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	07/28/2025

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 0600 Level of Harm - Actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to follow professional standards of care and protect the residents' right to be free from neglect for two residents (#3, and #4) out of four residents sampled related to 1) failure to follow up physician orders for laboratory and radiology testing, and failure to report abnormal laboratory test results. Findings included:Review of Resident #3's admission record revealed an initial admission date of 8/20/24 and a readmission date of 7/20/25 from a hospital stay, and a discharge date of 3/30/25, with diagnoses to include metabolic encephalopathy-7/20/25, acute renal failure with hypoxa-7/20/25, atrial fibrillation,- 7/20/25 and chronic kidney disease (stage 2) -8/20/24. Review of resident #3's care plan revealed the following focuses and interventions:-Focus: ADL - interventions include . requires total assist with feeding-is NPO (Nothing by Mouth) and had a PEG (Percutaneous Endoscopic Gastrostomy) tube in place.-Focus: Hypertension-interventions include observe, document and report any s/sx [signs and symptoms] of causative factors: dehydration .-Focus: .has a urinary tract infection-interventions include encourage adequate fluid intake and follow up as indicated. Focus: Nutrition care plan-interventions include observe lab diagnostic work as ordered. Report results to the MDReview of Resident #3's progress note dated 7/3/25 at 7:30 P.M. resident lethargic can follow simple commands . notified provider ordered labs and cxr [chest x-ray]. Review of Resident #3's July 2025 Order Recap Report revealed the following orders:On 7/3/25 a stat chest x-ray (CXR) for lethargy, urinalysis culture and sensitivity test (UA C&S) for symptoms of a Urinary Tract Infection (UTI) were ordered. On 7/3/25 the UA C&S was discontinued and reordered on 7/4/25. A progress note dated 7/5/25 at 11:59 P.M. revealed No straight cath [catheter] kits available at this time . The medical record did not include documentation the medical team was notified the test was reordered and not completed. On 7/4/25 at 5:50 A.M. Resident #3's laboratory reports revealed serum sodium and chloride tests were not completed (TNC) due to presence of unknown interfering substance(s). The medical record did not include documentation the medical team was notified the tests were not completed. A review of an eINTERACT Summary for Providers note, dated 7/5/25 at 1:03 P.M revealed there was a change in condition due to the altered mental status, shortness of breath and unresponsiveness. Nursing observations: resident unresponsive with 02 sat [oxygen saturation] at 91%. Dyspnea observed started 02 [oxygen] at 2 liters via nasal canula .obtained order to send to the ER [emergency room] for evaluation. Review of Resident #3's hospital records revealed transfer to the hospital by Emergency Medical Service (EMS) presenting with acute mental status change and shortness of breath. Blood tests results included abnormal values white blood cell (WBC) 11.2 K/ul, hemoglobin 15.0 g/dl, sodium 183 mEq/L (critical value), chloride 145 mEq/L and potassium 4.3 mEq/L Resident #3 was placed on heated hi flow oxygen 60%. The resident was admitted to the critical care unit (CCU) with diagnoses including acute hypoxic respiratory failure, severe hyponatremia and acute renal insufficiency. Review of Resident #3's Hospital Discharge Instructions dated 7/20/25 revealed diagnoses including acute hypernatremia, acute hypoxemic respiratory failure, altered mental status and dehydration During an interview on 7/28/25 at 11:45 the DON said Resident #3's CXR ordered on 7/3/25 was not completed, it fell through the cracks. She said the Resident #3's medical record did not show the medical team was notified the CXR was not completed Staff did not notify the medical team when Resident #3's sodium and chloride levels were not reported on 7/4/25 and the UA C&S was not completed.Review of Resident #4's admission record revealed Resident #4 was admitted to the facility on [DATE] with diagnoses including heart failure, cardiac pacemaker and high blood pressure (HBP). Review of Resident #4's care plans revealed the following: a-Focus: Potential for complications r/t (related to) an alteration in cardiac function d/t (due to) diagnoses of HBP, atrial fibrillation, has pacemaker. Interventions include labs and diagnostic tests as ordered; update physician of results. observe for c/o (complaints of) and sx/sx (signs and symptoms) of cardiac complications; notify physician if noted. It was initiated on 6/23/21. On 7/25/25 at 11:51 A.M. Resident #4's progress note revealed Spoke to nurse practitioner [name] about the patient appearing lethargic. He was very difficult to arouse despite trying to wake him up. Vital signs are within normal range. Received orders for a stat . troponin . Review of Resident#4's order recap report, dated 6/1/25 to 7/31/25 revealed on 7/25/25 a stat troponin test was ordered. On 7/26/25 at 2:50 A.M. Resident #4's Troponin level of 37ng/L (range 0-22) was available in the facility's lab vendor portal. On 7/26/25 at 11:34 A.M. Resident #4's Advanced Registered Nurse Practitioner (ARNP) note, revealed chief complaint (cc) follow up brief syncopal episode and labs, troponin T is 37ng/l

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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 interviews and record review the facility failed to review and revise the comprehensive care plan for one resident (#1) out of 3 residents reviewed.Based on interviews and record review the facility failed to review and revise the comprehensive care plan for one resident (#1) out of 3 residents reviewed.Findings include:Review of Resident #1's admission Record revealed he was admitted to the facility on [DATE]. Resident was discharged on 6/14/2025 and re-entered the facility on 6/28/2025.Further review of the medical record revealed the following diagnoses with a date of 6/28/2025: Non-ST Elevation myocardial infarction, type 2 diabetes, peripheral vascular disease, chronic obstructive pulmonary disease, dependence on renal dialysis.A review of Resident #1's active care plan revealed the following:-Focus: Resident#1 takes Plavix d/t {due to} having increased risk of blood clots, stroke, and heart attack. At risk for bleeding and bruising. -Goal: . will have no adverse effects of ASPIRIN use through next review. -Intervention: Administer Aspirin as ordered.-Focus: .is on diuretic therapy r/t {related to} edema, hypertension. -Interventions: Administer diuretic medications as ordered by physician.A review of the Order Summary Report revealed the following order: Clopidogrel Bisulfate {Plavix} Tablet 75 MG {milligram}. Give 1 tablet by mouth one time a day for blood clot prevention.There was no order for Aspirin.There was no order for diuretic medications.An interview on 7/28/2025 at 3:00 p.m. was conducted with Staff J, Licensed Practical Nurse (LPN) MDS and Staff K, Registered Nurse (RN), MDS Coordinator. They stated they are responsible for the care plans. They stated the process is to have a care plan meeting with the resident, which is usually attended by the unit manager. They do not attend the care plan meeting. They stated they do a review of the care plan when the quarterly Minimum Data Set (MDS) is completed. Staff J, LPN MDS stated Resident #1's care plan should have been updated. They stated Resident #1 should not have a diuretic therapy focus; it should not be there. They stated the care plan should have been updated to include administering Plavix, not aspirin. A review of the policy Comprehensive Care Plans with a revision date of 1/2025 Revealed the following: Policy: Policy Explanation and Compliance Guidelines:5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented as needed.

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F 0726 Level of Harm - Actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure licensed nursing staff were knowledgeable and competent to provide care and services for three residents (#1, #3, and #4) out of four residents sampled related to: 1) failure to recognize a change in condition and provide care resulting in a hospitalization 2) failure to follow physician orders for laboratory testing; 3) failure to report abnormal laboratory results.Findings Included: A review of Resident #3’s admission record revealed an initial admission date of 8/20/24 and a readmission date of 7/20/25 from a hospital stay, and a discharge date of 3/30/25, with diagnoses to include metabolic encephalopathy-7/20/25, acute renal failure with hypoxa-7/20/25, atrial fibrillation,- 7/20/25 and chronic kidney disease (stage 2)-8/20/24. A review of Resident #3’s July 2025 Order Recap Report revealed the following orders: On 7/3/25 a stat chest x-ray (CXR) for lethargy, urinalysis culture and sensitivity test (UA C&S) for symptoms of a Urinary Tract Infection (UTI) were ordered. On 7/3/25 the UA C&S was discontinued and reordered on 7/4/25. A progress note dated 7/5/25 at 11:59 P. M. revealed “No straight cath [catheter] kits available at this time .” The medical record did not include documentation the medical team was notified the test was reordered and not completed. On 7/4/25 at 5:50 A.M. Resident #3’s laboratory reports revealed serum sodium and chloride tests were not completed (TNC) due to presence of unknown interfering substance(s). The medical record did not include documentation the medical team was notified the tests were not completed. On 7/5/25 at 1:03 P.M of Resident #3’s eINTERACT Summary for Providers note, revealed “there was a change in condition due to the altered mental status, shortness of breath and unresponsiveness.” Nursing observations: “resident unresponsive with 02 sat [oxygen saturation] at 91%. Dyspnea observed started 02 [oxygen] at 2 liters via nasal canula .obtained order to send to the ER [emergency room] for evaluation. A review of Resident #3’s hospital records revealed transfer to the hospital by Emergency Medical Service (EMS) presenting with acute mental status change and shortness of breath. Blood tests results included abnormal values white blood cell (WBC) 11.2 K/ul, hemoglobin 15.0 g/dl, sodium 183 mEq/L (critical value), chloride 145 mEq/L and potassium 4.3 mEq/L Resident #3 was placed on heated hi flow oxygen 60%. The resident was admitted to the critical care unit (CCU) with diagnoses including acute hypoxic respiratory failure, severe hyponatremia and acute renal insufficiency. A review of Resident #3’s Hospital Discharge Instructions dated 7/20/25 revealed diagnoses including acute hypernatremia, acute hypoxemic respiratory failure, altered mental status and dehydration (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Some	During an interview on 7/28/25 at 11:45 the Director of Nursing (DON), said Resident #3’s CXR ordered on 7/3/25 was not completed, “it fell through the cracks.” She confirmed the medical team was not notified Resident #3’s CXR and UA C&S was not completed. The DON said on 7/4/25 the facility expected staff to notify the medical team Resident #3’s sodium and chloride levels were not included in the lab results. A review of Resident #4’s admission record revealed Resident #4 was admitted to the facility on [DATE] with diagnoses including heart failure, cardiac pacemaker and high blood pressure (HBP). A review of Resident #4’s order recap report, dated 6/1/25 to 7/31/25 revealed on 7/25/25 a stat troponin test was ordered. On 7/26/25 at 2:50 A.M. Resident #4’s Troponin level of 37ng/L (range 0-22) was available in the facility’s lab vendor portal. On 7/26/25 at 11:34 A.M. Resident #4’s Advanced Registered Nurse Practitioner (ARNP) note, revealed chief complaint (cc) follow up brief syncopal episode and labs .troponin T is 37ng/L On 7/27/25 a.t 1:19 P.M Resident #4’s SBAR summary for provider note revealed “ . The resident’s labs are abnormal, new orders obtained from NP to transfer to the emergency room (ER) for evaluation for elevated Troponin level 37 .” Resident #4’s medical record did not show the medical team was notified of elevated Troponin level before labs were reviewed by the ARNP. On 7/28/25 at 12:06 P.M, during an interview with Staff G, Licensed Practical Nurse said she checks for laboratory results at the beginning and end of her shift. On 7/28/25 at 12:30 P.M., during an interview Staff H, RN, Unit Manager said nurses are expected to notify the medical team of all tests results normal or abnormal and document in the medical record On 7/28/2025 at 4:30 P.M. during an follow-up interview the DON said on 7/24/25 when Resident #4’s elevated troponin level was available staff were expected to notify the medical team right away. She said when orders are received nurses are expected to enter the order(s) in the resident’s electronic health record (EHR) and the facility radiology vendor portal. The facility’s process is for nurses to check the lab vendor portal throughout their shift for test results. Stat orders for blood and radiology tests are completed within four hours. When orders are not completed staff are expected to notify the physician and follow orders. On 7/28/25 at 1:03 P.M. during a telephone interview Resident #4’s PCP said on 7/26/25 when troponin results were available, the on-call medical team should have been notified. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Some	On 7/28/2025 at 8:30 a.m. an interview with Resident #1 was conducted. Resident #1 stated about a month and a half ago, he did not feel well and had pneumonia. He stated he kept telling staff that something wasn’t right. The resident stated he was throwing up continuously for almost 3 days before anything was done for him. He stated staff didn’t seem to know what they were doing. He stated, “I told them if they weren’t going to take care of me, I will just go to the hospital.” The resident stated he called 911. Resident #1 further explained when he went to the hospital, the doctors told him his blood was toxic, and his kidneys weren’t working very well, and he needed dialysis. He stated he was not receiving dialysis before he went to the hospital, now he is currently on dialysis and is upset with his situation. A review of Resident #1’s medical record revealed he was admitted to the facility on [DATE] major depressive disorder, type 2 diabetes mellitus, anemia, anxiety disorders, hypertension, chronic kidney disease stage 3, hyperlipidemia, need for assistance with personal care, congestive heart failure. A review of Resident #1’s most recent Minimum Data Set (MDS) Section C- Cognitive Patterns revealed a Brief Interview of Mental Status (BIMS) summary score of 15, indicating he is cognitively intact. A review of a nursing progress note dated 6/10/2025 revealed the following text: “patient is continuously vomiting, med held per on call np {nurse practitioner} KUB {kidney, ureter, bladder x-ray}, CBC {complete blood count-lab test}, BMP {basic metabolic panel-lab test} is ordered for the morning” Further review of the medical record revealed no orders for the KUB, CBC, or BMP were entered or obtained on 6/10/2025. No change in condition was completed. A review of a nursing progress note dated 6/12/2025 revealed the following text: “alerted NP due to sudden weakness of resident. Resident was unable to use the slide board this shift to transfer to chair. VS {vital signs} were assessed, O2 sat {oxygen saturation} was 83%, NP ordered O2 {oxygen} at 2L{liters} via NC {nasal cannula}. diminished lung sounds posterior, chest x-ray ordered, Resident stated he had diarrhea for 2 days and emesis {vomiting} the past two days as well…Labs ordered for morning.” Further review of the medical record revealed a change in condition was completed on 6/12/2025. Review of the Lab Results Report revealed the lab sample for CBC and BMP were collected 6/13/2025 at 6:10 a.m. and were reported to the facility on 6/13/2025 at 10:33 a.m. The lab result Blood Urea Nitrogen (BUN) was 101 mg/dL (milligram per deciliter) with a reference range of 7-25 mg/dL indicating a high level. The lab result Creatinine serum was 3.89 mg/dL with a reference range of 0.7-1.3 mg/dL indicating a high level. Further review of the Progress notes revealed a change in condition on 6/14/2025 at 12:25 p.m. which stated the following: “The resident states he was not feeling well and wanted to transfer to the hospital…checked the resident labs and noted the BUN result was 101 on 6/13/2025…instructed the assigned nurse to transfer the resident to the ER {Emergency Room}…During the process, the resident called 911 himself to transfer to the ER. The resident is his own self representative. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Some	During an interview on 7/28/2025 at 11:30 a.m. with Staff F. Licensed Practical Nurse (LPN) She stated for lab orders, the doctor will put it in or will give us a verbal order to put it in. We put the lab order in for overnight shift and lab will come draw in the morning. Stat labs are called in to the lab, she stated she is not sure how long it takes for them to come complete stat labs. Same process for chest x-ray, she is not sure how long it takes for those to be completed stat, but routine she thinks should be completed within 24 hours. She stated they view the lab in the electronic medical record and call to let the doctor know they have resulted. If a lab result came back incomplete, she stated she would call the doctor and ask if they wanted to re-draw the lab. She stated if a resident was vomiting, she would call the doctor and do a change in condition. During an interview on 7/28/2025 at 11:35 a.m. with Staff I, LPN Unit Manager, she stated she checks to make sure labs are drawn, in the morning. When the results come in, she or the nurse would notify the physician or NP. If they are abnormal a change in condition should be done. Stat labs are to be done in 4 hours. During an interview on 7/28/2025 at 11:47 a.m. with the Director of Nursing (DON), she stated a change in condition should have been done on 6/10/2025. A review of the Licensed Nurse Competency form used to educate the licensed nurses provided by the DON revealed the following: Competency: Nursing Skills: Identification of Changes in Condition -Physical assessment -Lab values -Physician notification… Review of facility policy titled Provision of Physician Ordered Services, revised 5/7/24 revealed Policy: The purpose of this policy is to provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality. Definition: Professional Standards of Quality means that care and services are provided according to accepted standards of clinical practice. Policy Explanation and Compliance Guidelines: 1.Facility will maintain a schedule of diagnostic tests (laboratory and radiology) in accordance with the physician's orders. 2) Qualified nursing personnel will submit timely requests for physician ordered services (laboratory, radiology .) 3)Qualified nursing personnel will receive and review the diagnostic test reports . and communicate the results to the ordering Physician, physician assistant, nurse practitioner or clinical nurse specialist within 24 hours of receipt unless the reports fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician' s orders. Ordering Provider will be notified of results upon receipt if deemed critical and/or require immediate attention. 4)Documentation of consultations, diagnostic tests, the results, and date/time of Physician notification will be maintained in the resident's clinical record . A review of the facility’s Licensed Practical Nurse and Registered Nurse job descriptions includes the following: (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Some	Major Duties and Responsibilities: -Ensures that policies and procedures are complied with by nursing personnel assigned. -Evaluates for changes in residents' status, notifying the physician and resident's family or representative and documenting accordingly. -Transcribes physician orders to medical record and carries out orders as written. Additional Tasks: -Must be able to relay information concerning a resident's condition. -Must be able to follow oral and written instructions -Communicates with medical and nursing staff, and other departments -This job description is intended to convey the general scope of the major duties and responsibilities inherent in this position