

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2025
NAME OF PROVIDER OR SUPPLIER Oaks of Clearwater, The		STREET ADDRESS, CITY, STATE, ZIP CODE 420 Bay Ave Clearwater, FL 33756	

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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14161</p> <p>Based on resident record review, resident and staff interviews, observations, and policy and procedure review, the facility did not ensure an injury of unknown origin was thoroughly investigated in a timely manner for one resident (#1) of three residents reviewed for alleged violations of abuse and mistreatment.</p> <p>Findings included:</p> <p>Review of the record for Resident #1 revealed Resident #1 was admitted to the facility on [DATE] with diagnoses of unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disorder and anxiety; anxiety disorder; major depressive disorder; other specified persistent mood disorders; pain, unspecified; polyneuropathy; and unspecified mood affective disorder.</p> <p>Review of Resident #1's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status score of 5 out of 15, indicating severe cognitive impairment. The assessment revealed Resident #1 required substantial/maximum assistance for toileting hygiene.</p> <p>A review of Resident #1's care plan revealed a Focus, Resident #1 is at risk for recurring skin tears and bruising due to fragile skin, initiated 9/13/23 and revised 4/29/24. Interventions included use caution during transfer to reduce risk for recurring injuries.</p> <p>During an observation and interview on 4/17/25 at 11:00 am., Resident #1 was observed lying down in bed covered in her blanket. She was observed with a bandage on her top right forehead above her right eye. She had a black and blue colored bruise about two to three inches underneath her right eye. Resident #1 had purple and black colored bruising on her right shoulder and purple colored bruising on the top of her right hand. Resident #1 stated the bruise on her face came from a fall she had when she tried to get out of bed. She stated she was not able to remember how she got the bruise on her right hand.</p> <p>Review of Resident #1's nursing notes dated 4/11/25 at 6:42 p.m. and authored by Staff C, Licensed Practical Nurse (LPN), revealed:</p> <p>(continued on next page)</p>

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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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Note Text: Writer was coming out of another resident's room and overheard the patient screaming and fighting with the patient (sic). Writer went in resident's room to assess what was going on and the nursing aids were trying to change the patient and the patient was resisting and telling them in Greek not to touch her and to call her son. She also reported her right hand was hurting. Patient was offered pain medication but the patient declined. NP (Nurse Practitioner) and Unit manager were notified of the incident and pending orders from NP.</p> <p>The nursing notes also revealed a late entry nursing note authored by Staff C, LPN, created on 4/18/25 at 11:31 a.m., with an effective date of 4/11/25 at 6:42 p.m. The note revealed:</p> <p>Late entry, April ,2024 (sic) at 1842 pm. Writer intervened as the nurse in charge upon assessing patient noticed slight discoloration of right hand, patient was also holding hand and saying she was in pain. Writer offered the patient Tylenol for pain management, however patient declined, writer then offered an ice pack, however patient refused and was upset and requested that this writer and nursing assistant leave the room. Writer and nursing assistant left the room as requested by patient.</p> <p>An interview was conducted with the Interim Director of Nursing (DON) and Interim Nursing Home Administrator (NHA), on 4/17/25 at 12:15 p.m. The DON stated she investigated the incident involving Resident #1, checked on the resident, and saw the physician ordered an x ray. The DON stated Resident #1 is alert and confused but does not like to be changed and when they put her in bed she complained of pain to her right hand. The DON stated she interviewed the nurse involved, but not the CNAs involved in the incident. She stated she should have interviewed the CNAs and she was waiting for them to get back to her, but they did not called her back.</p> <p>The NHA stated to the DON, I asked you to get a statement from the CNAs. The DON replied, I didn't get statements, they didn't get back to me. During the interview, the DON could not recall the CNAs names involved in the incident with Resident #1. The DON stated the nurse told her they were changing Resident #1, she had a push back, and she complained of pain in her right hand. The DON stated she didn't get the whole story and she could not determine if Resident #1 was injured or abused by the CNA and it is still an open investigation.</p> <p>An interview was conducted with Staff D, LPN Unit Manager (UM) on 4/17/25 at 1:09 p.m. Staff D, LPN UM, stated the event with Resident # 1 happened on a Friday night and she had a bruise from the incident, so he obtained an order for an x-ray. He stated he received a phone call around 6:30 p.m. or 6:45 p.m., on 4/11/25 from the 3-11 p.m. nurse, who told him, during care, Resident #1 was swatting at the CNAs and complained of pain on her hand. Staff D, LPN UM stated the CNA involved was Staff A, CNA and this occurred while she was trying to change the resident. He stated he texted the Director of Nursing (DON) following the incident to inform her.</p> <p>An interview was conducted with Staff C, LPN on 4/17/25 at 1:33 p.m. She stated she was assisting a patient in another room and then she was coming out of the other room she heard Resident #1 yelling get out leave me alone. She stated Staff A, Certified Nursing Assistant (CNA) and Staff B, CNA were trying to change Resident #1 and she was swatting at them. Staff C, LPN stated, I don't know what she hit or what happened to her hand. She kept screaming her hand her hand. Staff C, LPN stated her nursing note on 4/11/25 should have documented the patient was screaming and fighting with a CNA, not a patient. Staff C, LPN stated she talked to Staff A, CNA, but did not talk to Staff B, CNA about what occurred. The staff member stated she tried to talk to Resident #1, however, she was irate and yelling in Greek. She stated she reached out to the provider to obtain an order for an X ray.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations;</p> <p>5. Focusing the investigation on determining if abuse, neglect, exploitation, and /or mistreatment has occurred, the extent, and cause; and</p> <p>6. Providing complete and thorough documentation of the investigation.</p>		