STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106041	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50434 Based on observation and interview, the facility failed to ensure dignity was providing by protecting and valuing residents' private space by knocking before entering one (#29) resident's room out of 31 residents sampled. Findings Included: During an observation on 12/02/2024 at 10:33 a.m., a staff member, in black scrubs was observed entering Resident #29's room without knocking or being invited in by Resident #29. During an observation on 12/03/2024 at 9:00 a.m., a staff member, in black scrubs was observed entering Resident #29's room without knocking or being invited in by Resident #29. During an observation on 12/04/2024 at 3:12 p.m., a staff member, in black scrubs was observed entering Resident #29's room without knocking or being invited in by Resident #29. During an interview on 12/04/2024 at 3:10 p.m., Staff F, Certified Nurse Assistant (CNA), stated that she usually knocked before entering a resident's room, she also made sure that the resident's door was closed, and the privacy curtain was pulled while she was providing care. During an interview on 12/04/2024 at 3:05 p.m., Staff G, CNA, stated he provided daily care to the residents. He stated he provided dignity to residents by closing curtains, talking with the residents while providing care, and asking if it was okay for him to provide their care. He stated he would also knock on the door before entering the room. During an interview on 12/04/2024 at 3:22 p.m., Staff H, CNA, stated before she entered a resident's room she knocked on the door. She stated if the resident did not answer she would ask if she could enter the room. During an interview on 12/04/2024 at 6:20 p.m., the Director of Nursing (DON) and Regional Nurse stated Dignity should be provided for every resident. They stated staff members were expected to knock before entering a resident's room. (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: 106041	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Promoting/Maintaining Resident Dignity dated 09/072022 revealed: Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and environment, that maintains or enhances residents' quality of life by recognizing each resident's individuality. 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights period. 11. Respect the residents living space and personal possessions . 12. Maintain resident privacy.

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498 Based on observations, interviews, and record review, the facility failed to notify the resident representative about a change in condition for one resident (#67) out of eight residents sampled. Findings include: On 12/2/2024 at 10:00 am., Resident #67 was sitting up in her wheelchair, dressed well-groomed with her call light within reach. She presented with no signs of distress. She stated she had an incident two weeks ago when two nursing aides pulled her up in bed. She stated she felt a sharp pain in her back and legs after they repositioned her. She stated one of the aides told the nurse about the resident complaint and she was provided with an x-ray. She stated she was never told the results of the x-ray. Review of the Admission Record, dated 12/5/2024, showed Resident #67 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses to include but not limited to, Type 2 Diabetes Mellitus with diabetic neuropathy, unspecified, presence of coronary angioplasty implant and graft. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 9/23/2024, revealed in Section C: Cognitively Patterns a Brief Interview of Mental Status (BIMS) score of 10, which indicated moderate cognitive impairment. Review of a progress note, dated 11/25/2024 at 15:19, revealed the following: Resident complain of back pain this morning and could not move, resident stated, this morning CNAs was tried to reposition her on the bed and somehow hurt her back mostly on the waist. On 12/04/2024 at 12:00 p.m., an interview was conducted with Resident #67's Healthcare Surrogate. She stated a family member called her to tell her something happened to Resident #67 when she was positioned by two nursing aides in the room. She stated she was never notified by the facility of what happened and was never told about the results of the x-rays the facility took on the resident. On 12/04/2024 at 4:00 pm., an interview was conducted with Staff AA, Registered Nurse (RN). She stated the Certified Nursing Assistant (CNA) that took care of the resident on 11/25/2024 came to her to tell her Resident #67 was complaining about back pain. She stated Resident #67 told her the nursing aides tried to reposition her in the bed and somehow, she hurt her back, and the pain was mostly on the waist. The nurse stated she asked the resident if she would like to have pain medication. The nurse stated the resident said she did not want anything for pain. Staff AA stated she did not know she needed to call the resident family to tell them about the resident complaint. She stated she did not call the family or notify the doctor when the x-ray results came in, she only reported the x-rays to the nurse from the next shift. On 12/4/2024 at 4:10 pm., an interview was conducted with Staff I, License Practical Nurse (LPN)/ Unit Manager (UM). She stated the x-ray report came back to the facility at 6 pm, during the first shift. She stated the nurse should have notified the doctor, and the resident representative about the incident and the x-ray findings. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/2024 at 4:30 pm., an interview was conducted with the Director of Nursing (DON). The DON stated the nurse should have notified the physician, the resident, and the resident representative about the x-ray findings. The DON stated the nurse should have followed the process of what the physician would have provided for the resident. She stated, We will just have to do some education from this point moving forward. The facility did not provide a policy regarding this citation.

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498 Based on observations, interviews, and record review, the facility failed to provide the opportunity to participate in care planning for one resident (#44) out of 8 residents sampled. Findings included: On 12/03/24 at 09:47 a.m., and 12:00 p.m., an observation was made of Resident #44. She was observed lying down in her bed with her call light in reach. She presented with no signs of distress. Resident #44 stated she would like to participate in her care plan meetings, but staff does not invite her to attend the meetings because her meetings are scheduled during the times she is out for her dialysis treatments. She stated she would like her voice to be heard. Review of the Admission Record, dated 12/5/2024, showed Resident #44 was admitted to the facility on [DATE], with diagnoses to include but not limited to, End Stage Renal Disease, Type 2 Diabetes Mellitus without Complication, Multiple Sclerosis, and need for assistance with personal care Review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed in Section C: Cognitively Patterns, a Brief Interview for Mental Status (BIMS) score of 15, which indicated cognitively intact On 12/04/2024 at 12:30 p.m., an interview was conducted with Resident #44's Healthcare Surrogate/ Power of Attorney. She stated she would really prefer Resident #44 be a part of the care plan meetings because she knows more about the care she is receiving at the facility. She stated the care plan meetings are scheduled on the days the resident has dialysis and that is why the resident is not invited to the meetings. On 12/05/2024 at 9:38 am. an interview was conducted with Staff V, MDS Coordinator. She stated Resident #44 is on the second floor, so her care plan meetings are held on Wednesdays. She stated the meetings are on the same day the resident goes to dialysis. She stated she does not conduct the care plan meetings, so she cannot answer questions as to why Resident #44 is not invited to her care plan meetings. She stated if a resident is not able to attend the meetings, then the Unit Manager should talk to the resident to provide an update about the meeting On 12/05/2024 at 10:00 a.m., an interview was conducted with Staff I, License Practical Nurse (LPN)/ Unit Manager (UM). Staff I stated every Wednesday she attends the care plan meetings. Resident #44 does not attend the meetings because the meeting is held on the same days she has dialysis. She stated when a resident is not able to attend a meeting, she or the Social Worker would go to the resident's room to update them about the care plan meeting. She said she has not followed up with Resident #44 about her care plan meetings. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/05/2024 at 1:00 p.m., an interview was conducted with Staff C, Social Service Director (SSD). The SSD stated she is provided with a list of residents who are scheduled for their care plan meeting for the week. She said care plan meetings are Tuesdays and Wednesdays. Tuesday meetings are for the first-floor residents and Wednesday meetings are for the second-floor residents. She said if a resident is not able to attend their meeting on their scheduled day, they would call the representative to inform them about the resident's plan of care. She stated she did not follow-up with Resident #44's care plan meeting because she was on vacation when her meeting was conducted. She stated nursing should have informed and followed -up with the resident about her care plan meeting. Review of the facility policy titled Comprehensive Care Plans, dated 9/7/22, showed the following: Policy Statement: 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. Policy Explanation and compliance Guidelines: 4. The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to: e. the resident and the resident's representative, to the extent practicable.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20536 Based on observations, interviews, and record reviews, the facility failed to ensure residents and/or resident representatives, were informed and provided written notice of the right to accept or decline medical and surgical treatments to formulate an Advance Directive for ten residents (#68, #167, #1, #93, #15, #48, #76, #43, #168, and #57) out of forty-eight residents sampled. Findings included: 1. On 12/2/2024 1:00 p.m. Resident #167 was visited while in her room. Resident #167 stated she had been at the facility for rehabilitation services for about ten days and staff members had gone over her admission packet when she was admitted . Resident #167 stated related to her Advance Directive, I'm not sure I know what exactly that is, and is that related to the decision if I want emergency staff to keep my heart going if something happens to me? Resident #167 stated she was not sure all the involvement with the advance directive and felt staff did not explain it to her in detail. She stated she was her own decision maker and only remembers signing a document to support the admission packet was gone over with her. She stated she was not told about her rights to decline medical and surgical treatments during the admission process. Review of Resident #167's medical record revealed she was admitted to the facility on [DATE] for short term rehabilitation services. Review of the Advance Directive section on the face sheet revealed the resident was her own decision maker. Review of the Admission Minimum Data Set (MDS) assessment, dated 11/26/2024, revealed; (Section C. Cognition/Brief Interview Mental Status (BIMS) 15 of 15, which indicated the resident was able to speak with relation to her medical care and services and all other daily decisions). Review of the medical record, under the Evaluations section/tab revealed, SUN Advance Directives, dated 11/25/2024. The Advance Directive section revealed an acknowledgement section (C), indicating I have received copy of center's policies on Advance Directives and have been given the chance to ask questions regarding my rights to make decisions regarding my medical care. I understand that I have the right to refuse or accept medical and / or surgical treatment, and the right to formulate advance directives concerning my health care. Honoring resident choices requires providing the center with necessary and / or legal documentation appropriate for Advance Directives. This electronic form had a section for Resident signature, Representative signature, and Center representative signature. The Resident and Resident Representative section was blank and had no documentation to indicate the resident was provided with this information. The document was electronically signed by Staff W, who was the Social Service Assistant. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/4/2024 at 10:00 a.m. an interview with Staff C, Social Service Director (SSD) revealed all residents are to have Advance Directives reviewed during the admission process. She stated there was a signature of understanding page at the end of the admissions packet and this acknowledgement form is to show that a resident/resident representative understood and received the admission packet during the admission process. Staff C. stated the signature of understanding did not necessarily show a resident and/or resident representative was in full understanding of the Advance Directive rights. Staff C. provided a signature page from the admission packet that Resident #167 electronically signed on 12/3/2024, which was eleven days after she was admitted to the facility. Staff C agreed this signature page still did not reveal Resident #167 was provided with, and in full understanding of her advance directives rights. 2. On 12/2/2024 at 1:00 p.m. Resident #1 was interviewed while in her room. Resident #1 stated she had been at the facility for rehabilitation services for about a month and she did remember upon her admitted , staff members had gone over her admission packet. Resident #1 did not remember staff going over advance directives with her, but she remembered signing a sheet to show she received the admission packet. Resident #1 stated the Social Worker, or the staff who works with Social Services went through the packet very quickly and it was a lot of information to take in. Resident #1 stated she did know what Advance Directive rights were, but did not remember staff going over those rights with her. She stated she certainly did not remember staff explaining she had the right to decline medical services and outside services as part of her advance directive rights. Review of Resident #1's medical record revealed she was admitted to the facility on [DATE] for short term rehabilitation services. Review of the advance directives notes on the face page revealed Resident #1 was her own responsible party. Review of the admission Minimum Data Set (MDS) assessment, dated 11/10/2024, revealed; (Cognition/Brief Interview Mental Status BIMS - 15 of 15, which indicated the resident was able to speak to her daily decisions and medical care and services). Review of Resident #1's medical record to include the Miscellaneous tab/section, revealed, Authorization for Treatment while Residing at the Healthcare, dated 11/5/2024. Under the Resident/Responsible party signature section, it was documented; Verbal. The resident did not sign this authorization. It was only signed and dated by a staff witness on 11/5/2024. Under the Evaluations section/tab of the record revealed, SUN Advance Directives dated 11/5/2024. The Advance Directive section revealed an acknowledgement section (C), indicating I have received copy of center's policies on Advance Directives and have been given the chance to ask questions regarding my rights to make decisions regarding my medical care. I understand that I have the right to refuse or accept medical and /or surgical treatment, and the right to formulate advance directives concerning my health care. Honoring resident choices requires providing the center with necessary and /or legal documentation appropriate for Advance Directives. This electronic form had a section for Resident signature, Representative signature and Center representative signature. Resident and Resident Representative section was blank and had no documentation to indicate Resident #1 was provided with this information. The document was only electronically signed by the Staff C. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/4/2024 at 10:00 a.m. an interview was conducted with Staff C., SSD. Staff C. provided a signature page from the admission packet Resident #1 electronically signed on 11/7/2024, which was two days after she was admitted to the facility. Staff C. confirmed this signature page does not reveal Resident #1 was provided with, and in full understanding of her advance directive rights. 3. On 12/2/2024 at 2:00 p.m. Resident #15 was observed in her room and lying in bed with her Head Over Bed (HOB) approximately forty-five degrees. The resident stated she had been at the facility for many years. She stated admission process was too many years ago for her to remember in detail, but she was aware of what Advance Directives were. She stated she did not remember ever signing any paperwork to show she understood this right. Resident #15 confirmed over the past few years she had been readmitted at the facility after she was hospitalized . Resident #15 could not remember any staff going over her Advance Directive rights when she returned from the hospital visits. Resident #15 revealed though she has her daughter who makes her medical decisions, she (Resident #15) still would have and is part of her daily decision making to include advance directive. Review Resident #15's medical record revealed she was admitted to the facility on [DATE] and readmitted on [DATE]. Review of the advance directives section of the resident profile revealed Resident #15 had a Power of Attorney in place to make her medical decisions. Review of the current Quarterly Minimum Data Set (MDS) assessment, dated 10/11/2024, revealed: (Cognition/Brief Interview Mental Status - 15 of 15, which indicated the resident was interviewable and able to speak related to her care and services).; Review of Resident #15's medical record, under the Evaluation tab/section, it did not indicate a SUN Advance Directive. There was no evidence in the chart the resident or resident representative was informed of and offered Advance Directive information. There was no evidence in the medical record of any signature of understanding from the resident/representative related to this right. On 12/4/2024 at 1:00 p.m. an interview with Staff C., SSD. The SSD could not find documentation to support notification and receipt of Advance Directives with regards to Resident #15 4. On 12/2/2024 at 11:00 a.m. Resident #168 was interviewed related to his care and services and revealed he had been admitted at the facility for less than two weeks and he was at the facility for rehabilitation, with plans to return home. Resident #168 revealed he remembered the social worker going over his admission rights and admission packet the day or day after he was admitted . He revealed he signed a form to show he received information, but did not remember the Social Worker, or even the Admission's coordinator going over any Advance Directive rights. He confirmed he was not aware he could refuse outside medical treatment, or medical services, and or surgical treatments. He confirmed he did not sign any paperwork of understanding related to those rights. Review of Resident #168's medical record revealed he was admitted at the facility on 11/25/2024. Review of the advance directives section of the resident profile revealed Resident #168 was his own responsible party. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the current Admission Minimum Data Set (MDS) assessment, dated 11/29/2024, revealed; (Cognition/BIMS score - 15 of 15, which indicated the resident was able to speak related to his medical care and service). Under the Evaluations section/tab of the medical record revealed, SUN Advance Directives dated 11/29/2024. The Advance Directive section revealed an acknowledgement section (C), indicating I have received copy of center's policies on Advance Directives and have been given the chance to ask questions regarding my rights to make decisions regarding my medical care. I understand that I have the right to refuse or accept medical and/or surgical treatment, and the right to formulate advance directives concerning my health care. Honoring resident choices requires providing the center with necessary and / or legal documentation appropriate for Advance Directives. This electronic form had a section for Resident signature, Representative signature and Center representative signature. Resident and Resident Representative section was blank and had no documentation to indicate the resident was provided with this information. The document was electronically signed by Staff C. There was no documented evidence in the chart that Advanced Directives rights were acknowledged and signed for by Resident #168. 5. A review of Resident #43's Admission Record revealed an original admitted [DATE] and a re-admitted [DATE]. The Admission Record revealed diagnoses to include Chronic Obstructive Pulmonary Disease, unspecified, Hemiplegia and Hemiparesis following cerebral infarction affecting left non-dominant side, aphasia following cerebral infarction, muscle weakness (generalized), and Chronic Kidney Disease, Stage 2 (mild). The Admission Record revealed the following under Advance Directive, Code Status: Full Code. On 12/2/24 at 4:38 p.m., an interview with the Social Service Director revealed when a resident is initially admitted or readmitted to facility the 3008 form from the hospital is reviewed to determine the resident's Advance Directive choices. She stated the Advance Directive is explained to the residents through the admission packet. She stated the Advanced Directive are also discussed in care plan meetings. The Social Service Director stated she talked to resident about Advanced Directive. She stated the health care surrogate election and documents the family, or resident, already has is discussed. She stated a hard copy of Advanced Directive, such as Do Not Resuscitate (DNR), are kept in her office as well as in each unit nurses' station. The Social Service Director stated Advanced Directive information can be found in the resident's care plan and in the electronic medical record. She stated the Advanced Directive documents should be uploaded to the resident's electronic medical record. She stated once or twice a month she does an audit regarding Advanced Directives. The Social Service Director stated if the resident is a non-English speaker, then she uses a tablet the facility has with a translating service to discuss Advanced Directive rights. She stated if the resident is not able to make decisions due to their cognitive level, then Advanced Directives are discussed with the health care surrogate or Power of Attorney (POA). She stated if a resident comes to the facility with an Advanced Directive of, Full code, then she would speak to them about continuing with those wishes or if they wanted to make changes. The Social Service Director stated she was not sure if a signature page or acknowledgement regarding Advanced Directive is included in the admission packet. On 12/3/24 at 10:48 a.m., an observation of Resident #43 revealed she was lying down in bed. An interview with the resident revealed she does not recall advanced directive rights being discussed with her by facility staff. She confirmed she was told she has the right to refuse services. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #43's evaluations revealed a document titled, SUN Advance Directives, with an effective date of 10/14/24 and an admitted [DATE]. A review of the document under, Acknowledgement, revealed no evidence of the Resident or Resident Representative's signature. Further review of the document revealed the Social Service Director's name next to the area which indicated, Center Representative Signature. A review of Resident #43's medical record revealed no evidence of acknowledgement of advanced directive, to include their right to formulate an advanced directive, or their right to accept/refuse medical or surgical treatment. A review of the resident's medical record revealed no documented evidence the facility provided Advance Directive information. 6. A review of Resident #76's Admission Record revealed an original admitted [DATE] and a re-admitted [DATE]. The Admission Record revealed diagnoses to include Type 2 Diabetes Mellitus with diabetic Polyneuropathy, muscle weakness (generalized), and moderate non-proliferative diabetic retinopathy without macular edema, bilateral. The Admission Record revealed the following under Advance Directive, Full Code. On 12/3/24 at 10:52 a.m., Resident #76 was observed ambulating herself in the wheelchair from the first floor nurses' station to the common room. An interview with the resident revealed a family member handled her medical decisions. She stated the advanced directive was discussed with her and most likely her family member as well. Resident #76 stated she did not recall signing a document to acknowledge advanced directive was discussed with her. A review of Resident #76's evaluations revealed a document titled, SUN Advance Directives, with an effective date of 11/25/24 and an admitted [DATE]. A review of the document under, Acknowledgement, revealed no evidence of the Resident or Resident Representative's signature. Further review of the document revealed the Social Service Director's name next to the area which indicated, Center Representative Signature. A review of Resident #76's medical record revealed no evidence of acknowledgement of advanced directive, to include their right to formulate an advanced directive, or their right to accept/refuse medical or surgical treatment. A review of the resident's medical record revealed no documented evidence the facility provided Advance Directive information. 7. A review of Resident #93's Admission Record revealed an initial admitted [DATE], original admitted [DATE], and a re-admitted [DATE]. The Admission Record revealed diagnoses to include acute myeloblastic leukemia, not having achieved remission, systemic lupus erythematosus, unspecified, muscle weakness (generalized), other specified soft tissue disorders, conversion disorder with seizures or convulsions, and Sjogren syndrome. The Admission Record revealed the following under Advance Directive, Code Status: DNR - Do Not Resuscitate. A review of Resident #93's Admission Agreement, on page 6, revealed an electronic acknowledgement from the resident and her representative. The document revealed no indication the signed agreement was related to Advance Directive discussion and acknowledgement. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106041	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER: Harbourwood Post-Acute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 549 Sky Harbor Dr Clearwater, FL 33759	

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #93's medical record, under miscellaneous documents, revealed signed forms to include durable power of attorney, designation of a healthcare surrogate, and a living will. Resident #76's medical record revealed no evidence of acknowledgement of advanced directive, to include their right to formulate an advanced directive, or their right to accept/refuse medical or surgical treatment. A review of the resident's medical record revealed no documented evidence the facility provided Advance Directive information. On 12/5/24 at 2:16 p.m., an interview was conducted with the SSD, the Director of Nursing (DON), and Staff K, Registered Nurse (RN) Consultant. The SSD stated the Advanced Directive acknowledgement is in the resident's admission agreement. She stated in the admission agreement, there is a section related to Advanced Directive. The SSD stated the resident welcome packet also included Advanced Directive information. She stated during the review of the Admission Agreement the resident and/or resident representative are present. A review of page 14 of the Admission Agreement revealed it is the acknowledgment, and the signature page related to Advanced Directive. The RN consultant stated the document titled, Sunview evaluations, is what the facility used for the Advanced Directive Acknowledgement. She stated the use of the Sunview form is a fairly new process the facility started implementing in 11/2024. The SSD stated when the resident is initially admitted or readmitted , she reviews the code status. She stated she interviews the resident and asks them information related to choosing a health care surrogate, completing a living will, delegating a durable POA and if they have any prepared paperwork related to Advanced Directive. The SSD stated she offers assistance if residents do not have a healthcare surrogate or power of attorney in place. The SSD confirmed she reviewed and discussed Advanced Directive with residents, however, there is no evidence of the resident's signature or documentation that she did. She stated when she completes the Social Service Assessment, she includes in her documentation she reviewed Advanced Directive, but confirmed the residents did not sign the acknowledgement form. 8. During an interview on 12/02/2024 at 2:48 p.m., with Resident #57's family member (FM) he stated he is happy with the care his father is receiving and had no concerns. He stated he was unsure of any triggers regarding Resident #57's Post Traumatic Stress Disorder (PTSD). He stated the facility, and staff are good at handling his care. Review of Resident #57's admission record revealed an initial admitted [DATE] and a readmitted [DATE]. Resident #57 was admitted to the facility with diagnosis of major depressive disorder, moderate brief psychotic disorder, other specified anxiety disorders, unspecified mood affective disorder, PTSD and seizures. Review of the medical record under the Evaluation section did not indicate a SUN Advance Directive. There was no evidence in the chart the resident/resident representative was informed of and received information on Advance Directive. 9. Review of the Admission Record showed Resident #68's initial admitted to the facility was on 10/11/24. Resident # 68's diagnoses included chronic respiratory failure, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus Type 2, Chronic Kidney Disease, atherosclerotic heart disease, and cardiac pacemaker. Review of Resident #68's Minimum Data Set (MDS), annual dated 10/15/24, Brief Interview for Mental Status (BIMS) revealed a score is 13 indicating, intact cognition. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/4/24 at 1:37 P.M., Resident # 68 was lying in bed, wearing nasal cannula and said he did not remember the facility discussing his right to accept or refuse medical treatment. A review of Resident #68's medical record on 12/2/24 and 12/3/24, revealed no signed acknowledgement of Advanced Directive were reviewed with Resident #68 or their resident representative. 10. Review of the Admission Record showed Resident #48's initial admitted to the facility was on 1/9/2020. Resident # 48's diagnoses included dementia, prostate cancer, heart disease, and Chronic Obstructive Pulmonary Disease (COPD). A review of Resident #48's medical record on 12/2/24 and 12/3/24, revealed no signed acknowledgement of Advanced Directive was reviewed with Resident #48 or the resident representative. Review of facility's policy titled, Residents' Rights Regarding Treatment and Advanced Directive, date implemented 12/1/2022 revealed the following: Policy: It is the policy of this facility to support and facilitate a resident's right to request, refused and or discontinue medical or surgical treatment and/to formulate an advanced directive. An advanced directive is a written instruction, such as a living will or durable power of attorney for health care, recognize under State law (whether statutory or as recognized by courts of the State), related to the provision of health care when the individual is incapacitated. Compliance Guidelines includes the following: 1) On admission, the facility will determine if the resident has executed an advanced directive, and if not, determine whether the resident would like to formulate an advance directive. 2) The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advanced directive. 3) Upon admission, should the resident have an advanced directive, copies will be made and placed on the chart as well as communicated to the staff. 4) The facility will periodically assess the resident for decision-making abilities and approach the health care proxy or legal representative if the resident is determined not to have decision making capacities. 5) The facility will identify or arrange for an appropriate representative for the resident to serve as primary decision maker if the resident is assessed as unable to make relevant healthcare decisions. 6) The facility will define and clarify medical issues and present them to the resident or legal representative as appropriate. 7) During the care planning process, the facility will identify, clarify, and review with the resident or legal representative whether they desire to make changes related to any advanced directives. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8) Decisions regarding advanced directives and treatment will be periodically reviewed as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions. 9) Any decision making regarding the resident's choices will be documented in the resident's Medical record and communicated to the interdisciplinary team and staff responsible for the resident's care. 10) The facility will not discharge or transfer our resident should they refuse treatment either through an advanced directive are directly unless the criteria for transfer or discharge are otherwise met. 11) Should the resident refuse treatment of any kind, the facility will document the refusal in the residence chart. 12) The facility will not initiate or discontinue any other care based on refusal of care by the resident. 50570 50434 49227

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50434 Based on observation and interview, the facility failed to ensure personal privacy was honored by providing a private space for one resident (R #16) out of 31 residents sampled to use the phone. Findings Included: During an observation on 12/03/2024 at 10:30 a.m., Resident #16 was observed sitting in a wheelchair in front of the nurse's station on the phone. During an interview on 12/03/2024 at 4:30 p.m., Resident #16 stated she did not want a phone in her room because there were plenty of other phones around the house she could use. An observation of Resident #16's room revealed Resident #16 did not have a phone in her room. Review of Resident #16's admission record revealed an admitted [DATE]. Review of the Resident #16's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 03 out of 15 revealing severe cognitive impairment. During an interview on 12/4/24 at 3:59 p.m., the Resident Council President and Resident Council Secretary revealed most residents had cell phones and or a phone in their room. The Resident Council Secretary stated it was normal for residents to talk on the phone at the nurse's stations. She stated the phone had a long cord. She stated the residents could go all the way around when they need to, to get privacy. She stated most residents sat at the nurse's station and used the phone. The Resident Council Secretary stated she did not think residents or staff listened to their conversations when they were talking on the phone. During an interview on 12/03/2024 at 10:45 a.m., Staff I, LPN, Unit Manager, stated Resident #16's family called the nurses station to speak with the resident. She stated she was not able to transfer the call to the resident's room because the phone in the resident's room had connection issues. During an interview on 12/03/2024 at 6:20 p.m., the Director of Nursing (DON) stated if a family called the nurse's station to speak with a resident, the call should be transferred to the resident's room so they could have a private call. She stated if the resident decided to take a call at the nurse's station, the resident should be moved into the Unit Managers office, so they were provided with privacy. ON 12/05/2024 the facility was asked to provide a policy on Privacy and it was not provided.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498 Based on observation, record review, and interview, the facility failed to provide a safe, clean, home like environment on one (2nd floor) out of 2 floors observed. Findings include: An observation was made on 12/2/2024 at 10:00 am. in room [ROOM NUMBER] on the second floor. The bathroom was observed with a hole in one of the ceiling tiles. Further observation showed a section of the bathroom floor tiled lifted from the floor. On 12/2/2024 at 1:00 p.m., during an observation on the second floor, three residents were seen sitting in their wheelchairs next to grab rails/chair rails near the nursing station. The rails were observed with a separated section and sharp gaps with potential to cause injuries. Photographic evidence obtained. 49227 2. On 12/2/24 at 10:10 a.m., a portable air conditioner unit with an exhaust hose to the outside was observed in room [ROOM NUMBER]. The resident in the room said the portable air conditioner had been in her room since admission to the facility. On 12/3/24 at 11:16 a.m., the portable air conditioner unit in room [ROOM NUMBER] had a thick layer of grey dust coating the filter located on the back part of the machine. A layer of particles coated the inside of the white air conditioner portable exhaust hose. On 12/5/24 at 11:26 a.m., an observation and interview was conducted with Staff I, Licensed Practical Nurse (LPN), Unit Manager (UM) in the second-floor shower room. The grab bars in three of four shower stalls had various areas of reddish-brown flaky coating. The third shower stall contained a shower gurney with a blue foam pad. Staff I, LPN, UM confirmed the shower gurney was a multi-resident use equipment. The blue foam pad had an approximately five inches by 0.5-inch linear tear on the upper half. Staff I, LPN, UM said a replacement foam pad for the shower gurney would be ordered. Photographic Evidence Obtained. On 12/5/24 at 5:02 p.m., a facility tour was conducted with the Nursing Home Administrator (NHA), Maintenance Director, and the Regional Maintenance Director (RMD). The Maintenance Director said the portable air conditioner unit would be removed. When shown the dust on the filter and in the tubing, he said I see. After observation of the rusted grab bars in the shower room the Maintenance Director said, that's an easy fix. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility's policy titled Safe and Homelike Environment, implementation date not documented revealed: In accordance with resident's rights, the facility will provide a safe, clean, comfortable and home light environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes residence independence and does not pose a safety risk. Comfortable and safe temperature levels mean that the ambient temperature should be in a relatively narrow range that minimizes residents' susceptibility to loss of body heat and risk of hypothermia hyperthermia and is comfortable for the residents. Comfortable sound levels means levels that do not interfere with the residents hearing, levels that enhance privacy when privacy is desired, and levels that encourage interaction when social participation is desired. Environment refers to any environment in the facility that is frequented by residents, including (but not limited to) the residents' room, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas. A home like environment is one that de-emphasizes the institutional character of the setting, to the extent possible, and allows the resident to use those personal belongings that support a home like environment. A determination of home like should include the resident's opinion of the living environment. Orderly is defined as an uncluttered physical environment that is neat and well kept. Sanitary includes, but is not limited to, preventing the spread of disease- causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes, but is not limited to equipment used in the completion of activities of daily living. Policy explanation guidelines includes: 1) the facility will create and maintain, to the extent possible, a home like environment and de-emphasize the institutional character of the setting. 1a) the facility will allow residents to use their personal belongings, including furnishings and clothing (as space permits) to assist in creating and maintaining a home like environment. This use must not infringe upon the rights or health and safety of other residents. 1b) The social service designee, or another designated staff member, will encourage residents and their family to bring in personal belongings (within space constraints) to personalize residents' rooms. 1c) the facility will honor and document a resident's choice not to personalize his/her room. 2) The facility exercises reasonable care for the protection of the residents property from loss or theft. 3) housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment. 4) The facility will provide and maintain bed and bath linens that are clean and in good condition. 5) The facility will provide sufficient individual closet space in each resident room. 6) the facility will provide and maintain adequate and comfortable lighting levels in all areas. 6a) The maintenance director will perform periodic rounds to ensure functioning lights. 6b) Even light levels should be utilized in common areas and hallways to avoid patches of low light. 6c) Daylight should be utilized as much as possible. 7. The facility will maintain comfortable and safe temperature levels. 7a) the facility should strive to keep the temperature in common resident areas between 71 F and 81 F. 7b) if and when a resident prefers his or her room temperature be kept below 71 F or above 81 F, the facility will assess the safety of this practice on the resident and the resident's roommate. 7c) if and when residents who share a room do not agree on the temperature of the room, the facility will assist in negotiating a compromise that the residents agree on, or will assist in a room change. 8) The facility will maintain comfortable sound levels in the facility. Overhead paging will be limited to emergency situations and as needed for providing prompt care and treatments of residents.

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498 Based on observation, record review, and interviews, the facility failed to accurately complete resident assessments, reflective of the resident's status at the time of the assessment, for two Residents (#77 and #113) of eight residents sampled. Findings included: 1. On 12/2/2024 1:47 PM an interview was conducted with Resident # 77, who was observed lying down in bed. She stated she is upset with the facility because they have lost two sets of her hearing aids, and nothing has been done about it. She stated she was told by staff she has to pay for her replacement hearing aids but no one has followed up with her to make the arrangements. Review of Resident #77's Admission Record showed Resident #77 was admitted to the facility originally on 1/26/2023 and readmitted on [DATE]. Review of Resident #77's Quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed under Section B - Hearing, Speech, and Vision, the resident had adequate hearing and did not use hearing aids. The MDS Assessment also revealed under Section C - Cognitive Patterns, a BIMS (Brief Interview for Mental Status) score of 15, which indicated the resident is cognitively intact. Review of Resident #77's Chart Notes dated 5/17/2024 showed Resident #77 reported on 5/17/2024 during her audiological evaluation with the clinician she had hearing aids but did not know where they were, and she would like to have a set of hearing aids to hear better. Further review of the Chart Note showed Resident #77 showed the resident could benefit from amplification due to the resident reporting having trouble understanding conversation and the need to have people repeat what they have said. Review of Resident #77's Audiologic Report dated 5/17/2024 showed Resident #77 has moderate-severe sloping hearing loss in the right ear and mild-severe sloping hearing loss in the left ear. During an interview on 12/5/2024 at 11:00 AM., with Staff BB, Registered Nurse (RN) and Lead MDS Coordinator. Staff BB, RN stated once Resident #77 was seen by the audiologist, she should have completed an MDS assessment to show the resident has hearing loss and requires the use of hearing aids. Once a resident has been seen by audiology, Social Services should have informed MDS so they could update the resident assessment to reflect the resident hearing loss and the use of hearing aids. 2. Review of Resident #113's Admission Record showed Resident # 113 was admitted to the facility on [DATE]. The Admission Record also showed Resident #113 was discharged home from the facility on 9/21/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106041	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024

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Harbourwood Post-Acute and Rehabilitation Center	549 Sky Harbor Dr Clearwater, FL 33759

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #113's MDS assessment dated [DATE] showed the following under Section A - Identification Information: - A0310. Type of Assessment - Discharge assessment-return not anticipated. - A2105. Discharge Status - Short-Term General Hospital. During an interview on 12/5/2024 at 11:00 AM with Staff CC, License Practical Nurse(LPN) and MDS Coordinator, Staff CC, LPN stated Resident #113's discharge status on the MDS Assessment showed she went to the hospital and was not discharged home. Staff CC, LPN also stated the MDS Assessment is inaccurate, which was an oversight on her part. Resident #113's MDS Assessment should have shown she was discharged home and not to the hospital. Staff CC, LPN stated the facility does not have a policy related to MDS Assessments because they use the Resident Assessment Instrument (RAI) as a guide for the MDS Assessments.

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20536 Based on record review and interviews, the facility failed to ensure the Preadmission Screening and Resident Review (PASARR) were completed accurately and updated to reflect new Mental Illness (MI), or Suspected Mental Illness (SMI) diagnoses for five residents (#51, #66, #75, #57, and #69) of forty-nine sampled residents. Findings included: 49227 1. Review of Resident #51's Admission Record showed an admitted [DATE], with diagnoses to include bipolar disorder, major depressive disorder, and claustrophobia. Review of Resident #51's Level I PASRR, dated 7/29/2024, showed the following: - Section I-Part A. MI (Mental Illness) or suspected MI: Bipolar and Depressive Disorder were marked. Part B. ID (Intellectual disability) or suspected ID was blank. - Section II: Other Indications for PASRR Screen Decision-Making: Questions 1 through 7 were marked no. - Section III: PASRR Screen Provisional Admission or Hospital Discharge Exemption: Not a Provisional Admission was marked. - Section IV: PASRR Screen Completion: Individual may be admitted to a Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required was marked. During a review of Resident #51's electronic health records, a Level II PASARR could not be located. 2. Review of Resident #66's Admission Record showed an admitted [DATE], with diagnoses to include alcohol abuse, major depressive disorder, and anxiety disorder. Review of Resident #66's Level I PASRR, dated 11/29/2024, showed the following: - Section I-Part A. MI (Mental Illness) or suspected MI: Depressive Disorder and Substance Abuse were marked. Part B. ID (Intellectual disability) or suspected ID, was blank. - Section II: Other Indications for PASRR Screen Decision-Making: Questions 1 through 7 were marked no. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Section III: PASRR Screen Provisional Admission or Hospital Discharge Exemption: Not a Provisional Admission was marked. - Section IV: PASRR Screen Completion: Individual may be admitted to a Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required was marked. During a review of Resident #66's electronic health records a Level II PASARR could not be located. On 12/03/2024 at 4:38 p.m. a request was made to the Social Services Director (SSD) for copies of resident #51 and #66's Level II PASARRs. On 12/4/2024 the SSD provided resident #51 and #66's Level I PASARRs and Level II PASARRs were not provided. On 12/5/2024 at 1:34 p.m. an interview was conducted with the Director of Nursing (DON), SSD, and Regional Clinical Nurse (RNC). The SSD confirmed Level II PASARRs were not available for residents #51 and #66. 50434 3. During an observation on 12/3/2024 at 8:50 a.m., Resident #75 was heard screaming Help from her room. During an observation on 12/04/2024 9:55 a.m., Resident #75 was heard screaming from her room. Review of Resident #75's Admission Record showed Resident #75 was initially admitted on [DATE] and a readmitted [DATE] with diagnoses of unspecified dementia, unspecified severity with agitation, bipolar disorder, current episode manic without psychotic features, and major depressive disorder, recurrent. Review of Resident #75's Level I PASRR, dated 11/26/2024, showed the following: - Section I-Part A: MI (Mental Illness) or suspected MI: Bipolar and Depressive disorder were marked. Part B. ID (Intellectual disability) or suspected ID, was blank. - Section II: Other Indications for PASRR Screen Decision-Making: Questions 1 through 7 were marked no. - Section III: PASRR Screen Provisional Admission or Hospital Discharge Exemption: Not a Provisional Admission was marked. - Section IV: PASRR Screen Completion: Individual may be admitted to a Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required was marked. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106041	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER: Harbourwood Post-Acute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During an interview on 12/2/2024 at 2:48 p.m. with Resident #57's family member (FM), he stated he is happy with the care his father is receiving and had no concerns. He stated he was unsure of any triggers regarding resident #57's Post Traumatic Stress Disorder (PTSD) and the facility, and staff are good at handling his care. Review of Resident #57's Admission Record revealed an initial admitted [DATE] and a readmitted [DATE]. Resident #57 was admitted to the facility with diagnosis of major depressive disorder, moderate brief psychotic disorder, other specified anxiety disorders, unspecified mood affective disorder, post-traumatic stress disorder and seizures. Review of the Level I PASRR, dated 3/14/2022, showed the following: - Section I-Part A MI (Mental Illness) or suspected MI (Mental Illness): major depressive disorder, moderate brief psychotic disorder, other specified anxiety disorders, unspecified mood affective disorder, post-traumatic stress disorder, and seizures, were not marked. Part B. ID (Intellectual disability) or suspected ID (Intellectual disability) was blank. - Section II: Other Indications for PASRR Screen Decision-Making: Questions 1 through 7 were marked no. - Section III: PASRR Screen Provisional Admission or Hospital Discharge Exemption: Not a Provisional Admission was marked. - Section IV: PASRR Screen Completion: Individual may be admitted to a Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required was marked. 46498 5. Review of Resident #69's Admission Record showed Resident #69 was admitted to the facility on [DATE] with diagnoses to include but not limited to encephalopathy, unspecified, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, major depressive disorder recurrent, moderate, and bipolar disorder, current episode depressed, mild. Review of a Document titled Florida Preadmission Screening and Resident Review (PASRR) Level II Determination Summary Report Administrative Closure dated 8/22/2024 showed Resident #69's review was closed due to the facility submitting an incomplete referral packet. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/5/2024 at 1:58 p.m. an Interview was conducted with Staff Z, Registered Nurse (RN) and 3 p.m. to 11 p.m. Supervisor. Staff Z, RN stated a Level II Preadmission Screening and Resident Review was submitted for Resident #69. The resident was triggered for a Level II due to her diagnoses. Staff Z, RN stated she reached out to KePRO regarding the Level II PASRR and was told she had to resubmit paperwork due to the lack of information submitted the first time. She stated she reached out to KePRO a while back but did not hear back from them. Review of the facility policy titled Resident Assessment - Coordination with PASARR Program, last revised on 12/20/2023, showed under the section titled Policy, this facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disabilities, or a related condition received cares and services in the most integrated sitting appropriate to their needs. The policy also showed under the section titled Policy Explanation and Compliance Guidelines, 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. 6. The Social Services Director will be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority. 9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or related condition will be referred promptly to the state mental health or intellectual disability authority for a Level II resident review.

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	106041	A. Building B. Wing	12/05/2024

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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 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** 50434 Based on observation, interview, and record review, the facility did not ensure a resident centered care plan was developed for one resident (#57) out of 31 residents sampled, related to Post-Traumatic Stress Disorder. Findings Included: During an interview on 12/2/2024 at 2:48 p.m. with Resident #57's family member (FM), he stated he is happy with the care his father is receiving and had no concerns. He stated he was unsure of any triggers regarding resident #57's Post Traumatic Stress Disorder (PTSD) and the facility, and staff are good at handling his care. Review of Resident #57's Admission Record revealed an initial admitted [DATE] and a readmitted [DATE]. Resident #57 was admitted to the facility with diagnoses of major depressive disorder, moderate brief psychotic disorder, other specified anxiety disorders, post-traumatic stress disorder (PTSD), and unspecified mood affective disorder. A review of Resident #57's care plan revealed no focus, goal or interventions related to PTSD. During an interview on 12/5/2024 at 10:50 a.m., the Social Services Director stated, Resident #57 has a diagnosis of PTSD and is care planned. She reviewed Resident #57's care plan and stated, Resident #57 is planned for potential for mood state issues related to PTSD/Depression. She stated they observe his mood and his psychosocial status and would notify the physician if there was a change. She was not able to specify if the resident had any specific triggers related to his PTSD. She stated she would review the psych notes to determine what triggers the resident has. She was not able to answer how other staff members would know what triggers to watch for residents who have PTSD. During an interview on 12/4/2024 at 6:28 p.m., the Director of Nursing (DON) and Regional Nurse stated, residents should be care planned if they have PTSD. There is a PTSD evaluation that is done by social services and quarterly. If an evaluation is completed at shows a resident has PTSD, they would then notify psych so they can get involved and do their own evaluation. Review of the facility policy titled Comprehensive Care Plans dated 9/7/2022, showed under Policy, 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. The policy also revealed under 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. 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.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide care and assistance to perform activities of daily living for any resident who is unable.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49227

Based on observation, interview, and record review, the facility failed to ensure Activities of Daily Living (ADL) care related to 1. removal of facial hair for one (#18) of 31 sampled residents and 2. did not ensure the cleaning and trimming of fingernails for two (#68 and #48) out of 31 residents sampled.

Findings Included:

1. During an interview on 12/02/2024 at 10:26 a.m., resident was observed sitting in a wheel chair in the hallway. She stated she was leaving her room for a little while. She was observed to have strands of white facial hair on her chin. She stated if she could just get a razor, she could take care of them herself. She stated no one had offered to help her.

During an interview on 12/04/2024 at 5:30 p.m., resident #18 was observed lying in bed dressed in a red sweater. She was observed to have strands of white facial hair on her chin. Resident #18 stated if they give me some tweezers I can take care of it, but I'm not sure if they even have tweezers here.

During an interview on 12/05/2024 at 4:31 p.m., with the Resident #18's family member (FM), she stated she had spoken with staff about her mom having facial hair and staff has told her They were not allowed to remove it.

Review of Resident #18's admission record revealed an admitted [DATE] and a re-admitted [DATE].

Review of Resident #18's quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 05 out of 15 which indicated severe cognitive impairment. Continued review of the MDS revealed Resident #18 was dependent with supervision or touching assistance with shower/bath.

During an interview on 12/04/2024 at 3:10 p.m., Staff F, Certified Nursing Assistant (CNA) stated she helped residents with their daily living activities such as brushing teeth, changing clothing, taking showers. She stated on shower days she asked the residents if they wanted their showers. She stated she liked to get most of her showers done in the morning. She stated during the showers she offered to wash the resident's hair and offered to shave the resident. She stated she would offer to help remove the facial hair from female residents as well.

During an interview on 12/04/2024 at 3:05 p.m., Staff G, CNA stated he assisted residents with dressing, and bathing. He stated on shower days he checked if the resident would like to take a shower. He stated the residents did like to refuse showers. He stated he attempted a few times to get the resident to take a shower and if they do not want a shower, he wrote it on the shower sheet and then notified the nurse. He stated when he gave the residents their shower he made sure to wash their hair, their body, and asked the resident if they needed help shaving. He stated he would also offer facial hair removal to a female resident during shower time.

(continued on next page)

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	106041	A. Building B. Wing	12/05/2024

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/04/2024 at 3:22 p.m., Staff H, CNA, stated on shower days they provided a shave, wash hair and wash the residents. Females with facial hair were asked if they would like it removed and was typically removed on their shower days. During an interview on 12/04/2024 at 6:20 p.m., the Director of Nursing (DON) and the Regional Nurse stated female residents who had facial hair should be asked if they would like it removed. CNAs and Nurses were responsible for asking the residents and removing the facial hair for those residents. 2. On 12/02/24 at 10:46 a.m., Resident #68 was observed lying in bed his fingernails were approximately 1/2 inch in length with a yellow and brown substance under the nails. Resident #68 said he requested to have his fingernails trimmed and it was not done. He pointed to his right thumb and said the nail tore and needed to be cut, it catches on things. Resident # 68 said he told the Certified Nursing Assistants (CNAs) and the nurses many times he would like to have his nails trimmed. Photographic Evidence Obtained. Review of the Admission Record showed Resident #68's initial admitted to the facility was on 10/11/24. Review of Resident #68's annual Minimum Data Set (MDS) dated [DATE], showed Section C, cognitive patterns, Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. Section GG, functional abilities showed Resident #68 required substantial/maximal assistance with shower/bath. Supervision or touching assistance was needed for personal hygiene. Review of Resident #68's Quarterly Nursing Evaluation, dated 11/28/24 showed assistance was needed for one or more Activities of Daily Living (ADL) and the resident was alert. Review of the ADL care plan showed a focus for Resident #68 as follows, has an ADL self-care performance deficit related to COPD/Chronic Respiratory failure/Obesity/Depression and Functional Quadriplegia, date Initiated, 07/15/2024. The care plan's goal was Resident #68 will maintain current level of function through the review date. The interventions included checking nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. On 12/3/24-12/4/24 Resident #68 was observed lying in bed, fingernails remain untrimmed with yellow and brown substance under the nail beds. Resident #68 said he would like his nails trimmed. Review of Resident #68's task list titled, ADL-bathing schedule, showed the showers were given on the following dates: 11/16/24, 11/20/24, 11/25/24, 11/27/24, 11/28/24, 11/29/24, and 12/4/24. During observation and interview on 12/02/24 at 11:26 a.m., Resident #48 was sitting in his wheelchair; his fingernails were approximately one inch in length with dried yellow/orange substance under nails and nail beds. Resident #48 said he wanted his fingernails trimmed. Review of Resident #48's ADL Bathing scheduled showed he was dependent with care and had showers on the following days: 11/18/24, 11/19/24, 11/21/24, 11/25/24, 11/26/24, 11/27/24, 11/28/24, 12/2/24, and 12/3/24. (continued on next page)

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	106041	A. Building B. Wing	12/05/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #48's care plan focused on self-care deficit with dressing, grooming, bathing related to cognitive deficit, generalized weakness and limited endurance, initiated on 1/10/20. The care plan goal was Resident #48 will have clean, neat appearance daily through the next review date. The care plan interventions include providing hands on assistance with dressing, grooming, and bathing as needed, initiated on 1/10/20. Review of the Admission Record showed Resident #48's initial admitted was on 1/9/2020. During daily observations of Resident #48's fingernails between 12/3/24 to 12/5/24 fingernails remained long, with dry yellow/orange substance under the nails. During an interview on 12/3/24 at 9:54 a.m., the Director of Nursing (DON) said residents were offered showers two times weekly and could request additional showers if preferred. During an interview on 12/5/24 at 7:49 a.m., Staff W, Patient Care Assistant (PCA), said she assisted residents with showers, she did not cut fingernails, and podiatry provided nail care. During an interview with the DON and Staff B, Registered Nurse (RN), Unit Manager (UM). The DON said the nursing assistants should provide nail care with showers, it's part of ADL care. During an interview on 12/5/24 at 11:18 a.m., Staff I, Licensed Practical Nurse (LPN), Unit Manager (UM) said everybody is responsible for fingernail care. Review of facility's policy titled, Activities of Daily Living (ADLs), date implemented 9/7/22 revealed: Policy- the facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities and ADL's do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1) bathing, dressing, grooming and oral care 2) transfer and ambulation 3) Toileting 4) Eating to include meals and snacks 5) Using speech, language or other functional communication systems. Policy explanation and compliance guidelines: 1) conditions which may demonstrate unavoidable decline in ADL include 1a) natural progression of the resident's disease state with known functional decline. 1b) Deterioration of the resident's physical condition associated with the onset of an acute physical or mental disability while receiving care to restore or maintain functional abilities. 1c) Refusal of care and treatment by the resident or his/her representative to maintain functional abilities after efforts by the facility to inform and educate about the benefits/risks of the proposed care and treatment, council and our offer alternatives to the resident or representative. 2) the facility will provide a maintenance and restorative program to assist a resident in achieving and maintaining the highest practicable outcome based on the comprehensive assessment. 3) A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene. 4) The facility will identify resident triggers through the Care Area Assessment (CAA) process to assess causal factors for decline, potential decline or lack of improvement. 5) The facility will maintain individual objectives of the care plan and periodic review and evaluation. 50434

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

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498 Based on observation, record review and interview the facility failed to coordinate audiology services for one resident out of eight residents sampled (#77). Findings include: On 12/02/24 at 9:00 AM and at 01:47 PM, Resident # 77 was observed lying down in bed with her call light within reach. She stated she is upset with the facility because they have lost two sets of her hearing aids, and nothing has been done about it. She stated she was told by staff that she had to pay for her replacement hearing aids but no one has followed up with her to make the arrangements. Review of an Admission Record dated 12/5/2024 showed Resident #77 was admitted to the facility originally on 1/26/2023 and readmitted on [DATE] with diagnoses to include but not limited to paroxysmal atrial fibrillation, morbid (severe) obesity due to excess. Review of Quarterly MDS assessment dated [DATE] Section C, Cognitive Patterns/ BIMS showed a score of 15 which indicated cognitively intact Review of an audiology note dated 5//17/2024 showed Resident #77 reported on 5/17/2024 during her visit with the clinician that she had hearing Aids but did not know where they were. She further reported she would like to have a set of hearing aids so she can hear better. Further review of the audiology report showed Resident #77 had moderate-severe sloping hearing loss in her right ear and mild-severe sloping hearing loss in her left ear. On 12/4/2024 at 12:30 PM, an interview was conducted with Staff I, License Practical Nurse/Unit Manager. Staff I stated when a resident is admitted to the facility with hearing aids the nurses write an order to put the hearing aid in and a time to take the hearing aid out of the resident's ear. After the residents hearing aids are taken out, they are stored on the nurse's cart. Residents hearing aids are inventoried on their inventory sheets. If a resident needs to be seen by an audiologist, she would report it to social services, and they would schedule the appointment to have them come to the facility to see the resident. She stated she is responsible for reviewing the notes once the clinician has seen the resident. She stated if a resident reports that they are missing their hearing aids and they wanted another pair to the clinician she would report it to social services. She stated she did not read the audiologist assessment note because the resident was not on her unit at that time. (continued on next page)

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	106041	A. Building B. Wing	12/05/2024

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/2024 at 5:00 PM., an interview was conducted with Staff C, Social Service Director. Staff C stated the facility did not have a lot of residents that requested hearing aids before. If a resident comes to social services or to nursing and says that they are not hearing right, they will have the practitioner, or the primary care see the resident to see if there is some type of wax build up to rule out any types of medical related issues. Then they would refer the resident to audiology for an evaluation if the resident were able to sit for the exam. They just had audiology come to the facility in May. Resident #77 was seen on May 17 of 2024. After the resident is seen the audiologist emails the notes. At that time if the resident is interested in hearing aids the audiologist reaches out to the resident or responsible party to coordinate in getting the resident hearing aids. Staff C stated she did not follow-up with their contract services to ensure Resident #77 received her hearing aids. She said that she should have checked with the resident to see if she was going to go through with the program to get her hearing aids. She stated that she will own that she did not follow-up with the resident after she was seen by the audiologist regarding getting her hearing aids. Resident # 77 filed a grievance on 9/5/22024 regarding her missing hearing aids. Staff C stated the solution was to refer her to audiology for possible new hearing aids. Staff C stated she dropped the ball because she did not follow-up with audiology services for Resident #77. On 12/5/2024 at 8:51 AM, an interview was conducted with the Nursing Home Administrator, NHA. The NHA stated the facility is not responsible for replacing the residents' hearing aids, but we are responsible for coordinating services to get the resident hearing aids. He stated if a resident lost their hearing aids the facility would help guide the resident through the process until they receive another set of hearing aids. Review of the facility policy titled, Social Services dated 9/7/2022 showed Policy, The facility, regardless of size, will provide medically - related social services to each resident, to attain or maintain the resident's highest practicable physical, mental, and psychological well-being. Policy Explanation and Compliance Guidelines: 4. The social worker, or social service designee, will pursue the provision of any identified need for medically-related social services of the resident. Attempts to meet the needs of the resident will be handled by the appropriate discipline(s). Service to meet the resident's needs may include d. Making arrangements for obtaining items, such as adaptive equipment, clothing, and personal items.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50570 Based on observation, record review, and interview, the facility did not ensure wound care was provided for one resident (#93) of two sampled residents. Findings include: On 12/2/24 at 9:39 a.m., Resident #93 was observed ambulating in a wheelchair towards the door of her room. She stated she had a sore on her toe and was being seen by a podiatrist not affiliated with the facility. Resident #93 stated the podiatrist ordered an antibiotic cream, but she had not received the treatment. She stated she had not received care at the facility for the toe wound. She confirmed the toe wound was not facility acquired, she stated she had it upon admission. A review of Resident #93's Admission Record revealed an initial admitted [DATE] and a re-admitted [DATE]. Further review of the Admission Record revealed diagnoses included but not limited to unspecified protein-calorie malnutrition, pressure ulcer of sacral region, stage 4, osteomyelitis of vertebra, sacral and sacrococcygeal region, and systemic lupus erythematosus, unspecified. A review of Resident #93's Comprehensive Minimum Data Set (MDS), Section C - Cognitive Patterns, dated 9/8/24 showed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. A review of Resident #93's Active Physician Orders revealed the following to include: Protein Liquid. two times a day for nutritional Support : Give 30 ml [milliliters] 2 times per day. May mix in beverage of choice. Record % consumed, with an order and start date of 4/17/24. Appt [Appointment]: [Physician name] DPM [Doctor of Podiatric Medicine] 12/4/24 @ [at] 2:00 PM . NEEDS TRANSPORT, with an order date of 11/27/24. Cleanse coccyx with n/s [normal saline], apply Santyl, calcium alginate loosely packed, and cover with foam dressing. Apply zinc oxide to peri-wound. every day shift for pressure ulcer, with an order and start date of 11/5/24. Complete skin check weekly on: Wednesday every day shift every Wed for Skin check Complete [Vendor name] Assessment/Evaluation, an order date of 4/10/24 and start date of 4/17/24. left heel: apply skin prep every shift for pressure ulcer, with an order and start date of 3/19/24. Santyl Ointment 250 UNIT/GM [gram] (Collagenase) Apply to Coccyx topically as needed for Coccyx, with an order and start date of 7/24/24. Santyl Ointment 250 UNIT/GM (Collagenase) Apply to Coccyx topically every day shift for Coccyx 1.3 x 0.8 x 30 (location- coccyx), with an order and start date of 7/24/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106041	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Harbourwood Post-Acute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #93's Progress Notes revealed the following to include: A review of a note titled, Pressure Ulcer wound progress note, dated 12/2/24 revealed the following, wound note: resident has 2 wound(s) . Offloading Boot(s) present. Heels are floated as tolerated . Pressure ulcer #1 present on admission. Pressure ulcer is a Stage 4 . admitted with Pressure ulcer #2 Wound #2 is a Stage 1 Pressure Ulcer . A review of a note titled, Skin observation progress note, dated 11/28/24 revealed the following, Skin observation progress note : Resident has existing skin impairment Resident nails cleaned and trimmed Pressure injuries to L [left] heel and coccyx, followed by wound care, orders in place. A review of a note titled, Pressure Ulcer wound progress note, dated 11/26/24 revealed the following, wound note: resident has 2 wound(s) . coccyx - zinc to peri area, Santyl, calcium alginate, foam QD [once a day] heels - skin prep q [every] shift . A review of a note titled, Physician Progress Note, dated 11/21/24 revealed the following, . She continues with reported stage 4 sacral wound, wound care following. Physical examination: . Skin: Warm, dry, no visible rash. Pressure ulcer sacrum not visualized A review of a note titled, Skin observation progress note, dated 11/20/24 revealed the following, Skin observation progress note : Resident has existing skin impairment Resident nails cleaned and trimmed Existing pressure injury. A review of a note titled, Pressure Ulcer wound progress note, dated 11/19/24 revealed the following, wound note: resident has 2 wound(s) . coccyx - zinc to peri area, Santyl, calcium alginate, foam heels - skin prep q shift . A review of progress notes from 12/3/24 to 11/1/24 revealed no documentation related to assessment, care or treatment for Resident #93's toe wound. Further review of the progress notes revealed a note titled, eMAR [Medication Administration Record] - General Note, dated 10/30/24 revealed the following, Note text : Writer has been observing/evaluation and applying treatment, as ordered, to resident Left-great toe. Area has resolved. Writer called [Podiatry office name], spoke with [staff member name], where [staff member name] confirmed if area has resolved, may discontinue order. Writer had wound nurse, re-evaluate and assess area as well. Wound nurse confirmed area healed. Writer has resolved/discontinued order as ordered. Writer will continue to monitor area to resident left-great toe for continual healing. A review of Resident #93's Weekly Pressure Wound Notes, documented by facility nursing staff, dated 12/2/24, 11/26/24, 11/19/24, and 11/13/24, revealed no documentation related to the resident's toe wound. Documentation in the pressure wound notes referenced wounds to include an abrasion to the resident's forehead, her coccyx and left heel. A review of Resident #93's Head to Toe Weekly Skin Checks dated 10/23/24, 10/30/24, 11/6/24, 11/13/24, 11/20/24, and 11/28/24, revealed no documentation related to the resident's toe wound. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106041	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Harbourwood Post-Acute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 549 Sky Harbor Dr Clearwater, FL 33759	

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #93's care plan revealed the following interventions under the, ADL [Activities of Daily Living] Care Plan, Bathing/Showering: The resident requires assist x 1 staff with bathing. Date Initiated: 10/03/2023, Dressing: The resident requires assistance x 1 staff to dress. Date Initiated: 10/03/2023, Personal Hygiene: The resident requires assistance by 1 staff with personal hygiene and oral care. Date Initiated: 10/03/2023. Further review of Resident #93's care plan revealed the following under the, Pressure Ulcer Care Plan, Pressure Ulcer location: stage 4 coccyx and Left heel DTI [Deep Tissue Injury] Diagnosis of Osteomyelitis of vertebrae and SLE [Systemic Lupus Erythematosus]. Date Initiated: 09/05/2023. Revision on: 09/11/2024. On 12/4/24 at 10:02 a.m., Resident #93 was observed ambulating in the wheelchair from the bathroom to the bed. An interview with the resident revealed staff were aware of the wound on her toe. She could not confirm who she spoke to. Resident #93 stated there was a prescription for treatment from the podiatrist. She confirmed she received treatment at the facility for her toe wound about a month ago. Resident #93 stated she was currently not receiving treatment. The resident stated she had a podiatry appointment today, in the afternoon. Resident #93 stated she was followed by wound care for her coccyx and heel, but not her toe. She stated, I think it has something to do with double billing. An observation of the left foot, in the presence of a Registered Nurse (RN) surveyor, revealed the top of the left great toe had a wound approximately 0.5 centimeters (cm) in size. The toe wound had a scab in the center and callous on the edges. Further observation of Resident #93's toe wound revealed the periphery was pink and blanches to touch. Photographic Evidence Obtained. On 12/4/24 at 10:07 a.m., an interview with Staff J, Licensed Practical Nurse (LPN) stated she was not aware of, and no one reported to her regarding Resident #93's toe wound. She confirmed the resident was on her assignment. On 12/4/24 at 10:09 a.m., an interview and review of Resident #93's electronic medical record with Staff B, Registered Nurse (RN)/Unit Manager (UM), revealed there was no information related to the resident's toe in the last skin assessment. An observation of the resident's left great toe was conducted with Staff B, RN/UM. During the observation, Resident #93 stated her toe wound had been there for months. The resident explained to Staff B, RN/UM the toe wound started as a fungus. At the end of the observation and interview with the resident, Staff B, RN/UM stated it was an issue that there was no documentation in the skin assessment related to Resident #93's toe wound. On 12/4/24 at 10:17 a.m., interviews were conducted with Staff B, RN/UM and the Director of Nursing (DON) regarding communication from outside services. Staff B, RN/UM revealed the facility sent information with the resident, when they went to appointments, to include demographics, medication list, updated labs, and other information that was pertinent to the service or doctor they were going to. She stated the resident should return with documents to include progress notes or new medications. Staff B, RN/UM stated if the resident did not come back with documents, then the nurse or herself would call the office where the resident had the appointment. The DON stated she expected the nursing staff to put a note in the resident's medical record when the resident returned from appointments. The DON stated herself, Resident #93's physician, and Staff B, RN/UM completed an assessment on this resident last Monday. She stated they assessed the resident, but did not observe her toe. The DON stated the resident had not mentioned anything to her. She stated it was the nursing staff's responsibility to check the resident from head to toe. The DON stated it's part of their assessment. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/24 at 10:25 a.m., Staff B, UM/RN stated Resident #93's last podiatry visit was on 11/11/24, however, the resident's medical record did not have documentation, to include progress notes or prescriptions, related to the recent podiatry visit. A review of the facility's policy titled, Skin Evaluations, with an implementation and reviewed/revised date of 8/22/22 revealed the following under, Policy, It is our policy to perform a full body skin evaluation as part of our systemic approach to pressure injury prevention and management. This policy includes the following procedural guidelines in performing the full body skin assessment. Further review of the policy revealed the following under, Policy Explanation and Compliance Guidelines, 1. A full body, or head to toe, skin evaluation will be conducted by a licensed or registered nurse upon admission/re-admission, and weekly thereafter. The Evaluation may also be performed after a change of condition or after any newly identified pressure injury. A review of the facility's policy titled, Guideline : Certified Nursing Assistant Skin/Body Audits, with an implementation and reviewed/revised date of 8/25/22 revealed the following under Guideline, It is our guideline to communicate changes in skin condition to appropriate personnel as part of our systematic approach for pressure injury prevention and management. This guideline establishes responsibilities of nursing assistants in communicating changes in skin condition. Further review of the policy under, Guideline Explanation and Compliance Guidelines, revealed the following, 1. Nursing Assistance shall inspect all skin surfaces during bath/shower and report any concerns to the resident's nurse immediately after the task. 3. Skin conditions that shall be reported include, but are not limited to: . f. Skin teas g. Open areas, ulcer, lesions. 4. Notification shall be made to the nurse verbally or in writing.

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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. 49227 Based on observation, record review, and interview, the facility failed to ensure the medication error rate was less than 5%. Twenty-eight medication administration opportunities were observed, and seven errors were identified for four residents (#4, #15, #68 and #93) of eight residents observed. These errors constituted a medication error rate of 25%. Findings Included: 1. On 12/04/24 at 7:28 a.m., during medications administration observation with Staff P, Registered Nurse (RN), Staff P administered Fiasp FlexTouch (insulin aspart) 30 units subcutaneously (SQ) to Resident #15. Review of Resident's #15's order summary report, active orders as of 12/4/24 revealed orders to include Fiasp FlexTouch 15 unit subcutaneously in the morning for (Diabetes Mellitus (DM) and Fiasp FlexTouch 15 unit subcutaneously with meals for DM. At the time Staff P administered Fiasp FlexTouch 30 units SQ Resident #15 was not eating, and meal trays were not being served. 2. On 12/4/24 at 8:21 a.m. during medications administration observation with Staff J, Licensed Practical Nurse (LPN), Staff J administered the following medications to Resident #93: Furosemide 20 mg Hydroxyurea 500 mg Levetiracetam 500 mg Metoprolol 25 mg Multiple Vitamins with Minerals 1 tab Omeprazole 20 mg Timolol Maleate Ophthalmic Solution 1 drop in each eye. Review of Resident #93's order summary report, active orders as of 12/4/24 revealed the following orders: Furosemide 20 mg Hydroxyurea 500 mg Levetiracetam 500 mg Metoprolol 25 mg Multiple Vitamins with Minerals 1 tab (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Omeprazole 20 mg Timolol Maleate Ophthalmic Solution 1 drop in each eye Cholecalciferol 125 mcg Eliquis 2.5 mg Fluticasone Nasal Spray 1 inhalation in nostrils. Review of the Medication Administration Record revealed Staff J, LPN initialed the record, indicating Cholecalciferol 125 mcg, Eliquis 2.5 mg, and Fluticasone Nasal Spray 1 inhalation in nostrils was administered. The administration of Cholecalciferol 125 mcg, Eliquis 2.5 mg, and Fluticasone Nasal Spray 1 inhalation in nostrils was not observed. During an interview on 12/4/24 at 1:28 p.m. with the Director of Nursing (DON), Regional Nurse Consultant (RNC) and Staff J, Staff J confirmed she did not administer all the medications initialed on the Medication Administration Record as administered. 3. On 12/4/24 at 9:18 a.m., during medications administration observation with Staff J, Staff J administered Victoza Pen-injector Inject 1.2 mg SQ and Insulin Glargine-yfgn pen-injector Inject 30-unit SQ to Resident #4. Prior to administration Staff J failed to use the proper technique of priming [procedure to ensure the correct dose is administer] the insulin pens prior to administration. Review of Resident #4's order summary report, active orders as of 12/4/24 showed orders to include: Victoza Subcutaneous Solution Pen-injector 18 MG/3ML (Liraglutide) Inject 1.2 mg subcutaneously one time a day related to Type 2 DM with unspecified diabetic retinopathy with macular edema and Insulin Glargine-yfgn 100 unit/ml Solution pen-injector Inject 30 unit subcutaneously two times a day related to Type 2 DM with unspecified diabetic retinopathy with macular edema. During an interview on 12/04/24 at 9:43 a.m., Staff J said she did not know insulin pens should be primed prior to medication administration. During an interview on 12/4/24 at 1:28 p.m. with the DON and the RNC, the DON said the expectation was for insulin pens to be primed before administration. 4. On 12/04/24 at 1:01 p.m., Staff R, LPN was observed administrating medications to Resident #68. Staff R said all medications due to be administered at 2:00 p.m. had been administered. On 12/04/24 at approximately 1:40 p.m., the medication order reconciliation review showed Staff R documented administration of Ipratropium-Albuterol Solution 0.5-2.5 three ml by nebulizer to Resident #68. During an interview on 12/4/24 at 1:52 p.m. with the DON and Resident #68, Resident #68 said he had not received a breathing treatment for more than 24 hours. (continued on next page)

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	106041	A. Building B. Wing	12/05/2024

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Harbourwood Post-Acute and Rehabilitation Center	549 Sky Harbor Dr Clearwater, FL 33759

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/04/24 at 3:34 p.m. with the DON and the RNC, the RNC said Staff R admitted he had not administered Ipratropium-Albuterol Solution as documented on the Medication Administration Record. Review of a facility's policy titled, Liberalized and Standardized Medication Administration Schedules revealed the following: Policy: in keeping with our philosophy of person-centered care and resident rights, medications will be delivered in a manner that is least restrictive and intrusive while allowing for optimal therapeutic effect of medications.time sensitive medications are medications with a narrow therapeutic index or medications that require specific administration times for clinical safety and efficacy . Medications are considered timely as long as they are administered within one hour before or after the standard administration time . a list of suggested time sensitive medications are .insulins . Review of a facility's policy titled, Administration of Injections, date implemented 1/22/23, revealed the following: Policy: Injections are administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice.

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498 Based on observation, record review and interview the facility failed to notify the ordering practitioner of Radiology results for one resident out of eight residents sampled (#67). Findings Include: On 12/2/2024 at 10:00 am., Resident #67 was sitting up in her wheelchair, dressed well-groomed with her call light within reach. She was presented with no signs of distress. She stated she had an incident two weeks ago when two nursing aides pulled her up in bed. She stated she felt a sharp pain in her back and legs after they repositioned her. She stated one of the aides told the nurse about the resident complaint and was provided with an x-ray. She stated she was never told the results of the x-ray findings. Review of an Admission Record dated 12/5/2024 showed Resident #67 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include but not limited to Type 2 diabetes mellitus with diabetic neuropathy, unspecified, presence of coronary angioplasty implant and graft Review of the Quarterly Minimum Data Set, MDS assessment dated [DATE] - Section C, Cognitively Patterns- BIMS score of 10 which indicated Moderate cognitive impairment. Review of an order summary dated 11/25/2024 showed a Stat order for a Lumber X-ray for lower back pain was ordered for Resident #67. Review of Radiology Results Report dated 11/25/2024 showed procedure for X-ray exam I-s spine 2/3/views. Interpretation findings showed The study is limited by the patient's body habitus and the lack of a lateral projection. Moderate disc space narrowing and degenerative endplate changes are noted. Osteopenia is present, Conclusion: Limited study. Degenerative changes. Follow-up Anteroposterior, AP and lateral views helpful. Review of the Electronic Medical Record (EMR) showed no evidence of documentation that the ordering practitioner was notified of the x-ray results, and no follow-up x-ray was ordered. On 12/04/2024 at 4:00 pm, an interview was conducted with Staff AA, Registered Nurse, RN. She stated the CNA who took care of the resident on 11/25/2024 came to her to tell her that Resident #67 was complaining about back pain. She stated Resident #67 told her the nursing aides tried to reposition her in the bed and somehow, she hurt her back, and the pain was mostly on the waist. The nurse stated she asked the resident if she would like to have pain medication. The nurse stated the resident said she did not want anything for pain. Staff AA stated she did not know she needed to call the resident's family to tell them about the resident complaint. She stated she did not call the family or notify the doctor when the x-ray results came in, she only reported the x-rays to the nurse from the next shift. (continued on next page)

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/2024 at 4:10 pm, an interview was conducted with Staff I, License Practical Nurse/Unit Manager. She stated the x-ray report came back to the facility at 6pm, during the first shift. She stated Staff AA should have notified the doctor and the resident representative about the incident and the x-ray findings. On 12/4/2024 at 4:30 pm, an interview was conducted with the Director of Nurses, DON. The DON stated the nurse should have notified the physician, the resident and the resident representative about the x-ray findings. The nurse should have also followed the process of what the physician would have provided for the resident. She stated we will just have to do some education from this point moving forward. Review of the facility policy titled, Provision of Physician Ordered Services dated 8/25/2024 showed 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. Policy Explanation and Compliance Guidelines: 3. Qualified nursing personnel will receive and review the diagnostic test reports or consults 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.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498 Based on observation, record review, and interview, the facility failed to provide one (#92) of eight sampled residents with therapeutic food to meet the resident's nutritional needs. Findings include: On 12/02 /2024 at 9:10 a.m., Resident #92 was observed sitting up in her bed with her breakfast tray in front of her. She was observed having a hard time opening her containers on her tray. She stated staff did not offer her assistance with opening her food containers on her tray, and she was not provided with hand hygiene. On 12/2/2024 at 12:45 p.m., Resident #92 was observed sitting up in bed eating her lunch left on her over the bed table. She was observed spitting her meat out of her mouth, saying she could not chew her meat because it was too hard for her to chew. She stated she was on a mechanical soft diet and the meat that was provided to her was not according to her diet. Review of an Admission Record dated 12/5/2024, showed Resident #92 was admitted to the facility on [DATE] with diagnoses to included but not limited to acute respiratory with hypoxia, iron deficiency anemia, unspecified, unspecified protein - calorie malnutrition, and nutritional marasmus. Review of a physician order with a start date of 7/1/2024, showed Resident #92 was on a Regular diet, mechanical soft texture, thin liquids consistency. Review of Resident #92's care plan showed a focus area of nutrition, date initiated 7/2/2024, with a revision date of 10/10/2024, Resident #92 had a potential for weight concerns, at risk for malnutrition, related to mechanically altered diet, significant weight gain on 10/10/2024. The goal showed Resident #92 would maintain stable weight through the next review date. Initiated on 7/2/2024, revised on 7/15/2024, target date on 1/1/2025. Interventions for focus areas of nutrition included the following for Resident #92: Honor food requests and preferences as applicable, date initiated 7/2/2024 Provide and serve diet as ordered, date initiated 7/2/2024 On 12/5/2024 at 12:33 p.m., an interview was conducted with Staff D, Dietary Manager. Staff D stated when a resident was initially admitted to the facility, she reviewed the resident's diet orders and cross referenced the order with the diet slips, The diet slips were given to the kitchen to ensure residents were receiving the correct diet. She stated she conducted spot checks on the tray line before trays were placed on the tray carts that were sent to each unit. She stated if a resident was on a mechanical soft diet the meat would be ground up. She stated she was not on the tray line when Resident #92's tray was prepared and placed on the cart, so she did not see the type of meat on her tray. Staff D reviewed the picture of the meal Resident #92 received on 12/02/2024 and stated that the meat was not mechanically altered. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/2024 at 12:40 p.m., an interview was conducted with Staff Y, Speech Therapist. Staff Y stated Resident #92 was evaluated because she was having trouble with chewing and orally controlling her food in her mouth. She improved in her chewing abilities and oral control abilities to the point she was able to handle some regular foods without difficulty. She said the resident requested to stay on a mechanical soft diet because of her difficulty with chewing her food. She stated when she discharged Resident #92 from speech therapy she kept the resident on a mechanical soft diet. When Staff Y reviewed the pictures of Resident #92's meal from 12/02/2024, she stated the ground meat would not be considered a mechanical soft diet. The consistency in the picture was considered soft bite size. It was a step above the mechanical soft diet. Review of the facility policy titled Therapeutic Diet Orders dated 11/5/2022 showed Policy: The facility provides all residents with foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his//her goals and preferences. Policy Explanation and Compliance Guidelines: 5. Dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form and/or the appropriate nutritive content as prescribed. Photographic Evidence Obtained.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20536 Based on observation, interview, and record review, the facility failed to honor food choices for three (#1, #167, and #19) of forty-forty sampled residents. Findings included: 1. On 12/2/2024 at 10:00 a.m., an interview and observation was conducted with Resident #1. She was able to speak related to her daily choices, medical care, and services. She was observed seated in her wheelchair, next to her bed, and was noted dressed for the day and well groomed. She wanted to speak about some concerns she had with dietary and nursing services related to breakfast this morning, 12/2/2024. Resident #1 revealed she had been at the facility for about a month and she kept asking staff to provide ketchup for breakfast, as she liked ketchup on her eggs. Resident #1 revealed she had spoken with various aides, nurses, dietary staff, and whoever passed by the room, many times. She revealed most of the time, staff would tell her either, the kitchen is out, or I'll be right back with that. Resident #1 said first of all, she knew the kitchen was not out of ketchup because everyone received it for various things for the same day's lunch and dinner. She said secondly, most of the time staff never returned after her initial ketchup request. She said there were times she had propelled herself, while in her wheelchair, to the kitchen to get ketchup. She revealed by the time she got back, her meal was cold. Resident #1 confirmed she had spoken with dietary staff to put this request on her meal ticket, but it was never updated with her ketchup request for breakfast. On 12/5/2024 at 8:10 a.m., Resident #1 was observed in her room and seated upright in bed with the over the bed table placed in front of her. She had already been served her breakfast and she was eating unassisted. The resident appeared to have received scrambled eggs, toast, hot cereal and milk, and purple juice. The resident was not happy and revealed she again did not receive ketchup for her eggs. She revealed she had asked staff when they initially served her meal and then asked again when staff walked by the room. She revealed each time, they told her they would get it. She could not remember the names of the staff but she explained she told at least two different staff members. She revealed this was about ten minutes ago and she still had not received ketchup. Observations revealed her over the table and breakfast tray did not have any ketchup packets. Further, review of her meal ticket did not identify to provide ketchup for breakfast. On 12/5/2024 at 10:00 a.m., the resident was observed walking with a therapy staff member down the hallway and when she saw this writer, she shouted, I never got the ketchup. She said it three times aloud. The resident appeared very upset to have not received the ketchup again. She had voiced in an earlier interview of speaking to both the Unit Manager and the Dietary Manager about it but never received the ketchup as requested. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106041	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024

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 0806

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

On 12/5/2024 at 10:15 a.m., an interview with Staff A, Certified Nursing Assistant (CNA) revealed when she, along with other staff, pass out meal trays, they review the meal ticket for likes and dislikes prior to setting up the meal tray for the resident. She revealed also, that if residents asked for certain condiments such as creamer, sugar, ketchup, mustard, etc., they would usually have most of that on the coffee cart, but when it came to ketchup and mustard, they would have to go to the kitchen to get it. She revealed she had honored resident's requests for condiments in the past and did not know Resident #1 wanted ketchup for breakfast. There were three other unidentified Certified Nursing Assistants in the general area and all confirmed the same interview as Staff A.

Review of Resident #1's medical record revealed she was admitted to the facility on [DATE] for short term rehab services.

Review of the current Physician's Order Sheet for the month 12/2024, revealed a diet order to include: NAS diet, Regular texture, thin liquid (start date 11/5/2024).

Review of the current Admission Minimum Data Set (MDS) assessment dated [DATE], revealed: Cognition/Brief Interview Mental Status or BIMS score - 15 of 15, which indicated Resident

#1 was cognitively intact.

A review of the current Care Plans with a next review date 2/10/2025, revealed the following:

a. Risk for impaired nutrition related to on No Added Salt NAS diet Related to History of Hypertension, with interventions to include but not limited to: Honor food requests and preferences as applicable.

2. On 12/2/2024 at 10:00 a.m., while in Resident #167's room speaking with her roommate, Resident #167 said she too was having concerns with her meal choices. She said at times, she would not receive the right condiments for coffee in the morning, and sometimes would not receive cold cereal for breakfast. Resident #167 revealed she received hot cereal in place of the cold cereal and she did not like hot cereal. She said she had spoken with both floor nursing staff and dietary staff/management about this concern, but there was no consistency of receiving what she liked on a daily basis.

On 12/4/2024 at 8:10 a.m., while visiting Resident #167 in her room, she pointed to her meal tray and revealed she did not get her cold cereal again, and the kitchen just gave her hot cereal. Observations revealed her breakfast tray was placed in front of her on the over the bed table and consisted of a regular textured meal to include: Two slices of French toast with syrup, small glass of red juice, one carton of 2% milk, one cup of dark coffee, and one bowl of what appeared to be hot oatmeal. The meal ticket on her meal tray revealed: Regular diet NAS, Beverage to include 2% milk, Cranberry Juice. The meal ticket also revealed Food Likes to include: Cold Cereal. It was evident Resident #167 did not receive cold cereal for this meal as requested.

Photographic evidence obtained.

(continued on next page)

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/2024 at 8:10 a.m., an interview with Resident #167 revealed she received her breakfast tray today, 12/5/2024, and did not get creamer for her coffee. She had asked staff for the creamer and they never brought it. She drank the coffee but she preferred to get creamer for it. Resident #167 revealed most days when she asked staff for creamer, they told her they were out or they just never returned with any. She had reported it to aides and a several nurses, but had no names of who she spoke with. Review of Resident #167's medical record revealed she was admitted to the facility on [DATE] for short term rehabilitation services. Review of the current Admission MDS assessment dated [DATE] showed Cognition/Brief Interview Mental Status BIMS 15 of 15, which indicated intact cognition. On 12/5/2024 at 10:20 a.m., in an interview with the Certified Dietary Manager (CDM), she stated how the meal tray line process was conducted. There were three staff in the kitchen and at the steam table food service station, including the cook, and two dietary aides. She revealed one dietary aide had the meal ticket and called out the diet, consistency, and food items of choice to the cook. She revealed after the cook plated the food, the tray moved down the line to another aide who would place other wanted condiment items and cold/boxed cereals on the tray. The CDM revealed prior to leaving the kitchen, the two aides were the staff who reviewed the meal tickets for accuracy. She revealed the aides would review the meal ticket and plate/tray for dislikes and food allergies. She said the tray was placed in a tray cart and taken out to the floor/hallways. The CDM revealed the direct floor staff would pull the tray from the cart and review the meal ticket prior to serving the resident. She revealed that she also monitored and reviewed meal tickets and plates as part of daily audits, but usually was not on the tray line the entire meal service, for all three meal services. The CDM confirmed the resident was served hot cereal rather than cold cereal for breakfast on 12/4/2024, and that it was a mistake. 3. On 12/2/2024 at 9:40 a.m., an interview and observation was conducted with Resident #19. He was noted seated upright in bed and had his over the bed table placed next to him, with personal belongings within his reach. Resident #19 was visibly angry and pointed to his red plastic cup of what appeared to be semi clear water. Resident #19 noted he had requested hot water for his tea and that was what was in his red plastic cup. Resident #19 revealed he was generally happy with the care and services at the facility, but he had one concern. He revealed when he was served his water for his tea, he was never provided with condiments to include creamer and sugar. He revealed he routinely asked the staff for these condiments and they always tell him, the kitchen is out, or they just never come back with his requested items. Resident #19 was upset because he knew the kitchen was never out, and he just felt staff were lazy and just did not want to walk to the kitchen to get creamer or sugar. He did not know why those normal condiments were not with the coffee cart to begin with. Resident #19 pointed to his over the bed table and plastic cup and said, see, nothing. It was observed no evidence Resident #19 was provided with creamer or sugar for his hot tea. The cup was observed full with the semi clear water/tea. Resident #19 further revealed he most likely will not drink any of it because it's cold from sitting too long. Resident #19 revealed he had been at the facility for about two months and this had been a continual problem. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/2024 at 8:15 a.m., Resident #19 was again interviewed and observed. He was seated upright in bed on the edge of the bed with the over the bed table positioned in front of him. He was also observed with his breakfast tray placed on the over the bed table. He had already eaten much of his breakfast and was noted with a red colored plastic cup of tea. The tea was observed plain and without any creamer or sugar in it. Resident #19 was asked how his meal was and he said it was fine other than he did not receive condiments for his tea. He said he had been asking staff all morning for creamer and sugar substitute for his tea. The resident began cursing regarding the situation and was visibly more and more upset because his tea was cold. Review of Resident #19's medical record revealed he was admitted to the facility on [DATE] for short term rehabilitation stay. Review of the current Admission MDS assessment dated [DATE], showed a Brief Interview for Mental Status (BIMS) of 15 of 15, which indicated intact cognition. A second interview with the Certified Dietary Manager (CDM) on 12/5/2024 at 10:00 a.m. revealed if a resident wanted extra condiments, which were not brought initially to the resident, they could make a request to the nursing staff, and nursing staff would come to the kitchen for the requested condiment. The CDM confirmed they were never out of items like creamer, salt, pepper, sugars, sugar substitutes, mustard, mayonnaise and ketchup. She revealed if she or her staff were asked by staff to get those types of condiments for a resident request, they certainly would have provided that condiment/condiments. On 12/5/2024 at 1:00 p.m., in an interview with the Director of Nursing and the Nursing Home Administrator, both confirmed the facility did not have a specific resident rights for food choices policy and procedure, and it would just be a basic right for a resident to receive condiments as requested and received meal items that were per choice.

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768 Based on observations, interviews, and record review, the facility failed to ensure the Quality Assessment and Assurance (QAA) Committee developed and implemented an effective Quality Improvement and Performance action plan, to correct deficient practice identified during a recertification survey conducted on 12/2/24 to 12/5/25, related to citations at F 552, F 677, F 686, F 777, and F 880. Findings included: Review of the facility's policy, Quality Assurance and Performance Improvement (QAPI), dated 08/25/2022, showed the following: It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides. Policy Explanation and Compliance Guidelines: 1. The QAPI program includes the establishment of a Quality Assessment and Assurance (QAA) Committee and a written QAPI plan. 3. the QAPI plan will address the following elements: C. Process addressing how the committee will conduct activities necessary to identify and correct quality deficiencies. Key components of this process include, but not limited to, the following: i. Tracking and measuring performance ii. Establishing goals and thresholds for performance improvements. Iii. Identifying and prioritizing quality deficiencies. Iv. Systematically analyzed and underlying causes of systemic quality deficiencies. V. Developing and implementing corrective action or performance improvement activities. VI. Monitoring and evaluating the effectiveness of corrective action / performance improvement activities and revisiting as needed. D. The prioritization of program activities that focus on resident safety, health outcomes, autonomy, choices and quality of care, as well as high-risk, high-volume, or problem-prone areas as identified in the facility assessment that reflects the specific units, programs, departments and unique population the facility serves the facility must also consider the incidents, prevalence and severity of problems or potential problems identified. F. Process to ensure care and services delivered meet accepted standards of quality. Program Development Guidelines: 1. Program design and scope--- a. the QAPI program will be ongoing, comprehensive, and will address the full range of care and services provided by the facility. 4. Program activities---a. All identify problems will be addressed and prioritized, whether by frequency of data collection, monitoring or by the establishment of sub-committees. Considerations include, but are not limited to: i. high- risk, high-volume, or problem-prone areas. ii. Incidence, prevalence, and severity of problems in those areas. iii. Measures affecting resident health, safety, autonomy, choice and quality of care. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/16/2025 at 2:05 p.m. the Nursing Home Administrator (NHA) and the DON stated they had an ADHOC (a meeting called suddenly to discuss a pressing issue) on 12/20/2024 after receiving the Statement of Deficiencies. They stated they reviewed the citations to match the education they had already started after the exit of the survey on 12/06/2024. They stated they adjusted the audit tools they had already created. They stated they determined the frequency of the audits. They discussed the findings with the Medical Director over the phone on 12/20/2024. They validated the Plan of Correction binders were prepared. The NHA left the interview and the DON continued with the interview. 1. The DON stated the F-tag 552 was related to Change in Condition notifications to the resident and resident representatives associated with x-ray results. The DON stated they educated the staff on change in condition which included the policy of notification of changes. The DON stated they started the education with the licensed staff on 12/16/2024 and completed it on 01/03/2025. The DON stated they did a look back of 30 days of labs and x-rays to ensure all had been reported to the medical providers, residents and families. The DON stated the audit did not show if they had to update anyone or not. The DON stated the ADON was to review the x-ray results to ensure the medical provider, resident and resident representative was notified. The DON stated the ADON took ownership and was responsible for the audits, Monday through Friday. The ADON was to give any results that needed to be reported to the Unit Managers for follow-up. The Unit Manager was to report or ensure the floor nurse had reported the results. The DON stated the ADON was supposed to be checking behind the staff to ensure the results were being reported. The DON stated the ADON was sick Monday (01/13/2025) and did not review and the when she returned on Tuesday (01/14/2025), the Unit Manager was off, so the labs were not reported to the appropriate people. The DON stated the ADON cannot be solely responsible. The DON stated the ADON was the checker and the floor nurse needs to notify all parties. The DON stated they would re-educate the staff regarding notifications for change in conditions. Resident #37 was admitted on [DATE] and readmitted on [DATE]. Review of the admission record showed diagnoses included cellulitis of the lower limb, COPD (Chronic Obstructive Pulmonary Disease) diabetes, protein-calorie malnutrition, acute bronchitis due to rhinovirus, anemia, and atrial fibrillation. Review of the physician orders showed two view chest x-rays for congestion on 01/12/2025. Review of the Chest X-ray results were dated 01/12/2025 at 8:50 p.m. showed the conclusion was mild pulmonary vascular congestion. Review of the progress notes showed On 01/13/2025, radiology note showed chest x-ray negative. On 01/14/2025, Physician Assistant (PA) progress note showed on 01/14/2025 at 4:40 p.m., She (Resident #37) reports new onset cough. Primary obtained CXR (chest x-ray) which was negative. She has finished ABX (antibiotics) for cellulitis. She reports decreasing left leg pain. Denies chest pain, SOB (shortness of breath), dizziness. No other concerns at this time. Review of the care plans showed (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #37 had a potential for complications of respiratory distress related to diagnoses of: COPD, history of Respiratory failure and current smoker Date Initiated: 11/10/2021 Created on: 11/10/2021 Revision on: 04/28/2024. Interventions included but not limited to Labs/diagnostics as ordered; notify physician of results Date Initiated: 11/10/2021 Created on 11/10/202. Resident #38 was admitted on [DATE] and readmitted on [DATE]. Review of the admissions record showed diagnoses included but not limited to Parkinson's, acute and chronic respiratory failure, congestive heart failure, COPD, hypertension, atrial fibrillation. Review of the physician's orders showed portable 2 view chest x-ray for cough on 01/14/2025. Review of the chest x-ray dated 01/14/25 at 2:00 p.m. showed the cardiac silhouette and mediastinal contours are normal. The lungs are free of infiltrates and focal consolidations. Elevation of the right hemidiaphragm is noted. No pleural fluid or masses are noted. No pneumothorax is present. Conclusions: No acute intrathoracic disease process. Review of the progress notes showed On 01/14/3025 at 12:127 p.m., attending physician visits and orders a 2 view CXR (chest x-ray) for continued cough. Resident continues on ABT (antibiotics) for URI (upper respiratory infection) at this time to same. No s/sx (signs and symptoms) of adverse effects noted at this time. Review of the Infection Care Plan showed resident was on antibiotic therapy related to URI as of 01/10/2025. Interventions included but not limited to observe for worsening respiratory symptoms such as increases SOB and rpt to MD. During an interview on 01/15/2025 at 2:19 p.m. the DON (Director of Nursing) verified Resident #37 did not have documentation in her chart verifying Resident #37 or her responsible party was aware of Resident #37's x-ray reports. The DON verified Resident #38 had no documentation the medical provider, the resident nor her responsible party had been notified of Resident #38's x-ray results. The DON stated she would expect to see documentation in the progress notes the medical providers and either the residents or responsible parties had been notified of the results. The DON stated the ADON (Assistant DON) was supposed to be auditing all x-ray and lab results and confirming the results had been notified to the medical provider or resident and responsible party. If the ADON was not here it was the UM's (Unit Manager's) responsibility. During an interview on 01/15/2025 at 2:40 p.m. with the DON and the ADON, the ADON stated she had called Resident #38's medical provider and informed the resident of the x-ray results this morning (01/15/2025) but did not document it in the medical record. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON and the ADON verified Resident #37's x-ray results were available on 01/12/2025 (Sunday). They verified the medical provider knew about the x-ray results for Resident #37 on 01/14/2025 (Tuesday). The DON and ADON verified the x-ray results for Resident #37 came to the facility on [DATE] at 8:50 p.m. The DON and ADON confirmed the medical provider was not informed for 2 days of the x-ray results for Resident #37. The DON stated the nurse may not have wanted to inform the medical provider until the next day (01/13/2025 Monday). The DON stated the supervisor should have called the medical provider over the weekend (01/12/2025) due to the results of Resident #37's x-ray showed mild pulmonary vascular congestion. The DON stated she did not know right now why they (x-ray) fell through the cracks. The ADON stated she was off on Monday sick, and she was responsible for the audits. The ADON stated the UM makes the calls to the medical provider and resident or representative as needed. The ADON stated the UM was off on Tuesday, so no calls were made. During an interview on 01/16/2025 at 12:04 p.m. the DON stated she spoke with the attending physician for Resident #38. The DON stated that the physician stated that if an X-ray result was normal the facility could wait until the next business hours to report to the physician. If it (x-ray result) was abnormal, they should call the on-call person. The DON stated that neither resident required new orders. The DON was informed her nurse s stated on interview that they were responsible to inform the medical provider and resident or representative with the results. The DON agreed the nurses had not documented they had called the appropriate persons. The DON agreed the checkers (ADON and UMs) should have been double checking the results were informed to the appropriate persons not being the staff who was to having to provide the x-ray results. 2. Review of education/ in-service attendance log, provided by the ADON, dated 12/5/24, with objectives related to nail care/shaving included the following information: staff must ensure that resident nails are clipped and cleaned underneath, failure to properly trim and clean resident nails can lead to health issues, Certified Nursing Assistants (CNAs) and nurses can clip resident's fingernails. CNAs are not allowed to clip the nails of residents who are diabetic, Patient Care Assistants (PCA) cannot clip fingernails but can file it. The signature page included the signatures of 110 staff members. Review of a resident census report, undated, showed a full audit was complete and done. Review of audit, dated 1/8/25, related to observations of ADLs related to shaving and nail care. The ongoing monitoring included quality review of five residents related to shaving and nail care, weekly for four weeks, then monthly for two months or until substantial compliance. Ten residents were observed for clean and trimmed nails, all residents were in compliance. Review of the Admission Record showed Resident # 56's initial admitted to the facility was on 8/7/23. Review of Resident #56's annual Minimum Data Set (MDS), dated [DATE], showed a Brief Interview for Mental Status (BIMS) score of 3 which indicated severe cognitive impairment. Section GG, functional abilities showed Resident #56 required supervision or touching assistance with shower/bath and was independent with personal hygiene. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the ADL care plan showed a focus for Resident #56, as follows: Has Activities of Daily Living (ADL) performance deficit related to Alzheimer's, dementia, musculoskeletal impairment, pain and history of a stroke, date initiated 8/14/23. The care plan's goal was Resident #56 will maintain current level of function through the review date. The interventions included checking nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. On 1/15/24 at 10:40 A.M. during interview and observation, Resident #56 was observed sitting in his wheelchair and said he did not like the length of his fingernails [it is] hard to pick up a spoon. His nails were approximately 1/8 inch in length. (Photographic evidence obtained with permission of resident). Review of Resident #56's task, titled: GG-Shower/Bathe self, showed on 1/6/25 supervision or touching assistance was provided. On 1/9/24 Resident #56 was independent with the task. Review of the Admission Record showed Resident # 55's initial admitted to the facility was on 2/29/24. Review of Resident #55's quarterly Minimum Data Set (MDS) dated [DATE], showed a Brief Interview for Mental Status (BIMS) score of 13 which indicates intact cognition. Section GG, functional abilities showed Resident #55 is dependent (helper does all the effort) for shower/bathe self and required substantial /maximal assistance with personal hygiene. Review of the ADL care plan showed a focus for Resident #55, as follows: Has and ADL self-care performance deficit related weakness, adult failure to thrive, cognitive deficit, depression and anxiety and requires maximum to dependent ADLs. Decline is expected related to terminal condition. The care plan goal was Resident #55 will maintain current level of function through the review date, created on 3/4/24. The care plan's goal was Resident #55 will maintain current level of function through the review date. The interventions included the resident required assistance by one staff with personal hygiene and personal care On 1/16/24 at 10:56 A.M. during interview and observation, Resident #55 was observed lying in bed, and said he would like to have his fingernails trimmed. His fingernails were approximately 1/4 inch in length, yellowing, with dry gray and yellow substance between the nail and nail bed. Resident #55 said he prefers bed baths. Review of Resident #56's task, titled: GG-Shower/Bathe self, showed daily between 1/10/25 and 1/16/25 he was dependent (helper does all the effort) with completing this task. Review of the Admission Record showed Resident # 57's initial admitted to the facility was on 6/16/22. Review of Resident #57's quarterly Minimum Data Set (MDS) dated [DATE], showed a Brief Interview for Mental Status (BIMS) score of 3 which indicated severe cognitive impairment. Section GG, functional abilities showed Resident #57 required substantial/ maximal assistance with shower/bath and required supervision or touching assistance with personal hygiene. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the ADL care plan showed a focus for Resident #57, as follows: Has Activities of Daily Living (ADL) performance deficit related to confusion, dementia, visual deficits, depression and anxiety created on 6/18/22. The care plan's goal was Resident #57 will maintain current level of function through the review date. The interventions included checking nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Resident #57 required assistance by 1 staff with personal hygiene and oral care. On 1/15/24 at 10 :30 A.M. during an interview and observation Resident #57's fingernails were approximately 1/8 inch in length, under the nails contained large amount of dry dark gray and black substances, and the edges between the finger and fingernail contained caked on brownish and black substances. (Photographic evidence obtained with resident permission). Review of Resident #57's task, titled: GG-Shower/Bathe self, showed daily between 1/10/25-1/14 the resident was dependent (helper does all the effort) for this task. During a group interview on 1/15/24 at 2:49 P.M. Certified Nursing Assistants (CNA) said they were recently provided education to offer nail care to each resident on their shower days and to document on the shower sheets. During an interview on 1/16/24 at 12:05 PM, the Assistant Director of Nursing (ADON) said Staff are expected to provide nail care with bathing. During an interview on 1/16/13 at 2:10 P.M. the Director of Nursing (DON) said nail care should be completed on shower days and documented on the shower sheets or weekly skin checks. Review of facility's policy titled, Activities of Daily Living (ADLs), date implemented 9/7/22 revealed: Policy- the facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities and ADL's do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1) bathing, dressing, grooming and oral care 2) transfer and ambulation 3) Toileting 4) Eating to include meals and snacks 5) Using speech, language or other functional communication systems. Policy explanation and compliance guidelines: 1) conditions which may demonstrate unavoidable decline in ADL include 1 a) natural progression of the resident's disease state with known functional decline. 1b) Deterioration of the resident's physical condition associated with the onset of an acute physical or mental disability while receiving care to restore or maintain functional abilities. 1c) Refusal of care and treatment by the resident or his/her representative to maintain functional abilities after efforts by the facility to inform and educate about the benefits/risks of the proposed care and treatment, council and our offer alternatives to the resident or representative. 2) the facility will provide a maintenance and restorative program to assist a resident in achieving and maintaining the highest practicable outcome based on the comprehensive assessment. 3) A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene. 4) The facility will identify resident triggers through the Care Area Assessment (CAA) process to assess causal factors for decline, potential decline or lack of improvement. 5) The facility will maintain individual objectives of the care plan and periodic review and evaluation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106041	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Harbourwood Post-Acute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 549 Sky Harbor Dr Clearwater, FL 33759	

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The DON stated the F-tag 686 was related to pressure ulcers and skin sweeps. She stated they performed skin sweeps on the entire building from 12/09/2024 t 12/13/2024. She stated they looked at the whole body. They educated the nurses on treatment services to prevent and heal pressure ulcers on 12/08/2024. They educated the staff that skin evaluations must be completed by a licensed nurse weekly, wounds must be evaluated weekly by an RN. The DON stated they educated the staff the medical provider must be contacted of a new skin impairment, and well as the resident and resident representative which includes change or addition of a treatment. The DON stated they are auditing 5 residents with wounds a week for 4 weeks. The DON stated they are auditing for process, skin checks completed, skin evaluations completed weekly, evidence of responsible party and medical provider notification. The DON stated she did the audits herself and visualized the dressings also. The DON stated she did not know what happened (dressings for Residents #39 and #40). The DON stated the ADON was re-educating the nursing staff on documentation process and following through with medical provider orders. The DON stated the nurse that documented she provided care for Resident #40 on 01/15/2025 stated, She did not have time to do the care. The DON stated the nurse stated she did not do the care on 01/15/2025 even though she documented she did. The DON stated they will continue to audit after the nurses have been re-educated. The DON stated they will discuss the audit frequency during the next ADHOC meeting with the team. Resident #39 was admitted on [DATE] and readmitted on [DATE]. Review of the admission record showed the diagnoses included nontraumatic chronic subdural hemorrhage, pneumonitis due to inhalation of food, acute respiratory failure, adult failure to thrive, Peripheral vascular disease, heart failure, dementia, and hypertension. Observation on 01/16/2025 (Thursday) at 10:28 a.m. of Resident #39 with Staff B, RN (Registered Nurse) and Staff C, CNA (Certified Nursing Assistant). Staff C, CNA was already in room with gloves in place, no gown. Staff B, RN entered room after applying gloves, no gown. Resident #39 was lying in bed. He had contractures of the lower extremities. Staff B and Staff C moved his blankets down and revealed his left heel dressing. The heel was wrapped in gauze and tape but was not dated. The heel dressing had a small amount of brownish draining on the heel area. The staff lowered the head of the bed and raised Resident #39's gown. His thigh had a dressing in place dated 01/13/2025 (Monday). The staff turned the resident onto his right side, toward Staff B. Resident #39's brief was opened, and the coccyx area was observable. The coccyx wound had no dressing applied. The coccyx area was a golf ball size open area. During the turning of the resident, Staff B, RN touched her gloved hand to her right sleeve, moving it up. The resident was placed back onto his back and the head was elevated. Staff B removed her gloves and hand sanitized. Staff B, RN stated he was on enhanced barrier (precautions). Staff B stated, I do not need to use a gown because I was not changing his dressings. When asked about touching his dressings, briefs, blankets, etc. stated she, I was not changing his dressings. Staff C, CNA was asked about the resident being on enhanced barriers, she just looked at the surveyor and had no response. Staff C stated if the resident was on enhanced barriers she should have had a gown on. During an interview on 01/16/2025 at 11:25 a.m. Staff D, RN, Unit Manager stated she verified the wound care for Resident #39. She stated the thigh dressing was to be done on Monday, Wednesday and Friday. She stated his coccyx wound was to be done daily. She stated the heel dressing was to be done daily. Staff D stated it (wound care) should have been done per the physician orders. Staff D, RN stated the negative outcomes could have included an increased size in pressure ulcer, worsening, infection, sepsis, not healing. (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	12/05/2024

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician orders showed cleanse coccyx with normal saline, apply calcium alginate and cover with superabsorbent border dressing daily as of 01/06/2025 cleanse left lateral thigh with normal saline, apply xeroform and border gauze 3 times a week, Monday, Wednesday and Friday as of 01/13/2025. Left heel, apply Santyl, xeroform, superabsorbent, and wrap with kerlix and apply zinc for peri-wound every shift as of 01/07/2025. Review of the January Treatment Administration Record (TAR) showed Cleanse coccyx with normal saline, apply calcium alginate and cover with superabsorbent border dressing daily as of 01/06/2025. The TAR showed the dressing was changed on 01/07/25, 01/08, 01/09, 01/10, 01/11, 01/12, 01/13, 01/14, 01/15/2025. The resident did not have a dressing on his coccyx during the observation. Cleanse left lateral thigh with normal saline, apply xeroform and border gauze 3 times a week, Monday, Wednesday and Friday as of 01/13/2025 (Monday). The thigh wound was observed dated 01/13/2025. Left heel, apply Santyl, xeroform, superabsorbent, and wrap with kerlix and apply zinc for peri-wound every shift as of 01/07/2025. The TAR showed the wound was performed on 01/07/25, 01/08, 01/09, 01/10, 01/11, 01/12, 01/13, 01/14, 01/15/2025. Review of the care plans showed Resident #39 was on Enhanced Barrier Precautions per CDC guidelines for Gastrostomy tube, wounds as of 04/14/2024. Interventions included but not limited to persons caring for the resident and providing high-contact resident care activities will require personal protective equipment (PPE), the use of gown and gloves. As of 4/17/2024. Clear signage will be posted on wall outside of room as of 07/01/2024. Resident #39 had a pressure ulcer located on the left heel stage 3 and coccyx stage 3. Decline in skin integrity is expected related to terminal condition as of 04/04/2024, revised on 12/27/2024. Interventions included but not limited to current treatment per order as of 04/04/2024. Document weekly: stage, length times width times depth, order, progress or lack of progress as of 04/04/2024. Notify MD and family for changes in wound status as of 04/04/2024. During an interview on 01/16/2025 at 11:25 a.m. Staff D, RN, Unit Manager stated she verified the wound care for Resident #39. She stated the thigh dressing was to be done on M-W-F. She stated his coccyx wound was to be done daily. She stated the heel dressing was to be done daily. Staff D stated it (wound care) should have been done per the physician orders. Staff D, RN stated the negative outcomes could have included an increased size in pressure ulcer, worsening, infection, sepsis, not healing. (continued on next page)

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

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #40 was admitted on [DATE] and readmitted on [DATE]. Review of the admission record showed diagnoses included cancer of the prostate, urinary catheter, hypertension, bladder-neck obstruction, and unspecified protein-calorie malnutrition. Observation on 01/16/2025 (Thursday) at 10:44 a.m. of Resident #40 with Staff D, RN. Staff D applied a gown and gloves after hand sanitizing. She entered the resident room and put his bed down and pulled up his gown. His suprapubic dressing was dated 01/13/2025 (Monday), there was drainage present on the dressing. Staff D placed his gown down and walked to the door. She removed her gloves and donned a new pair of gloves without hand sanitizing. She came back to the resident's bedside and pulled the cover up from his right lower extremity. His right heel was dressed, and it was dated 01/13/2025 (Monday). The resident stated his coccyx wound was healed and did not have a dressing. Staff D removed her gloves and gown and washed her hands. Review of the physician orders showed Cleanse right heel with normal saline, pat dry, apply xeroform, cover with border dressing every day as of 01/06/2025 to start on 01/07/2025 and discontinue as of 01/15/2025. Cleanse right heel with normal saline, pat dry, apply xeroform, cover with border dressing on Monday, Wednesday, Friday as of 01/13/2025 to start on 01/15/2025. Cleanse suprapubic catheter area with normal saline, pat dry, apply silver calcium alginate, cover with superabsorbent border dressing every day as of 01/06/2025 Review of the January 2025 TAR showed Cleanse right heel with normal saline, pat dry, apply xeroform, cover with border dressing every day as of 01/06/2025 to start on 01/07/2025 and discontinue as of 01/15/2025 showed performed on 01/07/25, 01/08, 01/09, 01/10, 01/11, 01/12, 01/13/25 Cleanse right heel with normal saline, pat dry, apply xeroform, cover with border dressing on Monday, Wednesday, Friday as of 01/13/2025 to start on 01/15/2025 (Wednesday), showed IA on 01/15/2024. Cleanse suprapubic catheter area with normal saline, pat dry, apply silver calcium alginate, cover with superabsorbent border dressing every day as of 01/06/2025 showed care performed on 01/16/25, 01/07, 01/08, 01/09, 01/10, 01/11, 01/12, 01/13, 01/14, 01/15/2025. Review of the care plans showed Resident #40 had a pressure ulcer care plan due to unstageable to right heel as of 04/02/2024. Interventions included but not limited to current treatment per order; document weekly: stage, length x width x depth, odor, progress or lack of progress; Notify MD and family. During on 01/16/25 at 11:12 a.m. Staff D, RN stated the heel was supposed to be dressed on Monday, Wednesday (01/15/2024) and Friday. Staff D, RN stated the nurse documented IA on the TAR which she does not know what that is. Staff D stated she would ask the nurse what that meant. Staff D stated the suprapubic dressing was to be performed daily and her nurse documented it was done. Staff D stated the nurse reported she did not have time to perform the care and told the next shift to do it. (continued on next page)

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

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/16/2025 at 12:04 p.m. the DON stated that the staff was to perform the wound care as per the medical provider order. The enhanced barrier precautions was to be performed during direct contact. 4. The DON stated F-777 related to reporting the x-ray results to the medical provider timely. She stated they used the same education and audits as for F-552. The DON stated she will re-talk about the process with the QAPI team. The DON stated they need to educate the nursing staff again to be the persons reporting the results and the ADON as the backup. Resident #37 was admitted on [DATE] and readmitted on [DATE]. Review of the admission record showed diagnoses included cellulitis of the lower limb, COPD (Chronic Obstructive Pulmonary Disease) diabetes, protein-calorie malnutrition, acute bronchitis due to rhinovirus, anemia, and atrial fibrillation. Review of the physician orders showed two view chest x-rays for congestion on 01/12/2025. Review of the Chest X-ray results were dated 01/12/2025 at 8:50 p.m. showed the conclusion was mild pulmonary vascular congestion. Review of the progress notes showed On 01/13/2025, radiology note showed chest x-ray negative. On 01/14/2025, Physician Assistant (PA) progress note showed on 01/14/2025 at 4:40 p.m., She (Resident #37) reports new onset cough. Primary obtained CXR (chest x-ray) which was negative. She has finished ABX (antibiotics) for cellulitis. She reports decreasing left leg pain. Denies chest pain, SOB (shortness of breath), dizziness. No other concerns at this time. Review of the care plans showed Resident #37 had a potential for complications of respiratory distress related to diagnoses of: COPD, history of Respiratory failure and current smoker Date Initiated: 11/10/2021 Created on: 11/10/2021 Revision on: 04/28/2024. Interventions included but not limited to Labs/diagnostics as ordered; notify physician of results Date Initiated: 11/10/2021 Created on 11/10/202. Resident #38 was admitted on [DATE] and readmitted on [DATE]. Review of the admissions record showed diagnoses included but not limited to Parkinson's, acute and chronic respiratory failure, congestive heart failure, COPD, hypertension, atrial fibrillation. Review of the physician's orders showed portable 2 view chest x-ray for cough on 01/14/2025. Review of the chest x-ray dated 01/14/25 at 2:00 p.m. showed the cardiac silhouette and mediastinal contours are normal. The lungs are free of infiltrates and focal consolidations. Elevation of the right hemidiaphragm is noted. No pleural fluid or masses are noted. No pneumothorax is present. Conclusions: No acute intrathoracic disease process. Review of the progress notes showed (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/14/3025 at 12:127 p.m., attending physician visits and orders a 2 view CXR (chest x-ray) for continued cough. Resident continues on ABT (antibiotics) for URI (upper respiratory infection) at this time to same. No s/sx (signs and symptoms) of adverse effects noted at this time. Review of the Infection Care Plan showed resident was on antibiotic therapy related to URI as of 01/10/2025. Interventions included but not limited to observe for worsening respiratory symptoms such as increases SOB and rpt to MD. During an interview on 01/15/2025 at 2:19 p.m. the DON (Director of Nursing) verified Resid

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49227 Based on observation, record review, and interview, the facility failed to follow professional standards to help prevent the development and transmission of communicable diseases and infections related to 1. hand hygiene for three (#85, #93, and #104) of eight sample residents, 2. Personal Protective Equipment (PPE) use for one (#27) of one sampled resident, and 3. cleaning of equipment for two (#4 and #27) of eight sampled residents. Findings included: On 12/3/24 at 11:58 a.m., Staff U, Certified Nursing Assistant (CNA) was observed in Resident #27's room without PPE (gloves and gown) On 12/3/24 at 12:48 p.m., Staff P, RN, Staff U, CNA entered Resident's #27 providing direct care (repositioning) without wearing PPE (gowns and gloves). On 12/04/24 at 9:21 a.m., Staff U, CNA existed in Resident #27's room without wearing PPE. Staff U, CNA said she was assisting Resident #27 with personal care (brushing her hair). Review of Resident #27's admission record showed admitted , 11/2/2024. Review of Resident #27's, order summary report, active orders as of 12/4/24 revealed contact precautions for extended-spectrum beta-lactamase (ESBL) in the urine (Urinary Tract Infection). During an interview on 12/4/24 at 9:26 a.m. Staff U, CNA said she wore gloves and used the hand gel or washed her hands before providing resident care. During an interview on 12/4/24 at 10:30 a.m., Staff B, RN, Unit Manager (UM) said she expected staff to wear gloves, gowns, and masks for residents in contact precautions. During an interview on 12/4/24 at 9:05 a.m., the DON said she expected staff to clean their hands between residents. She said multi resident use items should be cleaned and disinfected between residents and staff were expected to follow the posted PPE signs. 2. On 12/4/24 at 8:12 a.m., during medication administration observation, Staff J, LPN entered Resident #27's room, administered medication, on return to the medication cart placed the used blood pressure cuff and stethoscope on top of the medication cart. The items were returned to the case and placed in the medication cart. During an interview on 12/4/24 at 9:01 a.m., Staff P RN said blood pressure cuffs should be cleaned between patient use. On 12/2/24 during meal delivery observation for Resident #104 and Resident # 85, staff did not offer to provide or assist with hand hygiene during tray delivery. On 12/2/24 at 11:42 a.m., in an interview with Resident #104 she said she did not clean her hands before eating lunch and staff never offered or assisted with hand hygiene prior to meals. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/2/24 at 11:47 a.m., in an interview with Resident # 85 she said she did not clean her hands before eating lunch and staff did not offer or assist with hand hygiene prior to meals. 3. On 12/4/24 at 9:18 a.m., Staff J, LPN prepared to administer Resident # 4's Victoza and Glargine-yfgn pen-injectors. The rubber septum was not disinfected with alcohol prior to piercing with the needle and administering the medications. After administering the medications Staff J, LPN placed the pen injectors without caps in her pocket and returned the medications to the medication cart. On 12/04/24 at 8:21 a.m., during Resident #93's medication administration observation, Staff J, LPN, removed gloves from the glove box while wearing gloves that had been in direct contact with the resident. At the Resident #93's bedside Staff J, LPN, exchanged gloves. Hand hygiene was not performed after removing gloves and before donning clean gloves. On 12/5/24 at 8:33 a.m., during an interview with the Infection Preventionist (IP), Staff K, RN, and the Regional Nurse Consultant, the DON said staff were expected to clean and disinfect blood glucose machines, and perform hand hygiene before and after glove use. Review of the facility's Infection Prevention and Control Program policy, date implemented, 8/25/22, revised 7/13/23 revealed the following: Policy: The facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. Definitions: Staff includes all facility staff direct and indirect care functions, .who provide care and services to residents on behalf of the facility . Policy Explanation and Compliance guidelines: 1) the designated infection preventionist is responsible for oversight of the program and serves as a consultant for our staff on infectious diseases .2) All staff are responsible for following all policies and procedures related to the program. 4) . Standard precautions: All staff shall assume that all residents are potentially infected or colonized with an Organism that could be transmitted during the course of providing resident care services. Hand hygiene shall be performed in accordance with our facilities established hand hygiene procedures. All staff shall use personal protective equipment PPE according to established facility policy governing the use of PPE. Licensed staff shall adhere to safe injection and medication administration practices, as described in relevant facility policies. A resident with an infection or communicable disease shall be placed on transmission-based precautions. Review of the Centers for Disease Control and Prevention (CDC) revealed .In the absence of manufacturers' instructions, non-critical medical equipment (e.g. stethoscopes, blood pressure cuffs .,) require cleansing followed by low- to intermediate-level disinfection, depending on the nature and degree of contamination. Ethyl alcohol or isopropyl alcohol . is often used to disinfect small surfaces (e.g., rubber stoppers of multiple-dose medication vials . and thermometers) and external surfaces of equipment (e.g., stethoscopes and ventilators). However, alcohol evaporates rapidly, which makes extended contact times difficult to achieve unless items are immersed, a factor that precludes its practical use as a large-surface disinfectant. Retrieved on 12/6/24 Cleaning of Medical Equipment