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	09/18/2025

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 - 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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to protect the residents' right to be free from abuse for one resident (#3) out of 3 sampled residents. Findings included: An interview was conducted on 09/17/2025 at 10:30 a.m with Staff A,PCA (Personal Care Attendant). Staff A stated they witnessed Resident #3 being verbally abused by Staff B, CNA, whom they were training with that day. Staff A stated Resident #3, had finished receiving incontinence care from Staff B and was on the edge of the bed when Staff B voiced, Don't put your [EXPLICIT] hands on me or I'll let you fall on the [EXPLICIT] floor. Staff A stated they then saw the CNA aggressively lift up and set resident into her wheelchair and the resident was shaking after that. While assisting the resident with her shoe that had fallen off while being transferred into the chair, Staff A stated the resident voiced that the other CNA, Staff B, thought she was crazy. Staff A reported her observation to the Director of Nursing (DON), who directed them to return to the floor training with another CNA. Staff A stated the facility did an investigation, but the CNA did not know whether or not Staff B was still employed with the facility. Staff A reported being retaliated against because of reporting the abuse and stated being told when writing her statement, not to go into detail but write down the major points. Staff A stated Staff B came back upstairs and made a statement Snitches get stitches and this staff member felt it was directed to her. Staff A stated ever since that happened, the workplace has felt hostile, they talk about how some employees lie on other employees and they get fired. On 09/18/2025 at 2:55 p.m. an interview was conducted with Staff B, CNA. Staff B stated thinking Staff A, PCA, doesn't like me and she doesn't like to work because I made her get up and help change the resident and then they pulled me into the office and told me that the PCA complained about me. Staff B stated being suspended but refused to answer the question related to why she was suspended. She said she came back on the holiday and then a few days later she got suspended again because she was in the parking lot saying, snitches get stitches referring to Staff A. Staff B refused to acknowledge the allegation for Resident #3 and stated being done with the facility and not coming back to the facility. Staff B stated she already started another job and discontinued the interview. An observation of Resident #3 on 09/17/2025 at 3 p.m. revealed the resident in bed, resident appeared clean and dressed appropriately. Resident #3 presented pleasantly confused and was unable to answer questions about their care at the facility. When a CNA entered the room during the interview, the resident leaned back in the bed, closed eyes, and as though they were sleeping. The resident did not respond the CNA and discontinued the interview. Review of the admission record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses to include unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, mood disorder due to known physiological condition with depressive features, muscle weakness (generalized), unspecified protein-calorie malnutrition, sarcopenia, and anemia. A review of Resident #3's Minimum Data Set (MDS) dated [DATE] revealed the resident to have a Brief Interview for Mental Status (BIMS) score of 99 indicating severe cognitive impairment. The MDS revealed the resident required partial/moderate assistance for oral hygiene, eating; substantial/maximal assistance for personal hygiene and upper body dressing, and was dependent for toileting hygiene, showering/bathing, lower body dressing, and footwear and revealed resident was always incontinent of bowel & bladder. Review of Resident #3's care plan focus on self-care performance revised on 10/03/2034 showed the resident has deficits related to confusion, dementia, visual deficit r/t (related to) bilateral cataracts, depression and anxiety with goal of resident maintaining current level of function through the review. Interventions showed the resident was to request from staff to turn/reposition in bed, staff to check resident's nail length and trim as necessary, resident was to be assisted by staff with dressing, eating, bathing, and oral/personal hygiene. Staff was to observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse.A second focus in the same care plan showed the resident was at risk for falls related to cognitive deficits, weakness, incontinence, visual deficit and side effect of medication use with goal of resident would not sustain serious injury through the next review date and interventions of 1/4 side rails (sides of bed) per consent to aid in positioning, staff would anticipate and meet the resident's needs, staff to ensure resident's call light was within reach and encourage the resident to use it for assistance as needed. The resident needed prompt response to all requests for assistance, staff to encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility, staff to encourage the resident to participate in activities that promote exercise