STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105749	A. Building B. Wing	06/25/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to report an elopement (an unauthorized exit from a secure unit) in accordance with State law through established procedures for one resident (#1) out of three residents sampled.Findings Included:During a phone interview on 06/25/2026 at 11:43 a.m., the Resident Representative (RR) for Resident #1 stated, I received a call from the facility letting me know [Resident #1] had escaped from the secure unit. I spoke to the police who told me they found Resident #1 quite a ways away from the facility. The facility told me he left during a fire drill. [Resident #1] was placed at the facility on the secure unit because of the history of exit seeking and attempting to leave from another facility.Review of Resident #1's admission record revealed Resident #1 was admitted to the facility on [DATE] and discharged from the facility on 01/21/2026. Resident #1 was admitted to the facility with diagnoses to include; lack of coordination, unspecified dementia, unspecified severity, with agitation, unspecified mood [affective] disorder, muscle wasting and atrophy, not elsewhere classified, multiple sites, other specified disorders of muscle.Review of Resident #1's admission Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 01, indicating severe cognitive impairment.Review of Resident #1's nurse progress note for 01/14/2026 at 17:45 revealed, Narrative: Resident observed leaving the facility for a walk at approximately 3:51 p.m. Resident #1 returned to the facility. Upon return, Resident #1 remained at baseline. Vital signs obtained and within normal limits. A Skin assessment/pain was completed. No signs or symptoms of injury. Skin intact. Gait steady and unchanged from baseline. Resident #1 denies pain, dizziness, shortness of breath, or discomfort. Resident #1 returned safely to room/unit and resting comfortably on 1:1. Safety measures in place. There are no signs of distress.Review of the facility's reportable adverse and grievance log revealed no entries for elopement for the month of January 2026.During an interview on 06/25/2026 at 1:00 p.m., Staff A, Registered Nurse (RN) stated, A certified nursing assistant (CNA) came up to me and told me they were doing their rounds and the head count was off. We started searching for Resident #1 on the secure unit. I then called the code, so the rest of the facility would be aware and could start looking for Resident #1. Me calling the code alerted the Nursing Home Administrator (NHA), who called the police. I believe he was missing for 15 minutes, I'm not sure how long he had been missing. Staff A stated, the facility was doing back-to-back drills and this caused her to have to leave the unit during one of the drills. Staff A stated the police are the ones who located Resident #1 and brought him back to the facility. Staff A stated Resident #1 was able to leave the building because when the fire alarms go off it disables the locked doors. Staff A stated, I did not know this happened, until after this incident.During an interview on 06/25/2026 at 1:45 p.m., the Nursing Home Administrator (NHA) and Director of Nursing (DON) stated they report resident and family concerns about not being changed, and any allegation of abuse, misappropriation, or neglect. They stated they would report an unauthorized exit if it rises to that level, it depends on the circumstances. If the resident was unharmed and we did not deem the resident to be at risk we would not report it. They stated they were not sure if an elopement would be considered an adverse event and they would have (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to do an investigation first to determine if the elopement would be adverse or if it needed to reported. They stated, during a fire drill on January 14th, the Maintenance Director responded to the door in the second building on [local street] going off, he opened the door, looked left and right, did not see anything, turned the alarm off, and alerted the front desk, and we started doing a head count of all residents in the building. They stated after the head count they could not locate Resident #1, so the police and the family were notified. They stated the police found Resident #1 and brought him back to the facility. They stated Resident #1 left at 3:41 p.m. and was returned to the facility at 5:45 p.m. They stated they did not report it because Resident #1 was safe, and Resident #1 was able to demonstrate safety awareness with traffic and he was able to cross the road. They stated the path he took was not dangerous and he was dressed appropriately for the time of day. Review of the facility policy titled Abuse Prevention Program, dated September 2025, revealed the following:,.procedure, the facility has implemented the following processes in an effort to provide residents, visitors and staff with a safe and comfortable environment. The administrator is responsible for designating an abuse coordinator. The designated shift supervisor is identified as the responsible for immediate initiation of the reporting process. The administrator, DON, and or designated individual are responsible for the investigation and reporting of suspected, or alleged, abuse, neglect, and exploitation and misappropriation. The administrator, DON and or designated individual are also utliaetly responsible for the following: implementation, ongoing monitoring, investigation, reporting, and tracking and trending.Identification.Event reports and resident concern/grievance reports are reviewred, tracked, and trended for indicatgors suspicious for abuse, neglect, mistreatment, exploitation and or misappropriation.Reporting, the facility will identifyi person(s) responsible for the reporting and investigating, the facilty will follow federal regulations and stated specific reporting requirements. DCF will be notified promptly, the administrator of the facility and or designee will be notified immediately, an immediate report will be filed with AHCA for alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries or unknown source that is suspicious of abuse or neglect and misappropriation of resident property: not later than two hours after the allegations is made if the events that cause the allegation involve abuse or result n serious bodyily injury; or not later than 24 hours if the events that cause the allegation do not involve abuse and do not resulting in serious bodily injury.The facility reports alleged violations and substantiated incidents to the state agency and to other agencies, as required and takes necessary corrective actions depending on the results of the investigation.