

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105422	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Pinellas Park FL Opco, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8701 49th St N Pinellas Park, FL 33782	
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interviews, and record review, the facility failed to ensure medications were stored under proper temperature controls in the two medication storage rooms (2nd and 3rd) of two facility medication storage rooms observed. Findings Included: On 6/3/26 at 8:54 a.m., during a tour of the 2nd floor medication room, the Maintenance Director (DOM) checked the ambient temperature, which measured 82.20 F. On 6/3/26 at 9:27 a.m., during a tour of the 3rd floor medication room, Regional Maintenance Director (RDOM) checked the ambient temperature, which measured 85.2 F. During an interview on 6/3/26 at 8:54 a.m. the DOM said the air conditioning unit for the 2nd floor medication rooms has been out of service for approximately one month. He stated after the facility received three repair proposals, the repairs were approved the previous week, and the work would be completed soon. During both observation tours conducted on 6/3/26 at 8:54 a.m. and 9:27 a.m., the Over the counter (OTC) medications were observed stored in both medication rooms, and the automated medication dispensing machine was located in the third floor medication room. A random check of OTC medications stored in the 2nd and 3rd floor medication rooms showed the manufacturer storage recommendations for loperamide HCL 2 mg (milligrams) tablets, acetaminophen 650 mg suppositories, and acetaminophen 500 mg tablets was to store the medications between 68 F and 77 F and/or in a cool place. During an interview on 6/3/26 at approximately 9:00 a.m., Staff A, a Registered Nurse (RN) and Unit Manager (UM), stated her expectation was for medications to be stored at the appropriate temperature. During an interview on 6/3/26 at 9:53 a.m. the Director of Nursing (DON) stated, normally this is not an issue, and stated she would remove and discard all the over the counter (OTC) medications. During an interview on 6/3/26 at 3:36 p.m., the Regional Director of Maintenance (RDOM) provided a copy of a facility estimate statement, titled estimate to replace restricted Thermal Expansion Valve (TXV) and filter drier, dated 5/14/26 for the rooftop unit (RTU) . not cooling properly and work will start 2-3 days after approval. A report of the project timeline showed on 5/29/26 work for this job is not complete . temporarily fixed. During a telephone interview on 6/3/26 at 11:18 a.m., the facility pharmacy pharmacist stated loperamide HCL 2 mg tablets, acetaminophen 650 mg suppositories, and acetaminophen 500 mg tablets could tolerate elevated temperature conditions for 1 to 3 days, but not for a period of one month. Review of a facility policy titled, Medication Storage, revised, 4/2026, showed the following: Policy: It is the policy of this facility to ensure that all medications housed on the premises are stored, secured, and maintained under proper conditions to preserve integrity, . and ensure resident safety in accordance with federal and state regulations and according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Review of facility pharmacy policy, titled medication storage showed the following Medications will be stored in a manner that maintains the integrity of the product and ensures the safety of the residents and is in accordance with FL Department of Health guidelines G. Medications will be stored at the appropriate temperature in accordance with the pharmacy and/or manufacturer labeling. Appropriate temperature will be determined as per the following: 1. Controlled Room Temperature: 20 - 25 degrees (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Celsius (68 - 77 degrees F)2. Cool Place: 8 - 15 degrees Celsius (46 - 59 degrees F)3. Cold Place: 2-8 degrees Celsius (36 -46 degrees F)4. Warm Place: 30 -40 degrees Celsius (86 - 104 degrees F)5. Excessive Heat: >40 degrees Celsius (104 degrees F)(Photographic Evidence Obtained.)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to address and respond to resident council members, related to grievances voiced in their council meetings for four months (January, February, March, and April 2026) of five months reviewed and failed to respond to grievances for one resident (#84) of one resident reviewed. Findings included: Review of resident council minutes and the facility's grievance logs dated January 2026 through May 2026 showed grievance forms were not completed for grievances voiced in resident council meetings and a response was not provided to the committee members for the four-month period reviewed. Review of the Resident Council minutes dated 1/8/26 showed the residents reported concerns regarding cold food. The minutes showed there were no nursing, therapy, housekeeping/laundry, administration/social services, and maintenance concerns listed. The committee's concern about cold food was not listed on the grievance log and the facility did not provide a grievance form or documentation indicating the concern was addressed or that feedback was provided to the resident council. Review of the Resident Council minutes dated 2/12/26 showed the residents reported concerns regarding cold food and that place settings were not being provided. The minutes showed there were no nursing, therapy, housekeeping/laundry, administration/social services, and maintenance concerns. The committee's concern about cold food and place settings was not listed on the grievance log and the facility did not provide a grievance form or documentation indicating the concern was addressed or that feedback was provided to the council. Review of the Resident Council minutes dated 3/12/26 showed the residents reported concerns about cancellation of Wednesday outings and access to money from their Resident Funds Management System (RFMS) accounts when requested. The minutes showed there were no nursing, therapy, housekeeping/laundry, administration/social services, and maintenance concerns. A grievance form documenting the committee's concern about resident access to their RFMS accounts did not show the facility provided feedback to the council. Review of the facility's RFMS withdrawal record between 3/13/26 and 3/16/26 showed 20 resident withdrawals of less than \$50.00, less than what the residents requested. Review of the Resident Council minutes dated 4/16/26 showed the residents reported concerns regarding activities. The minutes showed there were no nursing, therapy, housekeeping/laundry, administration/social services, and maintenance concerns. The committee's concern about activities were not listed on the grievance log and the facility did not provide a grievance form or documentation indicating the concern was addressed or that feedback was provided to the council. Review of the Resident Council minutes dated 5/18/26 showed no concerns were documented. During an ad hoc Resident Council meeting conducted on 06/02/26 at 10:01 a.m., the council members reported, kitchen and food services are at a stalemate regarding frequently cold and inedible meals. The residents who require dialysis treatments are sent to their appointments without snack or a bagged meal. One of the residents said due to the lack of food post dialysis, their fatigue is increased. They reported these issues have worsened over the past two months. The committee attendees reported due to a lack of staff the first-floor dining room is often closed, and they miss having social interactions during mealtime. The council members stated the facility does not honor requests for access of up to \$50.00 of their funds daily and daily withdrawals limited to \$25.00. The committee members said the facility does not provide feedback regarding their concerns. While discussing concerns listed in the council meeting minutes, the attendees reported concerns about untimely call light response, delayed activities of daily living (ADL) assistance and facility maintenance concerns. An interview and resident council minutes review was conducted with the Regional Activities Director (RAD) and Staff H, Activities Assistant (AA) on 06/03/2026 at 4:07 p.m. Staff H, AA said the previous Activity Director left in April and she had completed the resident council minutes for April 2026 and May 2026. She said she was not shown how to complete the minutes and (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	uses a form with instructions. In response to the concerns reported by the committees not listed in the minutes, she said she did not write down all of the concerns discussed during the meeting. She said she did not receive any training. Staff H said each month she gives a copy of the minutes to the Certified Dietary Manager (CDM) and the Nursing Home Administrator (NHA). During an interview on 6/3/26 at 4:30 p.m. with the NHA and the Regional Business Office Manager (RBOM). The NHA said changes in staffing contributes to the residents' access to community events and she was not aware the residents were concerned about having access to the first-floor dining room. Regarding the residents' access to their RFMS accounts the RBOM, said the facility withdraws \$600.00 three times each week, which was not enough to cover all the resident's requests. The NHA said sometimes resident council concerns trigger a grievance, depending on what it is. Review of Resident #84's admission record revealed she was admitted [DATE] with a diagnosis to include dementia, hypertension, heart failure and anemia. Review of Resident #84's admission Minimum Data Set (MDS) dated [DATE] showed Brief Interview for Mental Status (BIMS) score was 00/15, indicating he resident could not complete the test. During a telephone interview on 6/2/26 at 1:15 p.m., Resident #84's family member stated that the facility does not follow up on the grievances they have filed. She said they have given the facility several notes with grievances and have not received a response. Resident #84's family member provided photographs of letters handed to facility staff containing the following information: A note dated 4/13/26 at 1:30 p.m. requested assistance in arranging (name of transportation company) transportation for Resident #84 and asked that the family member be contacted to confirm the transportation was scheduled. A note dated 4/18/26 at 3:56 p.m. addressed to the Administrator, DON, and Floor Manager regarding feet and ankle swelling and requested the facility and the doctor follow-up with the family member. A note dated 4/18/26 at 4:05 p.m. addressed to the Administrator, DON, Floor Manager. The note informed them to ensure that Resident #84's linens are changed every Monday, Wednesday, and Friday, and at any other time if soiled. The reason for the request was that the linens don't get changed. The family member also wrote that the facility should contact them with any questions. A note dated 4/18/26 at 4:15 p.m. addressed to the Administrator, DON, Floor Manager. The note informs the facility the family member spoke with facility staff about bathing and hygiene concerns. The family member wrote I look forward to hearing from someone. A review of the facility's grievance log dated April 2026 showed one grievance documented regarding Resident #84. A review of the grievance form showed dietary concerns. The documentations showed the facility addressed the concerns and followed up with the family member. The grievances dated 4/13/26 and 4/18/26 were not documented on the grievance log and the family said the facility did not provide feedback. During an interview on 6/4/26 at 11:26 a.m. the interim Social Services Director (SSD) stated not being familiar with the grievances filed by Resident #84's family member. She said once a grievance is received, it is reviewed and forwarded to the relevant department. The SSD said grievances that are not documented on the grievance form are transcribed to the form. In reference to the notes received from Resident #84's family member, the SSD said the facility should have written them on a grievance form. She said the facility notifies the person who files the grievance of the resolution. During an interview on 6/4/26 at 1:44 p.m. the Nursing Home administrator (NHA) said when grievances are received they are given to the appropriate department and the department is responsible for resolving the grievance. She said she had not seen the notes dated 4/13/26 and 4/18/26 regarding Resident #84. She said handwritten notes are transcribed to a grievance form. She said Resident #84's family members visit the facility often, and sometimes the facility will handle a concern from a family without completing a grievance form. Review of facility policy titles Resident and Family Grievances, reviewed 1/2026 showed the following: Policy: It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. Definitions: Prompt efforts to resolve include facility acknowledgment of a complaint/grievance and actively working toward resolution of that complaint/grievance. Policy Explanation and Compliance Guidelines: 1. Facility will have a (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	designated Grievance Officer. Their name and contact information will be posted in the facility so residents, family and staff have access to it.2.The Grievance Officer is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; coordinating any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations. 4. A resident or family member may voice grievances with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and other residents, and other concerns regarding their LTC facility stay .7 Grievances may be voiced in the following forums: a. Verbal complaint to a staff member or Grievance Officer. b. Written complaint to a staff member or Grievance Officer, c. Written complaint to an outside party. d. Verbal complaint during resident or family council meetings . 10.Procedure:a. The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form or assist the resident or family member to complete the form.i. Take any immediate actions needed to prevent further potential violations of any resident right.b. Forward the grievance form to the Grievance Officer as soon as practicable.c. The Grievance Officer will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form.i. Steps to resolve the grievance may involve forwarding the grievance to the appropriate department manager for follow up.ii. All staff involved in the grievance investigation or resolution should make prompt efforts to resolve the grievance and return the grievance form to the Grievance Officer.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation and interview, the facility failed to ensure the resident environment was free from accident hazards in one unsecured utility rooms (third floor) of two observed. Finding included: An observation on 06/01/2026 at 6:15 AM revealed the biohazard/ soiled utility room on the third floor was not locked or secured in a manner that would prevent residents on the third floor from accessing the contents of the room that could have the potential to cause injury or illness. The room was observed to contain a sharps container, a refrigerator marked with a biohazard symbol, and soiled linens. During multiple tours, residents were observed ambulating independently through the hallways on the third floor, near and around this utility room. An interview with Staff K, Registered Nurse (RN), on 06/03/2026 at 2:52 PM revealed the biohazard room should always be locked because there is a small refrigerator with biological samples in the room which need to be protected from contamination and/or tampering. Staff K said additionally, the room contains potentially hazardous items, such as a sharps container and linens that has been soiled with bodily fluids. An interview with Staff D, License Practical Nurse (LPN) on 06/03/2026 at 3:06 PM revealed the biohazard room should be locked because it contained materials and substances that residents should not come into contact with such as biohazardous waste. An observation was made with Staff D and Staff K of the biohazard/soiled utility room on the third floor, which was not locked. At the time of the observation of the biohazard/soiled utility room with Staff D and Staff K, residents were observed ambulating independently throughout the hallways on the third floor. On 06/03/2026 at 3:36 PM an observation and interview with Staff J, LPN/ Unit Manager (UM), revealed the biohazard/soiled utility room on the third floor was not locked or secured in a manner that would prevent residents from gaining access to the potentially hazardous materials contained in the room. Staff J said the room should be locked because it contained dangerous biohazardous materials such as used sharp medical instruments and linen soiled with bodily fluids. Staff J said all staff are responsible for ensuring the biohazard/soiled utility room is locked, and maintenance is responsible for ensuring that all door locks are functioning properly. On 06/04/2026 at 9:26 AM, and interview with the Maintenance Director revealed the maintenance department is responsible for ensuring that door locks in the facility are functioning properly. The Maintenance Director said all staff should notify maintenance via their online reporting system if they observe door locks that are not functioning properly. The Maintenance Director did not have previous maintenance requests for the repair of the lock for the door of the biohazard/soiled utility room on the third floor. The director said the online maintenance reporting system has an automated monthly prompt that reminds maintenance staff to check the functioning of doors and locks throughout the facility. The Maintenance Director did not provide an explanation for not verifying the functioning of the door lock. A review of a facility policy titled Accidents and Supervision, implemented on 09/01/2023, revised on 01/2026, revealed all staff (e.g., professional, administrative, maintenance, etc.) 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. The facility should make a reasonable effort to identify the hazards and risk factors for each resident. Various sources provide information about hazards and risks in the resident environment. Implementation of interventions showed - using specific interventions to try to reduce a resident's risks from hazards in the environment. The process includes: communicating the interventions to all relevant staff, assigning responsibility, providing training as needed, documenting interventions (e.g., plans of action developed by the Quality Assurance Committee or care plans for the individual resident), ensuring that the interventions are put into action. Monitoring and modification processes include: ensuring that interventions are implemented correctly and consistently. A review of a facility policy titled Regulated (Biohazard) Medical Waste, implemented 09/01/2023, revised on 01/2026, revealed it is the policy of this facility to ensure that regulated medical waste is managed, handled, (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stored, and transported as per Federal, State and local guidance and regulations. According to the policy, regulated waste means liquid or semi-liquid blood or other potentially infectious materials: contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials that are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or other potentially infectious materials.(Photographic evidence obtained)		

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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, interviews, and record review, the facility failed to ensure sanitation requirements were met in 1 out of 1 kitchens observed. Findings included, On 06/01/2026 at 05:51 AM, a kitchen tour was conducted. During the tour, a steam table was observed to be soiled with white debris on the bottom shelf. In the dishwasher area, a metal faucet with spiraling metal was observed with brown corrosion and deformed. A stove in the kitchen was observed, with ash-like debris in various areas on the stove top. Discolored noodles were observed on the stove top near an open flame. A dish rack in the kitchen was observed soiled with debris on various dishes, such as metal pans and lids. On a wall located in the bottom left corner, a tile was observed missing. In the area, a tile was missing from, the insides of the wall were visible, including metal, various wall construction elements, and debris. A cart in the kitchen was observed with various wet and dry discolored liquids and debris. On 06/02/2026 at 04:35 PM, a kitchen tour was conducted. The kitchen stove top was observed with black and white ash and an open flame. A griddle was observed with tan and taupe colored buildup. Dishware on a rack was observed with debris, in tan to taupe colors. The facet in the dishwasher area with spiraling metal was observed with brown corrosion. Ceiling vents were observed to be soiled. A ceiling above a food preparation area, adjacent to the dining hall was observed in disrepair with vinyl peeling off the ceiling tile. During an interview on 06/02/2026 at 04:39 PM, the Senior Certified Dietary Manager, (SCDM), stated the facility staff performed deep cleanings every month. The SCDM stated I don't even know how we're going to clean that, steam table, we obviously have missed it. The SCDM stated old food on a gas stove with an open flame was dangerous. The SCDM grabbed a metal dishware item from a dish rack of clean dishes, and stated I think these are dirty, I don't know why someone put them here. The SCDM stated the faucet in the dishwasher room, with spiraling metal definitely has rust on it, but I think it is clean. During an interview on 06/03/2026 at 10:13 AM, the SCDM stated the cleanliness of the kitchen was not where we want to be, and that the kitchen staff had been the problem. During an interview on 06/04/2026 at 12:48 PM, the SCDM stated some staff members had been signing the daily cleaning log and hadn't performed the cleaning. The SCDM stated the charge cook was responsible for supervision of task that needed to be completed. The SCDM stated the Certified Dietary Manager, (CDM), and the supervisor were responsible for supervision of the charge cook. The SCDM stated there was a failure in the process. During an interview on 06/04/2026 at 01:11PM, the Nursing Home Administrator, (NHA), explained having expectations for the kitchen to be clean. The NHA stated the CDM was responsible for performing audits in the kitchen. The NHA stated there should not be debris on the kitchen dish rack not with all that stuff. The NHA stated she would not feel comfortable eating items from the kitchen. A facility policy titled Sanitation Inspection, revised 01/2026 revealed: Policy: 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: All food service areas shall be kept clean, sanitary, free from liter, rubbish and protected from rodents, roaches, flies, and other insects. Photographic evidence 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, interviews and record review, the facility failed to maintain an effective pest control program in one kitchen (Main) out of one kitchen observed. Findings included: On 6/1/2026 at 6:02 a.m., during a tour of the kitchen, a small, slender winged, flying insect was observed in the hallway leading to the kitchen. Upon entering the kitchen, an observation was made of more of the same flying bugs in the dishwasher room, in the hallway where a locker room was located, and near the office located inside the kitchen. There were numerous flying bugs observed on the lid of a container on the ground near the dishwasher, and around a food disposal unit connected to a countertop near the dishwasher. A flying bug was observed on the handle of a cooking pot on a drying rack. During an interview on 6/2/2026 at 4:50 p.m., the Senior Certified Dietary Manager (SCDM) said he knew there were some flying bugs the day before, but he had not seen these many flying bugs previously. During an interview on 6/2/2026 at 4:44 p.m. the SCDM said the pest control company serviced the kitchen every other week. The SCDM stated the staff deep cleaned, scrubbed floors, and cleaned walls once a week. During an interview on 6/4/2026 at 1:11 p.m., the Nursing Home Administrator (NHA), stated the expectations for the kitchen were for it to be clean. The NHA stated the Certified Dietary Manager (CDM), was responsible for auditing the kitchen's cleanliness. The NHA said she was aware of gnats and stated she saw some little gnats, a few weeks ago. The NHA stated she had toured the kitchen with the pest control company and saw gnats. The NHA stated the pest control company treated the facility for pests as needed. The NHA confirmed there was a risk of gnats getting into resident's food, the fridge and freezer since the gnats were present in the kitchen. The NHA stated the gnats were difficult to eliminate. The NHA said maybe the pest control company needed to use different chemicals, as the gnats were probably getting used to whatever they are using. The NHA stated she was not aware of the hole in the pantry wall and stated she believed bugs could get into the pantry through the hole. The NHA stated the kitchen's food disposal should not have had leftover debris or standing water as it could have caused gnats to infest the kitchen. The NHA said she would not be comfortable eating food from the kitchen and that she was responsible for the kitchen's cleanliness. A review of the facility's pest control company's service inspection reports showed a report dated 3/23/2026 with comments including Heavy Phorid fly activity seen in the kitchen by wash sink and juices syrup boxes and in multiple floor drains. Multiple drains had food debris/organic build up. Standing water and organic build up by wash sinks. A review of the pest control company's service inspection reports showed a report dated 5/18/2026 with comments including Phorid fly activity in the kitchen by wash sink and juices syrup boxes. Review of the facility policy titled, Pest Control Program policy and procedures, revised 01/2026, revealed a policy: It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents. Definition: Effective pest control program is defined as measured to eradicate and contain common household pests (e.g., bed bugs, lice, roaches, ants, mosquitos, flies, mice and rats).		

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NAME OF PROVIDER OR SUPPLIER Pinellas Park FL Opco, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8701 49th St N Pinellas Park, FL 33782	
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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 maintain a safe, clean, comfortable and homelike environment in four resident rooms (235, 251, 304 and 324) of 36 rooms observed. Findings included: During an observation of room [ROOM NUMBER] with the Director of Maintenance (DOM) on 06/03/2026 at 11:15 a.m., the DOM observed and stated, he's seeing what appears to be water intrusion in to the walls from outside with the walls damaged. During an observation of room [ROOM NUMBER], the DOM stated, he was seeing that the window had failed and there was a leak in the thermal lining of the panes, there was also water intrusion into the wall with bubbling of the paint and unpainted surfaces. During an interview on 6/4/26 at 09:30 a.m. with the resident in room [ROOM NUMBER], she stated, the windows and the walls are in need of repair and has asked staff to fix, with no response. During an interview on 6/4/26 at 12:00 p.m. with the resident in room [ROOM NUMBER], he stated, the walls and the window are in disrepair. During a tour and observation on 6/1/2026 at 8:30 a.m. of room [ROOM NUMBER] the bathroom was observed with ceiling tiles removed and pushed to the side. This exposed pipes and wiring. During an observation on 6/2/26 at 9:56 a.m. of the ceiling tiles in room [ROOM NUMBER]. The ceiling had misaligned tiles in the closet, exposing the space above the ceiling. During an interview on 6/3/26 at 12:05 p.m. with the NHA, the DOM and the Director of Plant Operations, The DOM stated regarding determining what to repair, If I get a notice from someone verbally I'll fix the issue, but I do not have a plan to prioritize and identify issues throughout the structure. He said they do use angel rounds to help identify issues, but we don't have a current order to place priority to these issues, and we don't have angel round documentation to review. The DOM stated they did not currently have anything in their electronic reporting system or work orders for the two issues identified in rooms [ROOM NUMBERS]. He said we do use weekly monthly products to help us in the electronic reporting system to assist us in identifying items to fix, however we don't use an organized system to identify items to repair in each room. He said he uses life safety as a guide to help him prioritize issues once they're identified, meaning that life safety comes first and everything comes thereafter. He stated the staff is supposed to be putting issues in the electronic reporting system and they should have been trained during orientation regarding entering maintenance issues in the electronic reporting system. The DOM said they did not have any documentation of the training. Review of a document titled Maintenance Director Job Description, undated, signed on 4/8/26 by the employee and supervisor revealed;Major Duties and Responsibilities, Plans develops, organizes, implements, evaluates, and diets the Maintenance Department, it's programs and activities. Ensure the facility remains in compliance with all federal, state and local regulations for Life Safety Code compliance. Ensures proper planning, direction, participation, and supervision of both preventative and unplanned maintenance and repair activities in the facility, which includes painting, plumbing, carpentry, HVAC (heating ventilation and air conditioning), and electrical work.		

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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 record review and staff interview, the facility failed to complete/update the Pre-admission Screening and Resident Reviews (PASARRs) for residents with a mental disorder and individuals with intellectual disability following qualifying mental health diagnoses for two residents (#1 and #85) of 4 residents reviewed for PASARRs. Findings included: 1. Review of the transfer/discharge report showed Resident #1 was admitted to the facility on [DATE] with diagnoses to include anxiety disorder, depressive disorder, psychosis, psychoactive substance abuse, and schizophrenia. Review of Resident #1's level I PASARR dated 1/8/26 showed qualifying diagnoses including anxiety disorder, depressive disorder, psychosis, were not checked. The review showed the Level I PASARR was incomplete, and a level II was not submitted for consideration following qualifying diagnoses. During an interview on 6/4/26 at 12:57 p.m. with the Director of Nursing (DON) and the Interim Social Services Director (SSD) the SSD said, I have to do his (Resident #1) level II. He is on my list to do, and I have not gotten to him. 2. Review of Resident #85 admission record revealed an original admission date of 3/28/2026. Resident #85 was admitted to the facility with diagnosis to include but not limited to major depressive disorder - 3/28/2026, and other schizoaffective disorders - 3/28/2026. Review of a Level I PASARR for Resident #85 dated 3/27/2026 revealed a blank PASARR and the qualifying diagnoses were not checked. The review showed the Level I PASARR was incomplete, and a Level II was not submitted for consideration following qualifying diagnoses. During an interview on 6/4/2026 at 12:57 p.m., the Director of Nursing (DON) stated her process for PASARR was that she would determine if it was done by the hospital and if the resident required a level II. The Social Services Interim, Staff E, said her process was different as she waited for a psychiatry physician to do the resident's evaluation and then proceed with their recommendations. Staff E stated she had been attempting to catch up and fix everything. Staff E stated having a long list of PASARRs to work on as it was her responsibility to maintain their accuracy. Staff E said the PASARR the facility currently had for Resident #85 was wrong as it was not filled out. She said Resident #85 was on her to do list. Staff E said the diagnoses depression and schizoaffective disorders should have been checked in the PASARR. During an interview on 6/3/2026 at 10:54 a.m., Staff J, Licensed Practical Nurse (LPN) and Unit Manager (UM) said residents were sometimes admitted from the hospital with a completed PASARR. Staff J, Nurses, social services, administrators and Minimum Data Set (MDS) coordinators were responsible for checking PASARRs upon admission. Staff J said for the residents who did not have a completed PASARR, social services was responsible for filling them out. Staff J said an inaccurate or incomplete PASARR would be due to an oversight. Review of the facility policy titled, Resident Assessment & Coordination with PASARR Program policy and procedures, Revised 01/2026, revealed a policy: This facility coordinates assessments (continued on next page)		

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Printed: 08/27/2026
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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Policy explanation and compliance guidelines: 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and 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.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on record review and interviews, the facility failed to ensure dialysis residents were provided with snacks/meals consistent with professional standards of practice and the care plan for one resident (#8) of one sampled. Findings included: Record review revealed Resident #8 had medical diagnoses of dependence on renal dialysis and end stage renal disease. The order summary report for Resident #8 revealed an order to send snack with resident on dialysis days in the morning every Tuesday, Thursday, Saturday, with a start date of 04/09/2026. The care plan report for Resident #8 revealed a focus of Resident #8 is at risk for renal failure with dialysis, last revised on 01/19/2026. The intervention for that focus included to send snack/meal with Resident #8 on dialysis days, last revised on 10/22/2025. A progress note dated 05/30/2026 revealed no snacks available nor delivered by dietary staff. An interview with Staff M, Certified Nursing Assistant (CNA) on 06/03/2026 at 12:45 PM revealed it is the CNA's responsibility to ensure residents have breakfast or lunch before exiting the facility to be transported to receive dialysis services. Staff M said dietary staff should prepare and bring resident's meals up to the nourishment rooms before the resident's scheduled transportation time. Staff M said if a resident was scheduled to be transported for dialysis services before breakfast is served at the facility, dietary staff will bring their meal up to the nourishment room during the shift prior to their scheduled dialysis service. Staff M said if dietary staff do not bring the meal up, it is the CNAs or nurses responsibility to go to the kitchen to obtain the meal prior to the resident exiting the facility. An interview with Staff N, CNA on 06/03/2026 at 2:30 PM, revealed the facility's process for ensuring residents have meals when they leave the facility for dialysis services is for dietary staff to bring meals to the nourishment room sin the facility prior to the residents' scheduled transportation times. Staff N said if dietary staff do not bring resident dialysis meals, the CNAs should go to the kitchen to obtain a meal for the residents. Staff N said the expectation is for the resident to receive a meal to take with them to dialysis every time they go to dialysis. An interview with Staff K, Registered Nurse (RN), on 06/03/2026 at 2:52 PM revealed the facility's expectation for residents receiving dialysis services is for dietary staff to bring resident meals to the nourishment rooms the day before their scheduled dialysis. Staff K said residents are also provided with snacks to take with them to dialysis. Staff K said if dietary staff does not bring meals and/or snacks to the nourishment rooms, staff should go down to the kitchen to obtain resident meals or snacks prior to being transported for dialysis services. Staff K said nurses assigned to residents that receive dialysis services are always aware when the resident leaves the facility to be dialyzed because the nurse has to enter current information in the resident's medical record prior to their exit. Staff K said residents should never leave the facility to go to dialysis without a snack. An interview with the Senior Certified Dietary Manager (CDM) on 06/04/2026 at 9:43 AM revealed before a resident leaves the facility in order to be transported for dialysis services, dietary staff should place meals for those residents in the nourishment rooms during the shift prior to the resident's appointment. The CDM said if dialysis meals have not been placed in the nourishment room refrigerator, then nursing staff should go to the kitchen to obtain a resident meal prior to the resident exiting the facility. The CDM said dietary staff uses a log to ensure the meals and snacks for dialysis have been prepared but was unaware of a system used to ensure those meals are received by the resident prior to exiting the facility to be dialyzed. The CDM was unsure why there was a progress note for Resident #8 showing the resident did not receive nourishment prior to being transported to dialysis on 05/30/2026. An interview with the Director of Nursing (DON) on 06/04/2026 at 10:08 AM, revealed when a resident goes to dialysis, their assigned CNA assists them in getting ready for their appointment, such as performing or assisting with personal hygiene and activities of daily living. The DON said residents are always provided with a snack and/or meal before being transported from the facility to their dialysis appointment. The DON said the dialysis nourishment should be brought to the nourishment rooms by dietary staff, and nurses should give the dialysis nourishment to residents prior to them (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	leaving the facility. The DON said the process for ensuring that residents receive their snack or meals for dialysis if for the nurses to visually verify that the resident has their meal when leaving the facility. The DON said if no snacks or meals are available in the nourishments rooms, the nursing staff should go to the kitchen and ask for a snack, meal, or some form of nourishment to be provided to the residents. The DON said there are also snacks available at the nurses' stations in residents living areas. The DON said regarding Resident #8 on 05/30/2026, her expectation was for the nurse to assemble a form of nourishment to be provided to the resident if the kitchen did not supply one. The DON was unsure of the most recent education provided to staff informing them to ensure that residents are provided with nourishment when they leave the facility for dialysis services. Review of a facility policy titled Hemodialysis, implemented on 09/01/2023, revised 01/2026, revealed this facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis. Additionally, the policy states the licensed nurse will communicate to the dialysis facility via telephonic communication or written format, such as a dialysis communication form or other form, that will include but not limit itself to: nutritional/fluid management including documentation of weights, resident compliance with food/fluid restrictions or the provision of meals before, during and/or after dialysis and monitoring intake and output measurements as ordered.		

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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, interviews and record review, the facility failed to ensure the medication error rate was not greater than 5%. A total of 28 opportunities were observed with 2 errors constituting an error rate of 7.14%. Findings included: On 6/2/2026 at 9:26 a.m. a medication observation was conducted with Staff F, Registered Nurse (RN) for Resident# 59. Staff F, RN confirmed the tablets prior to administration. Staff F dispensed the following medication:-Methadone hydrochloride 10 MG/ML (milligrams per milliliter) Oral Solution 1ml-Amlodipine 5 MG Oral - 1 Tablet [Norvasc] this medication was held due to low blood pressure.-Folic acid 400 Mcg (microgram) Oral -1 Tablet-Tamsulosin hydrochloride 0.4 MG Oral Capsule - 1 capsule-Sertraline 50 MG Oral - 1 Tablet-Tiotropium 0.018 MG Inhalation Powder Review of Residents# 59's admission records showed she was admitted to the facility on [DATE] with a diagnosis to include: Type 2 Diabetes Mellitus, Cerebral Infarction, Atherosclerotic Heart disease, Acute Kidney failure, Abdominal Aortic Aneurysm.Review of Residents #59's active orders showed: -Folic Acid 1MG, give 1 tablet by mouth for Anemia with a start date 5/28/2026. An interview was conducted on 06/02/2026 at 2:45 p.m. with Staff F, RN regarding the medication observation. Staff F, RN administered Folic Acid 400 Micrograms (mcg) dose instead of the ordered dose of 1MG. Staff F, RN stated she was aware this is not the correct dose. Staff F said she did not want Resident #59 to not receive any of the medication, so she administered the 400-microgram dose. Staff F, RN said this was an over-the-counter medication.On 6/1/2026 at 11:00 a.m. a medication observation for Resident #33 was conducted with Staff G, RN. Staff G, RN obtained a blood glucose level reading of 196. Staff G, RN then opened the cover to the 3 ML (milliliter) insulin Aspart, Human 100 UNIT/ML (unit/milliliter) Pen Injector and pushed on the injection button without the needle attached. Staff G, RN then cleaned the hub of the injection pen and attached the needle. Staff G then turned the dial to show 2 units and administered the dose in the left lower abdomen and held the dose for approximately 2 seconds. Review of Resident #33's admission record showed he was admitted to the facility on [DATE] with a diagnosis to include Diabetes Mellitus (DM) Type 2.Review of Resident #33's Active orders showed:Insulin Aspart Subcutaneous Solution Pen-injector 100 UNIT/ML Inject as per sliding scale:if 151 - 200 = 2 units;201 - 250 = 4 units;251 - 300 = 6 units;301 - 350 = 8 units;351 - 400 = 10 units Notify MD if >400 or <70 and follow hypoglycemia protocol,subcutaneously before meals and at bedtime for DM (Active) On 6/1/2026 at 11:15 a.m. an interview was conducted with Staff G Registered Nurse (RN) for Resident#33. During the medication observation Staff G, RN did not prime the insulin pen prior to administering. Regarding the question on how to properly prime the insulin pen, Staff G, RN responded, can I have a do over? Review of the manufacturer's Novolog Aspart Flex Pen found on the manufacturer's website www.novomedlink.com retrieved on 6/1/2026, showed, Priming your Pen. Prime before each injection. Called the Air Shot after applying the needle turn the dial to reflect the number 2 holding pen upright push on the bottom of the penPriming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the Pen is working correctly.If you do not prime before each injection, you may get too much or too little insulin.Giving your injection-Insert the needle into your skin.-Push the dose knob all the way in.-Continue to hold the dose knob in and slowly count to 5 (5 seconds) before removing the needle. An interview was conducted on 6/04/2026 at 1:30 p.m. with Director of Nursing (DON). In reviewing the findings of the medication administration observations, the DON confirmed the correct dose of Folic Acid milligrams should have been administered. The DON said the nurse should have held the medication and reached out to the pharmacy for a refill or physician for an order. The DON confirmed the nurse should have primed the insulin pen prior to administration to ensure the resident receives the correct dose of insulin. The DON said she will immediately ensure education is provided to the nurses.Review of the facility's policy titled, Administering Medications, with a revision date, 1/1/2026, revealed: Administer medications as (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordered; correct any discrepancies and report to nurse manager. Medication should be verified, the right resident, the right medication, the right dosage, the right time, and the right route of administration before giving the medication. Review of the facility policy titled, Insulin Pen, Revision date, 1/1/2026, showed: It is the policy of the facility to use insulin pen to improve the accuracy of insulin dosing. A new needle will be used for each injection; Insulin pen will be primed prior to each use to avoid collecting air in the insulin reservoir.		