STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105688	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura at the Bay	10300 4th St N Saint Petersburg, FL 33716

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review and interview, the facility failed to ensure: 1) resident food and beverage items were labeled and dated in two (100 and 300 wings) out of four nourishment rooms, 2) refrigerator and freezer temperatures were documented on two (100 and 400 wings) out of four nourishment rooms, 3) equipment in the kitchen and one (100 wing) out of four nourishment rooms were functioning appropriately, and 4) hand hygiene/infection control practices were followed in the kitchen.Findings included:On 3/2/2026 at 7:35 a.m., an initial observation of the 100 wing nourishment room was conducted. An observation of the thermometer located in the refrigerator showed a temperature between 58 and 59 degrees Fahrenheit (ˆF). Further observation of the refrigerator revealed two small cups of cottage cheese and fruit with no resident name or room number written on the items. An observation of the thermometer located in the freezer showed a temperature of 40 degrees ˆF. Further observations of the freezer showed the following items were not labeled with a resident's name/room number: popsicles, a 20-ounce bottle of lemon lime soda, and a bag of individual pieces of pound cake dated 1/31.On 3/2/2026 at 8:14 a.m., an initial observation of the 300 wing nourishment room was conducted. An observation of the refrigerator revealed two small, round Tupperware with unidentifiable food and an unidentifiable food item in a large brown paper bag had no resident name or room number. Further observations revealed a large clear Tupperware with lettuce mix did not have a resident name/room number or a date on it. An observation of the freezer revealed a 16-ounce water bottle with no resident name or room number written on it.On 3/2/2026 at 8:59 a.m., an observation of Staff I, cook revealed he had a Smartwatch on his left wrist. He was observed in front of the stove preparing food on the preparation table. On 3/2/2026 at 9:00 a.m., an initial tour of the kitchen was conducted with the Kitchen Manager (KM) and Staff J, Registered Dietitian (RD). At 9:18 a.m., an observation of the dish machine revealed it was in use by Staff K, dietary aide. He walked to the dish machine area with gloves on and put on an apron. He said he assumed it was a low temperature machine and pointed to the information posted on the dish machine with sanitization information. Staff K, dietary aide said he pushed the primer located to the right of the machine, sanitizer came out, and he puts the food items and kitchenware through the machine four to five times. Staff K, dietary aide was observed putting items from the clean side to the dirty side with gloved hands and put the items through the dish machine approximately five times. After multiple attempts of pressing the primer and putting items through the dish machine, Staff K, dietary aide showed the sanitizer strip was white, after putting it on a bead water of water from a clean dome lid. He said the test strip is supposed to be a purple color, indicating the proper sanitizer concentration. At 9:24 a.m., the KM said he checked the sanitizer solution this morning for the dish machine, and it was giving him issues. He said the final rinse was reaching up to 115 degrees ˆF and not any higher, when it was supposed to be 120 degrees ˆF. The KM said he called the maintenance staff who fixed it. A review of the dish machine log was conducted with the KM and showed he logged the final rinse temperature at 120 degrees ˆF that morning and initialed next to the documentation.On 3/2/2026 at 9:26 a.m., an observation of the Director of Maintenance (DOM) and Staff L, Assistant DOM was conducted in the dish machine area, then in the walk-in freezer. The DOM had a beard guard that did (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	not fully cover his beard which exposed part of the facial hair around his chin and mouth area. An observation of Staff L, Assistant DOM revealed he had noticeable facial hair that would require a beard covering, but he was not wearing one. On 3/2/2026 at 9:31 a.m., an observation of the walk-freezer revealed ice build-up on top of and under the fan to the back of the freezer. Further observation of the back of the freezer received ice buildup on top of a large cardboard box that contained seafood patties of imitation snow crab and other fish products. Further observation of the walk-in freezer revealed ice buildup on the bottom of the fan by the door. The KM said he had not noticed the ice build up and would communicate with maintenance.On 3/2/2026 at 9:42 a.m., an observation of the dumpster area was conducted. There was debris and garbage, such used gloves, around the sides and back of the dumpster. The KM said the cleanliness of the dumpster area falls on the kitchen/dietary staff.On 3/2/2026 at 9:48 a.m., a follow-up observation of the 100 hall nourishment room was conducted with the KM. He said the temperature logs for the refrigerator and freezer are found at the nurse's station of each unit. A review of the 100 hall temperature log revealed the temperature on 3/1/26 was not documented. A review of the 3/2/26 temperature documentation showed the refrigerator temperature was at 34 ˆF and the freezer at 6 ˆF. Staff M, Registered Nurse (RN)/Unit Manager (UM) said the 11:00 a.m. to 7:00 p.m. nursing staff are expected to document the temperatures. The KM said it was the nursing staff's responsibility to label and date the residents' personal items in the refrigerator and freezer. He said approximately three months ago the nursing staff received education on labeling and dating items. The KM said he was not sure when the refrigerator/freezer stopped working in the 100 hall and he was not aware of the temperatures not being appropriate. Resident food and beverage items observed earlier in the refrigerator and freezer were seen on top of the counter in the nourishment room.On 3/2/2026 at 9:54 a.m., an observation of the 400 hall nourishment room revealed the temperature log for the refrigerator and freezer was filled out for February until 2/27/26. There was no temperature log observed for March 2026.On 3/2/2026 at 10:04 a.m., follow up observation of the 300 hall nourishment room was conducted with the KM. He observed the large Tupperware with lettuce mix and confirmed it did not have a resident name or date. He proceeded to remove the Tupperware and said it needed to be discarded. Further observation of the refrigerator revealed he removed a large brown paper bag with an unidentifiable food item in red sauce. He confirmed the food item in the brown paper bag did not have a resident name or room number written on it.On 3/3/2026 at 10:54 a.m., a follow-up tour of the kitchen was conducted. An observation of Staff I, cook revealed he had the same Smartwatch on his left wrist that was observed on 3/2/2026. Staff I, cook was observed completing a task by the area where dry kitchenware is stored and was asked by the KM to come to the tray line to take the lunch meal temperatures. He was observed walking to the steam table with gloves on, he did not remove his gloves and perform hand hygiene prior to taking the lunch meal temperatures. At 10:59 a.m., while observing the lunch meal tray line, the long string of the thermometer touched the Salisbury steak when Staff I, cook was taking the temperature of the zucchini. The thermometer string was not cleaned or sanitized after it touched the Salisbury steak.On 3/3/2026 at 11:19 a.m., a follow-up interview was conducted with the KM about the dish machine. He confirmed there was an issue today with the temperature and sanitizing concentration. He said maintenance fixed the issue today. The KM said the dish machine had the same issue approximately three to four weeks ago. He said it was an issue with the valve that needed to be adjusted to get the sanitizer out. The KM stated it, Keeps happening. He said he called maintenance every time the issue occurred and they fixed it. He said the parts for the dish machine were ordered and received but had not been put in yet.On 3/3/2026 at 1:48 p.m., Staff J, RD provided an order and delivery summary from an online purchasing vendor. The documentation showed the dish machine parts were ordered on 2/24/2026 and delivered on 2/26/2026. He said the parts for the dish machine arrived on 2/26/2026 and were installed, but he did not know the date of installment. On 3/5/2026 at 11:01 a.m., an interview was conducted with the DOM. A review of a work order dated 2/20/2026 for the 100 wing nourishment room refrigerator was conducted. He said the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	temperature of the refrigerator that day was 39 ˆF and 18 ˆF in the freezer. The DOM stated they were, On higher end of where they need to be. He said they cleaned the coil, checked the fan that was keeping the refrigerator/freezer cool, and moved it six inches away from the wall. He said the temperatures were checked again the next day, then the following day, and continued to increase; therefore, the refrigerator was removed. The DOM said from 2/20/2026 to current, the staff are using a miniature refrigerator, that was typically used for staff's personal items, for resident items. He said he thought around 2/22 or 2/23 the refrigerator/freezer was removed from the 100 hall nourishment pantry. He said there should not be a refrigerator in the nourishment room, was surprised to hear there was one there, and was not sure who put it there. Regarding the dish machine, he said there are issues with the final rinse not being high enough and the sanitizer not being produced due to the spare heads not functioning the way they should. He said they went to different stores in order to look for the spare head parts they needed and eventually found some online which arrived to the facility last week. He said the parts were installed on 3/2/2026. He said there had not been any issues since Monday as there was a better flow on all of them. The DOM said what he was previously doing was taking off the heads and tried to flush out the sanitizer supply line to to force the chemicals through. He said it was corroded/rusted which did not let the sanitizer through. He said cleaning out the lines and spare heads worked occasionally and he would loosen/tighten them for a temporary fix. He said this issue had been occurring for approximately three to four months. He said they thought they were in the clear as the dish machine would work for three to four weeks at a time.On 3/5/2026 at 11:25 a.m., an interview was conducted with Staff L, Assistant DOM. He said on 2/27/2026 he put a new refrigerator in the 100 hall nourishment room and confirmed it was not the one that was out of service. He stated it was working when he put the refrigerator in the nourishment room and the, Temperatures were where they need to be. Staff L, Assistant DOM said on Monday or Tuesday of this week he removed the refrigerator as the nursing staff told him it had not been working.On 3/5/2026 at 12:08 p.m., a follow-up interview was conducted with the KM. He said the nursing staff, to include certified nursing assistants (CNAs), should be writing the resident's name with the date received on the resident's items. The KM said juices are supposed to be dated when the nursing staff opened them. He confirmed the nursing staff and CNAs have had training. He said the nursing supervisor took over training to include the completion of the temperature log and labeling of resident items. The KM said approximately three months ago, the nursing supervisor took over the responsibility of educating the nursing staff. Regarding staff wearing jewelry, he said the expectations are no dangling from the wrists such as a bracelet that hangs. He said if staff were wearing a watch, they should have a glove over it. For hand hygiene, the KM said for every new task the dietary staff needed to take their gloves off, wash their hands with soap and water, dry them and put on new gloves. He confirmed that Staff I, cook came to the steam table, during the lunch meal service observed, without washing his hands and he should have since it was a new task. The KM said he did not think the thermometer string had ever been cleaned or sanitized. He said the staff used the thermometer three times day, before every meal, and hung it up between uses. Regarding the ice buildup in the walk-in freezer, the KM said the cause was the defrost cycle was occurring during the day and it should be at night. He said the defrost cycle is supposed to heat up the compressor to make sure it did not build up ice. The KM said the maintenance staff changed the cycle and timing of it.A review of the employee handbook, with an effective date of 7/26/23, revealed the following under dress code: . For All Employees in All Departments: . Jewelry may not interfere with job performance and personal or patient safety.A review of a facility policy titled Handwashing, dated 6/2025, revealed the following, Hands shall be washed in accordance with established procedures; before working, after eating, after smoking, after touching any part of the body, after using the restroom, after working with any dirty equipment, and between working with foods.A review of a facility policy titled Food Handling, dated 6/2025, revealed the following, Food shall be handled in a proper method to ensure retention of flavor, appearance, quality, nutrients, and to safeguard against contamination. Further review of the policy under, Policy (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interpretation and Implementation, revealed the following, . 3. When it is necessary for staff to touch food during preparation, they must wash their hands immediately before beginning the process. Disposable gloves are used. A review of a facility policy titled Food Receiving and Storage, dated 6/2025, revealed the following, 7. All foods stored in the refrigerator or freezer will be covered, labeled and dated.8. Refrigerated foods must be stored at 41 F or below.10. Freezer temperature maintained to keep frozen food solid. Frozen food wrapping must stay intact until thawing.11. Functioning of the refrigeration and food temperatures will be monitored at designated intervals throughout the day by the Food Service Manager or designee and documented on an approved log.13. Food items and snacks kept on the nursing units must be maintained as indicated below: Perishable food items will be covered/labeled and dated under refrigeration at 41 F or below. Frozen food items will be covered/labeled and dated at a temperature maintained to keep frozen food solid. All foods belonging to residents must be labeled with the resident's name, item and date. Refrigerators and freezers must have working thermometers and be monitored for temperature.A review of a facility policy titled Storage of Foods Brought to Residents by Family/Visitors, dated 6/2025, revealed the following, Policy Interpretation and Implementation .7. The nursing staff is responsible for discarding perishable foods within 3 days or before the use by/ expiration date, whichever comes first.8. The nursing and/or food service staff must discard any foods prepared for the resident that show obvious signs of potential foodborne danger (for example, mold growth, foul odor, past due package expiration dates).Potentially hazardous foods that are left out for the resident without a source of heat or refrigeration longer than 2 hours will be discarded.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, interviews and record review, the facility failed to protect residents from the risk of accidents and hazards related to:1. Ensuring resident rooms were free from accident hazards, to include sharp objects and chemicals in one unit (memory/dementia) of four units toured, 2. Addressing smoking hazards for two residents (#138, and #68) of two residents sampled for smoking, and 3. Failed to eliminate potential hot liquid hazards related to coffee temperatures in four nourishment rooms (100, 200, 300 and 400) of four units observed. Findings included: 1. During observational tours conducted on 3/2/2026 at 8:00 a.m., on 3/3/2026 at 8:45 a.m., on 3/4/2026 at 10:00 a.m. and on 3/5/2026 at 9:30 a.m. the facility's memory care/dementia unit revealed accessible and sharp thumbtacks stuck on walls and activities corkboards in resident rooms; 221 (A) and (B) side, 222 (A) side, 227 (A) and (B) side, 228 (B) side, 230 (A) and (B) side, 232 (B) side, 205 (B) side, 204 (A) and (B) side, 207 (A) and (B) side, 210 (A) side, 211 (A) and (B) side, 212 (A) and (B) side and 215 (A) and (B) side. Some of the cork boards were observed with ten to fifteen colorful thumbtacks that were easily accessible to the residents who have confusion, dementia, Alzthiemer's, and were walking in and out each other's rooms, putting them at risk for hazards. On 3/5/2026 at 1:30 p.m. an interview was conducted with the 200-unit nurse, Staff B, Registered Nurse (RN). Staff B confirmed the presence of thumbtacks in resident rooms that used to hold papers up on corkboards. She stated she had never thought about thumb tacks being accident/injury hazards. Staff B confirmed the residents who reside in the 200 memory/secured unit wander in and out of other resident rooms and present with confusion, dementia and other cognitive deficits. Staff B confirmed after making a tour, there were several resident rooms that had numerous unused thumbtacks stuck in the corkboards. Staff B confirmed the thumbtacks could be easily removed by residents and presented potential injury hazards. On 3/5/2026 at 2:00 p.m. an interview with the Activities Director (AD) revealed she and her staff post information on the cork boards in each individual resident rooms for both the (A) bed and the (B) bed area. The AD confirmed they had not posted information in the 200 memory/secured unit individual rooms for a while as most of the residents cannot read or understand the activity calendar. The AD and her two staff stated they did not think the thumbtacks were injury hazards. The AD said after thinking about it, they are injury hazards and should not be accessible to the residents who reside in that unit. On 3/5/2026 at 2:40 p.m. an interview with the Nursing Home Administrator, (NHA) revealed the 200 unit was the memory/secured unit which houses residents who require supervision due to cognitive deficits and various behaviors. The NHA confirmed many residents in this unit ambulate on their own and wander in and out from other resident rooms and spaces. The NHA stated not being aware of sharps hazards in the resident rooms, to include the activities cork boards. She stated she did not think the thumbtacks that were easily accessible to these residents were presenting as injury hazards. The NHA said, however, the thumbtacks are a hazard risk, and the activities staff should have been using other ways to secure paper to the corkboard. The NHA confirmed the facility did not have a specific policy with regards to sharps or injury hazards in the memory/secured unit but confirmed the thumbtacks should not be used in the memory/secured unit. During multiple tours on 03/02/2026 and 03/05/2026 tours were conducted of the facility's secured/memory care unit. The following was observed: On 03/02/2026 at 8:41 a.m. an observation of room [ROOM NUMBER] – B showed a large bottle of [Brand name] mouthwash which was a quarter full. This mouthwash was easily accessible (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on the shelf above the television. Additionally, there was a hole on the lower right side on the outside of the footboard. It was about four inches in diameter. On 03/05/2026 at 10:00 a.m. an observation and interview was conducted of room [ROOM NUMBER] with Staff A, Certified Nursing Assistant (CNA). A nail clipper was found inside the resident's nightstand. Staff A said the nail clipper should not have been in the nightstand. On 03/05/2026 at 9:22 a.m. an observation was made of room [ROOM NUMBER] revealing a nail [NAME] out of the cork board. On 03/05/2026 at 9:24 a.m. an observation was made of room [ROOM NUMBER] revealing a staple observed hanging from the cork board. One side of the sharp staple was slightly inserted inside the cork board while the other side was hanging off. On 03/05/2026 at 9:25 a.m. an observation was made of room [ROOM NUMBER] revealing a bottle of [Brand Name] wipes on the side table. The bottle label revealed the wipes contained dimethyl benzyl ammonium chloride and dimethyl ethylbenzyl ammonium chloride, alcohol, cleaning agents, and fragrances. On 03/05/2026 at 9:51 a.m. an observation of room [ROOM NUMBER] revealed a pinned badge on the table which was against the wall to the right of the bed. The pin contained sharp points. On 03/05/2026 at 10:00 a.m. and at 10.24 a.m. an interview ws conducted with Staff A, CNA, about the potentially hazardous items found in resident rooms in the secured /memory unit. Staff A revealed mouthwash, toothpaste and toothbrushes were to be put in a zipped bag if they were in a resident's room. Staff A stated if nail clippers were given to residents from staff, then they must give them back. Staff A said he did not know or did not think residents should have pinned badges. He stated he thought the family had brought it in as it was not given to the resident by the facility. Staff A said he did not know what the guests were told in terms of allowed items. He said he knew they were not allowedto bring glass vases and certain flowers are they are toxic if ingested. Staff A said if these items were seen, the staff would tell the guest they could not bring them into the unit. Staff A stated if he saw a resident with an item they could not have, he would give it to the nurses. On 03/05/2026 at 10:28 a.m. an interview was conducted with Staff B, Registered Nurse (RN) about what belongings residents in the secured/memory unit were allowed to have. She stated residents were allowed to keep their belongings such as badges with pins, nail clippers and mouthwash. Staff B did not identify these items as hazards. 2. A review of Resident #138's admission record showed she was readmitted to the facility on [DATE] with diagnoses including but not limited to nicotine dependence, cigarettes, dependence on supplemental oxygen, and need for assistance with personal care. A review of Resident #138's minimum data set (MDS), section C, dated 2/17/2026 revealed a brief interview for mental status (BIMS) score of 15 indicating cognitively intact. A review of Resident #68's admission record showed she was readmitted to the facility on [DATE] with diagnoses including but not limited to nicotine dependence, cigarettes and need for assistance with personal care. A review of Resident #68's minimum data set (MDS), section C, 1/4/2026 revealed a brief interview for mental status (BIMS) score of 15 indicating cognitively intact. An interview on 3/2/2026 at 7:35 a.m. with Resident #138 was conducted. She said she was caught smoking in a non-smoking area of the facility last week. Resident #138 said she leaves her cigarettes with the receptionist and gets them when she goes outside to the covered area by the pond. An interview on 3/4/2026 at 2:25 p.m. with Staff N, Administrative Assistant was conducted. She said residents that are competent can sign themselves out and walk around outside. She said the facility does have residents that smoke. An observation and interview on 3/4/2026 at 3:00 p.m. with Resident #138 and #68 was conducted. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #138 and #68 said they were headed outside to smoke. Resident #138 said she retrieves her cigarettes from Staff O, Receptionist before she goes outside. Resident #138 retrieved her cigarettes from Staff O, Receptionist and looked in her rolling walker chair for a lighter and stated, I can't find my lighter, Resident #68 stated, I have mine; it's under my [breasts]. An interview on 3/4/2026 at 3:03 p.m. was conducted with Staff O, Receptionist. He said Resident #138 is the only resident that keeps their cigarettes at the front desk. He said the facility does have residents sign out at the reception desk and go outside to smoke. On 3/4/2026 at 3:08 p.m. Resident #138 and #68 were observed smoking a cigarette under the covered patio area on the facility property. Resident #138 had a portable oxygen tank with her and was wearing a nasal cannula. The NHA was made aware of the observation of the resident's smoking under the covered patio area on the facility property and Resident #138 wearing oxygen on 3/4/2026 at 3:09 P.M. An observation on 3/4/2026 at 3:10 p.m. was made of the NHA and the DON exiting the building. The DON said she was going to the non-smoking area [using hand gesture air quotes]. The DON said that is where the residents are caught smoking a lot. An interview was conducted on 3/4/2026 at 3:15 p.m. with the NHA, Regional Nurse Consultant (RNC), and Staff P, Activity Consultant. The NHA confirmed Resident #138 was smoking on the facility property. Staff P, Activity Consultant said it was not acceptable for Resident #138 to be smoking because she was wearing oxygen. Staff P, Activity Consultant said smoking with oxygen was a safety risk. A review of Resident #138's medical record revealed the following progress notes:On 3/3/2026, history details: . Current smoker of cigarettes.On 2/27/2026 social services note, explained smoking policy to the resident. Resident is aware that this is a non-smoking facility and agreed to not smoke on the facility grounds.On 3/4/2026 a social services note read, Resident was observed smoking on facility premises. A review of the facility's policy titled, Campus Wide Non-Smoking Policy and Procedure, dated 2024, revealed, Facility prohibits smoking in any part of its facility or anywhere on its premises. This policy applies to all tobacco products. The procedure of the policy is II: C: Residents are not permitted to have any smoking paraphernalia in their room or on their person. 3. On 3/2/2026 at 9:43 a.m., a tour was conducted with the Kitchen Manager (KM) of the four nourishment room pantries on the 100, 200, 300 and 400 units. Single service coffee and hot water machines were observed in all four pantries. The KM said he did not know if staff were checking the temperatures of the coffee and hot water before providing them to residents. He said staff do not record the temperature. The KM said the coffee was brewed at 180 ˆ and came out of the machine at 160 ˆ. A review of an article from the American Burn Association titled, Scald Burns, accessed on 3/10/2026, revealed the following, Scald burns happen when hot liquids or steam come into contact with the skin. They're among the most common burns, especially in children and older adults, and can range from mild to severe. Further review of the article revealed common causes of scald burns came from hot water and hot drinks spilled on the skin, especially for older adults. Further review of information on the American Burn Association and from John Hopkins School of Public Health revealed times and temperatures for water to cause a serious burn:- 140 ˆ within 3 seconds.- 120 ˆ within 10 minutes. Referenced from: https://www.ameriburn.org/, https://publichealth.jhu.edu/. On 3/5/2026 at 9:32 a.m., an interview was conducted with Staff Q, Licensed Practical Nurse (LPN). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She said she assisted in the dining room in the secured unit and in the main dining room. Staff Q, LPN confirmed there was a coffee machine in the nourishment room. She said when a resident asked for coffee she would pour from the machine and ask how the resident liked it. She said there was also a button for hot water on the machine. Staff Q, LPN stated the coffee was, Usually hot when it comes out, the creamer cools it down. She said for residents with dementia staff needed to monitor to make sure it was not too hot. She said for residents with dementia she normally puts creamer in the coffee to cool and looks for the smoke that rises from the beverage. Staff Q, LPN said she also felt the mug with coffee or tea, with her hands to determine if it was too hot. She said for residents in the main dining, not the secured unit, they can monitor on their own if the coffee or water is too hot for them. On 3/5/2026 at 9:39 a.m., an interview was conducted with Staff T, CNA. She said when she worked in the secured unit, she gets coffee and tea from the machine in the nourishment room. She said residents who are alert and oriented usually asked for coffee. Staff T, CNA said coffee is typically provided with breakfast and lunch. She said during dining, the staff get a pot and fill it with coffee. She said she added whatever the resident wanted such as sugar or creamer. Staff T, CNA said she lets the alert and oriented residents decide if the temperature is okay and if they wanted to drink it or not. She said the residents who are not alert or oriented do not typically ask for coffee but may get it during activities. On 3/5/2026 9:48 a.m., an interview was conducted with Staff M, Registered Nurse (RN)/Unit Manager (UM). She said any staff member can provide a resident with coffee or tea. She said she asked the resident how they prefer their beverage such as black coffee/plain or with sugar. Staff M, RN/UM said the temperature for the coffee is already set. She said she was not sure what the temperature of the coffee or tea was when it comes out because the KM controlled that. Staff M, RN/UM said by the time staff prepared the beverage with sugar and creamer, the coffee is not very hot because there is no steam coming out. She said when it comes out of the machine the coffee is not extremely hot because there was no steam. She said by the time the coffee or tea is provided to the resident the temperature is warm. On 3/5/2026 at 12:08 p.m., a follow-up interview was conducted with the KM. He stated 180 ˆ is the temperature of the coffee recommended by the vendor because it is, The best flavor for coffee. He said the vendor told him the coffee temperature comes out at 160 ˆ. He said when the vendor comes to the facility, he will ask them to adjust the temperature to 150 ˆ. He said when the coffee came from the kitchen, they do not take the temperature. He said they put coffee in a pot, and it goes on the meal cart to the 100 wing as the machine in the nourishment room was not functioning at this time. He said all the other units get the coffee from the machine in the nourishment rooms. On 3/5/2026 at 1:06 p.m., an interview with the Director of Nursing (DON) was conducted. She said the nursing and CNA staff were provided an education/in-service in October 2025 about not putting hot liquids in Styrofoam cups. The DON said staff were educated to make sure there was no steam and letting the hot liquid cool before providing to the resident. She said staff were instructed to put the coffee from the coffee maker into carafes. She said when the beverage came directly from the machine it was hot, therefore staff are encouraged to use the carafes. She said the carafe gave the coffee time to cool when they are passing it out during mealtimes. The DON said non-clinical staff should ask the nursing staff before providing coffee or tea as the resident may have a restriction. She stated non-clinical staff, Do not get resident items such as food or beverages, they should tell the CNA or nurse. The facility did not have a policy for accident hazards related to hot liquids. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy titled Reporting Accidents and Incidents, revealed the following, PROCEDURE:1. The facility will ensure that:a. The resident environment remains as free from accident hazards as is possible; andb. Each resident receives adequate supervision and assistance devices to prevent accidents.2. The facility will provide an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes:a. Identifying hazard(s) and risk(s);b. Evaluating and analyzing hazard(s) and risk(s);c. Implementing interventions to reduce hazard(s) and risk(s); andd. Monitoring for effectiveness and modifying interventions when necessary. (Photographic Evidence Obtained)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews, and record review, the facility did not ensure the medication error rate was below 5% for one resident (#31) out of six residents sampled for medication administration. This resulted in 8 errors out of 25 medication administration opportunities for a medication error rate of 32%.Findings included:An observation of medication administration on 3/3/2026 at 11:02 a.m. with Staff V, Licensed Practical Nurse (LPN), at the C Wing, middle, medication cart was conducted. Observation of the medication administration record (MAR) revealed medications that were being prepared, were marked green on the MAR; green indicated medications were previously completed.An observation was conducted on 3/3/3036 at 11:02 a.m. of medication administration with Staff V, LPN. Staff V, LPN was observed preparing and administering the following medications for Resident #31:Methocarbamol oral tablet Give 250 mg - 1/2 tablet (equaling 250mg)Lisinopril oral tablet 10 MG - 1 tabletKeppra tablet 250 MG - 2 tabletsClopidogrel Bisulfate oral tablet 75 MG - 1 tabletCitalopram Hydrobromide tablet 10 MG - 1 tabletCarbidopa-Levodopa oral tablet 25-100 MG - 1 tabletAspirin oral tablet delayed release (enteric coated) - 1 tabletStaff V, LPN proceeded to crush 8 pills and administered the crushed medications to Resident #31 on 3/3/2026 at 11:34 a.m.Review of the medications not to be crushed list on the nursing cart listed Keppra, Carbidopa-Levodopa, and Aspirin enteric coated.A review of the medication audit report for Resident #31 revealed there was documentation 5 of the medications were administered at 9:26 a.m. and 9:27 a.m.An interview on 3/3/2026 at 2:45 p.m. with Staff V, LPN was conducted. She said she documented at 9:27 a.m. that she had administered 5 medications to Resident #31, but she said the medications were not given at that time. She said another resident needed their medications first. She said she administered the medications during the medication observation ending at 11:34 a.m. She said she did not document at that time and instead documented later in her shift at 12:48 p.m. She said she did not give Levetiracetam oral tablet 500 MG and she should not have documented that she administered that medication because she administered Keppra Tablet 250 MG x 2 tablets. She said the methocarbamol had only been administered one time during her shift at 11:34 a.m.An interview on 3/3/2026 at 10:35 a.m. with the Pharmacist was conducted. He said education was being completed with the nurses using the do not crush list located on the medication carts.An interview on 3/5/2026 at 3:04 p.m. with the DON was conducted. She said the medications should not have been crushed. She said the nurse that documented the wrong medications is an agency nurse. She does not know why she documented early or late.A review of an undated policy titled, Medication Administration Guidelines indicates the steps are: 10: Ensure that the six rights of medication administration are followed: b: Right drug, e: right time, f: right documentation. 12: Compare medication source with MAR to verify resident name, medication name, form, dose, route, and time. b: Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by a physician. 20: Sign MAR after administered. - Do not crush medications: Slow release and enteric coated.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interviews and record review, the facility failed to ensure voiced concerns from resident council meetings were documented as a grievance and acted upon during three meetings held on (12/10/2025, 1/16/2026, and 2/6/2026) out of seven resident council meeting minutes reviewed.Findings included:On 3/5/2026 at 2:15 p.m., a resident council meeting was conducted with Resident #134, Resident #186, Resident #73, and Resident #29 who regularly attended meetings The residents stated the following:- Resident #29 and #134 expressed they were missing clothing items, their items cannot be found, and they felt the items were, disappearing, despite them being labeled. They said they told social services and the administrator, Weeks ago, and the concerns were not addressed. They both confirmed their laundry is completed by the facility. Resident #73 expressed she also had missing clothing. She said she started washing her clothes in the bathroom sink as she was hesitant to give her clothes to laundry at the facility as they would not be returned.- Resident #134 and #73 stated concerns with having written grievances on their own, which is why they voiced them at resident council meetings. Resident #134, #73, and #186 discussed concerns with lack of supplies such as toilet paper, towels, sheets, blankets and the absorbent pads that go on the bed or chair. They all said there was a shortage of these items.- Resident #134 stated the resident council president (RCP), and/or Staff W, Activities Assistant (AA) completed the resident council meeting minutes.- All residents present expressed concerns with staff walking into their rooms without knocking and call light responses not being timely, especially on the weekend shifts. - -Resident #134 stated having waited an hour and a half sometimes for the call light to be answered.- Resident #73 and Resident #186 expressed concerns with cold food and stated it had been discussed in resident council. They said the kitchen manager was aware and his response was to send the food back if it was cold because the staff cannot reheat the items in the microwave. They both said when they had returned the food, and the food they received back was still cold.- All the residents present said they did know their rights and rules of the facility. They said they had asked for it in writing and asked for it to be discussed at the resident council meeting, but they had not received the requested information. A review of the resident council meeting minutes revealed the following:- On 12/10/2025 the resident council meeting conducted at 2:00 p.m., showed the following concerns were documented as discussed to include: timeliness of call light response/needs not being met, staff using personal items such as cell phones, medications being left at the bedside without explanation, and supply shortage such as towels.- On 1/16/2026 the resident council meeting conducted at 2:00 p.m., showed the following concerns were documented as having been discussed to include: call light response/needs not being met and staff use of personal items was a continued issue; new concerns related to staffing boards on the units did not include staff names, dietary concerns related to meal ticket accuracy/not receiving preferences, and the RCP asked on behalf of the group about resident rights.- On 2/6/2026 the resident council meeting conducted at 2:00 p.m., showed the following concerns were documented to include: continued issues with little to no improvement such as call light response, poor staff customer service, brief quality causing urine or bowel movement to leak, medications being left at bedside and being provided late, and a resident sitting in the dining room for prolonged periods of time with behaviors. Other concerns included environmental issue related to cleanliness of bathrooms, and the request for the ombudsman to discuss resident rights had not been addressed.A review of the grievance logs for 12/2025, 1/2026 and 2/2026 revealed the following:- 12/21/2025 documented grievances for Resident #73 related to care concern and customer service/interaction with reported resolutions on 1/6/26 and 1/9/26.- 12/30/2025 documented grievance for Resident #134 related to care concern with a reported resolution on 1/2/26.- 12/29/2025 documented grievances for Resident #134 related to care concern, dining, customer service/interaction with reported resolutions on 1/2/26 and 1/5/26.- 1/12/2026 documented grievances for Resident #134 related to care concern and dining with a reported resolution on (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/12/26.- 2/24/2026 documented grievance for Resident #134 related to customer service with no resolution date.A review of the grievance logs did not show any documented concerns from the resident council group. The individual concerns from Resident #73 and Resident #134 were not documented on the dates of resident council meetings.The review confirmed there were undocumented and unresolved grievances from resident council meetings.On 3/5/2206 at 3:28 p.m., an interview was conducted with Staff W, AA. She said she had been invited to the resident council meetings, On and off, since August 2025. She stated, It varies sometimes, who documented the resident council minutes. She said the resident council president (RCP) asked her to take the minutes this time. Staff W, AA said during meetings they reviewed old notes and concerns that were resolved or not. She said for concerns not resolved, they discussed if there was any progress or not. She stated the, Residents among themselves talk about problems. Staff W, AA said she recorded generalized complaints on the resident council minutes because she did not know if she was supposed to name the individuals. She said the RCP addressed the concerns and explained to the residents what they needed to do and who to address the complaint with. Staff W, AA confirmed she had not written a grievance on behalf of resident council. She said the nursing home administrator (NHA) received the resident council meeting minutes, reviewed them during morning meeting and delegated the concerns to those who needed to address them. She said the concerns from resident council are addressed by the RCP/ Resident #134. Staff W, AA said if a resident had a concern, she would address it with the department such as nursing or laundry. She said if a resident said they did not receive medications she would go straight to the nurse or if they did not receive care she would go straight to the certified nursing assistant (CNA). She said when she was first hired in 2016, she was trained by their director at the time on what to do during resident council meetings. She said since her training, what was changed about the process are the forms for the meeting minutes but nothing else had changed.On 3/5/2026 at 3:53 p.m., an interview was conducted with the Social Service Director (SSD) and Staff X, Social Service Assistant (SSA). The SSD said grievances are communicated to her in different ways such as verbally from residents and staff, a form given directly to her, or a phone call from a family member which she documented on the grievance log. The SSD said residents will typically tell her/another staff member or they would fill out the grievance form. She said when she received a grievance in written form, she read them for potential allegations that needed to be reported. The SSD said she made a copy of the grievances, then gives it to the corresponding department for them to investigate and resolve. She said during morning meetings she reminded staff about returning the resolved grievances. She said they tried to resolve grievances right away. The SSD said she speaks to the resident to let them know about the resolution and asked them to sign the grievance form if they were satisfied with the outcome. The SSD and Staff X, SSA both said even if the concern can be resolved immediately, the expectation is to document the grievance. The SSD said grievances from resident council would be written on the log individually if a resident is identified or it could be written as a group labeled, resident council. The SSD and Staff X, SSA said resident council concerns/complaints have not been communicated to them. The SSD stated, Not sure if they are given to someone else. She said she had never seen the resident council meeting minutes and expected concerns to be communicated to her. She said the NHA has access to the resident council minutes. A review of the resident council meeting minutes with the SSD and Staff X, SSA was conducted. They both confirmed concerns related to call lights, customer service, and staff cell phone use was being addressed. They both said they were not aware of concerns from resident council such as resident food items being discarded without their knowledge or dietary concerns. The SSD confirmed they did not have documented grievances for Resident #186, Resident #29, and Resident #73.On 3/5/2026 at 5:01 p.m., an interview was conducted with the NHA. She said she met with the residents who attended resident council the following day after the meeting. She said she frequently followed up with the RCP and was always invited to resident council meetings. The NHA said she also ate breakfast and lunch with them three times a week, which helped get information (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	about concerns. She stated, I already know information from resident council. The NHA said she talked about resident council concerns, from her interactions with them and the meeting minutes, in stand up and stand down meetings. The NHA said she documented grievances for resident council if it came from an individual resident and/or the group. She stated she was, On top of communication when it comes to concerns.A review of the facility's policy titled Resident and Family Concerns and Grievances Policy and Procedure, revealed the following, Purpose To provide for the prompt resolution of medical and non-medical grievances while maintaining confidentiality, in accordance with applicable federal and state statutes and regulations.Further review of the policy revealed the following under procedure:I. Filing of Grievances.A. Residents or their family members, guardian, or representative may voice a grievance to the Facility staff in person, by telephone, or via written communication.B. Should a resident require assistance in voicing a grievance, the Facility Associates shall provide any needed assistance to the resident.C. The Facility shall provide the attached Grievance Report Form to facilitate the voicing of a grievance if requested by a resident or family member.II. Documentation of GrievancesA. The Facility's Compliance and Ethics Officer or a designated Associate will document and keep a log of all grievances expressed either orally and/or in writing on the day that it is received or as soon as possible after the event or events that precipitated the grievance.IV. Responses to and Resolution of GrievancesA. The Facility will follow up with resident or their family members, guardian, or representative within 72 hours of the filing of the grievance.B. The Facility will make reasonable efforts to ensure that all grievances are adequately resolved within thirty (30) calendar days from the day the grievance is received.C. The Facility will advise the resident of the outcome of the grievance investigation and shall make reasonable efforts to contact the resident's family members to advise them of the outcome of the grievance investigation.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurate related to diagnosis for three residents (#134, #211 and #226) of three residents reviewed for MDS assessments. Findings Included: 1. A review of Resident #134's admission record showed an original admission date of 3/1/2024 with a readmission date of 4/19/2024 with diagnoses to include but not limited to bipolar disorder, major depressive disorder, and anxiety disorder. A review of Resident #134's behavioral health progress note dated 11/6/2025 showed a diagnosis of Post Traumatic Stress Disorder (PTSD). A review of Resident #134's annual Minimum Data Set (MDS), dated [DATE], Section I, revealed PTSD was not marked. Review of Resident #134's care plan initiated, 3/20/2024 showed the following focus: [Resident #134's] anxiety level associated with her trauma will be minimized through next review. Interventions include ensure Resident #134's privacy before starting care, Resident #134 prefers female care staff when available and staff will approach anxiety or behaviors as a trauma survivor with empathy and caring. During an interview and record review on 3/5/2026 at 10:41 a.m., Staff C, Registered Nurse (RN) and MDS Coordinator, stated the PTSD diagnosis for Resident #134 had been missed. She indicated the diagnosis should have been updated during the Gradual Dose Reduction (GDR) meeting. She further stated that an audit will need to be conducted. 2. A review of Resident #211's admission record revealed an admission date of 09/14/2025 with diagnoses to include urinary tract infection, site not specified, acute cystitis without hematuria, Parkinson's disease without dyskinesia, without mention of fluctuations, unspecified dementia, hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease, and chronic kidney disease, stage 3 unspecified. A review of Resident #211's quarterly minimum data set (MDS), dated [DATE], revealed under section I – active diagnoses to the following diagnoses were not marked:- Neurological: non-Alzheimer's dementia and Parkinson's disease.- Psychiatric/Mood Disorder: no diagnoses were marked. A review of Resident #211's physician orders revealed the following:- Nuplazid oral capsule 34 milligrams (MG) for Parkinson's psychosis.- Sinemet tablet 25-100 MG for Parkinson's.- Duloxetine hydrochloride (hcl) oral capsule delayed release sprinkle 30 mg for depression. 3. A review of Resident #226's admission record revealed an admission date of 01/29/2026 with diagnoses to include alcohol dependence with withdrawal, unspecified, difficulty in walking, not elsewhere classified, muscle weakness (generalized), and need for assistance with personal care. A review of Resident #226's comprehensive MDS, dated [DATE], revealed under section I – active diagnoses, the diagnosis of dementia was not marked. A review of Resident #226's physician orders revealed the following:- Donepezil hydrochloride (HCl) oral tablet 5 milligrams (mg), give one tablet via percutaneous endoscopic gastrostomy (PEG) tube, one time a day for dementia. On 3/5/2026 at 12:47 PM an interview with Staff C, MDS Coordinator was conducted. She reviewed Resident #211's medical record and confirmed a progress note, dated 1/27/2026, showed the diagnosis of psychotic disorder with delusions due to known physiological condition. Staff C confirmed the diagnoses were missed. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 3/5/26 at 1:21 p.m., Staff C, (RN) and MDS Coordinator said the facility follows the RAI manual and does not have an MDS specific policy. Staff C said the facility follows the Resident Assessment Instrument (RAI) manual and does not have an MDS policy.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure an accurate Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability review (PASARR) was completed for five residents (#2, #112, #9, #211, and #226) of six residents reviewed for PASARR.Findings included:1. A review of Resident #2's admission record revealed an admission date of 12/9/2025 with diagnoses to include psychotic disorder with hallucinations due to known physiological condition, unspecified dementia, unspecified severity, with mood disturbance, depression, unspecified, epilepsy, unspecified, not intractable, without status epilepticus and other seizures.A review of Resident #2's physician orders revealed the following:- Sertraline hydrochloride (HCl) oral tablet 50 milligrams (mg), give one tablet by mouth one time a day for mood.- Donepezil HCl oral tablet 10 mg, give one tablet by mouth one time a day for memory.- Quetiapine fumarate oral tablet 100 mg, give one tablet by mouth three times a day related to psychotic disorder with hallucinations due to known physiological condition.- Lorazepam oral tablet 0.5 mg, give one tablet by mouth every eight hours as needed for anxiety for 30 days. A review of Resident #2's care plan revealed the following:- At times I can have verbal outbursts by yelling out randomly and squirm myself in the bed to be sideways in the bed with legs hanging. Date Initiated: 12/11/2025.- I take a psychotropic medication: antianxiety, antidepressant, antipsychotic Date Initiated: Date initiated 12/22/25.- [Resident #2] is at risk for alteration in mood state r/t [related to] dx [diagnosis] of dementia with mood disorder, anxiety, depression. Date Initiated: 12/10/2025- The resident uses anti-anxiety medications r/t psychotic disorder Date Initiated: 12/10/2025.- The resident uses antidepressant medication r/t depression Date Initiated: 12/10/2025.- The resident uses antipsychotic medication r/t dx of dementia with mood disturbance Date Initiated: 12/17/2025.- Resident has a potential for seizure activity, Date Initiated: 12/20/2025.A review of Resident #2's level I PASSAR screen, dated 11/25/2025, showed depressive disorder was marked under section A - MI or suspected MI. Further review of section A showed no other diagnoses were marked. A review of section II - other indications for PASSAR screen decision-making, showed the question was marked yes for the following, Does the individual have a secondary diagnosis of dementia, related neurocognitive disorder (including Alzheimer's disease) and the primary diagnosis is an Serious Mental Illness or Intellectual Disability? A level II PASSAR evaluation and determination was not found in Resident #2's medical record and was not provided by the facility.2. A review of Resident #112's admission record revealed an admission date of 10/14/2021 with diagnoses to include epilepsy, unspecified, not intractable, without status epilepticus (primary), generalized anxiety disorder, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, mood disorder due to known physiological condition, unspecified, major depressive disorder, recurrent, mild, and unspecified psychosis not due to a substance or known physiological condition.A review of Resident #112's physician orders revealed the following:- Lorazepam intensol oral concentrate 2 mg/mL (milligrams/milliliters), give 0.25 mL by mouth every six hours for anxiety/restlessness.- Valproic acid syrup 250 mg/5mL, give 5 ml by mouth three times a day for seizures.A review of Resident #112's care plan revealed the following:- [Resident #112] has mood symptoms of: feeling sad at times, decreased energy, difficulty sleeping, due to my diagnosis and history of depression. I may become tearful at times. [Resident #112] prefers to remain in bed most of the time. Date Initiated: 10/22/2021.- [Resident #112] can be accusatory and critical of staff. Resident presents with a negative disposition mostly. [Resident #112] requires moderate assistance with ADL's [activities of daily living]. Resident #112 will frequently refuse such and may become physically and verbally aggressive towards staff. Refuses to have nails cut. Frequently refuses medication, supplements and treatments. Often refuses care and unable to redirect makes derogatory and defamatory statements toward and about staff refuse to be (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	turn/repositioned, refuse showers, meals refuse weights and showers refuses to have labs drawn. Resident at times makes inflammatory and confabulatory statements. Date Initiated: 04/20/2022.The care plan revealed:- I take a psychotropic medication: antianxiety. Date Initiated: 09/21/2022.- [Resident #112] impaired cognition with decreased ability to comprehend and/or express myself due to: Dementia, impaired short-term memory. Mental state may flux [fluctuate]. Date Initiated: 09/19/2022.- [Resident #112] has noted noncompliance with medications. She is not always easily redirected r/t [related to]. Patient education and 1:1 [one to one supervision] with [Resident #112] in regard to prescribed medications, risks of noncompliance. [Resident #112] does have dementia, impaired cognition. Staff will continue to encourage compliance, redirect as able. Physician/responsible party aware. Date Initiated: 03/17/2025.- [Resident #112] receives anticonvulsant medication secondary to seizure disorder. Date Initiated: 03/17/2025.A review of Resident #112's level I PASSAR screen, dated 7/15/2024, showed depressive disorder, anxiety disorder, and mood disorder was marked under section A - MI or suspected MI. Further review of section A showed no other diagnoses were marked. A level II PASSAR evaluation and determination was not found in Resident #112's medical record and was not provided by the facility.3. A review of Resident #9's admission record revealed an original admission date of 1/24/2024 and a re-admission date of 8/22/2025 with diagnoses to include bipolar disorder, unspecified and major depressive disorder, single episode, moderate.A review of Resident #9's physician orders revealed the following:- Trazodone hcl (hydrochloride) tablet 150 mg, give one tablet by mouth at bedtime related to major depressive disorder.- Oxcarbazepine tablet 300 mg, give one tablet by mouth in the morning and give one tablet by mouth in the evening related to bipolar disorder. A review of Resident #9's care plan revealed the following:- [Resident #9] takes a psychotropic medication: antidepressant, DX [diagnosis] of insomnia, potential for adverse drug effects such as falls, decline in mood, behavior, cognition and ADL's [activities of daily living] Date Initiated: 08/26/2025.A review of Resident #9's level I PASSAR screen, dated 8/20/2025, showed anxiety and depressive disorder was marked under section A - MI or suspected MI. On 3/5/2026 at 4:21 p.m., an interview was conducted with the Social Service Director (SSD). She said upon admission to the facility, she reviewed the residents Level I PASSAR to see what diagnoses were listed. The SSD said she also reviewed the residents' history and physical documents from the hospital. She said she did not have access to the PASSAR system. The SSD said she kept a log and provided the information to the Assistant Director of Nursing (ADON) who had access to the PASSAR system. She said about two to three weeks ago the Director of Nursing (DON) gained access to the PASSAR system and is now updating them. The SSD said through gradual dose reduction (GDR) meetings or if a diagnosis changed, she wrote it down to update the resident's Level I PASSAR. The SSD said since November 2025, she had been overseeing ensuring the PASSARs were accurate and communicating with the ADON to update them as needed. She said she reviewed the resident's PASSARs to see if the diagnoses matched and also reviewed the history and physical to catch a diagnoses that was not carried over. The SSD said for level II PASSAR evaluations she looked at the provisional information, then reviewed the observational page on the PASSAR and if one of the questions was marked Yes, she would submit for a level II PASSAR. She said if she thought a resident required a level II PASSAR evaluation and the system did not trigger it; the DON can override that and open a new case. She stated, A mental illness, sometimes if there's a developmental disability or TBI [traumatic brain injury], that might need a level II. A review of Resident #112's level I PASSAR was conducted with the SSD. She said a new Level I PASSAR would need to be completed to see if Resident #112 needed a Level II evaluation. She said the previous ADON identified PASSARs that needed to be updated but was not sure where they left off. The SSD said she was not aware Resident #112's Level I PASSAR needed to be updated. A review of Resident #2's PASSAR was conducted with the SSD. She confirmed the resident was admitted on [DATE]. The SSD confirmed the diagnoses of epilepsy and dementia would need to be added to the Level I PASSAR and may need a Level II evaluation. A review of Resident #9's Level I PASSAR was (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted with the SSD. She confirmed Resident #9 was admitted to the facility on [DATE]. She said the diagnosis of bipolar disorder should be on the Level I PASSAR and it would most likely be flagged for a Level II evaluation.4. A review of Resident #211's admission record revealed an original admission date of 09/14/2025. Further review of the admission record revealed diagnoses to include psychotic disorder with delusions due to known physiological condition, unspecified dementia, unspecified severity, with other behavioral disturbance, and adjustment disorder with anxiety.A review of resident #211's physician orders revealed the following:- Nuplazid oral capsule 34 milligrams (MG) for Parkinson's psychosis.- Sinemet tablet 25-100 MG for Parkinson's.- Duloxetine hydrochloride (hcl) oral capsule delayed release sprinkle 30 mg for depression.A review of Resident #211's Level I PASSAR screen, dated 9/13/2025, showed parkinsons disease and dementia. No diagnosis of psychotic disorder was found on the PASSAR. A level II PASSAR evaluation and determination was not found in Resident #211's medical record or provided by the facility.5. A review of Resident #226's admission record revealed an original admission date of 1/29/2026 and a readmission date of 2/19/2026. Further review of the admission record revealed diagnoses to include alcohol dependence with withdrawal, unspecified.A review of resident #226's physician orders revealed the following:- Quetiapine fumarate oral tablet 25 mg for mood.- Anti psychotic behavior monitoringA review of Resident #226's PASSAR Level I screen, dated 1/29/2026, showed no diagnoses were marked under section A- MI or suspected MI. A level II evaluation/determination was marked for dementia.An interview and review of Resident #226's level 1 PASSAR was conducted on 03/05/2026 at 4:37 PM with Social Service Director. She stated the alcohol dependence diagnosis for this resident would be marked under other on the PASARR. The SSD said she would not put in the dementia diagnosis as the minimum data set (MDS) coordinator would update the medical record to include that diagnosis code. She questioned, Why is his diagnosis not on there. She reviewed Resident #226's H&P (history and physical) which showed the diagnosis of dementia. She confirmed dementia is not on the list of current diagnoses. A review of the facility's policy titled Coordination with PASARR, revealed the following, This facility coordinates assessments with the preadmission screening and residents review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. Further review of the policy revealed the following under Policy Explanation and Compliance Guidelines, : 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. a. PASARR Level I - initial pre-screening that is completed prior to admission i. Negative Level I Screen - permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. ii. Positive Level I Screen - necessitates a PASARR Level II evaluation prior to admission. b. PASARR Level II - a comprehensive evaluation by the appropriate state- designated authority (cannot be completed by the facility) that determines whether the individual has MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure the resident had assistive devices to maintain hearing abilities for one resident (#3) of two residents reviewed for communication and sensory problems.Findings included:During an interview and observation on 3/2/2026 at 11:06 a.m. Resident #3 said to stand on the right side because there is no hearing in the left ear and stated difficulty hearing in the right ear. While speaking in a loud voice approximately six inches from Resident #3's ear, the same information had to be repeated multiple times before the resident was able to hear and understand it.A review of Resident #3's face sheet showed an original admission date of 3/21/2023 with a readmission date of 11/17/2025 and a primary diagnosis of acute gastroenteropathy due to Norwalk agent.A review of Resident #3's care plans showed the following focus: [Resident #3] has difficulty with communication due to hearing deficit, initiated on 3/23/2023. The interventions included:-Face when speaking and make eye contact. Turn off TV/radio as needed to reduce environmental noise.-Refer to audiology for hearing consult as needed.-Use strategies such as touch, facial expression, eye contact, gestures, tone of voice, non-threatening posture, short direct phrases, speak slowly, speak in a calm distant manner, speak with increased voice volume. Repeat statement or question as needed. Stand in close proximity.A review of Resident #3's social services (SS) progress note, dated 5/17/2023 revealed, Met with resident yesterday and encouraged the resident to lower volume on television .Resident agreeable, but stated it's hard for me to hear it when I don't have the volume high enough .she is hoping to receive hearing aids in the near future. Informed resident she may be able to receive headphones that would allow [the resident] to hear the television better [Resident #3] was agreeable to wear headphones if they were provided.A review of Resident #3's SS progress note dated 8/5/2024 revealed, SS sent out audiology referral per resident's request.A review of Resident #3's SS progress note dated 4/9/2025, Audiologist referral sent to [Vendor].A review of Resident #3's Minimum Data Set (MDS) dated [DATE] showed a Brief Interview Mental Status (BIMS) score of 13, which indicates moderate cognitive impairment.During an interview on 3/2/2026 at 11:14 a.m. Staff G, certified nursing assistant (CNA) said she must, Talk loud for Resident #3 to hear. The CNA demonstrated this by cupping one hand around her mouth while speaking to project her voice so the resident could hear her more clearly.During an interview on 3/4/2026 at 9:56 a.m. Staff H, Social Services Assistant (SSA) said, Sure there was an audiology consult for Resident #3. He said he communicated with the facility's audiology services vendor by email, and he will check email for additional communication. Staff H, SSA read Resident #3's audiology note, dated August 2024 for Debrox (medication used to soften and loosen excess earwax) 2 drops in each ear twice daily for 5 days repeat after two weeks. He said Resident #3's second audiology referral was April 9, 2025, and he will review the resident's records for additional information. During an interview on 3/4/2026 at 10:02 a.m. the Social Services Director (SSD) reviewed a list of residents with hearing aids or hearing aids pending from the facility's audiology vendor and said Resident #3's name was not listed.During an interview on 3/4/2026 at 10:57 a.m. the Nursing Home Administer (NHA) said the facility's expectation was to make sure all resident needs are met, the cost does not limit the resident's access to services or supplies.During an interview on 3/5/2026 at 9:55 a.m. the Director of Nursing (DON) said, once it is brought to my attention a resident is hard of hearing (HOH), SS is notified immediately.On 3/4/2026 at 3:45 p.m. the NHA said the facility does not have a policy regarding audiology services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to obtain physician orders for the percent of humidity to provide supplemental oxygen by tracheostomy according to professional standards of practice for one (#5) of two residents reviewed for respiratory care.Findings Included:On 03/02/2026 at 7:48 a.m. observed Resident #5's oxygen set to 3 L (Liters).Review of Resident #5's face sheet showed admission on [DATE] and readmission [DATE] with diagnoses to include acidosis, disorders of diaphragm, acute and chronic respiratory failure with hypoxia, pneumonitis and chronic respiratory failure.Review of Resident #5's Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form (3008 form) dated 12/12/25, Section V, Treatment Devices show order for oxygen at 6 liters (L) per [minute] means how much gas is moving and 28% how rich in oxygen the air is.Review of Resident #5's order recap report, dated 3/4/26 showed an order for Trach-continuous humidified oxygen 2.5 L via trach mask .Review of Resident #5's care plan include show care plan focus: resident has tracheostomy related to chronic respiratory failure. The interventions include give humidified oxygen as prescribed via trach mask.During an interview on 3/3/2026 at 5:26 p.m. when asked about Resident #5's oxygen settings Staff D, Licensed Practical Nurse(LPN) said she knows the setting is 2.5 liter and Respiratory Therapy (RT) takes care of the humidifier. During an interview on 3/4/2026 at 10:18 a.m. Staff E, LPN said Resident #5's humidifier setting is 28%.During an interview on 3/4/2026 at 10:27a.m.with Staff F, Registered Nurse, RN said there should be order for a mist setting. After reviewing Resident #5's 3008 form dated 12/12/25 said there should be an order for 28% humidity, I am going to fix the order right now.Review of the facility's Physician Orders policy, undated, showed the policy did not include guidance or relevant information regarding the requirement for physician orders for tracheostomy humidification or respiratory care interventions according to professional standards of practice.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to take a trauma-informed approach to deliver care that involves understanding, recognizing and responding to the effects of a specific trauma Post Traumatic Stress Disorder (PTSD) for one resident (#6) of five residents reviewed with PTSD. Findings included:On 3/2/2026 at 7:35 a.m. the facility's memory/dementia unit was toured and the dining room was observed with residents either being served their breakfast meal, or were waiting for their breakfast meal to be served. Resident #6 was observed seated in her wheelchair positioned at a table and awaiting her breakfast meal. Resident #6 appeared to be dressed for the day, well groomed and appeared generally in good spirits. She was observed interacting with other staff members and was laughing. Resident #6, who resides in the 200 memory/dementia unit, was observed with cognitive deficits and when attempted interview, she could not speak with relation to her medical care and services. She was able to answer simple questions about her day and revealed she had no immediate complaints. She was served her breakfast meal and was observed to take bites and eat without any staff assistance.At 9:50 a.m. while touring the facility's memory/dementia unit, Resident #6's room was approached and the door was closed. Upon knocking and announcing Resident #6 called out with permission to come in. Once the door was opened, Resident #6 was observed seated in her wheelchair, dressed for the day and positioned towards the glass window and was just looking out from it. Resident appeared to be isolated and with nothing to do. When attempting to interview her, she did not appear to be in the same pleasant mood as she was when she was eating breakfast. Resident was attempted interview and she did not want to offer any information about her day. She continued to look out the window. At 10:45 a.m. Resident #6 was visited while in her room again and she appeared to be in a very pleasant mood. She was still observed seated in her wheelchair but was laughing and offering information about her day. She had no complaints and stated she was just sitting in her room. When she was asked if she likes sitting in her room by herself and with the door closed, she stated, I don't know.On 3/2/2026 at 11:00 a.m. an interview with the 200 Unit Nurse staff B, and review of the facility's Resident Matrix, revealed Resident #6 had either Post Traumatic Stress Disorder (PTSD) or some form of it. Staff B was not sure of the reason why Resident #6 had PTSD, but she did present at times with behaviors, agitation, and yelling out.Review of the electronic medical record revealed Resident #6 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of the advance directives revealed Resident #6 had a Power of Attorney (POA) medical decision maker to make her decisions. Review of the diagnosis sheet revealed diagnoses to include but not limited to: Psychotic disorder, Dementia, Psychosis, Paranoid disorder, Adult failure to thrive, Anxiety, PTSD, and Depression. Review of the current Annual Minimum Data Set (MDS) assessment dated [DATE] revealed;(Cognition/Brief Interview, Mental Status or BIMS score - 5 of 15, which indicated Resident #6 had cognitive deficits preventing her from speaking to her medical care and services.); (Mood - Presents 7-11 days Feeling down with no other mood indicators during timeframe); (Behaviors - None documented as exhibited during timeframe); (Active Diagnosis - Anxiety, Depression, Psychotic disorder, PTSD).Further review of the medical record revealed evidence of psychiatric physician visits/assessments to include dates 12/10/2025, 12/18/2025, 1/15/2026, 1/29/2026, 2/19/2026, and 2/23/2026. Each of the assessment/visit documents revealed Resident #6 had PTSD, but did not mention what her PTSD history was, nor revealed any type of documentation to support specific triggers and trauma based behaviors.Review of the Certified Nursing Assistant Care Plan Kardex documents for the last three months reviewed to include months 3/2026, 2/2026, and 1/2026 all did not support any documentation to reflect Resident #6 with specific behaviors and triggers related to PTSD. There was no documentation to let the aides know what to look out for that may trigger Resident #6 to have trauma based behaviors. Review of the current care plans with a next review date 5/31/2026 revealed focus areas to include but not limited (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to:Resident #6 has a history of PTSD related to witnessing a traumatic event with her son, trigger includes talking about the event with interventions to include (Avoid the topic of [NAME]'s trauma unless she begins the conversation, If becomes agitated during a conversation, redirect the topic of conversation, [NAME] will be able to discuss my cultural, privacy gender issues, Will be afforded the opportunity for peer support of her choice, whether that be from peer support as desired.On 3/3/2026 at 10:00 a.m. a telephone interview with Resident #6's Power of Attorney (POA), revealed he was aware there was something that happened with Resident #6 in the past but did not know what. He revealed the facility staff does not bring it up during the care plan meetings he attends and he would also not know what types of behaviors may trigger her related to her past trauma/PTSD. Resident #6's POA was also not sure if psych services was addressing this diagnosis as nobody has ever told him. Review of the 3/2026, 2/2026, and 1/2026 Physician's Order Sheet revealed orders for Behavior monitoring and to perform each shift with documentation and to note codes for what behavior was observed. The order was for staff to document behaviors attributed to psychotropic medication use, and other behaviors not specific to PTSD.Further, review of the same noted month's Medication Administration Record revealed daily behavior monitoring for each shift, but also did not identify any types of specific behaviors that may be attributed to trauma/PTSD. On 3/4/2026 at 1:00 p.m. an interview with a Minimum Data Set (MDS) coordinator Staff C revealed she normally completes MDS assessments and care planning for the long term care residents and does not know everyone that well in the 200 memory/dementia unit. She stated the MDS coordinator for that unit is not available today (3/4/2026) for interview. However, Staff C revealed she can go over the record and answer questions about the resident. Staff C confirmed she did know Resident #6 very little and just knew she has Post Traumatic Stress Disorder (PTSD). Staff C confirmed she was not aware of why Resident #6 had PTSD, nor knew of types of behaviors that staff should be looking out for related to her trauma PTSD diagnosis. Staff C reviewed Resident #6's current care plans and identified and confirmed there was a focus area to include history of PTSD. Further review of the care plan and interview with Staff C confirmed the problem area of PTSD was related to witnessing a traumatic event with her son. Staff C confirmed the focus area did not detail in specific of what experience Resident #6 had, nor were there any specific interventions to capture the types of behaviors Resident #6 may present with related to PTSD.Further interview with Staff C stated she now understands there is nothing in the chart, MDS, care plans that identify what behaviors the resident may have, and therefore staff would not be able to quantify/monitor for specific behaviors. She said we (staff) do not know what to look out for to reduce trauma based PTSD behaviors.Staff C further confirmed psych. services assessments also only revealed diagnosis of PTSD but with no further detail and did not believe the doctor was evaluating for that diagnosis. On 3/5/2026 at 8:50 a.m. an interview with Staff B, Registered Nurse (RN) confirmed she knows Resident #6 well and knows her family is involved with her medical care. Staff B stated Resident #6 has confusion and a lower level of decision making skills. Also, Staff Q, Licensed Practical Nurse (LPN) was present during the interview and she too explained she knew Resident #6 and that she had cognitive impairment but could make her daily decisions. Staff B and Q both confirmed Resident #6 usually stays in her room for parts of the day, but she does come out for meals, group activities and out in the screened in porch with other residents and staff. Staff B and Q confirmed Resident #6 resides in the 200 memory/dementia unit because of her diagnosis of dementia with the need for more supervision. Staff B and Q both confirmed they were aware Resident #6 had Post Traumatic Stress Disorder (PTSD), but they vaguely knew what it was about. Staff B stated she only knew there was something related to her (Resident #6) and with one of her son's, which happened a long time ago. Both Staff B and Q were not aware of anything specific and did not know of what specific triggers and behaviors to look out for related to PTSD. Staff B revealed Resident #6 was care planned with a focus area of PTSD, but it did not reflect what specific behaviors/triggers to look out for. On 3/5/2026 at 9:30 a.m. an interview with Staff A, Certified Nursing Assistant (CNA) confirmed he knows Resident #6 well and speaks with her family when they (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	visit. Staff A Confirmed Resident #6 resides on the memory/dementia unit due to her dementia and behaviors. He stated Resident #6 will at time get sideways with her behaviors and will yell at staff and other residents. Staff A was aware Resident #6 has PTSD but did not really know the specifics of what happened to cause her PTSD. Staff A was unable to say what specific behaviors to look out for that would trigger her PTSD, but would report any type of behaviors to his nurse. On 3/5/2026 at 9:40 a.m. an interview with Staff R, CNA revealed she has Resident #6 on her assignment routinely and she is in the memory/dementia unit due to her dementia. Staff R further confirmed Resident #6 does have behaviors at times but did not know she had PTSD. Staff R could not say how she would determine what types of triggers/behaviors to look out for related to trauma/ PTSD.On 3/5/2026 at 5:00 p.m. an interview with the Nursing Home Administrator confirmed Resident #6's medical record and care planning did identify her as having past Trauma/PTSD, but she was not aware of the specific problem/focus area and also did not know what types of behaviors/triggers to look out for so the care planning team could further evaluate it. The Nursing Home Administrator provided the facility's Trauma Informed Care policy and procedure (no date) for review.The policy revealed;Guidelines:It is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally-competent, account for experiences and preferences, and address the needs of trauma survivors by minimalizing triggers and/or re-traumatization.Definitions: Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Common sources of trauma include, but not limited to: Natural and human caused diseases; Accidents; Rape; [NAME] crime; Physical, sexual, mental, emotional abuse; War; History of imprisonment; History of homelessness; Traumatic life events. Trauma informed care is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization. StepsThe facility will work to facilitate the principles of trauma informed care which include but not limited to:a . Safety - Ensuring residents have a sense of emotional and physical safety.b . Trustworthiness and transparency - Efforts to establish a relationship based on trust, and clear and open communication between the staff and the resident.The facility will use a multi-pronged approach to identifying a resident's history of trauma, as well as his or her cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI), admission Assessment, the history and physical, the social history/assessment, and others. 4 . The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plan interventions. 6 . The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident, and will be added to the resident's care plan. While most triggers are highly individualized, some common triggers may include, but are not limited to:Experiencing a lack of privacy or confinement in a crowded or small space.Exposure to loud noises, or bright/flashing lights.Certain sights, such as objects that are associated with their abuser.Sounds, smells, and physical touch. 7 . Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as the substance abuse, eating disorders, depression, and anxiety. These interventions will also recognize the survivor's need to be respected, informed, connected, and hopeful regarding their own recovery. 8 . The facility will evaluate whether the interventions have been able to mitigate (or (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reduce) the impact of identified triggers on the resident that may cause re-traumatization. The resident and/or his or her family or representative will be included in this evaluation to ensure clear and open discussion and better understand if interventions must be modified. 10 . In situations where trauma survivor is reluctant to share their history, the facility will still try to identify triggers which may re-traumatize the resident, and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident. The Nursing Home Administrator also provided a Comprehensive Care Plan policy and procedure (not dated), for review.The policy revealed;Guidelines:The facility will develop and implement a comprehensive person-centered care plan for each resident. The care plan will be consistent with resident rights, with measurable objectives and timeframes to meet a resident's needs as identified through comprehensive assessment.Steps:4. vii - Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma, as indicated.7. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105688	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura at the Bay	10300 4th St N Saint Petersburg, FL 33716

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interviews facility did not ensure medications were stored properly related to 1) an unlocked treatment cart; 2) expired medications on one unit (C-Wing) out of two units observed for medication storage. Findings included:An observation on 3/2/2026 at 7:38 a.m. of a treatment cart on the C-Wing was unlocked (photographic evidence obtained).An observation on 3/2/2026 at 7:40 a.m. of the medication room on the C-Wing revealed 4 immunizations in the refrigerator were expired (photographic evidence obtained).An interview on 3/2/2026 at 7:45 a.m. with the Assistant Director of Nursing (ADON) was conducted. The ADON said those immunizations should not be in the refrigerator. The ADON stated, the resident's must not have received them. The ADON said the medication storage rooms are messy.An observation of C- Wing HIGH medication cart revealed 3 bottles of expired medications.Sodium Chloride Tablets 1 gram Expired: 11/2025Vitamin D Tablets 400 Expired: 12/2025Zinc Oxide Expired: 1/2026An interview on 3/5/2026 at 11:40 a.m. with Staff S, Registered Nurse (RN) was conducted. Staff S, RN said the expired medications should not be in the cart.An interview on 3/5/2026 at 3:04 P.M. with the DON was conducted. The DON said the expired medications should not have been in the cart. The DON said all nurses are responsible for removing expired medications from the medication carts and refrigerators.A review of an undated policy titled, Labeling & Storage had the following steps: 4). Labels for individual drug containers must include h. the expiration date. 6). Labels for over-the-counter medications must include c: The expiration date. 9) Expired medications will be discarded.