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	04/14/2025

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

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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 - 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** 43453 Based on observations, review of medical records and facility policies, and interviews with residents and physicians, the facility failed to protect the resident's right to be free from physical, verbal and psychological abuse and failed to identify, correct and intervene in situations in which abuse and neglect was more likely to occur for one resident (#1) of two residents sampled. Findings included: During an interview on 04/13/25 at 10:51 a.m. Resident #1 stated he was forced to receive care by an [African American] CNA (Certified Nursing Assistant) who is a profanity, too rough and always has to have his way. Resident #1 said, I sometimes refuse care, but the [African American] CNA forced me to accept his care. When that CNA [Staff A] comes into my room I feel a sense of panic because I know he is going to be rough with me. The resident stated it had to be the CNA's way or no way. Resident #1 stated the CNA [Staff A] forcibly crossed his arms over his chest and was mean to him by laughing at him. Resident #1 said, I do not want him again and I have not seen him since. I feel like I have the right to choose to refuse care and I have choices, and it is against my rights and the law to force me to do something. The resident stated regarding PTSD (Post Traumatic Stress Disorder) diagnosis, I do not want to talk about it. During this interview, an observation revealed the resident had two dressings, one on the left wrist dated 04/12/25 and one on the right back of hand dated 04/12/25. Resident #1 stated those dressings were from the incident with the CNA. Review of a Situation Background Assessment and Recommendation (SBAR) note dated 04/10/25 at 7:33 p. m. showed, The Change In Condition/s (CIC) evaluation were: Skin wound or ulcer. The nursing observations, evaluation, and recommendations showed, Resident got skin tears from a staff member grabbing his arms. Review of a skin observation progress note dated 04/10/25 showed, Resident has existing skin impairment - Bruise Existing skin tear on left forearm: - Bruising and skin tear left hand. Review of the Admission Record showed Resident #1 was readmitted to the facility on [DATE] with diagnoses to include metabolic encephalopathy, adjustment disorder recurrent, insomnia, and generalized anxiety disorder. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a quarterly MDS (Minimum Data Set) dated 02/22/25, showed in section C, the resident had a Brief interview for Mental status (BIMS) score of 13 out of 15, indicating intact cognition. Section GG under toileting hygiene showed a code 01- which meant Resident #1 was dependent - meaning helper does all effort during care. Review of active physician orders for Resident #1 for the month of April 2025 showed: Cleanse left arm with n/s (normal saline), apply xeroform and dcd (dry clean dressing) daily and p.m., every day shift, date order 04/09/25. Cleanse right hand with n/s (normal saline), apply xeroform and dcd (dry clean dressing) daily and p.m., every day shift, date order 04/09/25. A telephone interview was conducted on 04/13/25 at 11:24 a.m. with Staff A, CNA. Staff A stated he was suspended on 04/10/25 after speaking with the Risk Manager (RM), about a claim a resident made. Staff A stated he worked with Resident #1 on 04/08/25 from 2.45 p.m. to 11:15 p.m. He stated the resident had used the typical references which are vulgar. Staff A said, I prepared him for dinner gave him snacks, water, and asked if he needed to be changed. I changed him around 7 p.m. and 11 p.m. I was by myself. He is one person for changing in bed. Staff A stated Resident #1 yelled profanity that night and at times used profanity and racial slurs on the staff member. The staff member said during care, the resident will have a reaction, like not wanting to be changed and when you try to assist him, he will use all kinds of words and then he will apologize. He says it is something he can't help. His reactions vary. He is unpredictable. Staff A stated when he changed Resident #1 on the 8th, he had asked for more clean linens and for some reason the resident went on a rant, name calling. Staff A stated Resident #1 had swung at him before, and this night he swung a few times. Staff A denied knowing the source of Resident #1's injuries after the care was completed and said, I don't know if he hit anything, he was swinging at me. He did not say stop caring from me. I was not near him. I walked out after that and yes, I changed him. Staff A said regarding the bruises and skin tears on the resident, I do not know how the injuries happened. He did not receive any injuries from me. Staff A stated he did not report this incident because Resident #1 had been doing this all along. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 04/13/25 at 12:01 p.m. with the Social Services Director (SSD). She stated Resident #1 had tendencies that are unusual. He uses racial slurs towards some staff. He yells out for staff. The SSD stated the resident has it more or so with male CNAs, especially African America males. The SSD stated the resident would much later in the day apologize. She stated when this happens, it has ended up being allegations that they report. The SSD said, Sometimes he says I got angry and that resolves it. The SSD stated none of the incidents had been substantiated. The SSD reviewed the care plan which showed general interventions which did not specify expectations for the staff when Resident #1 was yelling and cussing. The SSD said, I would hope staff would bring themselves down and not be confrontational with him and encourage him to express himself better. The SSD said on 4/7/25 she had visited Resident #1 in his room because of an incident that happened on 4/6/25 when he said a CNA had grabbed him by the throat. The SSD stated the resident could not tell what day specifically or what CNA it was. The SSD stated the resident had reported the CNA was caring for him, he did not want him to, and the CNA grabbed him by the throat. The SSD stated she had screened Resident #1 for trauma and the resident had reported an extensive history of sexual abuse. The SSD said on 12/2/24 Resident #1 had reported African American CNAs are short with him. The SSD stated regarding the follow up, I don't think I did anything with that information. I should have referred him to psych. I don't know if I did. The SSD stated when Resident #1 makes complaints of staff being rough or short with him, they should remove the CNA from his care. The SSD could not confirm if this had been done or not. An interview was conducted with the Risk Manager (RM) on 04/13/25 at 1:15 p.m. The RM stated Resident #1 has had two incidents. He stated on Sunday 4/6/25 he received a phone call from Staff B, Registered Nurse (RN). She stated she was called to the resident's room approximately 6 p.m., and the resident reported that an unidentified male staff member delivered his food to his next-door neighbor. He stated the staff member had threatened to take his wife. The resident said around 7:30 a.m. he had requested water, and the unidentified CNA said it was not his job to bring him water and they started arguing. The resident said at some point, the CNA grabbed him by the neck and left shortly after. He stated they started arguing and he started to choke him, and the resident choked him back. The RM stated they reported this incident. The RM stated the resident alleged to the law enforcement officer he had been battered and scratched by a light skinned male, but the officer did not find evidence of scratches. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During the interview on 04/13/25 at 1:15 p.m., the Risk Manager (RM) stated the second incident occurred on 4/8/25 at 11 p.m., and the incident was reported to the administration on 4/9/25 at 7:50 a.m. The RM stated Resident #1 called the desk and had told the receptionist he wanted to report abuse. The Nursing Home Administrator (NHA) and the RM went and spoke with the resident. The RM stated the resident reported an African American male with dreadlocks came into his room, referring to the evening of 4/8/25, as the resident wanted to be changed. Resident #1 refused and asked the staff member to leave. He stated, he did not like CNA [Staff A] because he is rude and walks like derogatory words. The RM stated the resident said that he and the staff member had words. The resident reported he crossed my hands and held me down, I was trying to hit the staff member but could not. The RM stated the resident said the staff member grabbed both of his hands and crossed them and pushed them down to his chest. The RM said during that interview the resident showed two areas post skin tear and another medial fore arm tear and wrist area tear to the left arm and a single area of bruises on left arm. The RM said the resident bruises easily and could have hit his arms on the end of the bedside table. The RM stated the resident appeared to have a problem with people of color. He stated the expectation was if they go in and he is yelling or says no, they are to leave. The RM stated he was not aware the resident had a history of sexual trauma or why he would potentially target African American male staff. The RM stated regarding the care plan, No, I did not review his care plan. I was not aware he had a history of abuse. If we would have thought so, we could have looked at the incidents differently. I did not know. A second interview was conducted on 4/14/25 at 9:25 a.m. with the Risk Manager (RM). The RM stated he had interviewed Staff A, CNA who reported Resident #1 had been abusive and called him derogatory and inappropriate racial slurs. The CNA stated he did not see the bruises and skin tears. The RM stated Staff A did not answer yes, or no, when asked if the resident had attempted to hit him. The RM stated Staff A confirmed he had changed the resident but denied causing him any injury. He stated he had interviewed Staff C, LPN/Agency assigned to Resident #1 that night and Staff C denied having knowledge of the incident. On 04/13/25 at 2 p.m. an interview was conducted with Staff D, LPN/Unit Manager (UM). Staff D stated Resident #1 had problems with dark skinned people. She said, He yells at them, sometimes he does not want care from them, they will come to the room, and he says he does not want to be changed. When he says that they come to me, I go to him and see if he needs to be changed, or if he has a smell, he then lets me change him. Staff D stated about a month earlier she became aware of the resident's history of abuse. She stated she reported it to the SSD. Staff D stated on the first day of the incident, I saw the bruising on his left arm, a small open area, which is now scabbed. On the Right arm, it was open, purple- ish in color, the bruising was not there before the incident. Staff D stated she saw the resident the day before, I saw the right arm, he has some drainage. I did treatment and xeroform dressing for the scabbed area on the left too. An interview with Resident #1's psychiatrist on 04/13/25 at 2:35 p.m. revealed she had seen the resident on 04/08/25 following an allegation of a staff member who molested him. The psychologist stated during the visit Resident #1 mentioned very little of the incident and wanted to discuss his sleep issues instead. The psychiatrist reported being unaware of this resident's history of trauma. She said, I have not been made aware of PTSD concerns or any events that could trigger him. She stated the Psychologist would probably be the one to provide the coping mechanisms as it was not something she was aware of, or she was addressing. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 04/13/29 at 4:49 p.m. an interview was conducted with Resident 1's psychologist. The psychologist stated she had assessed the resident following concerns of high anxiety. She stated she had witnessed an incident where an unidentified CNA had raised his voice at Resident #1. She stated when that CNA walked into the resident's room that day, the resident said, this is why I am so scared, this is the guy. The Psychologist stated the CNA raised his voice again. She stated, It was not a good response. The psychologist stated she notified the psych nurse and asked her to review medications and evaluate possible PTSD. The psychologist reported the resident said, I have crazy dreams that wake me up and cause me irritability. She stated they reviewed his medications. The Psychologist said, I know he has stated he does not like to be changed as he is afraid of people. He does not trust others. He likes to be isolated, and he wished his blinds were darker. He wished to be by himself. The Psychologist said she was not aware of the resident's history of sexual abuse. She stated that could be the reason he was refusing care and could explain the fear. She stated he was also afraid of a family member who had donehorrendous things. The psychologist stated the resident had not said why he was against African American staff, but confirmed they are doing some things he does not like. The psychologist could not explain what those things were. Review of a care plan for Resident #1 dated 3/5/25 showed a focus, Resident #1 is resistive to care, refusals to lab draws r/t (related to) Adjustment Disorder with mixed anxiety and depressed mood. Date Initiated: 01/24/2025, created on and revised on 02/26/2025. Interventions included to allow Resident #1 to make decisions about treatment regime, to provide a sense of control, encourage as much participation/interaction by the resident as possible during care activities, give clear explanation of all care activities prior to and as they occur during each contact. Resident #1 resists (ADLs) Activities of Daily living, reassure resident, leave and return 5-10 minutes later. Review of a psych progress note dated 04/09/25 revealed, As per collected information, the resident made an abuse allegation. As per his report, [Resident #1] felt threatened at the moment of the incident. He also complained about not been able to sleep through the night. As reported by staff, he has been irritable . No evidence of mania, psychosis, or agitation has been noted . History of Present Illness revealed [Resident #1] was seen upon request of SSD due to an allegation of aggression by staff member. Patient reports he has been tired during the day. Patient was asked to be seen after incident that happened over the weekend. Patient reports an African American male worker attacked him and his voice is not as clear. Provider talked about how the situation happened. Patient indicated that the staff came, and they were joking around and then he put his hands on his neck. His response was to do the same thing to defend himself. Patient previously has stated that he enjoys isolation and that he is afraid that something awful might happen. Patient stated he notices depression and anxiety are affecting him. Patient reports being aware and alert because he feels threatened. Provider addressed safety and calming techniques with patient such as deep breathing and being assertive. Patient reports he does not know the name of the staff member . Summary of the session: [Resident #1] reports from his bed and calming down techniques were discussed. Patient was approachable and shared an incident that was shared with facility staff. Patient is under the impression that he was attacked. According to patient. Staff member (African American male) put his hand on his neck after both were joking. Patient reports he also tried to defend himself and extended his arms. Facility staff is aware of incident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a psychiatry note dated 3/25/25 showed Resident #1 was seen upon request of SSD. Patient apparently enjoys being alone and does have altercations with people of color that work at the facility stating racial slurs. Patient reports fair eating and sleep is disturbed . Patient is under the impression that he is not getting helped at night especially after midnight. Patient reports having nightmares at night and wanting to talk to someone about his nightmare. Provider will contact psych nurse to address sleep medication and mood stabilizer if possible. Review of a facility policy titled Abuse, Neglect and Exploitation dated 09/07/22 showed 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. Definitions: Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Under 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. Establish 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 misappropriation of resident property, reporting procedures, and dementia management and resident abuse prevention; and d. Establish coordination with the QAPI program. Under prevention of Abuse, Neglect and exploitation: B. Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms. C. Assuring an assessment of the resources needed to provide care and services to all residents is included in the facility assessment. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on observations, interviews and record review, the facility failed to assess, develop and implement a care plan related to a documented PTSD (Post Traumatic Stress Disorder) diagnosis and failed to care plan potential trauma triggers for one resident (#1) of two residents sampled. Findings included: Review of the Admission Record for Resident #1 showed he was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include metabolic encephalopathy, adjustment disorder recurrent, insomnia, and generalized anxiety disorder. Review of an admission level I Pre-admission Screening and Resident Review (PASARR) dated 02/29/24 showed Resident #1had a diagnosis of adjustment disorder and PTSD (Post Traumatic Stress Disorder). Review of a social services progress note dated 04/07/25 showed, Resident has a history of trauma and or PTSD. Review of a document titled Social Services Trauma Screen dated 04/10/25 showed question P: Resident has a history of trauma and or PTSD (Post Traumatic Stress Disorder). Under questions A through N, it was noted the resident did not answer Yes, or No. It was marked prefers not to answer/unable. Question O. Events that really bothered the resident, it was noted, altercation with a male CNA. The question under P. on Trauma/PTSD assessment was marked, Yes. The question if the care plan was updated to reflect the resident's experiences, preferences, and cultural differences in order to eliminate or mitigate triggers that may cause re-traumatization, the answer showed - N/A (Not Applicable). Review of a document titled Social Services Trauma Screen dated 01/15/25 showed: Question O, [Resident #1] communicated that he was abused and talked about as a child and all through his life by his peers . Question P. showed the resident had PTSD. The question if the care plan was updated to reflect the resident's experiences, preferences, and cultural differences in order to eliminate or mitigate triggers that may cause re-traumatization, the answer showed - N/A. Review of a document titled Social Services Trauma Screen dated 12/02/24 showed in J. Resident's mother passed away and it still affects him at times. In Question O: List any events that really bothered you that were not mentioned, Resident #1 answered, While in the facility, he thinks he hears rumors of the facility throwing him out, feels he is served old food, and states the Black CNAs (Certified Nursing Assistants) are abrupt and short with him. The trauma/PTSD question was marked, No. Review of a document titled Social Services Trauma Screen dated 10/02/24 showed in F. Quetion - If the resident was forced to have sexual contact - as a child? The resident preferred not to answer. In question O. List events that really bothered you, Resident #1 answered, molested as a child. Question P. on Trauma/PTSD assessment was marked No, and the care plan update was not considered. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a document titled Social Services Trauma Screen dated 08/12/24 showed Question F. - If the resident was forced to have sexual contact - as a child? The resident answered, Yes F(2.) Describe what happened- it is noted, molested as a young child. He never told anyone. When asked if anyone got hurt, or if the resident was afraid someone else might get hurt, and if he felt afraid, helpless or horrified, Resident #1 answered, yes to all these questions. In question P. History of Trauma and or PTSD (Post Traumatic Stress Disorder) was checked, Yes. The question if the care plan was updated to reflect the resident's experiences, preferences, and cultural differences in order to eliminate or mitigate triggers that may cause re-traumatization, the question was left blank. Review of a Quarterly MDS (minimum Data Set) dated 02/22/25 revealed in Section I active diagnosis, the resident did not have a PTSD or trauma related diagnosis indicated. Review of a care plan for Resident #1 initiated 08/12/24 showed a Focus, Resident #1 has experienced trauma related to adjustment issues affecting the follow sadness - sad face, affect, statements of sadness. A focus on 1/23/25 showed Resident #1 expressed feelings of being claustrophobic - being afraid in enclosed areas/places. Date Initiated: 01/23/2025. Interventions included - Ensure that door in his room is open at all times. Refer to psychiatry and psychology services for medication review and behavior management. On 4/14/25 at 10:37 a.m. an interview was conducted with the Social Services Director (SSD) Risk Manager (RM) and the Nursing Home Administrator (NHA). The SSD stated regarding the process of ensuring communication with providers she stated, If a concern that warrants the care plan to be updated is brought up, it is discussed with nursing staff and IDT (Interdisciplinary Team) to make sure they can capture what they are looking for. She stated Resident #1's history of sexual abuse was discussed with the previous DON (director of Nursing). The SSD stated the resident was referred to psych on 8/12/24. Review of the psych note revealed there was no mention of the sexual abuse history or trauma related concerns. The SSD stated a care plan was put in place related to the resident being Claustrophobic, but not related to the abuse. The SSD said, The care plan should show known triggers if they are identified. I do not know if he had any. The SSD stated the plan of care should include letting staff know to approach the resident in a non-threatening manner, give space and observe for anxiety. The SSD reviewed the care plan and stated she did not see the interventions regarding sexual abuse or trauma. During an interview on 04/13/25 at 12:05 p.m. with Staff E, Licensed Practical Nurse, he stated he was Resident #1's nurse every time he works. The LPN said, Resident #1 has problems with his brief being changed. This is a behavior that he has. Staff E, LPN stated he did not know if Resident #1 had PTSD. He looked on the admission record and said, No, there is PTSD diagnosis. It is not on his list of diagnoses so, he must not have PTSD, and no triggers have been identified. Staff E, LPN stated changing his brief was the biggest problem and also closing his door when he was in his room alone. An interview was conducted with Staff F, CNA on 04/13/25 at 12:20 p.m. She stated she worked with Resident #1 sometimes, and he refuses care related to brief changes and he absolutely hates that. She stated he frequently refuses, and she tells him he would need to let her change his brief that is soiled, at least once before her shift is over. Staff F stated no one has ever told her Resident #1 had PTSD or any history of trauma. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 04/13/25 at 12:00 p.m. with Staff G, CNA. She stated she worked with Resident #1 and he does say racially and derogatory comments but as a CNA I signed up to put up with that and I just ignore it. He does refuse to change his brief often. Staff G stated most of the time she would ask him 3 or 4 times during her shift. Staff G said, This is just a behavior that he has. Staff G denied knowing if Resident #1 had PTSD or history of any kind of trauma. Staff G stated she was never told of this and had not been trained on any triggers. She stated she had been told to always have another person in with her when providing his care. Staff G said, He is usually good with me just not when it is time to change his brief he hates it and gets upset about it almost every time. Review of a care plan for Resident #1 dated 3/5/25 showed a focus, Resident #1 is resistive to care, refuses lab draws r/t (related to) Adjustment Disorder with mixed anxiety and depressed mood. Date initiated: 01/24/2025, created on and revised on 02/26/2025. Interventions included to allow Resident #1 to make decisions about treatment regime, to provide a sense of control, encourage as much participation/interaction by the resident as possible during care activities, give clear explanation of all care activities prior to and as they occur during each contact. Resident #1 resists (ADLs) Activities of Daily living, reassure resident, leave and return 5-10 minutes later. During an interview on 04/13/25 at 10:51 a.m. Resident #1 stated that he was forced to receive care by an [African American] CNA (Certified Nursing Assistant) who is a profanity, too rough and always has to have his way. Resident #1 said, I sometimes refuse care, but the [African American] CNA forced me to accept his care. When that CNA [Staff A,] comes into my room I feel a sense of panic because I know he is going to be rough with me. The resident stated it had to be the CNA's way or no way. Resident #1 stated the CNA [Staff A] forcibly crossed his arms over his chest and was mean to him by laughing at him. Resident #1 said, I do not want him again and I have not seen him since. I feel like I have the right to choose to refuse care and I have choices, and it is against my rights and the law to force me to do something. The resident stated regarding PTSD (Post Traumatic Stress Disorder), I do not want to talk about it. During this interview, an observation revealed the resident had two dressings, one on the left wrist dated 04/12/25 and one on the right back of hand dated 04/12/25. Resident #1 stated those dressings were from the incident with the CNA. Interviews were conducted with Resident #1's CNAs on 04/13/25 from 2:50 p.m. to 3:45 p.m. regarding his care and any knowledge of trauma history. The interviews revealed the following: Staff H, CNA said, Resident #1 has a problem with people. He yells at people and uses racial slurs with CNAs and the roommate. He says he has PTSD he is claustrophobic. He does not like people in his space. Staff I, CNA stated Resident #1 always asks her to hold his hand. He is always yelling. She stated she did not know of a PTSD or trauma diagnosis. She stated she was not trained on identifying triggers. Staff J, CNA stated Resident #1 refuses to be changed. He said, He used to cuss me out. I tried to be nice, I would go to the kitchen and get him sandwiches to pacify him. Staff J stated the previous nurse practitioner said to him, Do not do him alone he said you tried to kill him. Staff J stated he has heard Resident #1 calling racial slurs and did not know why. He denied knowing of a PTSD or trauma diagnosis. He stated he had not been told. He stated he did not know what would be triggering Resident #1. (continued on next page)

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	04/14/2025

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 0n 04/14/25 an interview was conducted with Staff B, Registered Nurse (RN). She stated Resident #1 yells racial slurs all day. She sated he says he does not like black derogatory term. Staff B stated when CNAs say he does not want to be changed, she tries to help. She stated Resident #1 refuses to be changed because he does not like the African American CNAs. She stated they had African American CNAs on assignment most of the time. Staff B, RN stated she was unaware of any history of abuse, trauma or a PTSD diagnosis. On 04/13/25 at 2 p.m. an interview was conducted with Staff D, LPN/Unit Manager (UM). Staff D stated Resident #1 had problems with dark skinned people. She said, He yells at them, sometimes he does not want care from them, they will come to the room, and he says he does not want to be changed. When he says that, they come to me, I go to him and he says he is refusing because he is dry, but I can see he needs to be changed, or he has a smell. He then lets me change him. Staff D stated about a month earlier she became aware of the resident's history of abuse. She stated she reported it to the SSD. An interview was conducted with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) on 4/14/25 at 12:01 p.m. The DON stated they had one resident with a PTSD diagnosis, but was taken off the diagnosis because they did not meet criteria. The DON stated she was not aware Resident #1 had a history of PTSD or any history of sexual abuse. She stated he would have to be assessed. The NHA stated Resident #1 was inconsistent. Sometimes he is receptive to care and sometimes he was not. The DON stated psych was planning an on-site visit. An interview with Resident #1's psychiatrist on 04/13/25 at 2:35 p.m. revealed she had seen the resident on 04/08/25 following an allegation of a staff member who molested him. The psychologist stated during the visit Resident #1 mentioned very little of the incident and wanted to discuss his sleep issues instead. The psychiatrist reported being unaware of this resident's history of trauma. She said, I have not been made aware of PTSD concerns or any events that could trigger him. She stated the Psychologist would probably be the one to provide the coping mechanisms as it was not something she was aware of, or she was addressing. On 04/13/29 at 4:49 p.m. an interview was conducted with Resident 1's psychologist. The psychologist stated she had assessed the resident following concerns of high anxiety. She stated she had witnessed an incident where an unidentified CNA had raised his voice at Resident #1. She stated when that CNA walked into the resident's room that day, the resident said, this is why I am so scared, this is the guy. The Psychologist stated the CNA raised his voice again. She stated, It was not a good response. The psychologist stated she notified the psych nurse and asked her to review medications and evaluate possible PTSD. The psychologist reported the resident said, I have crazy dreams that wake me up and cause me irritability. She stated they reviewed his medications. The Psychologist said, I know he has stated he does not like to be changed as he is afraid of people. He does not trust others. He likes to be isolated, and he wished his blinds were darker. He wished to be by himself. The Psychologist said she was not aware of the resident's history of sexual abuse. She stated that could be the reason he was refusing care and could explain the fear. She stated he was also afraid of a family member who had donehorrendous things. The psychologist stated the resident had not said why he was against African American staff, but confirmed they are doing some things he does not like. The psychologist could not explain what those things were. (continued on next page)

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	106041	A. Building B. Wing	04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy titled Comprehensive Care Plans, dated 9/7/22 showed it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Under definitions: Trauma-informed care is an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact, and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization. Policy Explanation and Compliance Guidelines: 1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma-informed. 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MOS (Measurable Objective Statements) assessment. All Care Assessment Areas (CAAs) triggered by the MOS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. b. Any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment. c. Any specialized services or specialized rehabilitation services the nursing facility will provide as a result of PASARR recommendations. d. The resident's goals for admission, desired outcomes, and preferences for future discharge. e. Discharge plans, as appropriate. f. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. If the resident is non-English speaking, the facility will identify how communication will occur with the resident. The care plan will identify the language spoken and tools used to communicate. g. Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma, as indicated. Trigger-specific interventions will be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident.