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 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 observations, staff interview and record review, the facility failed to 1. Ensure planned meals were held at and below required temperatures and were ready to serve to residents for consumption during one of three meal service observations, (on 4/1/2026). It was found several of the planned cold food times were held over 41 degrees F.; 2. The facility kitchen staff failed to conduct and promote good hand hygiene practices when handling food. Findings included:1.On 4/1/2026 at 10:00 a.m. the meal menu board posted in the main 100 hallway outside the kitchen revealed the following menu food items to be served: (1. Turkey Croissant, 2. Macaroni Salad, 3. Relish Salad, Pudding, and with an alternate menu item of Beef Stew).It was determined the primary meal to be served for lunch meal service were cold items and with beef stew to be the hot item as an alternate. The menu further revealed residents could order choice items to include grilled cheese, hot turkey sandwiches, etc.On 4/1/2026 at 11:00 a.m. the kitchen was entered and met with the Dietary Manager (DM). The DM stated the food items to be served for the lunch meal were prepared and ready for service and for resident consumption. He confirmed the primary food items for lunch were to be served cold and to be below 41 degrees F. He further confirmed they did have an alternate menu item to be served as hot food, which included beef stew. The DM stated the lunch meal for the day was already pre planned as cold food.The DM stated that the kitchen was ready for food temperature test/demonstration and that he would have Staff A, [NAME] conduct the food items temperatures. Staff A stated she conducts food item temperatures prior to meal service before setting up meal trays for both the breakfast and lunch meal service. Staff A stated another cook will do the same thing for the dinner meal service. Staff A confirmed all cooks had been trained and in serviced on how and when the kitchen staff take food item temperatures. Staff A stated she takes food item temperatures with a digital thermometer and will calibrate that thermometer three times a day by using a ice and water bath until the thermometer reads 32 degrees F. Staff A and the DM both confirmed that the thermometer had been calibrated and was ready to use.Prior to taking food item temperatures Staff A revealed the following about food holding temperatures. She stated if the food item is a hot item, then the holding temperature must reach at least 135 degrees F. or higher. She stated if the food item is a cold item and to be served cold, the holding temperature of that item should be below 41 degrees F. and not below 32 degrees F.Staff A confirmed all their lunch items were to be cold food items and the temperatures should be at least below 41 degrees F. Staff A and the DM again confirmed the thermometer was calibrated correctly and that all the food items were on the tray line and ready to be served to residents at that time. At 11:05 a.m. Staff A began to provide a food item temperature demonstration for all the food items on the holding table. The following was observed; Turkey Croissant with cheese slice only reached 47.9 degrees F. The thermometer never read below this temperature. At 11:07 a.m. another temperature demonstration was conducted and the food item only reached 46.9 degrees F. Macaroni Salad reached 40 degrees F. It was found this item met temperature requirement.Sandwich mechanical soft reached 40 degrees F. It was found this item met temperature requirement. Puree consistency turkey reached 44.4 degrees F. The thermometer never read below this temperature. It was found the Croissant sandwich and the puree turkey both did not (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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(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	reach safe serving and consumption temperatures.Since two of the food items did not reach the minimum food holding requirement, the Dietary Manager stated they would go ahead and take all the food items from the service table and bring them to the walk in freezer to have chill in there a bit longer. The Dietary Manager stated the normal process for preparing and serving cold food items is; staff will prepare the food items then place them in the walk in refrigerator for about an hour prior to meal service. He confirmed this process was completed today, but it appeared some of the items did not get to below 41 degrees F. The Dietary Manager continued to state when the items are removed from the walk in refrigerator, they are placed in a container with ice, to help keep the items at the required temperature and below. The Dietary Manager further stated his staff will conduct the temperatures with a thermometer and document the temperature on the food temperature log. He reviews the logs daily to ensure his staff are in keeping with temperature requirements. The kitchen was left at 11:10 a.m. and returned to at 11:41 a.m. for another food item temperature demonstration. Both Saff A and the DM revealed they were now ready and that again, they felt all the food items were at appropriate holding temperatures and were all ready to be served for resident consumption. At 11:42 a.m. the following was observed: Turkey Croissant with cheese slice 40.6. This food item barely met requirement of below 41 degrees F. Puree consistency turkey reached 44.6 degrees F. The thermometer never read below this temperature. At this point the food temperature demonstration was ended. The Dietary Manager confirmed he and his staff did not get the puree turkey to meet food holding requirement and stated he was not going to serve the food items that were temped over 40 degrees F. He revealed he would still need to place those items in the walk in freezer for a bit longer, until meeting requirement. He confirmed the lunch meals would be served a little late due to having to place the food items.2.On 4/1/2026 at 11:00 a.m. an observation was made with Staff A, [NAME] conducting food temperature demonstration at the food holding table. Staff A had one plastic glove on her left hand and no glove on her right hand. During the entire food temperature demonstration, which lasted approximately eight minutes, Staff A was observed to touch exposed food items and the side of her chin with her right hand. After making self contact, she did not wash her hands. She did not remove the plastic glove on her left hand during any point of the demonstration. It was not observed she had washed either of her hands prior to the food temperature demonstration. The Dietary Manager and Staff A both confirmed all the meal items were prepared and ready to be served to residents for consumption.On 4/2/2026 at 10:58 a.m. the kitchen was observed and Staff C, [NAME] walked to the steam table, where all the food items were held. Staff C was not observed to wash her hands prior to the temperature demonstration. Staff C and the Dietary Manager both confirmed all the meal items were prepared and ready to be served to residents for consumption. At 11:00 a.m. Staff C was noted touching food items with her right hand while taking temperatures with the digital thermometer. She was also observed using her right hand and touching the side of her pants and then her left hand and arm. She was not observed washing her hands at any point of the demonstration, which lasted approximately nine to ten minutes. During an interview with Staff C, she did not remember she touched herself, but remembered she did touch food items with her bare hands and did not wash her hands after. On 4/2/2026 at 2:56 p.m. the Dietary Manager confirmed all his staff have been trained and in serviced on hand hygiene and should be washing hands after touching self, other food items or other areas that may be potentially contaminated. The Dietary Manager could not remember if Staff A or C were promoting good hand hygiene during observations on 4/1/2026 and 4/2/2026. He did say Staff A was wearing a glove on her left hand due to having a previous cut injury. Continued interview with the Dietary Manager revealed best practices for handwashing is anytime hands are soiled or touching of surfaces, it is expected staff wash their hands.On 4/2/2026 at 4:00 p.m. the Dietary Manager and the Nursing Home Administrator provided the Food Holding policy and procedure, with effective date June 2025 for review. The policy stated;Policy - To ensure the quality and safety of foods that are being held hot or cold. Cold foods:Use cold-holding equipment that can keep foods at 41 degrees F. or lower. Cold holding equipment includes refrigerators, freezers, and coolers. The policy (continued on next page)

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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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	also stated to utilize food temperature logs. On 4/2/2206 at 4:00 p.m. the Dietary Manager and Nursing Home Administrator provided the Hand washing and glove use policy and procedure with an effective date June 2024 for review. The policy stated;Policy - Hand washing is a vital role in infection control, reducing the surface microorganisms on our hands. Gloves are used to provide a barrier between potential microorganisms and ready-to-eat food items being prepared and/or portioned by staff. Procedure:Hands must be washed prior to beginning work, after using the restroom, after smoking, when working with different food sources, following contact with unsanitary surfaces, and before wearing gloves. 5 . Gloves should be changed frequently, single use task. 6 . Hands must be washed between changing gloves.

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to promote and maintain dignity for residents during activities, during meal services, and while in their rooms for six residents (#87, #8, #34, #101, #52, and #51) out of sixty-one sampled residents.Findings included: 1. 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. On 3/30/2026 at 12:04 p.m. just before the lunch meal service, Resident #87 was still observed in her room and lying in bed in the same position with heavy saliva coming from her mouth to a white with brown stained towel, and all over her bed. During an interview on 3/31/2026 at 2:00 p.m. Resident #87 confirmed she receives her tobacco to chew from her family who come to visit. She said she at times she spits it out and sometimes it does not get on the towel or trash can. The resident stated she had been lying on the tobacco spit from the day before. She said she wanted to get staff to come in and clean it up, but her call light was out from her reach. 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. On 4/2/2026 at 4:00 p.m. an interview with the Director of Nursing (DON) revealed she was aware of Resident #87 and knew she at times has chewing tobacco in her room and that family continually bring it in. She confirmed the resident was care planned for this behavior and if staff find her using it, they are to take it away and store it for her, so she can use during smoking times in the smoking patio. The DON acknowledged being aware Resident #87 has saliva coming from her mouth after chewing tobacco and said they give her a clean towel daily to catch it. The DON reviewed the photographic evidence from 3/30/2026 where the saliva was all over the resident's bed and surrounding surfaces. She confirmed staff should have cleaned that up and said Resident #87 should not be lying in that for long periods of time. (Photographic Evidence Obtained). 2. During an observation on 03/30/2026 at 10:13 a.m., Resident #8 was observed standing in the hallway of the secured unit. Resident #8 was heard speaking in another language to several other residents and staff. Staff J, Licensed Practical Nurse (LPN) repeatedly redirected the resident from speaking a language of their choice. Staff J stated to Resident #8, Speak English Resident #8, speak English. Review of Resident #8's quarterly MDS dated [DATE] revealed in section C- cognitive Patterns, the resident had a BIMS score of 02 out of 15 meaning severe cognitive impairment. (continued on next page)

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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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During an observation on 03/30/2026 at 11:43 a.m., Resident #34 was observed standing in between dining tables and chairs in the dining room. Staff J, LPN, was observed briefly tapping Resident #34 on the buttocks while standing beside him. Staff J was not immediately available for an interview. Review of Resident #34's entry MDS dated [DATE] revealed in section C- cognitive patterns, a BIMS score of 02 out of 15 showing severe cognitive impairment. 4. During an observation on 03/30/2026 at 11:43 a.m., Resident #101 was observed seated alone in a chair in the dining room, she was positioned away from other residents near a sink. There was no table in front of Resident #101. Resident #101 remained waiting for her meal while other residents in the dining room were served and assisted with their meals. Resident #101 was the last resident to be served and assisted. During an observation on 04/01/2026 at 12:15 p.m., lunch trays were observed being delivered to the secured unit (300 unit). The residents were observed being served and assisted with their meals. Resident #101 was observed in her room in bed during this time period. Resident #101 was assisted out of bed for lunch at 12:45 p.m., after the other residents had been served and consumed their meals. During an observation on 04/02/2026 at 11:34 a.m., Resident #101 was observed sitting at a table in the dining room. Staff Q, Certified Nursing Assistant, CNA, told Resident #101 she could not sit at that table and was assisted to the back of the dining room to a chair without a table. At 12:00 p.m., after the residents in the dining room were served their meals, Resident #101 was assisted with her meal. Staff Q, CNA was observed sitting in front of Resident #101, with a Styrofoam container on her lap containing Resident #101's lunch. Review of Resident #101's entry MDS dated [DATE] revealed in section C - cognitive Patterns a BIMS score of 02 out of 15 meaning severe cognitive impairment. 5. During an observation on 04/01/2026 at 12:15 p.m., Staff Z, CNA was observed standing next to Resident #52 assisting him with his meal.During an observation on 04/02/2026 at 11:53 a.m. Staff Q, CNA was observed standing next to Resident #52 while assisting him with his meal. 6. During an observation on 04/02/2026 at 11:51 a.m., Staff V, CNA was overheard talking to Staff Q, saying, Resident #51 is a feeder, you have to help him eat. Review of Resident #51's quarterly MDS dated [DATE] revealed in section C - cognitive patterns, a BIMS score of 00 out of 15 meaning severe cognitive impairment. During an interview on 03/30/2026 at 3:01 p.m., Staff R, CNA, stated residents who need assistance with meals have to wait until last, because there are only two aides and a nurse on the floor to assist with feeding the residents. During an interview on 04/02/2026 at 12:15 p.m., Staff Q, CNA stated dignity is making sure residents are dressed appropriately and are clean. Staff Q said they assisted residents with their meals if they need the help. Staff Q said, We should sit down next to the residents when assisting them with their meal. (continued on next page)

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/02/2026 at 12:32 p.m., Staff V, CNA stated dignity was making sure residents are kept clean and assisting them with their meals. She stated they also make sure the curtain stays closed when providing them with care. During an interview on 04/02/2026 at 4:30 p.m., the Nursing Home Administrator (NHA) stated dignity should always be held. The NHA said, staff should be knocking on doors, covering residents and announcing themselves. The NHA said the residents should be addressed by their preferred names. Review of the facility policy titled Resident Rights, dated August 2025, revealed under Policy - The facility strives to ensure that each resident has a dignified existence, self-determination, and communication with, and access to, persons and services inside and outside the facility. The facility will protect and promote the rights of each resident the facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility and exercising his or her rights and to be supported by the facility and the exercise of his or her rights.

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	105749	A. Building B. Wing	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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations interviews and review of the facility policy, the facility failed to provide a homelike environment in15 resident rooms (#1 through #15) out of 15 rooms located on the secured unit (300 Hall).Findings Included: During multiple facility tours of the secured unit (300 Hall) conducted from 03/30/3026 through 04/02/2026, observations revealed a plain halls layout with minimal decor, and no personal touches or affects throughout the physical environment. The resident rooms were observed to be bare with no personal effects and the overall atmosphere lacking warmth, comfort and familiar features. The Common areas appeared sparce, with little decoration and non-inviting seating which failed to promote a comfortable living environment for the residents. Attempts to interview the residents of the secured unit were unsuccessful due to noted severe cognitive impairments.During an interview on 03/31/2026 at 11:50 a.m., a family representative stated, This place could use some personal touches. It is not very home like.During an interview on 04/01/2026 at 4:45 p.m., the Nursing Home Administrator (NHA) confirmed the secured unit could use some more items to make it feel more homelike. The NHA said the walls were bare.During an interview on 04/01/2026 at 4:51 p.m., the Director of Nursing (DON) stated they were working on getting things to add to the unit for the residents that are more interactive and things the residents cannot remove from the walls. The DON said, But, we have to wait for them to approve it in the budget.Review of the facility policy titled, Physical Environment, with an effective date of August 2024, revealed a policy: A safe, clean, comfortable, and home life environment is provided for each resident, allowing the use of personal belongings to the greatest extent possible. Sufficient space and equipment and dining, health services, recreation, in program areas are provided to enable staff to provide residents with needed services.(Photographic Evidence Obtained)

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interview the facility failed to ensure adequate staffing related to 1.) administering medications within their scheduled time frames or two residents (#100 and #94) out of two residents reviewed; 2.) answering call lights in a timely manner as reported by all residents in the Resident council meeting.Findings included: 1. On 3/30/2026 at 9:26 a.m., an interview was conducted with Resident #100 in his room. The resident stated over the weekend the nursing staff were low. The resident stated normally there are three nurses each with a cart on his hallway (100) but stated yesterday there were two nurses on the evening shift. The resident stated yesterday, the nurse [Staff Y] was running around and trying his best during his medication administration but the resident was not sure if he got his mediation on time. Resident #100 stated Staff Y, Licensed Practical Nurse (LPN) stated he had close to 40 residents to give all their medications to. Resident #100 stated he seemed very rushed. A record review of Resident #100 admission Record showed an admit date of 02/23/2026 with diagnoses to include but not limited to Major depressive disorder recurrent moderate, primary insomnia, opioid dependence uncomplicated, chronic pain syndrome, chronic systolic (congestive) heart failure and essential primary hypertension. A record review of Resident #100's Minimum Data Set (MDS) dated [DATE], Section C-Cognitive Patterns showed a Brief Interview for Mental Status (BIMS) of 15, indicating he was cognitively intact. A record review of physician orders for Resident #100 showed an order for the following: Pregabalin oral capsule 100 mg (milligram), give 100 mg by mouth three times a day for pain. Medication scheduled for 09:00 a.m., 13:00 (1:00 p.m., and 17:00 (5:00 p.m.). Oxycodone HCL (hydrochloride) oral tablet 10 mg, give 10 mg by mouth every 4 hours for Pain. Medication scheduled for 01:00 a.m., 05:00 a.m., 09:00 a.m., 13:00 (1:00 p.m.), 17:00 (5:00 p.m.), and 21:00 (9:00 p.m.) A record review of the Medication Admin Audit Report for Resident #100 showed on 3/29/2026, the resident received his scheduled 17:00 (5:00 p.m.)Pregabalin 100 mg and Oxycodone 10 mg at 19:06 (7:06 p.m.) Upon further review, Resident received his next dose of Oxycodone at 20:30 (8:30 p.m.) 2. On 3/30/2026 at 9:38 a.m., an interview was conducted with Resident #94. Resident #94 stated her medications were late yesterday during the evening shift. Resident #94 stated the nurse assigned to her hallway had 40 residents to administer medications to. Resident #94 stated the residents suffer when the staff are limited in providing quality of care. A record review of Resident #94 admission Record showed an admit date of 4/29/2025 with a (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	readmission date of 01/30/2026 with diagnoses to include but not limited to chronic obstructive pulmonary disease with (acute) exacerbation, essential hypertension, major depressive disorder recurrent moderate, generalized anxiety disorder, and dislocation of internal left hip prosthesis subsequent encounter A record review of Resident #94's Minimum Data Set (MDS) dated [DATE], Section C-Cognitive Patterns showed a Brief Interview for Mental Status (BIMS) of 15, indicating she was cognitively intact. A record review of physician orders for Resident #94 showed an order for the following: Baclofen oral tablet 10 mg, give one tablet by mouth two times a day for pain. Medication scheduled for 09:00 a.m. and 17:00 (5:00 p.m.) Ipratropium-Albuterol Solution 0.5-2.5 (3) mg/3 ml (milliliters), one vial orally via nebulizer four times a day related to sepsis, unspecified organism . Medication scheduled for 09:00 a.m., 13:00 (1:00 p.m.), 17:00 (5:00 p.m.) and 21:00 (9:00 p.m.) Buspirone HCL oral tablet 10 mg, give one tablet by mouth three times a day for anxiety. Medication scheduled for 09:00 a.m., 12:00 (1:00 p.m.) and 17:00 (5:00 p.m.) Oxycodone-Acetaminophen oral tablet 10-325 mg, give one tablet by mouth every 4 hours for chronic pain. Medication scheduled for 01:00 a.m., 05:00 a.m., 13:00 (1:00 p.m.), 17:00 (5:00 p.m.) and 21:00 (9:00 p.m.). A record review of the Medication Admin Audit Report for Resident #94 showed on 3/29/2026, the resident received her scheduled 17:00 (5:00 p.m.) Baclofen, Ipratropium-Albuterol, Buspirone HCL and Oxycodone-Acetaminophen at 19:40 (7:40 p.m.). Upon further review, Resident received her next dose of Oxycodone at 20:38 (8:38 p.m.) On 3/31/2026 at 5:40 p.m., an interview was conducted with Staff Y, Licensed Practical Nurse (LPN) assigned to the 100 low hallway. Staff Y, LPN stated it was him and another nurse for the entire 100 hallway. Staff Y, LPN stated on Friday (3/27/26), he was so busy trying to pass medications for the residents he was assigned to that he did not get a bathroom break or a break in general. Staff Y, LPN stated sharing a cart with another nurse is challenging. Staff Y, LPN stated his legs were so sore by the end of his shift. Staff Y, LPN stated on Sunday the same scenario presented itself where he was sharing a cart with one other nurse when normally it is three nurses on the 100 hallways. Current census for the 100 hallways was 71 residents. Staff Y, LPN stated he knew the residents were unhappy with their care. He stated he is new to the facility and has been told it will get better. Staff Y, LPN stated, I don't know what good nurse can realistically get their work done. On 4/01/2026 at 8:16 a.m., an observation was made of Staff O, LPN in the nurses' station for the 200 hallways. Staff O, LPN was observed taking report from the off going shift nurse. Staff O, LPN was observed starting her medication administration at 8:23 a.m. On 4/01/2026 at 8:55 a.m., an interview was conducted with Staff O, LPN during medication administration of a resident with a gastrostomy tube (g tube). Staff O, LPN stated she had 18 residents of which 4 residents had tracheostomies, 6 residents with gastrostomy tubes and three wound dressings to do today. Staff O, LPN stated she had a late start because the night shift nurse (continued on next page)

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

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	giving report was still providing care and overwhelmed by the workload. Staff O, LPN stated currently there is not a unit manager to assist with any additional job duties; therefore, the workload is challenging. On 4/01/2026 at 9:14 a.m., an interview was conducted with the DON. The DON stated Staff O, LPN should have started her medication pass when she arrived at the facility. The DON stated a quick medication cart exchange/narcotic count could have been done prior to off coming nurse finishing her documentation. The DON stated the 100 hallways could be managed with two nurses and added it is a matter of better time management. The DON stated she as well as the ADON have assisted numerous times with any assistance. On 4/01/2026 at 5:30 p.m., an observation was made of Staff O, LPN in the nurses' station documenting for her shift. Staff O, LPN stated a few concerns developed where she had to stay and document. Staff O, LPN stated they had an extra nurse come in for the evening shift so he is assisting with labs and calling for orders that she could not get to. 3. During an interview 03/31/2026 at 2:30 p.m., Residents of the resident council stated the 7 a.m.-3 p.m., and midnight shift needs extra help. They can take an hour to two hours to answer call lights. Two residents stated they have been left in the bathroom waiting for assistance for up to two hours. The lights don't make different noises, so they don't know that you are in the bathroom. This has happened a few times. Other residents stated they have had to wait for up two hours for incontinence care. It always happens on these shifts. During an interview on 04/02/2026 at 2:43 p.m., the staffing coordinator stated I am new to this position, I just started last week. I have experience with scheduling, but nothing with nursing. We use our hours per patient day (PPD), we total all of our CNA's hours to make sure there are enough on each shift and base it on the census. I have a chart in my office that I use to give me the guidelines and tells me how many CNAs and nurses I need for based off of the census. The 100 unit get the most the CNAs, because that is where our census the is highest compared to the other floors. We do get call outs. When I get a call out, I will try to reach out and see if I can have someone fill the position. I have had it happen to where I was not able to fill a position after a call out. Right now, it is hard, it seems like nobody wants to work. If we have enough people, then they don't have to wait. No, I have not used the facility assessment, to staff the building, I am not sure what that is. We need more staff. Review of the facility policy titled Staffing dated August 2024 revealed, Policy: The administrator and director of nursing are responsible to ensure sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable, physical, mental, and psychosocial well-being of each resident, as required by federal law and sufficient staff to meet applicable state law requirements the projected staffing plans are reevaluated on an ongoing basis in response to changes in the facility, resident population, or other circumstances. Staffing is monitored on an ongoing basis through reviews conducted by the facility. The facility administrator and director of nursing should evaluate staffing on a daily basis.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to follow standards of care for infection control related to; 1. offering hand hygiene to residents before meals for three of three meal observations; 2. Failed to follow hand hygiene practices during meal services; 3. Failed to use personal protection equipment (PPE) in one room (room [ROOM NUMBER]) of 3 rooms with transmission-based precautions.Findings included: 1. During an observation on 03/30/2026 at 11:44 a.m., multiple residents on the secure unit (300 hall) were observed sitting in the dining room at tables. Staff began passing meal trays without offering hand hygiene to residents. During an observation on 03/30/2026 at 1:18 p.m. of multiple rooms on the 300 unit revealed no paper towel holders in multiple resident rooms. During an observation on 04/01/2026 at 12:04 p.m., multiple residents on the secure unit (300 hall) were observed sitting in the dining room at tables. Staff began passing meal trays without offering hand hygiene to residents. During an observation on 04/02/2026 at 11:30 a.m., multiple residents on the secure unit (300 hall) were observed sitting in the dining room at tables. Staff began passing meal trays without offering hand hygiene to residents. During an observation on 04/02/2026 at 11:50 a.m., Staff I, Registered Nurse (RN) moved glasses from the top of her head to her face, began lifting lids off of food in the meal cart and passed meal trays to residents. No hand hygiene was performed. During an observation on 04/02/2026 at 11:52 a.m., Staff Q, Certified Nursing Assistant (CNA), passed meal trays to multiple residents with no hand hygiene in-between. While assisting a resident with the meal, Staff Q grabbed a food item with bare hands and began cutting the item up. During an interview on 03/31/2026 at 1:12 p.m., Staff R, CNA, stated It is hard to do hand hygiene when providing care to the residents on the 300 hall because they removed the paper towel dispensers. How do I do hand hygiene if there are no paper towels? We should use hand hygiene in-between residents when passing food trays. We have hand sanitizer to offer residents hand hygiene. During an interview on 04/02/2026 at 12:34 p.m., Staff H, CNA stated Hand hygiene sucks. I hate having to walk out of a residents room shaking my hands so they will dry. There are no paper towels in the rooms for me to dry when I am trying to provide care to residents on 300 units. During an interview on 04/02/2026 at 5:15 p.m., the Assistant Director of Nursing (ADON) stated there is hand sanitizer for staff to use and for residents to use before meals. Residents should be offered hand hygiene before their meals. Staff should do hand hygiene in-between residents, and no staff should not touch food with their bare hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 04/01/206 at 1:00 p.m., an observation was made outside of room [ROOM NUMBER] of Staff L, CNA. A contact precautions sign was posted on the door of room [ROOM NUMBER]. Staff L was observed exiting room [ROOM NUMBER] with gloves, Staff L removed and disposed gloves at the nurse's station. Staff L was not observed performing hand hygiene upon exiting room [ROOM NUMBER]. Staff L was then observed inside of room [ROOM NUMBER] not wearing a gown. Staff L was observed inside of room [ROOM NUMBER] wearing a glove, reaching outside of the room to obtain a gown. An interview was conducted with Staff L, CNA on 04/01/2026 at 1:11 p.m. Staff L said there are three residents in the 200 unit that are under contact precautions. room [ROOM NUMBER] is under contact precautions. Staff L said that hand hygiene is to be performed before and after providing care, in addition to putting on a gown and gloves before entering a room with a resident under contact precautions. An interview was conducted with Staff O, LPN on 04/01/2026 at 1:28 p.m. Staff O said she will enter a room with contact based precautions with gloves, gown, and mask. Staff O said to perform hand hygiene before entering a room with contact precautions and upon exit. Staff O said room [ROOM NUMBER] is on contact precautions. A review of Isolation Precautions-Categories of Transmission-Based Infections effective October 2021 revealed standard precautions shall be used when caring for residents regardless of the or suspected or confirmed infection status. Contact Precautions for resident known or suspected to infected or colonized with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. While caring for a resident, change gloves after having contact with infective material (for example, fecal material and wound drainage). Remove gloves before leaving the room and wash hands with an antimicrobial agent or antiseptic agent. After removing gloves and washing hands, do not touch potentially contaminated environmental surfaces or items in the resident's room. In addition to wearing a gown as outlined under Standard Precautions, wear a gown (clean, nonsterile) for interactions that may involve contact with the resident or potentially contaminated items in the resident's environment. Remove the gown and perform hand hygiene before leaving the resident's environment. Review of the facility policy dated June 2024, titled Hand Washing and Glove use, revealed, Policy: Hand washing is a vital role in infection control, reducing the surface microorganisms on our hands. 1. Hands must be washed prior to beginning work, after using the restroom, after smoking, when working with different food sources, following contact with unsanitary services, and before wearing gloves. 2. Follow proper washing procedures: .h. dry hands using disposable paper towels.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and review of the facility policy, the facility failed to ensure implementation of their abuse policy related to an allegation of physical abuse and failure to immediately remove the resident from the alleged perpetrator, for one resident (#80) out of one resident sampled. Findings included: On 3/30/26 at 9:46 a.m., an observation of the closed door of the shower room in the 300 (secured) unit revealed elevated voices, the sound of a loud smack, and a male voice stated, Ow, he slapped me. The Activities Director (AD) was observed walking to the closed shower room door; she asked who was in there and Staff F, Certified Nursing Assistant (CNA) opened the door. Staff F, CNA was behind Resident #80 who was observed in a wheelchair with a pink substance covering the front of his dark colored shirt and the top of his dark colored pants. Resident #80 said Staff F, CNA slapped him. Staff F, CNA said he did not slap the resident, but that Resident #80 slapped himself. Staff F stated the resident was care planned for accusing staff of hitting him. The Activities Director was observed asking Resident #80 if he wanted Staff J, Licensed Practical Nurse (LPN) to assist, to which he responded, Yes. Staff J, LPN walked over with the Activities Director and said he had a care plan for vomiting on himself. The Activities Director walked away after Staff J, LPN came to the door of the shower room. Resident #80 was observed saying he wanted the Activities Director to stay with him, but Staff J, LPN responded she could not. Staff J, LPN was observed turning Resident #80 in his wheelchair around, then escorted him into the shower room and left him with Staff F, CNA. The resident was not assessed by the nurse for markings or skin changes that may indicate a slap or hit following the resident's allegation. The shower room door closed with Staff F, CNA and Resident #80 inside and no other staff with them. Staff J, LPN was observed walking away. Resident #80 said loudly, from the shower room, You hit me, and continued to yell unidentifiable words. On 3/31/26 at 2:34 p.m., an interview was conducted with the Activities Director. She stated Resident #80 would accuse residents and say, Hey, you hit me. She said she had witnessed him accuse other residents of hitting or kicking him, but never towards staff. She said Resident #80 had never accused her of hitting him. She said she sometimes worked on the secured unit as a CNA and has observed Resident #80 say, She just kicked me or he hit me. She said she would ask Resident #80 who hit him and he would say, The resident over there, but there would be no one there. She said the resident would then shift to a different conversation and say he liked her outfit or requested to listen to a song. The Activities Director said on 3/30/26 she was walking up the stairs to the 300 unit. When she got to the unit she saw the shower room door was closed and heard Resident #80 yelling, He hit me, it hurts. She said she heard Staff F, CNA yelling as well. She said she went to the shower room to see what was going on. The Activities Director said she observed Resident #80 being pushed in a rough manner and aggressively by Staff F, CNA. She described Staff F, CNA as being, Very elevated, while Resident #80 was telling her the CNA hit and slapped him. The Activities Director said Staff F, CNA's tone of voice was inappropriate and felt he should not have been speaking in that manner. She stated she told Staff F, CNA, I need you to calm down. The Activities Director said she knelt down to talk to Resident #80 and told him, I see you have thrown up on you. She said she tried to get Resident #80 out of the shower room and away from Staff F, CNA as she felt it was hostile. She said Resident #80 told her, I don't want him, in reference to Staff F, CNA. She said she explained what happened to Staff J, Licensed Practical Nurse (LPN) and went back to the shower room with the nurse. She said Resident #80 told Staff J, LPN she wanted the activities director to come with him. She said Staff J, LPN responded that the activities director was in a different department and could not. She said she thought Staff J, LPN went in the shower room with Resident #80 and felt the resident was taken out of the situation. She said she had never observed that type of interaction before with Resident #80 and a staff member. She said she reported the allegation to the Nursing Home Administrator (NHA)/Risk Manager.On 3/31/26 at 4:09 p.m., a telephone interview was conducted with Staff F, (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA. He said right after breakfast, on 3/30/26, he was notified by the activities staff member that Resident #80 vomited, All over the place. He said he went to the dining area to clean the vomit. He stated Resident #80 had, Throw up all over his clothes from head to toe. He cleaned the resident and assisted him out of the dining room. Staff F, CNA said he told Resident #80 he needed to take a shower as he had a red substance all over him. He said he went to get towels and linens, as well as the residents' clothes. He said he approached the resident who told him, No, no I don't want a shower. Staff F, CNA stated he was leading Resident #80 to the shower room, and described the resident as, Already being dramatic. Being his normal self, and saying he did not want to take a shower. He said he pushed the resident in his wheelchair into the shower room, closed the door, then transferred the resident to the shower chair, and went to turn on the shower. Staff F, CNA said Resident #80 clapped his hands and stated, Ow you hit me, you hit me. Staff F, CNA said he told the resident, [Resident #80] you know I did not hit you. He said the activities director knocked on the door and he told her, [Resident #80] just being [Resident #80] saying I hit him and I didn't. Staff F, CNA said the activities director went to get Staff J, LPN. He said when Staff J, LPN came over Resident #80 was in his wheelchair saying, No, I don't want a shower. He said Staff J, LPN helped him transfer the resident to the shower chair and remove his shirt. He confirmed he provided a shower to the resident and Staff J, CNA was not present. He said Resident #80 told him, Thank you for cleaning me. Staff F, CNA said he assisted with dressing him and the resident asked where his wheelchair was. Staff F, CNA stated, This is what he does every day. He said the residents' behavior was normal for the staff and they were used to it. He confirmed Resident #80 had previously accused him and other staff of hitting him. He said he always notified the nurse when Resident #80 had behaviors. He said most of the staff who worked on the secured unit knew how the resident acted, there was nothing they could do about his behaviors, and they needed to continue to complete their jobs. He said in this situation, he and Resident #80 were not separated because the staff knew how the resident was. He said they would separate the Resident #80 and a staff member the resident accused of hitting him if it was new staff who did not typically work on the unit. On 3/31/26 at 4:35 p.m., a telephone interview was conducted with Staff J, LPN. She stated Resident #80 yells a lot and, Says someone is hitting me. She said he will accuse staff and residents of doing something, such as hitting him, or taking his items. Staff J, LPN stated when he makes the accusations, Most of the time there's no one around him. She said this was his behavior at a previous facility as well. She stated, If he didn't say it, I would think something is wrong with him, as he said it multiple times a day. She confirmed the resident has previously accused her of hitting him. Staff J, LPN said when Resident #80 makes the accusations she checked to make sure, but typically there was no one there. She said on 3/30/26 the resident has finished his meal, and he wheeled himself out of the dining room. She said she did not see any interaction between Staff, F, CNA and Resident #80. When asked if she was present in the shower room after the resident alleged that Staff F, CNA hit him, she said may have taken a step in but did not stay there. She said she observed Staff F, CNA put Resident #80 in the shower chair and she left. She said she was in the shower room for a few seconds. Staff J, LPN said they did not separate the resident and the CNA because that was Resident #80's normal behavior and he had a care plan that included him accusing staff.On 3/31/26 at 3:09 p.m., an interview was conducted with the Nursing Home Administrator (NHA). She said the activities director reported the allegation of abuse to her. She said she observed video footage of Staff F, CNA pushing Resident #80 wheelchair into the shower room. She said she did not like Staff F, CNA's motions or gestures and how the CNA pushed the resident's wheelchair.On 4/2/26 at 12:34 p.m., an interview was conducted with Staff S, central supply/activities. She stated Resident #80, Always yells when I'm up here, but normally he is good. Staff S said on 3/30/26 Resident #80 was agitated and did not want to take a shower after he vomited. She said he was in the dining yelling that he wanted to go to his room and was agitated, but not towards the staff. Staff S said at approximately 9:30 a.m. to 10:00 a.m., Staff F, CNA came to the dining room to assist with cleaning Resident #80. She said the resident was not aggressive or (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	combative toward Staff F, CNA and stated, He was wanting to go to his room and not get cleaned up.On 4/2/26 at 2:02 p.m., an interview was conducted with the NHA and the Director of Nursing (DON). They both confirmed they were not aware that Resident #80 had a behavior of making accusations towards staff and resident until after interviews about the incident on 3/30/26. The NHA said the expectation when staff responded to an allegation of abuse is making sure the resident was safe, intervening, and not let the action continue. She said for an allegation of abuse between a staff member and a resident, the expectation was for staff to separate themselves from the situation. The NHA and DON confirmed Resident #80 should not have gone back into the shower room with Staff F, CNA. They both said they were not aware Staff F, CNA went back into the shower room with the resident. The NHA said the CNA needed to be removed and staff should have sure the resident was safe.A review of Resident #80's admission record revealed an admission date of 7/17/25. Further review of the admission record revealed diagnoses to include personal history of traumatic brain injury, other recurrent depressive disorders, major depressive disorder, recurrent, mild, other schizophrenia, other specified persistent mood disorders, psychotic disorder with delusions due to known physiological condition, generalized anxiety disorder, unspecified psychosis not due to a substance or known physiological condition, and cerebral infarction, unspecified.A review of Resident #80's physician orders active as of 4/2/2026 revealed the following:- Side effects monitoring: agitation, blurred vision, cardiac or blood abnormalities, confusion, constipation, dry mouth, difficulty urinating, disturbed gait, drooling, drowsiness, headache, hypotension, involuntary movement of mouth, tongue, trunk or extremities, n&v [nausea and vomiting], pacing, seizure activity, stiffness of neck, sore throat, tremors, rashes every shift do not use if any side effects are present or resident appears to be lethargic, drowsy, or sedated. report change to practitioner if needed., with an order date of 7/17/25.- Clonazepam Oral Tablet 0.5 mg [milligrams] (Clonazepam) Give 1 tablet by mouth every 8 hours for anxiety hold for sedation, with an order date of 7/18/25.- Seroquel Oral Tablet 200 MG (Quetiapine Fumarate) Give 1 tablet by mouth three times a day for delusions, paranoia related to Schizophrenia, unspecified (f20.9), with an order date of 9/2/25.- Trazodone HCl [hydrochloric acid] Oral Tablet 100 MG (Trazodone HCl) Give 1 tablet by mouth at bedtime for Depression, with an order date of 10/10/25.- Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 MG (Divalproex Sodium) Give 4 capsule by mouth every morning and at bedtime for mood disorder, with an order date of 1/27/26.A review of Resident #80's quarterly minimum data set (MDS), dated [DATE], revealed the following: Under section C - cognitive patterns, the brief interview for mental status (BIMS) score was 8 out of 15, indicating Resident #80 was moderately impaired. Section E - behavior, showed, Behavior not exhibited, was marked under physical, verbal and other behavioral symptoms.A review of Resident #80's change in condition assessments dated 8/20/25 revealed, .increased audio and verbal hallucinations . continues to yell out . Recommendation of Primary Clinician(s) IM [intramuscular] Haldol injection . A review of Resident #80's assessments from 1/2026 to 3/2026 revealed the following:A review of the nursing quarterly assessment, dated 1/20/26, showed there no documentation under behaviors.a review of the psychosocial history and assessment, dated 2/27/26, showed the following: .a. mental health a. psychiatric diagnosis . a 2.if yes, what medication do you take? Depakote, trazadone, Seroquel, clonazepam . e. list mental health issue depression, schizophrenia, mood disorder, psychotic disorder, anxiety . f. document how resident and/or family are coping with current illness/placement coping well .memory/cognition 1a. long term a. yes . 1c. fluctuates a. yes . 2. cognitive skills/daily decision making 3.change in cognitive status in the last 6 months 1. no change . c. mood/behavior 1l. pleasant . change in mood or behavior in last 6 months? 1. no change. A review of Resident #80's progress notes from 1/2026 to 3/2026 revealed the following:On 1/1/26, CNA reported resident vomitted [sic] by bed. Noted moderate amount of undigested food. Medicated as ordered.On 1/5/26, . He is seen today for routine psychiatric follow-up, with the last psychiatric evaluation on 11/11/2025. Since the last visit, the presentation has remained stable without acute concerns. Staff observations during this interval are consistent with an (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unchanged clinical course, and the current plan is to continue the current medication regimen. Behavior remains cooperative without agitation, sleep problems are not reported, and appetite is noted as normal. Cognition appears consistent with baseline, with orientation to person and place and moderate attention and concentration. **Largely unknown--lot of anxiety and impulse control issues. Schizophrenia, MDD [major depressive disorder], GAD [generalized anxiety disorder], unspecified Mood affective d/o [disorder], other recurrent Depressive d/o, unspecified Psychosis, Seizures, TBI [traumatic brain injury], CI [cerebral infarction] . Attention and concentration are moderate, with deficient fund of knowledge and intact language and associations. Insight and judgment are poor. Behavior : Cooperative . Insight : Poor Judgment : Poor Attention and Concentration : Moderate .On 1/13/26, Labs received and reviewed results with NP [nurse practitioner]; resident does not exhibit behaviors at this time. No new orders given. All RPs [responsible parties] were notified.On 1/18/26, Resident gives CNA a lot of push back when attempting to deliver care. Yelling out and creating untoward behaviors without warrant. Resident assessed and there are no issues which lead to this behavior.On 2/4/26, Date of Service: 2026-02-03 . Today, he presents with loud speech and impulsive verbalizations . Summary: He is alert and oriented to person and place. Memory and attention were limited, with deficient fund of knowledge and moderate attention and concentration. Speech was loud, language was intact, and engagement was cooperative with a congruent affect. On 2/16/26, Date of Service: 2026-02-13 . The patient is being seen by a psychiatric nurse practitioner in a long-term care setting. Since the last visit, he presents for assessment of Gradual Dose Reduction (GDR) and has remained stable and cooperative with care without agitation . Mood appears stable, and there have been no behavioral concerns.-On 3/3/26, Emesis noted in hall in front of resident on floor. Med [medication] given as ordered.-On 3/12/26, Emesis reported and noted of undigested food. Med given as ordered.On 3/22/26, Date of Service: 2026-03-13 . According to staff, the patient has been stable and cooperative with care, displaying no signs of agitation. The patient has good medication compliance and no reported side effects. Plan: Given the patient's stability and minimally effective dosages of psychotropic medications, a GDR was deemed contraindicated as it could potentially lead to an exacerbation of the patient's psychiatric symptoms and instability. Therefore, all current psych [psychiatric] medications were continued without any changes.On 3/23/26, The resident is currently on a secure unit with two locked exit doors in place. Resident has short term memory impairment and is unable to recall exit door codes. No recent exit seeking behaviors were observed. No attempts of elopement were noted during recent assessment. IDT [interdisciplinary] met and discussed resident's safety status. Resident will continue to be monitored for exit seeking behaviors. Staff instructed to report any changes in behavior and/ or exit seeking behaviors. MD [medical doctor] notified.On 3/26/26 psych note, Date of Service: 03/25/2026 . The patient was observed seated in the dining room of the memory care unit and appeared confused but in no acute distress. Due to his cognitive status, history is significantly limited. He is noted to be fidgety during today's examination. The patient is typically observed in his wheelchair wandering the unit hallways. Neurological: Alert and pleasantly confused . A review of the behavior task for Resident #80 from the last 30 days showed daily documentation of, No behaviors observed.A review of Resident #80's care plan revealed the following: BEHAVIORAL: The resident is noted with the following behaviors: Difficulty communicating thoughts or needs: Territorial of personal space, picks at and eats scabs from sore or wound. Accuses others of hitting him .when there is no one around. Date Initiated: 08/20/2025, Revision on: 03/30/2026, with interventions to include, .Document episodes of behavior & [and] review to determine the effectiveness of intervention Date Initiated: 03/30/2026.A review of the facility's incident and accident log showed an alleged abuse incident for Resident #80 occurred on 3/30/26 at 11:00 a.m. A review of the facility's Abuse Prevention Program, dated November 2024, revealed the following, Policy- The facility has designated and implemented processes, which strive to reduce the risk of abuse, neglect, exploitation, mistreatment, and misappropriation of resident's property. These policies guide the identification, management, and reporting of suspected, or alleged, (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abuse, neglect, mistreatment, and exploitation. It is expected that these policies will assist the facility with reducing the risk of abuse, neglect, exploitation, and misappropriation of resident's property through education of staff and residents, as well as early identification of staff burn out, or resident behavior which may increase the likelihood of such events. Further review of the policy revealed the following, Verbal Abuse - Oral, written, or gestured language that includes disparaging and derogatory terms to the residents or their families to describe the resident with in their hearing distance, regardless of their age &/or ability to comprehend or disability. Physical Abuse - Includes hitting, slapping, pinching, scratching, spitting, holding roughly, etc. Under Training, the policy revealed the following, . How to provide protection for residents. Methods to reduce the risk of abuse, neglect, mistreatment, misappropriation, and exploitation that may include, but may not be limited to, recognizing signs of burnout, frustration and stress, stress management and relaxation techniques. Under Protection, the policy revealed the following, Upon identification of actual, suspected, or alleged abuse, neglect, mistreatment, exploitation, and/or misappropriation, systems are in place to provide for the protection of the resident. These systems may include but may not be limited to: . Moving another resident to another room or unit if indicated. Initiation of behavioral interventions per Behavior Management Program as indicated.

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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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(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 - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to complete the Pre-admission Screening and Resident Reviews (PASARRs) for residents with a mental disorder and individuals with intellectual disability following qualifying mental health diagnoses for three residents (#10, #34, #62) of seven residents sampled.Findings included: 1. A review of Resident #10's admission record revealed the resident was admitted to the facility on [DATE] with diagnoses to include; schizoaffective disorder, bipolar type, depressive disorder, Epilepsy, mood disorder, psychoactive substance abuse, antisocial personality disorder, generalized anxiety disorder, and alcohol use, Review of Resident #10's records revealed the resident did not have a level one PASARR completed prior to admission. The review further showed a level II PASARR was not submitted for consideration following qualifying diagnoses. 2.Review of Resident #34's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses to include unspecified sequelae of cerebral infarction, cognitive communication deficit, mixed receptive-expressive language disorder, dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance, mood disorder due to known physiological condition with mixed features; other psychotic disorder not due to a substance or known physiological condition; major depressive disorder, recurrent, mild; generalized anxiety disorder; anxiety disorder, unspecified; primary insomnia; alcohol abuse, uncomplicated. Review of Level I PASARR for Resident #34 dated 1/30/26 revealed the following mental illnesses: anxiety disorder, depressive disorder, psychotic disorder, substance abuse, mood disorder due to known physiological condition with mixed features, and other related conditions of unspecified sequelae of cerebral infarction. Review of Section I, part B, revealed no items marked for intellectual disability or suspected intellectual disability. Review of Section II revealed yes responses to questions 1 and 2B. Review of Section III revealed no provisional admission or hospital discharge exemption. Review of Section IV showed serious mental illness and intellectual disability. Review of Resident #34's medical record revealed a request for Level II PASARR evaluation was not submitted for consideration following the qualifying diagnoses. 3. Review of Resident #62's medical record revealed the resident was admitted on [DATE]. Review of diagnoses revealed the following to include but not limited to: unspecified dementia, unspecified severity, with anxiety; mood disorder due to known physiological condition, unspecified; major depressive disorder, recurrent, mild; other specified persistent mood disorders; primary insomnia; pseudobulbar affect; major depressive disorder, single episode, unspecified; insomnia, unspecified; cannabis use, unspecified, uncomplicated; bipolar disorder, unspecified; anxiety disorder, unspecified; unspecified dementia, unspecified severity, with agitation. Review of a level I PASARR for Resident #62 dated 1/30/26, revealed mental illness to include: anxiety disorder; bipolar disorder; depressive disorder; mood disorder due to known physiological condition, unspecified; other specified persistent mood disorders; pseudobulbar affect; and cannabis use, uncomplicated. Review of Section II revealed yes responses to questions 1 and 2B. Review of Section III revealed no provisional admission or hospital discharge exemption. Review of Section IV (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed serious mental illness. The review of Resident #62's medical record revealed a request for Level II PASARR evaluation was not submitted for consideration following the qualifying diagnoses. On 4/1/2026 at 1:02 p.m. an interview with the Social Services Director (SSD) revealed they stated an audit in the 100 hallway, and it was identified that the majority of the Level I PASARRs were incorrect. The stated SSD she completed all Level I PASARR screens for the 100, 200, and 300 halls. The SSD reported that once all Level 1 PASARRs were completed, she would work on Level II PASARRs. The SSD said, I had to wait to submit for Level II because we needed psychiatry notes. The SSD stated keeping a weekly audit log for tracking. A follow -up interview on 4/1/2026 at 1:52 p.m. with the SSD revealed the SSD cannot submit Level II evaluations without the assistance of the Director of Nursing (DON). The SSD confirmed a Level II is requested when there are, any related conditions. The SSD confirmed the expectation was for a Level II to be requested as soon as possible once they are triggered by the Level I screen. The facility did not provide a policy for PASARR evaluations.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure a care plan was revised in a timely manner related to behaviors for one resident (#80) out of seven residents reviewed. Findings included: On 3/30/26 at 9:46 a.m., an observation of the closed door of the shower room in the 300 (secured) unit revealed elevated voices, the sound of a loud smack, and a male voice stated, Ow, he slapped me. The Activities Director (AD) was observed walking to the closed shower room door; she asked who was in there and Staff F, Certified Nursing Assistant (CNA) opened the door. Staff F, CNA was behind Resident #80 who was observed in a wheelchair with a pink substance covering the front of his dark colored shirt and the top of his dark colored pants. Resident #80 said Staff F, CNA slapped him. Staff F, CNA said he did not slap the resident, but that Resident #80 slapped himself. Staff F stated the resident was care planned for accusing staff of hitting him. The Activities Director was observed asking Resident #80 if he wanted Staff J, Licensed Practical Nurse (LPN) to assist, to which he responded, Yes. Staff J, LPN walked over with the Activities Director and said he had a care plan for vomiting on himself. The Activities Director walked away after Staff J, LPN came to the door of the shower room. Resident #80 was observed saying he wanted the Activities Director to stay with him, but Staff J, LPN responded she could not. Staff J, LPN was observed turning Resident #80 in his wheelchair around, then escorted him into the shower room and left him with Staff F, CNA. The resident was not assessed by the nurse for markings or skin changes that may indicate a slap or hit following the resident's allegation. The shower room door closed with Staff F, CNA and Resident #80 inside and no other staff with them. Staff J, LPN was observed walking away. Resident #80 said loudly, from the shower room, You hit me, and continued to yell unidentifiable words.A review of Resident #80's admission record revealed an admission date of 7/17/25. Further review of the admission record revealed diagnoses to include personal history of traumatic brain injury, other recurrent depressive disorders, major depressive disorder, recurrent, mild, other schizophrenia, other specified persistent mood disorders, psychotic disorder with delusions due to known physiological condition, generalized anxiety disorder, unspecified psychosis not due to a substance or known physiological condition, and cerebral infarction, unspecified.A review of Resident #80's physician orders active as of 4/2/2026 revealed the following:- Side effects monitoring: agitation, blurred vision, cardiac or blood abnormalities, confusion, constipation, dry mouth, difficulty urinating, disturbed gait, drooling, drowsiness, headache, hypotension, involuntary movement of mouth, tongue, trunk or extremities, n&v [nausea and vomiting], pacing, seizure activity, stiffness of neck, sore throat, tremors, rashes every shift do not use if any side effects are present or resident appears to be lethargic, drowsy, or sedated. report change to practitioner if needed., with an order date of 7/17/25.- Clonazepam Oral Tablet 0.5 mg [milligrams] (Clonazepam) Give 1 tablet by mouth every 8 hours for anxiety hold for sedation, with an order date of 7/18/25.- Seroquel Oral Tablet 200 MG (Quetiapine Fumarate) Give 1 tablet by mouth three times a day for delusions, paranoia related to Schizophrenia, unspecified (f20.9), with an order date of 9/2/25.- Trazodone HCl [hydrochloric acid] Oral Tablet 100 MG (Trazodone HCl) Give 1 tablet by mouth at bedtime for Depression, with an order date of 10/10/25.- Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 MG (Divalproex Sodium) Give 4 capsule by mouth every morning and at bedtime for mood disorder, with an order date of 1/27/26.A review of Resident #80's quarterly minimum data set (MDS), dated [DATE], revealed the following: Under section C - cognitive patterns, the brief interview for mental status (BIMS) score was 8 out of 15, indicating Resident #80 was moderately impaired. Section E - behavior, showed, Behavior not exhibited, was marked under physical, verbal and other behavioral symptoms.A review of Resident #80's change in condition assessments dated 8/20/25 revealed, .increased audio and verbal hallucinations . continues to yell out . Recommendation of Primary Clinician(s) IM [intramuscular] (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Haldol injection . On 3/30/26 at 11:30 a.m., an interview was conducted with Staff F, CNA. He said Resident #80 bites and scratches himself. Staff F, CNA confirmed he has observed the resident biting himself.On 3/30/26 at 11:32 a.m., an interview was conducted with Staff G, Registered Nurse (RN). She said Resident #80 is verbally aggressive with residents sometimes, such as cursing. She said during medication administration if he did not get his medication right away, he would start touching the medication cart and would attempt to get the medications. She said he would stand up from the wheelchair and get agitated. Staff G, RN stated, If you don't get what he wants right away, he will get agitated.On 3/31/26 at 1:53 p.m., an interview was conducted with Staff H, CNA. She stated, [Resident #80] is pretty loud. She confirmed he would yell and accuse staff of taking his personal items. Staff H, CNA said he had accused her previously saying, That lady, that lady, she took all my money. She confirmed Resident #80 had accused her of hitting him as well. When asked about the scabs (hardened protective crust that forms over broken skin) on the resident's arms she stated, He picks and eats his scabs. She said she did not know how he got the scabs on the front of his hand but confirmed she had seen Resident #80 bite his own hand.On 3/31/26 at 1:56 p.m., an interview was conducted with Staff I, RN. She said Resident #80 would sometimes yell. She stated, He'll claim things that didn't happen. He'll say a person has fallen and nobody has fallen. He makes up things. She said he picks and eats his scabs. She said she was not aware how he obtained the scabs on his right hand and was not sure if he could bite himself. Staff I, RN was observed asking Staff H, CNA if Resident #80 was able to bite himself and Staff H, CNA stated, Yes. On 3/31/26 at 2:34 p.m., an interview was conducted with the Activities Director. She stated Resident #80 would accuse residents and say, Hey, you hit me. She said she had witnessed him accuse other residents of hitting or kicking him, but never towards staff. The Activities Director confirmed he picks at his skin and scabs. She said she sometimes worked on the secured unit as a CNA and had observed Resident #80 say, She just kicked me or he hit me. She said she would ask Resident #80 who hit him and he would say, The resident over there, but there would be no one there. The Activities Director said regarding documentation of the behaviors, she would tell the nurse about his behaviors and document in the Kardex (documentation system with the resident's plan of care). She said in the Kardex there was a specific task for behaviors. She said if the behaviors occurred in an activities setting, she would notify the nurse and document in the activities progress note and care plan.On 3/31/26 at 4:09 p.m., a follow up interview was conducted by telephone with Staff F, CNA. He said right after breakfast, on 3/30/26, he was notified by the activities staff that Resident #80 vomited on himself. Staff F, CNA said he informed Resident #80 he had to take a shower and the resident replied, No, no I don't want a shower. He said himself and other staff members informed the resident he needed to take a shower. He said Resident #80 continued to say, I don't want to do it. Staff F, CNA said he pushed the resident in his wheelchair to the shower room and closed the door; then Resident #80 clapped his hands and stated, Ow you hit me, you hit me. Staff F, CNA stated, [Resident #80] will accuse they [staff] hit him, take his stuff, everyone knows so it's not a red flag. He said he told the Activities Director who knocked on the door that, [Resident #80] just being [Resident #80] saying I hit him and I didn't. Staff F, CNA stated, This is what he does every day, and it was normal for the staff, so they were used to it. He confirmed Resident #80 had previously accused him and other staff of hitting him. He said the resident was loud in group settings such as in the dining room. He stated, He likes to get really loud and rowdy. Staff F, CNA confirmed Resident #80 bites himself, hits things, and scrapes his hands against the wheelchair.On 3/31/26 at 4:35 p.m., a telephone interview was conducted with Staff J, LPN. She stated Resident #80 yells a lot and says, Someone is hitting me. She said he will accuse staff and residents of doing something, such as hitting him, or taking his items. Staff J, LPN stated when he makes the accusations, Most of the time there's no one around him. She stated, If he didn't say it, I would think something is wrong with him, as he said it multiple times a day. Staff J, LPN said when he first came to the secured unit, she went to the MDS staff to care plan his behavior of accusing staff and residents of hitting him. She confirmed they had not initiated a care plan for his (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behaviors until yesterday. Staff J, LPN said typically when a resident had behaviors, she communicated with the MDS staff. She said she was not sure where the scabs on his arms came from, but they wrap his arms and Resident #80 removes them. She confirmed he picks at his scabs.On 4/2/26 at 11:18 a.m., an interview was conducted with Staff K, LPN/Clinical Reimbursement Specialist (CRS) and the Clinical Reimbursement Director (CRD)/RN. Staff K, LPN/CRS said they received communication through the nursing staff to make changes to a resident's care plan. She said for new residents they reviewed orders, the history and physical, past history, various provider notes, medications, and side effects of medications. Staff K, LPN/CRS said they reviewed the 24-hour report to include if a resident had a change in condition or update. She said they reviewed the order listing reports and new physician orders to update the care plan accordingly. Staff K, LPN/CRS said in the interdisciplinary meeting held every morning and at stand down meetings at the end of the day, they discussed new residents and changes in conditions. The CRD/RN said it was the same process if a resident had behaviors, they expected the nursing staff to communicate that information. Staff K, LPN/CRS said they also reviewed progress notes to identify if a resident was having behaviors and required an update to the care plan. She said staff would communicate directly or document the behaviors and she would update the care plan. Staff K, LPN/CRS confirmed a recent update to Resident #80's care plan that occurred on 3/30/26. She said the nurse informed her Resident #80 was accusing others of hitting him when no one was around. She stated she did not know about the resident's behavior of accusing staff but knew, He has fluctuating behaviors. The CRD/RN confirmed she was not aware of the behaviors prior to 3/30/26.On 4/2/26 at 2:31 p.m., an interview was conducted with the Director of Nursing (DON). She said the nursing staff should have documented in a note that Resident #80 had a behavior of accusing staff and residents when no one was around and there was no physical contact. She stated, That's when the care plan needed to be updated. She confirmed if Resident #80 had behaviors previously, the care plan should have been updated.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. Further review of the policy revealed the following, .The overall care plan should be oriented towards: . 2. Using an appropriate interdisciplinary approach to care plan development to improve the resident's functional abilities. b. Assessing and planning for care to meet the resident's medical, nursing, mental, and psychosocial needs. c. Involving the direct care staff with the care planning process relating to the resident's expected outcomes. d. Addressing additional care planning areas that are relevant to meeting the resident's needs in the long-term care setting. Further review of the policy under procedure, revealed the following, .8. Care Plan Meeting . 6. Nursing . i. Review current diagnosis, tests, or procedures, treatments (wounds, rashes, etc.), discuss current interventions and risk of further breakdown, if applicable, recent, or pending referrals, Physician consults, Restorative, medications, pain management plan, behavioral management plan, special needs, risk of falls and current interventions, and recent falls or other issues (informed consents, isolation, etc.) ii. Clinical representative will be UM or charge nurse familiar with the care of the resident. Assigned CNA also attends or provides input to IDT regarding care provided and resident response. Absence of UM or charge nurse should be by exception.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review the facility failed to provided assistance with meals for two residents (#34 and #61) out of two residents reviewed for activities of daily living (ADL).Findings Included:1.During an observation on 03/30/2026 at 11:56 a.m., Resident #34 was observed sitting at a table in the dining room of the secure unit (300 unit). Resident #34 was observed attempting to scoop food off of his plate and dropping it onto the table.During an observation on 04/02/2026 at 11:46 a.m., Resident #34 was observed sitting at a table in the dining room of the secure unit (300 unit), scooping food off of his plate, and feeding himself.Review of Resident #34's admission record revealed an admission date of 02/24/2026. Resident #34 was admitted to the facility with diagnosis to include unspecified sequelae of cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, unspecified protein-calorie malnutrition, other lack of coordination, dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance, muscle wasting and atrophy, not elsewhere classified, multiple sites, muscle weakness (generalized) , anxiety disorder, mood disorder due to known physiological condition with mixed features, generalized anxiety disorder and other psychotic disorder not due to a substance or known physiological condition.Review of Resident #34's Entry MDS dated [DATE] revealed, Section C. Cognitive Patterns, a BIMS of 02 out of 15 showing severe cognitive impairment.Review of Resident #34's care plan dated 10/27/2025 revealed:Focus:NUTRITIONAL: The resident has a potential nutritional problem related to history of dysphagia, protein calorie malnutrition, anemia, dementia and significant weight loss. Mechanically altered diet.Interventions:Assisted Dining . Observe/ document as indicated: meal Consumption, amount assistance needed with meal, tolerance to diet/fluids.2. During an observation on 03/30/2026 at 11:53 a.m. Resident #61 was observed sitting a table in the dining room of the secure unit (300 Hall). Resident #61 was observed feeding herself with no assistance.Review of Resident #61's admission record revealed an admission date of 03/18/2025. Resident #61 was admitted to the facility with diagnosis to include metabolic encephalopathy, dementia and other diseases classified elsewhere major depressive disorder altered mental status in unspecified convulsions.Review of Resident #61's Quarterly MDS dated [DATE] revealed Section C. Cognitive Patterns, a BIMS of 0 out of 15 showing severe cognitive impairment. Section GG. Functional Abilities revealed eating, Resident #61 was dependent meaning helper does all of the effort. Resident does none of the effort to complete the Activity. Or the assistance of two or more helpers is required for the resident to complete the activity.Review of Resident #61's care plan dated 03/18/2025 revealed:Focus:ADL: resident 61 has an ADL self-care performance deficit/cognitive deficit, may wander from task, poor focus on tasks assist for thoroughness, weakness, may require more assistance than allowing staff to render, self performance level need fluctuate throughout the course of the day.Intervention:. eating dependent assist of 1 .During an interview on 04/02/2026 at 12:15 p.m., Staff Q, Certified Nursing Assistant (CNA) stated we will assist resident with meals if we see they need assistance. Resident #34 needs assistance with meals on his bad days when he is in bed.During an interview on 04/02/2026 at 12:23 p.m., Staff H, CNA, stated yes Resident #61 needs assistance with her meals. I helped her with her meal today.During an interview on 04/02/2026 at 4:30 p.m. the Director of Nursing stated staff should be helping all residents who need assistance with their meals.The facility was asked to provide a policy related to this citation. The facility stated they did not have a policy related to ADL's.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure a notification of change was completed for one resident (#129) out of one resident reviewed who was severely cognitively impaired.Findings included: A review of Resident #129's admission record revealed an initial admission date of 3/5/26, and a re-entry date of 3/26/26 with diagnoses to include unspecified intracranial injury with loss of consciousness of unspecified, duration, subsequent encounter, unspecified sequelae of unspecified cerebrovascular disease, acute and chronic respiratory failure with hypoxia, encephalopathy, unspecified, and tracheostomy status. The admission record, under contacts, revealed Resident #129 was documented as the responsible party and two family members were listed as emergency contacts #1 and #3.A review of Resident #129's minimum data set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 0.0. indicating severe cognitive impact. A BIMS evaluation dated 3/30/26 showed severe cognitive impact and a score of 0.0.Review of a change in condition evaluation dated 3/11/26 revealed, . Representative Notification 1.Name of family/resident representative notified: SELF 2. Date and time of family/resident representative notification: 3/11/2026 1722 [5:22 p.m.] . Review of a transfer form dated 3/11/26 showed, . Section E. Key Contacts . 1. Resident Representative . a. Name: [Resident #129] b. Contact Type: Agent . Personal 2. Notified of Transfer? 1. Yes 3. Aware of clinical situation? 1. Yes . 3. Contact Person at SNF/NF [skilled nursing facility/nursing facility] for Further Information 1. Name and Designation: SELF . Review of a change in condition evaluation dated 3/28/26 showed, .Representative Notification 1.Name of family/resident representative notified: Resident own RP [responsible party] 2.Date and time of family/ resident representative notification: 3/28/2026 0000 .A review of Resident #129's progress notes revealed the following: On 3/9/26, ETA [estimated time of arrival] notification via [by] fax 645 p.m.-845 p.m. This is an estimated time based on current scheduling and may change depending on volume and resource availability.MD [medical doctor] and RP aware. On 3/29/26, Spoke with ARNP [advanced practice nurse practitioner] regarding labs. No new orders at this time. Resident own RP.On 3/29/26, Vancomycin trough (on 3/28/26- 11.1) Antibiotic kinetic dosing orders received from pharmacy. Continue current dose Vanco [vancomycin] 1000 mg [milligrams] IV [intravenous] every 12 hrs. [hours] no further labs required.MD aware Resident own RP.On 4/1/26 at 11:05 a.m., an interview was conducted with the Social Services Director (SSD). She confirmed Resident #29 had a BIMS score of zero. She said the nursing home administrator (NHA) and the Director of Nursing (DON) have communicated with two different family members. She said based on hospital documentation, there are two family members who have been communicated with in the past. The SSD said the resident returned on 3/26/26 from the hospital and she planned to work on his letter of incapacity and designating his family member as a healthcare surrogate.On 4/1/26 at 3:06 p.m., an interview was conducted with Staff O, Licensed Practical Nurse (LPN). She said for changes in condition she always communicated with the doctor and family member regardless of their BIMS. Staff O, LPN said for changes in medication, hospitalizations, and changes in condition, she would contact the residents' family. She said for Resident #129, his family lives out of the country. She said she thought the DON or SSD tried to communicate with the family member. She confirmed the resident is listed as the responsible party. Staff O, LPN said she had not communicated with the family as their phone numbers are from outside of the country.On 4/1/26 at 11:32 a.m., an interview was conducted with the DON. She confirmed Resident #129 had a BIMS of zero. She said the resident had a family member in a different country. The DON said she communicated with the care managers at the hospital who were asking for the family member's telephone number and how to dial the out of country number. The DON said she explained to the family member he was transferred to the hospital due to bleeding and told her she was going to receive a phone call from the hospital. She stated, [Family member name] is very involved. She said there was communication with the family member (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	about Resident #129's change in condition and medication changes. Regarding documentation about Resident #129 being his own responsible party, The DON stated, The documentation was probably fast, and they wrote it like that. She said for lab results, changes in condition, and updates, the expectation would be to call the family member. She said the family member is his next of kin. The DON confirmed Resident #129 cannot make decisions for himself due to his cognition.A review of the facility's policy titled Notification of Resident Change in Condition, effective February 2026, revealed the following, Nurses will notify the resident/resident representative, if there is a crucial/significant change in the resident condition. If the change in the resident's condition is not crucial or significant, the resident's Physician, resident representative or legal representative will be notified at the earliest convenient time during regular business hours. Further review of the policy under Procedure, revealed the following, 1. Notify the Physician resident/resident representative, and case management when indicated, if there is a significant change in condition, regardless of the time of day.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility did not ensure ongoing monitoring for changes in condition related to catheter use for one resident (#126) out of two resident sampled.Findings included: An observation on 03/20/2026 at 2:23 PM revealed Resident #126 had a catheter bag that contained dark red and cloudy urine. An observation was made on 04/01/2026 at 1:28 PM with Staff O, Licensed Practical Nurse, (LPN) of Resident #126 having red and amber urine in the catheter bags. Staff O stated the physician should be notified if changes are observed in the residents output or color.Review of Resident #126's admission record revealed Resident #126 was admitted to the facility on [DATE] with diagnoses to include anoxic brain damage and obstructive and reflux uropathy.Review of physician orders active as of 04/02/2026 revealed: Nephrostomy catheter, drain nephrostomy catheter bag every shift and PRN (as needed) every shift.Review of the care plan report for Resident #126 revealed a focus of catheter/nephrostomy: the resident uses a urinary catheter with risk for infection and/or complications, initiated on 03/13/2026 and revised on 03/16/2026. The goal showed - will minimize the risk of complications associated with catheter usage, will not develop signs or symptoms of UTI. The interventions/tasks related to this focus included to observe/document/report to MD (medical doctor) for signs and symptoms of UTI (urinary tract infection): pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urine frequency, foul smelling urine, fever, chills, altered mental status, change in behavior and change in eating patterns, initiated 03/13/2026. Review of the electronic medical record (EMR) revealed there was no documentation or follow up with the physician regarding the signs and symptoms as documented in the interventions.An interview conducted with Staff P, Certified Nursing Assistant (CNA), on 04/02/2026 at 12:56 PM revealed she provided morning care for Resident #126, which consisted of a bed bath and draining the urine from Resident #126's nephrostomy bag. Staff P said red urine was observed when providing morning care this morning but did not report the observations. Staff P confirmed having previously provided care to Resident #126, and there was red urine observed. Staff P did not notify the nurse because, It was believed to be normal.An interview and observation was conducted with Staff O, LPN on 04/01/2026 at 1:28 PM. The interview revealed Staff O was not aware Resident #126 was observed to have red urine in the catheter bag. Staff O said if red urine were to be reported, it would require a change in condition to be documented. Staff O said they frequently provided care for Resident #126 during morning medicine pass and during tracheostomy care. Staff O, LPN stated she did not notice red urine, nor was it reported to the physician. Staff O observed the red and amber urine at that time and immediately said a change in condition would be documented in addition to notifying Resident #126's primary care physician and family member.An interview with the facility's Assistant Director of Nursing (ADON) was conducted on 04/02/2026 at 3:05 PM. The interview revealed an expectation for the nephrostomy care provided by the CNA. The ADON said it should include draining the catheter bag at least every shift and monitoring for abnormal urine output every shift. The ADON stated the amount and color of the urine output should be documented every shift. The ADON said urine output would be considered abnormal if there was a change in color. The ADON said if abnormal urine output is observed, the CNA should notify the resident's nurse. The nurse should do an assessment, notify the resident's physician and their family. The ADON did not provide documentation of abnormal urine output for Resident #126.The facility did not provide a policy for catheter care.

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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 record review and interview, the facility did not ensure oxygen therapy was provided per physician orders for one resident (#126) out of one resident sampled.Findings included: On 03/30/2026 at 2:21 PM, an observation revealed Resident #126's oxygen concentrator was set to 9 liters per minute (LMP).Review of physician orders for Resident #126 active as of 04/02/2026 revealed: Humidified oxygen per trach continuously, 7 liters every shift for shortness of breath, effective 03/26/2026.Review of Resident #126's admission record revealed Resident #126 was admitted to the facility on [DATE] with diagnoses to include anoxic brain damage, chronic respiratory failure, unspecified whether with hypoxia or hypercapnia. Review of the care plan report for Resident #126 revealed a focus initiated on 03/13/2026, Revised 3/27/2026, Oxygen - Resident #126 has oxygen therapy related to O2 (oxygen) via tracheostomy, O2 dependent. The goals revealed; Will experience minimal to no shortness of breath (SOB), will have no untreated s/s (Signs and symptoms) of SOB through the next review. Interventions included special equipment oxygen, and administer oxygen as ordered by the physician. Monitor/document side effects and effectiveness.An interview with Staff O, Licensed Practical Nurse, (LPN) on 04/01/2026 at 1:28 PM revealed tracheostomy care was provided to Resident #126 by Staff O on 04/01/2026. Staff O stated the nurse is responsible for setting and maintaining the resident's oxygen concentrator according to their orders. Staff O said on 03/31/2026, a respiratory care therapist visited the residents and reported a resident's oxygen concentrator was excessively high but she did not recall which resident this report was specific to.An interview with the Assistant Director of Nursing (ADON) was conducted on 04/02/2026 at 3:05 PM. The interview revealed respiratory therapists visits the facility once per month and/or when a resident is admitted requiring the care of a respiratory therapist. The ADON said respiratory therapists evaluate the resident, determine the appropriate oxygen settings, and input the orders into the electronic medical records system. The ADON said if a resident was admitted into the facility from a hospital, the facility may follow the hospital orders, or the respiratory therapy may perform a separate evaluation to determine the resident's oxygen needs. The ADON said the residents' nurses should follow the orders in the electronic medical record system, and if a nurse notices the oxygen is not set in accordance with the orders, the nurse should change the oxygen concentrator. The ADON said the nurses should check the oxygen concentrator settings every time they provide care or pass medications. The ADON acknowledged the photographic evidence obtained of Resident #126's oxygen concentrator setting of 9 LMP on 03/30/2026. The ADON was unsure how or why the concentrator was not set to 7 LMP as ordered by the physician.A review of the policy and procedure titled, Oxygen Therapy effective August 2025, revealed oxygen is provided to residents based on physician's orders to supplement oxygen as needed per disease process. Procedure: 1. Verify physician order; 7. Apply device to the resident with appropriate liter flow.(Photographic Evidence Obtained)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to ensure nursing staff were competent, related to residents with behavioral health needs, as evidenced by the following: 1) accurately documenting behavior monitoring for three residents (#8, #62, and #80) out of three residents reviewed for behaviors; 2) supervising residents on the 300 (secured) unit for two residents (#61, and #34) out of two residents observed during dining; and 3) sufficient staffing to meet the needs of residents on the secured unit. Findings included: 1. On 3/30/2026 at 9:46 a.m., an observation of the closed door of the shower room in the 300 (secured) unit revealed elevated voices, the sound of a loud smack, and a male voice stated, Ow, he slapped me. The Activities Director was observed walking to the closed shower room door; she asked who was in there and Staff F, Certified Nursing Assistant (CNA) opened the door. Staff F, CNA was behind Resident #80 who was observed in a wheelchair with a pink substance covering the front of his dark colored shirt and the top of his dark colored pants. Resident #80 said Staff F, CNA slapped him. Staff F, CNA said he did not slap the resident, Resident #80 slapped himself, and he was care planned for accusing staff of hitting him. The Activities Director was observed asking Resident #80 if he wanted Staff J, Licensed Practical Nurse (LPN) to assist, to which he responded, Yes. Staff J, LPN walked over with the Activities Director and said he had a care plan for vomiting on himself. The Activities Director walked away after Staff J, LPN came to the door of the shower room. Resident #80 was observed saying he wanted the Activities Director to stay with him, but Staff J, LPN responded she could not. Staff J, LPN was observed turning Resident #80 and the wheelchair around, then into the shower room with Staff F, CNA. The resident was not assessed by the nurse for markings or skin changes that may indicate a slap or hit. The shower room door closed with Staff F, CNA and Resident #80 inside and no other staff with them. Staff J, LPN was observed walking away. Resident #80 said loudly, from the shower room, You hit me, and continued to yell unidentifiable words. A review of Resident #80's admission record revealed an admission date of 7/17/25. Further review of the admission record revealed diagnoses to include personal history of traumatic brain injury, other recurrent depressive disorders, major depressive disorder, recurrent, mild, other schizophrenia, other specified persistent mood disorders, psychotic disorder with delusions due to known physiological condition, generalized anxiety disorder, unspecified psychosis not due to a substance or known physiological condition, and cerebral infarction, unspecified. A review of Resident #80's physician orders revealed the following: -Side Effects Monitoring: Agitation, Blurred Vision, Cardiac or Blood Abnormalities, Confusion, Constipation, Dry Mouth, Difficulty Urinating, Disturbed Gait, Drooling, Drowsiness, Headache, Hypotension, Involuntary movement of mouth, tongue, trunk or extremities, N&V [nausea and vomiting], Pacing, Seizure Activity, Stiffness of Neck, Sore Throat, Tremors, Rashes every shift Do not use if any side effects are present or resident appears to be lethargic, drowsy, or sedated. Report change to practitioner if needed., with an order date of 7/17/25. A review of Resident #80's quarterly minimum data set (MDS), dated [DATE], revealed the following: (continued on next page)

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F 0741

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

- Under section C – cognitive patterns, the brief interview for mental status (BIMS) score was eight, indicating he is moderately impaired.

- Under section E – behavior, Behavior not exhibited, was marked under physical, verbal and other behavioral symptoms.

A review of Resident #80's change in condition assessments revealed the following:

- 8/20/25, .increased audio and verbal hallucinations . continues to yell out . Recommendation of Primary Clinician(s) IM [intramuscular] Haldol injection .

A review of change in condition assessments dated 8/2/25, 10/4/25, 12/24/25, and 1/20/26, were not related to behavioral symptom changes or concerns.

A review of Resident #80's assessments from 1/2026 to 3/2026 revealed the following:

- A review of the nursing quarterly assessment, dated 1/20/26, showed no documentation under behaviors.

- A review of the psychosocial history and assessment, dated 2/27/26, showed the following. Change in Mood or Behavior in last 6 months? 1. No Change.

A review of Resident #80's progress notes from 1/2026 to 3/2026 revealed the following:

- 1/1/26, CNA reported resident vomitted [sic] by bed. Noted moderate amount of undigested food. Medicated as ordered.

- 1/5/26, . He is seen today for routine psychiatric follow-up, with the last psychiatric evaluation on 11/11/2025. Since the last visit, the presentation has remained stable without acute concerns. Staff observations during this interval are consistent with an unchanged clinical course, and the current plan is to continue the current medication regimen. Behavior remains cooperative without agitation, sleep problems are not reported, and appetite is noted as normal. Cognition appears consistent with baseline, with orientation to person and place and moderate attention and concentration. **Largely unknown--lot of anxiety and impulse control issues. Schizophrenia, MDD [major depressive disorder], GAD [generalized anxiety disorder], unspecified Mood affective d/o [disorder], other recurrent Depressive d/o, unspecified Psychosis, Seizures, TBI [tramautic brain injury], CI [cerebral infarction] . Attention and concentration are moderate, with deficient fund of knowledge and intact language and associations. Insight and judgment are poor. Behavior : Cooperative . Insight : Poor Judgment : Poor Attention and Concentration : Moderate .

- 1/13/26, Labs received and reviewed results with NP [nurse practitioner]; resident does not exhibit behaviors at this time. No new orders given. All RPs [responsible parties] were notified.

-1/18/26, Resident gives CNA a lot of push back when attempting to deliver care. Yelling out and creating untoward behaviors without warrant. Resident assessed and there are no issues which lead to this behavior.

- 2/4/26, Date of Service: 2026-02-03 . Today, he presents with loud speech and impulsive verbalizations . Summary: He is alert and oriented to person and place. Memory and attention were
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F 0741

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

limited, with deficient fund of knowledge and moderate attention and concentration. Speech was loud, language was intact, and engagement was cooperative with a congruent affect.

- 2/16/26, Date of Service: 2026-02-13 . The patient is being seen by a psychiatric nurse practitioner in a long-term care setting. Since the last visit, he presents for assessment of Gradual Dose Reduction (GDR) and has remained stable and cooperative with care without agitation . Mood appears stable, and there have been no behavioral concerns.

- 3/3/26, Emesis noted in hall in front of resident on floor. Med [medication] given as ordered.

- 3/12/26, Emesis reported and noted of undigested food. Med given as ordered.

- 3/22/26, Date of Service: 2026-03-13 . According to staff, the patient has been stable and cooperative with care, displaying no signs of agitation. The patient has good medication compliance and no reported side effects. Plan: Given the patient's stability and minimal effective dosages of psychotropic medications, a GDR was deemed contraindicated as it could potentially lead to an exacerbation of the patient's psychiatric symptoms and instability. Therefore, all current psych [psychiatric] medications were continued without any changes.

- 3/23/26, The resident is currently on a secure unit with two locked exit doors in place. Resident has short term memory impairment and is unable to recall exit door codes. No recent exit seeking behaviors were observed. No attempts of elopement were noted during recent assessment. IDT [interdisciplinary] met and discussed resident's safety status. Resident will continue to be monitored for exit seeking behaviors. Staff instructed to report any changes in behavior and/ or exit seeking behaviors. MD [medical doctor] notified.

- 3/26/26 psych note, Date of Service: 03/25/2026 . The patient was observed seated in the dining room of the memory care unit and appeared confused but in no acute distress. Due to his cognitive status, history is significantly limited. He is noted to be fidgety during today's examination. The patient is typically observed in his wheelchair wandering the unit hallways. Neurological: Alert and pleasantly confused .

A review of Resident #80's care plan revealed the following

-BEHAVIORAL: The resident is noted with the following behaviors: Difficulty communicating thoughts or needs: Territorial of Personal Space, Picks at and eats scabs from sore or wound. Accuses others of hitting him .when there is no one around. Date Initiated: 08/20/2025 Revision on: 03/30/2026, with interventions to include, .Document episodes of behavior & [and] review to determine the effectiveness of intervention Date Initiated: 03/30/2026.

A review of the behavior task over the last 30 days, for Resident #80, showed daily documentation of, No behaviors observed.

On 3/30/2026 at 11:30 a.m., an interview was conducted with Staff F, CNA. He said Resident #80 bites and scratches himself. Staff F, CNA confirmed he has observed the resident biting himself.

On 3/30/2026 at 11:32 a.m., an interview was conducted with Staff G, Registered Nurse (RN). She said Resident #80 is verbally aggressive with residents sometimes, such as cursing. She said during medication administration if he did not get his medication right away, he would start touching the
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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All over the place. He said he went to the dining area to clean the vomit. He stated Resident #80 had, Throw up all over his clothes from head to toe. He cleaned the resident and assisted him out of the dining room. Staff F, CNA said he told Resident #80 he needed to take a shower as he had a red substance all over him. He said he went to get towels and linens, as well as the residents' clothes. He said he approached the resident who told him, No, no I don't want a shower. Staff F, CNA stated he was leading Resident #80 to the shower room, and described the resident as, Already being dramatic. Being his normal self, and saying he did not want to take a shower. He said he pushed the resident in his wheelchair into the shower room, closed the door, then transferred the resident to the shower chair, and went to turn on the shower. Staff F, CNA said Resident #80 clapped his hands and stated, Ow you hit me, you hit me. Staff F, CNA said he told the resident, [Resident #80] you know I did not hit you. He said the activities director knocked on the door and he told her, [Resident #80] just being [Resident #80] saying I hit him and I didn't. Staff F, CNA said the activities director went to get Staff J, LPN. He said when Staff J, LPN came over Resident #80 was in his wheelchair saying, No, I don't want a shower. He said Staff J, LPN helped him transfer the resident to the shower chair and remove his shirt. He confirmed he provided a shower to the resident and Staff J, CNA was not present. He said Resident #80 told him, Thank you for cleaning me. Staff F, CNA said he assisted with dressing him and the resident asked where his wheelchair was. Staff F, CNA stated, This is what he does every day. He said the residents' behavior was normal for the staff and they were used to it. He confirmed Resident #80 had previously accused him and other staff of hitting him. He said he always notified the nurse when Resident #80 had behaviors. He said most of the staff who worked on the secured unit knew how the resident acted, there was nothing they could do about his behaviors, and they needed to continue to complete their jobs. He said in this situation, he and Resident #80 were not separated because the staff knew how the resident was. He said they would separate the Resident #80 and a staff member the resident accused of hitting him if it was new staff who did not typically work on the unit. He said the resident was loud in group settings such as in the dining room. He stated, He likes to get really loud and rowdy. Staff F, CNA confirmed Resident #80 bites himself, hits things, and scrapes his hands against the wheelchair. On 3/31/2026 at 4:35 p.m., a telephone interview was conducted with Staff J, LPN. She stated Resident #80 yells a lot and, Says someone is hitting me. She said he will accuse staff and residents of doing something, such as hitting him, or taking his items. Staff J, LPN stated when he makes the accusations, Most of the time there's no one around him. She said this was his behavior at a previous facility as well. She stated, If he didn't say it, I would think something is wrong with him, as he said it multiple times a day. She confirmed the resident has previously accused her of hitting him. Staff J, LPN said when Resident #80 makes the accusations she checked to make sure, but typically there was no one there. She said on 3/30/26 the resident has finished his meal, and he wheeled himself out of the dining room. She said she did not see any interaction between Staff, F, CNA and Resident #80. When asked if she was present in the shower room after the resident alleged that Staff F, CNA hit him, she said may have taken a step in but did not stay there. She said she observed Staff F, CNA put Resident #80 in the shower chair and she left. She said she was in the shower room for a few seconds. Staff J, LPN said they did not separate the resident and the CNA because that was Resident #80's normal behavior. Staff J, LPN said when he first came to the secured unit, she went to the MDS staff to care plan his behavior of accusing staff and residents of hitting him. She confirmed they had not initiated a care plan for his behaviors until yesterday. Staff J, LPN said typically when a resident had behaviors, she communicated with the MDS staff. She said she was not sure where the scabs on his arms came from, but they wrap his arms and Resident #80 removes them. She confirmed he picks at his scabs. On 4/2/2026 at 10:49 a.m., a telephone interview was conducted with Staff U, Psychiatry (Psych) (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Advanced Practice Registered Nurse (APRN). She said Resident #80 had been seen on a monthly basis and at times more than monthly, about two times a month, by psych services. She said she took over for another psych provider about three to four weeks ago. She said she saw Resident #80 briefly on the secured unit. Staff U, Psych APRN had a history of confusion, anxiety, and impulse control issues. She said she had not heard of any behaviors since she has taken over and there have been no concerns about his behaviors communicated to her. She said she was on the secured unit on 3/31/2026 and the nurses did not have any concerns about Resident #80 that past week. She said even if she was not there to see Resident #80, she rounds and asked the nursing staff about the residents. Staff U, Psych APRN said she relied on staff, especially if the resident was confused, as they have direct contact and know about acute changes. She said it was her expectation that staff communicated with her about residents' behaviors. Staff U, Psych APRN stated she reviewed past documentation, from August 2025, for Resident #80 and, Did not see anything standing out. She said she should have been made aware of Resident #80 eating/ picking his scabs and accusing staff and residents of hitting him. She said she encouraged nursing staff to document when a resident had behaviors, especially if they are completing medication changes, and preferred documentation in real time. She said all behaviors should be documented, including new behaviors, as it could be a medical and/or psychiatric concern. She said when she is told something verbally, she will look at the chart but sometimes did not see the documentation. She stated, I like for it to be documented so it correlates with what I see. On 4/2/2026 at 11:18 a.m., an interview was conducted with Staff K, LPN/Clinical Reimbursement Specialist (CRS) and the Clinical Reimbursement Director (CRD)/RN. Staff K, LPN/CRS said through the nursing staff was how they received communication to make changes to a resident's care plan. The CRD/RN said if a resident had behaviors, they expected the nursing staff to communicate that information. Staff K, LPN/CRS said they reviewed progress notes to identify if a resident was having behaviors and required an update to the care plan. She said staff would communicate directly or document the behaviors and she would update the care plan. Staff K, LPN/CRS confirmed a recent update to Resident #80's care plan that occurred on 3/30/2026. She said the nurse informed her Resident #80 was accusing others of hitting him when no one was around. She stated she did not know about the resident's behavior of accusing staff but knew, He has fluctuating behaviors. The CRD/RN confirmed she was not aware of the behaviors prior to 3/30/26. On 4/2/2026 at 2:02 p.m., an interview was conducted with the NHA and the Director of Nursing (DON). They both confirmed they were not aware that Resident #80 had a behavior of making accusations towards staff and resident until after interviews about the incident on 3/30/2026. The NHA said the expectation when staff responded to an allegation of abuse is making sure the resident was safe, intervening, and not let the action continue. She said for an allegation of abuse between a staff member and a resident, the expectation was for staff to separate themselves from the situation. The NHA and DON confirmed Resident #80 should not have gone back into the shower room with Staff F, CNA. They both said they were not aware Staff F, CNA went back into the shower room with the resident. The NHA said the CNA needed to be removed and staff should have sure the resident was safe. The DON said the nursing staff should have documented in a note that Resident #80 had a behavior of accusing staff and residents when no one was around and there was no physical contact. She stated, That's when the care plan needed to be updated. She confirmed if Resident #80 had behaviors previously, the care plan should have been updated. The DON said any behaviors, such agitation, hitting, kicking, or biting, can be documented as a free text in the behavior monitoring on the medication administration record. She said nursing staff have their own behavioral task, or they could write a behavioral progress note. She stated, That's when they catch the data and update the care plan. The DON said I was important to document the residents' behavior because it was helpful for (continued on next page)

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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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychiatry staff to know when they are evaluating medications and side effects. 2. During multiple observations on 03/30/2026 thru 04/02/2026 residents located on the secure unit (300 Unit) residents remained confined to the secure unit and were not observed accessing outdoor activities or opportunities for time outside. During an observation on 03/30/2026 at 9:45, Resident #62 was observed in a room of three male residents with the door closed. Resident #62 moved around the room slowly, appearing confused but calm, Resident #62 opens drawers and looks through personal belongings on the bedside tables and dressers. During an observation on 03/30/2026 at 9:53 a.m., Staff were observed in the dining room with residents and sitting at the nurse's station. During an observation on 04/01/2026 at 9:43 a.m., Resident #62 was observed in a room of three male residents. Resident #62 was observed opening nightstand drawers and looking through personal belongings on the bedside tables and dressers. During an observation on 04/01/2026 at 9:54 a.m., Staff were observed in the dining room with residents and sitting at the nurse's station. Review of Resident #62's admission record revealed an admission date of 02/06/2023. Resident #62 was admitted to the facility with diagnosis to include unspecified dementia, unspecified severity, with anxiety, primary insomnia, mood disorder due to known physiological condition, major depressive disorder, recurrent, mild, other specified persistent mood disorders, pseudobulbar affect, anxiety disorder, and bipolar disorder. Review of Resident #62's Minimum Data Set (MDS) dated [DATE] revealed, Section C. Cognitive Patterns, Brief interview mental status of 01 out of 15 indicating severe cognitive impairment. Review of Resident #62's Care Plan dated 02/06/2023 revealed: Behavioral: The Resident is noted with the following Behaviors: Combative with staff at times, will yell and screams out. Diagnosis of dementia with behaviors. Resident wanders at times. Has the potential to hit others, yells and curses at others, enter others personal space and can be exit seeking at times. Sexually inappropriate at times. Can be destructive with furniture/surroundings. Making repetitive motions, rummages through stuff, and can appear sad or tearful. Physically aggressive towards others, expresses frustration/anger, threatens others and becomes easily agitated. Interventions: Observe/document for side effects and effectiveness. Document episodes of behavior and review to determine the effectiveness of intervention. Observe for changes and behavior and report to physician ie; insomnia, nervousness, loss of interest, decreased ability to concentrate, repetitive movements. Focus: (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Elopement Risk: Resident is at risk for elopement. Resident #62 has cognitive impairment and is independently mobile. Interventions: . If the residents wondering, offer frequent rest and snacks if indicated . Review of task Behavior Monitoring and interventions dated 03/20/2026 thru 04/02/2026 revealed no behaviors were marked. 3. During an observation on 03/31/2026 at 10:00 a.m., Resident #8 was observed carrying a yellow gift bag, yelling at Staff J, RN, stating I know you have it. Just give me my money. Staff J stated She does this, she always wants me to give her money. Review of Resident #8's admission record revealed an admission date of 11/24/2025. Resident #8 was admitted to the facility with diagnosis to include major depressive disorder, recurrent, moderate, generalized anxiety disorder, and unspecified dementia, unspecified severity, with agitation. Review of Resident #8's Quarterly MDS dated [DATE] revealed, Section C. Cognitive Patterns, a BIMS of 02 out of 15 showing severe cognitive impairment. Review of Resident #8's care plan dated 06/24/2026 revealed: Focus: Behavioral: The resident is noted with the following behaviors: Agitation . sits on floor at times. Interventions: . observe/document for side effects and effectiveness. document episodes of behavior and review to determine the effectiveness of intervention Focus: Mood: The resident has a mood problem related to crying, tearfulness Interventions: . observe/document for side effects and effectiveness Review of Resident #8's task for Behavior monitoring and interventions for 14 days revealed no behaviors was marked. 4. During an observation on 03/30/2026 at 11:56 a.m., Resident #34 was observed sitting at a table in the dining room of the secure unit (300 unit). Resident #34 was observed attempting to scoop food off (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of his plate and dropping it onto the table. During an observation on 04/02/2026 at 11:46 a.m., Resident #34 was observed sitting at a table in the dining room of the secure unit (300 unit), scooping food off of his plate, and feeding himself. Review of Resident #34's admission record revealed an admission date of 02/24/2026. Resident #34 was admitted to the facility with diagnosis to include unspecified sequelae of cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, unspecified protein-calorie malnutrition, other lack of coordination, dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance, muscle wasting and atrophy, not elsewhere classified, multiple sites, muscle weakness (generalized) , anxiety disorder, mood disorder due to known physiological condition with mixed features, generalized anxiety disorder and other psychotic disorder not due to a substance or known physiological condition. Review of Resident #34's Entry MDS dated [DATE] revealed, Section C. Cognitive Patterns, a BIMS of 02 out of 15 showing severe cognitive impairment. Review of Resident #34's care plan dated 10/27/2025 revealed: Focus: NUTRITIONAL: The resident has a potential nutritional problem related to history of dysphagia, protein calorie malnutrition, anemia, dementia and significant weight loss. Mechanically altered diet. Interventions: Assisted Dining . Observe/ document as indicated: meal Consumption, amount assistance needed with meal, tolerance to diet/fluids . 5. During an observation on 03/30/2026 at 11:53 a.m. Resident #61 was observed sitting a table in the dining room of the secure unit (300 Hall). Resident #61 was observed feeding herself with no assistance. Review of Resident #61's admission record revealed an admission date of 03/18/2025. Resident #61 was admitted to the facility with diagnosis to include metabolic encephalopathy, dementia and other diseases classified elsewhere major depressive disorder altered mental status in unspecified convulsions. Review of Resident #61's Quarterly MDS dated [DATE] revealed Section C. Cognitive Patterns, a BIMS of 0 out of 15 showing severe cognitive impairment. Section GG. Functional Abilities revealed eating, Resident #61 was dependent meaning helper does all of the effort. Resident does none of the effort to complete the Activity. Or the assistance of two or more helpers is required for the resident to complete the activity. Review of Resident #61's care plan dated 03/18/2025 revealed: Focus: (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ADL: resident 61 has an ADL self-care performance deficit/cognitive deficit, may wander from task, poor focus on tasks assist for thoroughness, weakness, may require more assistance than allowing staff to render, self performance level need fluctuate throughout the course of the day. Intervention: . eating dependent assist of 1 . During an interview on 03/30/2026 at 3:01 p.m, Staff R, CNA, stated there is normally three aides and one nurse. Today there is only two aides and a nurse because one of the aides got sent home. It can be challenging during lunch time. We have 20 residents assigned to us and our residents are very much hands on. You saw how lunch went, we have to pass lunch trays and the residents who need assistance with meals must wait to be eat because we can't help them until we have [NAME] all the lunch trays. During an interview on 04/01/2026 at 12:00 p.m., Staff J, LPN stated we only document behaviors like resident to resident or sexual behaviors. We don't document behaviors if they are behaviors the residents always have. We have one resident who always yel

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interviews and record review, the facility did not ensure pharmacy recommendations related to labs were completed for one resident (#13) out of five residents reviewed. Findings include:A record review of Resident #13's Medication Regimen Review (MMR) from 01/01/2026 - 01/08/2026 showed the following recommendation for the Nursing staff: The resident is no longer receiving drug therapy requiring lab monitoring. Please consider discontinuing the following lab orders: RECOMMEND DC [discontinue] LITHIUM LEVELS (MED DC'D) [medication discontinued] dated 01/08/2026. A further review of the documentation showed a column to the right labeled Follow-Through. The recommendation showed a hand-written note Done. A record review of Resident #13's MMR (Nursing Recommendations) dated 3/01/2026-3/05/2026 showed the following recommendation for the nursing staff: This resident is no longer receiving drug therapy requiring lab monitoring. Please consider discontinuing the following lab orders: RECOMMED TO DC LITHIUM LEVELS (MED DC'D) dated 3/05/2026.A record review of Resident #13's lab results showed the following lab results for Lithium: 10/13/2025 L <0.1010/28/2025 L<0.1012/29/2025 L<0.10 01/28/2026 L <0.1003/27/2026 L <0.10A record review of Resident #13's physician orders showed an order for Lithium Carbonate oral capsule 300 mg (milligrams) to give one capsule by mouth one time a day for MOOD DISORDER, ordered on 6/14/2025 and discontinued on 12/12/2025.A record review of Resident #13's admission Record showed an admit date of 02/26/2016 with a readmission date of 8/29/2022 with medical diagnoses to include but not limited to: other persistent mood disorders, undifferentiated schizophrenia, generalized anxiety disorder, unspecified psychosis not due to a substance or known physiological condition.A record review of the progress notes for psychiatric services dated 12/12/2025 under the section labeled Assessment/Plan showed the following: -Other Specified Persistent Mood Disorders- continue lithium 300 mg PO (oral) daily, Last lithium level was very low and patient has been stable. Will consider restarting if patient mood destabilizes.A record review of the progress notes for psychiatric services dated 3/13/2026 under section labeled Interval History showed the following: The patient's current psychotropic medications were reviewed and assessed for the need for any changes or adjustments. According to the staff, the patient has been stable and cooperative with care. There has been no reports of behavioral disturbances, anxiety, or agitation. The patient's behavior has been stable and uneventful. Medication compliance is good and no side effects have been reported or evidenced.On 4/02/2026 at 5:03 p.m., a telephone interview was conducted with the consulting pharmacist. The consulting pharmacist stated her recommendations were based on her record review of Resident #13. The consulting pharmacist stated the resident was getting lithium level labs every month but did not see an order for the medication. She stated it was an unnecessary lab order. The consulting pharmacist stated she wrote her first recommendation on 01/08/2026, saw the lab continued the next month during her recommendations prompting a second recommendation in February. The consulting pharmacist stated she rewrote her recommendation on March 5th to discontinue the lithium lab based on the fact the medication was discontinued and/or not reordered. On 4/02/2026 at 5:15 p.m., an interview was conducted with the Director of Nursing (DON). The DON acknowledged the consulting pharmacist recommendations. The DON stated there may have been some confusion over the lab orders because there were two orders, one for monthly lithium labs and the other was for every three months lithium lab order. The DON stated both orders have now been discontinued. A review of the facility's policy titled, Medication Monitoring Medication Regimen Review and Reporting, 2007, showed the following policy statement: Medication Regimen Review (MRR) or Drug Regimen Review is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risk associated with medication. The MRR includes review of the medical record in order to prevent, identify, report, and resolve medication related problems, medication errors, or other irregularities. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MRR also includes collaborating with other members of the IDT, including the resident, their family, and or resident representative.2. The consultant pharmacist reviews the medication regimen and medical chart of each resident at least monthly to appropriately monitor the medication regimen and ensure that the medications each resident receives are clinically indicated. Identification of irregularities may occur by the consultant pharmacist utilizing a variety of sources including medication administration records (MAR), prescribers orders, progress notes, nurses notes, the Resident Assessment Instrument (RAI), Minimum Data Set (MDS), laboratory and diagnostic test results, behavior monitoring information and information from the nursing care center staff and other health professionals involved in the resident's care.6. Resident specific MRR recommendations and findings are documented and acted upon by the nursing care center and or physician.8. The nursing care center follows up on their recommendations to verify that appropriate action has been taken. Recommendations should be acted upon within 30 calendar days or per facility specific protocols.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations and record review, the facility did not ensure outside physician appointments were arranged/scheduled in a timely manner for one resident (#5) out of two residents reviewed.Findings included:On 3/31/2026 at 9:30 a.m., an interview was conducted with Resident #5 in his room. Resident #5 stated he had missed an outpatient appointment for an ophthalmologist. Resident #5 pointed to his right eye and stated he needs to be seen by his eye doctor for his vision. An observation was made of the resident's appointment card scheduled for 01/16/2026 at 12:10 p.m. for an ophthalmologist appointment. Resident #5 stated he also missed his monthly urologist appointment for the month of March. Resident #5 stated he had a suprapubic catheter in which he sees the urologist monthly.On 3/31/2026 at 2:39 p.m., an interview was conducted with Staff T, Registered Nurse/Unit Manager (RN/UM)for the 100 hallways. Staff T, RN/UM stated she is new to the role of unit manager and was not familiar with the process of arranging appointments and deferred to her Assistant Director of Nursing (ADON). Staff T, RN/UM stated there is a transportation binder for outpatient appointments. An observation was made for the month of March without an entry for Resident #5 for any appointments. On 3/31/2026 at 2:42 p.m., an interview was conducted with the ADON. The ADON stated the nursing staff will arrange the follow-up appointments or referrals, and the medical records staff will arrange the transportation. The ADON stated if the medical record staff member is out, arrangements for transportation will default to the nurses.On 4/01/2026 at 8:20 a.m., the transportation log was reviewed for the months of January and February. There were no entries observed for Resident #5. A record review of Resident #5's progress notes showed the following:-01/12/2026- The resident has returned from his urology appointment with a follow up appointment scheduled for February 2, 2026, at 13:45 (1:45 p.m.), no new orders. The resident is his own responsible party and is aware.-01/16/2026- The resident declined to attend his scheduled ophthalmology appointment. The resident was educated on the risk vs. benefits associated with such appointments and confirmed their comprehension; however, they maintained their refusal. A new appointment has been arranged for February 2nd at 11:00 a.m. The MD (Medical Doctor) has been notified; the resident is his own responsible party.A review of Resident #5's progress notes dated 3/30/2026 from his nurse practitioner showed the following:-Missed recent urology appointment due to transport issues.-Recommend rescheduling urology [NAME]-up appointment as neededMonitor for recurrent infection given history of recurrent UTIs.On 4/01/2026 at 2:13 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated when outside appointments or referrals are made, the unit manager will make the appointment, contact the medical record staff responsible for arranging transport, and notify the resident and/or resident responsible party. The DON stated the request for the appointment will be transposed into the Medication Administration Record (MAR) for the nursing staff to view. The DON stated, on the night prior to the appointment, the nurse will print the appropriate documents for the resident's appointment, verify transportation and notify resident of the following day's appointment(s). The DON acknowledged the process did not get the outcome expected for Resident #5 and would be rectified.A review of the facilities policy titled, Resident Rights, effective August 2025, showed the following policy statement: the facility strives to ensure that each resident has a dignified existence, self- determination, and communication with, and access to, persons and services inside and outside the facility. The facility will protect and promote the rights of each resident. The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility and exercising his or her rights and to be supported by the facility in the exercise of his or her rights.