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	01/16/2026

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

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide notice of change in condition related to informing the resident's family regarding a fall and failed to follow-up with the Primary Provider after a fall for one resident (#3) of five sampled residents.Findings included: Resident #3 was admitted on [DATE], readmitted on [DATE] and discharged on 01/03/2026 to the hospital. Review of the admission record showed diagnoses included but not limited to diabetes, anemia, dementia, pancreatic cancer, depression, protein-calorie malnutrition, myocardial infarction, atrioventricular block first degree, nonrheumatic aortic valve stenosis, dysphagia, colostomy, history of breast cancer, atrial fibrillation, anxiety, history of falls, and hypotension.Review of the quarterly Minimum Data Set (MDS) dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 13 meaning cognitively intact. Section GG showed the resident required supervision or touching assistance for toileting and bathing.Review of progress notes and SBARs (Situation, Background, Assessment, Recommendation) showed on 12/31/25 at 12:00 p.m. resident had a fall. Vital signs are documented but the date and time are not shown on the SBAR. Neurological Evaluation showed not clinically applicable to the change in condition being reported. Reminded to use call light for assist. Primary Care Clinician notified on 12/31/25 at 12:00 p.m., no new orders. Family/Health Care Agent Notified: self on 12/31/25 at 12:00 p.m. signed by Staff A.LPN (Licensed Practical Nurse)Review of a progress note dated 12/31/25, documented at 3:06 p.m. SBAR (from progress notes) for fall, Vital signs were as follows: BP (blood pressure) 130/72 on 12/31/25 at 9:14 a.m.; pulse 72 on 12/31/25 at 10:07 a.m.; respirations 18 on 12/31/25 at 10:07 a.m.; pulse oximetry of 97% on 12/31/25 at 12:08 p.m. (Per the Director of Nursing (DON) interview the fall occurred on 12/31/25 at 10:45 a.m.). The Primary Care Provider responded with recommendations of no new orders. Signed by Staff A LPN.A progress note on 12/31/25 at 10:59 p.m., showed this writer returned from lunch break and was made aware by staff of resident being on the floor, went to room and found resident laying on the floor with her head facing her bed and her feet facing the TV, observed small amount of blood on her back of her head, also noted a small raised open area was cleansed with normal saline (NS), patted dry and band aid applied, resident was able to move all her upper and lower extremities well on command with no grimacing in pain, however complained of slight pain on her ankle but stated it was just ok,. Left a message for NP (nurse practitioner) on call, also left a message for husband, neuro-checks initiated per facility protocol of unwitnessed falls. Staff B, LPNAn SBAR fall assessment dated [DATE] at 11:00 p.m. showed - vital signs showed BP 112/82, Pulse 87, respirations 20/ pulse oximetry 98%. Skin evaluation showed no changes observed. Pain Evaluation showed resident did not have any pain. Reminded to use call light for assistance. Primary Care Clinician notified on 12/31/25 at 10:30 p.m., no orders / awaiting for call back. Husband notified on 12/31/25 at 11:00 p.m. Signed by Staff B, LPN01/02/26, 8:44 a.m., IDT (Interdisciplinary Team) note: Review of fall from 12/31/25. Resident observed on the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	floor beside her bed. Resident reported that she took medication from outside facility that increased drowsiness. New intervention: Education provided to resident and family about not bringing medications from outside the facility. Resident and family verbalized understanding.Review of the care plans showed Resident #3 was at risk for falls related to forgetfulness, history of falls, unsteady gait/poor balance, and multiple medication usage as of 04/10/2024. Interventions included but not limited to: educate family to not provide resident with outside medications, educate the resident to not take medication that is not provided by facility nursing staff as of 01/01/2026. Educate the resident to wait for assistance with transfers as of 01/01/2026. Labs to be obtained for acute change as of 01/02/2026.On 01/16/26 at 11:00 a.m. an interview with the DON and regional nurse consultant revealed Resident #3 had a fall on 12/31/25 at 10:45 a.m. The DON verified the SBAR only stipulated in the morning. The DON verified the resident herself was notified of the fall and the family should have been notified. The DON stated Resident #3 had another fall that evening. The DON stated the resident fell at 10:00 p.m. The DON stated Staff B, LPN put in a note that when he returned from his break the staff made him aware the resident was found on the floor. The DON verified the exact time of the fall was not in the progress note. The DON stated the vitals signs were done after the fall, per the documentation. The DON verified the SBAR (for the second fall) showed they were awaiting a call back from the medical provider. The DON verified there was no documentation the medical provider called back after the notification and no follow up was documented even though the resident hit her head in the fall. The DON stated the expectation was to find documentation they spoke to a doctor about the fall and her hitting her head. The DON verified the IDT note showed the resident had a family member bring medication from the outside. The DON stated they believe the family brought in Benadryl. The DON verified the documentation showed they spoke with the family but she was not sure who did, maybe the Unit Manager. The DON stated she expected to see neurological checks after the first fall. Review of the facility's policy, Change in Resident Condition or Status-Resident Rights, revised on 6.2023 showed Facility shall notify the resident, his or her Attending Physician, and representative of changes in their resident's medical / mental condition and / or status.Guideline: To ensure the facility provides timely notification in accordance with State and Federal regulations as it pertains to residents' rights.Procedure:1. The nurse will notify the resident's Attending Physician or physician on call when there has been a:A. Accident or incident involving the resident;D. Significant change in the resident's physical / emotional / mental condition;E. Need to alter the resident's medical treatment significantly;G. Need to transfer the resident to a hospital / treatment center;I. Specific instruction to notify the physician of physician of changes in the resident's condition.2. A significant change of condition is a major decline or improvement in the resident's status that:C. Requires interdisciplinary review and / or revision to the care plan;D. Ultimately is based on the judgment of the clinical staff and the guidelines outlined in the resident assessment instrument.3. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when:a. The resident is involved in an accident or incident that results in an injury including injuries of an unknown origin;E. It is necessary to transfer the resident to a hospital / treatment center.5. The nurse will record in the resident's medical record information relative to changes in the resident's medical / mental condition or status.

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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 and interviews the facility failed to ensure a safe and clean environment related to soiled/stained privacy curtains in two resident rooms (#206 and #325) out of three rooms observed. Findings included: On 1/15/26 at 9:16a.m., an observation of room [ROOM NUMBER]'s privacy curtain revealed multiple brown stains smeared along the length of the curtain.On 1/15/26 at 12:33p.m., an observation of room [ROOM NUMBER]'s privacy curtain revealed a large brown stain smeared on the curtain.On 1/15/26 at 11:45a.m., an interview with the Nursing Home Administrator (NHA) revealed it is the responsibility of housekeeping to put in orders for new privacy curtains.On 1/15/26 at 11:51a.m., an interview with the Housekeeping Manager (HM) revealed if a privacy curtain has any stains, it is addressed and swapped out right away. The HM stated the Certified Nursing Assistants (CNAs) or housekeeping staff will advise the HM of any stained or dirty privacy curtains, but the HM will try to check all curtains once a week. The HM said that he does not keep a log of changed privacy curtains, but will write on his notepad or a piece of paper for which rooms need to be changed. The HM stated majority of the curtains are stained and not actually dirty.On 1/15/26 at 12:15p.m., an interview with the Director of Operations (DOO), District Manager (DM), and the HM revealed that housekeeping does not do the orders for privacy curtains, but central supply is responsible for the privacy curtain orders after the HM advises of how many are needed. Participants in the interview revealed there is no formal tracking of the number of privacy curtains needed, and that needed privacy curtains can be written simply on a piece of scratch paper if it is what is available.On 1/15/26 at 12:34a.m., an interview with Staff K, Central Supply (CS) revealed it is not CS's responsibility to make privacy curtain orders, and calls are put out to the regional company, housekeeping, or maintenance.On 1/15/26 at 2:38pa.m., an interview with Staff L, CNA revealed that sometimes privacy curtains are not changed right away despite requests for them to be changed being made.On 1/16/26 at 10:13a.m., an interview with the Director of Nursing (DON) revealed it is expected for housekeeping to be notified right away when privacy curtains appear to be dirty so they can be switched out right away, and that housekeeping should be notified right away. After viewing photo evidence the DON admitted it is not expectation for privacy curtains to be or appear dirty, and the risk of dirty privacy curtains could be infections for all residents present in the room. The DON stated there is no way to determine when a curtain is stained compared to soiled.A review of the facility's Environmental - Cleaning policy revealed a standard: It is the policy of this facility to provide a clean, safe, orderly, comfortable and attractive home-like environment as outlined below: Accepted practices and procedures are used to keep the facility free from odors, accumulations of dirt, dust, and safety hazards. Walls and ceilings are maintained free from dirt or other matters. Fresh, clean and odor-free linen and pillows should be provided to the residents daily or as needed.Photographic Evidence Obtained.

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	105453	A. Building B. Wing	01/16/2026

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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 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. Based on observation, record review, and interview, the facility failed to develop a comprehensive grievance policy and procedure, failed to implement the grievance procedure to investigate customer care concerns for two residents (#8 and #2), and failed to have evidence of informing the results of grievance investigation for four residents (#9, #8, #10, and #2) of four residents sampled for grievances.Findings included: A review of the facility's Grievances - Resident Rights policy and procedure, last revised 07/2024, documented the guideline: The Administrator and staff will make prompt efforts to resolve grievance so the satisfaction of the resident and / or representative.The Procedure:Any resident, family member, or appointed resident representative may file a grievance or complaint concerning the care, treatment, behavior of other residents, staff members, theft of property, or any other concerns regarding his or her stay at the facility. Grievances also may be voiced or filed regarding care that has not been furnished. All grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to verbally and/or in writing upon request including a rationale for the response. 8. Upon receipt of a grievance and/ or complaint, the Grievance Officer will review and investigate the allegations and submit a report of such findings to the Administrator within five (5) working days of receiving the grievance and/ or complaint. In the event the facilities investigation exceeds five (5) working days, the resident/ responsible party will be notified. 9. The Grievance Officer will coordinate actions with the appropriate state and federal agencies, depending on the allegations. All alleged violations of neglect, abuse and / or misappropriation of property will be reported and investigated under guidelines for reporting abuse, neglect and misappropriation of property, as per state law. 10. The Grievance Officer, Administrator and Staff will take immediate action to prevent further potential violations of resident rights while the alleged violation is being investigated. 11. The Administrator will review the findings with the Grievance Officer to determine what corrective actions, if any, need to be taken. 12. The resident, or person filing the grievance and/ or complaint on behalf of the resident will be informed (verbally and/ or in writing as per request) of the findings of the investigation and the actions that will be taken to correct any identified problems.a. The Administrator, or his or her designee, will make such reports orally within ten (10) working days of the filing of the grievance or complaint with the facility.b. A written summary of the investigation will also be provided to the resident upon request, and a copy will be filed in the business office.Review of the facility Grievance policy and procedure revealed there was no listing of the notification to State Survey Agency and State Long-Term Care Ombudsman program.A review of Resident #2's clinical chart, the admission record, documented an admission of 12/04/2025. The diagnosis information included but not limited to chronic pain syndrome; heart failure; bipolar disorder, muscle weakness (generalized) and neuromuscular dysfunction of bladder. A review of a Brief Interview for Mental Status (BIMS), dated 12/08/2025, documented a score of 15, which indicated the resident was cognitively intact.Review of grievances showed Resident #2 filed a grievance dated as received 01/14/2026, filed by the resident, date of incident, 01/14/2026, documented as investigated by the Director of Nursing (DON), and resolved on 01/14/2026.For Resident #2's grievance, dated 01/14/2026, Call light response time., the SSA said, the concern was about call light response time. The SSA was unable to answer the length of time reported by the resident for the grievance.A review of Resident #8's clinical chart, the admission record, documented an admission of 12/05/2025. The diagnosis information included but not limited to Necrotizing Fasciitis, Type 2 Diabetes Mellitus without (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	complications; chronic combined systolic (congestive) and diastolic (congestive) heart failure; difficulty in walking; muscle weakness; and colostomy status. A review of a Brief Interview for Mental Status (BIMS), dated 12/08/2025, and 01/15/2026, documented a score of 15, which indicated the resident was cognitively intact.Review of grievances showed Resident #8 filed a grievance dated as received on 12/11/2025, date of incident 12/11/2025, documented as investigated by the Assistant Director of Nursing (ADON) and resolved on 12/12/2025. Review of grievances showed Resident #8 filed a second grievance dated as received on 12/11/2025, date of incident 12/11/2025, documented as investigated and resolved on 12/12/2025.On 01/15/2026 at 1:14 p.m., an interview was conducted with the Social Services Assistant (SSA) and Staff H, a social Worker at a sister facility. During the interview, review of Resident #8's 12/11/2025 grievance was conducted. The grievance showed Resident voiced concern about customer service and waited too long for call light to be answered, which was documented to have occurred on 12/10/25. During the interview, the SSA said she gave this one to the ADON and staff were trained on call lights. The SSA said she did not know the length of time the call bell light had not been responded to. When asked if a statement had been obtained from the resident, the SSA did not answer.For Resident #8's second grievance, dated 12/11/2025, Resident voiced concern about customer service. The SSA stated this one, the resident had a complaint about staff not answering phones when called. The SA stated staff were trained on phones are to be answered.A review of Resident #9's clinical chart, the admission record, documented an admission of 11/03/2025. The diagnosis information included: displaced comminuted fracture of shaft of left femur, lack of coordination and need for assistance with personal care. A review of a Brief Interview for Mental Status (BIMS), dated 11/14/2025, documented a score of 14, which indicated the resident was cognitively intact.Review of grievances showed Resident #9 filed a grievance received on 12/01/2025, filed by the resident's family member, date of incident, 12/01/2025, the Social Service Assistant (SSA) was listed as the person investigating the incident; dated as resolved on 12/02/2025.A review of Resident #10's clinical chart, the admission record, documented an admission of 12/19/2025. The diagnosis information included: Chronic pain syndrome; cervical disc degeneration; and muscle weakness (generalized). A review of a Brief Interview for Mental Status (BIMS), dated 01/07/2026, documented a score of 13, which indicated the resident was cognitively intact.Review of grievances showed Resident #10 filed a grievance, dated as received on 12/26/2025, filed by the resident, date of incident 12/26/2025, documented as investigated by the ADON, and resolved on 12/16/2025.On 01/15/2026 at 12:05 p.m., an interview was conducted with the SSA and Staff H. The grievances for #9, #8, #10, and #2 were reviewed. The grievance forms, the area for the resident/ responsible party notification of resolution name and signature area were blank on the grievances for #9, #8, #10, and #2. Staff H stated a follow-up should have taken place with the residents.On 1/15/2025 at 1:58 p.m., an interview was conducted with Resident #8. Regarding the grievance about call bell light response time dated 12/11/25, he stated, oh yea, that was when my colostomy bag had broken open and I had feces on my stomach. It took three hours for them to answer the call bell light. I thought that was a little excessive. He said, the colostomy is supposed to be changed as needed. It was coming away from the skin with feces on it. He said he was worried about the integrity of the wound. Resident #8 said, I had to wait for the nurse. The nurse had three admissions that night. That is why I filed the grievance. I filed it, and that is as far as it went. No one came and talked to me about it. An interview was conducted on 01/15/2026 at 3:41 p.m. with the Director of Nursing (DON). regarding Resident #8's grievance form, dated 12/11/2025, waited too long for call light to be answered. She stated the ADON took care of the grievance. The DON reviewed the grievance and stated it looks like it was a customer service issue. She stated, I do not (continued on next page)

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	105453	A. Building B. Wing	01/16/2026

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	know how long he waited. When asked if she should know, she stated, not necessarily. The DON confirmed she was the Abuse Coordinator. She stated the grievance was talked about in the morning meeting the day following the submission of the grievance. She stated she recalled the grievance was about the staff came in and were rude. When asked if a resident had waited three hours for the call bell light to be responded to, she stated, three hours, that would be a problem. No patient should have to wait for an extended period of time. The DON confirmed no resident interview was attached to the grievance as part of the investigation. When asked how an investigation could be conducted without an interview with the resident voicing the concern, the DON stated, call light response times are something we are educating staff on. For Resident #8's 2nd grievance, the 12/11/2025, Resident voiced concern about customer service, the DON confirmed no statement from the resident was available to review for the grievance. For Resident #2's grievance, dated 01/14/2026, call light response time. The DON confirmed she had filled out the grievance; she had received the grievance from staff. The DON confirmed no statement from Resident #2 was available to reflect the resident had been interviewed regarding her concern.

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	105453	A. Building B. Wing	01/16/2026

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on observation, record review, and interview, the facility failed to effectively implement the Abuse, Neglect, Exploitation, Misappropriation, Mistreatment, and Injury of Unknown Origin (ANEMMI) policy and procedure for 2 (#2 and #8) of fifteen sampled residents. Resident #8 complained on 12/11/25 about customer service which was not investigated or reported; subsequently Resident #2 reported an allegation of mental / verbal abuse on 12/27/2025 which was verified.Findings included: A review of Resident #8's clinical chart, the admission record, documented an admission of 12/05/2025. The diagnosis information included but not limited to Necrotizing Fasciitis, Type 2 Diabetes Mellitus without complications; chronic combined systolic (congestive) and diastolic (congestive) heart failure; difficulty in walking; muscle weakness; and colostomy status. A review of a Brief Interview for Mental Status (BIMS), dated 12/08/2025, and 01/15/2026, documented a score of 15, which indicated the resident was cognitively intact.A review of Resident #8's care plan included the following:Focus: Resident has colostomy, r/t (related to) large buttock wound, divergent colostomy, initiated 12/07/2025. Interventions included: Apply skin barrier around stoma to protect from excoriation secondary to urine feces, initiated 12/07/2025. Ostomy care daily and PRN (as needed), initiated 12/07/2025.Focus: Resident has an [sic] potential for ADL(Activities of Daily Living) self-care deficit r/t ADL needs and participation vary, fatigue, chronic medical conditions, initiated 12/07/2025. Interventions included: ADL Care: The resident may need limited to extensive assistance X 1 or X 2 for ADL care. This may fluctuate with weakness, fatigue, and weight bearing status, initiated 12/07/2025. Bed Mobility: The resident needs extensive help to move and reposition the bed (sic). Will need one-or two-person assistance to change position or scoot up in the bed. This may involve some lifting of the legs or boosts., initiated 12/07/2025.A review of the facility grievance log revealed the following entries: For Resident #8, a grievance filed by Resident #8, dated as received on 12/11/2025, date of incident 12/11/2025, documented as investigated by the Assistant Director of Nursing (ADON) and resolved on 12/12/2025.For Resident #8, a 2nd grievance, filed by Resident #8, dated as received on 12/11/2025, date of incident 12/11/2025, documented as investigated and resolved on 12/12/2025.On 1/15/2025 at 1:58 p.m., an interview was conducted with Resident #8. He was observed to be in bed, sheet up mid torso. He agreed to answer questions. He was alert and oriented. When asked about his 12/11/2025 grievance about call bell light response time, he stated, oh ya, that was when my colostomy bag had broken open and I had feces on my stomach. It took three hours for them to answer the call bell light. I thought that was a little excessive. The interview continued at 2:20 p.m., Resident #8 stated the colostomy bag broke during the 3p-11p shift. They kept coming and telling me they were going to get to it. The Certified Nursing Assistants (CNAs) can't provide service; broke about 9p.m., I cannot be sure, but it was around that time. They got it on at 11:00 p.m. He said, the colostomy is supposed to be changed as needed. It was coming away from the skin with feces on it. I was worried about the integrity of the wound. I had to wait for the nurse. The nurse had three admissions that night. That is why I filed the grievance. I filed it, and that is as far as it went. No one came and talked to me about it. For the phone call complaint. He stated that one I submitted because my POA (power of attorney) tried to call the nursing desk 5-6 times to address an issue and he got hung up on. He was pissed. The nursing home administrator came and talked to both of us about that one. When asked if he had been abused or neglected, he stated no. He stated there had been an aid on the 3-11 shift. In December. I do not remember her name, but she had attitude; she is gone now. I do not know her name, they do not wear name tags. If they wore name tags I would know the name.An interview was conducted on 01/15/2026 at 3:41 p.m. with the Director of Nursing (DON). Resident #8's grievance form, dated (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/11/2025, waited too long for call light to be answered was reviewed with the DON. She stated the Assistant Director of Nursing (ADON) took care of the grievance. When the DON was asked if she was aware of the grievance, she stated it looks like it was a customer service issue. When asked how long Resident #8 waited to have his call light answered, she stated I do not know how long he waited. When asked if she should know, she stated, not necessarily. The DON confirmed she was the Abuse Coordinator. She stated the grievance was talked about in the morning meeting the day following the submission of the grievance. She stated she recalled the grievance was about the staff came in and were rude. When asked if a resident had waited three hours for the call bell light to be responded to, she stated, three hours, that would be a problem. No patient should have to wait for an extended period of time. The DON confirmed no resident interview was attached to the grievance as part of the investigation. When asked how an investigation could be conducted without an interview with the resident voicing the concern, the DON stated, call light response times are something we are educating staff on. For Resident #8's 2nd grievance, the 12/11/2025, Resident voiced concern about customer service, the DON confirmed no statement from the resident was available to review for the grievance.A second interview with DON was conducted on 01/15/2026 at 4:34 p.m. The DON stated they were going to go ahead and file a report for neglect for Resident #8. He states his call light was on for 3 hours. He states he was having issues with his colostomy. He said he thought it had ruptured on one side. The DON said she believed the event occurred on 12/11. A review of Resident #2's clinical chart, the admission record, documented an admission of 12/04/2025. The diagnosis information included but not limited to chronic pain syndrome; heart failure; bipolar disorder, muscle weakness (generalized) and neuromuscular dysfunction of bladder. A review of a Brief Interview for Mental Status (BIMS), dated 12/08/2025, documented a score of 15, which indicated the resident was cognitively intact.A review of Resident #2's care plan included the following focus areas:Focus: The resident is at risk for skin impairment r/t (due to) weakness/ decreased mobility, episodes of incontinence, initiated 12/05/2025.Focus: The resident has a pressure ulcer to sacrum/ coccyx friction shear and DTI (deep tissue injury) on admission.Focus: Resident has an (sic) potential for ADL (Activities of Daily Living) self-care deficit r/t ADL needs and participation vary, fatigue, chronic medical conditions, chronic back pain, initiated 12/05/2025. Interventions included: ADL Care: The resident may need limited to extensive assistance X 1 or X 2 for ADL care. This may fluctuate with weakness, fatigue, and weight bearing status, initiated 12/05/2025. Bed Mobility: The resident is supervision to limited assistance and may need guided maneuvering for reposition in the bed but check with the resident every few hours to remind and assist if needed, initiated 12/05/2025.On 01/15/2026 at 9:15 a.m. an observation was conducted of Resident #2, in bed, on a specialized mattress, and clean in appearance. Resident #2 was holding her phone; she agreed to an interview. She was interviewed about an allegation of mental / verbal abuse that had been submitted by the facility on 12/27/2025. Resident #2 stated, the person (Staff I, Certified Nursing Assistant (CNA)) would speak to me disrespectfully, in a bad way. I have her on video. The aide worked on the 11 p.m.-7 a.m. shift. It went on for about a month. I did not let anyone know. I would just dread her coming in. For the day Resident #2 reported the aide, she said, I sent him (name / Registered Nurse Consultant (RNC)) the video I had taken on my phone. As far as I know, she no longer works here. The next day, they came in and questioned me and others. I assumed they fired her. No one let me know. Resident #2 was observed to review her phone, she said she was locating the video. Resident #2 showed the surveyor her phone and the video was reviewed. The video had no persons pictured, but a plain background of the resident room. Voices could be heard on the recording. The person (aide), female voice, could be heard in the exchange with Resident #2, an (continued on next page)

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	105453	A. Building B. Wing	01/16/2026

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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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incontinence care procedure was being performed. The female staff member was heard to say three times, I do not give a damn. During the episode, the resident was heard to request a gown replacement. The staff member was heard to say, no. Resident #2 was interviewed about the gown, and she confirmed she was not provided a replacement gown during the care.A review of the facility SNF (Skilled Nursing Facility) Risk Management Tracking Tool (the abuse/ neglect log), revealed an entry for Resident #2, dated 12/27/2025, an allegation of verbal abuse.An interview was conducted on 01/16/2025 at 11:39 a.m. with the Director of Nursing (DON) and Registered Nurse Consultant (RNC) regarding Resident #2's 12/27/2025 allegation. The RNC stated he became are of the allegation about 7:00 a.m. on 12/27/2025. He stated he had provided his contact information to the resident, she had a previous allegation, and I wanted to help with the follow up with her. She contacted me by phone. She sent me a recording. It was a verbal interaction, and you can hear her (presumed to be the resident). The verbal interaction sounded to me a negative interaction. The resident was saying, like are you going to change me. The CNA was pretty much discarding the resident, telling the resident she did not care what the resident was telling her. The RNC stated he contacted the DON and the Nursing Home Administrator (NHA) about 10-15 minutes after receiving the recording. He stated, then, they began an investigation immediately.The DON stated, I came to the facility. When asked when, she stated, I showered and I am 45 minutes away, maybe an hour and 1/2 after I was made aware. We suspended the CNA, Staff I on 12/27. The DON said she would have to look up the time Staff I had been suspended. The DON said, first we got her statement and then we suspended her. I had the Unit Manager, Staff J, Licensed Practical Nurse (LPN), make the phone call to suspend her. Yes, she had left for the day. The DON presented a statement, I (Staff I) can not recall the exact word that I used. I was frustrated and do not recall. The statement was not signed by the staff member but documented via (by way of) phone, signed by the NHA and the DON. The statement did not have a time or date on it. Also provided was an Education/ In-service form, dated 12/27/2025, with no time mark, signed by the DON, that documented she had provided the in-service via phone to Staff I for verbal abuse, providing customer service of quality, professionalism, challenging patients, and resident rights. The DON stated the Assistant Director of Nursing (ADON) assessed the resident's skin at 12:12 p.m.; her pain; her psychosocial base line; and followed up with psych. The allegation was verified. There was no update to Resident #2's care plan.A review of the facility's Abuse, Neglect, Exploitation, Misappropriation, Mistreatment, and Injury of Unknown Origin (ANEMMI) policy and procedure, last revised 03/2025, documented the standard: The resident has the right to be free from abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.Definitions included: Abuse, .Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Neglect, .means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. 7. Mistreatment, means inappropriate treatment or exploitation of a resident.Reporting:Staff are required to report any allegation of ANEMMI to the facility risk manager, direct supervisor, and/ or abuse coordinator immediately upon knowledge of the allegation.Allegations of possible ANEMMI will be reported to state agencies per the federal regulation timeframe. State agencies may include (but are not limited to):Abuse Hotline (Department of Children and Families);State Agencies (Agency for Health Care Administration)Local Law enforcement.The facility must thoroughly collect evidence to allow the (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator to determine what actions are necessary (if any) for the protection of residents. Depending upon the type of allegation received, it is expected that the investigation would include, but is not limited to:Conducting observations of the alleged victim, including identification of any injuries as appropriate, the location where the alleged situation occurred, interactions and relationships between staff and alleged victim and/ or other residents, and interactions/ relations between resident to other residents.Conducting interviews with, as appropriate, the alleged victim and representative, alleged perpetrator, witnesses, practitioner, interviews with personnel from Advance Copy outside agencies such as other investigatory agencies, and hospital or emergency room personnel.Conducting record review for pertinent information related to the alleged violation.Initial Reporting:In accordance with (Code of Federal Regulation) CFR483.12(c)(1), with response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the vents (sic)that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and Adult Protective Services where state law provides for jurisdiction in long term care facilities) in accordance with State law through established procedures.Follow-up Investigation Report.Within 5 working days of the incident, the facility must provide in its report sufficient information to describe the results of the investigation, and indicate any corrective actions taken, if the allegation was verified. It is important that the facility provide as much information as possible, to the best of its knowledge at the time of submission of the report, so that State agencies can initiate action necessary to oversee the protection of nursing home residents.Investigation:In response to allegations of abuse, neglect, exploitation, misappropriation, mistreatment, or injury of unknow origin the facility must: a). Have evidence that all alleged violations are thoroughly investigated.Prevent further potential abuse, neglect, exploitation, misappropriation, mistreatment, or injury of unknown origin while the investigation is in progress e). Conduct interviews with, as appropriate, the alleged victim and representative, alleged perpetrator, witnesses, .Residents will be protected from harm during an investigation.4. Staff person(s) suspected of ANEMMI will be suspended immediately pending results of the investigation.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, record review and interview, the facility failed to ensure an allegation of neglect regarding untimely care and services was investigated and reported within 24 hours to the State Survey Agency and adult protective services for one resident (#8) of fifteen sampled residents. Findings included: A review of Resident #8's clinical chart, the admission record, documented an admission of 12/05/2025. The diagnosis information included but not limited to Necrotizing Fasciitis, Type 2 Diabetes Mellitus without complications; chronic combined systolic (congestive) and diastolic (congestive) heart failure; difficulty in walking; muscle weakness; and colostomy status. A review of a Brief Interview for Mental Status (BIMS), dated 12/08/2025, and 01/15/2026, documented a score of 15, which indicated the resident was cognitively intact. A review of Resident #8's care plan included the following:Focus: Resident has colostomy, r/t (due to) large buttock wound, divergent colostomy, initiated 12/07/2025. Interventions included: Apply skin barrier around stoma to protect from excoriation secondary to urine feces, initiated 12/07/2025. Ostomy care daily and PRN (as needed), initiated 12/07/2025.Focus: Resident has an [sic] potential for ADL(Activities of Daily Living) self-care deficit r/t ADL needs and participation vary, fatigue, chronic medical conditions, initiated 12/07/2025. Interventions included: ADL Care: The resident may need limited to extensive assistance X 1 or X 2 for ADL care. This may fluctuate with weakness, fatigue, and weight bearing status, initiated 12/07/2025. Bed Mobility: The resident needs extensive help to move and reposition the bed (sic). Will need one-or two-person assistance to change position or scoot up in the bed. This may involve some lifting of the legs or boosts., initiated 12/07/2025. A review of the facility grievance log revealed the following entries: For Resident #8, a grievance filed by Resident #8, dated as received on 12/11/2025, date of incident 12/11/2025, documented as investigated by the Assistant Director of Nursing (ADON) and resolved on 12/12/2025.For Resident #8, a 2nd grievance, filed by Resident #8, dated as received on 12/11/2025, date of incident 12/11/2025, documented as investigated and resolved on 12/12/2025. On 1/15/2025 at 1:58 p.m., an interview was conducted with Resident #8. He was observed to be in bed, sheet up mid torso. He agreed to answer questions. He was alert and oriented. When asked about his 12/11/2025 grievance about call bell light response time, he stated, oh yea, that was when my colostomy bag had broken open and I had feces on my stomach. It took three hours for them to answer the call bell light. I thought that was a little excessive. The interview continued at 2:20 p.m., Resident #8 stated the colostomy bag broke during the 3p-11p shift. They kept coming and telling me they were going to get to it. The Certified Nursing Assistants (CNAs) can't provide service; broke about 9 p m, I cannot be sure, but it was around that time. They got it on at 11:00 p.m. He said, the colostomy is supposed to be changed as needed. It was coming away from the skin with feces on it. I was worried about the integrity of the wound. I had to wait for the nurse. The nurse had three admissions that night. That is why I filed the grievance. I filed it, and that is as far as it went. No one came and talked to me about it. For the phone call complaint. He stated that one I submitted because my POA (power of attorney) tried to call the nursing desk 5-6 times to address an issue and he got hung up on. He was pissed. The nursing home administrator came and talked to both of us about that one. An interview was conducted on 01/15/2026 at 3:41 p.m. with the Director of Nursing (DON). Resident #8's grievance form, dated 12/11/2025, waited too long for call light to be answered was reviewed with the DON. She stated the ADON took care of the grievance. When the DON was asked if she was aware of the grievance, she stated it looks like it was a customer service issue. When asked how long Resident #8 waited to have his call light answered, she stated I do not know how long he waited. When asked if she should know, she stated, not necessarily. The DON (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed she was the Abuse Coordinator. She stated the grievance was talked about in the morning meeting the day following the submission of the grievance. She stated she recalled the grievance was about the staff came in and were rude. When asked if a resident had waited three hours for the call bell light to be responded to, she stated, three hours, that would be a problem. No patient should have to wait for an extended period of time. The DON confirmed no resident interview was attached to the grievance as part of the investigation. When asked how an investigation could be conducted without an interview with the resident voicing the concern, the DON stated, call light response times are something we are educating staff on. For Resident #8's second grievance, the 12/11/2025, Resident voiced concern about customer service, the DON confirmed no statement from the resident was available to review for the grievance.A second interview with DON was conducted on 01/15/2026 at 4:34 p.m. The DON stated they were going to go ahead and file a report for neglect for Resident #8. He states his call light was on for 3 hours. He states he was having issues with his colostomy. He said he thought it had ruptured on one side. The DON said she believed the event occurred on 12/11. A review of the facility's Abuse, Neglect, Exploitation, Misappropriation, Mistreatment, and Injury of Unknown Origin (ANEMMI) policy and procedure, last revised 03/2025, documented the standard: The resident has the right to be free from abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.The Definitions included: Abuse, .Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Neglect, .means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.Reporting. b. Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury.4. Allegations of possible ANEMMI will be reported to state agencies per the federal regulation timeframe. State agencies may include (but are not limited to): Abuse Hotline (Department of Children and Families; State Agencies (Agency for Health Care Administration); Local Law Enforcement.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, interviews, and record review, the facility failed to ensure updates of care plans for two out of four residents reviewed (Resident #1 and #231B). Findings included: A review of the facility policy titled Comprehensive MDS Assessment and Care Plan, Revised 2/2024, revealed - It will be standard of this facility to make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS . The plan of care will be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. The plan of care will be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. The services provided or arranged by the facility, as outlined by the comprehensive care plan, will be provided by qualified persons in accordance with each resident's written plan of care and will also be culturally competent and trauma informed.On 1/15/26 at 9:17 a.m., an observation of Resident #1 revealed orange and brown build up underneath the resident's nails.A review of Resident #1's admissions record revealed an admission date of 11/18/22 with diagnoses to include chronic obstructive pulmonary disease, Parkinson's disease, ataxia and tremors.A review of Resident #1's quarterly Minimum Data Set (MDS) assessment, dated 12/10/25, in section C - cognitive patterns revealed a Brief Interview Mental Score (BIMS) of 07, severe impairment. A review of Section E- Behavior for Resident #1's Rejection of Care- Presence and Frequency scored a 0-behavior not exhibited.A review of Resident #1's original Care Plan dated 12/25/25 revealed Resident #1 has a ADL, self-care deficit related to their Parkinson's diagnosis, and the resident should be encouraged and assisted with all ADL tasks including but not limited to personal hygiene. Resident #1 may need limited to extensive assistance x1 or x2 for ADL care.A review of Resident #1's progress notes dated 11/16/25 reveal no documentation of the resident's refusal of ADLs, including nail care.A review of Resident #1's shower sheets revealed Resident #1 receives showers on Wednesdays and Saturdays, documentation was provided and read as for dates:11/26/25 no nail care documented or refused.12/10/25 no nail care documented or refused.12/27/25 no nail care documented or refused.1/14/26 both bed bath and shower are marked, and nail care originally marked as Clean, but then crossed out and marked as Refused, signed by Staff L, Certified Nursing Assistant (CNA).On 1/15/26 at 2:38 p.m., an interview was conducted with Staff L, certified nursing Assistant (CNA) and revealed when Resident #1 refuses nail care, they talk to the resident's family member, and the family member is able to convince Resident #1 to complete the task. Staff L, CNA stated nail care will be provided to resident on non-shower days if it is needed, and a shower sheet will be filled out and completed for these additional attempts at the task each time.On 1/15/26 at 1:10 p.m. and on 1/16/26 at 9:40 a.m., an observation of Resident #13 revealed brown and dark-colored build-up underneath the resident's nails.A review of Resident #13's admissions record revealed an original admission date of 7/12/25 and a re-admission date of 12/7/25 with diagnoses to include Type 2 diabetes, chronic obstructive pulmonary disease and hypertensive heart disease.A review of Resident #13's quarterly Minimum Data Set (MDS) assessment, dated 12/11/25, in section C - cognitive patterns revealed a Brief Interview Mental Score (BIMS) of 99, meaning the resident was unable to complete interview. A review of Section E- Behavior for Resident #Resident #13's Rejection of Care- Presence and Frequency scored a 0-behavior not exhibited.A review of Resident #13 ‘s original Care Plan dated 12/7/25 revealed Resident #13 has an ADL self-care deficit related to ADL needs, and the resident should be encouraged and assisted with all ADL tasks including but not limited to personal hygiene. Resident #13 may need dependent assistance x1 or x2 for ADL care.A review of Resident #13 ‘s progress notes dated (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/16/25 reveal there was no documentation of the resident's refusal of ADL nail care.A review of Resident #13 ‘s shower sheets revealed Resident #13 receives showers on Wednesdays and Saturdays, documentation was provided and read as for dates:12/21/25 no nail care documented or refused.12/29/25 no nail care documented or refused.On 1/15/26 at 2:44 p.m., an interview was conducted with Staff G, Licensed Practical Nurse (LPN) revealing shower sheets are to be filled out for any kind of hygienic care and/or refusals for each attempt. Staff G, LPN stated Resident #13 does not usually refuse care.On 1/15/26 at 2:59 p.m., an interview was conducted with Staff J, LPN Unit Manager (UM) revealing Resident #1 and 13's care plan should have been updated to reflect needing nail care often.On 1/16/26 at 10:13 a.m., an interview with the Director of Nursing (DON) revealed the expectation is for hygienic care to be provided to residents even if it is not their designated shower day, and all residents have the right to ask and be provided with care outside of those shower days. The DON revealed Resident #13's nails were not acceptable and should have been taken care of by staff. The DON stated Resident #1 and 13's care plan should have been updated to reflect needing nail care often. The DON stated that residents who do not get proper nail care are at risk for infection if they are not cleaned properly and regularly.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, interviews, and record review, the facility failed to ensure ADLs (activities of daily living) related to nail care was provided for two residents (#1, #13) out of four residents sampled.Findings included: On 1/15/26 at 9:17 a.m., an observation of Resident #1 revealed orange and brown build up underneath the resident's nails.A review of Resident #1's admissions record revealed an admission date of 11/18/22 with diagnoses to include chronic obstructive pulmonary disease, Parkinson's disease, ataxia and tremors.A review of Resident #1's quarterly Minimum Data Set (MDS) assessment, dated 12/10/25, in section C - cognitive patterns revealed a Brief Interview Mental Score (BIMS) of 07, severe impairment. A review of Section E- Behavior for Resident #1's Rejection of Care- Presence and Frequency scored a 0-behavior not exhibited.A review of Resident #1's original Care Plan dated 12/25/25 revealed Resident #1 has a ADL, self-care deficit related to their Parkinson's diagnosis, and the resident should be encouraged and assisted with all ADL tasks including but not limited to personal hygiene. Resident #1 may need limited to extensive assistance x1 or x2 for ADL care.A review of Resident #1's progress notes dated 11/16/25 reveal no documentation of the resident's refusal of ADLs, including nail care.A review of Resident #1's shower sheets revealed Resident #1 receives showers on Wednesdays and Saturdays, documentation was provided and read as for dates:11/26/25 no nail care documented or refused.12/10/25 no nail care documented or refused.12/27/25 no nail care documented or refused.1/14/26 both bed bath and shower are marked, and nail care originally marked as Clean, but then crossed out and marked as Refused, signed by Staff L, Certified Nursing Assistant (CNA).On 1/15/26 at 2:38 p.m., an interview was conducted with Staff L, certified nursing Assistant (CNA) and revealed when Resident #1 refuses nail care, they talk to the resident's family member, and the family member is able to convince Resident #1 to complete the task. Staff L, CNA stated nail care will be provided to resident on non-shower days if it is needed, and a shower sheet will be filled out and completed for these additional attempts at the task each time.On 1/15/26 at 1:10 p.m. and on 1/16/26 at 9:40 a.m., an observation of Resident #13 revealed brown and dark-colored build-up underneath the resident's nails.A review of Resident #13's admissions record revealed an original admission date of 7/12/25 and a re-admission date of 12/7/25 with diagnoses to include Type 2 diabetes, chronic obstructive pulmonary disease and hypertensive heart disease.A review of Resident #13's quarterly Minimum Data Set (MDS) assessment, dated 12/11/25, in section C - cognitive patterns revealed a Brief Interview Mental Score (BIMS) of 99, meaning the resident was unable to complete interview. A review of Section E- Behavior for Resident #Resident #13's Rejection of Care- Presence and Frequency scored a 0-behavior not exhibited.A review of Resident #13 ‘s original Care Plan dated 12/7/25 revealed Resident #13 has an ADL self-care deficit related to ADL needs, and the resident should be encouraged and assisted with all ADL tasks including but not limited to personal hygiene. Resident #13 may need dependent assistance x1 or x2 for ADL care.A review of Resident #13 ‘s progress notes dated 11/16/25 reveal there was no documentation of the resident's refusal of ADL nail care.A review of Resident #13 ‘s shower sheets revealed Resident #13 receives showers on Wednesdays and Saturdays, documentation was provided and read as for dates:12/21/25 no nail care documented or refused.12/29/25 no nail care documented or refused.On 1/15/26 at 2:44 p.m., an interview was conducted with Staff G, Licensed Practical Nurse (LPN) revealing shower sheets are to be filled out for any kind of hygienic care and/or refusals for each attempt. Staff G, LPN stated Resident #13 does not usually refuse care.On 1/15/26 at 2:59 p.m., an interview was conducted with Staff J, LPN Unit Manager (UM) revealing Resident #1 and 13's care plan should have been updated to reflect needing nail care often.On 1/16/26 at 10:13 a.m., an interview with the Director of Nursing (DON) revealed the expectation (continued on next page)

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	01/16/2026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is for hygienic care to be provided to residents even if it is not their designated shower day, and all residents have the right to ask and be provided with care outside of those shower days. The DON revealed Resident #13's nails were not acceptable and should have been taken care of by staff. The DON stated Resident #1 and 13's care plan should have been updated to reflect needing nail care often. The DON stated that residents who do not get proper nail care are at risk for infection if they are not cleaned properly and regularly.Review of the facility policy titled ADL Care and Services, revised 01/2024, revealed residents will be provided care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living.4. Appropriate care and services will be provided for residents who are unable to carry put ADLs independently with the consent of the resident in accordance with the plan of care, including appropriate supports and assistance with, including but not limited to: a.) .nail care. Photographic evidence Obtained.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide quality of care related to resident assessments for a change in condition of vascular wounds for two residents (#4 and #11) of six sampled residents. Findings included: 1. Resident #4 was admitted on [DATE], readmitted on [DATE] and discharged on [DATE]. Review of the admissions record showed diagnoses included but not limited to diabetes, acquired below knee amputation, Chronic Obstructive Pulmonary Disease (COPD), Peripheral vascular disease, muscle weakness, permanent atrial fibrillation, Chronic systolic congestive heart failure, and pulmonary hypertension. Review of the Minimum Data Set, dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 14 or cognitively intact. Section GG showed he required maximum assistance for toileting and bathing. Section O, showed he was on oxygen. Review of the physician orders showedResident was a full codeContinuous oxygen at 2 liters per minute via nasal cannula for shortness of breathAlbuterol sulfate inhalation nebulization solution 0.63 milligram/3 milliliter orally via nebulizer every 6 hours as needed for shortness of breath and / or wheezingProAir HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate) 2 puff inhale orally every 4 hours as needed for SOB Review of the [DATE] Medication Administration Record (MAR) showed ProAir HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate) 2 puff inhale orally every 4 hours as needed for SOB was given on [DATE] at 11:03 p.m. and was ineffectiveAlbuterol sulfate inhalation nebulization solution 0.63 milligram/3 milliliter orally via nebulizer every 6 hours as needed for shortness of breath and / or wheezing was given on [DATE] at 11:18 p.m. and was ineffective.Oxycontin ER 12 hour 40 mg give by mouth at bedtime as of [DATE] was given at 8:00 p.m. Review of the progress notes showed: On [DATE] per Medical Doctor (MD), change oxycontin to once daily at 8 p.m.On [DATE] at 11:02 a.m. ProAir HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate) 2 puff inhale orally every 4 hours as needed for SOB by Staff C, Licensed Practical Nurse (LPN)On [DATE] at 11:18 p.m. Albuterol Sulfate Inhalation Nebulization Solution 0.63 MG/3ML 3 ml inhale orally via nebulizer every 6 hours as needed for Shortness of Breath and/or wheezing by Staff C, LPNReview of a progress note for Resident #1 showed on [DATE] 12:20 a.m. received report at beginning of shift from outgoing nurse stating resident was not easily waking up. This writer went to check on resident, he appeared restless and sounded congested, gave albuterol inhaler, nebulizer treatment and called 911. Emergency personnel arrived immediately and attended to the resident. Resident expired at 11:59 p.m. Notified Provider through answering service, notified DON (Director of Nursing), and attempting to notify emergency contact. Staff C, LPN (Licensed Practical Nurse).Review of the Weights and Vitals Summary showed[DATE] at 8:39 a.m. blood pressure was [DATE]/25 at 8:39 a.m. pulse was 90 During an interview on [DATE] at 2:17 p.m. Staff C, LPN stated that she remembered the resident. He passed away at the beginning of her shift. She stated he was not doing well the outgoing nurse had said. Staff C stated she was doing her rounds and the outgoing nurse was sitting at nurses' station. Staff C stated he sounded like he was congested and wheezing. She stated she called his name. and he looked at her and was wheezing. Staff C stated she went out and got his breathing stuff, Albuterol and his nebulizer. She stated his pulse oximetry was in the 80s and she called 911. Staff C stated his pulse was elevated, but did not remember the number. She stated his respirations were elevated. Staff C, LPN stated she did not check his blood pressure. She stated the resident seemed to do better after the Albuterol and nebulizer. Staff C stated she called her co-worker, Staff D, LPN to check on him. Staff C stated the resident did have a pulse and was breathing when 911 got here. She stated 911 came right away. She stated the emergency people come in groups of three. The first group assessed him. She stated she thought (continued on next page)

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	105453	A. Building B. Wing	01/16/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they will put the resident on the gurney and take him out, but they started CPR (cardiopulmonary resuscitation). She stated then a second group and then a third group came in. Staff C stated she did not start CPR because he was alive when the paramedics came in. Staff C stated the outgoing aide stated the resident was not doing well all day. The aide told Staff C that he was more sleepy and not eating. Staff C stated his roommate stated he was not doing well all day. Staff C stated she does not know why they did not send him out earlier. Staff C stated he was on antibiotics and stuff. Staff C stated she had not seen him in a couple weeks. Staff C stated the outgoing nurse, Staff E, LPN, UM (Unit Manager), did not make it sound critical, we did our narcotic count. Review of the record did not show documentation that the resident's emergency contact was notified of the change.During an interview on [DATE] at 1:37 p.m. the Director of Nursing (DON) and regional nurse stated Staff E, LPN, UM worked day shift and evening shift that day, [DATE]. The DON stated Staff E reported to Staff C, LPN that the resident was fatigue most of the day but responsive. Staff C reported that when she came onto duty she went to check on him and confirmed he appeared to be fatigue and she stated in her note, that he appeared to restless and a little congested. The DON stated Staff C gave the resident the Albuterol inhaler with no improvement. Staff C called 911 and EMS arrived to the facility. The DON stated Staff C stated they (EMS) were in the room and hooking him up and he was alert at that time. And then he coded. The DON stated Staff C stated EMS initiated CPR. EMS pronounced at 11:59 p.m. The DON stated the staff called her after he had passed. The staff attempted to call his friend. The staff made the DON aware they were unable to reach his friend. The DON was not sure if the staff put oxygen on the resident or not. The DON stated EMS was only a block away. The DON stated she did not notice the time frames between the medication was administered at 11:02 p.m. and 11:18 p.m. and the time of death of 11:59 p.m. The DON stated she did not ask about the 40-minute difference. The DON stated she does not what was going on for the 40 minutes. The DON verified there was not an SBAR written, no assessment or vital signs documented as performed, no progress note. The DON stated she does not know if the resident had oxygen on or not. The DON read the progress note which showed she gave him his Proair at 11:02 p.m. for shortness of breath prn and his nebulizer treatment at 11:18 p.m. due to the wheezing. The DON stated the nurse showed they were ineffective. The DON stated he was being treated with Guaifenesin and on antibiotics for respiratory infection from a positive chest x-ray. The DON stated he was also getting Lasix for CHF. The DON stated she did not get a call that the resident was not feeling well. The DON stated she only got a call after the fact to report he did not look good and the breathing treatment did not work and 911 was called. The DON stated he coded when EMS got there and he died. The DON verified there were no vital signs in the chart since 8:39 a.m. The DON stated Staff E, LPN called the doctor at 1:32 p.m. it appears from the progress note that the oxycodone was decreased from every 12 hours to daily.2. Resident #11 was admitted on [DATE], readmitted on [DATE] and discharged on [DATE]. Review of the admissions record showed diagnoses included but not limited to congestive heart failure, heart transplant status, end stage renal disease and dependent on dialysis, diabetes, lymphedema, immunodeficiency due to drugs, non-pressure chronic ulcer of right lower leg, morbid obesity, atrial fibrillation, anemia, chronic embolism and thrombosis of right popliteal vein ([DATE]), chronic venous hypertension, heart transplant rejection, history of pulmonary embolism, Peripheral Vascular Disease, hypertensive heart disease with heart failure. Review of the admission Minimum Data Set (MDS) dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 15, cognitively intact. Section GG showed resident required moderate assistance for toileting and showering. Section M, skin conditions showed resident had 2 venous ulcers present. Review of the physician orders showedWound care to evaluate and treat as of [DATE].Wound Consult, (continued on next page)

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	105453	A. Building B. Wing	01/16/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	leg wound and buttock wound on [DATE]Upon discharge may have home health for SN/PT/OT to eval and treat as indicated as of [DATE]. Wound care: cleanse left buttock with normal saline, pat dry, apply Santyl and foam dressing daily as of [DATE] for pressure ulcerWound Care: Cleanse Left Buttock with Wound Cleanser, pat dry, apply Manuka Honey and cover With a silicone bordered dressing daily and prn for pressure ulcer as of [DATE] and again as of [DATE] after hospitalization. Wound Care: Cleanse right lower extremity with normal saline, pat dry, apply xeroform, calcium alginate, abdominal pads, and wrap with kerlix dressing daily as of [DATE].Wound Care: Cleanse right lower extremity with normal saline, pat dry, apply Santyl and Calcium Alginate, apply blue Superabsorbent pad and wrap with kerlix and secure with tape daily and prn for stasis ulcer as of [DATE] and [DATE] after hospitalization. Wound Care: cleanse right lateral and anterior lower leg with normal saline, pat dry and apply Santyl and Calcium Alginate AG. Apply blue superabsorbent pad and wrap with kerlix and secure with tape daily and prn as of [DATE] for stasis ulcer. Review of the [DATE] Treatment Administration Record (TAR) showed--Wound Care: Cleanse Left Buttock with Wound Cleanser, pat dry, apply Manuka Honey and cover With a silicone bordered dressing daily and prn for pressure ulcer as of [DATE] was performed on [DATE], [DATE] only. Not performed on [DATE] due to out of facility, [DATE] due to out of facility and refused; then on [DATE] he was sent to the hospital.--Wound Care: Cleanse Left Buttock with Wound Cleanser, pat dry, apply Manuka Honey and cover With a silicone bordered dressing daily and prn for pressure ulcer as of [DATE] after hospitalization showed performed on [DATE] through [DATE], [DATE] not in facility, 12/25 and [DATE] performed, [DATE] was blank; performed [DATE] to [DATE] and [DATE] was out of facility.--Wound Care: Cleanse right lower extremity with normal saline, pat dry, apply Santyl and Calcium Alginate, apply blue Superabsorbent pad and wrap with kerlix and secure with tape daily and prn for stasis ulcer as of [DATE] showed was performed on [DATE], [DATE] only. Not performed on [DATE] due to out of facility, [DATE] due to out of facility and refused; then on [DATE] he was sent to the hospital.--Wound Care: Cleanse right lower extremity with normal saline, pat dry, apply Santyl and Calcium Alginate, apply blue Superabsorbent pad and wrap with kerlix and secure with tape daily and prn for stasis ulcer as of [DATE] after hospitalization showed [DATE] through [DATE], [DATE] not in facility, 12/25 and [DATE] performed, [DATE] was blank;[DATE] was performed; [DATE] was not due to out of facility; [DATE] was blank as well as [DATE].--Wound Care: cleanse right lateral and anterior lower leg with normal saline, pat dry and apply Santyl and Calcium Alginate AG. Apply blue superabsorbent pad and wrap with kerlix and secure with tape daily and prn as of [DATE] for stasis ulcer showed not performed on [DATE] due to out of facility. Review of the [DATE] TAR showed --Wound Care: Cleanse Left Buttock with Wound Cleanser, pat dry, apply Manuka Honey and cover With a silicone bordered dressing daily and prn for pressure ulcer as of [DATE] after hospitalization showed performed on [DATE], [DATE] was blank, [DATE] showed out of facility, [DATE] through [DATE] was performed, [DATE] was blank, [DATE] through [DATE] showed performed. [DATE] (discharge) showed refused. --Wound Care: cleanse right lateral and anterior lower leg with normal saline, pat dry and apply Santyl and Calcium Alginate AG. Apply blue super absorbent pad and wrap with kerlix and secure with tape daily and prn as of [DATE] for stasis ulcer showed performed on [DATE], 1/2 /26 was blank; [DATE] was not done; [DATE] through [DATE] was performed; [DATE] was blank; 1/926 was not performed; [DATE] to [DATE] was performed; [DATE] (discharge) showed refused. Review of admission readmission Nursing Evaluation dated [DATE] showed right buttock with open area and left buttock with open area.Review of admission readmission Nursing Evaluation dated [DATE] showed left buttock open area wound team to evaluate. Right lower leg (rear) wound, wound [NAME] to evaluate. Progress notes showedOn [DATE], SBAR, due to resident had critical lab results. Obtained order from NP (nurse (continued on next page)

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	105453	A. Building B. Wing	01/16/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	practitioner) to send out to hospital for blood transfusion.On [DATE], Resident re-admitted from hospital [DATE] approx. 8:45 p.m. via wheelchair and escorted to room. Refused skin assessment at this time. Will try again later. Ambulates with slow gait. Denies pain at this time. Call light within reach. Will continue to monitor.On [DATE], On this date, writer and wound care provider attempted to render services with resident. Resident returned from dialysis and was asked to remain in his room to be seen. Resident agreed. When provider and writer went back to resident room for assessment resident was not in room. writer will re-attempt. Staff F, Registered Nurse (RN)On [DATE], resident discharged home today with all medications and personal belongings via family transport. No c/o pain or respiratory distress voiced. Resident educated on medications, wound care and to follow up with primary in 1-2 days following discharge. Resident refused wound care prior to discharge. VS stable 132/78,20,72,98%,97.2On [DATE], Resident discharged home with the refusal of home health services. discharged with all personal belongings and medications. Review of the Wound Evaluation - Weekly dated [DATE] showed right lower leg stasis ulcer identified on [DATE] that was 15 centimeters (cm) x 20 cm x 0.2 cm; serosanguineous moderate mild odor drainage; 30% granulation, 70% slough. cluster wounds. Treatment included Santyl and calcium alginate. Signed by Staff F, RNReview of the Wound Evaluation - Weekly dated [DATE] showed left buttock stage III pressure ulcer, identified on [DATE]. Preadmission area. Size: 1.5 cm x 1.3 cm x 0.2 cm.Review of the Wound Evaluation - Weekly dated [DATE] showed right lower leg venous ulcer. Size: 17 cm x18 cm x 0.8 cm, identified [DATE], Serous large copious amount of thin, watery drainage with no odor. 30% epithelial, 10% granulation, 10% slough, and 50% necrotic. cluster wounds. Santyl and silver alginate as treatment.Review of the Wound Evaluation - Weekly dated [DATE] showed right medial anterior lower leg venous wound identified on [DATE]. Size showed 19 cm x 25 cm x 0.8 cm. Serous, large copious amount thin watery drainage, no odor. 30% epithelial, 10% slough, 30% necrotic adipose exposed. Santyl and silver alginate as of [DATE] for treatment. Wound Evaluations provided on [DATE] (at the end of the survey) for the following dates were all blank: [DATE], [DATE], [DATE]. Wound Evaluations provided on [DATE] (at the end of the survey) for the following dates: [DATE], [DATE] and [DATE] for the right lateral lower leg and right medial anterior lower leg documented as written on [DATE]. Review of the Skin Check, Weekly dated [DATE] showed right buttock stage I DTI (Deep tissue injury), left buttock Stage III DTI; right lower leg front unstageable venous status ulcer; right lower leg (rear) unstageable venous status ulcer. Review of the Skin Check, Weekly dated [DATE] showed right later leg vascular and right medial anterior leg vascular. Review of the wound care Nurse Practitioner note dated [DATE] showed resident being evaluated for right lower leg ulcers. Reviewed progress note on [DATE]. Resident seen for initial evaluation of wound. Left buttock pressure ulcer assessed with facility wound care nurse. Patient with lymphedema in both legs, presenting with extensive ulcers on the right leg covering approximately 60% of the limb, with a large area of necrotic tissue. Considering that the patient is immunosuppressed, has chronic kidney disease with chronic anemia on hemodialysis, and diabetes, the risk of infection is significantly elevated. Due to the extent of the necrotic tissue and the large amount of drainage from the wounds, it is recommended to initiate Ivy antibiotic therapy then transfer the patient to a hospital for surgical debridement. In the meantime, we will continue treatment with Sanyl for enzymatic debridement and calcium alginate for secretion control period a discussion of the patients management was completed during the encounter with patient, wound care nurse and a ADON. Lower Extremity Assessment: Edema Assessment: left and right extremity edema. Wound Assessments: Wound #1, right lateral lower leg is a full thickness venous ulcer and has received a status of not healed. Initial wound encounter measurements are 17cm x 18 cm. 0.8cm, with area of 306 sq cm. Necrotic adipose is exposed. No (continued on next page)

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	105453	A. Building B. Wing	01/16/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tunneling has been noted. No sinus tract has been noted. No undermining has been noted. The patient reports a wound pain of 2/10. The wound margin is thickened. Wound bed has 10% granulation, 10% sloth, 50% escar, and 30% epithelialization. The peri-wound skin texture is normal. The peri-wound skin moisture is normal. The Peri-wound skin color is normal. Cluster wounds with skin in between area. Wound #2, right medial anterior lower leg is a full thickness venous ulcer and has received a status of not healed. Initial wounding counter measurements are 19 cm length x 25 cm width x 0.8 cm depth, with an area of 475 square centimeter. Necrotic adipose is exposed. No tunneling has been noted. No sinus tract has been noted. No undermining has been noted. There is a copious amount of serious drainage noted with which has no odor. The patient reports a wound pain of level 2/10. The wound margin is thickened. Wound bed has 10% granulation, 10% sloth, 50% escrow, and 30% epithelialization. The peri- wound skin texture is normal. The peri-wound skin moisture is normal. The Peri-wound skin color is normal. General notes: cluster wounds with skin between. Additional orders: Coordination of care / Education and Counseling Plan of Care discussed the facility nursing staff as below detailing need, progress, and goal wound care nurse and ADON plan of care discussed the patient as below detailing need, progress, and goal current wound status treatment to plan to transfer to hospital. Review of the care plans showed resident had a pressure ulcer related to history of area left buttock as of [DATE], Interventions included but not limited to administer medications and treatments as ordered by the MD as of [DATE]. Complete weekly skin checks. Measure length, width, and depth, if possible. Document status of wound and healing progress monitor for s/s of infection. Report changes to MD as indicated as of [DATE]. Wound Care MD/ APRN consult as ordered / indicated as of [DATE].Resident had a venous/stasis / lymphedema ulcer of the right and left lower leg, right medial anterior lower leg as of [DATE]. Interventions included but not limited to evaluate wound for size, depth, margins: per-wound skin, sinuses, undermining, exudates, edema granulation, infection, necrosis, eschar, gangrene. Document progress in wound healing on an ongoing basis. Notify physician and resident / representative as indicated as of [DATE]. Monitor for worsening of wound, change in skin status ie: s/s of infection, non-healing, new areas to MD and update resident/ representative as indicated as of [DATE]. Treatments as ordered and monitor effects, update MD/Resident/representative as indicated as of 1q[DATE]. Wound physician consult as indicated as of [DATE].Review of the Discharge Summary provided at the end of the survey on [DATE] showed resident refused to let nurse look at left buttock; chronic vascular wound right lower leg (front); lymphedema left lower leg (front); chronic vascular wound and lymphedema right lower leg (rear); lymphedema left lower leg (rear). Staff G, LPNDuring an interview on [DATE] at 1:59 p.m. with the DON and the regional nurse, the DON stated the resident had chronic vascular wounds of the lower extremity. The DON stated the wound nurse saw him on [DATE] showing the lower right leg wound. The DON could not verify if the wound was on the front or the back of the right leg. The DON verified that on [DATE] the resident had a Stage III buttocks pressure ulcer per the [DATE] Wound Evaluation. The DON verified the only Wound Evaluations in the e-chart were dated [DATE] for a right lower leg stasis ulcer and left buttocks and for [DATE] for right lower leg venous ulcer and right medial anterior lower leg venous wound. The DON stated the wounds were to be evaluated including size and description at least weekly. The DON stated maybe the wound care doctor did not send their notes in. The DON could not verify when the wound doctor starting seeing the resident or when the wound doctor saw the resident. The DON stated the wound care nurse should still be documenting at least weekly, following up. The DON verified the Discharge Summary (which was not completed) showed right lower leg front open wound, left lower leg front open wound, right lower leg rear open wound, left lower leg rear open wound. The DON stated when the resident first came in, he (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had a right and left buttock wound, then it changed to just the left buttock. The DON stated they were treating both of his lower extremities. The DON was reviewing the orders in the e-chart and stated they had treatment in place for his right lower leg. They had an order to place skin prep on both of his heels. The DON stated for the lower right leg they were using Santyl, Calcium Alginate and wrapping it with a pad. When asked about the wound care not consistently being provided, the DON stated on [DATE] at 2:45 p.m. he refused wound care upon discharge. The DON did not address the other lack of care. When asked about description of wound weekly, no answer. Review of the facility's policy, Prevention of Skin Impairment / Pressure Injury. Revised 01/2024 showed The purpose of this policy is to provide information regarding identification of skin wound risk factors and interventions for specific risk factors. Guideline: Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. ProcedureRisk Assessment:1. Assess the resident on admission for existing wound risk factors.2. Conduct a comprehensive skin assessment upon admission, including:a. skin integrity - any evidence of existing or developing pressure ulcers or injuries;B. Areas of impaired circulation due to pressure our positioning or medical devices.3. Inspect the skin when performing or assisting with personal care or ADL's.Risk Factors:2. Examples of these risk factors include but are not limited to:a. Impaired / decreased mobility and decreased functional ability;B. Comorbid conditions, such as end stage renal disease, thyroid disease or diabetes mellitus;C. Drugs such as steroids that may affect healing;d. Impaired diffuse or localized blood flow, for example, generalized arteriosclerosis or lower extremity arterial insufficiency;E. Resident refusal of some aspects of care and treatment;F. Cognitive impairment;G. Exposure of skin to urinary and fecal incontinence;H. Under nutrition, malnutrition, and hydration deficits;I. The presence of previously healed pressure ulcer / PiPrevention1. Select appropriate support services based on the residence mobility, continents, skin moisture and perfusion, body size, weight, and overall risk factors.Monitoring / Documenting:1. Evaluate, report, and document potential changes in the skin2. Notify the physician and the resident / resident representative of changes in the skin.3. Review the interventions and strategies for effectiveness on an ongoing basis.4. Evaluate open areas per physician orders. Review of the facility's policy, Change in Resident Condition or Status-Resident Rights, revised on 6.2023 showed Facility shall notify the resident, his or her Attending Physician, and representative of changes in their resident's medical / mental condition and / or status.Guideline: To ensure the facility provides timely notification in accordance with State and Federal regulations as it pertains to residents' rights.Procedure:1. The nurse will notify the resident's Attending Physician or physician on call when there has been a:D. Significant change in the resident's physical / emotional / mental condition;E. Need to alter the resident's medical treatment significantly;G. Need to transfer the resident to a hospital / treatment center;I. Specific instruction to notify the physician of physician of changes in the resident's condition.2. A significant change of condition is a major decline or improvement in the resident's status that:a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions;C. Requires interdisciplinary review and / or revision to the care plan;D. Ultimately is based on the judgment of the clinical staff and the guidelines outlined in the resident assessment instrument.3. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: b. there is a significant change in the resident's physical, mental, or psychosocial status;E. It is necessary to transfer the resident to a hospital / treatment center.5. The nurse will record in the resident's medical record information relative to changes in the resident's medical / mental condition or status.

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	01/16/2026

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 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 interview and record review the facility failed to provide assessments post falls including vital signs and neurological checks for one resident (#3) of three sampled residents.Findings included: Resident #3 was admitted on [DATE], readmitted on [DATE] and discharged on 01/03/2026 to the hospital. Review of the admission record showed diagnoses included but not limited to diabetes, anemia, dementia, pancreatic cancer, depression, protein-calorie malnutrition, myocardial infarction, atrioventricular block first degree, nonrheumatic aortic valve stenosis, dysphagia, colostomy, history of breast cancer, arial fibrillation, anxiety, history of falls, and hypotension.Review of the quarterly Minimum Data Set (MDS) dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 13, meaning cognitively intact. Section GG showed the resident required supervision or touching assistance for toileting and bathing. Review of progress notes and SBARs (Situation, Background, Assessment, Recommendation) showedOn 12/31/25 at 12:00 p.m. SBAR showed resident had a fall. Vital signs are documented but the date and time are not shown on the SBAR. 10. Neurological Evaluation showed not clinically applicable to the change in condition being reported. Reminded to use call light for assist. Primary Care Clinician notified on 12/31/25 at 12:00 p.m., no new orders. Family / Health Care Agent Notified: self on 12/31/25 at 12:00 p.m. signed by Staff A.LPN (Licensed Practical Nurse)On 12/31/25, documented at 3:06 p.m. SBAR (from progress notes) for fall, Vital signs were as follows: BP (blood pressure) 130/72 on 12/31/25 at 9:14 a.m.; pulse 72 on 12/31/25 at 10:07 a.m.; respirations 18 on 12/31/25 at 10:07 a.m.; pulse oximetry of 97% on 12/31/25 at 12:08 p.m. (Per the Director of Nursing (DON) interview the fall occurred on 12/31/25 at 10:45 a.m.). The Primary Care Provider responded with recommendations of no new orders. Signed by Staff A LPN.On 12/31/25 at 10:59 p.m., This writer returned from lunch break and was made aware by staff of resident being on the floor, went to room and found resident laying on the floor with her head facing her bed and her feet facing the TV, observed small amount of blood on her back of her head, also noted a small raised open area was cleansed with normal saline (NS), patted dry and band aid applied, resident was able to move all her upper and lower extremities well on command with no grimacing in pain, however complained of slight pain on her ankle but stated it was just okay,. Left a message for NP (nurse practitioner) on call, also left a message for [family member], neuro-checks initiated per facility's protocol of unwitnessed falls. documented by Staff B, Licensed Practical Nurse (LPN).On 12/31/25 at 11:00 p.m. SBAR showed for fall. Vital signs showed BP 112/82, Pulse 87, respirations 20/ pulse oximetry 98%. Skin evaluation showed no changes observed. Pain Evaluation showed resident did not have any pain. Reminded to use call light for assistance. Primary Care Clinician notified on 12/31/25 at 10:30 p.m., no orders / awaiting for call back. [Family member] notified on 12/31/25 at 11:00 p.m. Signed by Staff B, LPNOn 12/31/25 at 11:07 p.m., Pain Evaluation showed a pain level of 4. Pain located in front of left shoulder (chronic).01/02/26, 8:44 a.m., IDT (Interdisciplinary Team) note: Review of fall from 12/31/25. Resident observed on the floor beside her bed. Resident reported that she took medication from outside facility that increased drowsiness. New intervention: Education provided to resident and family about not bringing medications from outside the facility. Resident and family verbalized understanding.On 01/02/26, at 8:50 a.m.: IDT note: Review of fall from 12/31/25. Resident observed on the floor beside her bed after attempting to get out of bed (OOB) unassisted. New intervention: Labs, UA (urinalysis) ordered, education provided to resident to call and wait for assistance before transfer.Review of neurological checks documentation provided showed on 12/31/25 the neurological checks were started at 10:10 p.m. until 01/03/26 on 7-3 shift. No neurological checks documentation was provided (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	starting for the 12/31/25 fall at approximately 10:45 a.m.Review of the care plans showed Resident #3 was at risk for falls related to forgetfulness, history of falls, unsteady gait/poor balance, and multiple medication usage as of 04/10/2024. Interventions included but not limited to: educate family to not provide resident with outside medications, educate the resident to not take medication that is not provided by facility nursing staff as of 01/01/2026. Educate the resident to wait for assistance with transfers as of 01/01/2026. Labs to be obtained for acute change as of 01/02/2026.During an interview on 01/15/26 at 1:26 p.m. Staff A, LPN was reviewing the e-chart and stated Resident #3s first fall happened on 12/31/25 at around 10:59 p.m. per the SBAR. Staff A stated the fall happened on the 3-11 shift. She stated Staff B, LPN was working that shift. She stated Staff B found her and her head was bleeding. Staff A stated if a resident was found on the floor unwitnessed, they would do the vital signs, call the medical provider with a report and call the family. They would perform neuro checks on paper. Staff A stated the resident did not fall on her shift. Staff A stated the resident told her she found a pink pill (Benadryl) on the floor and took it.During an interview on 01/15/26 at 4:28 p.m. Staff B, LPN stated the resident had a previous fall that day and had a history of falling. Staff B stated the resident hit her head during the fall. He stated he was returning from his lunch break and an aide assigned to her got me. Staff B found her lying on with the side of her face toward the bed and her back to the doorway. He stated he asked the resident questions and noticed a raised area with blood on the back of her head. There was no active bleeding. Staff B stated the nurse working with him that night was doing the vital signs and neuro checks and pain assessment. The resident was having pain in her ankle and shoulder. The resident stated it was arthritis. Staff B stated the fall occurred on the 3-11 shift, around 9 p.m. or 10 p.m. Staff B stated they were doing the neuro checks on her, for an unwitnessed fall. Staff B stated the other nurse called the medical provider and sent an alert. Staff B stated we do vital signs, neuro checks and monitor closely while waiting for the medical provider to call back. The family was called. We do neuro checks on paper for 72 hours. Staff B stated he washed the cut with normal saline and put a Band-Aid on it. Staff B stated the resident was alert and had no confusion. We put her to bed, laid her down. Staff B stated we had one of the aides sit in the hallway to monitor her. Staff B stated the resident had a fall earlier in the day.On 1/16/26 at 10:44 a.m. the DON stated everything should be in the scanned into the e-chart unless waiting in medical records to be scanned (neurological checks). On documentation review on 01/16/26 at 10:46 a.m., no neuro checks in the e-chart. On 01/16/26 at 11:00 a.m. the DON and regional nurse consultant stated Resident #3 had a fall on 12/31/25 at 10:45 a.m. The DON verified the SBAR only stipulated in the morning. The DON stated the SBAR does not specifically the time of the fall. The DON stated the provider was notified at 12:00 p.m. and had no new orders. The DON stated the process for an unwitnessed fall was to assess the resident, initiate neuro checks, notified the doctor, and notify the family. The DON verified per their internal form the fall occurred at 10:45 a.m. and that the SBAR did not specify a fall time. The DON verified the vital signs on the SBAR (for the morning fall) showed the following blood pressure is from 9:14 a.m., pulse is from 10:07 a.m., respirations are from 10:07 a.m. O2 sats from 12:08 p.m. no neuro checks done for this patient. The DON verified the vital signs were documented as occurring before the fall occurred. The DON stated they did not have any vital signs or neuro checks at the time of fall. The DON verified the resident herself was notified of the fall and the family should have been notified. The DON stated the resident stated she found a pink pill on the floor, The DON stated they did look at her floor but did not find anything her floor. The DON stated she could not recall if they looked at any other rooms for pills on the floor. The DON stated Resident #3 had another fall that evening. The DON stated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident fell at 10:00 p.m. The DON stated Staff B, LPN put in a note that when he returned from his break the staff made him aware the resident was found on the floor. The DON verified the exact time of the fall was not in the progress note. The DON stated the vitals signs were done after the fall, per the documentation. The DON verified the SBAR (for the second fall) showed they were awaiting a call back from the medical provider. The DON verified there was no documentation the medical provider called back after the notification and no follow up was documented even though the resident hit her head in the fall. The DON stated the expectation was to find documentation they talked to a doctor about the fall and her hitting her head. The DON verified the IDT note stated the resident had a family member bring medication from the outside. The DON stated they believe the family brought in Benadryl. The DON stated the internal report showed the resident was leaning over in her chair for the pill on the floor and fell out of the chair. The DON verified this information was not in the e-chart. The DON stated we told the resident to not bring any medication in from the outside and ask us and we will get it for you. The DON stated she did not know who spoke with the family regarding not bringing medication in from the outside. The DON verified the documentation showed they spoke with the family but she was not sure who did, maybe the Unit Manager. The DON stated she expected to see neurological checks after the first fall. Review of the facility's policy, Change in Resident Condition or Status-Resident Rights, revised on 6.2023 showed Facility shall notify the resident, his or her Attending Physician, and representative of changes in their resident's medical / mental condition and / or status.Guideline: To ensure the facility provides timely notification in accordance with State and Federal regulations as it pertains to residents' rights.Procedure:1. The nurse will notify the resident's Attending Physician or physician on call when there has been a:A. Accident or incident involving the resident;D. Significant change in the resident's physical / emotional / mental condition;E. Need to alter the resident's medical treatment significantly;G. Need to transfer the resident to a hospital / treatment center;I. Specific instruction to notify the physician of physician of changes in the resident's condition.2. A significant change of condition is a major decline or improvement in the resident's status that:C. Requires interdisciplinary review and / or revision to the care plan;D. Ultimately is based on the judgment of the clinical staff and the guidelines outlined in the resident assessment instrument.3. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when:a. The resident is involved in an accident or incident that results in an injury including injuries of an unknown origin;E. It is necessary to transfer the resident to a hospital / treatment center.5. The nurse will record in the resident's medical record information relative to changes in the resident's medical / mental condition or status. Review of the facility's policy, Falls - Managing, Preventing, and Documentation, revised 09/2025 showed each resident will have an individualized plan of care that will be reviewed and modified as needed to include fall interventions most appropriate to their individual needs and diagnosis.Definition A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred.Resident - Centered Approaches to Managing Falls and Fall Risk1. The staff will implement a resident - centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with the history of falls.Monitoring Subsequent Falls and Fall Risk2. if the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed the attending physician will help the staff reconsider possible causes that may not previously have been identified.Documentation1. residents who experience a file will have appropriate documentation completed in the facility risk management portal or on paper.