STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105744	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Oaks Health Center	2770 Regency Oaks Blvd Clearwater, FL 33759

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20536 Based on record review and interview, the facility failed to ensure the Preadmission Screening and Resident Review (PASRR) was completed accurately, and updated to reflect new Mental Illness (MI), or Suspected Mental Illness (SMI) diagnoses for five (#8 , #18, #4, #19, and #36) of thirty-two sampled residents. Findings included: 1. On [DATE] at 10:03 a.m., Resident #8 was observed in her room and seated upright in bed and was going though some personal belongings. She had the television on and had the call light placed within her reach. Resident #8 was found able to answer most questions related to her medical care and services. Review of Resident #8's medical record showed she was admitted to the facility on [DATE] and readmitted on [DATE]. Review of the diagnosis sheet revealed diagnoses to include but not limited to; Anxiety (onset [DATE]), and Major Depression (onset [DATE]). Review of the annual Minimum Data Set (MDS) assessment, dated [DATE], showed a Brief Interview for Mental Status (BIMS) score 15 of 15, which indicated intact cognition. Review of the medical record revealed a Level 1 PASRR dated [DATE], was completed by a Registered Nurse from a Hospital. Section 1 (MI/SMI) did not have any MI/SMI diagnoses checked. There was a second Level 1 PASRR dated [DATE], completed by a Registered Nurse from a Hospital. Section 1 (MI/SMI) did not have any MI/SMI diagnosis checked. A third Level 1 PASRR screen was completed by a Registered Nurse on [DATE] from the Hospital. Section 1 (MI/SMI) did not have any MI/SMI diagnosis checked. Resident #8 had a MI/SMI diagnosis of Anxiety on [DATE] and Major Depression on [DATE] that were not reflected on any of the Level 1 PASRR screens. (continued on next page)

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

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 9:30 a.m., an interview with the Social Service Director revealed as part of process, it was either the Social Service Department or Admissions Department's responsibility to obtain a fully accurate and timely Level 1 PASRR screen prior to the resident's admission. She revealed if she or Admissions noticed missing MI/SMI diagnoses, she would notify either the Director of Nursing or the Nursing Home Administrator of the incomplete assessment, and then another one would be completed to reflect missing MI/SMI diagnoses. She revealed often times the Level 1 that was completed at the Hospital, were not correct and the facility would have to complete an accurate one, after the resident had been admitted to the facility. The Social Service Director confirmed the admission Level 1 PASRR screen for Resident #8 was not reflective of MI/SMI diagnoses to include Anxiety and Major Depression. The Social Service Director confirmed Resident #8 developed these diagnoses after her admission, but there should have been new Level 1 PASRR screens completed to reflect Anxiety and Major Depression. 2. On [DATE] at 10:00 a.m., Resident #18 was observed in her room, lying flat in bed, and under the covers with her legs out from the sheets. Resident #18 appeared not responsive to an interview, and was observed with cognitive deficits Review of Resident #18's medical record revealed she was admitted to the facility on [DATE] and readmitted on [DATE]. Review of the diagnosis sheet revealed the following but not limited to diagnoses; Major Depression (onset [DATE]), and Anxiety (onset [DATE]). Review of the quarterly MDS assessment dated [DATE], showed a BIMS score 3 of 15, which indicated severe cognition impairment. Review of the medical record revealed a Level 1 PASRR screen completed on [DATE] by a Medical Social Worker from a Hospital. Further review of the screen under section 1 (MI/SMI) did not have diagnoses of Major Depression and Anxiety checked. On [DATE] at 9:30 a.m., an interview with the Social Service Director revealed as part of process, it was either the Social Service Department or Admissions Department's responsibility to obtain a fully accurate and timely Level 1 PASRR prior to the resident's admission. She revealed if she or Admissions noticed missing MI/SMI diagnoses, she would notify either the Director of Nursing or the Nursing Home Administrator of the incomplete assessment, and then another one would be completed to reflect the missing MI/SMI diagnoses. The Social Service Director revealed the admission Level 1 PASRR screen completed on [DATE] for Resident #18 did not have diagnosis of Anxiety at the time of admission. She did confirm Resident #18 did develop a diagnosis of Anxiety after her admission and there should have been an updated Level 1 PASRR screen to reflect that diagnosis. 50732 (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On [DATE] at 9:59 a.m., an observation and interview was conducted of Resident #36 in his room. The resident resided in a private room which was clean and organized. Resident #36's room was decorated with many family pictures and lifetime mementos. The resident was dressed, groomed and sitting in his wheelchair. Resident #36 was pleasant and talkative. The resident said his wife died a few years ago and he was ready to die. He said he did not understand why he was still alive. The resident said his children lived nearby and visited him often. He said his wife resided with him in the facility until she died , and they used to go to activities together. However, he said he did not have much interest in the facility offered activities any longer, preferring to spend time with his family or watch television in his room. Review of the Admission Record showed Resident #36 was admitted to the facility on [DATE] with admitting diagnoses that included Alzheimer's Disease and major depressive disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE], Section C-Cognitive Patterns, revealed Resident #36 had a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. Review of Resident #36's Care Plan dated [DATE] showed: -Resident #36 was at risk for communication problems related to Alzheimer's Disease. The resident will be able to make basic needs known on a daily basis through the review date. Anticipate and meet needs. Discuss with resident/family concerns or feelings regarding communication difficulty. Monitor/document for physical/ nonverbal indicators of discomfort or distress, and follow-up as needed. Monitor/document/report to physician changes in: ability to communicate, potential contributing factors for communication problems, potential for improvement. Provide a safe environment: call light in reach, adequate low glare light, bed in lowest position and wheels locked, avoid isolation. Validate resident's message by repeating aloud. -Resident #36 used antidepressant medication related to depression. The resident will be free from discomfort or adverse reactions related to antidepressant therapy through the review date. Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of (Specify: anti-depressant drugs being given). Give antidepressant medications ordered by the physician. Monitor/document side effects and effectiveness. -Resident #36 was at risk for depression, at risk for sadness, behavior and mood changes. He misses his wife, expresses desire to die so he can be with her. The resident will remain free of signs and symptoms of distress, symptoms of depression, anxiety or sad mood by/through review date. Administer medications as ordered. Monitor/document for side effects and effectiveness. Behavioral Health Services Consult as needed. Monitor/document/report to physician and/or nurse as needed. Resident #36 was at risk for harm to self: suicidal plan, risky actions, (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. Monitor/document/report to physician and/or nurse signs and symptoms of depression, including: hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing negative statements, repetitive anxious or health related complains, tearfulness. Pharmacy review of medications monthly. The resident needs adequate rest periods. The resident needs time to talk(reminisce). Encourage the resident to express his feelings. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #36's PASRR dated [DATE] showed the following: -Section I: PASRR Screen Decision-Making: Section A. MI or suspected MI no qualifying diagnoses were checked. -Finding is based on: Documented History was checked. -Section II: Other Indications for PASRR Screen Decision-Making Question #5: Does the individual have a primary diagnosis of dementia? The answer checked was No. Related Neurocognitive Disorder (including Alzheimer's Disease)? The answer checked was No. Question #6: Does the individual have a secondary diagnosis of dementia, related neurocognitive disorder (including Alzheimer's Disease) and the primary diagnosis is a Serious Mental Illness or Intellectual Disability? The answer checked was No. Question #7: Does the individual have validating documentation to support the dementia or related neurocognitive disorder (including Alzheimer's Disease)? The answer checked was No. -Section III: PASRR Screen Provisional Admission or Hospital Discharge Exemption: Not a Provisional Admission was checked. -Section IV: PASRR Screen Completion Individual may be admitted to a Nursing Facility: No diagnosis or suspicion of Serious Mental Illness or intellectual Disability indicated, Level II PASRR evaluation not required was checked. Review of Psychiatric Follow-Up Note dated [DATE] showed Resident #36 was diagnosed with major depressive disorder and other mixed anxiety disorders. Review of physician orders for Resident #36 showed the resident was prescribed Sertraline HCl to be given daily for major depressive disorder. 46498 4. On [DATE] at 10:00 a.m., Resident #4 was sitting up in her wheelchair, dressed well-groomed with no signs of distress. She stated that she had no concerns with staff and that she loved the food at the facility. Review of an Admission Record dated [DATE] showed Resident #4 was admitted to the facility on [DATE] with diagnoses to include but not limited to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, Alzheimer's Disease, unspecified, mood disorder due to known physiological condition with depressive features. Review of the quarterly Minimum Data Set (MDS) dated [DATE] showed Section C- Cognitive Patterns- Brief Interview for Mental Status, BIMS score of 03 which indicated severe cognitive impairment Review of the Medical Record showed an Incomplete PASRR Level 1 dated [DATE] and [DATE]. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 2:00 p.m., an interview was conducted with the Nursing Home Administrator, Director of Nurses, and the Social Services Director. The Social Services Director stated that prior to admission the PASRR was reviewed by admissions, unless a resident came from home. She stated she reviewed the PASRR for accuracy, if she identified something wrong, she would refer the PASRR back to Admissions or to the Director of Nurses. The Social Service Director stated she referred Resident #4's level I PASRR to admissions because the resident was admitted under the 30-day hospital discharge exemption, and she felt that the resident needed a level II PASRR. The Director of Nurses stated that she did not review Resident #4's PASRR because it was not brought to her attention. 49227 4. Review of the admission record revealed Resident #19's admitted was [DATE] with diagnoses to include alcohol dependence, major depressive disorder, anxiety disorder, schizoaffective disorder. During a review of Resident #19's medical records a Level II PASRR could not be located. During an interview on [DATE] at 11:53 a.m., with the Social Services Director (SSD), the Nursing Home Administrator (NHA) and the Director of Nursing (DON), the DON said a Level II PASRR was not completed for Resident #19. Review of the facility's policy titled, Admission Criteria, revised ,d+[DATE] revealed policy statement: our facility admits only residents whose medical and nursing care needs can be met. Policy interpretation include 1b admit residents who can be cared for adequately by the facility; 9) all new admissions and readmissions are screened for mental disorders (MD) intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre Admission Screening and Resident Review (PASARR). 9a) the facility conducts a level 1 PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for an MD, ID, or RD. 9b) If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process. 9bi) The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID or RD. 9bii) The social worker is responsible for making referrals to the appropriate state-designated authority. 9c) Upon completion of the Level II evaluation, the state PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, whether placement in the facility is appropriate. 9d) The state PASARR representative provided a copy of the report to the facility. 9e) The interdisciplinary team determines whether the facility is capable of meeting the needs and services of the potential residents that are outlined in the evaluation. 9f) Once a decision is made, the state PASARR representative, the potential resident and his or her representative are notified.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 49227 Based on observation, interview, and record review, the facility failed to provide restorative services to maintain or improve functional abilities, when formalized physical and occupational therapy were discontinued for one (#19) of one sampled resident. Findings Included: During an interview and observation on 12/9/24 at 9:18 a.m., Resident #19 said she was frustrated because her therapy was stopped due to insurance, she was notified by the facility and filed an appeal immediately because she was not receiving therapy. Also an emergency appeal had been submitted and she should receive feedback today, 12/9/24. Review of the admission record showed Resident #19's admitted was 9/29/24 with diagnoses to include but not limited to polyneuropathy, congestive heart failure, rheumatoid arthritis, muscle weakness, and abnormalities of gait and mobility. Review of Resident #19's order summary report showed on 9/30/24 an Occupational therapy (OT) clarification order: OT five times weekly for sixty days for self-care training, therapeutic exercises, therapeutic activity, neuro reeducation, groups and discharge planning. Physical Therapy (PT) clarification order: PT to treat five times per week for eight weeks, which may include therapy exercises, therapy activities, neuro reeducation, gait training, wheelchair management. Review of Resident #19's care plan focus showed, [Resident #19] has actual functional abilities decline related to unsteady gait, neuropathy and COPD. The goal is [Resident #19] will return to desired/usual level of function; date initiated 9/29/24. Care plan focus, [Resident #19] has an activity of daily living (ADL) self-care performance deficit related to disease process, initiated 9/29/24. The goal was [Resident #19] will improve current level of function in bed mobility, transfers, eating, dressing, toilet use and personal hygiene. Review of Resident #19's Minimum Data Set, admitted d 10/6/24, Section C, Cognitive Patterns Brief Interview For Mental Status (BIMS) revealed a score of 15, which indicated intact cognition. Section O, Special Treatments, Procedures and Programs showed PT and OT five days per week starting on 9/30/24. Review of Resident #19's care plan progress dated 10/24/24 showed, [Resident #19] is working with PT, OT her progress fluctuates, she is able to get in/out of bed with stand by assist . transfers for wheelchair to chair with standby assist .contact guard assist with ambulating up to 50 feet. Review of Resident #19's progress notes revealed on 10/25/24, the Social Services Director notified the resident and a family member that a Notice of Medicare Non-Coverage (NOMNC) was received and services would end on 10/27/24. During an interview on 12/10/ 24 at 11:35 a.m., the Director of Therapy (DOT) was unable to provide documentation that Resident #19 was referred for restorative services between 10/27/24 and 12/9/24. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/10/24 at 12:08 p.m., the Director of Nursing (DON) said Resident #19 had never received restorative services. Review of a facility policy, titled Restorative Nursing Services, revised 7/2017 revealed the following: Policy Statement: Residents will receive restorative nursing care as needed to help promote optimal safety and independence. The policy interpretation and implementation include: 1) restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services (e.g., physical, occupational, or speech therapies). 2) residents may be started on a restorative nursing program upon admission and during the course of their stay. 3) Restorative goals objectives are individualized, and resident centered and are outlined in the resident's plan of care. 4) the resident or representative will be included in determining goals and plan of care. 5) Restorative goals may include but are not limited to supporting and assisting the resident in a) adjusting or adapting to changing abilities b) developing, maintaining or strengthening his /her physiological and psychological resources; c) maintaining his dignity, independence and self-esteem; and d) participating in the development and implementation of his /her plan of care. Review of a facility policy, titled, Care Planning Interdisciplinary Team reveals the following: Policy Statement: The interdisciplinary team is responsible for the development of resident care plans. Policy Interpretation an Implementation: 1) resident care plans are developed according to the time frames and establish by ss 483.21. 2) Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT). 3) The IDT includes but is not limited to, 3a) the resident's attending physician, 3b) a nurse with the responsibility for the resident 3d) the resident or the resident's representative 3e) other staff as appropriate or necessary to meet the needs of the resident . Review of a facility policy, titled, Specialized Rehabilitative Services, revised 12/2009, policy statement revealed our facility will provide rehabilitative services to residents as indicated by the MSDS. Policy interpretation and implementation 1) in addition to rehabilitative nursing care, the facility provides specialized rehabilitative services by qualified professional personnel. 2) Specialized rehabilitative services include the following physical therapy; speech pathology /audiology; occupational therapy/ activity therapy. 5) Once a resident has met his /her care plan goals, a licensed professional can either discontinue treatment or initiate a maintenance program that nursing aids will implement to assure that the resident maintains his/ her functional and physical status.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20536 Based on observation, record review, and interview, the facility failed to provide an ongoing activities program of their choice for one (#18) of thirty-two sampled residents. Findings included: On 12/9/2024 at 10:00 a.m., Resident #18 was noted in her room lying in bed under the covers and resting with her eyes closed. A visitor, a Private Care Sitter, was seated in a chair next to the bedside. The Private Care Sitter said she had been hired to sit in with Resident #18 on Mondays through Fridays, and mainly during the 7:00 a.m.- 3:00 p.m. shift. She said she typically came in the facility at 10:00 a.m. and left around 3:00 p.m. or 4:00 p.m. She revealed her responsibilities included to assist Resident #18 with toileting, transferring from bed to chair, personal hygiene, showering, and eating assistance. She said, at times, she took the resident from her room to some scheduled activities. She said Resident #18 loved to have books read to her, loved listening to music, and loved participating in group music and religious activities. She revealed that Resident #18 was legally blind and needed assistance with set up with personal items, etc. The Private Care Sitter was asked if Resident #18 used audio books and she revealed she and Resident #18's family were not aware they could ask for that, and that it was a great idea because Resident #18 had been an avid reader before losing most of her eye sight. An attempt to interview Resident #18 revealed she had cognitive deficits and was not able to answer questions related to her medical care and services, and was not able to answer questions related to her choice of activities. On 12/9/2024 at 10:45 a.m., 11:30 a.m. 12:45 p.m., 1:00 p.m., 2:00 p.m. and 3:00 p.m., Resident #18 was observed in her room and still lying flat in bed, under the covers, with the private care sitter seated at her side. The private care sitter said the resident had been in bed all day and she had not been up and out of her room. Review of the posted current month (December 2024) activities calendar revealed scheduled activities to include but not limited to: Daily Chronicle group at 9:00 a.m., Hot Chocolate Chat group at 10:00 a.m., Instrumix Class group at 10:00 a.m., and Trivia time group at 3:00 p.m. Resident #18 was not offered or assisted to any of these activities. On 12/10/2024 at 11:15 a.m., the large activity/lounge (Day Room), which was located near the unit station, was observed with approximately ten residents seated in wheelchairs and participating in a religious music activity. An outside activity service was singing and playing musical instruments, as well as religious studies. Resident #18 was not offered and or assisted to this group activity. Review of the posted current month (December 2024) activities calendar revealed scheduled activities to include but not limited to: Daily Chronicle group at 9:00 a.m., Hot Chocolate & Chat group at 10:00 a.m., Church Services and music group at 11:00 a.m. Resident #18 was not offered and/or assisted to any of these scheduled activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Review of Resident #18's medical record revealed she was admitted to the facility on [DATE] and readmitted on [DATE]. Review of the diagnosis sheet revealed diagnoses to include but not limited to Dementia, Cognitive communication deficit, Legal Blindness, Macular degeneration, Major Depression,and Anxiety. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed; Cognition/Brief Interview for Mental Status or BIMS score of 3 which indicated severe cognitive impairment; Vision - Moderately Impaired, no corrective lenses; Activities - this section was not completed. Review of the Data Collection Admission assessment dated [DATE] revealed; (Ability to see in adequate light - Adequate; Corrective lenses - None). Review of the PEAK Activity Interview for daily Activities dated 12/16/2022 revealed; (How important is it to you to have books, newspapers, and magazines to read = VERY IMPORTANT; How important is it to you to listen to music = VERY IMPORTANT; How important is it to you to be around animals = VERY IMPORTANT; How important is it to you to keep up with the news = VERY IMPORTANT; How important is it to do thing with groups of people = VERY IMPORTANT; How important is it for you to go outside for fresh air = VERY IMPORTANT; How important is it for you to participate in religious services or practices = VERY IMPORTANT). Review of the Life Enrichment Quarterly Data Collection dated 3/1/2024 revealed; [Resident #18] had likes to include: Family/Friends visits, Men's groups, Happy Hour, Social events, Table games, bingo, likes puzzles, Resident program chat, Religious services, Nature appreciation, Movies, Music, Pet therapy, Social visits and listens to movies, small groups. Review of the Live Enrichment Quarterly Data Collection dated 5/28/24 revealed; [Resident #18] had likes to include: Family/Friends visits, Men's groups, Happy Hour, Social events, Table games, bingo, likes puzzles, Resident program chat, Religious services, Nature appreciation, Movies, Music, Pet therapy, Social visits and listens to movies, small groups. Review of the Life Enrichment Quarterly Data Collection dated 8/21/2024 revealed; [Resident #18] had likes to include: Family/Friends visits, Men's groups, Happy Hour, Social events, Table games, bingo, likes puzzles, Resident program chat, Religious services, Nature appreciation, Movies, Music, Pet therapy, Social visits and listens to movies, small groups). A review of the medical record to include daily nurse progress notes for all departments and dated from 6/1/2024 thought to 12/11/2024 did not reveal any documented evidence of Resident #18 having behaviors of refusing daily scheduled group or daily 1:1 room visit activities. Review of the current care plans with a next review date 3/20/2025 revealed the following areas: a. Risk for falls due to decreased standing balance and tolerance, decreased mobility due to weakness of extremities, she has impaired vision has decreased awareness of physical limitations due to cog. Loss and is receiving psychotropic medications, with interventions in place, to include educate private aide to watch resident at all times, resident is blind, Encourage resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Displays restlessness, anxiousness, paranoia, refusal of care with interventions to include but not limited to: Encourage to attend group activities to divert behavior. c. Resident would benefit from associate support for resident programs with interventions to include: Assure that the activities the resident is attending are: compatible with physical and mental capabilities, Compatible with known interests and preferences; Adapt as needed, Compatible with individual needs and abilities, and age appropriate; POA send resident interactive cat to keep her company and provide positive interaction through the day; Encourage ongoing family involvement. Invite the resident's family to attend special events, activities, meals; Establish and record the resident's prior level of activity involvement and interests by talking with the resident, caregivers, and family on admission and as necessary; Invite resident to scheduled programs; Modify the resident's daily schedule, treatment plan PRN to accommodate activity participation; Provide a program of activities that is of interest and empowers the resident by encouraging/allowing choice, self expression and responsibility; Provide resident with activities calendar; Review the resident's activity needs with the family/representative. On 12/10/2024 at 8:10 a.m., an interview with Staff A,Certified Nursing Assistant (CNA) who was assigned to Resident #18 revealed he had Resident #18 on his assignment at times and knew that she was legally blind. He revealed she required moderate to full staff assistance with most of her Activities of Daily Living (ADLs) to include: Eating, Personal Hygiene, Transferring, Dressing, Showering, Toileting. Staff A confirmed Resident #18 stayed in her room and in bed most of the days, or at least the days he worked with her, and as far as he knew, it was by her choice. Staff A revealed he did not know what types of activities the resident enjoyed, and therefore had not seen or assisted her to activities. He revealed the activities staff were usually the staff that would offer and assist her with activities and was unaware if Resident #18 enjoyed group activities, music activities, religious activities and arts and crafts activities. On 12/11/2024 at 9:00 a.m., the facility's Activities Director was interviewed. She revealed she had been the Activities Director for about two and a half years and that she had one other assistant to help her with departmental activities. The Activities Director revealed she conducted admission activities assessments on all admitted residents approximately twenty four to forty eight hours upon their admission. She revealed he activities assessments go over things like the resident's prior occupation, religion, and what they were during before Long Term Care. She reviewed hobbies, what music they liked, and what they would like to do when they were at the facility. She would provide an electronic I Pad device for those who wished to go on the internet. The Activities Director also revealed she completed Activities Assessments at least once a quarter as well. She also revealed she would do 1:1 room visits, do daily chronicles, tell them about daily calendar, and would have a chat with him or her. She revealed Resident #18 was legally blind and needed assistance to and from scheduled group activities and that her private duty sitter was the person who usually took her out of the room and to activities. The Activities Director further revealed Resident #18 liked live music, live religious activities, and other group activities, and did not know why she was not in attendance in any of the group activities on 12/9/24 and 12/10/2024. She confirmed she did not follow up with the resident or the private duty sitter with relation to the scheduled activities for both days. The Activities Director also revealed Resident #18 was in most to all the scheduled group activities and did not realize she was not in attendance. On 12/11/2024 the Nursing Home Administrator provided the Activity Program policy and procedure with a last revision date of 6/2028 for review. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105744	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Oaks Health Center	2770 Regency Oaks Blvd Clearwater, FL 33759

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Policy stated; Activity programs are designed to meet the interests of and support the physical, mental and psychosocial well-being of each resident. The Policy interpretation and implementation section of the policy revealed the following but not limited areas; 1. The activities program is provided to support the well being of residents and to encourage both independence and community interaction. 2. Activities offered are based on the comprehensive resident-centered assessment and the preference of each resident. 3. The activities program is ongoing and includes facility-organized group activities, independent individual activities and assisted individual activities. 4. Activities are considered any endeavor, other than routine ADLs, in which the resident participates, that is intended to enhance his or her sense of well being and to promote or enhance physical, cognitive or emotional health. 5. Our activities programs are designed to encourage maximum individual participation and are geared to individual resident's needs. 6. Activities are scheduled 7 (seven) days a week and residents are given an opportunity to contribute to the conducting, cleanup and critique of the programs. 7. Our activity programs consist of individual, small group and large group activities that are designed to meet the needs and interests of each resident. Activity programs include activities that promote: a. Self-esteem; b. Comfort; c. Pleasure; d. Education; e. Creativity; f. Success; and g. Independence. 8. Activities are not necessarily limited to formal activities being provided only by activities staff. Other facility staff, volunteers, visitors, residents and family members may also provide the activities. 10. Individual and group activities are provided that: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Reflect the schedules, choices and rights of the residents; b. Are offered at hours convenient to the residents, holidays and weekends; c. Incorporate family, visitor and resident ideas of desired appropriate activities. 11. Residents are encouraged, but not required, to participate in scheduled activities.