STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105749	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbey Rehabilitation and Nursing Center	7101 Dr Martin Luther King Jr St N Saint Petersburg, FL 33702

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to implement care plan interventions related to 1. Positioning of adaptive eating equipment and 2.Ensuring call light bell/cords are within reach for two residents (#87 and #114) of sixty-one sampled residents, during four days (3/30/2026, 3/31/2026, 4/1/2026, and 4/2/2026) of four days observed. Findings included: 1. On 3/30/2026 at 12:29 p.m. the main dining room was observed for the lunch meal service. There were nine residents including Resident #114 seated at various tables and being served and assisted by staff with their meals. Resident #114 had already received his plate of food, observed with adaptive eating assistive equipment including a high scoop plate. Resident #114 was noted with his left hand and arm positioned on his lap while he used his right hand to grip the eating utensil. Resident #114 used the eating utensil and began to scoop food inward towards him as the high side of the scoop plate was positioned outwards and away from him. Due to the improper positioning of the scoop plate, Resident #114 at times was scraping some food items off the plate, to the table and some to his lap. The staff observed in the room did not adjust the plate to accommodate his scooping need. Review of the meal ticket placed on the table read; use of scoop plate. It did not mention how the scoop plate needed to be positioned. Resident #114 was not able to answer questions related to his medical care and services. On 3/31/2026 at 12:20 p.m. Resident #114 was observed seated in the main dining room at a table by himself. He was served his lunch meal and set up done by staff. Resident #114 received a scoop plate, adaptive eating equipment with the high side of the scoop plate facing away from him. Resident #114 continued to use his eating utensil and was scooping food inwards on the short side of the plate. He was found to scrape food items onto the table from not having the high side of the scoop plate nearest to him. Staff in the room did not readjust the plate as he was scooping some food items on the table. On 4/2/2026 at 12:23 p.m. an interview was conducted with with Staff T, Registered Nurse (RN)supervisor, who was in the main dining room and supervising the lunch meal service. She stated she and the staff in the dining room are to review the meal tickets for diet orders, diet consistency, food allergies, likes and dislikes, and use of adaptive eating equipment. She confirmed Resident #114 had the use of adaptive eating equipment to include a scoop plate. She reviewed the meal ticket, and it did not indicate how the scoop plate needed to be positioned. Staff T confirmed the scoop plate has a high side and a low side, and the high side should be positioned in a manner where the resident can scoop the food comfortably and properly. Staff T stated that based on how the resident uses and scoops his eating utensil, staff should place the high side towards him. She stated she was not aware the scoop plate was in the wrong position during the lunch meal of 3/30/2026 and 3/31/2026. Review of Resident #114's medical record revealed he was admitted on [DATE] with diagnoses to include but not limited to cerebral infarction, seizures, dementia, dysphagia, anxiety, mood, lack of coordination, muscle wasting and atrophy, cognitive communication deficit, and stiffness of joint. Review of the current quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed - Cognition/Brief Interview Mental Status (BIMS) score - not scored but revealed Short Term/Long Term memory problem and with severely impaired decision-making skills.). Under (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: 105749	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026
NAME OF PROVIDER OR SUPPLIER Abbey Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7101 Dr Martin Luther King Jr St N Saint Petersburg, FL 33702	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ADL (activities of daily living) Resident #114 was impaired on one side, upper extremity, and impaired one side, lower extremity. For eating the resident requires set up and clean up assistance. Review of the current care plans with a next review date 5/17/2026 revealed a focus- CVA stroke with L (left) side neglect hemiparesis, with interventions in place to include but not limited to: use of adaptive equipment. Focus - Nutrition has a potential nutritional problem r/t (related to) cerebral infarct, dementia, HTN (hypertension), dysphagia, dx. (diagnosis), BMI (Body Mass Index) low, hx. (history) sig (significant) wt. (weight) changes, need for mech. (mechanical) altered diet, with interventions to include: Diet as ordered, Adaptive device: Scoop plate.On 4/1/2026 at 10:20 a.m. an interview with the Director of Rehabilitation (DOR) confirmed Resident #114 had been screened and provided with care and services from Speech Therapy. The DOR confirmed Resident #114 utilizes a scoop plate when eating meals and the scoop plate should always be positioned in a manner where the resident can easily scoop food items with an eating utensil. She confirmed it would not be beneficial for the scoop plate high side to be away from the resident when he scoops inward. She stated that the high side should be close and towards the resident when scooping inward. 2. On 3/30/2026 at 10:39 a.m. Resident #87 was observed lying in bed with the call light cord/button was on the floor, out from her reach. Resident was noted with what appeared to be a dark color saliva from her mouth. Resident #87 was attempted interview, but she did not want to answer. The resident was lying on brown colored saliva with brown matter all over her upper buttock area, the surface of the mattress, the side of the mattress, the bed frame, and trash can on the side of the bed. Resident could not reach her call light.On 3/31/2026 at 9:40 a.m. Resident #87 was observed in bed. Her call light button/cord was clipped on the rear right side of the pillow. Her head was positioned on the very low side of the pillow, and she would not have been able to reach it. An interview was obtained with Resident #87 who confirmed she would not be able to reach the call light cord as staff routinely clip it to the top of her pillow. She stated, This happens all the time.On 4/1/2026 at 10:30 a.m. Resident #87 the resident was observed in her room with her call light attached to the back end of the right side of the pillow, out from her reach. Resident #87 stated she needed to speak to a nurse during the time of the visit but was not able to call due to her call light cord being out of reach. On 4/2/2026 at 9:41 a.m. Resident #87 was observed in her room and lying flat in bed and her call light cord on the floor behind her head of bed. The resident confirmed she would not be able to reach the cord if she needed to get help from staff. On 4/2/2026 at 9:43 a.m. the Assistant Director of Nursing (ADON) went into the Resident #87's room and confirmed the call light cord was on the floor. The ADON was observed to talk with the resident as she picked up the call light cord and clipped it to the right side of the bed linen, near the resident's hand. The resident reacted well to the ADON placing the call light within her reach and thanked her. The ADON confirmed the call light should be placed within Resident #87's reach while in bed and it did not matter if they could use it or not. The ADON confirmed the resident utilizes the call light but did not know if she had any behaviors of dropping it on the floor. She was not sure why staff would clip it to the back of the pillow. Review of Resident #87's medical record revealed she was admitted to the facility on [DATE] with diagnoses to include encephalopathy, dysphagia, dementia, lack of coordination, depression, schizoaffective disorder, mood, and anxiety. Review of Resident #87's most current quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed under cognition, the resident had a Brief Interview for Mental Status BIMS) score of 15 out of 15, which meant the resident was cognitively intact. The assessment revealed the resident had no behaviors and required set up/clean up assistance for personal hygiene, toileting and toilet transfer. Review of the current care plans with a next review date 5/4/2026 revealed Resident #87 has an ADL self-care performance deficit as evidenced by: Cannot complete ADL tasks independently and requires individualized interventions to maintain hygiene, with interventions in place to include: Call Bell within reach while in room/bathroom, shower room and remind to use. A second focus revealed Resident #87 is at risk for falls or fall related injuries with interventions in place to include, provide environment adaptations: Call light within reach. On 4/2/2026 at 4:00 p.m. an interview was conducted with the (continued on next page)

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	105749	A. Building B. Wing	04/02/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Home Administrator (NHA) and Director of Nursing (DON). They both confirmed all residents whether they can use the call lights or not are to have the call light cord placed within their reach while in bed or while in the shower room/bathroom. The DON confirmed the call light cord is to be securely placed in an area that is beneficial for the resident to use. A review of the facility's policy Care Plan - Interdisciplinary Plan of Care from Interim to Meeting, effective February 2024, revealed the following, The facility shall support that each resident must receive, and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The facility shall assess and address care issues that are relevant to individual residents, to include, but may not be limited to, monitoring resident condition, and responding with appropriate interventions.