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	02/12/2026

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

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to complete and submit for review the Pre-admission Screening and Resident Review (PASARR) Level II upon acquiring new or qualifying mental health diagnoses for 6 residents (#24, #7, #84, #6, #4 and #241) out of 11 residents sampled for PASARRs.Findings included: 1.) Review of the admission record for Resident #24 revealed the resident was admitted to the facility on [DATE] with diagnoses to include a primary diagnosis of schizophrenia, anxiety disorder, bipolar, major depressive disorder, and schizoaffective disorder. Review of the resident's record revealed a level I PASARR (Preadmission Screening and Resident Review) dated 12/5/23. The level I PASARR showed question 6 was marked No to indicate the individual did not have a serious mental illness. The review showed a level II PASARR was not submitted for consideration. 2.) Review of the admission record for Resident #7 revealed the resident was admitted to the facility on [DATE] with diagnosis to include Bipolar disorder, major depressive disorder, seizures, and personal history of traumatic brain injury (TBI). Review of a Level I PASARR for Resident #7 dated 10/30/24 reveled the seizure and TBI diagnosis were not checked. The level I PASARR showed question 6 was marked No to indicate the individual did not have a related neurocognitive disorder, a serious mental illness or intellectual disability. The review showed the level I PASARR was incomplete and level II PASARR was not submitted for consideration. Review of the resident's record revealed a level I PASARR (Preadmission Screening and Resident Review) dated 12/5/2023. The level I PASARR showed question 6 was marked No to indicate the individual did not have a serious mental illness. The review showed a level II PASARR was not submitted for consideration. 3. A record review for Resident #84's admission record revealed the resident was admitted with a primary diagnosis of Schizophrenia. Other diagnoses included generalized anxiety disorder, unspecified convulsions, cognitive communicative disorder, vascular dementia, epilepsy, and major depressive disorder. A review of resident #84's care plan revealed that resident #84 has or is suspected to have a serious mental illness, intellectual disability or other related conditions that require a PASARR level II. The care plan further asserts a goal that PASARR level II recommendations are established and carried (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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	out to attain or maintain the highest functional and emotional level. Interventions included psychiatric and psychological services as needed. A review of the PASARR level I screen for resident #84 revealed that the resident has confirmed or suspected mental illnesses with diagnoses of anxiety disorder, depressive disorder and schizophrenia checked. The diagnoses of epilepsy and dementia were not checked. The review showed a level II screen was not submitted for consideration. An interview was conducted with the social services director (SSD) on 02/12/26 at 2:19 p.m., revealed that they found issues with resident #84's PASARR screening. The SSD said schizophrenia was a serious mental health condition, and a PASARR level II screening should have been conducted. The SSD said that they were under the assumption the PASARR level II screening was completed but was unable to present the documentation to confirm the assumption. 4.) A review of Resident #6's admission record revealed an original admission date of 8/18/18 and a re-entry date of 7/17/24. Further review of the admission record revealed diagnoses to include bipolar disorder, current episode mixed, unspecified, major depressive disorder, recurrent, unspecified, other bipolar disorders and schizophrenia, unspecified. A review of Resident #6's Preadmission Screening and Resident Review (PASSAR) level I screen, dated 7/16/24, showed anxiety disorder, bipolar disorder, depressive disorder, and schizophrenia were marked. A level II evaluation/determination was not found in Resident #6's medical record or provided by the facility. 5.) A review of Resident #4s admission record revealed an initial admission date of 02/06/2018 with a readmission date of 5/25/2020. Further review of the admission record revealed diagnoses to include unspecified mood [affective] disorder, anxiety disorder unspecified, other seizures, unspecified psychosis not due to a substance or known physiological condition, major depressive disorder recurrent unspecified and impulse disorder unspecified.A review of Resident #4's Preadmission Screening and Resident Review (PASSAR) level I screen, dated 02/27/2025, did not have unspecified psychosis and epilepsy checked under mental illness (MI) or suspected MI. The review showed a Level II PASSAR was not submitted for consideration.6.) A review of Resident #241's admission record revealed an admission date of 01/26/2026. Further review of the admission record revealed diagnoses to include traumatic subdural hemorrhage with loss of consciousness status unknown sequela, bipolar disorder unspecified, alcohol abuse uncomplicated, schizophrenia unspecified, other seizures and insomnia unspecified. A review of Resident #241's Preadmission Screening and Resident Review (PASSAR) level I screen, dated 01/23/26, showed qualifying diagnoses were not marked under mental illness (MI) or suspected MI, and a level II was not submitted for consideration. On 0202/12/26 2:17 p.m., an interview was conducted with the Social Services Director (SSD). The SSD stated during the morning meetings, the team will look at the PASSAR(s) that are sent, review medical diagnoses and/or H&P (history and physical) to see if there's anything that needed to be changed. The SSD stated, if a change were needed, he would adjust/change, the PASSAR level I. The SSD stated, if there was an issue or something that would flag he would update the Level I, and he would submit for a Level II review. He clarified he would flag diagnoses such as schizophrenia, bipolar, and schizoaffective. He said if sometimes they don't flag to submit a level II PASSAR, he would still send it for review. The SSD stated the Director of Nursing DON or Assistant DON (ADON) would also review the PASSAR(s) to see if they needed to be updated or if they need a level II. The SSD stated SMI included schizophrenia and schizoaffective diagnoses. A review of the facility's policy titled, PASRR- Requirements for Completion, effective August 2025 showed the following (continued on next page)

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	policy statement: Pre-admission Screening & Resident Review (PASRR) - Preadmission screening will be conducted prior to admission as the PASRR process is a federally mandated pre-admission screening program (see 42 CFR 483.100) required to be performed on all individuals prior to admission to a Nursing Home. The screening is reviewed by Admissions for suspicion of serious mental illness and intellectual disability to ensure appropriate placement in the least restrictive environment and to identify the need to provide applicants with needed specialized services. PASRR screening applies to all new admissions into a Medicaid certified nursing facility and includes private pay, Medicare, and Medicaid admissions regardless of payer source. Procedure: This screening is typically done by discharge planners & hospital staff as a step in the discharge process. It is separate from a medical needs assessment, which most often occurs after a person applies for Medicaid, and is a required step to qualify for Medicaid long-term care assistance. 1. During the admissions process, Admissions will communicate with the facility regarding prospective admissions. A Level I PASRR will be provided prior to admission to the Skilled Nursing Facility. The facility administration will confirm that a Level I review has been completed prior to transfer to the SNF setting. 2. Determine if a serious mental illness and / or intellectual disability or a related condition exists while reviewing the PASRR form completed by the Acute Care Facility. (Trigger for Level II Completion) 3. If Serious Mental Illness or ID is indicated, determine if the resident will be admitted from a hospital for an acute care stay and the attending physician has certified that the individual is likely to require less than 30-days of Nursing Facility services. Assure that the certification is signed and dated. 4. If the Physician indicates the stay will likely be less than 30-days SNF services, the resident can be admitted to an SNF. If anticipated stay becomes longer than 30 days a Level II must be completed prior to day 40. Florida Specific Guidelines Florida Facilities (Form 004 Part A effective November 2014) Assure that sections 1-5 are completed prior to admission. If section TV (Provisional Admission) is applicable, the form is only valid if the MD has signed and dated the form. If the admission is a provisional admission, the Social Service Director must start a tickler file and assure the level II is completed within the state-specified time frame. Delirium - within seven (7) days of admission Caregiver respite within 14 days of admission Emergency placement within seven (7) days of admission 30-day hospital exemption within 30-40 days of admission If the preadmission screening requires a Level II evaluation submit all required documents to [contracted state review company] timely, so that a Level II can be completed within the required time frames.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure the Preadmission Screening and Resident Reviews (PASARRs) for residents with a mental disorder and individuals with intellectual disability with qualifying mental health diagnosis, were completed accurately for 5 residents (#7, #84, #11, #208, and #241) of 11 residents sampled.Findings included: 1. Review of the admission record for Resident #7 revealed the resident was admitted to the facility on [DATE] with diagnosis to include Bipolar disorder, major depressive disorder, seizures, and personal history of traumatic brain injury (TBI).Review of a Level I PASARR for Resident #7 dated 10/30/24 reveled in section B the seizure and TBI diagnoses were not checked. The level I PASARR showed question 6 was marked No to indicate the individual did not have a related neurocognitive disorder, a serious mental illness or intellectual disability. The review showed the level I PASARR was incomplete and level II PASARR was not submitted for consideration. 2. A record review for Resident #84's admission record revealed the resident was admitted with a primary diagnosis of Schizophrenia. Other diagnoses included generalized anxiety disorder, unspecified convulsions, cognitive communicative disorder, vascular dementia, epilepsy, and major depressive disorder.A review of resident #84's care plan revealed that resident #84 has or is suspected to have a serious mental illness, intellectual disability or other related conditions that require a PASARR level II. The care plan further asserts a goal that PASARR level II recommendations are established and carried out to attain or maintain the highest functional and emotional level. Interventions included psychiatric and psychological services as needed. A review of the PASARR level I screen for resident #84 revealed that the resident has confirmed or suspected mental illnesses with diagnoses of anxiety disorder, depressive disorder and schizophrenia checked. The diagnoses of epilepsy and dementia were not checked. The review showed a level II screen was not submitted for consideration. An interview with staff the social services director (SSD), revealed that they found issues with resident #84's PASARR screening. The SSD said schizophrenia was a serious mental health condition, and a PASARR level II screening should have been conducted. The SSD said that they were under the assumption the PASARR level II screening was completed but was unable to present the documentation to confirm the assumption. 3. A review of Resident #11's admission record revealed an original admission date of 6/27/25 and a re-entry date of 12/5/25. Further review of the admission record revealed diagnoses to include unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, other seizures, and depression, unspecified. A review of Resident #11's Preadmission Screening and Resident Review (PASSAR) level I screen, dated 6/26/25, showed no qualifying diagnoses were marked under mental illness (MI) or suspected MI. 4. A review of Resident #208's admission record revealed an admission date of 7/24/2025. Further review of the admission record revealed diagnoses to include other psychoactive substance dependence, in readmission, unspecified psychosis not due to a substance or known physiological condition, anxiety disorder unspecified, and adjustment disorder with depressed mood. A review of Resident #208's Preadmission Screening and Resident Review (PASSAR) level I screen, dated 7/22/2025, showed anxiety as the only qualifying diagnoses marked under mental illness (MI) (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	or suspected MI. 5. A review of Resident #241's admission record revealed an admission date of 01/26/2026. Further review of the admission record revealed diagnoses to include traumatic subdural hemorrhage with loss of consciousness status unknown sequela, bipolar disorder unspecified, alcohol abuse uncomplicated, schizophrenia unspecified, other seizures and insomnia unspecified. A review of Resident #241's admission record revealed an admission date of 01/26/2026. Further review of the admission record revealed diagnoses to include traumatic subdural hemorrhage with loss of consciousness status unknown sequela, bipolar disorder unspecified, alcohol abuse uncomplicated, schizophrenia unspecified, other seizures and insomnia unspecified. A review of Resident #241's Preadmission Screening and Resident Review (PASSAR) level I screen, dated 01/23/26, showed qualifying diagnoses were not marked under mental illness (MI) or suspected MI, and a level II was not submitted for consideration. On 02/12/26 2:17 p.m., an interview was conducted with the Social Services Director (SSD). The SSD stated during the morning meetings, the team will look at the PASSAR(s) that are sent, review medical diagnoses and/or H&P (history and physical) to see if there's anything that needed to be changed. The SSD stated, if a change were needed, he would adjust/change, the PASSAR level I. The SSD stated, if there was an issue or something that would flag he would update the Level I, and he would submit for a Level II review. He clarified he would flag diagnoses such as schizophrenia, bipolar, and schizoaffective. He said if sometimes they don't flag to submit a level II PASSAR, he would still send it for review. The SSD stated the Director of Nursing DON or Assistant DON (ADON) would also review the PASSAR(s) to see if they needed to be updated or if they need a level II. The SSD stated SMI included schizophrenia and schizoaffective diagnoses. A review of the facility's policy titled, PASRR- Requirements for Completion, effective August 2025 showed the following policy statement: Pre-admission Screening & Resident Review (PASRR) - Preadmission screening will be conducted prior to admission as the PASRR process is a federally mandated pre-admission screening program (see 42 CFR 483.100) required to be performed on all individuals prior to admission to a Nursing Home. The screening is reviewed by Admissions for suspicion of serious mental illness and intellectual disability to ensure appropriate placement in the least restrictive environment and to identify the need to provide applicants with needed specialized services. PASRR screening applies to all new admissions into a Medicaid certified nursing facility and includes private pay, Medicare, and Medicaid admissions regardless of payer source. Procedure: This screening is typically done by discharge planners & hospital staff as a step in the discharge process. It is separate from a medical needs assessment, which most often occurs after a person applies for Medicaid, and is a required step to qualify for Medicaid long-term care assistance. 1. During the admissions process, Admissions will communicate with the facility regarding prospective admissions. A Level I PASRR will be provided prior to admission to the Skilled Nursing Facility. The facility administration will confirm that a Level I review has been completed prior to transfer to the SNF setting. 2. Determine if a serious mental illness and / or intellectual disability or a related condition exists while reviewing the PASRR form completed by the Acute Care Facility. (Trigger for Level II Completion) 3. If Serious Mental Illness or ID is indicated, determine if the resident will be admitted from a hospital for an acute care stay and the attending physician has certified that the individual is likely to require less than 30-days of Nursing Facility services. Assure that the certification is signed and dated. 4. If the Physician indicates the stay will likely be less than 30-days SNF services, the resident can be admitted to an SNF. If anticipated stay becomes longer than 30 days a Level II must be completed prior to day 40. Florida Specific Guidelines Florida Facilities (Form 004 Part A effective November 2014) Assure that sections 1-5 are completed prior to admission. If section TV (Provisional Admission) is applicable, the form is only valid if the MD has signed and dated the form. If the admission is a provisional admission, the Social Service Director must start a tickler file and assure (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the level II is completed within the state-specified time frame. Delirium - within seven (7) days of admission Caregiver respite within 14 days of admission Emergency placement within seven (7) days of admission 30-day hospital exemption within 30-40 days of admission If the preadmission screening requires a Level II evaluation submit all required documents to [contracted state review company] timely, so that a Level II can be completed within the required time frames.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interview and facility policy review, the facility did not ensure the kitchen was maintained in a safe and sanitary manner related to food storage, cross contamination of food prep surfaces, general cleanliness and maintaining appropriate dishwashing sanitization levels in one kitchen (main) of one observed.Findings included: On 02/09/2026 at 8:39 AM to 9:15 AM a kitchen tour was conducted with the facility's Registered Dietician (RD) with the following observations made: An observation was made of brown-grease stains and built-up grime above the stove. The Kitchen Manager /Cook (KM) stated this was just from this morning. The RD stated, I see it. It should be clean. An observation was made of a personal water bottle on the Cook's prep station, noted half empty. The RD stated it should not be there and proceeded to remove it. An observation was made of a ceiling vent with dirt, debris and brown matter. The ceiling vent was located above the cooking area. The RD stated he would put in a work order to get it cleaned. An observation was made of the filter in the juice machine with dust, grime and debris. The RD stated he did not know who should be cleaning it. The floor area between the juice machine and the service table was observed with black substances of food particles, dust and debris. An observation was made of two employee jackets hanging on the clean dish rack, touching clean dishes. The RD stated they should not be hanging there and proceeded to remove them. An observation was made of deserts on a cart in a hallway outside the cooler. The RD stated the desert was pears to be served for lunch and they should be stored in the cooler. A tour of the kitchen walk in cooler revealed a box with bags of lettuce, observed wilted, discolored with white bio growth. The RD stated they would discard these items. In the walk-in cooler an observation was made of food boxes with brown- sticky residue on the box. The RD stated he was not sure what it was but would remove it. An observation was made of a log of meat labeled, Ham, dated 2/3/26. The meat was in the middle shelf and not on a tray. The RD stated the ham should be thrown out adding, it is no longer good. He stated cooked foods should not be served after three days. He confirmed the ham was cooked on 2/3/26. An observation was made of numerous plated salads dated 2/2/26 - 2/5/26. The RD stated the salad should have been thrown out on 2/5/26. An observation was made of an undated tray with served portions of ice-cream and brown cake. The RD stated the desserts were to be served later on this day. The RD could not confirm when the desserts were prepared. He stated there should be a date and time. An observation was made of raw chicken stored on the top shelf dated 2/6. The meat was not set on a tray and was directly above food boxes. He stated it would not be at risk of contamination because it was still frozen. On 02/11/2026 at 11:54 AM a second tour of the kitchen was conducted with the RD with the following observations made: Observations were made of the previously observed ceiling vents noted with built in dust, grime and debris, The RD stated, They are not cleaned yet. A temperature check of the milk being served was conducted the milk temperature reading showing 42.4 degrees. The RD stated cold foods should be served at 41 degrees. The RD instructed the aide to add ice on top. An observation was made of an employee's jacket hanging on a chair near the stove with boiled eggs set on top of it and a muffin pan touching the surface. The RD stated that it was unsanitary. He stated employee's personal items should not be in food service/prep areas. He proceeded to remove the eggs. An observation was made of unsanitary dishwashing rags and used cleaning sponges, observed discolored and with brown surfaces. The RD stated, Yes, we should remove those. They would cause cross contamination. An observation was made of a food service utility cart with pieces of napkins and food pieces on the surface. The cart was observed with debris. The RD stated this was a cart for holding dirty dishes cart. He stated nonetheless, the carts should be wiped down daily. On 02/11/2026 at 12:05 PM, an interview and observation was conducted with Staff X, Dietary Aide. Staff X was observed at the dishwashing compartment prepping the sink. He stated prior to washing dishes, he tests the water temp. He did not identify the need to test the sanitization. He stated he never tested the water before. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff X did not know what the required level was. On 02/11/2026 at12:08 PM, The RD was observed running the dish machine, he stated this was a low temp dish machine. He stated they monitor the sanitization levels. He ran the dishes and tested the sanitizer levels, and the test strip came out with no color. He primed the machine and ran it again. He repeated the process 7 times and each time the color was white, meaning there was not enough sanitizer in the washing solution. He stated he was looking for a purple color. On 02/11/2026 at 12:14 PM, The Regional RD proceeded to assist the RD with testing. He stated the buckets should be primed and the levels tested each time. He proceeded to change the sanitization bucket and primed the dish machine at which the machine levels tested between 50 -100 PPM (parts per million). He stated if the test strip showed no color or white, it meant the concentration was too low, which would be considered unsafe. An interview with the Kitchen Manager on 02/11/2026 at 12:18 PM revealed they would re-wash the dishes that were ran previously. He stated the residents should be served in clean, sanitary dishes. On 02/12/2026 at 1:14 PM, an interview was conducted with the RD. He stated their plan was to avoid food borne contamination. He stated employee clothing coats/jackets and personal items should not be in food prep or storage areas. The RD stated the staff were in serviced, and they should test the water for acceptable PPM every time they change it. he stated they should make sure it is not too high or too low.Review of a facility policy titled, Policy and Procedure - Storage, dated June 2024, revealed 3. Label products with delivery date indicating month and year the product was received.7. Discard leftovers per use by date.8. Cover all prepared items with plastic wrap or foil to prevent off-flavors, drying, and/or cross-contamination.9.Label all prepared items with the product name, preparation date and use by date.Refrigerator Storage1.Store perishable foods in refrigerator and/or foods marked Keep Refrigerated by the manufacturer.2. Maintain refrigerator at a temperature of34-38 degrees F to maintain the food temperature at 41 degrees For less.The facility provided a daily cleaning checklist but not a policy regarding maintaining a clan safe and sanitary kitchen.Photographic Evidence Obtained.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to maintain an effective infection prevention and control program to control the spread on infection related to: 1. failing to ensure the proper isolation signage was posted for one (Resident #246) of five residents sampled; 2. failing to ensure personal protective equipment (PPE) was available and hand hygiene was performed in room [ROOM NUMBER]; 3. failing to ensure proper placement of medical equipment to prevent infection; and 4: failing to ensure 3 (Staff U, Staff V, and the DON) of 3 staff fingernails did not create a safety or infection control issue.Findings include: 1. Resident #246 was observed in her room resting in bed. An observation was made of a Contact Precautions sign posted on the door. There was no PPE (Personal Protective Equipment) observed on the door or nearby. The sign revealed a STOP sign with the following information:Everyone must: Clean their hands, including before entering and when leaving the room. Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gone before room exit. Use dedicated or disposable equipment clean and disinfect reusable equipment before you use on another person. On 02/09/2026 at 12:43 p.m. an interview was conducted with Staff V, Registered Nurse (RN). She stated Resident #246 was newly admitted and was on contact precautions for ESBL (Extended-Spectrum Beta-Lactamase). Staff V, RN stated the resident arrived the previous day at 4:30 PM. She confirmed there was no PPE available for staff to use throughout the night and earlier that morning. She stated the staff should wear full PPE for direct care contact. On 02/10/2026 at 1:35 p.m. an observation was made of Staff W, Certified Nursing Assistant (CNA) walking into Resident #246's room. An observation was made of an over-the door PPE shelf storage with gloves and gowns. Staff W proceeded to assist the resident with meal. The Staff member did not wash hands, don gloves or gown. Staff W was observed moving a chair and using a paper towel to grab it, placing in it in the middle of the shared room after assisting Resident #246 with her meal. On 02/10/2026 at 1:41 p.m. an interview was conducted with Staff W, CNA. She confirmed she did not wear gown a gown or gloves when feeding Resident #246. Staff W stated as she read the sign on the door, I should have worn gloves and gown. On 02/10/2026 at 1:45 p.m. an interview was conducted with Staff M, Licensed Practical Nurse (LPN)/Unit Manager (UM). She stated prior to entering the room, staff should wash hands and pay attention to what is on the door. Staff M LPN/UM stated for contact precautions the staff should wear gown and gloves when working directly with patient to include assisting the resident with meal. 2. On 2/9/2026 at 7:42 a.m., an observation of room [ROOM NUMBER]'s door revealed a sign that showed contact precautions with a caddy hanging that contained gowns. An observation of Staff A, Certified Nursing Assistant (CNA) revealed she entered room [ROOM NUMBER] without performing hand hygiene or putting on personal protective equipment (PPE). Staff A, CNA was observed walking to bed B and touched the bedside table, eyeglasses, and telephone. She then walked to bed C and touched the resident's blanket. Further observations of Staff A, CNA revealed she walked to bed A and touched the Styrofoam cup with water on the resident's bedside table. Staff A, CNA was (continued on next page)

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	105299	A. Building B. Wing	02/12/2026

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed exiting the room and did not perform hand hygiene. On 2/9/2026 at 7:46 a.m., an interview was conducted with Staff A, CNA. She said the residents in bed B and bed C are on contact precautions. She said she wore gloves and PPE when she performed direct patient care. Staff A, CNA said she was adjusting the resident's items, which did not require her to wear gloves. On 2/9/2026 at 9:25 a.m., a second observation of Staff A, CNA was conducted. She went into room [ROOM NUMBER] with no PPE on, which had a contact precaution sign on the door. Further observations revealed she went to bed A, then exited the room. Staff A, CNA entered room [ROOM NUMBER] again with no PPE on. She was observed leaving the room with a resident's meal tray. 3. On 2/9/2026 at 1:04 p.m., Resident #16 was observed lying down in bed. Further observations of the area around the resident's bed revealed the connected humidifier reservoir for Resident #16's tracheostomy was in the garbage can. Photographic evidence obtained. On 2/9/26 at 1:05 p.m., an observation of room [ROOM NUMBER] revealed the resident in bed B was requesting to be assisted into bed. Staff B, Registered Nurse (RN) entered the room to assist the resident and was observed putting gloves on, however no other PPE was put on. On 2/9/26 at 1:15 p.m., an interview was conducted with Staff C, Licensed Practical Nurse (LPN). She said the bag in the middle of the humidifier is to collect fluid from the condensation. Staff C, LPN said it is not a closed system because once the bag is full, she can exchange out the bag and keep the tubing connected to the resident and the humidifier. Staff C, LPN said proper placement for the bag should not be on the ground. Staff C, LPN confirmed the humidifier bag should not be in a garbage can. A review of Resident #16's admission record revealed an initial admission of 1/15/25 and a re-admission date of 7/26/25. Further review of the admission record revealed diagnoses to include chronic respiratory failure, unspecified whether with hypoxia or hypercapnia, chronic obstructive pulmonary disease, unspecified, other diseases of larynx, bronchitis, not specified as acute or chronic and malignant neoplasm of larynx, unspecified. A review of Resident #16's physician orders included the following: - Transmission Based Precautions Contact Precautions: trach [tracheostomy] infection every shift until 02/14/2026, with an order date of 2/10/26. - Cefdinir Oral Suspension Reconstituted 250 MG [milligrams]/5ML [milliliters] (Cefdinir) Give 6 ml via G-Tube [gastrostomy tube] two times a day for Trach infection for 10 Days, with an order date of 1/31/26. A review of Resident #16's care plan included the following: - The resident had a surgical infection, to trach and requires Contact Precaution, with an initiated date (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of 2/6/26. Further review showed goals to include, To minimize the Spread of Infection, and interventions to include, Contact Precautions. - Behavioral: [Resident #16] is noted with the following behaviors: noncompliant with NPO [nothing by mouth] status, refuses to be suctioned, noncompliant with using walker, refuses to sleep with dehumidifier at times Res: [resident] Is noncompliant with removing his oxygen and trach and NPO status, with an initiated date of 1/27/26. On 2/11/2026 at 10:05 a.m., an interview was conducted with Staff B, RN. She said enhanced barrier precautions is an intervention as they protect staff from carrying something on their clothes. Staff B, RN said she would wear PPE if a resident had a wound, foley, tracheostomy, or G-tube. She said she wore a gown and gloves when residents are on precautions such as enhanced barrier and contact. On 2/11/2026 at 10:30 a.m., an interview was conducted with Staff D, RN/Unit Manager (UM). She said she expected staff to follow the recommendations on the signage for contact precaution. Staff D, RN/UM said staff should wear a gown, mask, glove or face shield. 4. An observation on 2/9/2026 at 9:15 a.m. of the DON revealed long-tan colored nails with rhinestones. Her nails appear to be around ¾ beyond the fingertip. An observation and interview on 2/12/2026 at 12:55 p.m. with Staff U, Licensed Practical Nurse (LPN) was conducted. Staff U, LPN was observed with not natural, painted white French-tip style, and contained rhinestones. Staff U, LPN said the facility educated that staff should have natural nails and only 1/4 long, but it is not enforced. An observation and interview on 2/12/2026 at 1:08 p.m. with Staff V, Registered Nurse (RN), was conducted. Staff V, RN was observed with not natural, painted red French-tip style, and extended beyond 1/4 long. Staff V, RN said her nails are too long, but the policy is not enforced. An interview on 2/12/2026 at 10:36 a.m. with the DON regarding her fingernails. The DON said she does not do direct care. The DON said the direct care staff should not have long nails. The DON stated, I said I got the point, they are long. A review of the facility provided Employee Handbook revealed on page 30 a section titled, Personal Hygiene & Dress Code. The personal hygiene and dress code revealed: The facility requires that all employees present a professional image. Accordingly, each employee is expected to wear appropriate business attire for his or his position while representing the facility. The following are general guidelines to be adhered to by all employees: Personal Hygiene 5: Fingernails should be kept neat, clean, and nails short so not to create safety or infection control issues. No artificial nails, appliqués, or studs on nails may be worn at any time. A review of a facility provided policy effective October 2021 titled, Isolation Precautions – Categories of Transmission-Based Infections revealed the policy is In addition to Standard Precautions, implement Contact Precautions for resident known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. C: Gloves and Handwashing; 1: While caring for a resident, change gloves after having contact with infective (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	material (for example, fecal material and wound drainage). 2: Removed gloves before leaving the room and wash hand with an antimicrobial agent or a waterless antiseptic agent. 3: After removing gloves and washing hands, do not touch potentially contaminated environmental surfaces or items in the resident's room. D: Gown; 1: In addition to wearing a gown as outlined under Standard Precautions, wear a gown (clean, nonsterile) for interactions that may involve contact with the resident or potentially contaminated items in the resident's environment. Remove the gown and perform hand hygiene before leaving the resident's environment. 2: After removing the gown, do not allow clothing to contact potentially contaminated environmental surfaces.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility did not ensure an assessment for self-administration related to enteral feedings was completed for one resident (#16) out of one resident reviewed.Findings included: On 02/10/2026 at 4:15 p.m., a medication administration was observed for Resident #16 by assigned nurse, Staff Q, Registered Nurse (RN). On 02/10/2026 at 5:10 p.m., an observation and interview was conducted with Resident #16 in his room. Resident #16 stated he had not received his 4:00 p.m. scheduled dose of Jevity. The resident stated he would take care of it. Resident #16 was observed walking to the sink, filling a cup with tap water, returned to his bed, sat on the edge and opened a small commercial eight-ounce container of Jevity 1.5, and poured into another cup. An observation was made of Resident#16's bedside table with three unopened boxes of Jevity 1.5 eight-ounce containers. Resident #16 was observed administering his Jevity along with flushes of water. Resident #16 stated he normally gives himself his enteral feedings and water. Resident #16 stated sometimes the nurse would check in to see if he took his Jevity and the other half do not check in with him. Resident #16 could not state how often he would take the Jevity but stated he usually takes his feedings when he was due for medication. A review of Resident #16's admission record showed an original admit date of 01/15/2025 with a readmission date of 7/2/2025 with diagnoses to include but not limited to: dysphagia, oropharyngeal phase, gastrostomy status, other disease of the larynx, and adult failure to thrive.A record review of Resident #16's physician orders include but not limited to:- Enteral feed order six times a day enteral feed: Jevity 1.5 cal. (calorie) 8oz (ounces) ARC(reference to commercial enteral feeding) bolus PEG (percutaneous endoscopic gastrostomy) tube. Administer 237 ml (milliliters) bolus 6 times per 24 hours during waking hours. Total volume to infuse 1422 ml/24 hours, ordered 7/28/2025-Delegate to dietitian the responsibility to alter, change, or modify dietary orders including oral supplements, measured of height and weight, modification to or addition of diet restrictions/therapeutics, downgrade of diet consistency in consultation with SLP (Speech-Language Pathology) when needed, enteral feeding and water flushes, ordered 7/28/2025.- NPO (nothing by mouth) diet, ordered 7/26/2025.- Evaluate for displacement of tube (PEG) by observing for abdominal distress, nausea/vomiting, pain, distention. If displacement is suspected, clamp tube and call MD every shift, ordered 7/26/2025.- Flush enteral tube (PEG) with 250 ml of water every 4 hours for patency and hydration, ordered 8/01/2025.A record review of Resident #16's Self-Administration of Mediation Resident assessment dated [DATE] and a locked date of 9/26/2025, showed in Section A (mental assessment). Question 6- Can state what time or how often is to be taken? The assessment was checked no . Question 7- Remembers to take medication- the assessment was checked no. Section B (physical assessment): Question 5- Can correctly measure the appropriate amount of medication from the container- the assessment was checked no. Question 15- The resident is deemed able to safely self-administer medications and that it is clinically appropriate- the assessment was checked no. On 02/11/2026 at 10:36 a.m., an interview was conducted with the Registered Dietician (RD). The RD stated he was not aware of Resident #16 self-administering his bolus feedings nor had the resident told the RD he was taking his own bolus feedings. The RD stated if a physician order for bolus feedings was given, then the nurse would be the one to administer. A record review of Resident #16's care plan showed the following focus area: Tube feeding: [Resident #16] is receiving enteral nutrition because of dysphagia, initiated 01/16/2025 with the following interventions to include but not limited to: Administration of enteral nutrition as ordered (refer to MD (physician) orders for current orders). Administration of flushes as ordered (refer to MD orders for current orders). Observe/document /report to MD PRN (as needed) aspiration-fever, SOB (shortness of breath) tube dislodged, infection at tube site, tube dysfunction or malfunction, abnormal breath/lung sounds.On 02/11/2026 at 1:28 p.m., an interview was conducted with the primary Advanced Registered Nurse Practitioner (ARNP) (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for Resident #16. The ARNP stated, when an order is placed for enteral feeding boluses, the order would be for the nurses to implement. On 02/11/2026 at 11:49 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated she was unaware of Resident #16 self-administering his enteral feedings/boluses. The DON stated residents should be assessed for appropriate self-administering medication, the IDT (interdisciplinary team) input, and a physician order would be required. A review of the facility's policy titled, Medication Administration Self-Administration by Resident initiated on 11/17 showed the following policy statement:Residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team has determined that the practice would be safe and the medications are appropriate and safe for self-administration. Procedures to include but not limited to:1. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility, during the care planning process. 2. The interdisciplinary team determines the resident's ability to self-administer medications by means of a skill assessment conducted as part of the care plan process.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations interviews and record review, the facility failed to ensure a safe environment was provided related to the use of a fan for one resident (#34) out of one resident observed.Findings included: An observation and interview on 2/9/2026 at 8:35 A.M. revealed Resident #34 lying in bed. A box fan approximately 21-23 inches in height was observed in between the resident's headboard and pillow. The pillow was observed resting on the box fan, next to the resident's head. The box fan was not running at the time. Resident #34 said he liked the fan there because he gets hot and cold quickly, so it's easy for him to reach it and turn it on or off.An observation on 2/10/2026 at 10:05 A.M. and on 2/11/2026 at 10:40 A.M. of Resident #34's bed revealed the box fan in between his headboard and his pillow as previously observed.A review of Resident #34's admission record revealed the resident was admitted on [DATE] and included diagnoses not limited to muscle weakness (generalized) and need for assistance with personal care. A review of Resident #34's brief interview for mental status (BIMS) score conducted on 12/21/2025 revealed a score of 15 indicating Resident #34 is cognitively intact.An interview on 2/11/2026 at 10:42 A.M. with Staff J, Registered Nurse (RN)/ Unit Manager (UM) was conducted. He observed the fan and stated the placement of the fan is, Not good, it's a risk. Staff J, UM said the placement of the fan is a problem as it was too close to the resident and the rotating blades could cause injury if touched accidentally. Staff J, stated, it's not safe.An interview on 2/11/2026 at 10:50 A.M. with [NAME] President of Operations (VPO) and Assistant Nursing Home Administrator (ANHA) was conducted. The VPO and ANHA said they observed the fan and they did not like the placement of the fan and it should be moved. The VPO said the fan placement was a safety concern because of the distance, how close it was to the resident's body. The ANHA said the fan should not be placed on Resident #34's bed.Review of a facility policy titled, Free of Accident Hazards/Supervision/Devices, effective September 2025, revealed: The facility shall ensure that patient-centered care and services are provided to residents in accordance with each resident's preferences and goals, and in accordance with professional standards of practice that meet each resident's physical, mental, and psychosocial needs. The procedure included: 1.The facility shall ensure that: a. The resident environment remains free of accident hazards to the extent possible. b. Each resident receives supervision and assistance to prevent accidents to the extent possible.

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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** Based on observations, interviews, and record reviews, the facility failed to update and implement an individualized person-centered care plan related to an indwelling urinary catheter device for one resident (#12) of one resident reviewed.Findings included:An observation on 2/9/2026 at 9:00 A.M. revealed Resident #12 sleeping in bed with street clothes on. The resident was observed with a urinary catheter hanging and draining at the side of the bed.A review of Resident #12's admission record revealed the resident was admitted on [DATE] and included diagnoses not limited to obstructive and reflux uropathy, specified disorders of urethra, and benign prostatic hyperplasia.A review of Resident #12's minimum data set (MDS) dated [DATE] revealed the resident had a brief interview for mental status (BIMS) score of 15 indicating Resident #12 is cognitively intact. Section H revealed under Bladder and Bowel the resident had an indwelling catheter.A review of Resident #12's progress notes related to urinary catheter revealed the following:On 1/9/2026 at 10:48 p.m. the nurse wrote- Received new orders from NP (Nurse Practitioner) to straight cath (Catheterize)and if greater than 500mL (milliliters), leave foley (indwelling urinary catheter) in. Care continued.On 1/9/2026 at 11:25 p.m. the nurse wrote - Straight cath'ed (catheterized) the resident. Over 700mL of yellow urine. Notified NP. Left foley in as ordered. Orders in [documentation software]. Care ongoing.A review of Resident #12's care plan revealed there was no care plan area related to an indwelling urinary catheter. An interview was conducted on 2/11/2026 at 2:08 P.M. with Staff K, Licensed Practical Nurse (LPN). Staff K, LPN said care plans are updated with every quarterly MDS assessment and if a significant change occurs. Staff K, LPN said Resident #12 had a significant change on 1/9/2026 and his care plan should have been updated during that time.An interview was conducted on 2/11/2026 at 2:55 P.M. with Staff L, Clinical Reimbursement Director (CRD). Staff L, CRD said the interdisciplinary team (IDT) meets every morning and reviews the order listing report for the past 24 hours or 72 hours. Staff L, CDR said based on that information, care plans are updated. Staff L, CDR said Resident #12's indwelling urinary catheter orders were overlooked during the IDT meeting, and his care plan had not been updated.A review of a care plan audit report for Resident #12 revealed a care area related to indwelling urinary catheter had been created on 1/9/2021 and resolved on 12/20/2022.Review of a facility policy effective February 2024, titled, Care Plan - Interdisciplinary Plan of Care from Interim to Meeting revealed a policy - The facility shall support that each resident must receive, and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The facility shall assess and address care issues that are relevant to individual residents, to include, but may not be limited to, monitoring resident condition, and responding with appropriate interventions. The care plan is reviewed and revised periodically, and the services provided or arranged are consistent with each resident's written plan of care.The policy's procedure was, 2: Update to care plans: a: ongoing updates to care plans are added by a member of the IDT (interdisciplinary team), as needed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review, and interview, the facility failed to provide residents who are unable to carry out activities of daily living (ADLs) the necessary services to maintain good grooming and personal hygiene for two (#84 and #151) out of three sampled residents. Findings included: On 02/09/2026 at 8:19 AM an observation of Resident #84 having long and overgrown nails. Resident #84's nails were about half an inch past the fingertips. Review of Resident #84's medical record revealed medical diagnoses of schizophrenia, other drug induced secondary parkinsonism, muscle wasting and atrophy, weakness, cognitive communications deficit, muscle weakness (generalized), and vascular dementia with unspecified severity, without behavioral disturbance, mood disturbance, and anxiety. Review of Resident #84's medical record revealed a Brief Interview for Mental status (BIMS) score of 00. A BIMS score of 00 indicates severe cognitive impairment. Resident #84 required partial/moderate assistance for personal hygiene. Partial/moderate assistance is described as the helper does less than half of the effort. The helper lifts, holds, or supports, trunk or limbs, but provides less than half the effort. Personal hygiene is defined as the ability to maintain personal hygiene including combing hair, shaving, applying makeup, washing/drying face and hands (excludes, baths, showers, and oral hygiene). Resident #84 would require a helper in order to have trimmed nails. Nail care records for Resident #84 revealed no nail care was provided on01/22/2026 at 8:40 PM and nail care provided on 02/10/2026 at 1:46 PM. Personal hygiene records for Resident #84 revealed personal hygiene care was completed from 01/14/2026- 02/12/2026. There were no documented refusals of care found. Review of Resident #84's care plan revealed a focus area for, ADL self-care performance deficit as evidenced by: impaired cognition, impaired balance, and impaired vision. The interventions that were implemented to mediate this deficit were as follows: observe for pain during activity and report to nursing if noted, physical, speech, and occupational therapies to evaluate and treat per orders, call bell within reach while in room/bathroom/shower room, and remind Resident #84 to use the call bell light, supervision for locomotion, one staff assist for personal hygiene, provide cues, and segment tasks as needed, provide/encourage Resident #84 to accept assistance as necessary to ensure task successfully completed. Additional interventions included: discuss resident preferences for time or routine changes in daily activities and honor the resident within reasonableness if Resident #84 refused care, report changes in ADL performance to nursing, and observe/report changes in ADL ability, any potential for improvement, and/or reasons for inability to perform ADLs to licensed nursing staff as needed. An interview and observation occurred on 02/09/2026 at 12:05 PM Resident #151 with facial hair on the upper lip and chin/neck area, approximately a quarter of an inch long. Resident #151 stated having ear pain due to needing to be cleaned. Review of Resident #151's medical records revealed medical diagnoses of other lack of coordination, weakness (generalized), peripheral vascular disease, atherosclerotic heart disease of native coronary artery without angina pectoris, dizziness and giddiness, syncope and collapse, type 2 diabetes mellitus without complications, legal blindness, as defined in USA, and age related physical debility. Review of Resident #151 medical record revealed a BIMS score of 14, indicating Resident #151 was cognitively intact with little to no memory or thinking impairment. Resident #151 required substantial/maximal assistance for personal hygiene care. Substantial/maximal assistance is described as the helper does more than half of the effort, additionally, the helper lifts or holds the trunk or limbs and provides more than half of the effort. Resident #151 would require a helper in order to have clean ears and a shaved face. Personal hygiene records for Resident #151 revealed that they were provided with personal hygiene care from 01/30/2026- 02/12/2026. There was no documented refusals of care. Review of Resident #151's personal hygiene task revealed documented completion of the task at 1:48 PM on 02/10/2026. Review of Resident #151's care plan revealed a focus area for ADL self-care performance deficit. The interventions implemented to mediate this deficit include the following: the call bell should be within reach in room/bathroom/shower and remind the resident to (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	use the call bell light, assistance from one staff for personal hygiene tasks, limitations to range of motion in the resident's upper extremity, encourage/provide passive/active assistance with routine care withing their physical capacity, and report changes in ADL performance to nursing. During an interview on 02/10/2026 at 1:39 PM Staff H, Certified Nursing Assistant (CNA), stated when providing personal hygiene care to residents, they are expected to shave the resident's face, wash their face, brush their teeth, and wash their hair. Staff H, stated Resident #84 and Resident #151 have not refused care when she has been assigned to the residents. Staff H stated Resident #84, is able to use verbal communication to express likes and dislikes. Staff H said that when Resident #84 wants something, they are able to make it known. Staff H said that Resident #84's shower days are Tuesday, Thursday, and Saturday. Staff H said she is unaware if Resident #151 normally gets her face shaved. Staff H said that most residents are dependent on staff for assistance with shaving, and few are able to shave themselves independently. An interview was conducted with Staff G, Licensed Practical Nurse (LPN) on 02/10/2026 at 12:52 PM. Staff G, LPN said the expectation for ADL care is each resident receive a baths/showers on their assigned days. Each resident should receive oral care, everyday along with their faces washed, proper feeding, and their hair combed/brushed. An observation was made with Staff G of Resident #84. Staff G said that Resident #84's nails were long and that it was time for a trim. Staff G said there were no shower sheets in any residents' electronic medical record. Staff G said that Resident #84 should receive nail care as needed. Staff G, LPN said that CNAs are responsible for nail care. Staff G said that she is not aware of Resident #84 refusing any care and Resident #84 verbally communicates his wants and needs. Staff G said that Resident #84's ADLs are steady. Staff G, LPN, said that residents should have their ears cleaned during ADL care and/or their shower days, and did not know of Resident #151 reporting any pain. Staff G said Resident #151 is not known to refuse care. During the interview Staff G, LPN observed Resident #151's facial hair and asked Resident #151 about her ear pain. Staff G, LPN said she would look into ear cleaning and facial hair removal. Staff G, LPN said there were no shower sheets in any residents' electronic medical record. Staff G said that staff does not document ear cleaning or shaving as specific tasks in a resident's electronic record. The visible check mark in a resident's personal hygiene task is indicative that all personal hygiene was provided. During an interview on 02/10/2026 at 4:07 PM Staff I, CNA stated the personal hygiene responsibilities of a CNA include ensuring the resident is clean. Personal hygiene care includes ensuring residents receive showers, and their hair and nails are clean. Staff I said that they respect a resident's refusal, but if their hygiene is poor and the resident refuses care three times, they will report the refusal to their supervisor. Staff I said that they will trim fingernails as needed. An interview was conducted with Staff M, LPN/Unit Manager (UM) on 02/10/2026 at 4:47 PM. Staff M, LPN/UM stated the staff should follow orders of the task listing provided in the electronic medical record when they are providing personal hygiene care to residents. Staff M said ADL care should include toileting, brushing teeth, washing the face, combing the hair, and ensuring residents look presentable. Fingernails are cared for depending on medical diagnoses. Staff M said CNA's responsibility includes shaving residents and checking their hygiene every day, every shift. Each resident's hygiene should be how you would want to be presented. Personal hygiene tasks should be documented inside each resident's electronic medical record. Staff M, LPN/UM said they assume if a resident's personal hygiene task has a check mark, all personal hygiene care has been completed. Staff M said that CNAs document what residents consume, baths, level of independence or dependence, range of motion, how many times they provide residents with cups of water, and teeth brushing. Staff M, LPN/UM said if a resident refuses care, a CNA should document the refusal and let the nurse know, Staff M said nail care should be documented in the resident's electronic medical record, and sometimes, activities provide nail care- polish nails etc. Staff M, LPN/UM reviewed Resident #84's electronic medical record and noted that Resident #84 received nail care one time during his residency at the facility, on 02/10/2026 at 1:46 PM, there was no prior history. Staff M said they observed Resident #151 earlier today and has a lot of contact with (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #151. Staff M said during the interaction, she did not notice hair on Resident #151's upper lip and chin/neck area. Staff M said shower days for Resident #151 are Monday, Wednesday, and Friday, but staff are still expected to provide residents with baths and check resident hygiene every day. Staff M said that Resident #151 never refuses care. During this observation, Staff M observed Resident #151 had facial hair. An interview was conducted with the Director of Nursing (DON) on 02/11/2026 at 3:46 PM. The DON stated a lot of residents refuse care. If resident refuses care another staff member should make another attempt to provide care. If a resident refuses on multiple occasions, staff should try to contact the resident's family. The family may be able to speak with the resident or support the facility in personal hygiene/ ADL care. The DON said some residents are extremely resistant to change and will continue to refuse care. The DON said every resident should be clean to ensure there are no foul odors. Nail care should occur once per week, on shower days, or every two weeks. The DON said ear care should be completed during a resident's shower; staff should wash the resident's outer ear; however, staff cannot use cotton swabs, a resident can do so if they choose to. If there are ear cleanliness concerns, the facility would consult with the physician for further directions. The DON stated follow standards of care related to resident hygiene. No policy and procedure was received for ADL care by the end of the survey.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review, the facility failed to ensure residents were monitored for antipsychotic medication behaviors and side effects, for two out of six residents, (#15 and #17), sampled.Findings included: 1. On 02/12/2026 at 1:53 p.m., Resident #15 was observed fully covering her head with her shirt. During an interview on 02/12/2026 at 1:45 p.m., Staff HH Certified Nursing Assistant (CNA), stated Resident #15 had behaviors such as yelling and refusing care. Staff HH stated the resident had often requested staff to leave me alone. Staff HH stated this happened two to three times a week. During an interview on 02/12/2026 at 1:55 p.m., Staff II CNA, stated Resident #15 sometimes yelled at staff and other residents. Staff II stated Resident #15 refused to comply with being dressed and changed. During an interview on 02/12/2026 at 2:02 p.m., Staff JJ Registered Nurse (RN), stated Resident #15 sometimes has her days. Staff JJ stated the week of 02/02/2026, Resident #15 refused to get out of bed and voided [urinated] on herself. Staff JJ stated, because Resident #15's actions weren't extreme or aggressive, they weren't documented. Staff JJ stated the refusals should've been documented. Staff JJ stated having no expectations for CNAs to perform monitoring for behaviors and side effects of antipsychotics as ordered by the physician. Staff JJ stated regardless if a resident presented with behaviors or not, it should have been documented. Review of Resident # 15's medical record revealed the resident was admitted into the facility on [DATE]. The medical diagnoses of the resident included: unspecified psychosis not due to a known physiological condition, dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance, schizophrenia, unspecified, schizoaffective disorder, unspecified, bipolar disorder, unspecified, major depressive disorder, recurrent, unspecified generalized anxiety disorder. Review of Resident #15's Minimum Data Set (MDS), dated [DATE], section C revealed the resident had a Brief Interview Minimum Status of 00, which indicated severe cognitive impairment. Section I revealed active diagnoses, for resident #15 including: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	non-alzheimer's dementia anxiety disorder, depression bipolar disorder psychotic disorder schizophrenia. Section N revealed the resident was taking antipsychotic medication. Review of Resident #15's orders, revealed an order for aripiprazole oral tablet 20 MG, to be given enterally [by mouth] at bedtime, dated 01/27/2025, with no end date. There was an order to record behavior monitoring seen and any side effects with use of psychotic medications given. If side effects are seen physician should be notified. Please record behavior even if dose of medication is not given, every shift, dated 02/17/2025. Review of Resident #15's Medication Administration Record (MAR), revealed the resident had received aripiprazole oral tablet 20 MG, daily, from 11/01/2025 through 02/11/2026. Review of Resident #15's Behavior Monitoring (BH), revealed for the order to record behavior monitoring seen and any side effects with use of psychotic medications given. If side effects are seen physician should be notified. Please record behavior even if dose of medication is not given, every shift, had not been completed. There was no data from 11/01/2025 through 02/11/2026, in Resident #15's record for behavior monitoring of medications given. Review of Resident #15's care plan, revealed a focus: Resident #15 was noted to have the following behaviors: placed blankets over head. Chose to not to have vital signs taken, chose not to take medication. Threw suitcase towards staff, threw bed linen and milk that was on a tray to the floor. Refused activities of daily living care, refused to wear shoes; wandered to other resident rooms, opened lockers, took other resident clothing and put them on, slammed doors, took meal trays to different locations, cursed at staff, took clothes off naked in room. Removed resident name labels from walls. Refused ADL care when soiled/wet, revised 10/30/2025. The goal was to control or minimize outburst, revised 09/25/2025. The interventions included: observe/document for side effects and effectiveness, document episodes of behaviors & review to determine the effectiveness of intervention, initiated 09/02/2021. There was an intervention to observed for changes in behavior and report to physician, insomnia, nervousness, loss of interest, decreased ability to concentrate, repetitive movements, initiated 09/02/2021. A focus of Resident #15's care plan was of the resident using psychotropic medications related to dementia and schizophrenia, revised 12/17/2024. The goal was to have minimum side effects, revised 09/25/2025. The interventions included: administer medications as ordered and to observe or document for side effects and effectiveness. The anti-psychotropic side effect monitoring was for agitation, blurred vision, cardiac or blood abnormalities, confusion, constipation, dry mouth, difficulty urinating, disturbed gait, drooling, drowsiness, headache, hypotension, involuntary movement of mouth, tongue, trunk or extremities, pacing, seizure activity, stiffness of neck, sore throat, tremors, and rashes. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of Resident #17's admission record showed an original admit date of 02/28/2025 with a readmission date of 10/05/2025, with diagnoses to include but not limited to: mixed receptive-expressive language disorder bipolar disorder, current episode manic severe with psychotic features generalized anxiety disorder schizophrenia dementia in other diseases classified elsewhere , mild A record review of Resident #17's physician orders showed the following: Haloperidol oral tablet 1 (one) MG (milligram), give one tablet by mouth one time a day related to other schizophrenia, ordered 12/19/2025. Haloperidol oral tablet 2 (two) mg, give two tablets by mouth in the evening related to other schizophrenia, ordered 12/19/2025. Trazadone HCL (hydrochloride) oral tablet 50 mg, give one tablet by mouth at bedtime for depression, ordered 10/27/2025. Trihexyphenidyl HCL oral tablet two mg, give two tablets by mouth three times a day for dystonia give with meals, ordered 10/27/2025 No orders were found for behavior monitoring or monitoring for side effects. A review of Resident #17's care plan showed the following focus, goals and interventions (to include but not limited to) and position: PASRR (Pre-admission Screening and Record Review) Level II: [Resident #17] has or is suspected to have a serious mental illness (SMI), Intellectual disability (ID) or other related conditions that require a PASRR Level II, date initiated 10/14/2025. Goal: Recommendations are established and carried out to attain or maintain the resident highest functional and emotional level. Interventions: behavior modification plan as follows: no plan entered. medication management as follows: no entries. psychiatric/psychological service follow up. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Behavioral: [Resident #17] is noted with the following behaviors: pulls out foley catheter, poor safety awareness, date initiated 4/03/2025 Goal: Control/minimize outburst Interventions: Document episodes of behavior and review to determine the effectiveness of interventions. Psychotropic Med (medication): [Resident #17] uses psychotropic medications related to antipsychotic to manage : schizophrenia, date initiated 3/03/2025 Goals: Will have minimal side effects, date initiated 03/03/2025, revision date 6/20/2025 and target date 3/07/2026 Interventions: Psychotropic side effect monitoring: agitation, blurred vision, cardiac or blood abnormalities, confusion, constipation, dry mouth, difficulty urinating, disturbed gait, drooling, drowsiness, headache, hypotension, involuntary movement of mouth, tongue, or extremities, nausea or vomiting, pacing, seizure activity, stiffness of neck sore throat, tremors, rashes, date initiated 3/03/2025 Administer medications as ordered. Observe/document for side effects and effectiveness, date initiated 3/03/2025 A review of Resident #17's psychiatry progress note date 11/21/2025 showed the following in review of systems: Depression -depressed mood, insomnia Psychosis- auditory hallucinations, delusions (of persecution, grandeur, jealousy, erotogenic), diminished emotional expression, disorganized behaviors, disorganized speech, visual hallucinations Mania- abnormally and persistently elevated, expansive or irritable mood Dementia- executive functions, impairment of complex attention, language, learning and memory, perceptual motor, social cognition. Assessment/Plan: Schizoaffective disorder, bipolar type Plan: -Continue haloperidol (antipsychotic). Consider [Brand name medication] if able to obtain it for the patient. -Continue Trazodone -Monitor for adverse effects of haloperidol, particularly dyskinesia and extrapyramidal symptoms EPS. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #17's psychiatry progress note date 12/19/2025 showed the following in review of systems: Cognition summary impaired related to dementia. Under review of systems the following: Depression -depressed mood, insomnia Psychosis- auditory hallucinations, delusions (of persecution, grandeur, jealousy, erotogenic), diminished emotional expression, disorganized behaviors, disorganized speech, visual hallucinations Mania- abnormally and persistently elevated, expansive or irritable mood Dementia- executive functions, impairment of complex attention, language, learning and memory, perceptual motor, social cognition. Plan: -Reduce Haldol to one mg po (oral) q (every) am (morning) and 2 mg po qhs (every night) in GDR attempt -Continue Trazodone -Monitor for adverse effects of haloperidol, particularly dyskinesia and extrapyramidal symptoms EPS. A review of Resident #17's psychiatry progress note date 01/16/2026 showed the following in review of systems: Depression -depressed mood, insomnia Psychosis- auditory hallucinations, delusions (of persecution, grandeur, jealousy, erotogenic), diminished emotional expression, disorganized behaviors, disorganized speech, visual hallucinations Mania- abnormally and persistently elevated, expansive or irritable mood Dementia- executive functions, impairment of complex attention, language, learning and memory, perceptual motor, social cognition. Plan: -Continue Haldol -Continue Trazodone -Monitor for adverse effects of haloperidol, particularly dyskinesia and extrapyramidal symptoms EPS. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/12/2026 at 9:47 a.m. an interview was conducted with Staff R, Licensed Practical Nurse (LPN). Staff R, LPN stated the resident should be monitored for behavior and side effects. Staff R, LPN stated normally when she documents a medication such as Haldol, she would see it in the MAR to then document any side effects. On 02/12/2026 at 12:35 p.m. an interview was conducted with the Director of Nursing (DON). The DON stated the facility has a psych provider who comes in multiple times during the week and does the monitoring of residents. The DON stated the providers know their residents and monitor every day all day. The DON stated monitoring is something that happens daily. The DON stated she needed to confirm something before explaining how monitoring behavior and side effects happens. The DON stated we monitor our residents, we all do. On 02/12/2026 at 1:37 p.m. the DON stated monitoring is done by the team and provided a copy of the Certified Nursing Assistant (CNA) TASK titled Behavior Monitoring and Interventions Report, but stated it is the nurse's responsibility to report if the CNA documents to a behavior. On 02/12/202 at 1:52 p.m., an interview was conducted with Staff J, Registered Nurse/Unit Manager (RN/UM). Staff J, RN/UM stated the resident psychotropic medications and behavior should be monitored by the nurses. If the resident had behaviors, then the nurse would refer them to psych. Staff J, RN/UM stated, It's nursing 101 and each nurse should know what behaviors to look for related to psych diagnosis and medication side effects. For example, a resident with tardive dyskinesia (tremors), the nurse should be able to know what to assess the resident for. The facility does Gradual Dose Reduction (GDR) meetings, and stated, he believes they are done weekly and psych is here all the time. If the resident had behaviors, typically that would be documented in the progress notes and then the nurse would call the doctor. Staff J, RN/UM stated, if you do not see it in the MAR/TAR (medication administration record/treatment administration record), you should see this in a progress note. If the CNA notices behaviors, the CNA should notify the nurse, because the CNA does not know what the signs and symptoms of psychotropic medications are. Staff J, RN/UM stated he did not expect CNAs to know what behaviors are for specific psych diagnosis or medications. On 02/12/2026 at 1:45 p.m., an interview was conducted with Staff S, CNA. Staff S, CNA stated, for behavior monitoring, she would look in the chart to see how the resident is to be transferred either with one or two person assist, look to see how they are to be showered, check for bowel and/or bladder incontinence every two hours, make sure they have water and/or coffee. On 02/12/2026 at 1:48 p.m., an interview was conducted with Staff T, CNA. Staff T, CNA stated for behavior monitoring she would check on her rooms, check for water, change residents for incontinence care, check to see if residents are fighting, make sure bed for fall risk residents, help residents to the bathroom and how a resident transfers either with one or two persons assist. A review of the policy titled, Behavior Management Program Overview, effective October 2021 showed the following policy statement: The facility promotes the utilization of a behavior management program based on individual resident needs. The facility Behavior Management Program is provided by the interdisciplinary team and recognizes that behaviors exhibited by residents require appropriate identification, data collection, intervention, management, and evaluation to assist the resident in obtaining their highest practicable level of functioning. The interdisciplinary team works in partnership with the resident/resident (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	representative to establish effective interventions and goals. Non- pharmacological interventions are the first choice in management of behavioral symptoms. PROCEDURE Psychoactive medications are used after non-pharmacological interventions have been attempted without success. The lowest possible effective dose of psychoactive medication will be prescribed for documented clinical symptoms. Dose management is reviewed by the Interdisciplinary Team (IDT) and in conjunction with physician and pharmacist recommendations. Clinical contraindications to dose reduction are documented. Side effects of the psychoactive medications are monitored by observation and documented on the eMAR (electronic medication administration record) The facility does not use chemical restraints, which are drugs used for discipline or convenience and are not required to treat medical symptoms. 1. Complete the Admission/re-admission Data Collection 2. Complete the Psychosocial History and Assessment 3. Review potential causes of behavioral symptoms with the IDT. Potential causes include, but are not limited to: Illness/conditions (i.e., pain, constipation, Alzheimer's disease) Cognitive status problems (i.e., confused) Mood and/or relationship problems (i.e., grief. placement adjustment) Environmental conditions (i.e., noise, crowding) Current treatment/management procedures (i.e. how are behaviors currently being addressed) Medication side effects Behavior Management Program Overview 4. Identify and implement interventions based on identified triggers and possible causes of behaviors. 9. Monitor the frequency of the behavior(s) and the effectiveness of the interventions 10. Review side effects from medication, notify practitioner if needed 12. Review the Resident at the next clinical meeting if a crisis occurs