

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106147	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2026
NAME OF PROVIDER OR SUPPLIER Blue Heron Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 5085 Eagleston Blvd Wesley Chapel, FL 33544	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime related to an allegation of sexual abuse for one resident (#5) out of three residents sampled. Findings included: During a telephone interview with the Resident Representative on 06/13/2026 at 12:02 p.m., he reported receiving a call in May 2026 informing them that another resident entered Resident #5's room, threw objects, and exposed their genitals to Resident #5. The Resident Representative stated the resident was traumatized and avoided discussing the incident for weeks, stating, [Resident #5] did not want to talk about it when I would ask about it. This was a really hard things she had to deal with. Review of Resident #5's admission record revealed Resident #5 was admitted to the facility on [DATE] and discharged from the facility on 05/26/2026. A minimum data set (MDS) dated [DATE] revealed Section C. Cognitive Patterns, a brief interview mental status (BIMS) score of 14 out 15 showing intact cognition. Review of Resident #5's nurse progress note for 05/09/2026 at 20:34 revealed, Narrative: Patient across the hall went into resident's room scaring her. Resident stated that he was unzipping and zipping his pants and was being sexually inappropriate. Both families called with notification, as well as the administrator. Resident's family assured that she will remain safe and that the other patient will not come into her room again. [The family member] stated that he wanted the male patient moved away .to another room. Review of the facility's reportable/adverse/grievance log showed no entries for any sexual abuse allegation during May 2026, despite the allegation documented in clinical notes. On 06/13/2026 at 12:10 p.m., Staff A, Licensed Practical Nurse (LPN) stated that Resident #5 reported the male resident entered her room and unzipped/zipped his pants, saying he was going to fix it. Staff A confirmed Resident #5 was visibly upset. The supervisor and administrator were notified. A statement was given to the administrator. Staff A was uncertain whether the incident was reported. During an interview on 06/13/2026 at 2:20 p.m., the assistant director of nursing (ADON) stated that any exposure of genitalia from one resident to another would be considered sexual abuse and should be reported to the Agency for Health Care Administration (AHCA), Department of Children and Families (DCF), and police. The ADON denied knowledge of any such incident involving Resident #5 and said, I do not remember [Resident #5], or any other resident ever having an incident where another resident exposed themselves to another resident. If we did I would definitely had reported it. During an interview on 06/13/2026 at 2:53 p.m., the Nursing Home Administrator (NHA) and the Corporate Risk Manager, the NHA stated the facility did not report the allegation, asserting that their policy's definition of sexual abuse did not include a resident exposing himself to another resident. The NHA read their policy out loud, contradicting the facility's written policy, which defines abuse broadly and includes sexual abuse among reportable violations. Review of the facility policy titled Abuse, Neglect, and Exploitation with an implemented date of 11/01/2023 and a reviewed/ revised date of 03/25/2025 revealed, the facility must: Protect residents from abuse, Identify all forms of abuse including sexual abuse, Report all alleged violations to the administrator, state agency, Adult Protective Services, and any other required agencies within 2 hours if involving abuse or serious bodily injury, or within 24 hours otherwise.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to follow their own policy regarding conducting and documenting their investigation of an allegation of sexual abuse for one resident (#5) out of three sampled residents. Findings included: During a phone interview on 06/13/2026 at 12:02 p.m., the Resident Representative (RR) stated he received a call from facility staff during an evening in May 2026 informing him that another resident entered Resident #5's room, was throwing things at Resident #5, and exposed his genitals. The RR stated the nurse notified him of the incident. The RR reported he instructed staff to move the other resident away from Resident #5. The RR stated he did not receive any further follow-up from the facility. The RR reported Resident #5 required several weeks before she was able to discuss the incident with him. Record review showed Resident #5 was admitted on [DATE] and discharged on 05/26/2026. Review of Resident #5's admission MDS dated [DATE] revealed a brief interview mental status (BIMS) score of 14, indicating intact cognition. Review of the nurse progress note dated 05/09/2026 at 20:34 documented: Patient across the hall went into resident's room scaring her. Resident stated that he was unzipping and zipping his pants and was being sexually inappropriate. Both families called with notification, as well as the administrator. Resident's family assured that she will remain safe and that the other patient will not come into her room again. [The family member] stated that he wanted the male patient moved away to another room. Review of the facility's reportable, adverse, and grievance log for May 2026 revealed no entries related to an allegation of sexual abuse. During an interview on 06/13/2026 at 12:10 p.m., Staff A Licensed Practical Nurse (LPN) stated she recalled an incident during one of her shifts in which she was informed that a male resident had gone into Resident #5's room and was zipping and unzipping his pants and saying he was going to fix it. Staff A stated she immediately checked on Resident #5, who was upset and reported the same behavior. Staff A stated she notified her supervisor, the administrator, and Resident #5's family. Staff A stated the other resident was moved to another floor. Staff A reported she provided a written statement to the administrator and believed an investigation occurred. During an interview on 06/13/2026 at 2:00 p.m., the Assistant Director of Nursing (ADON) stated sexual abuse includes verbal sexual statements, exposure of genitals, or touching without consent. The ADON stated they did not recall Resident #5 or any incident in which a resident exposed themselves to another resident. The ADON stated such an allegation would have been investigated. During an interview on 06/13/2026 at 2:53 p.m. with the Nursing Home Administrator (NHA) and Corporate Risk Manager, the NHA read from the facility's abuse policy and stated sexual abuse was defined as non-consensual sexual contact. The NHA stated their interpretation of the policy did not include exposing oneself as sexual abuse. The NHA reported Resident #5 told them during a phone interview that the other resident had not exposed himself. The NHA stated staff told her they stopped the resident before he reached Resident #5's room. When asked to provide documentation of the investigation, the NHA was unable to produce a file, reports, or notes. When asked which log recorded the investigation, the NHA was unable to identify one. Review of the facility's policy titled Abuse, Neglect, and Exploitation, implemented 11/01/2023 and revised 03/25/2025, showed the facility requires immediate investigation of alleged violations and includes steps such as identifying responsible staff, preserving evidence, interviewing the alleged victim, alleged perpetrator, and witnesses, determining whether abuse occurred, and maintaining complete documentation. Policy definitions included abuse as willful infliction of injury or intimidation causing physical harm, pain, or mental anguish, including sexual abuse. The policy defined alleged violation as any reported or observed event that may indicate non-compliance and requires investigation.		