STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105486	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gateway Post-Acute and Rehabilitation Center	8600 US Hwy 19 N Pinellas Park, FL 33782

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and policy review, the facility failed to perform a thorough investigation following an allegation for one resident out of three, (#1). Findings Included: During an interview on 01/07/2026 at 10:18 AM, Resident #1 stated an incident happened two weeks prior while she was being changed by a CNA (Certified Nursing Assistant). Resident #1 stated she was on her bed being pressured by an aide, while being changed. The resident stated the right and left forearms were crossed, both palms facing down and stated having asked the CNA, What are you doing. The resident stated she was on the right side of the bed. The wheelchair was facing a nightstand on the right of the bed. She stated the arms were crossed one over the other and pressed against the surface of the bed and wheelchair. Resident #1 stated having hurt wrists and bruising on her forearms. Resident #1 was observed with two- penny sized dark pink spots on both inside forearms near the wrists. The resident explained being confused about the CNA's actions.Review of Resident #1's medical record revealed the resident was readmitted to the facility on [DATE] with diagnoses to include traumatic subarachnoid hemorrhage without loss of consciousness, hemiplegia and hemiparesis, need for assistance with personal care, unsteadiness of the feet, epilepsy, aphasia and major depressive disorder.Review of Resident #1's quarterly Minimum Data Set (MDS) dated [DATE], showed in section C a Brief Interview Mental Status (BIMS score), of 14, which indicated cognition was intact. Section GG revealed Resident #1 had functional limitation in range of motion with impairment on one side. Resident #1 used a walker and a wheelchair. Section GG revealed for toileting hygiene, showering hygiene and personal hygiene, the resident required partial or moderate assistance.An interview was conducted on 01/07/2026 with Staff A COTA, (Certified Occupational Therapy Assistant). Staff A stated having worked with Resident #1 for balance and coordination, bilateral integration, strengthening, independence and self-care. Staff A stated the resident had a balance deficit and weakness in the right side. Staff A stated during a visit in therapy, later identified as happening on 12/22/2025, upon asking Resident #1 to show her forearms for an exercise, she noticed bruising on the inside forearms. Staff A explained asking Resident #1 about the bruising and stated Resident #1 requested to speak with the person in charge. Staff A stated the bruising's color was dark purple and definitely appeared to be fresh. Staff A stated having been told the bruising was related to two aides the resident was mad at.Review of a psychiatry progress note dated 12/24/2025 revealed, The patient was seen today at staff request after alleging that a CNA grabbed her in a manner, she found uncomfortable during assessment. Patient was unable to describe the CNA involved or provide specific details regarding the alleged event. The patient appeared calm during the evaluation. No injuries or signs of distress were noted at the time of the assessment.Review of a Nurse Practitioner skin and wound assessment note dated 12/22/25 revealed under HPI (History of Presenting illness); Information necessary for today's visit was obtained from the patient evaluated for comprehensive skin assessment for in house skin sweep. scattered bruises noted to upper extremities . Assessment showed: contusion of unspecified upper (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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	105486	A. Building B. Wing	01/07/2026

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	arm, initial encounter.Review of a social services progress note dated 12/23/25 revealed, Due to an injury of unknown origin, other SW (social worker) was asked to conduct a BIMs (Brief Interview for Mental Status) interview . [Resident #1] declined to answer any of the questions and expressed that she did not want to participate. Review of Resident #1's care plan revealed a focus of potential/actual impairment to skin integrity related to decreased cognition, decreased mobility, fragile skin, incontinence, initiated 11/07/2025. The intervention was to monitor/document location size and treatment of skin injury. The intervention included: report abnormalities, failure to heal, signs and symptoms of infection, maceration and more to the medical doctor, initiated 11/07/2025. The intervention included: use caution during transfers and bed mobility to prevent striking arms, legs, and hands up against any sharp or hard surfaces. The intervention included: weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations, initiated 11/07/2025.During an interview on 01/07/2026 at 03:40 PM, with the Director of Nursing (DON) and the Nursing Home Administrator, the (NHA), the NHA stated on 12/22/25 at an unknown time, [Resident #1] had requested to speak with the NHA. The NHA stated there was an incident that happened on 12/18/25. The NHA stated Therapy staff had noticed bruising on the resident. The NHA stated during the interview the resident was upset and was having difficulty speaking due to Aphasia. The DON stated not knowing about the resident having bruising prior to the incident even though the resident was taking an anticoagulant. The DON stated the resident was seen by a psych and there were no bruises noted at the time. The NHA stated they interviewed everyone on shift, but the resident did not know who the CNA was. The NHA stated not having spoken to the Nurse Practitioner who documented the bruising on the resident. They both confirmed the resident had acquired bruising which she alleged occurred during care. The facility could not identify the resident's perpetrator or how the resident acquired the bruising. Review of a policy titled Clinical Guideline Skin & Wound Effective, dated 04/01/2017, revealed: Overview: To provide a system for identifying skin at risk, implementing individual interventions including evaluation and monitoring as indicated to promote skin health, healing and decrease worsening of/prevention of pressure injury.Process: On admission/re-admission the resident's skin will be evaluated for baseline skin condition and documented in the medical record Braden Risk Evaluation to be completed on admission/re-admission, weekly for 4 weeks from admission, quarterly and with a significant change in condition Licensed Nurse to complete skin evaluation weekly and prior to transfer/discharge and document in the medical record CNA to complete skin observations and report changes to Licensed Nurse Licensed Nurse to document presence of skin impairment/new skin impairment when observed and weekly until resolved Licensed Nurse to report changes in skin integrity to the physician/practitioner and resident/responsible party and document in the medical record Develop individualized goals and interventions and document on the care plan and the CNA Kardex Refer to therapy as indicated Monitor residents' response to treatment and modify treatment as indicated Evaluate the effectiveness of interventions, and progress towards goals during the care management meeting and as needed QAPI: Patterns and trends of newly developed and/or worsening skin conditions will be reviewed by the QAPI team.