STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105299	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whispering Oaks	1514 E Chelsea St Tampa, FL 33610

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to prevent the right to be free from verbal abuse for one of three sampled residents (#3) related to verbal abuse during activities of daily living care. Findings included: Resident #3 was admitted on [DATE]. Review of the admission Record showed diagnoses included but not limited to spinal compression, functional quadriplegia, dysarthria and anarthria, spinal stenosis cervical region, muscle weakness, cognitive communication deficit, diabetes, joint contracture, chronic obstructive pulmonary disease, spondylosis with myelopathy of cervical region, pulmonary hypertension, generalized anxiety disorder, hypertension, and recurrent major depressive disorder. Review of the quarterly Minimum Data Set, dated [DATE] showed Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). Section GG Functional Abilities showed the resident was dependent for eating, toileting hygiene, bathing, and rolling on the bed.Review of the physician orders showed:Duloxetine HCl Oral Capsule Delayed Release Particles 60 MG daily for depression as of 05/24/25Duloxetine HCl Oral Capsule Delayed Release Particles 30 MG at bedtime for depression as of 08/08/25buspirone HCl Oral Tablet 7.5 MG BID for anxiety as of 08/08/25 to 11/07/25buspirone HCl Oral Tablet 10 MG bid for anxiety as of 11/07/25Vistaril Oral Capsule 50 MG every 8 hours as needed for anxiety for 14 days as of 11/12/25 Alprazolam Oral Tablet 1 MG every 24 hours as needed for anxiety for 14 days as of 11/12/25 Review of the progress notes showed:On 11/07/25, psychiatrist note, Patient seen at staff request following a reportable incident in which a staff member was reportedly rude and verbally inappropriate toward the patient. Patient is alert with speech impairment but able to speak very slowly. States he is still feeling upset with anxiety symptoms? Denies trauma-related symptoms. No suicidal or homicidal ideation reported.O: Objective: Patient alert, cooperative, and calm throughout visit. Communicates appropriately with slow speech and nodding head yes or no. No behavioral agitation, tearfulness, or withdrawal observed. Affect stable, mood appears euthymic. Patient is NOT in need of additional referral or follow up servicesIncrease Buspar 10mg BIDContinue Duloxetine 60 mg PO QD and 30 mg PO QHS for depression.Schedule regular follow-up appointments to reassess mood and treatment efficacy.Major Depressive Disorder and Generalized Anxiety Disorder? on Cymbalta 60 mg AM + 30 mg PM and Buspar 7.5 mg BID. No evidence of psychiatric decompensation related to the incident. Emotional response appropriate to situational stressor, he would like Buspar increased to 10mg bid for increased anxietyOn 11/12/25, psychiatrist note showed Resident is being seen for a follow-up psychiatric appointment and is noted to be a poor historian due to his expressive aphasia. During today's visit, he appeared drowsy and was not fully participating in the interview, having difficulty making his needs known. Despite these communication challenges, he reports himself to be doing fine and denies any mistreatment.He appears to be well cared for by facility staff with no signs or symptoms of caregiver neglect or concerning issues noted at this time. Generalized Anxiety disorder: - Start Alprazolam 1 mg PO every 24 hours PRN for 14 days (End date: 11/27/2025)- Start Vistaril 50 mg PO every 8 hours PRN for 14 days (End date: 11/27/2025)- Continue Buspirone 10 mg PO BID for anxiety.11/17/25, Resident denies any pain or discomfort. Resident is resting in bed with eyes (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	closed. Safety measures in place. Call light and bed control within reach of the left hand. I will continue to monitor. Review of the Trauma Informed Care on 11/11/25 showed --Has the resident ever been diagnosed with PTSD (Post Traumatic Stress Disorder) had a life altering event or life changing event? Yes. --If yes, what type of event? Had a life altering event. --Is there a smell, sound, touch, taste, sight or other sensation that causes a flashback or trigger? No.--Is the resident being seen by any of the following: psychologist and psychiatrist--Does he attend support groups? No. --Care Plan Update:Trauma Informed CareGoal: staff will assist in managing the resident's response to the trigger; staff will make efforts to avoid the flashback or trigger; the frequency or severity of my trauma related signs and symptoms will not increase.Interventions: coordinate psychology or psychiatric services on admission and as needed; coordinate support groups as requested; encourage to express feeling, concerns and thoughts; know what triggers are and minimize expose if possible; observe for reported symptoms of a trigger; provide with meaningful activities. Review of the PHQ-9 dated 1/11/15 showed minimal depression Little interest or pleasure in doing things-symptoms presence: Yes.Little interest our pleasure in doing things- symptom frequency. two to six days Feeling down, depressed, or hopeless - symptom present. Yes Feeling down, depressed or hopeless - symptom frequency. 2 to 6 days. Trouble falling or staying asleep, or sleeping too much- symptom present. Yes Trouble falling or staying asleep, or sleeping too much - symptom frequency. 7 to 11 days Review of the care plans showed:Trauma Informed Care-Had a life altering event. Interventions included but not limited to: coordinate psychology or psychiatric services on admission and as needed, encourage to express feeling, concerns and thoughts, observe for reported symptoms of a trigger. Resident #3 uses psychotropic medications related to anxiety. Interventions included but not limited to psychological services per order and prn, psychiatry services per order / prn/ protocol, use of psychotropic medications will be reviewed at least quarterly with the IDT/MD to review continued need for the medication and ensure lowest dose. Resident #3 uses psychotropic medications related to depression. Interventions included but not limited to monitor for psychotropic side effects, administer medications as ordered and observe/document for side effects and effectiveness. Activities of Daily Living (ADL): The Resident has an ADL Self Care Performance Deficit. Interventions included but not limited to: BED MOBILITY: Assist of x 2 to turn and/or reposition. During an interview on 11/19/25 at 11:00 a.m. Resident #3 was lying in bed with a brief in place and blankets. Resident #3 was able to put his bed up and down. Resident #3 had difficulty speaking. He nodded his head yes to the following questions: does the staff answers your call light; do you feel safe at the facility; does the staff treat you well; do they keep you dry? When asked if anyone else had verbally or physically abused him, he nodded no. He typed on his phone the following: Staff C, Certified Nursing Assistant (CNA) when told her to get my phone and call light she didn't and told me to get it myself and she closed the door, when I was yelling for the nurse she said see if you get any food, get it yourself and she knew I could not lift my right arm and then I was very scared because I didn't know what she was capable of because when she was trying to turn me she was yelling at me, you're not gonna break my fckn back and she rolled me with no assistance and I have pads underneath my bum because I have a bone spur on my tailbone and she never put that back I felt helpless and humiliated because I'm here for therapy and she knows that. Resident #3 stated the Nursing Home Administrator (NHA) and Director of Nursing (DON) spoke with him. He stated he feels safe here. He stated all the other staff was great. He stated he just started sleeping all night after the incident. He was sleeping before the incident. He stated he was just getting back to his normal self. During an interview on 11/19/25 at 12:45 p.m. Staff C, CNA via phone conversation stated she was assigned to Resident #3. She stated she fed him breakfast and lunch. She stated he said he did not want any more food that he was full. She stated no incident happened when turning him. She stated she talked about the resident with the NHA, and the Risk Manager and my union representative. She stated she knew Resident #3 was a little upset because he was staying in bed too long and the nurse and therapist talked to him about getting out of bed. Staff D, Licensed Practical Nurse (LPN), the (continued on next page)

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