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	05/18/2026

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and clinical professional standards, the facility failed to ensure medications were administered as prescribed, with physician orders for four residents (#1, #2, #3, and #10) out of six sampled.Findings Included: A review of Resident #1's admission record showed an admission date of 4/22/2026, with diagnoses including type 2 Diabetes Mellitus, protein calorie malnutrition, and high blood pressure. A review of Resident #1's physician order summary report showed orders dated 4/22/26 for the following: oxycodone 5 mg (milligram) by mouth every 6 hours as needed for pain, pain evaluation every shift to monitor the resident's pain level, and pain management consult with treatment as needed. A review of Resident #1's nurse's note dated 4/23/26 at 3:57 p.m. showed: Resident ambulating around unit. Complains of pain (9/10). Attempted to retrieve [medication] from the automated medication dispensing machine and request denied. Tylenol given and resident states are not effective. Resident able to make needs known. Will monitor for changes. A current order for acetaminophen (Tylenol) was not found on the Resident #1's order summary report, dated 4/22/26. A review of Resident #1's Medication Administration Record (MAR) dated April 2026 showed on 4/23/26 during the 7:00 a.m.-3:00 p.m. the resident reported a pain level of 9 on a 0-10 scale, and during the 11:00 p.m. to 7:00 a.m. a pain level of 6. On 4/24/26 during the 7:00 a.m.-3:00 p.m. shift, a pain level of 8 was documented. On 4/22/26 at 8:30 p.m. the order for oxycodone 5 mg by mouth every 6 hours as needed for pain was ordered, Resident #1's first dose was administered on 4/24/26 at 1:10 p.m. During an interview on 5/18/26 at 3:31 p.m. with the Director of Nursing (DON) and the Regional Director of Clinical Services (RDCS). The DON said the first dose of oxycodone Resident #1's received was on 4/24/26 at 1:12 p.m. The DON said the process is to email or fax the prescription to the facility's pharmacy which may take 10-15 minutes, and pharmacist reviews the orders. She expects staff to reassess the resident, call the physician. The DON said she is not sure why the medication request was denied and will contact the staff member for additional information. A review of Resident #2's admission record showed an initial admission date of 4/22/25 and readmission on [DATE], with diagnoses including metabolic encephalopathy, infection of the skin and subcutaneous tissue, and cellulitis of the right lower extremity. A review of Resident #2's order summary report, as of 5/18/26, showed an order with a start date of 4/22/26 for Doxycycline 100 mg by mouth two times a day, a oneˆday course for treatment of a urinary tract infection (UTI). A review of Resident #2's Medication Administration Record (MAR) for April 2026 showed an order for Doxycycline 100 mg by mouth two times a day for treatment of a urinary tract infection (UTI) for a oneˆday course. The MAR documentation showed on 4/22/26 during the 7:00 p.m. to 11:00 p.m. medication pass, code 9 (other, see progress notes) was listed for this medication, and the antibiotic was administered on 4/23/26, during the 7:00 a.m. to 11:00 a.m. medication pass. A review of Resident #2's progress notes did not show documentation related to the missed dose of the Doxycycline or any notification to the physician regarding the missed medication. A review of the facility's automated medication dispensing machine inventory showed that Doxycycline 100 mg capsules were included in the available stock. During an interview on 5/18/26 at 3:31 p.m. with the DON and the RDCS, the DON said staff should have followed the physician orders and confirmed the Doxycycline order dated 4/22/26 (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

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	05/18/2026

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for a oneˆday course was to be completed on 4/22/26. A review of Resident #3's admission record showed an admission date of 4/22/2026, with diagnoses including metabolic encephalopathy, A review of Resident #3's order summary report showed active orders that included: blood thinners-check for bleeding and bruising every shift; Apixaban (Eliquis) 5 mg by mouth two times daily for clot prevention; Synthroid 200 mcg (microgram) by mouth daily for hypothyroidism; Metoprolol Tartrate 37.5 mg by mouth two times daily for hypertension; and Sertraline 100 mg, two tablets by mouth daily, for depression. A review of Resident #3's MAR showed an active order for Synthroid 200 mcg by mouth daily, with a start date of 4/23/26 at 6:00 a.m.; code 9 (other, see progress notes) was documented instead of administration. The order for Sertraline 100 mg, two tablets by mouth daily, with a start date of 4/23/26 at 7:15 a.m., showed no documentation on the MAR. The order for Apixaban (Eliquis) 5 mg by mouth, with a start date of 4/23/26 at 7:00 a.m., showed code 9 (other, see progress notes) documented in place of administration. The order for Metoprolol Tartrate 37.5 mg by mouth, with a start date of 4/23/26 at 9:00 a.m., also showed code 9 (other, see progress notes) documented. A review of Resident #3's admit/readmit progress note dated 4/22/26 at 11:49 p.m. showed the entry: Arrived on the unit approximately 7:00 p.m. Reasons for missed or late medication administration and/or notification of the medical team are not documented in the progress note. A review of the facility's automated medication dispensing machine inventory showed Eliquis 2.5 mg tablets and Synthroid 25 mcg tablets are included in the available stock. During an interview on 5/18/26 at 3:31 p.m. with the DON and the RDCS, the DON said Resident #3 arrived at the unit on 4/22/26 at approximately 7:00 p.m. and the medications were ordered during admission. The DON reviewed the MAR and acknowledged that several medications-Synthroid, Apixaban (Eliquis), Metoprolol Tartrate, and Sertraline-were documented with code 9 (other, see progress notes) or left blank. The DON said Synthroid is a high-risk medication and if it was not available in the automated drug dispensing machine staff are expected to notify the doctor. The DON said staff are expected to notify the doctor when high risk medications are not administered and complete documentation. A review of Resident #6's admission record showed an initial admission date of 8/7/23, and a readmission date of 3/14/24, with diagnoses including cerebral infarct, type 2 Diabetes Mellitus, difficulty walking and dementia. A review of Resident #6's prescription dated 5/1/26 for Amoxicillin-clavulanate (Augmentin) 875-125 mg per tablet, take 1 tablet two times daily, start date 5/1/26. A review of Resident #6's nurse's note dated 5/3/26 at 7:15 p.m. showed the following entry: Patient's daughter came in today and asked if the patient had started on the antibiotic that was prescribed when the resident went to his appointment with the urologist on 5/1. She stated that she gave the script to the unit manager when they returned. I reached out to the unit manager, and she stated she gave the script to the primary nurse on the cart that day. The nurse passed on to the oncoming nurse to let the nurse in the morning know to call the urologist in the morning to obtain an order for the antibiotic. A review of Resident #6's Medication Administration Record (MAR) for May 2026 showed an order for Amoxicillin and Potassium Clavulanate (Augmentin), one tablet by mouth two times daily for 14 days, for treatment of a urinary tract infection (UTI). The MAR showed the first dose was administered on 5/4/26 during the 7:00 p.m. to 11:00 p.m. medication administration time. During an interview on 5/18/26 at 3:31 p.m. with the DON and the RDCS, the DON said there was a delay with administering antibiotics to Resident #6. A review of Resident #10's admission record showed an admission date of 5/16/26 with diagnoses including hypothyroidism and hypertension. A review of Resident #10's order summary report showed orders to include Levothyroxine 100 mcg in the morning for hypothyroidism, start date 5/16/26 A review of Resident #10's Medication Administration Record (MAR) for May 2026 showed that on 5/16/26 during the 4:00 a.m. to 7:00 a.m. medication pass, the administration of Levothyroxine 100 mcg was documented with code 9 indicating other, see progress notes. A review of Resident #10's ordersˆadministration note showed the entry: New admission, medication on order. There was no documentation indicating that the medical team was notified that the medication had not been administered as ordered. A review of the (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	05/18/2026

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility's automated medication dispensing machine inventory showed Levothyroxine 25 mcg tablets are included. During an interview on 5/18/26 at 3:31 p.m. with the DON and the RDCS, the DON said medications were ordered on the 6/16/26 an Resident #10 first doses were administered on the 5/17/27. She said if Atorvastatin is not available in the automated drug dispensing machine staff has to wait for the pharmacy delivery. The DON confirmed Synthroid was not administered as ordered and there should have been a progress note regarding why the medication was held and the physician was notified. She said the Metoprolol said the medication may have been held due to the resident's BP and the reason medication were not administered is not documented. A Review of the facility's medication administration policy, revised 1/2026 showed the following: Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Compliance guidelines . 20. Sign MAR after administered. For those medications requiring vital signs, record vital signs onto the MAR .22. Report and document any refusals Institute for Safe Medication Practices (ISMP) high-alert medication list for long-term care emphasizes increased risk when doses are missed and recommends safeguards like documentation protocols and escalation procedures for errors. Retrieved on 5/25/2026 https://www.ismp.org/sites/default/files/attachments/2017-11/LTC-High-Alert-List.pdf