

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105045	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/18/2024
NAME OF PROVIDER OR SUPPLIER  Braden River Rehabilitation Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  2010 Manatee Ave E Bradenton, FL 34208	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453</b></p> <p>Based on staff interviews, record review and facility policy review, the facility failed to ensure an injury of an unknown source resulting in physical injury and subsequent death, were reported to the proper authorities within the prescribed timeframes for 1 (#1) of 3 residents reviewed.</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility on [DATE] and discharged on [DATE].</p> <p>Review of a progress note for Resident #1 dated 06/13/24 showed: Resident noted sitting up, leaning over in bed and was unresponsive. Hematoma and laceration noted to back of head. Wheelchair next to bed in locked position and blood noted on leg rest area of wheelchair. Resident appears to have had unwitnessed fall. MD [Medical Doctor] notified, and EMS [Emergency Medical Service] called to send resident to [name of Hospital] emergency room for evaluation and treatment. Resident's [Healthcare Surrogate] was notified of resident's status and transfer to hospital.</p> <p>Review of a progress note for Resident #1 dated 06/13/24 showed a progress note documented by Staff A, Licensed Practical Nurse (LPN) assigned to Resident #1. It read: Received a call from resident's [family member stating they were at a local hospital trauma center and were asking if Resident #1 had any advanced directives in her chart. Resident's [family member] stated, We aren't really sure if she does, but we think she might. This nurse checked chart and located HCS (Health Care Surrogate). Staff A, LPN confirmed with social services that there were no other Advanced Directives. Staff A inquired about the resident's status and resident's [family member] stated The doctor said she has a very big brain bleed, and the brain has shifted. The doctor said she is not going to come out of this. Resident's [family member stated, I don't know what she hit her head on this time, it must have been something very hard. Resident's [family member] stated .they need to have her HCS sign paperwork to remove her from a ventilator.</p> <p>Review of the facility's adverse and incident report log dated April 2024 to July 2024 showed the facility had not had any reportable incidents.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a quarterly MDS (Minimum Data Set) dated 04/04/24, showed in section GG: for chair/bed-to-chair transfer meaning the ability to transfer to and from a bed to a chair (or wheelchair). The resident required partial/moderate assistance. Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. The assessment confirmed Resident #1 was not independent to self-transfer after a presumed unwitnessed fall.</p> <p>On 07/18/24 at 1:48 p.m., an interview was conducted with the Nursing Home Administrator (NHA). The NHA said, I conducted an investigation. I observed her bed which was the door bed. She had two little impressions or skin tears that looked like an equals (=) sign. I noticed a small amount of blood on the wheel of her wheelchair, larger than a nickel. The blood was by the connection of the wheelchair and the footrest. I saw a skid mark from the shoe, a sneaker on the floor. The bed was moved like she had slid from the bed. The fall was not witnessed. No one saw her on the floor, and no one put her back to bed. From history, she has poor safety awareness. We had educated her to use the call light. She preferred to be independent. She had been rounded on within the hour and throughout the shift. The NHA stated she did not report the injury because they had conducted a risk assessment and determined the injury came from a fall that was not witnessed. The NHA stated she was not speculating but had analyzed based on furniture placement and a small amount of blood on the wheelchair. She stated she did not consider the injury to be from a different source or the possibility someone with a different object could have struck the resident. She confirmed there was no one in the room when the injury occurred. She confirmed the resident was not observed on the floor. The resident was found on her bed, leaning to her side. The NHA stated she had conducted her own analysis of the situation and determined the cause of injury was unwitnessed fall.</p> <p>Review of a Facility policy titled, Abuse and Neglect Prohibition, dated 08/2023, showed each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion, exploitation, and misappropriation of propriety.</p> <p>Under definitions: Serious bodily injury means an injury involving extreme physical pain, involving substantial risk of death .</p> <p>Under Reporting and Response (1.) The center will report all allegations and substantiated occurrences of abuse, neglect . to the state/federal agency and law enforcement officials as designated by state/federal law.</p> <p>Review of a facility policy titled, Incident Reporting for Residents and Visitors, dated 08/2023 showed an adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury or risk thereof. Under procedure (4.) The facility Risk Manager or designee must notify the appropriate state agency as required by state regulations. The exact date, time, and the name of contact at the state agency must be recorded on the appropriate investigation.</p> <p>Review of a document titled, Job Description - Administrator, dated 03/15/18, showed the Administrator serves as the Risk Manager of the center. Ensures compliance with applicable legal, regulatory, accreditation and reimbursement guidelines and standards.</p>		