STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105343	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heather Hill Healthcare Center	6630 Kentucky Ave New Port Richey, FL 34653

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 0689 Level of Harm - 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, interviews, and record review, the facility failed to ensure monitoring and supervision for the safety of one resident (#1) out of three sampled residents. Resident #1 suffered a fall with major injury requiring transfer to a higher level of care for treatment. Findings included: Review of the report titled incidents by incident type for 1/1/2026 to 5/20/2026 showed Resident #1 as having an unwitnessed fall on 1/11/2026, 2/10/2026, 3/9/2026, and 4/12/2026. Review of Resident #1's progress notes revealed:4/12/2026 at 11:40 p.m. Resident returned back to facility from the hospital with a comminuted left humeral head fracture with surgical neck involvement and displacement of the greater tuberosity (meaning: a severe, multi-part break near the shoulder joint. It signifies the bone is shattered into multiple pieces, the main ball of the shoulder joint is damaged, and the rotator cuff attachment is pulled out of place).2/10/2026 at 3:31 p.m. Resident was pushing another resident in wheelchair and tripped an fell on the wheelchair, no injuries noted, did not hit head, physician and POA notified. A review of Resident #1's nursing notes did not reveal documentation of the reported falls on 1/11/2026, 2/10/2026 and 3/9/2026. On 5/20/2026 at 9:45 a.m. an interview and observation occurred with Resident #1 in resident's room. Resident #1 was observed seated in a wheelchair wearing a hospital gown with a sling on her left arm Resident #1 was able to speak about her day and answer simple questions. Resident #1 confirmed she had a fall and broke her shoulder and staff are providing relief for the pain. Resident #1 could not remember nor say exactly what happened on 4/12/2026 but confirmed she was pushing Resident #2 in the parking lot in his wheelchair, tripped and fell on Resident #2. Resident #1 stated we go outside on the porch all the time. Review of Resident #1's record revealed she was admitted to the facility on [DATE] including the following diagnoses: cerebral Infarction (stroke), Type 2 Diabetes Mellitus with hyperglycemia, sudden vision loss, severe vascular dementia, displaced fracture of surgical neck of left humerus, muscle weakness, abnormalities of gait, need for assistance with personal care. Review of Resident #1's Advance Directives revealed an Incapacity to give informed consent and/or make health care decisions form, which was signed and dated by a physician on 9/30/2025. Resident #1 had a Durable Power of Attorney (DPOA) in place to make her medical and financial decisions. Review of Resident #1's physician order sheet revealed an order to include; Leave Of Absence (LOA), resident may go out on LOA without medications with escort for assistance with an original order date 9/6/2025. Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, dated 3/20/2026 revealed a Brief Interview Mental Status Score or BIMS score of 7 of 15, meaning significant cognitive deficits; patient generally requires assistance to participate in daily activities. No behaviors exhibited during time frame assessed. Resident has no impairment of upper and lower extremities, utilizes a wheelchair for mobility and is independent with other activities of daily living (ADL). No fall history prior to admission. Resident #1 has had two or more falls since admission with no major injuries. A review of Resident #1's care plans revealed: Focus: Impaired cognitive function or impaired thought process related to cerebral vascular accident (CVA). Date initiated: 9/24/2025. Intervention included: Cue, reorient and supervise as needed. Date initiated 9/24/2025.Focus: ADL self-care performance deficit (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 0689 Level of Harm - Actual harm Residents Affected - Few	and requires cues, setup, and/or assistance with ADLs related to activity intolerance, impaired balance, limited mobility, limited range of motion. Date initiated: 9/17/2025. Intervention included: The resident requires limited assistance by one staff to move between surfaces as necessary. Date initiated 9/17/2025.Focus: Limited physical mobility or is at risk for decline with mobility related to CVA. Date initiated: 9/15/2025. Interventions included: Mobility and/or assistive devices utilized by residents: manual wheelchair. Provide cues, direction and assist as necessary to [NAME] safety awareness with mobility. Date initiated: 9/15/2025.Focus: High risk for falls related to CVA, history of falls. Date initiated: 9/15/2025. Interventions included: Resident needs a safe environment with even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light; bed in low position at night; enabling devices to sides of bed; handrails on walls; personal items within reach. Date initiated: 9/17/2025 with a revision date of 9/24/2025.Focus: Actual fall related to poor safety awareness Date initiated: 11/3/2025 and revised on 3/12/2026. Interventions included: Continue interventions on the at-risk plan. Date initiated: 11/3/2025Keep personal items within reach. Date initiated: 11/3/2025Offer and encourage assistance with items out of reach. Date initiated: 1/12/2026Offer resident afternoon rest from ambulation and pushing another resident's wheelchair. Date initiated: 2/11/2026Encourage resident to sit while getting dressed. Date initiated: 3/10/2026 No identification, evaluation or analysis related to Resident 1's falls were found in the care plan or record. On 5/20/2026 at 9:57 a.m. an interview with Staff C, Licensed Practical Nurse (LPN), assigned nurse for Resident #1. Staff C, LPN, confirmed knowing both of the Resident #1 and #2 and their care needs. Staff C confirmed hearing that Resident #1 and #2 were both outside on the front lobby porch sometime about a month ago, as they usually do, and for some reason Resident #1 pushed Resident #2 off the porch and into the parking lot. Staff C continued to state that during the time Resident #1 and #2 left the front porch area, they had a fall which resulted in Resident #1 having a left shoulder/arm fracture. Staff C did not have any other information to offer related to the fall event that occurred on 4/12/2026 with Residents #1 and #2. An interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on 5/20/2026 at 12:00 p.m. both confirmed they would provide notes related to those falls but never provided them for review. The NHA and DON confirmed Resident #1 was at risk for falls and fall injuries due to having actual falls on 1/22/2026 and 2/10/2026. On 5/20/2026 at 12:57 p.m. an interview was conducted with Resident #3 about the incident on 4/12/2026. Resident #3 stated he saw Resident #1 and #2 and they said they were going to the library. Resident #1 was pushing the wheelchair that Resident #2 was sitting in. When Resident #1 fell on the grassy area, Resident #3 quickly went back in the facility to get help from staff members. On 5/20/2026 at 2:10 p.m. an interview was conducted with Staff E, Licensed Practical Nurse (LPN) who stated residents do not need to sign LOA if they were going to the front porch area of the facility. Staff E said on 4/12/2026 Resident #3 came back into the building and alerted staff that something happened. When staff went outside, they saw Resident #1 lying on the ground complaining of pain, and Resident #2 was in the wheelchair. On 5/20/2026 at 11:00 a.m., 3:00 p.m. and 3:40 p.m., the Nursing Home Administrator (NHA), and the Director of Nursing (DON) were interviewed about Resident #1's fall history and the fall with injury on 4/12/2026. The DON stated Resident #1, prior to 4/12/2026 had been able to walk on her own and without any assistive devices. The DON stated Resident #1 was observed most times walking and pushing Resident #2 out to different spaces, while Resident #2 was seated in the wheelchair. This included going out to the front lobby porch area. The DON stated Resident #1 mostly did not present with unsteady gait, but her cognition had been declining.The DON stated both Resident #1 at times would go to the front porch area. DON did confirm Resident #1 had prior falls on 1/11/2026 and on 2/10/2026 and was declining both physically and cognitively since those falls. The NHA stated that through his and the DON's investigation, it was determined on Sunday 4/12/2026, Resident #1 pushed Resident #2 while he was seated in his wheelchair outside to the porch area. The DON revealed per their investigation, Resident #1 had decided to stand up and push Resident #2 off the porch area and then out through the parking lot. The NHA explained that (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	when Resident #1 was pushing Resident #2, Resident #1 then tripped and fell onto the Resident #2 and both fell to the ground. The NHA revealed no staff had observed this, but Resident #3 who was on the front porch witnessed the fall and then called out for help from inside the facility. The NHA stated nursing staff to include nurse staff E reported outside to intervene and take vitals. The DON revealed as per report from Staff E, Resident #1 had told her, I just wanted to take [Resident #2] to the library. The NHA then stated per Staff E assessment, she was told by Resident #1 that she tripped on something caused both her and Resident #2 to fall to the ground. The NHA revealed Resident #1 presented with pain and the family, and physician were immediately contacted. The physician ordered X rays, and they ultimately returned with results with Resident #1 having a left shoulder fracture. The NHA confirmed Resident #1 was sent to the emergency room for treatment and Resident #2 stayed at the facility. The DON also confirmed perhaps Resident #1 and #2 should have been better supervised as their cognition declined and with Resident #1 having prior falls. The DON wanted to say that though Resident #1 and #2 were assessed during the MDS timeframe of having lower cognitive function, that both were still able to talk about their day and express their daily choices. The NHA stated that all residents are supervised while on the front porch by the reception staff. The NHA also confirmed there is not supervisory staff, or reception staff manning the front desk on the weekends, and that the incident that occurred with Resident #1 and #2 did happen on the weekend. The DON Review of a facility policy titled Accidents and Supervision, undated, showed the following: Policy: The resident environment will remain as free of accident hazards as is possible.Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes:1. Identifying hazard(s) and risk(s).2. Evaluating and analyzing hazard(s) and risk(s).3. Implementing interventions to reduce hazard(s) and risk(s).4. Monitoring for effectiveness and modifying interventions when necessary.Definitions: Accident refers to any unexpected or unintentional incident, which results in injury or illness to a resident.Supervision/Adequate Supervision refers to intervention and means of mitigating risk of an accident.Policy Explanation and Compliance Guidelines: The facility shall establish and utilize a systematic approach to address resident risk and environmental hazard to minimize the likelihood of accidents.1. Identification of Hazards and Risks the process through which the facility becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident.A. All staff (e.g., professionals, administrative, maintenance, tec.) are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident.2. Evaluation and Analysis- the process of examining data to identify specific hazards and risks and to develop targeted interventions to reduce the potential for accidents.3. Implementing of Interventions- using specific interventions to try to reduce a resident's risks from hazards in the environment.The process includes:.i. Resident-directed approaches may include:.i. supervising staff and residents, etc.5. Supervision- supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents.