| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105528 | A. Building<br>B. Wing | 11/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Terrace of St Cloud, The | 3855 Old Canoe Creek Road<br>Saint Cloud, FL 34769 |

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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>(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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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 2 out of 2 residents, of a total sample of 7 residents, (#2, and #6).Findings:1. Resident #2 was admitted to the facility on [DATE] with diagnoses that included vascular dementia, type 2 diabetes mellitus, end stage renal disease, dependence on renal dialysis, anxiety disorder and seizures. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed resident # 2's cognition was severely impaired, and she was dependent on two or more staff for assistance with activities of daily living (ADL) and transfers.Review of resident #2's care plan initiated on 10/27/23 and most recently revised on 10/01/25 indicated the resident required two-person assistance for transfers via mechanical lift, bed mobility and ADLs. On 11/04/25 at 10:23AM, resident # 2 was in bed and had a small, round, bluish mark on her left cheek. She was calm but did not answer any questions when asked. Later in the morning at 11:48 AM, her husband stated a few weeks ago on 10/01/25, his wife got the bruise to her face while she was on another unit. He explained a nurse had called him during the night to inform him of the bruise and because the facility could not tell him what happened, he called the police to report an allegation of abuse.On 11/05/25 at 9:16 AM, Certified Nursing Assistant (CNA) C said he took care of resident #2 while she resided on Unit 2. He remembered working the morning as well as the evening shift and reported to the nurse the bruise on her face an hour before his shift ended. He recalled he had not noticed any bruises on her before. CNA C acknowledged sometimes he provided ADL care to resident #2 without the assistance of another staff member but could not remember if he had assistance on that day. CNA C conveyed he knew what care the resident required from the care plan. He said he knew resident #2 required two persons to assist with ADLs and transfers but explained he still sometimes provided care by himself. CNA C did not give a reason why he did not follow the care plan for two staff for ADL care when caring for resident #2. He explained he might have asked for assistance but could not remember if anyone helped him that day.On 11/04/25 at 3:52 PM, in a telephone interview, CNA A said she learned from report that resident #2 had a bruise to her face. The CNA acknowledged she had assisted resident #2 on 10/01/25, the night the bruise was found. CNA A expressed she changed the resident herself, and stated, I've changed her by myself before, she does not fight, she is calm.On 11/04/25 at 4:07 PM, CNA B stated she had assisted resident #2 when she was on Unit 2 but did not recall her having any bruises on her body. CNA B acknowledged she had provided ADL care to resident #2 by herself previously. On 11/05/25 at 11:15 AM, the lead MDS Coordinator said that resident #2 moved around a lot and it was hard for one staff member to assist her. She explained that resident #2 was very fragile, and CNAs should not decide to assist her by themselves. She stated that care plan interventions for two staff were put in place to minimize bruising and the only time it would have changed was if the resident had a physical therapist evaluation. She continued to explain that unless the resident was improving or if there was some other change in the care plan, those interventions would not change.On 11/04/25 at 1:25 PM, the Nursing Home Administrator (NHA) and the Director of Nursing (DON) acknowledged that the incident resulted in a federal report for abuse filed on 10/01/25. The DON continued to explain that from their investigation, the assigned Certified Nursing Assistant (CNA) C did not follow the resident's care plan for assistance of two persons with ADL care which resulted in bruises to her leg and face.2. Resident #6 was admitted to the facility on [DATE] with diagnoses that included unspecified congestive heart failure, malignant neoplasm of the colon, Alzheimer's disease, unspecified dementia, and generalized anxiety disorder.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed resident #6's cognition was severely impaired. The assessment indicated resident #6 required two or more staff for care and was dependent on staff for ADL care.Review of resident #6's plan of care initiated on 10/09/25, revealed the resident was at risk for easy bruising due to fragile skin, unsafe hand movement behaviors, impulsively grabbing items on the floor or surroundings, combative behaviors, and flings and swings her hands. Resident #6 also had a care plan for risk for skin breakdown and pressure injuries related to combative behaviors, impaired cognition, decreased mobility, incontinence, require assist with care, poor oral intake, daily use of psychiatric medications, fragile skin, impulsive body movement behaviors when in bed or chair. Interventions included the use of two staff members as needed to prevent shearing during positioning. In contradiction to the MDS of 10/09/25, the plan of care indicated resident #6 required one person assistance with transfers, bed mobility and ADL care.On 11/05/25 at 12:46 PM, resident # 6 was in bed with torn pool noodles on the |