STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105453	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kensington Gardens Rehab and Nursing Center	2055 Palmetto St Clearwater, FL 33758

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48441 Based on observation, record review, interviews, and review of the Plan of Correction (PoC) the facility failed to ensure it had a functioning Quality Assurance Performance Improvement (QAPI) plan. The facility was actively involved in the creation, implementation, and monitoring of their PoC for deficient practice identified during a complaint survey on 05/13/2025. The plan was ineffective resulting in citation F908 being recited related to ensuring timely repairs of essential equipment, for one roof-top Air-Conditioning (A/C) unit (#11) of 19 roof- top A/C units and F908 being recited related to failure to ensure equipment was safe, sanitary and operational, and failure to provide a safe, functioning, sanitary and comfortable environment in resident's rooms for six residents (#5, #6, #7, #11, #12 and #13) out of 15 residents sampled, and in common areas to include food storage areas. Findings included: A review of an undated facility policy titled, Quality Assurance and Performance Improvement (QAPI), showed a policy statement: This facility shall develop, implement, and maintain on ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for out residents. The objectives of the QAPI program are to: 1. Provide a means to measure current and potential indicators for outcomes of care and quality of life. 2. Provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators. 3. Reinforce and build upon effective systems and processes related to the delivery of quality care and services. 4. Establish systems through which to monitor and evaluate corrective actions. Authority: 1. The owner and/ or governing board body of our facility is ultimately responsible for the QAPI program (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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The governing board/owner evaluates the effectiveness of its QAPI program at least annually and presents findings to the QAPI committee. 3. The administrator is responsible for assuring that this facilities QAPI program complies with federal, state, and local Regulatory agency requirements. 4. The QAPI committee reports directly to the administrator Implementation: 1. The QAPI Committee overseas implementation of our QAPI plan, which is the written component describing the specifics of the QAPI program, how the facility will conduct its QAPI functions, and the activities of the QAPI committee. 2. The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include: a. Tracking and measuring performance. b. Establishing goals and thresholds for performance measurement. c. Identifying and prioritizing quality deficiencies. d. Systematically analyzing underlying causes of systemic quality deficiencies. e. Developing and implementing corrective action or performance improvement activities and f. Monitoring or evaluating the effectiveness of corrective action performance improvement activities, and revising is needed. Coordination: 1. The QAPI Coordinator coordinates QAPI Committee activities and changes to the QAPI plan. 2. The QAPI coordinator assists other committees, individuals, departments, and/or services in developing quality indicators, monitoring tools, assessment methodologies and documentation, and in making adjustments to the plan. 3. The QAPI coordinator serves as a liaison between the QAPI committee and the individuals, services, and/or department regarding QAPI activities 1. On 6/11/2025 at 10:45 a.m., an observation and interview were conducted with Resident #5 in his room. Resident #5 stated his overhead light does not work very well, and stated, it flickers on and off, and stated his roommate's [Resident #6] light, does not work at all. Staff P, Certified Nurse Assistant (CNA), entered the room and agreed the lights were not working properly. Staff P, CNA stated this was not her assignment. She stated she will notify their nurse. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/11/2025 at 10:52 a.m., an interview was conducted with Resident #7. Resident #7 stated she received a new bed this morning because the other bed was not working but stated, this bed's head will not go up and down. The resident stated she will have to start the whole process of requesting a new bed all over again. On 6/11/2025 at 10:11 a.m., an observation was made of the activities room on the south hallway. Inside the activities room ceiling was a ceiling tile to the left upon entry with scattered areas of small gray/black circles, then concentric circles of various shades of tan, rusty brown. During observation, Staff P, CNA stated, that's been there for a while.' Staff P, CNA stated over the weekend there was water on the floor in the activity room when she came to work. An observation was made of loose baseboards along the perimeter of the activities room. An observation was made of thick green bio growth substance outside the sliding glass door to the left of the activities room exiting to a courtyard. Directly outside the activities room adjacent to the ceiling tile, there was black bio growth substance and peeling paint with a heavy color of dark brown/black substance. Some missing ceiling texture were observed with light brown discoloration and dark heavy collection of black bio growth at the area where the wall meets the ceiling. A tall white garbage can was observed underneath this area with a collection of lightly discolored water inside garbage can approximately six inches. On 6/11/2025 at 10:30 a.m., an observation and interview was conducted with the Nursing Home Administrator (NHA) and Director of Nursing (DON) during tour of south hallway in the activities room. The NHA and the DON stated they had not seen these two areas before. On 6/11/2025 at 11:03 a.m., an observation and interview was conducted with Resident #11. Resident #11 stated her overhead bed light does not work. Staff P, CNA arrived in the room and stated her light works, She said, you don't have the switch. Staff P, CNA turned the light switch on by the doorway of Resident #11's room, then went to the bedside to pull the cord to turn on the overhead light. The light did not go on, and Staff P, CNA pulled the cord multiple times until the light flickered, and stated, see it works. Staff P, CNA had to pull the cord aggressively again to turn off the light. Resident #11 stated she did not think she could pull the cord the same way Staff P, CNA pulled the cord. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/11/2025 at 1:20 p.m., an observation was made of the pantry room in the east hallway. The refrigerator for the residents in the east hall had a temperature log on the outside door. A documented entry for 6/11/2025 showed a reading for the refrigerator at 50 degrees Fahrenheit and the freezer was documented at 28 degrees Fahrenheit. No documented entries were entered for 6/10/2025. The current refrigerator temperature reading was 58-60 degrees Fahrenheit, and the freezer temperature reading was 36-40 degrees Fahrenheit. Staff J, CNA was witness to the current temperatures for the refrigerator. Inside the refrigerator there were four quarts of milk with a resident's name on them. The milk was lukewarm to touch. In the freezer, there were three half gallons of orange sherbert ice cream, a box of ice cream sandwiches and a box of popsicles. All of the freezer items were observed to be thawed. Staff J, CNA agreed the items were soft to touch and not frozen. Staff D, Licensed Practical Nurse/Unit Manager (LPN/UM) for the east hallway was made aware of the refrigerator temperature readings. Staff D, LPN/UM stated according to the temperature log on the refrigerator, the temperature for the refrigerator had been adjusted but agreed the temperature reading were out of normal range. An observation was made of the inside of the cupboard under the sink of the east pantry room. Under the sink there was a large collection of dark brown/black bio growth matter throughout the underside inside the pantry cabinet. An observation was made of the ceiling tile directly above the door partially hanging down. Directly across the entry doorway, was a fan in the wall with a collection of leaves and debris and an opening to the outside environment approximately one inch wide. Staff D, LPN/UM acknowledged these findings. On 6/11/2025 at 3:15 p.m., an observation was made of room [ROOM NUMBER] with open areas of flooring visualized from the hallway. The resident in the room allowed further observation revealing the flooring could be lifted with a slide of the foot. On 6/11/2025 at 3:20 p.m., an observation was made in Residents #12 and #13. The room was designed for a three-resident occupancy. The room was noticeably warmer. Resident #12 stated his roommate #13's AC does not work but his works. Resident #12 had his headboard directly next to his AC unit with his privacy curtain over his headboard where he could receive a direct flow of air from his AC personal unit. Resident #12 stated he moved the curtain because he gets better direct airflow from his AC unit. Resident #12 stated, they know about his AC unit not working. Resident #13's AC unit was powered on, set at 61 degrees Fahrenheit. No air flow was noted. AC filters were observed with a heavy black bio growth. Resident #13 stated he felt his room was hot. A hygrometer reading of 80 degrees Fahrenheit was obtained. Photographic evidence obtained On 6/11/25 at 3:36 p.m., observation was conducted of the bathroom for Resident's #12 and #13. A ceiling tile was observed to be missing with exposed pipes present. On 6/11/2025 at 3:40 p.m., an observation was made of loose flooring on the east hallway. An unidentified resident was walking the hallway with her walker and stated, be careful, you can trip over the loose floor. during this tour, numerous observations were made of loose flooring. The flooring easily would come up when sliding foot over the areas. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/11/2025 at 4:46 p.m., a walking tour was conducted with the NHA, DON, maintenance assistant, maintenance director from another facility and Staff D, LPN/UM. The NHA became aware of the loose flooring, especially in the 200 hallways. The team acknowledged the refrigerator was removed in the east hallway pantry. The team acknowledged the ceiling tile directly above the entry door, the heavy dark brown/black bio growth under the sink cabinet, and the exposed area to the outside environment along the wall fan/vent. The team toured Resident #13's room to witness a non-functioning A/C (Air Conditioning) unit, with dark black bio growth substance on the A/C filter. The administration team confirmed the observations and the missing bathroom ceiling tile with exposed pipes. During the tour on 6/11/2025 at 5:20 p.m., the NHA, DON, maintenance assistant, maintenance director from another facility and Staff D, LPN/UM confirmed these areas of concerns and stated they would be addressed immediately. Review of a facility policy titled, Standards and Guidelines: General cleaning dated 01/2024 showed a standard: It is the policy of this facility to provide a clean, safe, orderly, comfortable and attractive home-like environment as outlined below: 1. Accepted practices and procedures are used to keep the facility free from odors, accumulations of dirt, dust and safety hazards. 2. Floors and horizonal surfaces are cleaned routinely. Finishes on floors provide an appropriate finish and disinfectants are used where required. 3. Walls and ceilings are maintained free from dirt or other matters. 4. Entrances, exits, walkways, driveways and other outside or entry areas are kept free from debris and dirt. 5. Beds, bedside tables, chairs overbed tables, nightstands and dressers should be cleaned with a germicidal and allowed to air dry. 6. Dry dusting is used on items such as pictures, plaques, mirrors, bulletin boards, tops of partitions, vents, tops of cabinets, coat racks and window/door frames. Damp dusting may be used as needed. (Photographic Evidence Obtained.) 2. On 6/11/2025 at 11:38 a.m., an interview was conducted with Staff O, Maintenance Assistant and a Maintenance Director from another facility. Staff O stated the Air Conditioner (A/C) unit #11 was not functioning properly and stated there was a bent blade in the A/C fan causing the issue. Staff O stated the issue had been going on since October 2024. The maintenance director from another facility stated they were contacting the A/C company to have the A/C fixed. An unidentified nursing staff member was witnessed standing in the south hallway close to the nurses' station down the hallway to the right, fanning her face with her hand and stated, I found a cool spot. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a tour on 6/11/2025 at 4:46 p.m. with the administrative team - Nursing Home Administrator (NHA), the director of Nursing (DON) and Staff O, Maintenance Assistant, Maintenance Director from another facility and Staff D, Licensed Practical Nurse/Unit manager (LPN/UM) of the east hallway. The NHA stated the A/C company was up on the roof today taking measurements to fix A/C unit #1 in the physical therapy gym) and A/C unit #19 (north nurses' station and hallway). The NHA stated A/C unit #11 was a new request. Staff O, Maintenance Assistant confirmed A/C unit #11 in the south hallway/activities room area had been an on-going problem since October 2024. On 6/12/2025 at 12:11 p.m., an interview was conducted with the administrative team. The NHA stated the A/C company took measurements yesterday, (6/11/2025) during the revisit survey to fix the A/C concerns identified previously. The NHA could not confirm a payment had been made to the A/C company for the original requests, but provided a new quote dated 6/11/2025 for repairs of A/C unit #11. The NHA stated she was unaware of the issues with A/C unit #11 until yesterday, but the maintenance assistant stated it had been an ongoing issue since October 2024. The facility did not have a policy on A/C units maintenance and repairs.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 22481 Based on observation, record review, and interviews, the facility failed to ensure timely repair of essential equipment, two (#5 and #19) roof top air-conditioning units of 19 roof top air-conditioning units. Findings included: An interview was conducted on 5/13/2025 at 10:30 a.m. with the facility's Maintenance Director. He stated the facility had 19 rooftop air conditioning (A/C) units and the units were assigned numbers 1 through 19. He expressed concerns for A/C unit #19, located over the facility's North Wing near the nurse's station; A/C unit# 5, located over the facility's dining room; and A/C unit #1, located over the facility therapy gym. The Maintenance Director stated A/C unit #5, over the dining room, had been out of working order since 1/19/2025. He said if the dining room gets too warm, 81 degrees or anything above that, they move the residents to their room. The Maintenance Director stated A/C unit #19, over the North Wing nurses station, was an older unit and it started having issues at the end of 7/2024. At the end of 7/2024 or the beginning of 8/2024, A/C unit #19 went out. The Maintenance Director stated A/C unit #1, over the therapy unit, went out of service 10/2024 and a portable A/C unit was placed in the therapy room. The Maintenance Director stated he received quotes for the A/C service repair, but the facility had a lot of past due monies owed to A/C companies and so it has been difficult to get the companies back out to do the work since they wanted to be paid for the prior work before coming out. He said he had a quote for A/C units #19 and #1, but not for #5. He stated, at this time, there were no estimate of the time for the work to start on the repair of the A/C units. On 5/13/2025, the Maintenance Director provided the following two quote documents: One for proposal dated October 17, 2024, quote for A/C unit #1 for replacement of the unit. One for proposal dated September 5, 2024, quote for A/C unit #19 for replacement of the unit. No evidence was provided by the facility during the survey for the repair of A/C unit #5 over the dining room. On 5/13/2025 at 1:10 p.m. an interview was conducted with Staff A, Licensed Practical Nurse. She stated the dining room would get warm and the residents would come back to their room because of it.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 22481 Based on observations and interviews, the facility failed to ensure one pantry (South Wing) of three pantries and one of five eye wash stations, was maintained in a safe and sanitary manner. Findings included: On 5/13/2025 at 1:10 p.m. during the tour of the facility's South Wing, an odor of strong musty smell was identified at the rear corner of the nurses station. The odor was located near the pantry door at the rear of the nurses station. When the door was opened, a strong smell was present in the room. The room was observed to have multiple areas of water damage. (Photographic Evidence Obtained) During the observation, interviews with staff were conducted: Staff A, Licensed Practical Nurse (LPN) stated she could smell the odor from the pantry. She said some of the nurses will not work on the South Wing due to the odor. Staff A, LPN stated, We cannot use the pantry. The refrigerator was moved to the small activity room across from the nurses' station. We have to go to the East Wing for ice. Snacks are stored in the activity room. We do not let the residents in the activity room because of the refrigerator and the snacks there. The residents used to hang out and watch television there. Not now. An observation was conducted of the activity room across from the South Wing nurses station. The door was closed with a number code key lock present on the door. The room was observed to have a refrigerator present. Staff B, Certified Nursing Assistant (CNA), said, You cannot go into the pantry, it smells so bad. We cannot use it. Staff C, CNA, said, There is mold in the panty, the smell is really bad. Staff D, CNA, said, The pantry has been like that for about 8 months, there is an odor standing outside of the door. An interview was conducted with the facility Maintenance Director on 5/13/2025 at 1:39 p.m., regarding the pantry on the South Wing. He stated the building had 3 pantries and, The one on the South, there was a pipe leaking in the wall. We shut it off. It had leaked and caused damage. I was in the process of ordering the materials. When asked when the pipe damage occurred, he stated, two months ago. He stated, I put a key code on the activity door so there would not be any unauthorized access to the refrigerator now located in the activity room. He confirmed the residents did not have the code to the door. During the interview, the Maintenance Director was asked to provide evidence date of finding the issue of the broken pipe in the pantry and any evidence of an attempt to resolve the issue. He stated on 2/5/2025, the refrigerator was moved out of the pantry and he requested materials to work on the room. He stated he had not been back to the room until today, 5/13/2025. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the South Wing pantry was conducted on 5/13/2025 at 1:47 p.m. with the Maintenance Director. The door was observed to have a Do Not Enter sign present on the outside of the door. The Maintenance Director stated, the staff must have put the sign on the door. When the door was opened to the pantry room, the Maintenance Director confirmed the smell in the room, stating it was strong. The Maintenance Director stated, the room has an eye wash station, five eye wash stations in the building total. I cannot put a lock on the pantry door due to the room having an eye wash station. It is the only eye wash station on the South Wing. The Maintenance Director confirmed staff would have to use the eye wash station in an emergency; he confirmed it worked; and demonstrated by turning it on. The sink was observed to have water collect in it. The bottom of the sink was observed to have brown and tan crusted material present. When the under the sink cabinet area was observed, the Maintenance Director stated the darkened black areas were mildew. Towels, loose floorboard material; an unclean resident hospital gown; brown, black discoloration on the wall behind the pipe; and a black discoloration on the flooring area under the sink were observed in the room. (Photographic Evidence Obtained) During the review, an observation was made of a window a/c (air conditioning) unit located in the wall, approximately 5 feet above the floor. The wall under the a/c unit was observed to have dislodged wall covering, exposing the innards of the wall from under the a/c unit down to the floor, with blackish brown discoloration present on the innards of the wall; cracked wall; and dislodged floorboard material. An ice maker machine was present in the room. The Maintenance Director stated, They had put the wrong size a/c unit there and there was water damage. The Maintenance Director stated, The ice machine would have to be replaced. The pipe leak had occurred under the sink. On 5/13/2025 at 3:30 p.m., an interview was conducted with the Director of Nursing. When asked what the eye wash station was used for, she stated, In case you get hazardous materials in your eyes, it is to clean them out, in case of emergencies, and emergencies happen. Yes, it is important to have the eye wash station in a clean and sanitary environment to prevent contamination. Yes, I have seen the room, it needs some work. On 5/13/2025 at 3:30 p.m. during an interview with the Nursing Home Administrator, he stated, I did not know about the condition of the pantry.