

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105478	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2025
NAME OF PROVIDER OR SUPPLIER Advanced Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 401 Fairwood Ave Clearwater, FL 33759	

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews the failed to maintain a home-like environment for fourteen rooms (# 3, 4, 6, 8, 11, 14, 20, 32,33, 37, 48, 50, 54, 55, 62) out of fifty rooms sampled. Findings included: During a facility tour conducted throughout the facility starting at 10/15/2025 at 9:40 A.M., the following environmental concerns were observed: room [ROOM NUMBER] was observed with missing paint on the walls, and the bed had a reddish-yellowish-brown flaky coating of oxidizations on the metal frame. The same stained coloring was observed on the floors in the room. In room [ROOM NUMBER] the toilet was observed without sealant round the base of the toilet, missing paint from the frame of the bathroom door area, and the beds were with reddish-yellowish-brown flaky coating of oxidizations on the metal frame. One of the beds were noted with a broken side rail. One bedside table was observed with the edging detached from the table. room [ROOM NUMBER], was observed with holes in the walls room [ROOM NUMBER] was observed with black marks and missing board from off the wall. room [ROOM NUMBER] was observed with paint chipped off the bathroom door. room [ROOM NUMBER] was observed with unfinished work under the sink in the bathroom, toilet without sealant around the base of the toilet. Room # 37 was observed with missing paint and borders detached from the wall .Room numbers 3, 8, 11,37 48, and 50 were observed with baseboards detached from the walls. room [ROOM NUMBER] observed with missing paint in the bathroom and toilet paper stored on a plunger. room [ROOM NUMBER]'s air mattress cord was observed laying across the floor and going up the wall and plugged in to the Television. On 10/15/2025 at 2:00 p.m. an interview was conducted with the Director of Maintenance (DOM). The DOM said environmental concerns are brought to his attention when the staff puts the information in their work order system. He said he has access to the system on his phone, and he checks the system multiple times a day to see if there are any concerns. He said at this time he only had five open tasks to complete, and none of the issues were the concerns identified in rooms numbers (3, 4, 6, 8, 11,14, 20, 32, 33, 37, 48, 50, 54, 55, and 62). The DOM said this was the first time these concerns were brought to his attention. He said he stated he would also be informed about environmental concerns during morning meetings, but those rooms were never mentioned to him as having any environmental concerns. He said he would like to replace the beds in some of the rooms, but if he could not. He stated he would have to sand the beds down to remove the brownish oxidizations. The DOM said they were working on the holes in the walls using a patch and paint system, but have not gotten to some of the rooms yet. The DOM said they will have to wait until the residents are discharged from the rooms to make the repairs. On 10/15/2025 at 3:48 p.m., an interview was conducted with the Nursing Home Administrator (NHA). The NHA said he was notified of environmental concern during the morning meeting. The NHA stated the department heads make room rounds before the meeting every morning, then report any concerns they find in the meeting. He stated most of the time they make sure they put the concern in their work order system. The NHA said he also identifies concerns when he make his rounds in the facility. The NHA said nursing aides are o trained to report concerns in the work order system. The NHA said he would expect his staff to report any room lights that are out , electrical cords hanging from light fixtures, holes in the walls, any bed cords plugged in inappropriately, and other environmental concerns in the facility. He said when the staff bring concerns about beds with brown colored oxidization, he orders new ones. The NHA said staff should have brought the concerns to his attention. Review of the facility policy titled, Homelike Environment Revision date 02/2021, revealed policy statement: Resident are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belonging to the extent possible. Policy Interpretation and implementation: 2. The facility staff and management, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a clean, sanitary and orderly environment (Photographic Evidence Obtained)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record reviews, the facility failed to investigate an injury of unknown origin, related to bruising on one resident (#3) of three sampled residents. Findings included: Review of the admission Record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses included but not limited to osteoarthritis of knee, disorders of brain, neutropenia, osteoarthritis of both knees, spondylosis without myelopathy or radiculopathy of the lumbar region, epilepsy, disc degeneration of lumbar region with back pain and anemia. Review of the current physician orders showed Aspirin 81 mg (milligrams) at bedtime for DVT (deep vein thrombosis) prophylaxis since 09/24/25. Review of the Nursing PRN Skin Check dated 10/17/25 showed resident skin intact. No skin impairments noted at this time, full body check performed by this nurse with husband at bedside. Review of a nursing daily skilled note dated 10/13/25 showed skin was warm/dry. No surgical wound noted. No open wound noted. Review of a nursing daily skilled note dated 10/15/2 at 3:36 p.m. showed skin was warm/dry. No surgical wound noted. No open wound noted. Review of a Change in Condition (CIC) dated 10/15/25 at 11:00 p.m. showed the resident had a fall. Review of the progress note on 10/15/25 at 11:36 p.m. showed, this writer was notified by a staff member that this resident was on the floor. Upon my arrival, she was sitting upright, on the floor, between her bed and the window, trying to fold a blanket. She denied having any pain or hitting her head; however, because of her confusion and inability to describe in detail why she was on the floor, Neuro-checks have been initiated. Resident has full ROM (range of motion). Darker bruises on her upper thighs were present upon inspection, that appeared to be from prior falls. Review of the Nursing Daily Skilled Note dated 10/16/25, 10/17/25, 10/18/25, 10/19/25, 10/20/25, 10/21/25 and 10/22/25 showed the same note, Skin was warm/dry. No surgical wound noted. No open wound noted. Review of the care plan dated 09/29/25 showed Resident #3 was at risk for falls and / or fall related injury related to generalized weakness, limited endurance, impaired balance, unsteady gait, requires staff assist with transfers and ambulation, has a history of falls, has poor safety awareness as of 09/25/25, the resident is noted to have actual skin impairment, see wound notes and /or physician orders as of 09/29/25. Interventions included but not limited to observe skin impairment for signs and symptoms of infection and for significant decline: update physician if noted as of 09/29/25. A second focus in the same care plan showed - Resident has a potential for skin impairment related to impaired mobility, requires staff assist to turn and reposition, incontinence of bowel, incontinence of bladder, history of pressure ulcers, fragile skin, receives medication that may increase risk for bleeding and bruising as of 10/04/25. Interventions included but not limited to perform skin treatments as ordered as of 10/04/25. Observed skin for signs and symptoms of breakdown during care as of 10/04/25. Notify physician of any signs and symptoms of skin breakdown / pressure ulcer if noted as of 10/04/25. During an interview and observation on 10/23/25 at 10:00 a.m. Resident #3 was observed in their room. The therapy aide was with her. The resident did present any bruising on her thighs at the time. The aide stated she did not have any bruises, except she had bruising on her chest after a fall. During an interview and observation on 10/23/25 at 10:22 a.m. Resident #3 was observed in the dining room in her wheelchair. Resident #3 was noted to have 5 small areas of bruising, and tears on her left forearm. She stated it was from a bracelet she had on. Resident #3 stated she had not had any falls recently. During an interview on 10/23/25 at 1:06 p.m. Staff A, Licensed Practical Nurse (LPN) (agency staff) stated she took care of Resident #3 today. She stated Resident #3 was alert with confusion and a high fall risk. Staff A stated the report she received was Resident #3 had no changes. Staff A stated Resident #3 had not had any recent falls. Staff A stated Resident #3 was wheelchair bound. Staff A stated if a resident falls, the following should be done: assess the resident, assess for pain, check vital signs, do neuro checks, and check ROM (range of motion). Staff A stated the findings should be documented in the progress notes and facility form in the electronic chart. Staff A stated the neuro checks were in the electronic chart. She stated Resident #3 was currently not on neuro checks. Staff A stated the residents are supposed to have weekly skin checks that are done on their shower days. During an interview on 10/23/25 at 1:12 p.m. Staff B, Certified Nursing Assistant (CNA) stated Resident #3 was incontinent and required incontinent care, help with dressing, redirecting, coaching, and showers. Staff B stated she wakes Resident #3 up, takes her to the bathroom, brushes her teeth and wash her face. Staff B stated she takes Resident #3 out of the room to go to activities, therapy, bathroom, and the dining room. She stated Resident #3 was not on 1:1, but we keep an eye on her. Staff B, CNA stated Resident #3 has a bruise on her upper left hip the size of a fist. Staff</p>		

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<p>F 0635</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide doctor's orders for the resident's immediate care at the time the resident was admitted.</p> <p>(continued on next page)</p>

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<p>F 0635</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on interviews and record reviews the facility did not ensure two residents (#1 and #2) out of four residents reviewed had physician orders to ensure the residents received necessary care and services upon admission. Findings included: 1.) An interview was conducted on 10/15/2025 at 10:06 a.m. with the resident representative (RR) for Resident #1. The RR said the resident had been discharged from the facility and was in the hospital for an issue with a foot wound. The RR said she had concerns about the facility not giving Resident #1 insulin when he was initially admitted to the facility. She said the resident finally received insulin, but only half of his normal dose. The RR said she had spoken to the nurse assigned to Resident #1 about her concerns. The RR said the resident also informed the nurse he was supposed to be on insulin his first day in the facility and asked about his insulin multiple times and filed a grievance. Review of admission Records showed Resident #1 was admitted from the hospital on 9/24/25 with diagnoses including type 2 diabetes mellitus (DM) with foot ulcer, type 2 diabetes with other specified complications, diabetes mellitus with diabetic peripheral angiopathy, and peripheral vascular disease. Review of Resident #1's Brief Interview for Mental Status (BIMS), completed 9/25/25, showed a score of 14, indicating he was cognitively intact. Review of Resident #1's hospital Medication Discharge Report, dated 9/24/25, showed: Stop Taking the Following Medications-Insulin Aspart (Novolog Flex pen 100 units (u)/milliliter (ml) injectable solution. Sliding scale. Subcutaneous. Three times a day before meals.-Insulin Glargine (Lantus Solostar pen 100 u/ml subcutaneous injection. 20 u once a day. No additional medications for diabetic control were listed on the Medication Discharge Report. Review of Resident #1's Hospital Medication Administration Record (MAR) showed the resident last had Insulin Aspart 14 u on 9/24/25 at 6:01 p.m. and Insulin Glargine 10 u on 9/23/25 at 8:57 p.m. Review of Resident #1's progress notes did not show any documentation the discharge medication list was reviewed and reconciled with a provider upon admission. Review of Resident #1's weights and vitals showed no documentation the resident's blood glucose level was checked at the facility until 9/26/25 at 9:21 p.m., when the level reading was 240 milligram (mg)/deciliter (dL). (Normal range: fasting: 70-140 mg/dL; Post-meal: less than 160 mg/dL) Review of Grievance/Concern Reports showed a grievance filed by Resident #1 on 9/25/25 with concerns including the facility not having his medications at admission. Review of Resident #1's facility orders did not reveal any insulin orders until:-Novolog Flex Pen Subcutaneous Solution Pen-injector 100 u/ml (Insulin Aspart) Inject as per sliding scale: if 150 - 200 = 2 units give glucagon notify MD of BS <60; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units give 10 units and notify MD of BS > 400, subcutaneously before meals and at bedtime for diabetes mellitus (DM) type II for 7 Days. Start date 9/26/25.-Insulin Glargine Subcutaneous Solution. Inject 10 units subcutaneously two times a day for diabetes mellitus. Start date 9/29/25. Review of Resident #1's facility MAR showed Novolog insulin was administered for the first time of 9/26/25 at 4:40 p.m. and the resident had a blood glucose level of 240 mg/dL, two days after admission to the facility. The MAR showed Insulin glargine was administered for the first time on 9/28/25 at 6:00 a.m., four days after admission to the facility. 2.) An interview was conducted on 10/15/25 at 6:15 p.m. with the RR for Resident #2. The RR said when Resident #2 arrived at the facility it apparently wasn't clear in the hospital paperwork that the resident was on insulin. The RR said when the admitting nurse reviewed medication with them, they notified the nurse the resident needed insulin. The RR said Resident #2 went a day or so without insulin but didn't have any negative effects. Review of admission Records showed Resident #2 was admitted from the hospital on 9/27/25 with diagnoses including diabetes mellitus type II, chronic obstructive pulmonary disease, and obesity. Review of Resident #2's hospital paperwork did not list insulin on the Med Rec Discharge meds however, the Medication Discharge Summary from the hospital showed the resident was on Insulin, regular 70/30 100 u/ml 20 u twice daily before meals and Insulin Lispro 100 u/ml before meals and at bedtime. Review of Resident #2's progress notes did not show any documentation the discharge medication list was reviewed and reconciled with a provider upon admission. Review of Resident #2's orders did not show any orders for insulin put in at the facility upon admission. Review of Resident #2's Weights and Vitals Summary showed the resident's blood glucose level was not checked until 9/29/25 at 1:37 p.m., two days after admission to the facility, with a reading of 296 mg/dL. Review of Resident #2's facility orders and MAR showed an order for Novolin 70/30 flexpen 100 u/ml. Inject 45 u subcutaneously before meals related to type 2 DM, start date 9/29/25. The first dose was signed off as administered on 9/29/25 at 4:30 p.m. and the resident had a blood glucose level of 393 mg/dL. An order for Novolin 70/30 flexpen 100 u/ml Inject 25 u</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to ensure referral for urology consultation/evaluation was provided for one resident (#5) of three residents sampled. Findings Included: Review of an admission Record dated 10/23/2025 revealed Resident #5 was admitted to the facility on [DATE] with diagnoses to include but not limited to Type 2 Diabetes Mellitus with hyperglycemia, neuromuscular dysfunction of bladder, unspecified, infection and inflammatory reaction due to indwelling urethral catheter, subsequent encounter, chronic kidney disease, stage 3A. Review of an order summary dated 10/23/2025 showed: Consult Urology for urinary retention, verbal active order, dated 10/23/2025. Review of a progress note dated 10/08/2025 created by Staff G, Advanced Registered Nurse Practitioner (ARNP) noted to start a voiding trial on Resident #5. If voiding trial fails reinsert indwelling foley and consult urology. Review of a progress note dated 10/13/2025 created by Staff G, ARNP showed Staff G gave verbal orders previously on Friday for voiding trial, but it was not done for unknown reasons. Staff G noted she spoke with nursing and the Director of Nurses (DON) about the plan and requested voiding trial to be done and if voiding trial fails, consult urology. Review of a progress note dated 10/20/2025 created by Staff G, ARNP showed on 10/20/2025, Resident #5 did not pass voiding trial despite electronic record documentation indicating otherwise. Staff G noted Resident #5 had not voided with need for straight cath (catheterization) and greater than 400 mls [milliliters] output with urinalysis with culture and sensitivity obtained and + yeast, see labs and plan. On 10/23/2025 at 2:00 p.m. an interview was conducted with the Director of Nurses, DON. The DON said the ARNP put Resident #5 on a voiding trial because she did not have justification for the use of a foley catheter. The DON stated the ARNP wanted Resident #5 to start a voiding trial. The DON said, When we conducted the trial, the resident failed. The DON said the Nurse Practitioner noted to consult urology if Resident #5 failed the trial, but she did not put an order in the system. The DON said when she reached out to the ARNP she told them to just leave the foley in. The DON said the ARNP could have put the urology consult order in the system if she wanted Resident #5 to be seen by urology. On 10/23/2025 at 3:30 p.m. an interview was conducted with Staff G, ARNP. The ARNP said she wrote in her progress notes to start a voiding trial on Resident #5 because she had a diagnosis on her 3008 for acute retention. She said she told the nurse and the director of nurses twice if the resident failed the voiding trial to consult urology. She said the director of nurses reached out to tell her the resident was not voiding, and they only obtained 2000 milliliters of urine. The ARNP said she told the DON they needed to get a consultation from urology. The ARNP said once she gave the facility a verbal order they should have put the urology consult order in the system. She said she told the Unit Manager and the DON both to consult urology if the resident did not pass the voiding trial. She said she told the Unit Manager on Friday and told the DON again on Monday to consult urology for Resident #5. She said she told them to leave the foley in and consult urology. The facility did not have a policy/procedure regarding care consultation and referral.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on interviews and records review facility did not ensure residents received necessary prescribed medications upon admission for two residents (#1, #2) out of four residents reviewed. Findings included: 1.) An interview was conducted on 10/15/2025 at 10:06 a.m. with the resident representative (RR) for Resident #1. The RR said the resident had been discharged from the facility and was in the hospital for an issue with a foot wound. The RR said she had concerns about the facility not giving Resident #1 insulin when he was initially admitted to the facility. She said the resident finally received insulin, but only half of his normal dose. The RR said she had spoken to the nurse assigned to Resident #1 about her concerns. 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No additional medications for diabetic control were listed on the Medication Discharge Report. Review of Resident #1's Hospital Medication Administration Record (MAR) showed the resident last had Insulin Aspart 14 u on 9/24/25 at 6:01 p.m. and Insulin Glargine 10 u on 9/23/25 at 8:57 p.m. Review of Resident #1's progress notes did not show any documentation the discharge medication list was reviewed and reconciled with a provider upon admission. Review of Resident #1's weights and vitals showed no documentation the resident's blood glucose level was checked at the facility until 9/26/25 at 9:21 p.m., when the level reading was 240 milligram (mg)/deciliter (dL). (Normal range: fasting: 70-140 mg/dL; Post-meal: less than 160 mg/dL) Review of Grievance/Concern Reports showed a grievance filed by Resident #1 on 9/25/25 with concerns including the facility not having his medications at admission. Review of Resident #1's facility orders did not reveal any insulin orders as follows:-Novolog Flex Pen Subcutaneous Solution Pen-injector 100 u/ml (Insulin Aspart) Inject as per sliding scale: if 150 - 200 = 2 units give glucagon notify MD of BS <60; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units give 10 units and notify MD of BS > 400, subcutaneously before meals and at bedtime for diabetes mellitus (DM) type II for 7 Days. Start date 9/26/25.-Insulin Glargine Subcutaneous Solution. Inject 10 unit subcutaneously two times a day for diabetes mellitus. Start date 9/29/25. Review of Resident #1's facility MAR showed Novolog insulin was administered for the first time of 9/26/25 at 4:40 p.m. and the resident had a blood glucose level of 240 mg/dL, two days after admission to the facility. The MAR showed Insulin glargine was administered for the first time on 9/28/25 at 6:00 a.m., four days after admission to the facility. 2.) 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