STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105155	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sarasota Health and Rehabilitation Center	1524 East Avenue South Sarasota, FL 34239

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on observation, review of facility's policies and procedures, and staff interviews, the facility failed to protect the residents' right to be free from abuse. The facility neglected to have effective processes in place in the secured unit to supervise 15 (Residents #13, #6, #14, #1, #2, #15, #16, #17, #3, #4, #7, #8, #10, #9, #12) of 15 cognitively impaired residents with aggressive behaviors resulting in multiple avoidable resident-to-resident altercations. On 3/12/25, Resident #13 with known aggressive behavior towards others was not adequately supervised. Resident #6 was blocking the door to the hallway. Resident #13 hit Resident #6 to get past him. On 3/12/25, Resident #14 with known aggressive behavior towards others was not adequately supervised. Resident #14 ran into Resident #13 with her wheelchair then hit Resident #13. On 3/14/25, Resident #2 with a diagnosis of dementia with other behavioral disturbance wandered unsupervised into Resident #1's room. Resident #2 scratched Resident #1's cheek when she asked him to leave the room. On 3/18/25, Resident #15 with a history of anxiety, Resident #16 with a history of verbal aggression related to dementia and Resident #17 with impaired cognition and agitation were not adequately supervised in the activity room of the secured unit. Resident #15 hit Resident #16. Resident #17 then hit Resident #15. On 3/20/25, Resident #4 with a history of wandering behavior and agitation wandered unsupervised into Resident #3's room. Resident #4 grabbed Resident #3's arm when she asked him to leave her room causing a skin tear to Resident #3's right forearm. On 3/28/25, staff did not adequately supervise Resident #8 who had a care plan for aggression with other residents. Resident #8 hit Resident #7 causing a scratch to Resident #7's left hand. On 3/29/25, staff did not adequately supervise residents in the dining room. Resident #4 scratched Resident #6. Resident #6 sustained scratches to bilateral cheeks, left ear and left upper arm. On 4/7/25, Resident #9 wandered unsupervised into Resident #10's room. Resident #10 hit Resident #9. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105155	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sarasota Health and Rehabilitation Center	1524 East Avenue South Sarasota, FL 34239

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/8/25, staff did not adequately supervise residents in the activity room. Resident #13 hit Resident #16. On 4/8/25, Residents #13 and #12 were not adequately supervised. Resident #13 hit Resident #12 in the hallway. The facility failure to have effective processes in place to supervise cognitively impaired residents with known aggressive behaviors toward others resulted in physical injuries to Residents #1, #3, #6 and #7 from the altercations and resulted in the determination of Immediate Jeopardy. On 5/1/25 at 5:57 p.m., the Administrator was notified of the determination of Immediate Jeopardy. The findings included: Cross reference to F689 Review of the facility's Abuse Prevention Program, with a change date of November 2024 revealed, The facility has designated and implemented processes, which strive to reduce the risk of abuse, neglect . Prevention . Facility leadership will identify situations in which abuse, neglect, mistreatment . may be more likely to occur, such as: Residents with needs/behaviors which might lead to conflict or abuse/neglect . Analyze the occurrences to determine what changes are needed, if any, to policies & procedures and education to prevent further occurrences . Tracking and trending. A monthly report of reportable events is prepared and provided to the Quality Assurance, Assessment, and Compliance committee for review. Events are tracked and trended to identify similarities, causative factors and any other area that may increase the risk of repeat occurrences of the same or similar nature. Review of the facility's Abuse/Neglect log for February 2025 revealed the facility investigated four incidents of resident-to-resident allegations of physical abuse and one incident of resident-to-resident verbal abuse. On 4/7/25 at 2:06 p.m., in an interview the Assistant Director of Nursing (ADON) stated that on 2/15/25 the facility implemented a monitoring program called the eagle eye program to address incidents of resident-to-resident altercations. A Certified Nursing Assistant (CNA) is assigned to monitor the dementia unit to make sure residents are observed every 15 minutes for their safe whereabouts. The facility provided a document showing the eagle eye CNA documented rounds every 15 minutes. On 4/7/25 at 2:32 p.m., during a tour of the secured unit, Resident #10 was observed standing in the doorway of room [ROOM NUMBER] facing outside of the room. Resident #9 was observed sitting in a wheelchair in front of room [ROOM NUMBER], facing Resident #10. No staff was observed supervising the residents. Residents #9 and #10 started to argue loudly. Resident #9 started to stand up. Resident #10 pushed Resident #9 back in the wheelchair. No staff responded to the resident-to-resident altercation. Three female staff were observed at the nursing station to the right of the hallway. Residents #9 and #10 were not visible from the nurse's station. When notified of the verbal and physical altercation between Residents #9 and #10 the three staff members got up and walked towards room [ROOM NUMBER]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105155	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sarasota Health and Rehabilitation Center	1524 East Avenue South Sarasota, FL 34239

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/7/25 at 5:27 p.m., an interview was held with the Director of Nursing (DON) to discuss incidents of resident-to-resident physical aggression and altercations in the secured unit. The DON said when he began employment at the facility approximately 1.5 month ago, he had never seen so many incidents of resident-to-resident altercations. He said since the implementation of the eagle eye program, the incidents of resident-to-resident altercations on the secured unit have been reduced by 50%. The DON said he and the Administrator take turns coming to the facility on weekends to supervise staff and make sure the program is being conducted. The DON said he thought they were doing good. On 4/8/25 at 8:58 a.m., in an interview the Administrator said he thoroughly investigates all allegations of abuse, including resident-to-resident abuse. The Administrator said he verified the resident-to-resident abuse involving Residents #1, #3, #6 and #7 and started an investigation of the altercation between Residents #8 and #9. The Administrator said on 2/15/25 the eagle eye program was implemented. One staff member was assigned to tour the dementia unit every 15 minutes to ensure residents' safety and prevent incidents of resident-to-resident altercation. The assigned staff person is to round and redirect residents on the secured unit. The staff person is to report to the IDT (Interdisciplinary Team) any new resident behavior. The IDT care plans the behavior, do psychosocial consultation and discuss/monitor the resident's behavior. The IDT implements safety measures such as activities, verifies any trauma and develops a care plan to add to the resident's quality of life. The eagle eye staff is to delegate a relief person for breaks to ensure no gaps in supervision of the secured unit. He keeps a spreadsheet to monitor the program daily (coverage/behavior). Review of the facility's investigations of incidents of resident-to-resident altercations/abuse for March 2025 revealed: On 3/12/25, Resident #13 was not adequately supervised. Resident #6 was blocking the door to the hallway. Resident #13 hit Resident #6 to get past him. On 3/12/25, Resident #14 was not adequately supervised. Resident #14 ran into Resident #13 with her wheelchair then hit Resident #13. On 3/14/25, Resident #2 wandered unsupervised into Resident #1's room. Resident #2 scratched Resident #1's cheek when she asked him to leave the room. On 3/18/25, Residents #15, #16 and #17 were not adequately supervised in the activity room of the secured unit. Resident #15 hit Resident #16. Resident #17 then hit Resident #15. On 3/20/25, Resident #4 wandered unsupervised into Resident #3's room. Resident #4 grabbed Resident #3's arm when she asked him to leave her room causing a skin tear to Resident #3's right forearm. On 3/28/25, staff did not adequately supervise Resident #8. Resident #8 hit Resident #7 causing a scratch to Resident #7's left hand. On 3/29/25, staff did not adequately supervise residents in the dining room. Resident #4 scratched Resident #6. Resident #6 sustained scratches to bilateral cheeks, left ear and left upper arm. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105155	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sarasota Health and Rehabilitation Center	1524 East Avenue South Sarasota, FL 34239

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/8/25, staff did not adequately supervise residents in the activity room. Resident #13 hit Resident #16. On 4/8/25, Residents #13 and #12 were not adequately supervised. Resident #13 hit Resident #12 in the hallway. On 4/29/25 at 12:40 p.m., an interview was held with the Administrator to discuss the effectiveness of the eagle eye program implemented on 2/15/25. The Administrator said they added a designated Activity Staff to the secured unit instead of an activity floating staff. They re-educated the staff on abuse, neglect, reporting and redirecting residents. He said at the end of January 2025, they implemented a weekly behavior management meeting. The Psychiatric Advanced Practice Registered Nurse (APRN) attends the meetings. When asked about the multiple incidents of resident-to-resident altercations since 2/15/25, the Administrator said they were monitoring the residents' behaviors. The Administrator said the facility held a Quality Assurance and Performance Improvement (QAPI) meeting on 4/9/25 to discuss the effectiveness of the eagle eye program and residents' supervision on the secured unit. He said they added an additional eagle eye staff person. They trained staff on behavioral management and de-escalation techniques and added the training to their new hire orientation program. He was also hiring an Activity Director with more specific dementia training and behavior management. The DON and him review potential new admission together, including their history before accepting them. He said since April 1, 2025, they admitted four new residents to the dementia unit and had three re-admissions. He said since April 9, 2025, there has not been another incident of resident-to-resident altercation on the secured unit. The Administrator said the next QAPI meeting was scheduled for 4/30/25 to discuss the effectiveness of the new interventions. 46824 The immediate actions implemented by the facility and verified by the survey team on 5/2/25 included: The Risk Consultant educated the Administrator and Director of Nursing on abuse, neglect, and exploitation as well as the reporting requirements to the Facility Risk Manager, Nursing Home Administrator, or direct supervisor as they relate to ensuring adequate supervision to ensure the safety of cognitively impaired residents on the secured dementia unit to prevent further incidents of resident-to-resident physical altercations and abuse. This education was completed on 4/9/25. On 5/2/25 the surveyor verified through review of the abuse education and interview with the Administrator. Administrator educated staff on abuse, neglect, and exploitation as well as the reporting requirements to the Facility Risk Manager, Nursing Home Administrator, or direct supervisor. Education started 4/9/25 and was completed on 4/12/25. 147 out of 147 staff members were educated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105155	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sarasota Health and Rehabilitation Center	1524 East Avenue South Sarasota, FL 34239

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 5/2/25 the survey verified through review of the education documentation provided. 147 of 146 staff members were educated. Random staff interviewed and verified receipt of the education. Administrator educated staff on abuse, neglect, and exploitation as they relate to ensuring adequate supervision to ensure the safety of cognitively impaired residents on the secured dementia unit to prevent further incidents of resident-to-resident physical altercations and abuse. Education started 4/9/25 and was completed on 4/12/25. 147 out of 147 staff members were trained. On 5/2/25 the surveyor verified through review of the education provided to the staff and random staff interviews. Observation of the dementia unit revealed adequate staffing and supervision. Process Change: An ADHOC (unplanned) Quality Assurance and Assessment meeting was held on 04/09/2025. Psychiatric services attended with the facility interdisciplinary team and reviewed high risk residents with behaviors. Medications and care planned interventions for behaviors were reviewed. Psychiatric service visits were increased to three times per week for high-risk residents. In the ADHOC Quality Assurance meeting, facility leadership along with the interdisciplinary team planned for enhanced oversight of the secured unit to monitor hallways and common areas for negative behaviors that could lead to a resident to-resident altercation. Enhanced oversight was initiated 4/10/25. Two staff were assigned per shift to conduct enhanced oversight. The Administrator or designee is responsible for ensuring that enhanced oversight of the secured unit is in place. Additionally, a qualified activity staff member was assigned to activities in the secured unit on 4/10/25. On 5/2/25 the surveyor verified through review of the content of the Ad Hoc QAPI meeting and interview with the Administrator. Another Ad Hoc Quality Assurance meeting was conducted on 04/30/2025 to review the effectiveness of the implemented interventions. The interventions have been a success. There has been no verified resident to resident altercations on the secured unit since implementation. On 5/2/25 the surveyor verified through review of the content of the Ad Hoc QAPI meeting and interview with the Administrator. Review of the incident investigation log revealed no incident of resident-to-resident altercations since 4/9/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105155	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sarasota Health and Rehabilitation Center	1524 East Avenue South Sarasota, FL 34239

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on observation, record review and interviews, the facility failed to implement processes on the secured dementia unit to ensure adequate supervision of 15 (Residents #13, #6, #14, #1, #2, #15, #16, #17, #3, #4, #7, #8, #10, #9, #12) of 15 cognitively impaired residents with aggressive behaviors to prevent multiple avoidable incidents of resident-to-resident physical altercations. On 3/12/25, Resident #13 was not adequately supervised. Resident #6 was blocking the door to the hallway. Resident #13 hit Resident #6 to get past him. On 3/12/25, Resident #14 was not adequately supervised. Resident #14 ran into Resident #13 with her wheelchair then hit Resident #13. On 3/14/25, Resident #2 wandered unsupervised into Resident #1's room. Resident #2 scratched Resident #1's cheek when she asked him to leave the room. On 3/18/25, Residents #15, #16 and #17 were not adequately supervised in the activity room of the secured unit. Resident #15 hit Resident #16. Resident #17 then hit Resident #15. On 3/20/25, Resident #4 wandered unsupervised into Resident #3's room. Resident #4 grabbed Resident #3's arm when she asked him to leave her room causing a skin tear to Resident #3's right forearm. On 3/28/25, staff did not adequately supervise Resident #8. Resident #8 hit Resident #7 causing a scratch to Resident #7's left hand. On 3/29/25, staff did not adequately supervise residents in the dining room. Resident #4 scratched Resident #6. Resident #6 sustained scratches to bilateral cheeks, left ear and left upper arm. On 4/7/25, Resident #9 wandered unsupervised into Resident #10's room. Resident #10 hit Resident #9. On 4/8/25, staff did not adequately supervise residents in the activity room. Resident #13 hit Resident #16. On 4/8/25, Residents #13 and #12 were not adequately supervised. Resident #13 hit Resident #12 in the hallway. The facility's failure to provide the necessary structures to closely supervise cognitively impaired residents with aggressive behaviors on the secured unit resulted in physical altercations and injuries to Residents #1, #3, #6, and #7. This failure created a likelihood that other residents could be seriously harmed or injured from physical resident-to-resident altercations and resulted in the determination of Immediate Jeopardy as a scope and severity of pattern (K) starting on 3/12/25. On 5/1/25 at 5:57 p.m., the Administrator was notified of the Immediate Jeopardy (IJ). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105155	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sarasota Health and Rehabilitation Center	1524 East Avenue South Sarasota, FL 34239

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The census was 60 residents on the secured memory care unit. The findings included: Cross reference to F600 Review of the facility's Abuse Prevention Program with a change date of November 2024 revealed, Abuse . Willful infliction of injury by . another resident . Willful is defined as meaning the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm . 1. Review of the clinical record for Resident #14 revealed an admitted [DATE]. Diagnoses included encephalopathy (brain disease that alters brain function), altered mental status, and unspecified dementia. Review of the Quarterly Minimum Data Set (MDS) assessment with a target date of 2/3/25 noted Resident #14 scored 04 on the Brief Interview for Mental Status, indicating severe cognitive impairment. The care plan created on 1/22/25 noted Resident #14 becomes agitated with staff when they try to redirect her at times. Resident #14 was resistive to care and exhibited aggressive behaviors towards others at times. The goal as of 1/22/25 was to Honor Resident's rights. The interventions included to administer psychotropic medications as ordered. Observe/document for side effects and effectiveness. Document episodes of behavior and review to determine the effectiveness of intervention. Do not corner if agitated. Provide space, remove other residents, remain calm and call for assistance. Review of the facility's event notes revealed a resident-to-resident altercation between Residents #14 and #13 in the hallway near the nursing station on 3/12/25 at 2:30 p.m. Resident #14's description of the event was she thought Resident #13 was striking her friend, so she slapped him in the back of the head. The event note documented the cause of the event was, Close proximity. Review of the nursing progress note dated 3/12/25 at 3:27 p.m., revealed at 2:30 p.m., the nurse was advised that Resident #14 became agitated while standing at the nurses station and began swatting her hand striking another resident on the top of his head. The resident was redirected to her room. Resident #14 stated that she struck Resident #13 because she witnessed him hitting another female resident that she knew. On 3/12/25 at 4:28 p.m., a general progress note documented the Advanced Practice Registered Nurse ordered to increase Depakote 125 milligrams (mg) to two capsules twice daily for mood disorder/agitation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105155	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sarasota Health and Rehabilitation Center	1524 East Avenue South Sarasota, FL 34239

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 3/12/25 the facility updated the care plan with intervention for Continuous monitoring 1:1 (one to one supervision) with every 15-minute documentation. On 3/14/25 at 6:01 a.m., an interdisciplinary progress note documented Resident #14 had no further aggressive behaviors and the medication adjustment appears effective. Recommendation to remove the 1:1 sitter and introduce 15 minute checks for 24 hours and review. On 4/7/25 Resident #14 was discharged to an Assisted Living Facility. 2. Review of the clinical record for Resident #13 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, and unspecified dementia. The Quarterly Minimum Data Set (MDS) assessment with a target date of 2/3/25 noted Resident #13 scored 03 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. Review of the behavioral care plan initiated on 1/7/25 revealed Resident #13 was easily agitated, was combative with staff at times, climbs on furniture at times, refuses care and exhibits aggressive behavior towards others at times. The goal was, Will not harm staff. The interventions included, Do not corner if agitated. Provide space, remove other Residents, remain calm & call for assistance. The care plan did not include individualized interventions to ensure adequate supervision of Resident #13 and protect other residents from Resident #13's aggressive behavior. Review of the facility's event notes revealed a resident-to-resident altercation in the dining room on 3/12/25 at 3:30 p.m. Resident #13, Struck other resident (Resident #6) in the side three times. Resident #13's description of the event read, He was standing too close to me, and I wanted him to back up. The event note documented Resident #13 was having a new onset or escalation of the following behaviors: Anger, agitation, distress causing increased or new onset of aggression. Shoving, biting, scratching self or others, threatening, screaming, cursing, crying, moaning, combative behavior that was above baseline. The cause of the resident-to-resident altercation was, Behaviors related to dementia, residents in close proximity to each other. On 3/13/25, Resident #13's care plan was updated with Continuous Monitoring 1:1 (one to one supervision) with every 15-minute documentation. On 3/14/25 at 8:41 p.m., a progress note documented the 1:1 monitoring was completed. Resident #13 was calm and pleasant. On 3/15/25 at 4:41 a.m., a progress note documented, The following interventions are in place to assist in the prevention of another altercation: Regular rounds . On 4/8/25 at 3:00 p.m., a progress note documented, Resident (#13) was observed pushing other resident in wheelchair and struck resident in the head. The resident has provided the following description of the event: unable to describe . This event was caused by: Resident wandering. This resident is noted to be the aggressor in this event. 1:1 has been initiated as an intervention . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105155	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sarasota Health and Rehabilitation Center	1524 East Avenue South Sarasota, FL 34239

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/8/25 at 3:29 p.m., a behavior note documented Resident #13, used open hand and slapped a female resident, when female resident got too close. Both parties separated and engaged in other activities . Review of the incident investigation dated 4/8/25 revealed a resident-to-resident physical abuse involving Residents #13, #16 and #12. The investigation noted: Resident #16 was admitted to the facility on [DATE]. Diagnoses included dementia, major depressive disorder, mood disorder, anxiety disorder. Resident #16 was rarely/never understood. Resident #12 was admitted to the facility on [DATE] and had a BIMS score of 00 On 4/8/25 at 3:20 p.m., Resident #13 and #16 were in the activity room. Resident #13 hit Resident #16. Resident #13 also hit Resident #12 in passing in the hallway. The Registered Nurse on duty redirected Resident #13 and placed him on one-to-one supervision. The psychiatric Practitioner reviewed and changed Resident #13's psychotropic medications. On 4/11/25, the progress notes documented Resident #13 became agitated, angry at the sitter. He hit the sitter in the back , began swinging his arms and fists and making racial slurs towards the sitter. Resident #13 was transferred to an acute hospital under a [NAME] Act (Temporary involuntary detention for evaluation and treatment). 3. Review of the clinical record for Resident #2 revealed an admitted [DATE]. Diagnoses included: Brain disorder, communication deficit, dementia with other behavioral disturbance and major depressive disorder. Review of the Quarterly MDS with a target date of 3/3/25 revealed Resident #2 scored 03 on the BIMS, indicating severe cognitive impairment. Resident #2 was independent for walking 150 feet. Review of the care plan initiated on 11/26/24 revealed Resident #2 had impaired cognitive function/dementia or impaired thought processes related to severely impaired BIMS score. The goal was for the resident to remain oriented to person, place, situation, time within current cognitive capacity. The interventions included re-approach later if the resident was restless or agitated, cue, reorient and supervise as needed. The care plan noted Resident #2 had a wander bracelet (alerts staff when a resident is leaving a safe area). On 2/20/25 at 3:12 p.m., an activity progress note documented Resident #2, wanders hallways during the day and enjoys sitting at outside patio doors in the sun . On 3/14/25 at 2:45 p.m., Resident #2 was not adequately supervised and wandered into Resident #1's room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105155	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sarasota Health and Rehabilitation Center	1524 East Avenue South Sarasota, FL 34239

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the post event note dated 3/14/25 at 2:45 p.m., revealed, Resident to Resident Altercation . This event was caused by: Resident wandered into other resident's room. This resident (Resident #2) is noted to be the aggressor in this event. What caused this event? Resident wandered into other resident's room. Review of the progress note dated 3/14/25 at 8:30 p.m., revealed, Staff heard yelling and responded immediately. Noted Resident (Resident #2) sitting on other resident's bed (Resident #1). Other resident (Resident #1) had a fine red line of discoloration noted to right cheek. Resident (Resident #2) was escorted from the room and placed on 1:1 observation . The progress note documented the psychiatric Advanced Practice Registered Nurse (APRN) was notified and ordered Depakote 125 milligrams (mg) in the morning then 250 mg at 5:00 p.m. Depakote is anti-seizure medication that is sometimes used as a mood stabilizer. On 3/16/25 at 8:32 a.m., an interdisciplinary (IDT) note documented Resident #2 remained on one-to-one supervision. The medication change was effective. No additional behaviors identified or reported by the nursing staff. On 3/16/25 at 9:10 a.m., an IDT progress note documented the psychiatric practitioner agreed to discontinue the one-to-one supervision and start every 15 minutes check. On 3/18/25 an IDT progress note documented the one-to-one supervision was discontinued and every 15-minute check was initiated. The care plan updated on 3/19/25, five days after the altercation, noted Resident #2 was noted with the following behaviors, Resident exhibits aggressive behaviors towards others at times. The goal was for Resident #2 not to harm other residents and to honor the residents' rights. The interventions included redirect resident to decrease and manage behaviors, administer psychotropic medications, document episodes of behavior and review to determine the effectiveness of intervention, do not corner if agitated. Provide space, remove other residents, remain calm and call for assistance. The care plan did not address necessary supervision to prevent Resident #2 from wandering into other residents' rooms. On 4/4/25 at 5:00 p.m., a nursing progress note documented Resident #2 was, increasingly wandering into other residents' rooms and lying in other residents' beds. Resident at times responding angrily when redirected. On 4/4/25 the care plan was not updated with appropriate interventions, including necessary supervision to prevent Resident #2 from wandering into other residents' rooms which could lead to further incidents of resident-to-resident physical altercations. On 4/7/25 at 3:38 during a telephone interview, Resident #1's son said the nurse called him to inform him of the altercation. He said the nurse told him the resident involved in the altercation with his mother wandered into other residents' rooms unsupervised. The nurse told him that his mother was hit or pushed. Resident #1's son said he was upset and moved Resident #1 out of the facility. He said the facility did not properly supervise the residents on the secured dementia unit and nobody would be happy about that. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105155	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sarasota Health and Rehabilitation Center	1524 East Avenue South Sarasota, FL 34239

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/8/25 at 8:58 a.m., in an interview the Administrator said Resident #2 wandered into Resident #1's bedroom unsupervised. Staff did not see the altercation. The Administrator said the investigation determined abuse was verified. On 4/8/25 at 1:40 p.m., in an interview Licensed Practical Nurse (LPN) Staff A said she was receiving report and did not witness the altercation. She said she went to the room and Resident #2 was on Resident #1's bed. Resident #1 was crying and holding her right cheek. LPN Staff A said she did not see Resident #2 wander into the room and said the facility does a good job at keeping residents safe. Review of the Psychiatric follow up visit note dated 4/15/25 revealed staff reported Resident #2 can be irritable with redirection. Psychiatry discontinued the Depakote 125 and started Resident #2 on Depakote 500 mg twice a day (BID). On 4/18/25, the psychiatrist documented in a progress note Resident #2 was seen for aggressive, agitated behaviors. Resident #2 was seen as he continues to be wandering, trying to get out of his bed and becomes agitated. The practitioner added Ativan (relieves anxiety) 0.5 mg every four hours as needed. 4. Review of the clinical record for Resident #15 revealed an admitted [DATE]. Diagnoses included major depressive disorder, unspecified mood disorder, cognitive communication deficit, anxiety and brief psychotic disorder. Review of the Admission MDS assessment with a target date of 1/14/25 revealed Resident #15 scored 10 on the BIMS, indicating moderate cognitive impairment. Resident #15 required partial/moderate assistance to walk 150 feet. Resident #15 also used a wheelchair and required supervision to wheel 150 feet. Review of the physician's orders revealed Resident #15's medication regimen as of 1/7/25 included Depakote Sprinkles oral capsule delayed release 125 mg, two capsules by mouth two times a day for mood disorder. The care plan initiated on 1/8/25 noted the resident receives psychotropic medications related to behavior/Mood management. The goals included for the resident to be at the lowest dose required to reduce symptoms while minimizing adverse effects to ensure maximum functional ability both mentally and physically. The interventions included to monitor for side effects of the psychotropic medication, administer the medication as ordered and observe/document for side effects and effectiveness. The care plan did not specify the target behaviors to be monitored. Review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) for January 2025, February 2025, March 2025 and April 2025 failed to show documentation of target behaviors to be monitored. The MARs and TARs noted, No order data found for behavior monitoring. On 2/7/25 at 2:53 p.m., a psychotropic medication note documented Resident #15 was prescribed an antipsychotic. Under Targeted Behaviors: What behaviors is the resident demonstrating that warrants the use of the psychotropic medication?: Agitated, anxious, Restless . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105155	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sarasota Health and Rehabilitation Center	1524 East Avenue South Sarasota, FL 34239

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 3/3/25 an IDT note documented, . Resident has history of wandering and anxiety . On 3/12/25 at 10:36 p.m., a progress note documented the IDT review during monthly behavior management meeting. Resident behaviors have been stable. Mood is stable on current medications. Continue current interventions. On 3/14/25 a post event note documented Resident #15 was involved in a resident-to-resident altercation. The resident's current mood and/or behavior was, calm and cooperative. The following interventions are in place to assist in the prevention of another altercation: Monitor resident behavior . The progress note did not document details of the resident-to-resident altercation. Review of the facility's incident investigations revealed on 3/18/25 at 10:12 a.m., Residents #15, #16 and #17 were in the activity room. Staff witnessed Resident #16 reaching for Resident #15's cookie. Resident #15 took the cookie back and hit Resident #16. Resident #17 then hit Resident #15 in defense of Resident #16. The facility's incident investigation verified the resident-to-resident physical abuse. Resident #15 was placed on one to one monitoring until 3/21/25. 5. Review of the clinical record for Resident #4 revealed an admitted [DATE]. Diagnoses included Dementia with behavioral disturbances. Resident #4 was admitted on [DATE]. Diagnoses included syncope, collapse, dementia with unspecified severity with other behavioral disturbances. Review of the Quarterly Minimum Data Set (MDS) assessment with a target date of 2/11/25 noted the resident's cognition was severely impaired with a Brief Interview for Mental Status score of 03. The MDS noted the resident was independent for transferring and walking 150 feet. Review of the resident's care plan initiated on 9/13/23 and revised on 2/12/25 noted Resident #4 exhibited the following behaviors: Wandering behaviors. Resident #4 becomes agitated at times and when other residents enter his room and when redirected by staff. The goal was to Honor Resident's rights. The interventions dated 9/13/23 included but were not limited to observe for behaviors, administer psychotropic medications, observe for changes in behavior and report to the physician, do not corner if agitated. Provide space, remove other residents, remain calm and call for assistance. Review of the progress notes revealed on 1/13/25 Staff saw Resident #4 in the dining room upset at another resident and threatened to hit them. Staff intervened and separated the residents. On 1/16/25 Resident #4 became upset with a staff and tried to assault staff. Resident was placed on one to one supervision. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105155	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sarasota Health and Rehabilitation Center	1524 East Avenue South Sarasota, FL 34239

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 1/16/25 the Psychiatric practitioner was notified of the resident's aggressive behavior towards staff. A new order was given for Vistaril (can be used to treat short term anxiety) 50 milligrams daily for seven days. On 2/25/25 at 8:00 p.m., a progress note documented Resident #4 was pushing another resident in a wheelchair up and down the hallway. The resident in the wheelchair started to have episodes of yelling out loud repeatedly. Resident #4 told the other resident in the wheelchair to please stop yelling and appeared to become increasingly irritable that the resident would not stop yelling. Resident #4 became triggered by the excessive yelling and yelled at the resident from behind the wheelchair and appeared to be attempting to initiate a physical altercation from behind the wheelchair. The resident in the wheelchair was not able to see the potential assault. Staff separated the residents and took Resident #4 to his room. On 3/20/25 Resident #4 was not adequately supervised and wandered into Resident #3's room. On 3/20/25 at 7:37 p.m., a nursing progress note documented at approximately 7:00 p.m., staff heard Resident #3 screaming for assistance. Upon investigation staff observed Resident #4 confused and agitated, exiting Resident #3's room. Resident #3 said Resident #4 was retrieving clothing from her closet. When she attempted to stop him, Resident #4 reportedly grabbed Resident #3's hand. Staff observed a skin tear to Resident #3's left wrist. Resident #4 was placed on one to one supervision until 3/26/25. On 3/26/25 at 3:15 p.m., a progress note documented Resident #4 was placed on every 15 minutes checks to assist in the prevention of another altercation. On 3/29/25 Resident #4 was not adequately supervised and got into a physical altercation with Resident #6. Review of the facility's investigation dated 3/29/25 revealed the facility nurse heard raised voiced from the hallway. She entered the dining room and witnessed Resident #4 scratch Resident #6. Resident #4 was redirected and placed on one to one supervision. The psychiatric Advanced Practice Registered Nurse (APRN) was notified and made changes to Resident #4's medications. Residents #4 and #6 had severe cognitive impairment with a BIMS of 06 and were not able to provide information related to the incident. Review of the post event noted effective 3/29/25 at 3:38 p.m., revealed Resident #6 sustained scratches to the left cheek, left ear, right cheek, underside of left upper arm, and a small scratch to the right side of the neck. The cause of the event was, Unknown. The facility's investigation did not include how the residents were supervised to prevent the physical altercation. On 3/29/25 at 3:24 p.m., a progress note documented a Certified Nursing Assistant notified the nurse of a resident-to-resident altercation. The nurse went to the resident and separated in room. The nurse documented Resident #4 was on every 15 minutes checks and was last seen in the dining room, resting in a chair. Resident #4 was again placed on one to one observation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105155	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sarasota Health and Rehabilitation Center	1524 East Avenue South Sarasota, FL 34239

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/7/25 at 1:50 p.m., in an interview Certified Nursing Assistant (CNA) Staff B said she was collecting dinner trays and did not see Resident #4 wandering into Resident #3's room. She said she saw Resident #4 in the wrong room trying to open the closet and take the clothes out. Staff B said she saw Resident #4 grab Resident #3's arm causing a skin tear. She told Resident #4 it was not his room and redirected him. She went and got the nurse and gave her statement. 6. Review of the clinical record for Resident #8 revealed an admitted [DATE]. Diagnoses included early onset Alzheimer's disease, and anxiety. Review of the Quarterly MDS with a target date of 2/28/25 revealed Resident #8's cognition was moderately impaired with a BIMS score of 12. He used a wheelchair for mobility. Review of the behavioral care plan initiated on 11/22/24 and revised on 3/28/25 revealed Resident #8 was accusatory of staff, made inappropriate comments at times. Resident #8 refused care and medications at times, used profanities towards staff at times and may show aggression with other residents at times. The goal was for the resident to take medications as prescribed. The interventions initiated on 11/22/24 included to document episodes of behavior and review to determine the effectiveness of the interventions, observe for changes in behavior, do not corner if agitated. Provide space, remove other residents, remain calm and call for assistance. Review of the progress notes revealed on 2/12/25 at 6:51 p.m., Resident #8 was observed arguing with another resident. Staff immediately separated the residents. On 3/28/25 Resident #8 with known behavior of aggression towards other residents was not adequately supervised to prevent a physical altercation with his roommate, Resident #7. Review of the facility's incident investigations revealed on 3/28/25 at 12:30 a.m., the nurse heard raised voices from the hallway and entered Resident #8's room. The nurse observed Resident #8 hit Resident #7. Review of the initial event note dated 3/28/25 at 12:55 a.m., revealed Resident #7 sustained bruising to the right upper chest and a skin tear to the dorsal area of the left hand from the physical altercation. On 3/28/25 at 1:05 a.m., a progress note documented the residents were last seen 10 to 15 minutes prior to the incident. Resident #7 was in bed and Resident #8 was in his wheelchair. Resident #8 was assigned a one-to-one sitter and separated from the roommate. The Physician was notified and gave a new order for Trazodone 50 mg at bedtime (antidepressant that can be used for conditions like anxiety and agitation). Resident #8 description of the event was, You guys keep putting a bunch of predators in my room to attack me. Residents #8 and #7 remained roommates despite the physical altercation. Resident #8 was placed on one to one supervision. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105155	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sarasota Health and Rehabilitation Center	1524 East Avenue South Sarasota, FL 34239

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	7. Review of the clinical record revealed Resident #9 was admitted to the facility on [DATE]. Review of the care plan initiated on 12/11/24 revealed Resident #9 had anxiety, depression with progressing dementia. The resident was intermittently aggressive with other residents at times. Resident #9 also lowered herself to the floor at times. The goal was for the resident to have fewer episodes of lowering herself to the floor. There was no goal addressing the intermittent aggressivity with other residents and prevent resident to resident altercations. The interventions in the care plan included but were not limited administering medications as ordered, document behaviors, and resident's response to interventions, intervene as necessary to protect the rights and safety of others, approach, speak in a calm manner, divert attention, remove from situation and take to alternative location as needed, redirect resident to decrease and manage behavior as needed. The care plan initiated on 5/15/24 and revised on 8/28/24 noted Resident #9 was at risk for elopement and resided in the secured unit of the facility. The interventions included to offer Resident #9 frequent rests and snacks if she was wandering. On 4/7/25 at 2:32 p.m., Residents #10 and #9 were not adequately supervised. Resident #10 was observed standing in the doorway of room [ROOM NUMBER] facing outside of the room. Resident #9 was observed sitting in a wheelchair in front of room [ROOM NUMBER], facing Resident #10. No staff was observed supervising the residents. Residents #9 and #10 started to argue loudly. Resident #9 started to stand up. Resident #10 pushed Resident #9 back in the wheelchair. Staff did not respond to the resident-to-resident altercation. Three female staff were observed at the nursing station to the right of the hallway. Residents #9 and #10 were not visible from the nurse's station. When notified of the verbal and physical altercation between Residents #9 and #10 the three staff member got up and walked towards room [ROOM NUMBER]. Review of the facility's incident investigations revealed on 4/7/25 at 2:00 p.m., Resident #10 was lying in bed when Resident #9 entered the room and grabbed Resident #10's collar. Resident #10 hit resident #9 in defense. Resident #9 was redirected by the facility nurse and provided one-on-one supervision. On 4/7/25 at 2:06 p.m., in an interview the Assistant Director of Nursing (ADON) said the facility implemented a monitoring (Eagle Eye) program on 2/15/25 to address incidents of resident-to-resident altercations. The ADON said the Eagle Eye program consists of one Certified Nursing Assistant (CNA) who is assigned to monitor the dementia unit to make sure residents are observed every 15 minutes for their safe whereabouts. Documents provided by the facility showed the Eagle Eye CNA documented every 15 minutes rounds on a form. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105155	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sarasota Health and Rehabilitation Center	1524 East Avenue South Sarasota, FL 34239

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/7/25 at 5:27 p.m., an interview was held with the Director of Nursing (DON) to discuss the supervision of the cognitively impaired and confused residents on the secured unit and the multiple incidents of resident-to-resident physical altercations. The DON said when he began working at the facility he had never seen so many resident altercations. He said the resident altercations on the secured dementia unit have been reduced by half, and he thought they were doing good. 46824 The immediate actions implemented by the facility and verified by the survey team on 5/2/25 included: The Risk Management Consultant educated the Administrator and Director of Nursing on ensuring that residents on the secured dementia unit are provided with adequate supervision to prevent incidents of resident-to-resident physical altercations and ensure resident safety. This education was completed on 4/9/25. On 5/2/25 the surveyor verified through review of the of the education provided by the Risk Management Consultant to the Administrator and the Director of Nursing and interview with the Administrator. The Administrator educated staff on ensuring that residents on the secured dementia unit are provided with adequate supervision to prevent incidents of resident-to-resident physical altercations and ensure resident safety. Additionally, the Administrator/designee gave specific examples of behavioral patterns that potentially lead to resident-to-resident altercations such as wandering patterns and behaviors, proximity of residents, verbal queues, and physical queues. Education started 4/9/25 and was completed on 4/12/25. 147 out of 147 staff members were educated. On 5/2/25 the surveyor verified through review of the education provided and interview with one CNA, two Licensed Practical Nurses and one Registered Nurse. All verified they received the education and were able to verbalize content of the education. Process Change: An Ad Hoc Quality Assurance Meeting was held on 4/9/2025 and the following was developed: Enhanced monitoring and oversight was initiated by facility leadership over the secured unit in order to monitor patient care areas and resident rooms for resident behaviors that could lead to resident-to-resident altercations. Enhanced monitoring and oversight was initiated 4/10/25. The Administrator and Director of Nursing will be responsible for ensuring that enhanced oversight of the secured unit is in place. On 5/2/25 the surveyor verified through review of the content of the AD Hoc QAPI meeting held on 4/9/25 and interview with the Administrator. On 5/2/25 the surveyor verified through documentation provided the enhanced monitoring and oversight was initiated on 4/10/25. An Ad Hoc Quality Assurance meeting was held on 04/30/2025 to review the process change. The process change has been successful as there have been no resident to resident altercations in the secured unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105155	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sarasota Health and Rehabilitation Center	1524 East Avenue South Sarasota, FL 34239

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 5/2/25 the surveyor verified through review of the content of the Ad Hoc QAPI meeting held on 4/30/25 and interview with the Administrator. Review of the facility's incident log revealed no incident of resident-to-resident altercation since 4/9/25.