room. He administered the medication, left the room, returned to the medication cart to pour additional medications for other residents and did not perform hand hygiene. During an interview on 8/18/2021 at 4:45 PM, Staff P, LPN, stated, I should have used hand sanitizer before getting the medications and after I left the room. We should use hand sanitizer before we put on gloves and after we remove them. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 - Many	Review of the policy and procedure titled Infection Control Guidelines for all nursing procedures 2205 Med-Pass, revised in August 2012, reviewed on 12/28/2020, reads, General Guidelines: 1. Standard precautions will be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases . 3. In most situations, the preferred method of hand hygiene is the alcohol based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations: a. Before and after direct contact with residents . f. Before donning sterile gloves . h. Before preparing or handling medications . n. After removing gloves.