

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105147	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Pines of Sarasota		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 N Orange Ave Sarasota, FL 34236	

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 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>37256</p> <p>Based on record review and interview, the facility failed to ensure training was appropriate and effective as determined by staff need, following an incident resulting in 1 (Resident #19) sustaining a burn from over-heated food.</p> <p>The findings included:</p> <p>Facility policy titled Re-Heating Resident Food and Beverages effective 4/22/24 indicated: 4. Staff will set microwave to 30 seconds on initial and the 15 seconds on any additional, stirring with clean utensil to ensure even heating throughout and check temperature. 5. When the temperature of 165 degrees F (Fahrenheit) is reached, allow to sit covered for 2 minutes prior to serving. Item not to be greater than 140 degrees F at the time of service.</p> <p>On 04/29/24 at 12:31 p.m., Resident #19 picked up his shirt and pointed at a dressing on his abdomen. Resident #19 said it was from spilling hot soup on himself. He said he didn't like that. He said the dressing was changed daily.</p> <p>Record review of Resident #19's chart found a progress note dated 4/21/24 that indicated Resident #19 was found with burns on the lower right abdomen which had raised into vesicles. The Doctor and family were notified, dressing order was obtained, and wound care consult was ordered.</p> <p>On 5/1/24 at 3:29 p.m., Staff D Licensed Practical Nurse Unit Manager (LPN) said Resident #19 was discovered with a burn on his abdomen and said it was from soup his family had brought in. He said a Certified Nurse Assistant (CNA) had heated the soup in the microwave and when he went to eat it, he spilled it on himself. She said Resident #19 did not need to be sent out to the hospital and the wound was being treated in-house.</p> <p>On 5/2/24 at 10:10 a.m., the Director of Nursing (DON) said the incident had occurred because the CNA had not followed procedure and had not checked the temperature of the soup before serving it to Resident #19. The DON said the Assistant Director of Nursing Risk Manager (ADONRM) had provided training for the staff on re-heating food and the ADON was conducting audits to ensure policy is followed. The DON said Agency staff were trained by going through an orientation book and were included in in-services. The DON said the policy was also posted at the nurses' stations, break rooms and nutrition rooms.</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 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/2/24 at 10:11 a.m., the ADON said she had been conducting audits by watching staff if they rewarm residents' food. She said she checks to ensure they temp after reheating and clean the thermometer.</p> <p>On 5/2/24 at 9:35 a.m., Staff A (CNA) said he wouldn't reheat food but if he had to, he would make sure it fits their diet. He said he wouldn't do over 30 seconds. He said he had training, but it was about a year ago. He said there was a thermometer in the nourishment room and when asked how hot food should temp, he said nothing over 100 degrees F.</p> <p>On 5/2/24 at 9:50 a.m., Staff B (Agency CNA) said she thought dietary would reheat food. She said she did not know if she could reheat food. Said she did some computerized training but doesn't remember anything about reheating food.</p> <p>On 5/2/24 at 9:54 a.m., Staff C (Agency CNA) said she had not had to heat up food and asked can she heat it up? She said she knows she is not allowed to take food out of the room once it's in there. She said if they ask to heat up the food, she honestly did not know what to do. She said she was not aware of any training on reheating food. On entry to nourishment room, the policy was posted on the cabinet and Staff C said no one had ever gone over that with her.</p> <p>On 5/2/24 at 10:15 a.m., the Director of Nursing (DON) was informed 3 CNAs were unable to explain the procedure for reheating food safely. The DON said they will have to begin retraining again.</p>		