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	11/12/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interviews, the facility failed to have documentation of a thorough investigation for an injury of unknown origin for 1 (Resident #2) of 3 residents reviewed. The findings included:Review of the facility's policy and procedure titled, Abuse Prevention Program with a review date of September 2025, revealed, The facility has designated and implemented processes, which strive to reduce the risk of abuse . Investigation: NHA [Nursing Home Administrator] or designee is notified and will initiate and conclude a complete and thorough investigation within the specific timeframe. Investigation may include but may not be limited to: Resident statements/interviews; Employee statements/interviews . Observation of resident(s), staff, environment . Re-enactment of event .Review of the clinical record for Resident #2 revealed an admission date of 1/1/24 with a most recent admission date of 9/22/25. Diagnoses included displaced fracture of base of neck of right femur, unspecified dementia, and anxiety disorder.Review of the Discharge Minimum Data Set (MDS) with an assessment reference date of 11/4/25 documented Resident #2 was dependent on staff for toileting, personal hygiene, bathing, bed mobility and transfer. The MDS noted the residents' cognitive status was severely impaired.Review of the progress notes revealed on 10/31/25 at 11:16 p.m., a nursing Post Event Note documented Resident #2 had a bruise to the right medial knee/shin. The noted date and time of the event was 10/31/25 at 9:02 p.m. the event took place in the dining room table. The resident was oriented to person and was not able to provide a description of the event.The description of the event as provided by licensed staff was as follows, noted bruise to right medial knee.A progress note dated 11/3/25 documented a Stat (immediate) X-ray of the right hip and leg were ordered.On 11/4/25 an Interdisciplinary Note documented Resident #2 sustained a bruise to the right knee/shin, per event, hit on table in dining room. Per Unit Manager and Nurse, bruising was spreading in size, yellow and black. Out of abundance of precaution, x-ray ordered from hip to ankle. Results showed age unknown, non-acute fracture of the right femur head. The physician and Medical Director aware of the results and agree with history of Osteopenia (lower than normal bone density) and osteoarthritis, left hip repair and bilateral knee replacements, found fracture is not an acute fracture.On 11/4/25 a progress note documented the discolored area on Resident #2's right hip, knee and shin was unchanged. The resident had facial grimacing with movement. Resident #2 was sent to the local Emergency Department.Review of the hospital Trauma History and Physical progress note dated 11/4/25 revealed: Chief complaint of Fall, right hip fracture. The patient was nonverbal and was unable to give a history. The examination of the extremities noted, Obvious deformity to the right hip. The patient's right lower extremity is externally rotated and shortened. Significant bruising down the entire right lower extremity. Hip Right 2 views/AP Pelvis (11/4/25). Acute displaced transcervical fracture of the right femoral neck with angulation of the femoral diaphysis in relation to the femoral head.On 11/12/25 at 12:02 p.m., in an interview the Director of Nursing (DON) said staff reported the bruise to him and said the resident bumped her knee on the table in the dining room. The DON said he believed it was a Certified Nursing Assistant (CNA) who saw the resident hit her leg on the table and reported it to the nurse.Review of the facility provided incident investigation dated 10/31/25 at 9:02 p.m., revealed, Nursing Description: Blue/purple color skin discoloration noted to Right medial knee/shin, placement consistent on table in dining room today. Resident description: Resident unable to give description.The incident investigation form noted that the incident was not witnessed.The Immediate Action taken noted Resident #2 had no pain and an X-Ray was ordered out of abundance of precaution. The resident was not taken to the hospital. Increase table height or overbed table instead of dining table.On 11/12/25 at 2:32 p.m., in an interview the DON said no one witnessed the resident hitting her leg on the table. He didn't know where or when the resident sustained the bruising but the injury was consistent with the resident hitting her leg on the table. He could not locate statements from the nurse or the CNA. The Unit Manager verbally asked staff about the incident but did not document it. The DON said he usually investigates, goes back to the previous shifts and obtain statements from staff.On 11/12/25 at 3:21 p.m., in an interview CNA Staff B said on 10/31/25 at approximately 3:00 p.m., she was doing rounds. Resident #2 was lying in bed. She saw a large black bruise on the resident's right leg from the middle of her inner thigh to halfway down her shin. She reported it to the nurse on duty. CNA Staff B said she did not see the resident in her wheelchair that day and did not witness the resident hitting her leg on the table. Staff B said the DON called her today and asked her to write a statement.On 11/12/25 at 3:36 p.m., in an interview Licensed Practical Nurse (LPN) Staff C said on 10/31/25 late evening, CNA Staff B was putting Resident #2 to bed in

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to follow infection control procedures to prevent the potential spread of scabies to residents, staff and visitors in 1 (Memory Care Unit) of 3 units.The findings included:Review of the Facility policy and procedure titled, Infection Prevention and Control Program with an effective date of October 2021 revealed, The Infection Prevention and Control Program is comprehensive program that addresses detection, prevention and control of infections and communicable diseases among residents, visitors, volunteers, and personnel. Goals: (a) Provision of a safe, sanitary, and comfortable environment. (b) decrease the risk of infection and communicable diseases development and transmission to residents, visitors, volunteers, and personnel. (c) Monitor for occurrence of infections and communicable diseases and implement appropriate prevention measures to reduce occurrences.Review of the Facility Policy and Procedure Scabies: Management effective August 2025 documented Policy: The facility will strive to identify the early stages of potential resident infestation with scabies during daily personal care and weekly skin assessments. Procedure: 5 (b) Treatment of roommates and close contacts that the resident might have had prolonged skin to skin contact with for an outbreak is recommended. (c) Contacts who have had prolonged skin to skin contact with the infested person should be treated. 7. Double bag clothes, bedding privacy curtains and towels (in the room) used by the residents prior to treatment. Place in laundry hamper and transport to laundry. 8. Place all items that cannot be laundered in a plastic bag. Maintain items in plastic bag for seven days before using. 9. Request housekeeping thoroughly cleans the infected resident's room and thoroughly vacuum upholstered furniture.Review of the clinical record for Resident #2 revealed an original admission date of 1/1/24. The most recent admission date was 9/22/25. Current diagnoses included displaced fracture of base of neck of right femur, unspecified dementia, and anxiety disorder.Review of the Discharge Minimum Data Set (MDS) with an assessment reference date of 11/4/25 revealed Resident #2's cognition was severely impaired. The resident was dependent on staff for toileting, personal hygiene, bathing, bed mobility and transfer.Resident #2 resided in the Memory Care Unit of the facility.Review of the progress notes revealed on 11/4/25 Resident #2 was transferred to a local hospital for evaluation of a fracture of the right femur head.Review of the hospital physician progress note dated 11/5/25 revealed a conditional discharge order was placed for the resident to return to the memory care facility, awaiting to hear back from patient's husband if he would like her to return to prior facility or find alternate placement given that she was admitted with scabies infection. She was treated with permethrin cream (medication to treat scabies) on arrival for this.A nursing progress note dated 11/6/25 revealed Resident #2 was readmitted to the facility on [DATE] at 10:45 a.m.On 11/12/25 at 4:47 p.m., an interview was held with the facility's Infection Preventionist (IP) related to the hospital documentation that Resident #2 was diagnosed and treated for scabies upon arrival to the hospital. The IP said she found out that Resident #2 was treated for scabies at the hospital from the pre-admission paperwork. She said she assessed Resident #2's skin upon her return from the hospital. She did not see evidence of a rash but did not document her assessment. The IP said the Advanced Practice Registered Nurse (APRN) also assessed Resident #2 but she could not find the APRN's assessment. The IP said the resident's roommate was checked for scabies as well as the 2 residents who share the adjoining bathroom. The IP said she did not document her findings and should have. The IP said she did skin checks on the residents of the entire unit but did not document the results of the skin checks. She also asked staff if they had a rash or any skin issues but that was not documented anywhere either. The IP said the facility's protocol for scabies was to treat the resident, wash all their clothing and bedding, then repeat the treatment. She verified the resident's or the roommate's clothing, bedding or room were not cleaned prior to the resident's return from the hospital. The IP said no in-services were done regarding scabies because they did not think it was necessary.