Florida State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1083095	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENSINGTON GARDENS REHAB AND NURSING CENTER	2055 PALMETTO ST , CLEARWATER, Florida, 33758

(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
N0000	INITIAL COMMENTS An unannounced complaint survey for complaint numbers 2025006813, 2025007990, and 2025008120 was conducted in conjunction with a revisit to a complaint survey (Event ID: S4FF12) on 6/11/2025 to 6/12/2025 at Kensington Gardens Rehab and Nursing Center. Previously identified deficiencies were found not to be corrected. New deficiencies were identified during the complaint survey. The facility has been out of compliance since 5/13/2025. Complaint number 2025006813 and 2025007990 were cited at N110. Complaint number 2025008120 was cited at N917.	N0000		
N0110	Physical Environment - Safe, Clean, Homelike CFR(s): 400.141(1)(h) FS; 59A-4.122(1) FAC 400.141(1)(h) FS Maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner. 59A-4.122(1) FAC The licensee must provide a safe, clean, comfortable, and homelike environment, which allows the resident to use his or her personal belongings to the extent possible This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews and record review, the facility did not ensure opertaional equipment and a safe, functioning, sanitary and comfortable environment was provided in resident's rooms for six residents (#5, #6, #7, #11, #12 and #13) out of 15 residents sampled, and in common areas to include food storage areas.	N0110	N110 What corrective actions (s) will be accomplished for those residents found to have been affected by the deficient practice: 1. By 7/12/2025, Residents #5, #6, #7, #11, #12, and #13 interviews and room audits completed. 2. By 7/12/2025 Residents #5, #6, and #11 overbed light repaired. 3. By 7/12/2025, Resident #7 bed replaced with head of bed working properly. 4. By 7/12/2025, the ceiling tile in the activities room on the south hallway replaced. 5. By 7/12/2025, the loose baseboard along the perimeter of the activities room was replaced. 6. By 7/12/2025, the bio-growth substance outside of the sliding glass door to the left of the activities room exiting to the courtyard was cleaned.	07/12/2025

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

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N0110	Continued from page 1 Findings included: Review of a facility policy titled, "Standards and Guidelines: General cleaning" dated, 01/2024 showed a standard: It is the policy of this facility to provide a clean, safe, orderly, comfortable and attractive home like environment as outlined below: 1. Accepted practices and procedures are used to keep the facility free from odors, accumulations of dirt, dust and safety hazards. 2. Floors and horizontal surfaces are cleaned routinely. Finishes on floors provide an appropriate finish and disinfectants are used where required. 3. Walls and ceilings are maintained free from dirt or other matters. 4. Entrances, exits, walkways, driveways and other outside or entry areas are kept free from debris and dirt. 5. Beds, bedside tables, chairs overbed tables, nightstands and dressers should be cleaned with a germicidal and allowed to air dry. 6. Dry dusting is used on items such as pictures, plaques, mirrors, bulletin boards, tops of partitions, vents, tops of cabinets, coat racks and window/door frames. Damp dusting may be used as needed. On 6/11/2025 at 10:45 a.m., an observation and interview were conducted with Resident #5 in his room. Resident #5 stated his overhead light does not work very well, and stated, "it flickers on and off", and stated his roommate's [Resident #6] light, does not work at all. Staff P, Certified Nurse Assistant (CNA), entered the room and agreed the lights were not working properly. Staff P, CNA stated this was not her assignment. She stated she will notify their nurse. On 6/11/2025 at 10:52 a.m., an interview was conducted with Resident #7. Resident #7 stated she received a new	N0110	Continued from page 1 7. By 7/12/2025, the ceiling outside of the activities room adjacent to the ceiling tile was repaired and repainted. 8. By 7/12/2025, the refrigerator in the nourishment room on the east hallway was removed, discarded and replaced. The cupboard under the sink of the east pantry was cleaned. The ceiling tile above the door was replaced. The exhaust fan in the wall was cleaned. 9. By 7/12/2025, the air conditioning was replaced in Resident #12 and #13 shared room. The missing ceiling tile in the bathroom was replace. The flooring in resident #12 room was replaced. 10. By 7/12/2025 The loose flooring was replaced/repaired in the east 200 hallway. How will you identify other residents having potential to be affected by the same practice and what corrective actions will be taken: By 7/12/2025, resident interviews, resident room and common area audited to ensure equipment is safe, sanitary, comfortable and operational. The audit included resident room HVAAC, refrigerator and cupboards in pantry rooms, ceiling tiles, flooring, beds for proper function, resident room overbed lights and fans in the pantry rooms. Maintenance equipment and/or environmental items identified on the audit will be repaired and/or replaced as appropriate. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: 1. By 7/12/2025, Administrator and/or designee educated staff on reporting safe, sanitary, confortable and operational equipment via TELS. 2. Newly hired staff will be educated on reporting safe equipment, maintenance and environmental concerns via TELS. How the corrective actions will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place:	

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N0110	Continued from page 2 bed this morning because the other bed was not working but stated, "this bed's head will not go up and down". The resident stated she will have to start the whole process of requesting a new bed all over again. On 6/11/2025 at 10:11 a.m., an observation was made of the activities room on the south hallway. Inside the activities room ceiling was a ceiling tile to the left upon entry with scattered areas of small gray/black circles, then concentric circles of various shades of tan, rusty brown. During observation, Staff P, CNA stated, "that's been there for a while.' Staff P, CNA stated over the weekend there was water on the floor in the activity room when she came to work. An observation was made of loose baseboards along the perimeter of the activities room. An observation was made of thick green bio growth substance outside the sliding glass door to the left of the activities room exiting to a courtyard. Directly outside the activities room adjacent to the ceiling tile, there was black bio growth substance and peeling paint with a heavy color of dark brown/black substance. Some missing ceiling texture were observed with light brown discoloration and dark heavy collection of black bio growth at the area where the wall meets the ceiling. A tall white garbage can was observed underneath this area with a collection of lightly discolored water inside garbage can approximately six inches. On 6/11/2025 at 10:30 a.m., an observation and interview was conducted with the Nursing Home Administrator (NHA) and Director of Nursing (DON) during tour of south hallway in the activities room. The NHA and the DON stated they had not seen these two areas before. On 6/11/2025 at 11:03 a.m., an observation and interview was conducted with Resident #11. Resident #11 stated her overhead bed light does not work. Staff P, CNA arrived in the room and stated her light works, She said, "you don't have the switch." Staff P, CNA turned the light switch on by the doorway of Resident #11's room, then went to the bedside to pull the cord to turn on the overhead light. The light did not go on, and Staff P, CNA pulled the cord multiple times until the light flickered, and stated, "see it works." Staff P, CNA had to pull the cord aggressively again to turn off the light. Resident #11 stated she did not think she could pull the cord the same way Staff P, CNA pulled the cord.	N0110	Continued from page 2 The administrator and/or designee will conduct an interview of 5 residents and audit 5 resident rooms on each unit to ensure equipment is safe, sanitary, comfortable and operational weekly for 4 weeks then monthly for 3 months. The findings of the audits will be reported to the QAPI committee monthly until committee determines substantial compliance has been met and sustained.	

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N0110	Continued from page 3 On 6/11/2025 at 1:20 p.m., an observation was made of the pantry room in the east hallway. The refrigerator for the residents in the east hall had a temperature log on the outside door. A documented entry for 6/11/2025 showed a reading for the refrigerator at 50 degrees Fahrenheit and the freezer was documented at 28 degrees Fahrenheit. No documented entries were entered for 6/10/2025. The current refrigerator temperature reading was 58-60 degrees Fahrenheit, and the freezer temperature reading was 36-40 degrees Fahrenheit. Staff J, CNA was witness to the current temperatures for the refrigerator. Inside the refrigerator there were four quarts of milk with a resident's name on them. The milk was lukewarm to touch. In the freezer, there were three half gallons of orange sherbert ice cream, a box of ice cream sandwiches and a box of popsicles. All of the freezer items were observed to be thawed. Staff J, CNA agreed the items were soft to touch and not frozen. Staff D, Licensed Practical Nurse/Unit Manager (LPN/UM) for the east hallway was made aware of the refrigerator temperature readings. Staff D, LPN/UM stated according to the temperature log on the refrigerator, the temperature for the refrigerator had been "adjusted" but agreed the temperature reading were out of normal range. An observation was made of the inside of the cupboard under the sink of the east pantry room. Under the sink there was a large collection of dark brown/black bio growth matter throughout the underside inside the pantry cabinet. An observation was made of the ceiling tile directly above the door partially hanging down. Directly across the entry doorway, was a fan in the wall with a collection of leaves and debris and an opening to the outside environment approximately one inch wide. Staff D, LPN/UM acknowledged these findings. On 6/11/2025 at 3:15 p.m., an observation was made of room 215 with open areas of flooring visualized from the hallway. The resident in the room allowed further observation revealing the flooring could be lifted with a slide of the foot. On 6/11/2025 at 3:20 p.m., an observation was made in Residents #12 and #13. The room was designed for a three-resident occupancy. The room was noticeably warmer. Resident #12 stated his roommate #13's AC does not work but his works. Resident #12 had his headboard directly next to his AC unit with his privacy curtain over his headboard where he could receive a direct flow of air from his AC personal unit. Resident #12 stated he moved the curtain because he gets better direct	N0110		

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N0110	Continued from page 4 airflow from his AC unit. Resident #12 stated, "they know about his AC unit not working." Resident #13's AC unit was powered on, set at 61 degrees Fahrenheit. No air flow was noted. AC filters were observed with a heavy black bio growth. Resident #13 stated he felt his room was hot. A hygrometer reading of 80 degrees Fahrenheit was obtained. Photographic evidence obtained On 6/11/25 at 3:36 p.m., observation was conducted of the bathroom for Resident's #12 and #13. A ceiling tile was observed to be missing with exposed pipes present. On 6/11/2025 at 3:40 p.m., an observation was made of loose flooring on the east hallway. An unidentified resident was walking the hallway with her walker and stated, "be careful, you can trip over the loose floor." during this tour, numerous observations were made of loose flooring. The flooring easily would come up when sliding foot over the areas. On 6/11/2025 at 4:46 p.m., a walking tour was conducted with the NHA, DON, maintenance assistant, maintenance director from another facility and Staff D, LPN/UM. The NHA became aware of the loose flooring, especially in the 200 hallways. The team acknowledged the refrigerator was removed in the east hallway pantry. The team acknowledged the ceiling tile directly above the entry door, the heavy dark brown/black bio growth under the sink cabinet, and the exposed area to the outside environment along the wall fan/vent. The team toured Resident #13's room to witness a non-functioning A/C (Air Conditioning) unit, with dark black bio growth substance on the A/C filter. The administration team confirmed the observations and the missing bathroom ceiling tile with exposed pipes. During the tour on 6/11/2025 at 5:20 p.m., the NHA, DON, maintenance assistant, maintenance director from another facility and Staff D, LPN/UM confirmed these areas of concerns and stated they would be addressed immediately. {Photographic Evidence Obtained.} Class III.	N0110		
N0917 SS = D	Report Abuse, Neglect, & Exploitation	N0917	N917	07/12/2025

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N0917 SS = D	Continued from page 5 CFR(s): 400.147(8), FS (8) Abuse, neglect, or exploitation must be reported to the agency as required by 42 C.F.R. s. 483.13(c) and to the department as required by chapters 39 and 415. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review, the facility failed to develop and implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for one resident (#3) out of four residents sampled. Findings included: Review of Resident #3's "Admission Record" revealed she was admitted to the facility on 4/8/2025 with medical diagnoses of displaced fracture of upper end of right humerus, with routine healing, asthma, dysphagia, unsteadiness on feet, lack of coordination, abnormalities of gait and mobility, muscle weakness, major depressive disorder, post traumatic stress disorder (PTSD), and generalized anxiety disorder. An interview was conducted on 6/11/25 at 11:03AM with Resident #3. She said it was a Saturday around the last week of May 2025; she came out of the bathroom and was in a towel. She said Staff C, Occupational Therapist Assistant (OTA) knocked, came into her room, and she realized it was a male, so she said, "I'm not dressed get out!" She said Staff C, OTA said to her "I can walk in anytime I want to I'm with physical therapy." She said she told him again to get out of her room, and he left. She said he tried to come into her room the next day for therapy, but she refused therapy because she did not want to work with Staff C, OTA. Resident #3 said she did not have any problems with him leaving her room that day. She said she felt "sexually harassed and abused." She said on the Monday after it happened, she told a female supervisor what happened and she told the Director of Nursing (DON) she did not want Staff C, OTA in her room anymore and told her what happened over the weekend as well. Review of Resident #3's Admission Minimum Data Set (MDS) dated 4/10/25, Section C, Cognitive Patterns, revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicating she is cognitively intact.	N0917	Continued from page 5 Resident #3 abuse allegation was reported, an investigation conducted and investigative findings confirm unsubstantiated for sexual abuse. Resident #3 discharged home as planned and no longer resides in the facility. The facility DOR and Staff C no longer are employed at the facility. How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken: Like resident interviews conducted with no reported concerns regarding sexual abuse or care concerns. Process of reporting abuse, neglect and exploitation reviewed with residents at Resident council by 7/12/2025 Staff interviews and education conducted to ensure no reported allegations of abuse, neglect, or exploitation. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: 1. The administrator educated the DON on reporting requirements of abuse, neglect and exploitation allegations with competencies. 2. The administrator and/or designee educated Staff on reporting requirements to the facility abuse coordinator of allegations of allegations of abuse, neglect, and exploitation with staff competencies. 3. Newly hired staff will be educated on reporting requirements to the facility abuse coordinator of abuse, neglect, and exploitation allegations and the facility abuse coordinator. How the corrective actions will be monitored to ensure	

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N0917 SS = D	Continued from page 6 Review of the facility's state agency reportable log did not reveal evidence a report was filed to stage agencies, or an investigation was conducted related to Resident #3. An interview was conducted on 6/12/25 at 9:56AM with the Director of Rehabilitation. She said it was around Memorial Day (the last Monday in May) Resident #3 came to her and said Staff C, OTA came into her room and she was in the bathroom and he knocked on the door and she said enter, she saw it was a man and she said "oh my god I'm naked get out!" The Director of Rehabilitation said Resident #3 told her Staff C, OTA said something back to her but the Director of Rehabilitation could not remember what Resident #3 told her Staff C, OTA said "But then he left the room." The Rehabilitation Director said Resident #3 told her Staff C, OTA came back on Sunday to work with her, but she kicked him out of her room. "However, he did not come back on Sunday because no one was on the schedule on Sunday." The Director of Rehabilitation said she went to talk to Staff C, OTA the same day Resident #3 told her what happened. The Director of Rehabilitation said Staff C, OTA told her he knocked on the door heard enter, he poked his head in the bathroom, and she said, "oh my god I'm naked get out!" and he said, "no you're dressed" and she said, "no I'm not get out." The Director of Rehabilitation said Resident #3 had also told her "Therapy was sexually harassing her" but she changed the story, it wasn't about Staff C, OTA anymore. The Director of Rehabilitation said after Resident #3 told her what happened, and she interviewed Staff C, OTA, she told the DON what Resident #3 had said and what Staff C, OTA had said. The Director of Rehabilitation said she could not remember what the DON told her, but she thinks she said she'd look into it. "I'm sure they took action." The Director of Rehabilitation said she reported it to the DON because the DON was the abuse coordinator and Resident #3 reported a serious allegation of Sexual Harassment. An interview was conducted on 6/12/25 at 11:07 AM with the DON and the Nursing Home Administrator (NHA). The DON said the Director of Rehabilitation did not come to her with sexual harassment concerns related to Resident #3 and Staff C, OTA. The DON said Resident #3 came to her and said when "the therapist" went into her room she said she was not ready for therapy, so "he" left. The DON said to Resident #3 well maybe we can come up with a schedule, so she was ready for therapy, and she	N0917	Continued from page 6 the practice will not recur, ie, what quality assurance program will be put in place: The Administrator and/or designee will conduct an interview of 5 residents on each unit. This audit will be completed weekly for 4 weeks the monthly for 3 months. The administrator and/or designee will conduct random 10 staff interviews for competencies on reporting allegations of abuse, neglect and exploitation. This audit will be completed weekly for 4 weeks, then monthly for 3 months. The findings of the audits will be reported to the QAPI committee monthly until committee determines substantial compliance has been met. This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law.	

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N0917 SS = D	Continued from page 7 said well who is going to be my therapist, and she said she didn't want it to be "this person and that person." The DON said she does not recall Resident #3 saying any specific therapist names. So, the DON went to the Director of Rehabilitation and asked if Resident #3 could have a therapy schedule so she could be ready for therapy. The Director of Rehabilitation said, "okay I'll take care it." The DON said the Director of Rehabilitation never came to her and told her there was a sexual harassment allegation against Staff C, OTA. If there was, she would have suspended the staff member, reported the allegation and carried out an investigation. The DON said if a resident tells any staff member of an allegation of abuse or sexual harassment, they are to report the allegation to her immediately so it could be reported and investigated. The DON reviewed the reportable events log and confirmed there was not a report, or an investigation conducted related to Resident #3's allegation. A phone interview was conduncted on 6/12/25 at 11:24PM with Staff C, He said Resident #3 is hard to forget because she confabulates a lot, you have to redirect her into what is actually going on. He said about three weeks ago, he knocked on Resident #3's door, "someone" said come in, so he walked in, Resident #3 said get out of here I'm not dressed, and he said "you're dressed" and she said no I'm not, and he said" you are fully dressed, shirt, pants," and she "no I'm not, get out of here" and so he left the room. Staff C, OTA said no one talked to him or asked him what happened except for another therapist told him Resident #3 was very mad at him and all he said was "okay sorry." He said he went to the Director of Rehabilitation and asked not to be assigned to Resident #3 anymore and the Director of Rehabilitation said she wouldn't assign her to him anymore. Review of the facility's policy "Abuse, Neglect, Exploitation, Misappropriation, Mistreatment, and Injury of Unknown Origin (ANEMMI)" revised on 3/2025 revealed "Standard: The resident has the right to be free from abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and exploitation as defined in this subpart ... Definitions: 1. Abuse, is defined...as the willful infliction of injury, unreasonable confinement, intimidation, or	N0917		

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N0917 SS = D	Continued from page 8 punishment with resulting physical harm, pain or mental anguish ...Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. 4. Willful, ... in the definition of abuse, and means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Reporting: The facility must develop and implement written policies and procedures that: 1. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. 3. Staff are required to report any allegation of NEMMI to the facility risk manager, direct supervisor, and/or abuse coordinator immediately upon knowledge of the allegation. 4. Allegations of possible ANEMMI will be reported to state agencies per the federal regulation timeframe. State agencies may include (but are not limited to): - Abuse Hotline (Department of Children and Families) - State Agencies (Agency for Health Care Administration) - Local Law Enforcement ..." Class III	N0917		

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F0000	INITIAL COMMENTS An unannounced complaint survey for complaint numbers 2025006813, 2025007990, and 2025008120 was conducted in conjunction with a revisit to a complaint survey (Event ID: S4FF12) on 6/11/2025 to 6/12/2025 at Kensington Gardens Rehab and Nursing Center. The facility was not in compliance with 42 CFR, Part 483, Requirements for Long Term Care Facilities. Previously identified deficiencies were found not to be corrected. New deficiencies were identified during the complaint survey. The facility has been out of compliance since 5/13/2025. Complaint number 2025006813 and 2025007990 were cited at F925, F921 and F584. Complaint number 2025008120 was cited at F609 and F610.	F0000		
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F0584	F584 What corrective actions (s) will be accomplished for those residents found to have been affected by the deficient practice: 1. By 7/12/2025, Residents #5, #6, #7, #11, #12, and #13 interviews and room audits completed. 2. By 7/12/2025 Residents #5, #6, and #11 overbed light repaired. 3. By 7/12/2025, Resident #7 bed replaced with head of bed working properly. 4. By 7/12/2025, the ceiling tile in the activities room on the south hallway replaced. 5. By 7/12/2025, the loose baseboard along the perimeter of the activities room was replaced. 6. By 7/12/2025, the bio-growth substance outside of the sliding glass door to the left of the activities room exiting to the courtyard was cleaned.	07/12/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105453	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENSINGTON GARDENS REHAB AND NURSING CENTER	2055 PALMETTO ST , CLEARWATER, Florida, 33758

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F0584 SS = E	Continued from page 1 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews and record review, the facility did not ensure equipment was safe, sanitary and operational, and failed provide a safe, functioning, sanitary and comfortable environment in resident's rooms for six residents (#5, #6, #7, #11, #12 and #13) out of 15 residents sampled, and in common areas to include food storage areas. Findings included: On 6/11/2025 at 10:45 a.m., an observation and interview were conducted with Resident #5 in his room. Resident #5 stated his overhead light does not work very well, and stated, "it flickers on and off", and stated his roommate's [Resident #6] light, does not work at all. Staff P, Certified Nurse Assistant (CNA), entered the room and agreed the lights were not working properly. Staff P, CNA stated this was not her assignment. She stated she will notify their nurse. On 6/11/2025 at 10:52 a.m., an interview was conducted with Resident #7. Resident #7 stated she received a new	F0584	Continued from page 1 7. By 7/12/2025, the ceiling outside of the activities room adjacent to the ceiling tile was repaired and repainted. 8. By 7/12/2025, the refrigerator in the nourishment room on the east hallway was removed, discarded and replaced. The cupboard under the sink of the east pantry was cleaned. The ceiling tile above the door was replaced. The exhaust fan in the wall was cleaned. 9. By 7/12/2025, the air conditioning was replaced in Resident #12 and #13 shared room. The missing ceiling tile in the bathroom was replace. The flooring in resident #12 room was replaced. 10. By 7/12/2025 The loose flooring was replaced/repaired in the east 200 hallway. How will you identify other residents having potential to be affected by the same practice and what corrective actions will be taken: By 7/12/2025, resident interviews, resident room and common area audited to ensure equipment is safe, sanitary, comfortable and operational. The audit included resident room HVAAC, refrigerator and cupboards in pantry rooms, ceiling tiles, flooring, beds for proper function, resident room overbed lights and fans in the pantry rooms. Maintenance equipment and/or environmental items identified on the audit will be repaired and/or replaced as appropriate. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: 1. By 7/12/2025, Administrator and/or designee educated staff on reporting safe, sanitary, confortable and operational equipment via TELS. 2. Newly hired staff will be educated on reporting safe equipment, maintenance and environmental concerns via TELS. How the corrective actions will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place:	

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F0584 SS = E	Continued from page 2 bed this morning because the other bed was not working but stated, "this bed's head will not go up and down". The resident stated she will have to start the whole process of requesting a new bed all over again. On 6/11/2025 at 10:11 a.m., an observation was made of the activities room on the south hallway. Inside the activities room ceiling was a ceiling tile to the left upon entry with scattered areas of small gray/black circles, then concentric circles of various shades of tan, rusty brown. During observation, Staff P, CNA stated, "that's been there for a while.' Staff P, CNA stated over the weekend there was water on the floor in the activity room when she came to work. An observation was made of loose baseboards along the perimeter of the activities room. An observation was made of thick green bio growth substance outside the sliding glass door to the left of the activities room exiting to a courtyard. Directly outside the activities room adjacent to the ceiling tile, there was black bio growth substance and peeling paint with a heavy color of dark brown/black substance. Some missing ceiling texture were observed with light brown discoloration and dark heavy collection of black bio growth at the area where the wall meets the ceiling. A tall white garbage can was observed underneath this area with a collection of lightly discolored water inside garbage can approximately six inches. On 6/11/2025 at 10:30 a.m., an observation and interview was conducted with the Nursing Home Administrator (NHA) and Director of Nursing (DON) during tour of south hallway in the activities room. The NHA and the DON stated they had not seen these two areas before. On 6/11/2025 at 11:03 a.m., an observation and interview was conducted with Resident #11. Resident #11 stated her overhead bed light does not work. Staff P, CNA arrived in the room and stated her light works, She said, "you don't have the switch." Staff P, CNA turned the light switch on by the doorway of Resident #11's room, then went to the bedside to pull the cord to turn on the overhead light. The light did not go on, and Staff P, CNA pulled the cord multiple times until the light flickered, and stated, "see it works." Staff P, CNA had to pull the cord aggressively again to turn off the light. Resident #11 stated she did not think she could pull the cord the same way Staff P, CNA pulled the cord.	F0584	Continued from page 2 The administrator and/or designee will conduct an interview of 5 residents and audit 5 resident rooms on each unit to ensure equipment is safe, sanitary, comfortable and operational weekly for 4 weeks then monthly for 3 months. The findings of the audits will be reported to the QAPI committee monthly until committee determines substantial compliance has been met and sustained.	

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F0584 SS = E	Continued from page 3 On 6/11/2025 at 1:20 p.m., an observation was made of the pantry room in the east hallway. The refrigerator for the residents in the east hall had a temperature log on the outside door. A documented entry for 6/11/2025 showed a reading for the refrigerator at 50 degrees Fahrenheit and the freezer was documented at 28 degrees Fahrenheit. No documented entries were entered for 6/10/2025. The current refrigerator temperature reading was 58-60 degrees Fahrenheit, and the freezer temperature reading was 36-40 degrees Fahrenheit. Staff J, CNA was witness to the current temperatures for the refrigerator. Inside the refrigerator there were four quarts of milk with a resident's name on them. The milk was lukewarm to touch. In the freezer, there were three half gallons of orange sherbert ice cream, a box of ice cream sandwiches and a box of popsicles. All of the freezer items were observed to be thawed. Staff J, CNA agreed the items were soft to touch and not frozen. Staff D, Licensed Practical Nurse/Unit Manager (LPN/UM) for the east hallway was made aware of the refrigerator temperature readings. Staff D, LPN/UM stated according to the temperature log on the refrigerator, the temperature for the refrigerator had been "adjusted" but agreed the temperature reading were out of normal range. An observation was made of the inside of the cupboard under the sink of the east pantry room. Under the sink there was a large collection of dark brown/black bio growth matter throughout the underside inside the pantry cabinet. An observation was made of the ceiling tile directly above the door partially hanging down. Directly across the entry doorway, was a fan in the wall with a collection of leaves and debris and an opening to the outside environment approximately one inch wide. Staff D, LPN/UM acknowledged these findings. On 6/11/2025 at 3:15 p.m., an observation was made of room 215 with open areas of flooring visualized from the hallway. The resident in the room allowed further observation revealing the flooring could be lifted with a slide of the foot. On 6/11/2025 at 3:20 p.m., an observation was made in Residents #12 and #13. The room was designed for a three-resident occupancy. The room was noticeably warmer. Resident #12 stated his roommate #13's AC does not work but his works. Resident #12 had his headboard directly next to his AC unit with his privacy curtain over his headboard where he could receive a direct flow of air from his AC personal unit. Resident #12 stated he moved the curtain because he gets better direct	F0584		

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F0584 SS = E	Continued from page 4 airflow from his AC unit. Resident #12 stated, "they know about his AC unit not working." Resident #13's AC unit was powered on, set at 61 degrees Fahrenheit. No air flow was noted. AC filters were observed with a heavy black bio growth. Resident #13 stated he felt his room was hot. A hygrometer reading of 80 degrees Fahrenheit was obtained. Photographic evidence obtained On 6/11/25 at 3:36 p.m., observation was conducted of the bathroom for Resident's #12 and #13. A ceiling tile was observed to be missing with exposed pipes present. On 6/11/2025 at 3:40 p.m., an observation was made of loose flooring on the east hallway. An unidentified resident was walking the hallway with her walker and stated, "be careful, you can trip over the loose floor." during this tour, numerous observations were made of loose flooring. The flooring easily would come up when sliding foot over the areas. On 6/11/2025 at 4:46 p.m., a walking tour was conducted with the NHA, DON, maintenance assistant, maintenance director from another facility and Staff D, LPN/UM. The NHA became aware of the loose flooring, especially in the 200 hallways. The team acknowledged the refrigerator was removed in the east hallway pantry. The team acknowledged the ceiling tile directly above the entry door, the heavy dark brown/black bio growth under the sink cabinet, and the exposed area to the outside environment along the wall fan/vent. The team toured Resident #13's room to witness a non-functioning A/C (Air Conditioning) unit, with dark black bio growth substance on the A/C filter. The administration team confirmed the observations and the missing bathroom ceiling tile with exposed pipes. During the tour on 6/11/2025 at 5:20 p.m., the NHA, DON, maintenance assistant, maintenance director from another facility and Staff D, LPN/UM confirmed these areas of concerns and stated they would be addressed immediately. Review of a facility policy titled, "Standards and Guidelines: General cleaning" dated 01/2024 showed a standard: It is the policy of this facility to provide a clean, safe, orderly, comfortable and attractive home like environment as outlined below:	F0584		

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F0584 SS = E	Continued from page 5 1. Accepted practices and procedures are used to keep the facility free from odors, accumulations of dirt, dust and safety hazards. 2. Floors and horizonal surfaces are cleaned routinely. Finishes on floors provide an appropriate finish and disinfectants are used where required. 3. Walls and ceilings are maintained free from dirt or other matters. 4. Entrances, exits, walkways, driveways and other outside or entry areas are kept free from debris and dirt. 5. Beds, bedside tables, chairs overbed tables, nightstands and dressers should be cleaned with a germicidal and allowed to air dry. 6. Dry dusting is used on items such as pictures, plaques, mirrors, bulletin boards, tops of partitions, vents, tops of cabinets, coat racks and window/door frames. Damp dusting may be used as needed. (Photographic Evidence Obtained.)	F0584		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term	F0609	F609 Resident #3 abuse allegation was reported, an investigation conducted and investigative findings confirm unsubstantiated for sexual abuse. Resident #3 discharged home as planned and no longer resides in the facility. The facility DOR and Staff C no longer are employed at the facility. How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken: Like resident interviews conducted with no reported concerns regarding sexual abuse or care concerns.	07/12/2025

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F0609 SS = D	Continued from page 6 care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review, the facility failed to develop and implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for one resident (#3) out of four residents sampled. Findings included: Review of Resident #3's "Admission Record" revealed she was admitted to the facility on 4/8/2025 with medical diagnoses of displaced fracture of upper end of right humerus, with routine healing, asthma, dysphagia, unsteadiness on feet, lack of coordination, abnormalities of gait and mobility, muscle weakness, major depressive disorder, post traumatic stress disorder (PTSD), and generalized anxiety disorder. An interview was conducted on 6/11/25 at 11:03AM with Resident #3. She said it was a Saturday around the last week of May 2025; she came out of the bathroom and was in a towel. She said Staff C, Occupational Therapist Assistant (OTA) knocked, came into her room, and she realized it was a male, so she said, "I'm not dressed get out!" She said Staff C, OTA said to her "I can walk in anytime I want to I'm with physical therapy." She said she told him again to get out of her room, and he left. She said he tried to come into her room the next day for therapy, but she refused therapy because she did not want to work with Staff C, OTA. Resident #3 said she did not have any problems with him leaving her room that day. She said she felt "sexually harassed and abused." She said on the Monday after it happened, she told a female supervisor what happened and she told the Director of Nursing (DON) she did not want Staff C, OTA in her room anymore and told her what happened over the weekend as well.	F0609	Continued from page 6 Process of reporting abuse, neglect and exploitation reviewed with residents at Resident council by 7/12/2025 Staff interviews and education conducted to ensure no reported allegations of abuse, neglect, or exploitation. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: 1. The administrator educated the DON on reporting requirements of abuse, neglect and exploitation allegations with competencies. 2. The administrator and/or designee educated Staff on reporting requirements to the facility abuse coordinator of allegations of allegations of abuse, neglect, and exploitation with staff competencies. 3. Newly hired staff will be educated on reporting requirements to the facility abuse coordinator of abuse, neglect, and exploitation allegations and the facility abuse coordinator. How the corrective actions will be monitored to ensure the practice will not recur, ie, what quality assurance program will be put in place: The Administrator and/or designee will conduct an interview of 5 residents on each unit. This audit will be completed weekly for 4 weeks the monthly for 3 months. The administrator and/or designee will conduct random 10 staff interviews for competencies on reporting allegations of abuse, neglect and exploitation. This audit will be completed weekly for 4 weeks, then monthly for 3 months. The findings of the audits will be reported to the QAPI committee monthly until committee determines substantial compliance has been met. This plan of	

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F0609 SS = D	Continued from page 7 Review of Resident #3's Admission Minimum Data Set (MDS) dated 4/10/25, Section C, Cognitive Patterns, revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicating she is cognitively intact. Review of the facility's state agency reportable log did not reveal evidence a report was filed to stage agencies, or an investigation was conducted related to Resident #3. An interview was conducted on 6/12/25 at 9:56AM with the Director of Rehabilitation. She said it was around Memorial Day (the last Monday in May) Resident #3 came to her and said Staff C, OTA came into her room and she was in the bathroom and he knocked on the door and she said enter, she saw it was a man and she said "oh my god I'm naked get out!" The Director of Rehabilitation said Resident #3 told her Staff C, OTA said something back to her but the Director of Rehabilitation could not remember what Resident #3 told her Staff C, OTA said "But then he left the room." The Rehabilitation Director said Resident #3 told her Staff C, OTA came back on Sunday to work with her, but she kicked him out of her room. "However, he did not come back on Sunday because no one was on the schedule on Sunday." The Director of Rehabilitation said she went to talk to Staff C, OTA the same day Resident #3 told her what happened. The Director of Rehabilitation said Staff C, OTA told her he knocked on the door heard enter, he poked his head in the bathroom, and she said, "oh my god I'm naked get out!" and he said, "no you're dressed" and she said, "no I'm not get out." The Director of Rehabilitation said Resident #3 had also told her "Therapy was sexually harassing her" but she changed the story, it wasn't about Staff C, OTA anymore. The Director of Rehabilitation said after Resident #3 told her what happened, and she interviewed Staff C, OTA, she told the DON what Resident #3 had said and what Staff C, OTA had said. The Director of Rehabilitation said she could not remember what the DON told her, but she thinks she said she'd look into it. "I'm sure they took action." The Director of Rehabilitation said she reported it to the DON because the DON was the abuse coordinator and Resident #3 reported a serious allegation of Sexual Harassment. An interview was conducted on 6/12/25 at 11:07 AM with the DON and the Nursing Home Administrator (NHA). The DON said the Director of Rehabilitation did not come to	F0609	Continued from page 7 correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law.	

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F0609 SS = D	Continued from page 8 her with sexual harassment concerns related to Resident #3 and Staff C, OTA. The DON said Resident #3 came to her and said when "the therapist" went into her room she said she was not ready for therapy, so "he" left. The DON said to Resident #3 well maybe we can come up with a schedule, so she was ready for therapy, and she said well who is going to be my therapist, and she said she didn't want it to be "this person and that person." The DON said she does not recall Resident #3 saying any specific therapist names. So, the DON went to the Director of Rehabilitation and asked if Resident #3 could have a therapy schedule so she could be ready for therapy. The Director of Rehabilitation said, "okay I'll take care it." The DON said the Director of Rehabilitation never came to her and told her there was a sexual harassment allegation against Staff C, OTA. If there was, she would have suspended the staff member, reported the allegation and carried out an investigation. The DON said if a resident tells any staff member of an allegation of abuse or sexual harassment, they are to report the allegation to her immediately so it could be reported and investigated. The DON reviewed the reportable events log and confirmed there was not a report, or an investigation conducted related to Resident #3's allegation. A phone interview was conducted on 6/12/25 at 11:24PM with Staff C, He said Resident #3 is hard to forget because she confabulates a lot, you have to redirect her into what is actually going on. He said about three weeks ago, he knocked on Resident #3's door, "someone" said come in, so he walked in, Resident #3 said get out of here I'm not dressed, and he said "you're dressed" and she said no I'm not, and he said" you are fully dressed, shirt, pants," and she "no I'm not, get out of here" and so he left the room. Staff C, OTA said no one talked to him or asked him what happened except for another therapist told him Resident #3 was very mad at him and all he said was "okay sorry." He said he went to the Director of Rehabilitation and asked not to be assigned to Resident #3 anymore and the Director of Rehabilitation said she wouldn't assign her to him anymore. Review of the facility's policy "Abuse, Neglect, Exploitation, Misappropriation, Mistreatment, and Injury of Unknown Origin (ANEMMI)" revised on 3/2025 revealed "Standard: The resident has the right to be free from abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and exploitation as defined in this subpart ...	F0609		

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F0609 SS = D	Continued from page 9 Definitions: 1. Abuse, is defined...as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish ...Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. 4. Willful, ... in the definition of abuse, and means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Reporting: The facility must develop and implement written policies and procedures that: 1. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. 3. Staff are required to report any allegation of NEMMI to the facility risk manager, direct supervisor, and/or abuse coordinator immediately upon knowledge of the allegation. 4. Allegations of possible ANEMMI will be reported to state agencies per the federal regulation timeframe. State agencies may include (but are not limited to): - Abuse Hotline (Department of Children and Families) - State Agencies (Agency for Health Care Administration) - Local Law Enforcement ..."	F0609		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation	F0610	F610	07/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105453	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/12/2025

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F0610 SS = D	Continued from page 10 CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate a resident-to-resident allegation of abuse involving two residents (#14 and #15) out of four reportable events sampled. Findings included: Review of the facility's state agency reportable log revealed on 5/22/25 a resident to resident report was made involving Resident #14 and Resident #15. An interview was conducted on 6/11/25 at 1:21 PM with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) on 6/11/25 at 1:21PM. The DON said she was the one who reported and investigated the event and the NHA said she was not working at the facility at the time the event occurred. The DON said the event occurred on 5/22/25 around 6:00 PM and she reported the event the state agencies on 5/22/25 at 6:00 PM. The DON said staff reported to Staff D, Eat Wing Unit Manager (UM) that Resident #14 made contact with Resident #15 to the back of his head. Staff were noted to be within close immediate proximity with both residents and intervened immediately and placed Resident #14 on	F0610	Continued from page 10 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Resident #14 discharged and no longer resides in the facility. Resident #15 was sent to the hospital for further evaluation and returned with no new orders, CT was negative and the resident is back to baseline. Resident #15 was interviewed and has no concerns regarding care. Resident #15 head to toe skin assessed and pain assessed, with no skin alterations and no complaints of pain. How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken. Like resident interviews conducted with no reported concers of abuse, neglect, or exploitation or care concerns. Process of reporting abuse, neglect, and exploitation reviewed with residents at Resident Council by 7/12/2025. Staff interviews conducted to ensure no reported allegations of abuse, neglect or exploitation. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: 1. The administrator educated the DON on reporting requirements of abuse, neglect, or exploitation allegations with competencies. 2. The administrator and/or designee educated Staff on reporting requirements to the facility abuse coordinator of allegations of abuse, neglect, and exploitation allegations with staff competencies.	

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F0610 SS = D	Continued from page 11 one-to-one supervision monitoring. Resident #15 was immedieiltly assessed by nursing, vitals were within normal limits, they notified the physician and out of the abundance of caution Resident #15 was sent to the emergency department where a computed tomography (CT) scan was conducted, and the results were negative. Resident #14 did not say what caused the interaction to happen and he was unable to state what he was attempting to do. The DON said from staff interviews Resident #14 grazed the back of Resident #15's head with a white plastic tube (The DON clarified the white plastic tube was a polyvinyl chloride (PVC) pipe). The DON said Resident #15 returned to the facility the same day. The DON said Resident #14 was sent to the hospital for increased agitation. The DON said at the time of the incident both residents were under adequate supervision on the smoking patio. And staff responded immediately to the residents change in behavior. Other alert and oriented residents were interviewed without concerns for care, safety, or supervision. The DON said, "after a thorough investigation the allegation of abuse was not substantiated." The DON said she obtained statements as part of her investigation and said Staff B, Licensed Practical Nurse (LPN) statement was collected and said, she was sitting at the nurse's station when she heard yelling coming from one of the CNA's. Resident #14 had made contact with the CNA. After making contact with the CNA the resident was placed on one-on-one supervision. Resident #14 had increased agitation after being placed on one-on-one supervision, so the resident was then placed on 15-minute checks and within the first 15 minutes, he was noted outside in the smoking area pacing but not showing aggressive behaviors at that time. The DON said Staff D, East wing UM statement said "on 5/22/25 I was notified that [Resident #14] was outside on the smoking area and made contact with [Resident #15's] head. The residents were immedieiltly separated Resident #15 was assessed and he had a reddened raised area which was observed on Resident #15's posterior scalp. He denied pain. He notified DON. [Physician] was notified, and new orders were received to send the resident to the ER [emergency room] for further eval [evaluation]. Resident #14 was assisted to his room and [Physician] was notified to send the resident to the ER for further eval [evaluation] and treatment." The DON said the facility's Psychologist initiated an involuntary hospitalization for Resident #14. They attempted medication to manage his behaviors, but his behaviors continued to escalate." The DON said Resident #14 was emergently transferred related to the incident because they could not redirect him." The DON said Staff T, CNA was the CNA who was out on the smoking patio at the time of the event and his statement was, he was sitting	F0610	Continued from page 11 3. Newly hired staff will be educated on reporting requirements to the facility abuse coordinator of abuse, neglect, and exploitation allegations and the facility abuse coordinator. 4. The Director of Nursing and/or designee educated licensed nurses on resident change in condition to include physician notification of the change in condition, completion of skin and pain assessments to be included for abuse allegation investigation events. How the corrective actions will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place: The Administrator and/or designee will conduct an interview of 5 residents on each unit. This audit will be completed weekly for 4 weeks, then monthly for 3 months. This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is submitted to meet requirements established by state and federal law.	

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F0610 SS = D	Continued from page 12 in the smoking patio when he saw Resident #14 behind Resident #15. He said Resident #14 had his hand behind his back and he kept walking closer to Resident #15. He said Resident #14 pulled his hand out from behind his back and he had a PVC pipe in his hand, the CNA said he yelled at Resident #14 to drop it, and Staff T, CNA said he got closer to Resident #14 and when he got closer to Resident #14, he swung at Resident #15 with it. The DON said there are no cameras on the smoking patio therefore there was no video footage to review. An interview was conducted on 6/11/25 at 11:03AM with Resident #3. Resident #3 said she has not seen Resident #14 since he left when he hit another resident over the head with a pipe. 1. Review of Resident #14's "Admission Record" revealed he was admitted to the facility on 11/10/23 and discharged on 5/22/25. His medical diagnoses included Major depressive disorder, Post Traumatic Stress Disorder (PTSD), generalized anxiety disorder, insomnia, Parkinsons disease, and dementia without behavioral disturbances, psychotic disturbances, mood disturbance, and anxiety. Review of Resident #14's care plan with an initiated date of 12/13/25 and a revision date of 5/22/25 revealed a focus of "[Resident #14] has a history of exhibiting the following behaviors: Confabulation, verbally aggressive. Pacing. removing wander guard, combative at times." The goal revealed "[Resident #14] will have fewer episodes of the identified behavior through the next review date." The intervention dated 12/13/2023 revealed Acknowledge/commend the resident's progress/improvement in behavior. Administer medications as ordered. Monitor/document for side effects and effectiveness. Encourage and assist the resident to develop more appropriate methods of coping and interacting as able. Encourage the resident to express feelings as needed. Encourage resident to interact with staff members as tolerated. Explain procedures to the resident before starting and allow the resident time to adjust to changes as needed. If reasonable/appropriate, discuss the behavior with the resident. Explain/reinforce why behavior is inappropriate and/or unacceptable. Intervene and/or redirect resident behavior as necessary. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Minimize potential for the resident's disruptive behaviors by offering tasks which divert	F0610		

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F0610 SS = D	Continued from page 13 attention/redirect behavior as indicated. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Offer Psychology/Psychiatry services as needed. Provide a program of activities that is of interest and accommodates residents status. Social Services will offer education for the resident/family member on successful coping and interaction strategies specific to individual resident needs." Review of the intervention with an initiated date of 5/22/25 revealed "Intervene and/or redirect resident behavior as necessary. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed." Review of Resident #14's Crisis Intervention Note with a service date of 5/22/25 at 6:49PM revealed "Summary Narrative of Session: Staff reported that the patient has unpredictable episodes of aggression towards others. Another provider attempted medication earlier today to manage aggressive behaviors after the patient hit a CNA with his hands, pushing her face and later hitting her arms. This afternoon, the patient managed to remover [sic] forcefully a PVC pipe from the courtyard area of the facility and hit another patient with the pipe on their head. Attempts to use behavioral redirection and psychotropic medication failed. [involuntary hospitalization] initiated." 2. Review of Resident #15 "Admission Record" revealed he was admitted on 4/21/23 with medical diagnoses of Dementia with mild agitation, spinal stenosis, lumber region without neurogenic claudication, muscle wasting and atrophy. An interview was conducted on 6/11/25 at 4:07pm with Resident #15. He said about two weeks ago a guy hit him on my head, "[explicit] yes it hurt." Review of Resident #15's Annual, Minimum Data Set (MDS) dated 3/25/25 revealed a brief interview for mental status (BIMS) score of 11 out of 15 indicating moderate cognitive impairment. Review of Resident #15's change in condition dated	F0610		

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F0610 SS = D	Continued from page 14 5/22/25 at 9:57PM revealed the change in condition, symptoms or signs was: ...head injury. This started on 5/22/25 in the afternoon. "Is a skin assessment relevant to the change in condition been reported? Not clinically applicable to the change in condition being reported. Were the change in condition and notifications reported to the primary care clinical? No ..." Review of Resident #15's Progress notes revealed on 5/22/25 at 9:57PM a Situation Background Assessment Recomendation (SBAR) summary for providers revealed a change in condition "other change in condition" outcome of physical assessment: Positive findings reported on the residents evaluation for this change in condition were: no changes in mental status observed, no changes in functional status observed, no documentation for a skin status evaluation, no documentation for a pain status evaluation and there was no documentation the physician was notified of the change in condition. Review of Resident #15's medical record did not reveal documentation of a skin assessment from the time of the event. Review of Resident #15's transfer form dated 5/22/25 revealed he was being transferred to a hospital for an unplanned CT of the head. Review of Resident #15's progress note dated 5/22/25 at 10:00PM, written by the DON, revealed "Resident returned from [Hospital] after being sent out in the abundance of caution for ED [Emergency Department] evaluation. CT of head completed with no acute findings, no intracranial hemorrhage. Skin assessment completed skin remains intact, resident denies pain at this time. MD [Medical Doctor] made aware of return, NNO [no new orders.] An interview was conducted on 6/11/25 at 3:46pm with Staff D, East Wing Unit Manager (UM). He said Staff T, CNA came to him and told him Resident #14 hit Resident #15 in the back of the head with a PVC pipe. Staff D, UM said Resident #15 did not have any injures but he was sent out to the hospital to get evaluated. He said Resident #14 definitely got hit by the PVC pipe on his head.	F0610		

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F0610 SS = D	Continued from page 15 An interview was conducted on 6/12/205 at 1:17PM with Staff B, Licensed Practical Nurse (LPN) she confirmed she was familiar with Resident #14, and she was his nurse on 5/22/25. Staff B, LPN said shortly after the start of the 3:00 PM to 11:00PM shift Resident #14 started to "sundown." She said when it comes to "sundowning" time Resident #14 is a whole different person. On 5/22/25 around the start of the 3:00PM-11:00PM shift we heard his CNA yelling and when we went in there, he was hitting her, and she was covering her face. So, she separated him from the CNA and placed Resident #14 on one-to-one supervision. Staff B, LPN said they called his physician and his psychiatrist to get as needed medications to calm him down they ordered an extra dose of Rexulti and Vistaril and labs for the next day. Staff B, LPN said she gave him his as needed Ativan and the other medications, but nothing worked. So, they put him on one-to-one supervision. Staff B, LPN said Resident #14 wasn't too comfortable with the one-to-one supervision and he was very annoyed with someone being close by him. Staff B, LPN said either Staff D, UM or The DON gave her directive to place Resident #14 on 15-minute checks because he was getting agitated with the one-to-one supervision "and we didn't want to make things worse." She said she was the one who completed the 15-minutes checks, and he was observed to be outside on the smoking patio pacing with his hands behind his back "but that's just how he walks." Staff B, LPN said Staff T, CNA was the smoking aide that day and he brought Resident #14 to her and Staff T, CNA told her he just hit a resident in the back of his head with some kind of pole. Staff B, LPN said she escorted Resident #14 to his room, he was agitated because it had just happened. Staff B, LPN said she sat with him for a little bit and started to talk to him he calmed down a little bit but you could tell he was still a little agitated because he started to run down the hall so we ran down the hall with him and then he ran back down the hall and into his room. Staff B, LPN said she continued to sit with him and shortly after, the Emergency Medical Technicians (EMT) came and got him. She said from the CNA got hit by Resident #14 to the time Resident #14 hit Resident #15 with the PVC pipe was about two hours. She confirmed she was told by Staff T, CNA Resident #14 hit Resident #15 with the PVC pipe on his head. An interview was conducted on 6/12/25 at 9:03AM with the DON she stated she reported to the State Agency Resident #14 "attempted" to make contact with Resident #15 with a "white tube" which she clarified was a PVC pipe. She said she reported Resident #14 "attempted" to hit Resident #15 because since Resident #15 did not	F0610		

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F0610 SS = D	Continued from page 16 have any injuries to his head and the CT scan results did not show any injuries she could not prove he was actually hit by the PVC pipe therefore she did not substantiate the allegation of abuse. Review of the facility's policy "Abuse, Neglect, Exploitation, Misappropriation, Mistreatment. and Injury of Unknown Origin (ANEMMI)" revised on 3/2025 revealed "Standard: The resident has the right to be free from abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and exploitation as defined in this subpart ... Definitions: 1. Abuse, is defined...as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish ...Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. ...4. Willful, ... in the definition of abuse, and means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Follow-up investigation Report 1. Within 5 working days of the incident, the facility must provide in its report sufficient information to describe the results of the investigation, and indicate any corrective actions taken, if the allegation was verified. It is important that the facility provide as much information as possible, to the best of its knowledge at the time of the submission of the report, so that State agencies can initiate action necessary to oversee the protection of the nursing home residents ... The facility should include any updates to information provided in the initial report. ...Investigation:	F0610		

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F0610 SS = D	Continued from page 17 1. ...In response to allegations of abuse, neglect, exploitation, misappropriation, mistreatment, or injury of unknown origin the facility must: ... a. Have evidence that all alleged violations are thoroughly investigated ... b. Prevent further potential abuse, neglect, exploitation, misappropriation, mistreatment, or injury of unknown origin while the investigation is in progress ... c. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. d. Conduct observations of the alleged victim, including identification of any injuries as appropriate, the location where the alleged situation occurred, interactions and relationships between staff and the alleged victim and/or other residents, and interactions/relationships between resident to the other residents; e. Conduct interviews with, as appropriate, the alleged victim and representative, alleged perpetrator, witness, practitioner, interviews with personnel from outside agencies such as other investigatory agencies, and hospital or emergency room personnel. f. Conduct record review for pertinent information related to the alleged violation, as appropriate, such as progress notes (Nurse, social services, physician, therapist, consultants as appropriate, etc.), financial records incident reports (if used), reports from hospital/emergency room records, laboratory or x-ray reports, medication administration records, photographic evidence, and reports from other investigatory agencies.	F0610		
F0925	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control	F0925	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is	07/12/2025

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F0925	Continued from page 18 program so that the facility is free of pests and rodents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews and record review, the facility did maintain an effective pest control program related to roaches for their residents. Findings include: On 6/11/2025 at 10:11 a.m., an observation was made in front of Resident #4's room of a large moving roach on its back swept up in a pile of debris from Staff A, housekeeping. An interview was conducted with Resident #4 in his room. Resident #4 stated roaches are a problem and he sees them all the time in his room. Upon observation, live roaches were seen on the windowsill, walls and dressers. An observation was made behind Resident #4's dresser of a heavy growth of dark brown/black dusty-like debris on the floor by the baseboards behind his dresser. Staff A, housekeeping, returned to the room and was witnessed moving the dresser to sweep the debris on the floor. Staff A, housekeeping through an interpreter's phone, stated she sees roaches all the time. Photographic evidence obtained. On 6/11/2025 at 10:52 a.m., an interview was conducted with Resident #7. Resident #7. Resident #7 stated, "roaches are definitely a problem here." Resident #7 stated, "I don't think they come in my room to spray for bugs." On 6/11/25 at 11:03 a.m., an interview was conducted with Resident #3. Resident #3 said she sees roaches in her room all the time and pointed to a roach located under her dresser. She said the roach was dead but it had been there for longer than she can remember. She said she had told staff about the roaches in her room. She said she had never seen a pest control company come into her room to treat the roaches. (Picture evidence obtained) On 6/11/2025 at 11:03 a.m., an interview was conducted with Resident #11 in her room. Resident #11 stated she sees roaches all the time but has not witnessed anyone coming into her room to spray for them.	F0925	Continued from page 18 submitted to meet requirements established by state and federal law. F925 What corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. Resident #4 provided pest control. Housekeeping cleaned Resident #4 windowsill, walls and dressers. The growth of dark brown/black dusty like debris behind Resident #4 dresser was cleaned. Resident #4 interviewed and room observed with no pest control concerns. 2. Resident #7 provided pest control. Resident #7 interviewed and room observed with no pest control concerns. 3. Resident #3 provided pest control. Housekeeping cleaned Resident #3floor and under her dresser. Resident #3 interviewed and room observed with no pest control concerns. 4. Resident #11 provided pest control. Resident #11 interviewed and room observed with no pest control concerns. 5. Resident #8 provided pest control. Housekeeping cleaned Resident #8 dresser drawer. Resident #8 interviewed and room observed with no pest control concerns. 6. Housekeeping cleaned the pantry room in the north hallway. Both sides of the refrigerator were cleaned as well as the floor. 7. Shared room for Resident #12 and #13 were provided pest control. Housekeeping cleaned the room and bathrooms. Resident #13overbed light fixture replaced. How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken: 1. An audit of resident rooms were completed, with no observations of pest concerns.	

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(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
F0925	Continued from page 19 On 6/11/2025 at 11:20 a.m., an interview was conducted with Resident #8 in his room. Resident #8 stated he sees roaches all the time and stated, "I saw two big one's last night." Resident #8 allowed observations to be made of his dresser drawers and a large live roach moving quickly was witnessed in one of the drawers. Resident #8 stated he has never seen anyone come in his room to spray for bugs. On 6/11/2025 at 2:40 p.m., an observation was made of the pantry room in the north hallway. On the right side of the refrigerator were various dead body parts of roaches on the ground. An interview was conducted with the nursing staff at the nurses' station related to roaches. An unidentified staff member stated, "they have taken residency here." All staff were aware of the pest control log. Photographic evidence obtained. On 6/11/2025 at 3:17 p.m., an observation and interview were conducted with two residents in a room designed for three residents. Residents #12 and #13 stated they see roaches in their room all the time. Resident #12 stated he can walk to his bathroom and stated he sees live roaches on a frequent bases especially at nighttime. Resident #13 pointed to his overhead fluorescent light fixture over his bed and stated, "I watched that roach for a while until he flipped over and died." An observation was made of a large dead roach on its back in the overhead fluorescent light. On 6/12/2025 at 9:42 a.m., an interview was conducted with Staff E, Certified Nurse Assistant (CNA). Staff E, CNA stated she sees numerous roaches, dead and alive, in residents' rooms and will place concerns in the pest control log book. On 6/12/2025 at 9:55 a.m., an interview was conducted with Staff F, Licensed Practical Nurse (LPN). Staff F, LPN stated roaches are a concern but stated it was worse two months ago. On 6/12/2025 at 10:09 a. m., an interview was conducted with Staff H, housekeeping, with Staff I, CNA, utilized for interpretation. Staff H, housekeeping, stated she sees lots of roaches dead and alive. Staff H, housekeeping, stated she just kills the live ones when she can.	F0925	Continued from page 19 2. Resident interviews completed to ensure prompt response for any pest control items reported. 3. An audit of exterior of the facility was completed to ensure holes identified are repaired to minimize points of entry by 7/12/2025. 4. The Facility's lawn service provider cleaned the foliage and trees on the exterior of the facility to minimized points of entry. 5. Two filters, one located on east nurse's station and one located in the kitchen were replaced with new bulbs and filters continue to be cleaned and changed out monthly and as needed. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: 1. Staff educated by the administrator/designee on pest control process and use of pest control log of any observed pest control concerns. 2. Housekeeping staff educated on cleaning of resident rooms and other common areas and the use of the pest control log is any observation made. 3. Residents educated during resident council meetings regarding proper storage of food in the room to minimize pest control concerns and to report any observations to staff. 4. Maintenance staff educated on walking rounds of the exterior of the facility to identify any holes,, points of entry and foliage to minimize pest control concerns. 5. The pest control serviceman was educated by the adminstrator to provide written reports of each service/ to the administrator and maintenance staff. 6. The administrator and/or designee will review the pest control service reports to identify any issues or trends and follow up with the pest control company as needed. 7. Pest control service increased from once/week to 2x per week and as needed. How the corrective action will be monitored to ensure the practice will not recur, i.e., what quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105453	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/12/2025

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F0925	Continued from page 20 On 6/12/2025 at 10:16 a.m., an interview was conducted with Staff I, CNA. Staff I, CNA stated sees roaches all the time and they are worse on the east hallway. Staff I, CNA stated she just kills the roaches herself. On 6/12/2025 at 10:33 a.m., an interview was conducted with Staff J, CNA. Staff J, CNA stated he sees alive roaches every other day during his shift. On 6/12/2025 at 10:30 a.m., an interview was conducted with Staff K, CNA and Staff L, CNA. Both staff members stated they see roaches. Staff K, CNA stated she sees all kinds of roaches, "big, small, dead and alive." Staff K, CNA stated there are lots of holes in the building, "that's how they are getting in." Staff K, CNA stated she just kills them when she sees them and cleans up the mess. Staff L, CNA stated she has put pest concerns in the pest control log. On 6/12/2025 at 11:09 a.m., an observation and interview were conducted with Staff M, housekeeping. An observation was made by Staff M, housekeeping, servicing Residents #12 and #13's room. Staff M, housekeeping, was in the room mopping the floor and, in the doorway entrance, was a swept-up pile of dead roaches. An interview was conducted with Staff M through her phone utilized for interpretation. Staff M, housekeeping, stated she sees lots of roaches, dead and alive. She said she tries to kill the lives one as best as she can. On 6/12/2025 at 11:13 a.m., an interview was conducted with Staff N, LPN. Staff N, LPN stated she sees roaches dead and alive, and she will use the pest control log and added, "we make morning rounds every morning and they will take care of it. " On 6/12/2025 at 11:20 a.m., an interview was conducted with the representative servicemen for the facility contracted commercial pest control service company(pest control serviceman). The pest control serviceman stated he has been servicing the facility on and off for the past 8-9 years but more on a continually basis for the past one and one-half years. The pest control serviceman stated his point of contact for the facility has always been Staff O, maintenance assistant. The pest control serviceman stated he will contact Staff O upon arrival and they will review the pest logs from	F0925	Continued from page 20 assurance program will be put in place: The Administrator and/or designee will conduct an interview of 5 residents and audit 5 room on each unit and common areas to ensure the facility maintains an effective pest control program. This audit will be completed weekly for 4 weeks, then monthly for 3 months./or designee will audit the pest control log for trends. The audit of the pest control log will be completed weekly for 4 weeks, then monthly for 3 months. Identified concerns or trends will be communicated with the pest control company for follow up as needed. The findings of the audits will be reported to the Quality Assurance Performance Improvement Committee monthly until substantial compliance sustainability is met. The maintenance director and and/or designee will audit the pest control log for trends. The audit of the pest control log will be completed weekly for 4 weeks then monthly for 3 months. Identified concerns or trends will be communicated with pest control service company for follow up as needed. The findings of the audits will be reported to the Quality Assurance Performance Improvement committee monthly until committee determines substantial compliance is maintained.	

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F0925	Continued from page 21 each nurses' station and other concerns Staff O would bring to his attention. The pest control serviceman stated he comes every Thursday. The pest control serviceman stated he will make his rounds and then provide a verbal and written report to Staff O, maintenance assistant, of his findings. The pest control serviceman stated he would make suggestions in his report such as fixing holes in the facility to minimize entrance of pests. The pest control serviceman stated, "Staff O has too much on his plate." The pest control serviceman stated points of entry include such places as air conditioning units, pipes and dead foliage around the facility The pest control serviceman stated the pest log is not utilized appropriately and added sometimes he will come in for service and there would be very little rooms on the pest control ledger and then next week the ledger will be a full page. The pest control serviceman stated he sees American roaches and German roaches. He stated German roaches are not good to have in a facility and are difficult to maintain once you have an outbreak. The pest control serviceman stated another job duty while in the facility is to maintain the numerous ultraviolet pest control lights. The pest control serviceman stated he cleans and changes out the filters monthly but stated two are in need of new bulbs with one located in the east nurses' stations, out for four months, and the other in the kitchen, out for two months. The pest control serviceman stated Staff O, maintenance assistant was aware. On 6/12/2025 at 12:26 p.m., an interview was conducted with Staff O, maintenance assistant, a maintenance director from another facility and the Nursing Home Administrator (NHA). Staff O, maintenance assistant, stated he will meet up with the pest control serviceman every Thursday to review the pest logs at each nurses' station. Staff O stated he does not get the emailed written reports. The maintenance director from another facility stated she thinks the former Maintenance Director was getting them. The maintenance director from another facility stated she printed the emails yesterday to be viewed during the survey. The NHA stated she has not received any emails but will rectify the issue. Staff O, maintenance assistant, stated he was aware of the holes outside in need of repair to minimize entry but the NHA, newly hired, stated she was not aware. Staff O stated the facility has a lawn service but it would need approval to have the perimeter cleared from the facility. The NHA stated Staff O, maintenance assistant, is doing the work of three at this time and attempts have been made to hire more staff for maintenance.	F0925		

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F0925	Continued from page 22 A review of the facility's policy titled, "Pest Control", revised on 7/2024 stated the following standard statement: Our facility shall maintain an effective pest control program. ... 6. Maintenance services assist, when appropriate and necessary, in providing pest control services.	F0925		