STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105117	A. BUILDING B. WING	04/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH HERITAGE HEALTH & REHABILITATION CENTER	718 LAKEVIEW AVE S , SAINT PETERSBURG, Florida, 33705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS An off-hours complaint survey for complaint numbers 2025015862, 2025016685, 2025016774, 2026000642, 2026000956, 2026003606 and 2026006227 was conducted on 04/25/2026 at South Heritage Health and Rehabilitation Center. The facility was not in compliance with 42 CFR, Part 483, Requirements for Long Term Care Facilities. Complaint #2026003606 had deficiencies cited at F677 and F684. Complaint #2026006227 had deficiencies cited at F550.	F0000		05/12/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F0550	Corrective Action for Resident Affected: The resident was transferred and evaluated for appropriate medical services. Resident #5 no longer resides in the facility. Identification of Other Residents at Risk: An audit was conducted on residents with recent changes in condition, emergency transfers, and documented requests for outside medical services from the past 30 days to identify any additional requests to be sent out for medical necessity. No other residents were identified. Systemic Changes Implemented: The Director of Nursing or designee re-educated licensed nurses, and interdisciplinary staff on resident rights related to accessing medical care and services outside the facility, including timely physician notification, emergency response procedures to prevent delayed emergent care, and honoring resident/responsible party requests for outside medical evaluation. Monitoring to Ensure Compliance: The Director of Nursing/designee will audit return to hospital/transfers change in condition and resident requests for outside medical services weekly for four	05/25/2026

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 reverse for further 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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F0550 SS = D	Continued from page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to protect the resident's right to seek medical services outside the facility, resulting in delayed emergent care and services for one resident (#5) of two residents sampled. Findings included: During a follow-up telephone interview on 4/25/26 at 2:50 p.m. with Resident #5's family member, the family member revealed being upset and frustrated with the facility because they did not want to send Resident #5 out to the ER (emergency room). The family member stated the resident had requested to go to the hospital following discomfort after laparoscopic surgery. The family member stated Resident #5 had symptoms of pain, bloating and had been vomiting all night. He stated a nurse said the inhouse doctor would assess Resident #5 first. He stated she was given nausea medication and continued to have diarrhea all night through the next day. The family stated having begged the nurse to send the resident out. He stated he eventually called non-emergency police to do a wellness check and request Resident #5 to be sent out. The family member said, "no one was helping her. she had not been checked on all night and had a pail of vomit at bedside. I begged the nurse to send her out and she would not." The family member stated eventually he advised the resident to call 911 herself and that was when she went out. The family member said, "The sad thing was that the hospital actually found that she had fluid build-up, and yet she was ignored and yet she not well."	F0550	Continued from page 1 weeks, then monthly for two weeks to ensure timely response to resident requests to go out to the hospital. Audit findings will be reported through the facility's Quality Assurance Committee monthly until substantial compliance is met.	05/25/2026

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F0550 SS = D	Continued from page 2 Review of the admission record revealed Resident #5 was admitted to the facility with diagnoses to include other specified diseases of pancreas, disorder involving the immune mechanism, anemia, muscle wasting and atrophy. Review of Resident #5's progress notes revealed a change in condition as follows: On 3/26/26 at 2:25 p.m. Writer called and left a message for MD (Medical Doctor) to call facility back regarding resident condition. Writer informed desk nurse of call being placed. On 3/26/26 at 11:49 p.m. Resident complained of pains and vomiting by 7p.m. MD was notified, pain medication was changed from every six hours to every four hours, and MD ordered milk of magnesium to be given and same was offered to Resident #5 with good results. Note please call MD to get an order for intravenous (IV) infusion normal saline for resident to prevent dehydration per family request (MD was called but no response). On 3/27/26 12:20 p.m. Patient complains of stomach pain and is insisting on going to hospital. VITALS: 97.3-104-18 173/99 97%. Paged doctor to advise. On 3/27/26 4:11 p.m. writer returned from lunch and saw paramedics at patient's room and writer was advised that the patient had called the paramedics to be taken to the hospital. On 3/28/26 at 8:19 a.m. Resident admitted to hospital. Review of Resident #5's hospital records dated 3/27/2026, revealed: chief complaint sepsis, suspended pseudocyst. ...comes to the ED secondary to abdominal pain and discomfort. Patient was previously admitted 12/25 and underwent Magnetic Resonance Imaging (MRI), secondary to similar symptoms, which revealed stricture at the pancreatic body–tail junction involving the main pancreatic duct with upstream pancreatic duct dilation and parenchymal atrophy. Patient underwent laparoscopic distal pancreatomy with sphincterotomy and en bloc partial gastrectomy on January 26, 2026. Postoperatively, patient had to be treated with IV	F0550		05/25/2026

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F0550 SS = D	Continued from page 3 antibiotics secondary to blood cultures positive for Serratia bacteremia with suspected source being urine versus abdomen. Patient was discharge on additional seven days of oral antibiotics with drain still in place after undergoing procedure. Patient underwent removal of surgical drain on 03/18, but reports she gradually had increased distention and pain at the site of drain removal. Patient reports in the last 24 hours she began to have significant increase in abdominal pain, swelling and discomfort. Patient reporting fevers at home, chills, abdominal pain, and inability to tolerate oral intake. The physical exam, Vitals & Measurements revealed T: 97.8 °F (Oral) HR: 59 (Pulse) RR: 15 BP: 106/63 SpO2: 100% HT: 149.86 cm HT: 59-inch(es) WT: 60.8 kg BMI: 27.1. The assessment plan revealed …presents with worsening abdominal pain, swelling, and systemic symptoms following removal of the drain. Evaluation revealed leukocytosis with left shift and Computed Tomography (CT) imaging showing gastritis with inflammation near the prior drain site as well as two postoperative fluid collections or possible pseudocysts. Given her symptoms and imaging findings, concern is raised for postoperative complications such as infected fluid collections versus recurrent pancreatitis-related issues. Further review of the assessment plan showed abdominal pain, with evidence of a fluid collection and differential of pseudocyst versus surgical collection, chronic pancreatitis post Whipple's procedure and splenectomy. An interview was conducted with Staff B, Registered Nurse (RN)/Unit Manager on 4/25/26 at 12.42 p.m. Staff B said Resident #5 was here for recovery after laparoscopic. She stated the resident had complications and had been discharged from the hospital to home. Resident #5 had complications at home and was readmitted to the hospital, needing a drain, the drain was subsequently removed, without complications. Resident #5 developed pain afterwards. Staff B said there was an order for dressing which came off and she was fine. Staff B stated if a resident has a change, and they want to go to the ER, "We assess first, we look at the entire picture and review vital signs, we look if we can treat the issue here at the facility." Staff B said, Resident #5 was given pain and nausea medication. Staff B said Resident #5 ended up going to the hospital, having called 911 herself. Staff B stated usually the nurse would call. She said, "I don't know what happened." Staff B stated she did not know Resident #5's condition upon admission to the hospital. She said the Director of Nursing (DON) calls after they leave to check on them.	F0550		05/25/2026

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F0550 SS = D	Continued from page 4 An interview with Staff D, Licensed Practical Nurse (LPN) revealed Resident #5 stayed in her room but would come out for smoking. She stated she heard the resident was sick and was throwing up, she does not remember the timeline, and whether she was sent out immediately or not. An interview was conducted with Staff A, Certified Nursing Assistant (CNA) on 4/25/2026 at 11:20 a.m. . She stated she remembered Resident #5 and said, "She was ambulatory. She was getting sick towards the end, … she was too sickly, like throwing up all the time." On 4/25/26 at 11:38 a.m. an interview was conducted with Staff C, CNA. Staff C said Resident #5 was independent with care. Staff C said, Resident #5 got sick, throwing up. An interview was conducted with the Director of Nursing (DON) on 4/25/26 at 3:24 p.m. The DON stated if the doctor would have ordered for Resident #5 to go to the hospital, they would have documented. She stated she heard about her being sick. She said, "I did hear about it. I heard the police were here for Resident #5, I did not get any details." The DON confirmed if someone wanted to go to the hospital, the nurse would assess and notify the physician. She stated there should be notes showing the assessment and monitoring following a change in condition. The DON stated the nurses should have documented the monitoring and vitals obtained during the period of the change. The DON said, "I agree, if it is not documented it did not happen. The nurse should have documented vitals, if the resident wanted to be sent out, assess, call the doctor and send them out." the DON confirmed the resident has a right to seek medical care and should be assisted if they choose to do so. Review of a facility policy titled, Resident Rights, effective August 2025, revealed a policy: The facility strives to ensure that each resident has a dignified existence, self-determination, and communication with, and access to, persons and services inside and outside the facility. The facility will protect and promote the rights of each resident. The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. The resident has the	F0550		05/25/2026

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F0550 SS = D	Continued from page 5 right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising bis or her rights and to be supported by the facility in the exercise of his or her rights. Procedure: 5. Assist the resident with such things including, but not limited to, the following: b. Maintaining communication with outside agencies.	F0550		05/25/2026
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and interviews, the facility failed to ensure nail care was provided to one resident (#4) out of three resident reviewed for total assistance with activities of daily living (ADLs). Findings included: A review of Resident #4's admission record showed an admission date of 1/20/26. Further review of the admission record showed diagnoses to include quadriplegia, unspecified, muscle wasting and atrophy, not elsewhere classified, multiple sites, and other lack of coordination. On 4/25/26 at 9:19 a.m., an interview and observation occurred with Resident #4. Resident #4's nails were observed approximately one to one and a half inches long. During the interview, he stated he wanted his nails cut, and he had been asking the assigned certified nursing assistant (CNA) for the last three days. Resident #4 said the assigned CNA would tell him, "No, not yet I'm on break." He said one of the days the assigned CNA assisted with soaking his nails for 30 minutes. Resident #4 said when she came back, she said he had to wait for them to be trimmed because it was the change of shift. He said his family member cut his nails approximately six weeks ago. He said the Director of Nursing (DON) was told about his request for nail trimming by the psychiatry provider. On 4/25/26 at 10:40 a.m., a telephone interview was conducted with Resident #4's family member. She said the resident's nails were cut by a family member approximately six weeks ago.	F0677	Corrective Action for Resident Affected: Nail care was provided to Resident#4. Identification of Other Residents at Risk: Director of Nursing or designee conducted a house-wide audit to identify residents in need of nail care. Any identified concerns were addressed, and nail care services were provided as indicated. Systemic Changes Implemented: The Director of Nursing or designee re-educated the Licensed nurses and certified nursing assistants on resident nail care requirements, including timely identification and reporting of nail care needs. Licensed Nurses and Certified Nursing Assistants were educated on documenting completion of nail care in the electronic health record and communicating unmet care needs to nursing supervision. Monitoring to Ensure Compliance: The Director of Nursing or designee will conduct weekly audits of residents requiring nail care needs are addressed and documented appropriately. Random audits will be completed weekly for four weeks, then monthly for two months. Findings will be reviewed during the facility's Quality Assurance Committee meetings, until substantial compliance is met.	05/25/2026

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F0677 SS = D	Continued from page 6 On 4/25/26 11:00 a.m., an interview was conducted with Staff A, CNA. She said she typically was assigned to Resident #4. She stated, "He likes stuff done a certain way. A lot of CNAs are scared to go in there because he reports people who don't do their job." She said nail care for residents was supposed to be completed every weekend or as needed. Staff A, CNA said whenever a resident asked to cut their nails, staff should do it. She said the facility did not always have enough staff which prolonged them being able to cut the residents' nails. She said nail care is an as needed (PRN) task and documented in the Kardex. She said his nails were cut approximately a month ago when his family member had visited and cut his nails. Staff A, CNA said she was going to cut Resident #4's nails today because he asked her to do it. A review of Resident #4's nail care task, dated 3/28/26 to 4/23/26, showed, "No Nail Care," was documented. On 3/30/26, "Resident Refused," was documented. Review of the nail task documentation showed no nail care was provided for the last 30 days. A review of Resident #4's care plan revealed the following: "PREFERENCE/CHOICE: [Resident #4] has indicated the following preferences and/or has made the following choic [sic] heir [sic] health care: Resident chooses to decline recommended or ordered health care interventions of: -refusing medications, weights, personal care, incontinence care, bathing/showers -turned and positioned, refusing to allow staff to roll him side to side for care -Requests for staff to wear gloves when they feed him -refusing to get OOB [out of bed]. Date Initiated: 02/09/2026 Revision on: 04/22/2026." "[Resident #4] has an ADL [Activity Daily Living] Self Care Performance Deficit r/t [related to] quadriplegia … Date Initiated: 01/22/2026 Revision on: 02/16/2026." "BEHAVIORAL: [Resident #4] has a behavior problem r/t psychosocial well-being -alleging extended amount of time between care, staff handling roughly -confabulates regarding care being given, staff not feeding him, no water being offered (has adaptable water bottle at bedside) -c/o [complains of] pain but refuses pain medication -threatens to call DCF [department of children and families] -requesting fitted sheet on air mattress, explained those are not used, family threatening to	F0677		05/25/2026

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F0677 SS = D	Continued from page 7 call DCF -allegations of dietary "spiking his food" -refuses wound care photos Date Initiated: 02/16/2026 Revision on: 04/08/2026." "QUADRIPLEGIA: [Resident #4] has Quadriplegia r/t Spinal injury, Trauma Date Initiated: 01/28/2026 Revision on: 01/28/2026," with interventions to include, "Assist with ADLs and locomotion as required. Encourage resident to perform as much as possible of these activities. Date Initiated: 01/28/2026." "RANGE OF MOTION: [Resident #4] has an actual limitations in Range of Motion as evidence by impaired ROM [range of motion] to BUE [bilateral upper extremities] and BLE [bilateral lower extremities], quadriplegia. Date Initiated: 01/28/2026 Revision on: 01/28/2026." On 4/25/26 at 3:33 p.m., an interview was conducted with the Director of Nursing (DON) and Staff B, Registered Nurse (RN)/Unit Manager (UM). The DON said the CNAs or nurses provided nail care depending on the diagnosis of the resident. The DON said nail care is provided as needed. She stated staff would observe the resident's nails upon assessment and, "See how long they are getting." The DON said nail care should be completed if the resident asked the staff to do it. The DON and Staff B, RN/UM were not aware where completion of nail care was documented. The DON stated if a resident refused nail care a nursing note should be completed or, "The same spot it's supposed to be documented." She stated nail care was, "Part of hygiene and infection control." She said she had attempted to assist with cutting Resident #4's nails but he would not let staff. She said she could not confirm if that was documented. Staff B, RN/UM said she thought the resident refusing nail care was in his care plan. The facility did not provide a policy related to ADLs or nail care.	F0677		05/25/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the	F0684	Corrective Action for Resident Affected: Resident #4 was evaluated by nursing staff and the Dietician to ensure the physician-ordered diet was implemented accurately. The order was changed in the electronic health record and on the meal ticket to add large portions to breakfast, lunch, and dinner. Identification of Other Residents at Risk: The Dietician and Clinical Reimbursement Director completed an audit of current residents with	05/25/2026

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F0684 SS = D	Continued from page 8 comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure diet-related physician orders were implemented for one resident (#4) out of three resident reviewed. Findings included: On 4/25/26 at 12:30 p.m., an observation of Resident #4's lunch meal revealed the meal ticket did not show large or double portions was documented. A review of Resident #4's admission record showed an admission date of 1/20/26. Further review of the admission record showed diagnoses to include quadriplegia, unspecified, muscle wasting and atrophy, not elsewhere classified, multiple sites, and other lack of coordination. A review of Resident #4's physician orders revealed the following: "House diet Regular texture, Regular(Thin) consistency, No pork, lactose intolerant, no dairy (milk or cheese)," with a start date of 1/26/26. "Resident may have double portions for all meals six times a day," with a start date of 3/7/26. A review of Resident #4's care plan revealed the following: "NUTRITIONAL: [Resident #4] has a potential nutritional problem r/t [related to] Diagnoses - Quadriplegia, Spinal Stenosis, HTN [hypertension], Hyperlipidemia, Hypotension. Weight - Elevated BMI [body mass index] – IBW [ideal body weight] adjusted for quadriplegia - Resident requests large entree portions at meals. Medications - Duloxetine, may impact appetite. Date Initiated: 01/22/2026 Revision on: 01/26/2026." A review of Resident #4's nutrition evaluation, dated 1/26/26, revealed the following: "New admit [admission] 1/21. CBW [current body	F0684	Continued from page 8 physician-ordered dietary interventions to ensure dietary orders were accurately transcribed both in the electronic health record and displayed accurately on the meal ticket. Any discrepancies identified were corrected as indicated. Systemic Changes Implemented: The Director of Nursing/designee re-educated Licensed nurses on the importance of implementing physician-ordered diets as written in the electronic health record. Education included the process for verifying diet orders following admissions, readmissions, and physician changes. Monitoring to Ensure Compliance: The Director of Nursing and/or Dietary Manager/designee will conduct audits of physician-ordered diets and meal tray accuracy weekly for four weeks, then monthly for two months to ensure compliance with ordered dietary interventions. Audit findings will be reviewed during the facility's Quality Assurance Committee meetings until substantial compliance is met.	05/25/2026

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F0684 SS = D	Continued from page 9 weight] 249.8 lbs [pounds] (1/21). BMI 34.8. IBW adjusted for quadriplegia. Resident reports his UBW [usual body weight] prior to his recent hospitalization was 270 lbs. House diet, regular textures, thin liquids. Resident requests large entree portions at meals. No problems chewing/swallowing reported. Dependent with meals. On duloxetine, which may impact appetite. … Continue with diet as ordered. Large entree portions provided, per resident request. Resident denied the need for additional snacks/supplements at this time. Tray ticket updated with food preferences. Will monitor weights weekly, per new admit. …" On 4/25/26 at 2:30 p.m., an interview was conducted with the Food Service Manager (FSM). He said Resident #4 received large portions for breakfast, but not with the other meals. The FSM provided today's meal tickets which showed, "Large Portion," for breakfast. A review of Resident #4's lunch and dinner meal ticket did not show large portions was documented. On 4/25/26 at 2:48 p.m., a follow-up interview was conducted with the FSM. He said all dietary orders are placed in the electronic medical record and automatically transferred to the food service meal tracker system. He said the meal tracker system printed the meal tickets. The FSM said he was not able to adjust the orders. He said the orders needed to be placed in the electronic medical record by the nursing staff or the registered dietitian (RD). He said he received a notification everyday if there was a change to the resident's diet order. The FSM said he did not see the order for double portions for all meals as it was categorized as, "other," not under dietary. On 4/25/26 at 3:33 p.m., an interview was conducted with the Director of Nursing (DON). She said the DON, nurse, or unit manager (UM) would put in a resident's diet order. She said the order is documented on a dietary slip and provided to the dietary personnel. She said the FSM has a list of the residents' diet orders. The DON said whoever put in Resident #4's order for double portions for all meals, put it under the "other," category. She stated, "Other orders floats in the nursing space." The DON confirmed the order for double portions for all meals should have been put under the dietary category. She said the diet slip should have been written and handed off to the dietary personnel as well. The facility did not provide a policy related to physician orders or dietary orders.	F0684		05/25/2026

Florida Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15030961	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH HERITAGE HEALTH & REHABILITATION CENTER	718 LAKEVIEW AVE S , SAINT PETERSBURG, Florida, 33705

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N0000	INITIAL COMMENTS An off-hours complaint survey for complaint numbers 2025015862, 2025016685, 2025016774, 2026000642, 2026000956, 2026003606 and 2026006227 was conducted on 04/25/2026 at South Heritage Health and Rehabilitation Center. Deficiencies were identified at the time of the survey. Complaint #2026003606 and #2026006227 had deficiencies cited at N201	N0000		05/12/2026
N0201 SS = D	Right to Adequate and Appropriate Health Care CFR(s): 400.022(1)(l), FS (l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and interviews, the facility failed to ensure:1. a) nail care was provided to one (Resident #4) out of three resident reviewed for total assistance with activities of daily living (ADLs) and b) diet-related physician orders were implemented for one (Resident #4) out of three resident reviewed and 2. failed to protect the resident's right to seek medical services outside the facility, resulting in delayed emergent care and services for one (Resident #5) of three residents sampled. Findings included: 1.A) The facility did not provide a policy related to ADLs or nail care. A review of Resident #4's admission record showed an admission date of 1/20/26. Further review of the admission record showed diagnoses to include quadriplegia, unspecified, muscle wasting and atrophy, not elsewhere classified, multiple sites, and	N0201	Corrective Action for Resident Affected: Nail care was provided to Resident#4. Identification of Other Residents at Risk: Director of Nursing or designee conducted a house-wide audit to identify residents in need of nail care. Any identified concerns were addressed, and nail care services were provided as indicated. Systemic Changes Implemented: The Director of Nursing or designee re-educated the Licensed nurses and certified nursing assistants on resident nail care requirements, including timely identification and reporting of nail care needs. Licensed Nurses and Certified Nursing Assistants were educated on documenting completion of nail care in the electronic health record and communicating unmet care needs to nursing supervision. Monitoring to Ensure Compliance: The Director of Nursing or designee will conduct weekly audits of residents requiring nail care needs are addressed and documented appropriately. Random audits will be completed weekly for four weeks, then monthly for two months. Findings will be reviewed during the facility's Quality Assurance Committee meetings, until substantial compliance is met.	05/25/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15030961	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/25/2026

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N0201 SS = D	Continued from page 1 other lack of coordination. On 4/25/26 at 9:19 a.m., an interview and observation occurred with Resident #4. Resident #4's nails were approximately one to one and a half inches long. Resident #4 stated he wanted his nails cut, and he had been asking the assigned certified nursing assistant (CNA) for the last three days. Resident #4 said the assigned CNA would tell him, "No, not yet I'm on break." He said one of the days he asked the assigned CNA, assisted with soaking his nails for 30 minutes. Resident #4 said when she came back, she said he had to wait for them to be trimmed because it was the change of shift. He said his family member cut his nails approximately six weeks ago. He said the Director of Nursing (DON) was told about him wanting his nails cut by the psychology provider. On 4/25/26 at 10:40 a.m., a telephone interview was conducted with Resident #4's family member. She said the resident's nails were cut by a family member approximately six weeks ago. On 4/25/26 11:00 a.m., an interview was conducted with Staff A, CNA. She said she typically was assigned to Resident #4. She stated, "He likes stuff done a certain way. A lot of CNAs are scared to go in there because he reports people who don't do their job." She said nail care for residents was supposed to be completed every weekend or as needed. Staff A, CNA said whenever a resident asked to cut their nails, staff should do it. She said the facility did not always have enough staff which prolonged them being able to cut the residents' nails. She said nail care is an as needed (PRN) task and documented in the Kardex. She said his nails were cut approximately a month ago when his family member had visited and cut his nails. Staff A, CNA said she was going to cut Resident #4's nails today because he asked her to do it. A review of Resident #4's nail care task, dated 3/28/26 to 4/23/26, showed, "No Nail Care," was documented. On 3/30/26, "Resident Refused," was documented. Review of the nail task documentation showed no nail care was provided for the last 30 days. A review of Resident #4's care plan revealed the following: "PREFERENCE/CHOICE: [Resident #4] has indicated the following preferences and/or has made the following choic [sic] heir [sic] health care: Resident chooses to decline recommended or ordered health	N0201		05/25/2026

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N0201 SS = D	Continued from page 2 care interventions of: -refusing medications, weights, personal care, incontinence care, bathing/showers -turned and positioned, refusing to allow staff to roll him side to side for care -Requests for staff to wear gloves when they feed him -refusing to get OOB [out of bed]. Date Initiated: 02/09/2026 Revision on: 04/22/2026." "[Resident #4] has an ADL [Activity Daily Living] Self Care Performance Deficit r/t [related to] quadriplegia … Date Initiated: 01/22/2026 Revision on: 02/16/2026." "BEHAVIORAL: [Resident #4] has a behavior problem r/t psychosocial well-being -alleging extended amount of time between care, staff handling roughly -confabulates regarding care being given, staff not feeding him, no water being offered (has adaptable water bottle at bedside) -c/o [complains of] pain but refuses pain medication -threatens to call DCF [department of children and families] -requesting fitted sheet on air mattress, explained those are not used, family threatening to call DCF -allegations of dietary "spiking his food" -refuses wound care photos Date Initiated: 02/16/2026 Revision on: 04/08/2026." "QUADRIPLEGIA: [Resident #4] has Quadriplegia r/t Spinal injury, Trauma Date Initiated: 01/28/2026 Revision on: 01/28/2026," with interventions to include, "Assist with ADLs and locomotion as required. Encourage resident to perform as much as possible of these activities. Date Initiated: 01/28/2026." "RANGE OF MOTION: [Resident #4] has an actual limitations in Range of Motion as evidence by impaired ROM [range of motion] to BUE [bilateral upper extremities] and BLE [bilateral lower extremities], quadriplegia. Date Initiated: 01/28/2026 Revision on: 01/28/2026." On 4/25/26 at 3:33 p.m., an interview was conducted with the DON and Staff B, Registered Nurse (RN)/Unit Manager (UM). The DON said the CNAs or nurses provided nail care depending on the diagnosis of the resident. The DON said nail care is provided as needed. She stated staff would observe the resident's nails upon assessment and, "See how long they are getting." The DON said nail care should be completed if the resident asked the staff to do it. The DON and Staff B, RN/UM were not aware where completion of nail care was documented. The DON stated if a resident refused nail care a nursing note should be completed or, "The same spot it's supposed to be documented."	N0201		05/25/2026

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N0201 SS = D	Continued from page 3 She stated nail care was, "Part of hygiene and infection control." She said she had attempted to assist with cutting Resident #4's nails but he would not let staff. She said she could not confirm if that was documented. Staff B, RN/UM said she thought the resident refusing nail care was in his care plan. B) The facility did not provide a policy related to physician orders or dietary orders. On 4/25/26 at 12:30 p.m., an observation of Resident #4's lunch meal revealed the meal ticket did not show large or double portions was documented. A review of Resident #4's admission record showed an admission date of 1/20/26. Further review of the admission record showed diagnoses to include quadriplegia, unspecified, muscle wasting and atrophy, not elsewhere classified, multiple sites, and other lack of coordination. A review of Resident #4's physician orders revealed the following: "House diet Regular texture, Regular(Thin) consistency, No pork, lactose intolerant, no dairy (milk or cheese)," with a start date of 1/26/26. "Resident may have double portions for all meals six times a day," with a start date of 3/7/26. A review of Resident #4's care plan revealed the following: "NUTRITIONAL: [Resident #4] has a potential nutritional problem r/t [related to] Diagnoses - Quadriplegia, Spinal Stenosis, HTN [hypertension], Hyperlipidemia, Hypotension. Weight - Elevated BMI [body mass index] – IBW [ideal body weight] adjusted for quadriplegia - Resident requests large entree portions at meals. Medications - Duloxetine, may impact appetite. Date Initiated: 01/22/2026 Revision on: 01/26/2026." A review of Resident #4's nutrition evaluation, dated 1/26/26, revealed the following: "New admit [admission] 1/21. CBW [current body weight] 249.8 lbs [pounds] (1/21). BMI 34.8. IBW adjusted for quadriplegia. Resident reports his UBW [usual body weight] prior to his recent hospitalization was 270 lbs. House diet, regular textures, thin	N0201		05/25/2026

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N0201 SS = D	Continued from page 4 liquids. Resident requests large entree portions at meals. No problems chewing/swallowing reported. Dependent with meals. On duloxetine, which may impact appetite. … Continue with diet as ordered. Large entree portions provided, per resident request. Resident denied the need for additional snacks/supplements at this time. Tray ticket updated with food preferences. Will monitor weights weekly, per new admit. …" On 4/25/26 at 2:30 p.m., an interview was conducted with the Food Service Manager (FSM). He said Resident #4 received large portions for breakfast, but not with the other meals. The FSM provided today's meal tickets which showed, "Large Portion," for breakfast. A review of Resident #4's lunch and dinner meal ticket did not show large portions was documented. On 4/25/26 at 2:48 p.m., a follow-up interview was conducted with the FSM. He said all dietary orders are placed in the electronic medical record and automatically transferred to the food service meal tracker system. He said the meal tracker system printed the meal tickets. The FSM said he was not able to adjust the orders. He said the orders needed to be placed in the electronic medical record by the nursing staff or the registered dietitian (RD). He said he received a notification everyday if there was a change to the resident's diet order. The FSM said he did not see the order for double portions for all meals as it was categorized as, "other," not under dietary. On 4/25/26 at 3:33 p.m., an interview was conducted with the DON. She said the DON, nurse, or unit manager (UM) would put in a resident's diet order. She said the order is documented on a dietary slip and provided to the dietary personnel. She said the FSM has a list of the residents' diet orders. The DON said whoever put in Resident #4's order for double portions for all meals, put it under the "other," category. She stated, "Other orders floats in the nursing space." The DON confirm the order for double portions for all meals should have been put under the dietary category. She said the diet slip should have been written and handed off to the dietary personnel as well. 2. Review of a facility policy titled, Resident Rights, effective August 2025, revealed a policy: The facility strives to ensure that each resident has a dignified existence, self-determination, and communication with, and access to, persons and services inside and	N0201		05/25/2026

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N0201 SS = D	Continued from page 5 outside the facility. The facility will protect and promote the rights of each resident. The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising bis or her rights and to be supported by the facility in the exercise of his or her rights. Procedure: 5. Assist the resident with such things including, but not limited to, the following: b. Maintaining communication with outside agencies. During a follow-up telephone interview on 4/25/26 at 2:50 p.m. with Resident #5's family member, the family member revealed being upset and frustrated with the facility because they did not want to send Resident #5 out to the ER (emergency room). The family member stated the resident had requested to go to the hospital following discomfort after laparoscopic surgery. The family member stated Resident #5 had symptoms of pain, bloating and had been vomiting all night. He stated a nurse said the inhouse doctor would assess Resident #5 first. He stated she was given nausea medication and continued to have diarrhea all night through the next day. The family stated having begged the nurse to send the resident out. He stated he eventually called non-emergency police to do a wellness check and request Resident #5 to be sent out. The family member said, "no one was helping her. she had not been checked on all night and had a pail of vomit at bedside. I begged the nurse to send her out and she would not." The family member stated eventually he advised the resident to call 911 herself and that was when she went out. The family member said, "The sad thing was that the hospital actually found that she had fluid build-up, and yet she was ignored and yet she not well." Review of the admission record revealed Resident #5 was admitted to the facility with diagnoses to include other specified diseases of pancreas, disorder involving the immune mechanism, anemia, muscle wasting and atrophy. Review of Resident #5's progress notes revealed a change in condition as follows: On 3/26/26 at 2:25 p.m. Writer called and left a message for MD (Medical Doctor) to call facility back regarding resident condition. Writer informed desk nurse of call being placed.	N0201		05/25/2026

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N0201 SS = D	Continued from page 6 On 3/26/26 at 11:49 p.m. Resident complained of pains and vomiting by 7p.m. MD was notified, pain medication was changed from every six hours to every four hours, and MD ordered milk of magnesium to be given and same was offered to her with good results. Note please call MD to get an order for intravenous (IV) infusion normal saline for resident to prevent dehydration per family request (MD was called but no response). On 3/27/26 12:20 p.m. Patient complains of stomach pain and is insisting on going to hospital. VITALS: 97.3-104-18 173/99 97%. Paged doctor to advise. On 3/27/26 4:11 p.m. writer returned from lunch and saw paramedics at patients' room and writer was advised that the patient had called the paramedics to be taken to the hospital. On 3/28/26 at 8:19 a.m. Resident admitted to hospital. Review of Resident #5 hospital records dated 3/27/2026, revealed: chief complaint sepsis, suspended pseudocyst. …comes to the Emergency Department (ED) secondary to abdominal pain and discomfort. Patient was previously admitted 12/25 and underwent Magnetic Resonance Imaging (MRI),secondary to similar symptoms, which revealed stricture at the pancreatic body~tail junction involving the main pancreatic duct with upstream pancreatic duct dilation and parenchymal atrophy. Patient underwent laparoscopic distal pancreatomy with sphincterotomy and en bloc partial gastrectomy on January 26, 2026. Postoperatively, patient had to be treated with IV antibiotics. Patient was discharge on additional seven days of oral antibiotics with drain still in place after undergoing procedure. Patient underwent removal of surgical drain on 03/18. Patient reports in the last 24 hours she began to have significant increase in abdominal pain, swelling and discomfort. Patient reporting fevers at home, chills, abdominal pain, and inability to tolerate oral intake. The physical exam, Vitals & Measurements revealed T: 97.8 °F (Oral) HR: 59 (Pulse) RR: 15 BP: 106/63 SpO2: 100% HT: 149.86 cm HT: 59-inch(es) WT: 60.8 kg BMI: 27.1. The assessment plan revealed …presents with worsening abdominal pain, swelling, and systemic symptoms following removal of the drain. Her evaluation revealed leukocytosis with left shift and Computed Tomography (CT) imaging showing gastritis with inflammation near the prior drain site	N0201		05/25/2026

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N0201 SS = D	Continued from page 7 as well as two postoperative fluid collections or possible pseudocysts. Given her symptoms and imaging findings, concern is raised for postoperative complications such as infected fluid collections versus recurrent pancreatitis-related issues. Further review of the assessment plan showed abdominal pain, with evidence of a fluid collection and differential of pseudocyst versus surgical collection, chronic pancreatitis post Whipple's procedure and splenectomy. An interview was conducted with Staff B, Registered Nurse (RN)/Unit Manager on 4/25/26 at 12:42 p.m. Staff B said Resident #5 was here for recovery after surgery. Staff B stated there were no complications after drain was removed, but she developed pain afterwards. Staff B said there was an order for dressing which came off and she was fine. Staff B stated if a resident has a change, and they want to go to the ER, "We assess first, we look at the entire picture and review vital signs, we look if we can treat the issue here at the facility." Staff B said, Resident #5 was given pain medicine and nausea medicine. Staff B said the resident she ended up going to the hospital, having called 911 herself. Staff B stated usually the nurse would call. She said, "I don't know what happened." Staff B stated she did not know Resident #5's condition upon admission to the hospital. She said the Director of Nursing (DON) calls after they leave to check on them. An interview with Staff D, Licensed Practical Nurse (LPN) revealed Resident #5 stayed in her room but would come out for smoking. She stated she heard the resident was sick and was throwing up, she does not remember the timeline, and whether she was sent out immediately or not. An interview was conducted with Staff A, Certified Nursing Assistant on 4/25/2026 at 11:20 a.m. . She stated she remembered Resident #5 and said, "She was ambulatory. She was getting sick towards the end, ... she was too sickly, like throwing up all the time." On 4/25/26 at 11:38 a.m. an interview was conducted with Staff C, CNA. Staff C said Resident #5 was independent with care and was throwing up, they sent her out and she did not come back. An interview was conducted with the Director of Nursing (DON) on 4/25/26 at 3:24 p.m. The DON	N0201		05/25/2026

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N0201 SS = D	Continued from page 8 stated if the doctor would have ordered for Resident #5 to go to the hospital, they would have documented. She stated she heard about her being sick. She said, "I did hear about it. I heard the police were here for Resident #5, I did not get any details." The DON confirmed if someone wanted to go to the hospital, the nurse would assess and notify the physician. She stated there should be notes showing the assessment and monitoring following a change in condition. The DON stated the nurses should have documented the monitoring and vitals obtained during the period of the change. The DON said, "I agree, if it is not documented it did not happen. The nurse should have documented vitals, if the resident wanted to be sent out, assess, call the doctor and send them out." the DON confirmed the resident has a right to seek medical care and should be assisted if they choose to do so. Class III	N0201		05/25/2026