STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106041	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbourwood Post-Acute and Rehabilitation Center	549 Sky Harbor Dr Clearwater, FL 33759

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48441 Based on interviews and record review, the facility failed to report and thoroughly investigate an allegation of abuse in a timely manner for one resident (#31) out of three residents sampled. Findings included: A review of Resident #31's Admission Record showed an admitted [DATE] with a diagnoses to include Alzheimer's disease, contracture of right knee, contracture of left knee, age-related nuclear cataract, bilateral, unspecified dementia, unspecified severity, without behavioral, psychotic, mood, and anxiety disturbances, brief psychotic disorder, cognitive communication deficit, and history of falling. A review of Resident #31's Minimum Data Set (MDS), Section GG- Functional Abilities, showed the resident dependent for eating, toileting, hygiene, shower/bathe, dressing upper and lower body and personal hygiene. Resident #31 was dependent for mobility to roll left to right or from sit to lying in bed. Resident #31 had not attempted due to medical condition or safety concerns checked for chair/bed to chair transfer. On [DATE] at 3:06 p.m., an interview was conducted with the Nursing Home Administrator (NHA) and the Director of Nursing (DON). The DON stated she had received a phone call Friday the 27th of December approximately 6:00 p.m. from Staff M, Licensed Practical Nurse (LPN). Staff M, LPN informed the DON of an alleged abuse scenario where Resident #31 was struck by Staff R, Certified Nurse Assistant (CNA) approximately two weeks ago. Staff M, LPN stated Staff N, CNA stated the information to her via her personal cell phone minutes prior to calling the DON. Staff M, LPN stated Staff N, CNA will be calling the DON to give her testimony to the events of alleged abuse. The DON stated Staff N, CNA was calling her the same time Staff M, LPN was calling her and took Staff M's call first. The DON stated it was a short conversation between her and Staff M, LPN. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON stated she had a telephone conversation [DATE] with Staff N, CNA after her brief phone call from Staff M, LPN informing her of an alleged abuse to Resident #31. The DON stated she talked to Staff N, CNA and took her statement. Staff N, CNA told the DON she received report from Staff R, CNA and noticed a scrape Resident #31's nose and asked Staff R, CNA if the resident had a fall. Staff N said Staff R, CNA stated to her she hit the resident because he would not let go of her. The DON asked Staff N, CNA if she had reported this allegation to anyone at time and Staff N, CNA stated she had not. The DON asked Staff N, CNA why she had not reported this allegation and Staff N, CNA stated she was in fear of retribution from Staff R, CNA. The DON stated there was a connection of Staff N's child to Staff R's family. The DON stated after she had informed the NHA/Abuse Coordinator, she called Staff R, CNA. Staff R, CNA stated she had provided care for Resident #31 on a couple of occasions. Staff R, CNA denied any inappropriate physical acts towards Resident #31. Staff R, CNA stated the resident was not combative with her. Staff R, CNA told the DON an incident occurred approximately two weeks ago when she provided care for Resident #31 and he hit his face on the side rails and sustained an injury. Staff R, CNA stated Resident #31 sustained a skin tear to the bridge of his nose and immediately reported to the nurse supervisor, which the DON stated would have been Staff E, LPN/Supervisor. The DON stated Staff R, CNA was suspended pending the investigation. Staff N, CNA was not suspended and was allowed to work her normal hours as a weekend staff member. The DON stated she interviewed Staff E, LPN/Supervisor to verify she placed a note regarding the incident to Resident #31's medical record. The DON stated Staff E, LPN/Supervisor stated someone told her about the skin tear to the bridge of his nose but she could not recall who told her. The DON stated they interviewed seven residents in the same vicinity as Resident #31 and all the residents denied any concern of abuse. The NHA stated he completed the reporting side of the allegation. He contacted law enforcement on [DATE] at 7:57 p.m., and the Department of Children and Family Services (DCF) via their portal at 7:53 p.m. The NHA stated law enforcement arrived at the facility, visited the resident and called the NHA and stated no further investigation was warranted. The NHA stated DCF arrived at the facility on [DATE] and interviewed Staff N, CNA but could not state if the conversation was done via by phone or in person. The NHA stated DCF representative who came to their facility stated there is a [NAME] between the two staff members. The NHA stated from the information they had gathered during their investigation, Staff N, CNA's conduct was done in a spiteful manner and was terminated for failure to report abuse, neglect and/or misappropriation in a timely manner. The DON stated she arrived at the facility on [DATE] and conducted a skin assessment for Resident #31. The physician was notified but unfortunately a communication lapse occurred in the notification of the family. The DON stated the family was notified on [DATE] after staff realized they were not notified immediately post allegation. The DON stated Staff R, CNA was adamant she did not hit Resident #31 and her story matched with the events documented in the resident's medical records. The facility decided to move Staff R, CNA to the first floor and terminated Staff N, CNA for failure to report the abuse in a timely manner per policy. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 6:35 p.m., a phone interview was conducted with Staff N, CNA. Staff N, CNA stated her normal assignments would include Resident #31. Staff N, CNA stated she normally will work doubles exclusively on the weekends from the ,d+[DATE] p.m. and ,d+[DATE] a.m. shifts. Staff N, CNA described the resident as normally confused due to his Alzheimer's/dementia, Spanish-speaking only but would understand simple questions. Staff N, CNA stated the resident has a good relationship with another CNA, Staff T, who speaks his native language and has a good relationship with the resident's family. Staff N, CNA stated she has known Staff R, CNA since 2006. Staff N, CNA stated she was on friendly terms with Staff R, CNA. Staff N stated Staff R, CNA worked the same doubles on the weekends. Staff N stated on Saturday, [DATE], she received report from Staff U, CNA. Staff N, CNA stated Staff U, CNA did not mention Resident #31's face to her. Staff N, CNA stated she started her shift as she normally would and brought linen into Resident #31's room as well as his roommate. Staff N, CNA stated Resident #31 was in his bed. Staff N, CNA stated Staff R, CNA came into Resident #31's room as she was placing linen onto Resident #31's roommate's bed. Staff N stated Staff R, CNA walked into the room behind her and stated, Did you see his face? When Staff N, CNA looked to see Resident #31's face she saw a left black eye with a gash over his left eyebrow. Staff N, CNA stated she did not receive report about concerns to the resident's face. Staff N, CNA stated she thought he had a fall but Staff R, CNA stated she punched the resident because he had her fingers bent backwards and would not let go of her. Staff N, CNA stated she had no idea why Staff R, CNA divulged this information to her. Staff N, CNA stated Staff R, CNA did this a few days ago on a Tuesday or Wednesday. Staff N, CNA stated Staff R told her she left Resident #31's room to check on another resident but she said something told her to go back and check on Resident #31. Staff N, CNA stated Staff R stated Resident #31 had a gash with blood running into his eye down his nose. Staff N, CNA stated Staff R stated she put on a pair of gloves and rubbed it into the resident's bloodied face and then took the bloodied glove and wiped it on the inside of the left side rail. Staff N, CNA stated Resident #31 tends to navigate to his left side naturally. Staff N, CNA stated Staff R, CNA stated to her she went out to notify the nurse the resident hit the side of the rail when she was rolling him. Staff N, CNA stated Staff R, CNA told her this information (alleged abuse) as she was beginning her shift the first day of the weekend, [DATE]th, 2024. Staff N, CNA stated she did not report it the day she was told but stated, It did not sit right with me. Staff N, CNA stated she could not tell upper management because, I felt it would have been swept under the rug. Staff N, CNA stated the next day she tried calling Staff M, LPN/Supervisor on her personal cell phone but she (Staff M) stated she was busy and stated she would call her back but she did return her call. Staff N, CNA stated she eventually called Staff M, LPN/Supervisor a week to a week and a half after her first attempt and explained the whole situation to her. Staff N, CNA stated Staff M, LPN/Supervisor told her to immediately call the DON and report this allegation of abuse. Staff N, CNA stated Staff M, LPN/Supervisor stated because she was told this information she now will report to the DON as well. The DON called Staff N, CNA to discuss the allegations of abuse with Staff N, CNA. After Staff N, CNA gave her statement, she was allowed to return to work the next day for her normal weekend shifts. Staff N, CNA stated DCF interviewed her. Staff N, CNA stated the DCF representative took her statement along with images of Resident #31. Staff N, CNA stated she gave the same statement. The DCF representative asked Staff N, CNA why she had waited to report the allegation of abuse in which Staff N, CNA stated she was afraid of retribution. Staff N, CNA stated she was terminated on [DATE]. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:09 a.m., an interview was conducted with Staff R, CNA related to the allegation of abuse to Resident #31. Staff R, CNA stated she will work doubles on the weekends from ,d+[DATE] p.m. to ,d+[DATE] a.m. shift. Staff R, CNA stated her normal assignment is rooms ,d+[DATE] but stated her assignment may change for the ,d+[DATE] a.m. shift depending on the number of CNAs available. Staff R, CNA stated if the number of CNAs goes down to three, she will pick up ,d+[DATE] as well as 212 around the corner. Staff R, CNA stated one night shift she was doing her room checks she noticed Resident #31's feet were hanging out of his bed, and his hand was on the left side rail. Staff R, CNA stated she went into the room and placed herself in front of Resident #31 to prevent him from falling out of the bed. Staff R, CNA stated she placed one of her arms under the resident's legs and her other hand to undo the resident's tight grip on the side rail. Staff R, CNA denied she asked for help and stated there was no one in the hallway or nurse's station to assist her. Staff R, CNA stated she was able to loosen Resident #31's hand from the side rail and basically barrel rolled him to the other side and flipped him to his right side. Staff R, CNA stated Resident #31 hit his face onto the side rail. Staff R, CNA stated she started to see a lump form on his forehead but could not describe on what side and stated there was no blood. Staff R, CNA stated she got Staff S, Registered Nurse (RN) to report the event. Staff R, CNA stated Staff S, RN examined the resident and got a gauze to see if there were any openings to his face and reported her findings to Staff E, LPN/Supervisor after she returned from her break. Staff E, LPN/Supervisor had Staff R, CNA write a statement on the events of the incident and stated Staff E, LPN /Supervisor coached her to write the letter by stating moving forward she will utilize a two -person assist. Staff R, CNA stated Staff N, CNA has a problem with her family. Staff R, CNA stated she did not have any issues with Staff N. Staff R, CNA stated she received a call from the DON the day after Christmas stating an allegation was made against her. Staff R, CNA stated DCF called her on Monday, [DATE] for an interview. During survey 13 separate interviews were conducted with various nursing staff employees. Staff directly involved with Resident #31 and others working on the same floor as the resident. All staff members stated none of them were interviewed regarding any allegation of abuse or abuse towards Resident #31. On [DATE] at 12:20 p.m., a second interview was conducted with the DON and the NHA with the facility's investigative folder regarding allegations of abuse towards Resident #31. The DON confirmed an incident report was completed by Staff E, LPN/Supervisor. The DON stated incident reports are reviewed by the Interdisciplinary Team (IDT) but this report was not reviewed. The DON stated pillows were added to Resident #31's ,d+[DATE] side rails to protect his face. The DON stated a written statement was found in the nurses' station on [DATE] from Staff R, CNA regarding the incident on [DATE] of the resident sustaining injuries during ADL (activities of daily living) care. The letter was not dated. The DON stated no interviews were conducted with the nursing staff who was immediately notified by Staff R, CNA. The DON stated Staff Q, CNA who was working with Staff R, CNA the night the incident occurred, [DATE]th, 2024, was not interviewed. The DON stated Staff R, CNA was giving report to Staff N, CNA in real time on [DATE]/, d+[DATE]. A review of the time punch card for Staff N, CNA showed a punch in at 2:09 p.m. and a punch out time of 11:39 p.m. Staff N, CNA did not work on [DATE]. A review of the facility's policy and procedure titled, Abuse, Neglect and Exploitation, implemented on [DATE], showed the following: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy statement: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. b. Established policies and procedures to investigate any such allegations; and c. Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriate of resident property, reporting procedures, and dementia management and resident abuse prevention; and d. Establish coordination with the QAPI I program 2. V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation: 2. Exercising caution and handling evidence that could be used in a criminal investigation (example, not tampering or destroying evidence) 3. Investigating different types of alleged violations. 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. 5. Focusing the investigation on determining if abuse, neglect, exploitation, and /or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation.