

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 10/02/2025
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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record reviews, and interviews, the facility failed to ensure the kitchen met sanitation requirements for one kitchen of one during 3 days (09/30/2025, 10/01/2025 and 10/02/2025) of three days observed. Findings included: During kitchen tours conducted with the Certified Dietary Manager (CDM), on 9/30/2025 at 9:25 a.m., on 10/1/2025 at 11:15 a.m. and 1:16 p.m., the following observations were made. Upon entering the kitchen, there was no garbage can readily accessible to dispose used paper towels after washing hands. The CDM revealed they did have one but was not sure where it went. The hand washing sink area to include, the back wall, the floor, floor drain area, and the sink had approximately eight small flying insects flying around and landing on the sink, the floor, and the walls. The CDM stated not being aware of any issues causing the flying insects and did not notice them until it was just brought to their attention. The floor drain next to the hand washing sink was observed with several soiled plastic pipes. The floor drain metal plate was observed with a thick clear, grey and orange colored gelatinous substance. The substance appeared to be bio-growth. The CDM confirmed the drain growth and stated not being aware of the drain plate in that condition. The dish washing machine room revealed a large metal dish washing machine. The CDM revealed the kitchen operates a high temperature dish washing machine and revealed the outside sourced maintenance operator was at the facility about a week prior and performed routine maintenance. The CDM identified problems getting the water boosted to high level water temperatures and stated it takes some time to do so. The CDM revealed the machine was very old and the facility was trying to get another one. Observations of the dish machine revealed the top had a reddish-brown, flaky surface, leaving a non-cleanable surface, with pieces of brown colored metal debris on it. The front side of the dish washing machine was observed oxidized in a white and green color on the corners of the doors, leaving a non-cleanable surfaces. At the top left corner of the dishwashing machine, where one metal plate met another, a clear liquid substance was observed squirting from the dish washing machine onto the oxidized area. The floor under the dish washing machine and in front of the dish washing machine was observed with calcification and oxidation from the water from the machine. The floor under the dish washing machine was observed soiled with build-up debris. Observations of the walk-in refrigerator revealed the floor had debris and dirt-like substances, with oxidization revealing a reddish-brown, flaky surface, leaving a non-cleanable surfaces around the corners. The areas were with dirt and debris which appeared to be build-up on the surface, leaving a non-cleanable surfaces. The CDM did not have a cleaning schedule to show when the unit was cleaned and maintained. The walk-in refrigerator was observed with several round containers with unidentified food product. The products were liquid, and the outside of the containers were covered with the spilled over product. The CDM revealed the containers of stored food products should be clean and free from any spilled product. Observations in the walk-in freezer revealed icing on the ceiling of the unit, with icicles hanging approximately six inches long. There were large chunks of ice debris on the floor and in the mat holes. The CDM confirmed the ice build-up and revealed the icing does happen frequently. Observations in the walk-in freezer revealed a large brown box positioned on the bottom shelf of one of the racks. The box was opened and lined with a blue (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	revealed no performance improvement plans related to the kitchen or dietary services. Review of a facility policy titled Sanitation Inspection, dated 10/01/2025, showed: It is the policy of this facility, as part of the department's sanitation program, to conduct inspections to ensure food service areas are clean, sanitary and in compliance with applicable state and federal regulations. Policy Explanation and Compliance Guidelines: 1. All food service areas shall be kept clean, sanitary, free from litter, rubbish and protected from rodents, roaches, flies and other insects. 2. The department shall establish a sanitation program for food services based on applicable state and federal requirements. 3. The sanitation program will provide for inspections to be conducted of the food service areas. 4. Sanitation inspections will be conducted in the following manner: a. Daily: Food service staff shall inspect refrigerators/coolers, freezers, storage area temperatures, and dishwasher temperatures daily. b. Weekly: The dietary manager shall inspect all food service areas weekly to ensure the areas are clean and comply with sanitation and food service regulations. 5. Inspections will be conducted but not limited to the following areas: a. Dry storage, b. Freezer, c. Refrigerator, d. Dish room, e. Pot wash, f. Main production area, g. Food preparation area, and h. General dietary observations. 6. The dietary manager shall develop and provide food service personnel with standard operating procedures for sanitation and daily inspections. Managers may familiarize staff with these procedures through various means such as monthly meetings, posted memorandums, training sessions and orientation of new personnel. 7. Inspection Score (from Sanitation Inspection Report): The dietary manager, as part of the department's QAPI program, will perform an in-depth analysis of the data obtained during the inspection utilizing the following: Numerator (The number of positives) divided by Denominator (the number of total opportunities) = Inspection Score 8. Inspection score will be formulated on each area being evaluated. Scores will then be compared to department goals. 9. Feedback will be reported to the food service staff and the QAPI Committee.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on record review and interviews, the facility did not ensure a water management plan was in place to assess, identify and monitor for Legionella and other opportunistic waterborne pathogens. Findings include: The facility was asked to provide their water management plan. On 10/2/25 at 11:30 a.m., the facility provided a water treatment contract invoice and a service report dated 7/7/25. Further review of the report revealed it was the quarterly service for the chilled loop which included testing of the pH (power of hydrogen measuring acidity of alkalinity), conductivity, iron, alkalinity, and sodium nitrate. The service report does not have documentation regarding water testing for Legionella and other waterborne pathogens. On 10/2/25 at 1:02 p.m., an interview was conducted with the Regional Director of Maintenance (RDOM) and the DOM. The DOM initially said he did not know if the facility had a water treatment plan as he had been in the position for two weeks. The Regional DOM said the facility recently changed water treatment companies. The facility has a signed agreement, but the company has not conducted their first water treatment yet. The Regional DOM reviewed the service report dated 7/7/25 and could not confirm if the water was tested for Legionella and other waterborne pathogens. The facility was unable to provide their Legionella facility assessment. A review of the facility's policy titled, Legionella Surveillance, revealed the following. It is the policy of this facility to establish primary and secondary strategies for the prevention and control of Legionella infections. Further review of the policy, under policy explanation and compliance guidelines, revealed the following, 1. Legionella surveillance is one component of the facility's water management plans for reducing the risk of Legionella and other opportunistic pathogens in the facility's water systems. A review of the facility's policy titled, Legionella Water Management Program, revised July 2017, revealed the following, Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella. Further review of the policy, under policy interpretation and implementation, revealed the following, 1. As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team. 3. The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. 5. The water management program includes the following elements: . b. A detailed description and diagram of the water system and the facility, including the following: . c. The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, including: . A review of a facility document titled, Water Management Program, revealed the following: Abstract: All facilities are required to demonstrate measures to minimize the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems and devices. It is recommended that facilities form a water management team which could include a variety of people with expertise to assist in the development of the most effective program possible. The following is a sample water management team charter which can be modified to address your facility's unique needs.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, record review and interviews, the facility failed to ensure resident rooms, resident equipment and shower rooms equipment were maintained in a clean and sanitary manner during three days (9/30/2025, 10/1/2025, and 10/2/2025) of three days observed. Findings included: During facility wide tours on 9/30/2025 at 10:45 a.m., 10/1/2025 at 8:20 a.m., 1:00 p.m. and on 10/2/2025 at 8:27 a.m., observations were made of resident wheelchair armrests cracked and torn, resident rooms soiled, toilet devices and shower chairs were not maintained in a sanitary manner and were observed with biogrowth. 1. During multiple tours of the main community shower room, observations revealed two plastic shower chairs that were wet and appeared to have been just used. One white plastic shower chair with white plastic seating and backing was observed with heavy black and pink biogrowth on all four of the legs, at the wheel castors, as well as the connection pivot areas. The plastic backing and fabric were observed with a large amount of dark black biogrowth. Three privacy curtains were observed with spotty dark areas and lined black biogrowth near the bottom half. The resident room tours revealed the following: In room [ROOM NUMBER] a wheelchair was found with a cracked and torn right side of the armrest. In room [ROOM NUMBER] the bathroom was observed with a commode device with a brittle, reddish-brown, flaky coating on the metal surface. In room [ROOM NUMBER] a wheelchair was found with both the right side and lefts side armrests cracked and torn. In room [ROOM NUMBER] a wheelchair was found with both the right side and left side armrest cracked and torn. In room [ROOM NUMBER] the bathroom toilet lid was observed with a toilet seat with a painted surface scrapped off and leaving a non-cleanable surface. In room [ROOM NUMBER] a wheelchair was found with both the right and left side armrest cracked and torn. In room [ROOM NUMBER]a wheelchair was found with both the right and left side armrest cracked and torn. In room [ROOM NUMBER] a wheelchair was missing a right-side armrest pad. The resident stated not aware why the arm rest was missing, and it would be better and more comfortable to have one. In room [ROOM NUMBER] the ceiling was observed with heavy amounts of dust and debris on the ceiling and near the ceiling vent. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In room [ROOM NUMBER] the ceiling vent was observed with a heavy amount of black biogrowth and with paint chipping and cracking. The wheelchair in bed b was observed with both the right and left side armrests cracked and torn. The resident revealed about his wheelchair, being terrible and stated having notified them to replace my armrests. The back room of the North dining/activity room where residents dine, an observation was made of two ceiling vents that were constantly dripping water onto the floor. The back room of the South dining room where residents dine, an observation was made of two ceiling vents that were constantly dripping water onto the floor. On 10/2/2025 at 11:00 a.m. an interview with the Housekeeping Director revealed housekeeping staff are responsible for the day-to-day cleaning of resident rooms, resident spaces and non-resident spaces. She confirmed housekeeping staff were responsible for cleaning community shower room. The housekeeping director revealed she was not aware of the dust and debris on the resident room ceilings, nor was she aware of the shower room having biogrowth on the shower chairs and the curtains. The housekeeping director revealed it was the nursing department's responsibility to clean the shower chairs after each use. She stated she was not aware how often or if the shower chairs were deep cleaned and or power washed. On 10/2/2025 at 1:00 p.m. an interview with the Maintenance Director revealed he was not sure who was responsible for the cleaning of shower chairs. The Maintenance Director confirmed the maintenance department was responsible for the general maintenance of resident wheelchairs. The Maintenance Director revealed himself and his staff do daily walk-throughs to look out for things such as broken wheelchairs. The Maintenance Director revealed if direct care staff or any staff see any problems with the wheelchairs, to include torn and cracked arm rests, they are to report it to his department either verbally or by electronic work order system. The Maintenance Director was unaware there were so many wheelchairs that needed maintenance and replacing of armrests. The Maintenance Director confirmed he did not have pending work orders for the stated concerns. On 10/2/2025 at 1:45 p.m., an interview with the Nursing Home Administrator (NHA) revealed the facility did not have a general housekeeping or wheelchair maintenance policy and procedure. The NHA revealed there was no documentation to show who was responsible for cleaning the shower room equipment and who was responsible for the general maintenance of resident rooms and resident equipment. 2. On 9/30/25 at 10:08 a.m., an observation of the bathroom in room [ROOM NUMBER] revealed a commode over the toilet with multiple areas of a brittle, reddish-brown, flaky coating on all four legs, as well as where the legs and arms of the chair meet. On 10/1/25 at 9:26 a.m., an observation of room [ROOM NUMBER] revealed the ceiling vent by the bed closest to the bathroom had cracked and chipped paint and was covered with an unknown, black-colored substance. Further observations of the bathroom in room [ROOM NUMBER] revealed the vent had the same concerns as the ceiling vent in the room. On 10/1/25 at 9:32 a.m., an observation of room [ROOM NUMBER] revealed multiple areas of an unknown, black-colored substance across the ceiling in the middle of the room. A resident in the room stated she was concerned it was, black mold, and said it was in other rooms as well. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/1/25 at 10:56 a.m., an observation of room [ROOM NUMBER] revealed an unknown-black colored substance across the bottom ledge under the air conditioning (a/c) vent. The resident in the room stated he was concerned about the substance being, black mold. He said he let the maintenance staff know about his concerns. Further observation of the bathroom in room [ROOM NUMBER] revealed the vent blades had multiple spots of a grey and white colored substance. A review of completed work orders from 7/1/25 to 10/1/25 revealed there were no work orders for rooms [ROOM NUMBER]. Further review of completed work orders revealed room [ROOM NUMBER] had a work order in July 2025, about a water leak in the ceiling. A review of current work orders revealed no work orders for rooms 200 to 203. On 10/2/25 at 1:02 p.m., an interview with the Maintenance Director revealed he had been in the position for two weeks. He said he was not aware of the concerns identified during the survey in rooms 200 to 203. A review of the completed work order for room [ROOM NUMBER] in July 2025 revealed he was not aware of the ceiling water leak in that room. An interview with the Regional Maintenance Director revealed the rooms seen with a black unknown substance could be removed by, Scraping the area with a broom. On 10/2/25 at approximately 7:45 a.m., an observation was made of the area under the East hallway handrails. The wall covering, simulating square tiles, was observed peeling away from the walls in numerous areas. On 10/2/25 during an 8:00 a.m. tour of the unit with the Nursing Home Administrator (NHA), the NHA observed the areas and stated she would put in a work order for the areas. The NHA stated the peeling wall coverings would not have been acceptable in her home. Photographic evidence was obtained.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations, staff interviews and record review, the facility failed to ensure an effective pest control program related to small flying insects in the kitchen, during two days (9/30/2025 and 10/1/2025) of three days observed. Findings included: On 9/30/2025 at 9:18 a.m. a kitchen tour was conducted with the Certified Dietary Manager (CDM). An observation was made of several small flying insects at the hand washing sink, approximately eight of these flying insects flying around and landing on the walls, the paper towel dispenser, the sink, and floor. The floor drain that had a metal plate was observed with gelatinous bio growth on it. The CDM revealed he had not seen them before until they were just pointed out. He confirmed there were more than a few insects flying around the hand washing sink but did not know exactly how long they had been in the area. A second tour of the facility on 10/1/2025 at 11:15 a.m. and at 1:30 p.m. revealed small flying insects in the area where the hand washing sink and floor drain was. Several more flying insects were observed in the food preparation and food service area of the kitchen. Dietary staff who were walking by were observed swatting at the insects from time to time. None knew where they were coming from. An interview with the CDM revealed the facility had a pest control program and that an outside sourced pest control company came out once a month for general treatment but has come out more frequently to treat any outbreaks of pests/insects. The CDM was not sure how the maintenance department was involved with treatment, but there was an electronic work order program that was used by staff and acts as a reporting system for any staff member if there were any concerns that need to be worked on, to include pest control. The CDM revealed the kitchen staff do know how to utilize the electronic work order reporting program and have done so in the past. The CDM confirmed flying insects in the kitchen space at and near the hand washing sink area, as well as in and around food preparation areas. The CDM did not know the exact date the pest control company was last out to treat for insects. On 10/1/2025 at 2:15 p.m. an interview with the maintenance director stated any staff member who observed any type of insect or pest, has been trained to utilize the electronic work order system and he checks that reporting system daily. He confirmed if there were any work orders/reports of pests or insects, he would call the pest control company to come out to treat in between their regular weekly visits. The maintenance director revealed he did not have any current work orders the past one week to include any reports of insects in the kitchen. The maintenance director was unaware of a backed up or clogged up drain near the hand washing sink in the kitchen and was not aware of insects in and around this area. The maintenance director provided the last pest control company treatment reports that included visits on 5/20/2025, 6/17/2025, 8/18/2025, and 9/16/2025, related to the treatment for flying insects. The reports did not specify which areas were treated. The Maintenance director provided the facility and outside sourced pest company contract for review. The contract reviewed revealed an effective date of 7/25/2021 and revealed the pest control company would come out the facility for maintenance treatment on a weekly basis. The contract revealed the following pests/insects would be treated for; All general pests: cockroaches, ants, spiders, silverfish, earwigs, millipedes, springtails, etc. The list did not specify treatment for small flying insects. Further, the contract revealed the outside of the building would be treated on a monthly basis. The maintenance director revealed he was not able to provide a pest control policy and procedure for review.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a Notice of Medicare Non-Coverage (NOMNC) was provided to notify when Medicare covered services would terminate and inform the beneficiary of the right to appeal the decision, for three residents (#31, #40, and #55) of three residents sampled for the provision of the NOMNC. Findings included: Review of Resident #31's clinical chart, the admission record, documented an admission in 11/2024 with a readmission of 02/18/2025 with a family member designated as a responsible party. The diagnoses list included: Cerebral Infarction, Chronic Obstructive Pulmonary Disease (COPD) and Adult Failure to Thrive. Review of Resident #31's most recent quarterly Minimum Data Set (MDS) cognitive section dated 08/23/2025, revealed a Brief Interview for Mental Status (BIMS) score of six, indicated severe memory and orientation problems. Review Resident #31's medical record revealed the resident had received a Medicare Part A Skilled Services episode which started on 02/18/2025 and terminated on 04/16/2025. Review of Resident #31's electronic health record on 10/02/2025 revealed there was no presence of a Notice of Medicare Non-Coverage (NOMNC) being issued to Resident #31, or the responsible party for the notification of the termination of Medicare Part A Skilled Services which terminated on 04/16/2025. Review of Resident #40's clinical chart, documented an admission on [DATE]. The face sheet reflected a family member was designated as Resident #40's Power of Attorney (POA). The diagnoses list included Spinal Stenosis and cognitive communication deficit. Review of Resident #40's most recent quarterly BIMS cognitive section showed a BIMS score of 12, which showed moderate problems with thinking and memory. Further review of the chart reflected Resident #40 had received a Medicare Part A Skilled Services episode which started on 03/01/2025 and terminated on 04/17/2026. Review of Resident #40's electronic health record on 10/02/2025 revealed no presence of a NOMNC being issued to Resident #40 or the POA for the notification of the termination of Medicare Part A Skilled Services which terminated on 04/17/2025. Review of Resident #55's clinical chart, the admission record, documented an admission on [DATE] with a family member designated as an emergency contact. The diagnoses list included metabolic encephalopathy and acute respiratory failure with hypoxia. Further review of the chart reflected Resident #55 had received a Medicare Part A Skilled Services episode which started on 03/29/2025 and terminated on 04/16/2025. Review of Resident #55's electronic health record on 10/02/2025 revealed no presence of a NOMNC being issued to Resident #55 or the family member for the notification of the termination of Medicare Part A Skilled Services which terminated on 04/16/2025. During an interview conducted on 10/02/2025 at 10:57 a.m. the Social Service Director stated, the NOMNC for the three residents requested, does not exist. I will ask for medical records, but I did not find a copy of the NOMNC in the electronic health record. There was no further documentation presented by the facility during the survey that would support Resident #31, #40, and #55, had received a NOMNC to detail when the Medicare-covered services would terminate and inform the beneficiary the right to appeal the decision. The facility did not provide a policy or procedure for NOMNC notifications.		

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NAME OF PROVIDER OR SUPPLIER Oaks of Clearwater, The		STREET ADDRESS, CITY, STATE, ZIP CODE 420 Bay Ave Clearwater, FL 33756	
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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 - Few	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 observations, record reviews, and interviews the facility failed to obtain Level II Pre-admission screening and resident reviews (PASARR) for two residents (#8 and #9) of twenty-five initially sampled residents. Findings included: 1.) Review of Resident #8's clinical record showed the resident was admitted on [DATE] and 9/12/25. The record revealed diagnoses and onset dates of bipolar type schizoaffective disorder (onset 4/11/25), severe unspecified dementia with psychotic disturbance (onset 4/11/25), unspecified anxiety disorder (onset 4/11/25), unspecified epilepsy not intractable with status epilepticus (onset 4/11/25), unspecified depression (onset 4/11/25), and unspecified mood (affective) disorder (onset 6/23/25). Review of Resident #8's Agency for Healthcare Administration (AHCA) Nursing Home Transfer and Discharge Notice, dated 6/3/25, which the facility provided upon request for the resident's PASARR, showed the resident was being transferred to an acute care facility as needs could not be met at the facility and was Going for Mental Health eval (evaluation). Review of Resident #8's Level I PASARR, dated 4/22/25 showed screening was completed at the facility and included the diagnoses of anxiety disorder, bipolar disorder, depressive disorder, schizophrenia, and mood affective disorder. The screening showed the resident had previously received services for mental illness (MI), had no indicators for decision-makings, no dementia or related neurocognitive disorders, no diagnosis or suspicion of serious mental illness (SMI) or intellectual disability, and a Level II PASARR evaluation was not required. Review of Resident #8's progress notes showed an admission note, dated 6/5/25 revealing the resident had been sent to an acute care facility for auditory hallucinations. The note showed the resident had a history of dementia, schizophrenia, depression, and seizures. Review of Resident #8's psychiatric note dated 6/5/25 showed the resident had a chronic psychiatric history including schizoaffective disorder, generalized anxiety disorder (GAD), depression, and mood order. The note revealed the resident had been receiving long-term psychiatric treatment and was residing in a skilled nursing facility due to progressive psychiatric and functional decline. The note showed the resident had recently been hospitalized under a [NAME] Act after expressing the need to be hospitalized for paranoia, delusional thinking, and presented with acute mental status changes which was stabilized with medication and supportive care. Review of Resident #8's psychiatric note dated 9/22/25 revealed the resident had a longstanding psychiatric history with multiple psychiatric hospitalizations most recently under the [NAME] Act in May 2025 for psychiatric decompensation. The note revealed the resident continued to demonstrate obsessive preoccupation with vitamins. The diagnoses included with the note was hoarding disorder, generalized anxiety disorder, recurrent moderate major depressive disorder, and depressive type schizoaffective disorder. Review of Resident #8's clinical record and the requested documents did not reveal the facility had obtained a Level II PASARR for the resident. 2.) Review of Resident #9's admission Record showed the resident was admitted on [DATE] and readmitted on [DATE]. The record revealed the resident's principal diagnosis on 10/21/24 was neurocognitive disorder with Lewy bodies and included diagnoses of cognitive communication deficit (onset 6/19/23), unspecified schizoaffective disorder (onset 6/9/23), not otherwise specified mental disorder (onset 10/25/23), generalized anxiety disorder (1/4/20), unspecified single episode major depressive disorder (onset 1/4/20), alcohol dependence in remission (onset 10/21/24), and unspecified mood (affective) disorder (onset 9/27/23). Review of Resident #9's Preadmission Screening and Resident Review (PASARR) dated 1/2/20, revealed the resident had alcoholism and a history of Lewy Body dementia. The Level I screening was completed by a rehabilitation hospital and revealed the resident did not have a diagnosis or suspicion of Serious Mental Illness (SMI) or Intellectual Disability (ID), and a Level II PASARR evaluation was not required. An interview was conducted with the Social Service Director (SSD) on 10/2/25 at 9:33 a.m. The SSD revealed they did (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not do PASARRs. The SSD stated knowing how to do them but did not do them at this facility. The SSD admitted to working at the facility since July 2025 and nursing did the PASARRs, specifically the Unit Manager. An interview was conducted with Staff H, Licensed Practical Nurse/Unit Manager on 10/2/25 at 9:49 a.m. The staff member revealed they did not do PASARRs, and Social Services did them. An interview was conducted with the Nursing Home Administrator (NHA) on 10/2/25 at 9:58 a.m. The NHA reported the Director of Nursing (DON) was responsible for PASARRs but did not know if the current DON had access. The NHA stated the other past DONs had access to the PASARR system. On 10/2/25 after 10:00 a.m. an interview was attempted with the Director of Nursing (DON). The DON was unavailable for interview. Review of the policy - Resident Assessment Coordination with PASARR Program, revised/reviewed 10/2/25, showed This Facility coordinates assessments with the pre admission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs.1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities in related conditions in accordance with the State's Medicaid rules for screening.a. PASARR Level I - Initial pre-screening that is completed prior to admission: i. Negative Level I screen - permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later.ii. Positive Level I screen - Necessitates a PASARR Level II evaluation prior to admission.b. PASARR Level II - a comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that determines whether the individual has MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs.2. The facility will only admit individuals with a mental disorder or intellectual disability who the State mental health or intellectual disability authority has determined as appropriate for admission.6. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority.7. Recommendations, such as any specialized services, from a PASARR level II determination and/or PASARR evaluation report will be incorporated into the resident's assessment, care planning, and transitions of care.8. Any level II resident who experiences a significant change in status will be referred promptly to the state mental health or intellectual disability authority for additional resident review. Examples include:a. A resident who demonstrates increased behavioral, psychiatric, or mood-related symptoms.b. A resident with behavioral, psychiatric, or mood-related symptoms that have not responded to ongoing treatment.c. A resident who experiences an improved medical condition - such that the residents' plan of care or placement recommendations may require modifications.d. A resident whose significant change is physical, but has behavioral, psychiatric, or mood-related symptoms, or cognitive abilities, that may influence adjustment to an altered pattern of daily living.e. A resident whose condition or treatment is or will be significantly different than described in the resident's most recent PASARR Level II evaluation and determination.9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Examples include:a. A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis).b. A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR.c. A resident transferred, admitted , or readmitted to the facility following an inpatient psychiatric stay or equally intensive treatment.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews the facility failed to obtain an accurate Preadmission Screening and Resident Review (PASARR) for one resident (#9) of twenty-five sampled residents. Findings included: Review of Resident #9's Preadmission Screening and Resident Review (PASARR) dated 1/2/20, revealed the resident had alcoholism and history of Lewy Body dementia. The screening showed the resident did not have a diagnosis or suspicion of Serious Mental Illness (SMI) or Intellectual Disability (ID) and a Level II PASARR evaluation was not required. The Level I screening was completed by a rehabilitation hospital. Review of Resident #9's admission Record showed the resident was admitted on [DATE] and readmitted on [DATE]. The record revealed the resident's principal diagnosis on 10/21/24 was neurocognitive disorder with Lewy bodies and included diagnoses of cognitive communication deficit (onset 6/19/23), unspecified schizoaffective disorder (onset 6/9/23), not otherwise specified mental disorder (onset 10/25/23), generalized anxiety disorder (1/4/20), unspecified single episode major depressive disorder (onset 1/4/20), alcohol dependence in remission (onset 10/21/24), and unspecified mood (affective) disorder (onset 9/27/23). Review of Resident #9's psychiatric note, dated 7/10/25, showed a Gradual Dose Reduction (GDR) was not to be attempted and was clinically contraindicated. The note included diagnoses of generalized anxiety disorder, major depressive disorder recurrent severe without psych features, unspecified schizoaffective disorder, and alcohol dependence in remission. An interview was conducted with the Social Service Director (SSD) on 10/2/25 at 9:33 a.m. The SSD revealed they did not do PASARRs. The SSD stated knowing how to do them but did not do them at this facility. The SSD admitted to working at the facility since July 2025 and nursing did the PASARRs, specifically the Unit Manager. An interview was conducted with Staff H, Licensed Practical Nurse/Unit Manager on 10/2/25 at 9:49 a.m. The staff member revealed they did not do PASARRs, and Social Services did them. An interview was conducted with the Nursing Home Administrator (NHA) on 10/2/25 at 9:58 a.m. The NHA reported the Director of Nursing (DON) was responsible for PASARRs but did not know if the current DON had access. The NHA stated the other past DONs had access to the PASARR system. On 10/2/25 after 10:00 a.m. an interview was attempted with the Director of Nursing (DON). The DON was unavailable for interview. Review of the policy - Resident Assessment Coordination with PASARR Program, revised/reviewed 10/2/25, showed This Facility coordinates assessments with the pre admission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs.1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities in related conditions in accordance with the State's Medicaid rules for screening.a. PASARR Level I - Initial pre-screening that is completed prior to admission: i. Negative Level I screen - permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later.ii. Positive Level I screen - Necessitates a PASARR Level II evaluation prior to admission.6. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority.9. Any resident who exhibits A newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Examples include: a. A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis).b. A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR.c. A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews the facility failed to ensure ambulatory residents did not have access through an unlockable door to a functioning four-burner glass top stove located in one of two activity/dining rooms on the west hall for three residents (#23, #39, #45) of 27 sampled residents and failed to ensure safety of handrails for one handrail of one located next to the nursing station. Findings included: On 10/1/25 at approximately 8:45 a.m. an observation was conducted of an unlockable room at the southwest end of the unit. The room contained a functioning four- burner glass top stove. The clock was observed working and one of four burners turned red with heat emitting from it when the knob was turned to the on position. An interview was conducted with Staff I, Licensed Practical Nurse (LPN) on 10/1/25 at 8:54 a.m. The staff member stated the room was for resident's activities, luncheons, and sometimes for quiet time with families. On 10/1/25 at 9:50 p.m. Resident #23 ambulated with a 4-wheel walker into the northwest common/dining room. The resident stated the northwest room was for independent diners and the southwest room was for dependent residents. During the interview with the resident, Resident #39 was observed sitting in wheelchair propelling self in and out of the southwest common/dining room. Review of Resident #23's clinical record showed the resident was admitted on [DATE]. The resident's quarterly Minimum Data Set revealed the resident scored 15 of 15 on the Brief Interview of Mental Status (BIMS) indicating an intact cognition. Review of Resident #39's clinical record showed the resident was admitted on [DATE]. The resident's Minimum Data Set (MDS) dated [DATE] revealed the resident scored 9 of 15 on the BIMS score interview indicating moderate cognitive impairment. On 10/1/25 at 1:26 p.m. Resident #45 was observed propelling self into the southwest common/dining room. The resident was observed alone in the room with stove and reported coming into the room sometimes. Review of Resident #45's clinical record showed the resident was admitted on [DATE]. The resident's MDS dated [DATE] revealed the resident's BIMS score of 8 of 15, indicating a moderate cognitive impairment. On 10/2/25 at approximately 7:33 a.m. an observation was made of an approximately 3-4 foot section of handrail attached to the wall next to the nursing station. The handrail did not have curved ends and revealed silver metal brackets attached to the wall. The brown linear rail did not cover the silver areas. On 10/2/25 at 8:00 a.m. an observation was made with the Nursing Home Administrator (NHA). The NHA stated the southwest room was used for dining and did not think the door had ever been shut. The NHA reported thinking the stove did not work and the box above the stove contained a switch which turned the stove off. A demonstration revealed the stove becoming red with heat. The NHA stated she saw the issue and removed the knobs from the back of the stove. The NHA confirmed the residents could have burned themselves. A continued tour of the unit with the NHA revealed the missing ends to the handrail and the NHA agreed a resident could injure themselves on the exposed areas. Photographic evidence was obtained.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on observations, record reviews, and interviews the facility failed to address pharmacy recommendations for one resident (#9) of five residents sampled for the unnecessary administration of medications. Findings included: On 9/30/25 at 10:30 a.m. Resident #9 was observed sitting in wheelchair in room with television playing. The resident replied to introduction with nonsensical speech. Review of Resident #9's active orders as of 10/2/25 at 12:27 p.m. revealed the diagnosis for rifaximin was other symbolic dysfunctions. An interview was conducted with the Director of Nursing (DON) on 10/1/25 at approximately between 3:00 and 6:00 p.m. The DON provided one pharmacy recommendation for Resident #8 and reported the facility continued to look for the rest of the requested recommendations. An interview was conducted with the Nursing Home Administrator (NHA) on 10/2/25 at 1:42 p.m. The NHA stated they were waiting for pharmacy to send the pharmacy recommendation policy. The NHA provided on 10/2/25 at 2:12 p.m. the July, August, and September pharmacy recommendations. The received documents did not contain recommendations for all of the requested residents and did not reveal pharmacy recommendations had been made during the requested times and did not reveal pharmacy had reviewed the medications to determine if there were any recommendations or not. Review of a pharmacy recommendation obtained on 10/2/25 at approximately 2:00 p.m. from the Nursing Home Administrator (NHA) showed a recommendation had been printed on 8/29/25 asking for the physician to consider changing the diagnosis of Resident #9's Xifaxan (rifaximin) from other symbolic dysfunctions to other irritable bowel syndrome. The recommendation explained the Food and Drug Association (FDA) had not labeled other symbolic dysfunctions as an approved indication for the medication. The recommendation showed the physician/prescriber response was the diagnosis (dx) changed to anxiety 09/18/25 and signed illegibly. The recommendation was not dated. Review of policy & Documentation and Communication of Consultant Pharmacist Recommendations, effective March 2019, revealed The consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist observations and recommendations regarding residents medication therapies are communicated to those with authority and/ or responsibility to implement the recommendations, and are responded to in an appropriate and timely fashion. The policy included but not limited to the following procedures: A. A record of the consultant pharmacist observations and recommendations is made available to in an easily retrievable form to nurses, prescribers, and the care planning team. This should include: 1) documentation on the appropriate form of the date each medication regimen review is completed and notation of the findings in the medical record or other designated site. 2) A standard format utilized by clinical care providers, such as SOAP (Subjective, Objective, Assessment, and Plan) or FARM notes (See Appendix 11: SOAP and FARM formats for clinical notes) 3) The consultant pharmacist documents potential or actual medication related problems, (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	irregularities, and other medication regimen review findings appropriate for prescriber and/ or nursing review. C. Recommendations are acted upon and documented by the facility staff and/or the prescriber. If the prescriber does not respond to recommendation directed to him/her within a reasonable time frame/ within 30 days, the Director of Nursing and/ or the consultant pharmacist may contact the medical director. F. Recommendations regarding implementation of facility policies, procedures, and/ or methods of medication administration are made by the consultant pharmacist when appropriate. Review of a facility policy titled, Medication Regimen Review, effective March 2019, revealed The consultant pharmacist performs a comprehensive review of each resident's medication regimen at least monthly. The medication regimen review (MRR) includes evaluating the resident's response to medication therapy to determine that the resident maintains at the highest practicable level of functioning and preventing or minimizing adverse consequences related to medication therapy period findings and recommendations are reported to the Director of Nursing and the attending physician, and if appropriate, the medical director and/ or the administrator. The policy included but not limited to the following: C. While MRRs Are generally conducted in the facility, off site MRR's are acceptable when a review is requested in the following conditions are met: 1) the consultant pharmacist is not present in the facility, and 2) it is not possible for the consultant pharmacist to visit the facility within a reasonable time frame. If a consultation is needed when the pharmacist is off site: 3. The findings are found, faxed, or emailed within (24 hours) to the director of nursing or designee and or documented in stored with the other consultant pharmacist recommendations in the resident's active record. F. Resident specific irregularities and/ or clinically significant risk resulting from or associated with medications or documented in the residence active record and reported to the Director of Nursing and/ or prescriber as appropriate. G. Recommendations are acted upon and documented by the facility staff and/or the prescriber. 1) Prescriber accepts and acts upon suggestion or rejects and provides an explanation for disagreeing. 3) the director of nursing or designated licensed nurse address and document recommendations that do not require a physician intervention, e. g., monitor blood pressure.		

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews the facility failed to ensure a medication error rate of less than 5.00%. Thirty-one medication administration opportunities were observed, and four errors were identified for three residents (#50, #25 and #46) of eight residents observed. These errors constituted a 12.9% medication error rate. 1). On 9/30/25 at 11:15 a.m. an observation of medication administration with Staff K, Licensed Practical Nurse (LPN)/Charge Nurse (CN) was conducted with Resident #50. The staff member obtained a blood glucose level from the resident. The staff member returned to the medication cart, cleaned the glucometer and reviewed the resident's insulin sliding scale order for insulin lispro. Staff K removed the resident's Kwik pen of insulin lispro [NAME] (opened 9/25), applied a needle to the cartridge and dialed the dosage selector to 8 (units). The resident was injected with 8 units into the left upper arm. An interview was conducted with Staff K immediately after returning to the medication cart. The staff member reported being educated on the use of an insulin pen, not sure of priming the pen, had been educated but could not remember. During an interview on 10/1/25 at an unknown time, the Director of Nursing (DON) reported being aware of the insulin pen not being primed and stated how do you not know about priming the insulin. 2). On 10/1/25 at 3:29 p.m. an observation of medication administration with Staff C, Licensed Practical Nurse (LPN) was conducted with Resident #25. The staff member dispensed one 6.25 milligram (mg) tablet of Carvedilol. The electronic medication profile was observed to contain parameters for the resident's Carvedilol. The staff member reported not having to take the resident's blood pressure (prior to administration) and entered the resident's room with the medication. The staff member was asked what the resident's blood pressure was and again Staff C stated not having to take the resident's blood pressure, saying, (the medication) did not have parameters. Staff C was asked to check the physician order. The staff member reviewed the resident's Carvedilol order and reported the order was to hold under (systolic) 110 or (heart rate) 60. Staff C returned to the resident and obtained a blood pressure of 130/72 and a heart rate of 55. The staff member reported having to check the order, returned to the med cart and stated the medication was to be held due to pulse under 60. The staff member documented the blood pressure and pulse. Review of Resident #25's September Medication Administration Record (MAR) showed the resident was to receive 6.25 mg of Carvedilol by mouth two times a day for congestive heart failure (CHF), hold for systolic blood pressure (SBP) less than (<) 110 or diastolic (DBP) <60 or heart rate <60. The MAR did not have a location for staff to document the resident's blood pressure prior to each dose. Review of Resident #25's progress note, effective 10/1/25 at 3:33 p.m. revealed a blood pressure of 130/72 and pulse of 55, however the note did not document whether the medication had been held due to the parameters. 3). On 10/2/25 at 7:36 a.m. a medication observation with Staff G, Licensed Practical Nurse (LPN) was conducted with Resident #46. The staff member obtained from the resident a blood pressure of 158/75, returned to the medication cart, and dispensed the following medications:- amlodipine 10 milligram (mg) oral tablet- escitalopram 10 mg oral tablet- losartan potassium 100 mg oral tablet- metoprolol tartrate 50 mg oral tablet- tizanidine 2 mg oral tablet- buspirone hydrochloride 10 mg oral tablet- morphine sulfate 30 mg oral tablet- trelegy ellipta inhaler- ipratropium/albuterol 0.5/3 mg/3 milliliter (mL)The staff member stated during the dispensing, the Buspar (buspirone) and Morphine was not showing up (on electronic medication profile) because they were 9 a.m. medications. The staff member dispensed the Morphine then obtained the narcotic count binder from the nursing station, saying it had a shower list on it, so it's everywhere. The staff member confirmed dispensing 7 oral tablets. Staff G entered Resident #46's room at 7:46 a.m., administering the inhaler trelegy, at 7:48 a.m. the staff member handed the medication cup containing the oral medications to the resident who swallowed them, the staff member opened the top of the nebulizer pipe and squirted the vial of ipratropium/albuterol into it. The staff member left the resident's room at 7:49 a.m. informing Resident #46 of returning to shut (continued on next page)		

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 10/02/2025
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)		
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	off the nebulizing machine. An interview was conducted with Staff G on 10/2/25 at 7:49 a.m. The staff member confirmed the resident's buspar and morphine were not due till 9:00 a.m. Review of Resident #46's physician orders revealed the resident's buspar was to be given twice daily at 9:00 a.m. and 5:00 p.m. The orders revealed the resident was to receive Morphine every 12 hours for pain and per Staff G's interview was scheduled at 9:00 a.m. and at 9 p.m. Review of Resident #46's progress notes, on 10/2/25 at 11:33 a.m. did not reveal the physician was notified of the early administration of buspar and/or morphine. During an interview on 10/2/25 at 11:31 a.m. the observation of medication administration was discussed with Staff H, Licensed Practical Nurse/Unit Manager (LPN/UM). The staff member stated medications are to be given one hour before and after the scheduled time. Staff H stated the observation of Resident #46's buspar and morphine were errors (due to being administered early). Review of policy - Medication Administration, reviewed/revised by the Nursing Home Administrator on 10/2/25, revealed Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. The compliance guidelines included but not limited to the following:8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physicians prescribed parameters.10. Ensure the six rights of medication administration are followed: a. Right resident b. Right drug c. Right dosage d. Right route e. Right time f. Write documentation12. Compare medication source (bubble pack, vial, etcetera) with MAR to verify resident name, medication name, form, dose, route, and time.a. Refer to drug reference material if unfamiliar with the medication, including its mechanism of action or common side effects.b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician.20. Sign MAR after administered. For those medications requiring vital signs, record vital signs on to the MAR.The policy included examples of medication timing (excluding insulin) which showed twice daily (BID) medications to be administered at 9:00 a.m. and 9:00 p.m., daily (QD) at 9:00 a.m. The policy revealed medications, including Carvedilol, which required administration after meals or with food.Review of policy - Insulin Pen, reviewed/revised by the NHA on 10/2/25 revealed It is the policy of this facility to use insulin pens in order to improve the accuracy of insulin dosing, provide increased resident comfort, and serve as a teaching aid to prepare residents for self-administration of insulin therapy upon discharge. The compliance guideline included but was not limited to:6. Insulin pens will be primed prior to each use to avoid collection on air in the insulin reservoir.		

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NAME OF PROVIDER OR SUPPLIER Oaks of Clearwater, The		STREET ADDRESS, CITY, STATE, ZIP CODE 420 Bay Ave Clearwater, FL 33756	
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure documentation was accurate and complete in the Electronic Medical Record (EMR) for one resident (#35) out of 13 residents reviewed. Findings included: Resident #35 was admitted to the facility on [DATE]. Review of Resident #35's medical record revealed medical diagnosis to include muscle wasting and atrophy, difficulty in walking, generalized anxiety disorder, and dementia. Review of the Minimum Data Set (MDS) dated [DATE], section C revealed the resident had a Brief Interview Mental Status of 09, which meant the cognition of Resident #35, was moderately impaired. Section GG of the MDS revealed the resident required supervision or touching assistance. It showed Resident #35 required partial or moderate assistance for toilet transfers. Section H revealed Resident #35 was incontinent frequently. Review of a Certified Nursing Assistant (CNA) Kardex (A documentation platform used by staff with instructions to specific resident care needs) revealed missing incontinence documentation for Resident #35 on 09/03/2025, 09/05/2025 - 09/10/2025, 09/17/2025, 09/27/2025 and 09/28/2025. On 10/01/2025 at 05:32 P. M., an interview was conducted with Staff E CNA. Staff E stated documentation should be completed at least once each shift. Staff E stated there was no reason documentation could not be completed, unless there was a system failure, of which Staff E stated there had been no system failure in the past 30 days. On 10/01/2025 at 05:40 P. M., an interview was conducted with Staff A CNA. Staff A stated there is no paper charting and all charting was performed electronically. Staff A stated incontinence care should be documented at the time of service or by the end of the shift. On 10/01/2025 at 05:50 P. M., an interview was conducted with Staff B CNA. Staff B stated incontinence care should be documented every shift and after meals. On 10/02/2025 at 07:32 A. M., an interview was conducted with Staff D CNA and Staff F CNA, at the same time. Staff D and Staff F stated incontinence care should be provided every two hours or as needed. Staff D and Staff F stated documentation must be added to the chart and there was no reason it would be missing unless it didn't happen. On 10/02/2025 at 07:48 A. M., an interview was conducted with Staff C Licensed Practical Nurse (LPN). Staff C stated appropriate supervision of CNAs included looking at their charting. Staff C stated no charting means the action didn't happen. Staff C stated, how would CNAs know otherwise? On 10/02/2025 at 07:48 A. M., an interview was conducted with Staff G LPN. Staff G stated CNAs are given rounds and they are made aware of residents who are incontinent and who is not incontinent. Staff G stated CNAs are observed throughout their shifts to ensure services were provided. Staff G stated if it wasn't documented it didn't happen. On 10/02/2025 at 07:48 A. M., an interview was conducted with the Director of Nurses (DON). The DON stated charting should be completed at the time of service or at the end of the shift. The DON stated if it isn't documented, it didn't happen. Review of a policy dated 04/21/2025, revised 10/02/2025, and titled Documentation in Medical Record, showed the following: Policy: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Policy Explanation and Compliance Guidelines: 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. 3. Documentation may be performed manually or as per the facility's specific electronic medical record software.		