STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105812	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Care of Avon Park	1213 W Stratford Rd Avon Park, FL 33825

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide supervision to prevent resident to resident abuse for two (#2 and #3) of eight sampled residents. Findings included: A review of Resident #2's clinical chart, the admission record, documented an admission of 06/13/2024, readmission [DATE]. The diagnoses list included but not limited to: abnormalities of gait and mobility, muscle weakness, need or assistance with personal care, and type 2 diabetes mellites without complications. A review of a Brief Interview for Mental status (BIMS) assessment, dated 02/10/2026, documented a score of 15 which indicated the resident was cognitively intact. An observation conducted on 02/19/2026 at 9:38 a.m. of Resident #2, in the resident's room. Resident #2 was observed in bed, her eyes closed, sheet up to her shoulders, sleeping. A second observation was conducted at 11:45 a.m. of Resident #2, in bed sleeping. Her roommate stated the resident has been in and out sleeping, she still is not feeling well. A review of Resident #3's clinical chart, documented an admission of 02/21/2025 with the diagnoses list included but not limited to: unspecified mood (affective disorder); depression, unspecified; unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. A review of a BIMS assessment, dated 10/16/2025, documented a score of 6 which indicated severe impairment. An observation conducted on 02/19/2026 at 9:43 a.m. of Resident #3, in her room, in bed. Staff A, Certified Nursing Assistant (CNA), was observed in the room. She was interviewed and stated she was providing 1:1 supervision for Resident #3. A review of Resident #3's care plan revealed: Category: Behavioral Symptoms, problem start date, 02/24/2025.(Resident #3) has displayed behaviors of verbally and physically threatening the staff and other residents, physically [sic] altercations with staff, yells at times, refuses showers/bed bath, refusing medications/accucheck and refusing care/vitals/labs, aggressive and hits others, using profanity and pilfers through nurses' desk and taking others snacks and taking things off of the nurses carts. Approaches included:Approach start date, 02/03/2026: 1:1 sitterApproach start date, 11/03/2025: offer snacks of choice when able.Approach start date, 07/25/2025: distract her by offering changes in environment, encourage activity she likes.Approach start date, 07/25/2025: redirect resident to another area away from others, and talk with her, attempt to calm her down. Category: Cognitive Loss/ Dementia, problem start date, 02/24/2025.ST (short term)/ LT (Long Term) member loss and impaired decision-making ability related to diagnosis (dx) of dementia Approaches included:Approach start date, 02/24/2025: Reorient as needed.Approach start date, 02/24/2025: Observe and document behavior.Approach start date, 02/24/2025: Offer diversional activities. A review of Resident #3's physician orders revealed: Behavior monitoring for the use of Depakote dx mood instability due to -Mood swings, aggression, start date 06/19/2025. Special instructions: Interventions codes for psychoactive meds:7=give food8=give fluids10=encourage rest A review of Resident #3's Treatments Administration History for 01/01/2026 -01/31/2026, the order for Behavior monitoring for the use of (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Depakote, revealed no documentation of type of behavior, but documented interventions on the following dates:01/02, 6 a.m. codes 7, 8, 1001/22, 6 a.m. codes 7, 8, 1001/29, 6 a.m. codes 8, 1001/30, 6 a.m. code 10 On 02/19/2026 at 1:20 p.m. an interview was conducted with the Minimum Data Set (MDS) Coordinator I, Registered Nurse (RN) and MDS Coordinator II, Licensed Practical Nurse (LPN). MDS Coordinator I, RN stated she was familiar with Resident #3. MDS Coordinator I, RN said She [Resident #3] does her own thing. I have not had any problems with her. I know she has a past history of psych diagnosis. I know she had behaviors. She could be verbal and cuss. MDS Coordinator I, RN stated, the nursing staff for a long-term resident will document a weekly note regarding behavior; if something else were to happen, they could document in the progress notes additionally. Resident #3 did have the behavior monitoring for Depakote. MDS Coordinator II, LPN said, for (Resident #2) She came back with a fracture. Currently, I think they tested her [Resident #2] for the flu, may have been negative; she is usually up. MDS Coordinator II, LPN said, Resident #3 has been having 1:1 with staff due to verbal aggression, and try to re-direct. If Resident #3 is in the atrium and gets in her verbal we do try to redirect; ask her if there is something else. For the monitoring of behavior, both MDS Coordinator I, RN and MDS Coordinator II, LPN, stated the (electronic clinical record) captures the monitoring of mood instability, although does not capture the specific type of behavior exhibited. Both confirmed Resident #3 was exhibiting some kind of behavior on the dates reviewed of the 01/2026 Treatment Administration History because interventions were documented. Neither one could state what the behaviors were. A review of the facility's Abuse and Neglect log documented an allegation of Physical Abuse, 02/03/2026 for Resident #2 and #3. An interview was conducted on 02/19/2026 at 12:15 p.m. with Staff A, CNA. Staff A stated she had not been here at the time of the event on 02/03/2026 but had been working the prior shift. Staff A stated the event had happened in the east wing atrium. Staff A stated Resident #2's room number (#) and Resident #3's room number (#), which were on the same assignment. Staff A stated Staff C, CNA, was the aid for both residents, they were in her section. Staff A stated Staff D, LPN had Resident #3 on her assignment that day from 7:00 a.m. until 7:00 p.m. and then Staff E, LPN, came in at 7:00 p.m. Staff A stated Staff F, LPN had Resident #2 until 7:00 p.m. and then Staff B, Registered Nurse (RN) came in for that assignment. When Staff A was asked about Resident #3 and if she had behaviors, she stated, No physical behavior, but she would pick, verbally. We always had to keep (Resident #3) away from other residents because of her talk. I try to sit the resident with enough space. She has had altercations with other residents, not physical, but verbal. To the point of having to separate them. That particular day, (Staff C, CNA) had brought (Resident #2) out of the shower. She was in a wheelchair (w/c). Then (Resident #2) came to the west wing nurses' station. I was sitting at west wing nurses' station with (Staff D, LPN), she was there charting. She (Resident #2) was complaining that (Resident #3) had stole her ritz crackers. This was 3:30-4:00 p.m. (Staff D, LPN) was telling (Resident #2) there was no way (Resident #3) had taken anything-she was in bed. When she (Resident #3) is in bed like that, she will normally get up 5:30-6:30, suppertime. She uses a w/c to self-propel from one location to another. I left about 5:30 p.m. On 02/19/2026 at 12:45 p.m. and at 1:53 p.m., an attempt to phone and interview Staff C, CNA was conducted with no return call received during the survey. On 02/19/2026 at 12:50 p.m. and 1:54 p.m., an attempt to phone and interview Staff E, LPN was conducted with no return call received during the survey. On 02/19/2026 at 3:10 p.m., an attempt to phone and interview Staff B, RN was conducted. A return phone call was received at 4:25 p.m. and Staff B was interviewed. Staff B, RN stated for the 02/03/2026 event, she had been sitting at the nurses' station and I heard (Resident #2) crying. I saw (Resident #2) in her w/c. She was not on the floor. I separated the residents. (Resident #3) rolled away. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff B, RN stated informing the Director of Nursing (DON) of the event. Staff B, RN said, Resident #2 told me her shoulder was hurting. When asked if she assessed Resident #2, Staff B, RN said, I just stayed there while calling the DON. Staff B, RN stated Resident #2 just continued to state, my shoulder was hurting. Staff B, RN said she did not see or hear anything. Staff B, RN said I was at the east wing nurses' station. (Resident #3) was on the west wing. I was not her assigned nurse. I just heard (Resident #2) crying, asking for help. 02/19/2026 at 4:49 p.m., an interview was conducted with Resident #8. Resident #8 confirmed she had witnessed the event between Resident #2 and Resident #3. Resident #8 stated Resident #3 had kicked her [Resident #2] down. Resident #2 fell on her left side. Resident #2 got up and sat back into her wheelchair. Resident #8 said the facility asked me what happened, I told them. Resident #8 said no staff were around when it happened. An interview was conducted on 02/19/2026 at 2:08 p.m. with the DON, she stated there was an event on 02/032026, at 8:00 p.m., a physical abuse allegation. The residents involved were Resident #2 and Resident #3. It happened in the east atrium, the common area with the television in front of the nursing station. When asked if there were witnesses to the event, the DON stated, there was a resident, Resident #8. Staff assigned to the resident was Staff B, RN and Staff C, CNA. The DON stated only received written statements from Staff B, RN and Staff C, CNA. The DON read the written statements which were undated and unsigned. The DON read: DON interviewed resident (Resident #3) on 02/03/2026 with officer: stated that she pushed a lady but couldn't remember her name. Stated that they got into a verbal altercation.DON interviewed (Resident #2) on 02/06/2026 and 02/09/2026 stated that she was walking behind her wheelchair and (Resident #3) kicked her causing her to fall.DON interviewed (Resident #8) on 02/04/2026 and stated she was sitting with (Resident #2) when (Resident #3) came up in w/c. They both called each other derogatory names. Both stood up from wheelchairs, and (Resident #3) kicked (Resident #2) in the chin (shin) causing her to fall.DON interviewed Staff B and stated that she was at nurses station on phone with hospital around 7:59 pm giving report when she witnessed (Resident #2) sitting at table.CNA (Staff C) stated she saw (Resident #2) around 7:40 p.m. in atrium and (Resident #3) on opposite wing at approximately 7:50 p.m. The DON confirmed she did not obtain written statements from staff. The DON stated, Staff B, RN called me at 8:03 p.m., I came to the facility, here about 8:10 p.m. or 8:15 p.m. The DON stated during the event Staff B, RN was on the phone; she did not hear anything; she was sending another resident out to the hospital; she did not hear anything until Resident #2 was yelling from the floor. The DON stated she interviewed Staff E, LPN, she was on west wing, passing her medication. Staff E, LPN was assigned to the two residents. No statement was obtained, from Staff E. When the DON was asked where Staff C, CNA was at the time of the event, she stated she was in a room. The DON confirmed she had not obtained a statement from Staff C. When asked if there was anything preceding this event, the DON stated, they used to be roommates, they did not get along. Resident #2 asked to be moved. I know we moved Resident #3 out of the room. For the investigation, the DON stated, I interviewed staff on the shift. I interviewed the resident who witnessed. I interviewed both of the residents, involved. Reviewed Resident #3's record 60 days back including, lab, md (medical doctor) notes, which revealed we had done a GDR (gradual dose reduction) on (Resident #3) the month preceding for Depakote (a psychotropic medication). The decrease was from 500 mg (250, 2 x per day) per day to 375 (250 hs (evening) and 125 a.m.) per day. Psych recommended the dose reduction. When asked if psych requested any monitoring, the DON said, She [psch provider] just said to continue to monitor for behaviors ie., agitation, mood swings, striking out. Psych came back and saw her [Resident #3] 02/05/2026, and documented the Depakote was recently reduced. No changes were made to Resident #3's medications. The DON continued about the 02/03/2026 event, she stated, Resident (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#2 was immediately assessed by the nurse, Staff B, RN. The resident complained of pain left arm. The nurse called EMS (emergency medical services), and the doctor. When I came in, EMS was already here; I notified DCF (Department of Children and Families) online; called the Sherrif department. Called both families. Resident #3 was placed on 1:1. Resident #2 returned to the facility on 02/07. She had fractured her left shoulder; she had an immobilizer on. A review of the Psychotropic Medication Use policy and procedure, reference #6008, non-dated, documented the definition: Psychotropic drugs-any drug that affects brain activities associated with mental processes and behavior. Thes drugs include but are not limited to drugs in the following categories: Anti-psychotics; Anti-depressants; Anti-anxiety; and hypnotics. The policy included:. Residents of the facility who are prescribed a psychotropic medication shall be monitored. A review of the facility's policy and procedure for Abuse, effective 06/2000, last revised 02/19/2021, documented: The facility maintains that all Residents have the right to be free from neglect and exploitation and prohibits the mistreatment, neglect, and abuse of residents/ patients and misappropriation of resident/ patient property by anyone including staff, family, friends, etc. The facility has designed and implemented processes which strive to ensure the prevention and reporting of suspected or alleged. The facility acknowledges the following definitions: they are not intended as all-inclusive but as examples to assist in the immediate identification and reporting of abuse and/ or neglect.Abuse: . Deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.Misappropriation of Resident / Patient Property .Verbal Abuse: Oral, written, or gestured language that includes disparaging and derogatory terms to the resident/ patient or their families or within their hearing distance, to describe residents/ patients, regardless of their age, ability to comprehend or disability.Physical abuse: Includes hitting, slapping, pinching, scratching, spitting, holding roughly, etc. it also includes controlling behavior through corporal punishment.PreventionIn order to identify, correct and intervene in situations in which abuse, neglect and/ or misappropriation of resident property is more likely to occur, the facility will analyze and:Deploy sufficient number of staff on each shift to meet the needs of the residents, assuring that staff assigned have knowledge of the individual resident's care needs. Staffing is to be determined to the number of beds and resident acuity level.Staff is to be observant of residents daily for any changes that would trigger abusive behavior, and residents are to be reassessed routinely by an interdisciplinary team which includes the primary care giver at Risk Management Meeting though the interdisciplinary care planning process.3) Prevention:. b. Identify, correct, and intervene in situations where abuse, neglect, and / or mistreatment are more likely to occur. This includes, but is not limited to,Identification/ analysis of:*Secluded areas of the facility.*Sufficient staffing on each shift to meet the needs of Residents/ patients.*Assigned staff demonstrating knowledge of individual resident/ patient needs.*Sufficient and appropriate supervisory staff to identify inappropriate behaviors.*Residents/ patients with needs and behaviors which might lead to conflict or neglect. 5) Protection:Provide for the immediate safety of the resident/ patient upon identification of suspected abuse, neglect, mistreatment, and/or misappropriation of property. Means of providing protection include, but are not limited to:Moving resident/ patient to another room or unitProvide 1:1 monitoring as appropriate.Investigation: . b. Obtain witness statements if possible/ applicable.Conduction an Investigation.4. Develop a list of known and possible witnesses-to the alleged incident. Interview and obtain signed statements from each staff or resident separately. Interview staff that cared for the resident(s) at the time of the alleged incident; Interview staff on other shifts that may have (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	seen or heard anything, such as 24: hours prior to the alleged incident.Federal Immediate (2 hr) / 5-Day Reporting Requirements:Definitions:Definitions used in this document are based on federal regulations and guidelines as well as state law.Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, and/ or mental anguish.Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. An incident involving a resident who willfully inflicts injury upon another resident should be reviewed as abuse. Even though a resident may have a cognitive impairment, he/she could still commit a willful act, however there are incidents when a resident's willful intent cannot be determined, in those cases, a resident-to-resident altercation should be reviewed as lack of supervision. In extreme situations, this would be reportable under neglect.E.) Intent- The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents. Each resident has the right to be free of mistreatment, neglect and misappropriation of property. This includes the facility identification of residents, whose personal histories render them at risk for abusing other residents and development of intervention strategies to prevent occurrences, monitoring for changes that would trigger abusive behavior and reassessment of the interventions on a regular basis.In support of our mission to ensure the provision of quality health care, the facility will analyze all events in an attempt to determine the cause of the event.