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	06/05/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on clinical record review, and staff interviews the facility failed to obtain a Do Not Resuscitate Order (DNRO) in accordance with the advanced directives of 1(Resident #92) of 2 residents reviewed for code status and advanced directives. The findings included: Review of the clinical record for Resident #92 revealed an admitted [DATE]. Diagnoses included anxiety disorder, and Parkinson's disease. The Admission Minimum Data Set (MDS) assessment with a target date of [DATE] noted the resident's cognition was severely impaired with a Brief Interview for Mental Status score of 4. The Quarterly MDS assessment with a target date of [DATE] noted a BIMS score of 3 (severe cognitive impairment). Review of the resident's advance directives dated February 5, 2024, noted Resident #92 designated his sister as durable power of attorney. This designation did not include health care decisions. Review of the physician's orders revealed on [DATE] the physician issued a Do Not Resuscitate Order (DNR), directing the withholding or withdrawing of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. The clinical record lacked documentation Resident #92 verbalized the wish to not receive CPR in the event of cardiac or respiratory arrest. Review of the Policy on CPR, Code Status Orders and Response Updated February 2023, noted, If the resident or resident representative verbalizes the wish not to receive CPR, two staff members will witness and document this request, the conversation of the request will be printed and placed as the first document of the medical record. On [DATE] at 9:10 a.m., in an interview the Social Services Director (SSD) said Resident #92's sister made the decision and signed the yellow State of Florida Do Not Resuscitate Order. She said the form was in her office waiting for the physician's order. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 4:50 p.m., the SSD provided a yellow Florida DNR Order form dated [DATE] and signed by Resident #92's sister directing the withholding or withdrawing of CPR. The form was not signed by the physician and was not in the clinical record available to staff in the event of cardiac or respiratory arrest. The clinical record lacked documentation of an incapacity statement noting Resident #92 lacked health care decision making capacity and authorized his sister to make health care decisions on his behalf. On [DATE] at 5:22 p.m., in an interview Licensed Practical Nurse (LPN) Staff N said she was always under the impression if there is no yellow in the chart, you perform CPR even if the computer and order said they are DNR. She said, You need the yellow DNR form to withhold CPR. On [DATE] 1:50 p.m., in an interview LPN Staff U said if a resident goes into cardiac arrest, she checks the computer and then the paper chart. She said if the computer lists the resident as DNR but there was no signed yellow Florida DNR form the resident is given full CPR. She said the DNR is not valid until the physician signs the form.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25618 Based on observation, clinical record review, and staff interview, the facility failed to ensure the MDS (Minimum Data Set) assessment accurately reflected the dental status for 1 (Resident #25) of 4 residents reviewed for accurate dental assessment. Inaccurate MDS assessments could result in a resident not receiving or a delay in the appropriate health care. The findings included: On 6/2/24 at 10:55 a.m. via observation noted Resident #25 had multiple missing and broken teeth. Resident #25 said she was admitted to the facility with multiple missing, and broken teeth. She said she had told multiple nursing staff she would like to have all her teeth extracted so she could get upper and lower dentures. Review of the MDS, a resident assessment and care screening tool, dated 2/15/24 coded Resident #25's Brief Interview for Mental Status (BIMS) score as 14 out of 15. A BIMS score of 13 to 15 meant the resident was cognitively intact and capable of daily decision making. Section L (Oral/Dental Status) stated Resident #25 had natural teeth which were not broken, cracked, uncleaned, or loose. Nursing Admission Data Collection and Baseline Care Plan form dated 2/13/24 stated the resident had natural teeth which were not broken or carious. On 6/4/24 at 5:58 p.m., during an interview with the Social Service Director (SSD), she said when a resident is admitted to the facility each department does a full resident assessment, and uses the information to complete their portion of the admission MDS which is reviewed for accuracy by the MDS Coordinator. The SSD said all residents' dental status was assessed and documented on the MDS assessment form. If a resident's teeth were noted to be missing, broken, cracked and/or discolored the facility staff would arrange for a dental consult as needed and/or requested by the resident or their legal representative. The SSD reviewed Resident #25's medical record and confirmed the resident was admitted to the facility on [DATE]. She said the MDS dated [DATE] and Nursing Admission Data Collection dated 2/13/24 noted Resident #25 had all her natural teeth which were not broken, cracked, unclean, or loose teeth. On 6/4/24 at 6:30 p.m., the SSD and this surveyor conducted an interview with Resident #25. Resident #25 told the SSD she was admitted to the facility with broken, missing, and cracked teeth and she told multiple people in nursing she would like her remaining teeth pulled so she could get a full set of dentures. Resident #25 proceeded to show the SSD her missing, broken, cracked and discolored teeth. In an interview with the SSD on 6/5/24 at 6:40 p.m., she confirmed Resident had missing, broken, cracked and discolored teeth. The SSD said the MDS dated [DATE] and Nursing Admission Data Collection dated 2/13/24 for Resident #25 were coded incorrectly and did not reflect Resident #25's missing, broken, cracked, unclean, and/or loose teeth as required. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/24 at 11:05 a.m., in an interview with the MDS Coordinator, she said when a resident was admitted to the facility each department did their resident assessment and used the information to complete their portion of the admission MDS which was reviewed for accuracy by the MDS Coordinator. The MDS Coordinator reviewed Resident #25's medical record and said she had completed Resident #25's admission MDS assessment dated [DATE]. She confirmed she had coded Resident #25 as having her natural teeth which were not broken, missing, cracked and/or discolored teeth. On 6/5/24 at 11:35 a.m., MDS Coordinator and this surveyor conducted an interview with Resident #25. Resident #25 told the MDS Coordinator she was admitted to the facility with broken, missing, and cracked teeth and she told multiple people in nursing she would like her remaining teeth pulled so she could get a full set of dentures. Resident #25 proceeded to show the MDS Coordinator her missing, broken, cracked and discolored teeth. In an interview with the MDS Coordinator on 6/5/24 at 11:45 a.m., she confirmed Resident #25 had missing, broken, cracked and discolored teeth. The MDS Coordinator said the Admission MDS dated [DATE] for Resident #25 was coded incorrectly and did not reflect Resident #25's missing, broken, cracked, uncleaned, and/or loose teeth as required. She said she would update the admission MDS dated [DATE] to accurately reflect Resident #25 was admitted to the facility with missing, broken, cracked and discolored teeth.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38570 Based on observation, record review and staff interview the facility failed to provide necessary assistance with grooming and nail care for 2 (Resident #29 and #44) of 3 dependent residents reviewed for activities of daily living. The findings included: Review of facility Certified Nursing Assistant (CNA) job description, indicated the CNA is responsible for assisting with direct resident care within the scope of their practice. Work includes components of direct patient care such as hygiene. Direct care responsibilities include: Ensures that each resident's personal care needs are being met in accordance with the resident's wishes, Bathes residents, provides nail and hair care and provides denture care. 1. Review of Resident #29's clinical record revealed admitting diagnoses included a history of traumatic brain injury, epilepsy, dementia, stiffness of joints, speech and language deficit. The Quarterly Minimum Data Set (MDS) dated [DATE] indicated that Resident #29 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment. The assessment indicated that the resident did not have the behavior of rejecting care. The Resident had functional limitation in range of motion of both upper and lower extremities and was dependent for all care such as oral hygiene, toileting, shower/bathing, and personal hygiene. Review of Resident #29's Activities of Daily Living Care Plan initiated on 12/6/17 and last revised on 2/23/23 indicated that resident will have his ADL needs anticipated and met by staff. The Care Plan indicated the resident was dependent for personal hygiene and on bathing days to check nail length, trim and clean on bath day and as necessary report any changes to the nurses. On 6/2/24 at 10:48 a.m., Resident #29 was observed in the day room area sitting in a Broda Chair (a special type of wheelchair). The resident was noted to have a beard growth of approximately two to three days. The resident's fingernails extended approximately half to three quarters of an inch. A scratch mark was observed to the right side of the resident's face and the left forearm. On 6/3/24 at 9:56 a.m., Resident #29 was observed in the day room. His fingernails were still long. The resident's left hand appeared contracted (fixed deformity). Resident #29 attempted to use his right hand to open his left hand. The left hand fingernails extended approximately 1/2 to 3/4 of an inch. On 6/4/24 at 1:05 p.m., Resident #29 was observed sitting in a Broda chair in the day room. The fingernails of both hands remained long, extending approximately 3/4 of an inch. Review of Resident #29 Plan of Care Response History for nail care from 5/8/24 to 6/5/24 showed documentation the resident received nail care only once on 5/19/24 at 6:29 p.m. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/24 at 1:13 p.m., CNA Staff O said Resident #29 received a shower on Mondays and Thursdays during the 3:00 p.m., to 11:00 p.m. shift. She said the resident was not able to take care of himself and did not refuse his showers. Staff O stated that normally the resident gets shaved and his nails trimmed on shower days. Staff O observed and acknowledged that the resident's nails were long and extending at least 1/2 inch and needed to be trimmed. 2. Review of Resident #44's clinical record revealed admitting diagnoses included Cerebral infarction (stroke), muscle wasting and atrophy (wasting), dementia, depression and muscle weakness. The significant change in status Minimum Data Set (MDS) dated [DATE] indicated that Resident #44 scored a 10 on the Brief Interview for Mental Status (BIMS), which indicated moderate cognitive impairment. The assessment indicated the resident did not have the behavior of rejecting care. The resident had functional limitation in range of motion on one upper and one lower extremity. The resident's assistance for care such as oral hygiene, toileting, shower/bathing and personal hygiene was maximal assistance to dependent. On 6/2/24 at 10:40 a.m.,, Resident #44 was observed outside in the patio area sitting in a wheelchair. Resident #44 appeared very thin. His fingernails extended past his fingertip approximately 3/4 of an inch, and he had facial hair growth of approximately three to four days. Resident #44 stated he needed assistance with showering, dressing and to get cleaned up. On 6/3/24 at 9:33 a.m., Resident #44 was observed in bed dressed in a hospital gown. His fingernails remained long, extending approximately 3/4 of an inch. The resident remained with the facial hair growth of approximately three to four days. Review of Resident #44's Activities of Daily Living Care Plan initiated on 1/31/23 and last revised on 1/31/23 noted the goal was to prevent decline in ADL self-performance. The Care Plan noted the resident required the assistance of one staff member for personal hygiene, incontinence care, bathing, and showers. The Care Plan did not address nail care. Review of Resident #44's Plan of Care Response History showed no documentation that the resident received nail care from 5/7/24 to 6/5/24. On 6/4/24 at 1:25 p.m., in an interview CNA Staff O said Resident #44's shower days were scheduled for Mondays and Thursdays on the day shift, and he did not refuse care. Staff O said that normally the resident gets shaved and gets their nails trimmed on shower days. CNA observed and acknowledged the resident's nails were long, extended at least 1/2 an inch and needed to be trimmed. She said the resident was unable to shave or cut his own nails. On 6/4/24 at 4:40 p.m., in an interview the Director of Nursing (DON) said normally residents are showered and shaved twice a week. The residents' nails are trimmed on shower days if needed. She said her expectation is for the CNAs to trim the residents' nails on shower days if needed. The DON said she was not aware of Resident #44's loose dentures. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/24 at 11:50 a.m., in an interview the Regional Nurse Consultant said the facility did not have a policy for ADL, and nail care. She said it was included in the CNAs job description. On 6/5/24 at 4:14 p.m., Licensed Practical Nurse Staff U said if a resident refuses care, such as shower or hygiene, the CNA would notify her. She would try to get the resident to receive care and document if the resident refused.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25618 Based on observation, record review, and staff interview, the facility failed to ensure 2 Residents (#24, and #106) of 5 residents reviewed for attended activities of their choice, to ensure they maintained and/or improved their psychosocial well-being and independence. The findings included: 1. On 6/2/24 at 10:30 a.m., 11:16 a.m., 12:35 p.m., and 3:00 p.m., Resident #24 was observed in her room, in bed. The television or radio was not on and the resident was not observed in an in-room or an out of room facility activity program during the day. On 6/4/24 at 9:30 a.m., 11:30 a.m., 1:25 p.m., and 4:00 p.m. Resident #24 was observed in her room, in bed, without the television or radio on. The resident was not observed in an in-room or an out of room facility activity program during the day. Review of Resident #24's clinical record revealed she was admitted to the facility on [DATE] with diagnoses of anemia, end stage renal disease, heart failure, history of falling, gastroenteritis, and colitis. The Activity Admission assessment dated [DATE] stated Resident #24 preferred activities in the afternoon, to include watching television and movies, word puzzles and attending small and large group, in room activities and general facility activities programs. Resident #24's quarterly activity assessment dated [DATE] stated Resident #24 preferred one-to-one activities, watching television and movies, and pet interaction. Resident #24's activity care plan dated 1/15/24 stated Resident #24 required staff assistance with involvement in activities, preferred to stay in her room and required physical assistance to and from activities. The goal of the care plan stated the resident would participate in activities of choice; the resident would receive one-to-one activities two times a week. The staff was to encourage the resident to participate in activities of choice. The care plan noted Resident #24 would benefit from attending small and large group activities and preferred going to activities in the afternoon. Review of the Director of Activities (DOA) job description stated they were responsible for supervising and provide an activity program appropriate to meet the physical, social, cultural, spiritual, emotional, and recreational needs and interests of each resident. They were required to provide the opportunity for the resident to engage in normal pursuits, as well as promoting a successful and well-balanced leisure lifestyle. The DOA was required to plan, develop, organize, implement, evaluate and direct the activity program. She was also required to assess individual/group resident needs and develop a related meaningful morning, afternoon, evening and special program for each resident. The DOA would coordinate, direct and/or conduct all planned activities, and document in the resident's medical record as appropriate, and chart the resident's attitude, participation level, etc. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/24 at 12:00 p.m., in an interview the DOA said she had worked at the facility for almost two years. The DOA said the facility had 169 licensed beds and she was responsible for ensuring all the residents in the facility received the activity of their choice on a routine basis. The DOA said as part of her job duties she was responsible for supervising and providing an activity program appropriate to meet the physical, social, cultural, spiritual, emotional, and recreational needs and interests of each resident. She was required to provide each resident the opportunity for the resident to engage in the normal pursuits, as well as promoting a successful and well-balanced leisure lifestyle. The DOA confirmed the job duties of the DOA was required to plan, develop, organize, implement, evaluate and direct the activity program, to assess individual/group resident needs and develop related meaningful morning, afternoon, evening and special programs. The DOA would coordinate, direct and/or conduct all planned activities, and document in the resident's medical record as appropriate, and chart the resident's attitude and participation level. The DOA further said as part of her job duties she was required to document in each resident's medical record an admission and quarterly activity assessment. She said she documented on a daily basis what activity the resident attended each day to ensure each resident had attended and participated in an activity of their choice. She used the documentation/data to assist her in completion of an accurate activity daily documentation/data to create an accurate activity assessment on a quarterly assessment. The DOA said she spent the majority of her time in the memory care unit because those residents were at a higher level of care and needed a structured activity program. She said she had one part-time activity assistant who worked Mondays, Wednesdays and Fridays for about four to five hours in the afternoon. She said she tried to follow the posted activity calendar in the memory care unit and in the nursing home side. She said when she was running the activity program in the memory care unit, the activity program on the nursing home side of the facility was conducted by the residents. She said the facility did not assign a staff member to ensure the activities posted on their activity calendar were conducted as required at the time noted on their activity calendar. On 6/5/24 at 3:10 p.m., the DOA reviewed Resident #24's medical record. The DOA confirmed Resident #24 was admitted to the facility on [DATE] with diagnoses of anemia, end stage renal disease, heart failure, history of falling, gastroenteritis, and colitis. The Activity Admission assessment dated [DATE] stated Resident #24 enjoyed activities in the afternoon, watching television and movies, word puzzles and attending small and large group activities, in room activities and general facility activity programs. The quarterly activity assessment dated [DATE] stated the Resident #24 preferred one-to-one activities, watching television and movies, and pet interaction. She confirmed Resident #24's activity care plan dated 1/15/24 stated Resident #24 required staff assistance with involvement in activities, preferred to stay in her room and required physical assistance to from activities. The goal was stated that the resident would participate in activities of choice, the resident would receive one-to-one activities two times a week, and the staff was to encourage the resident to participate in activities of choice. The care plan noted Resident #24 would benefit attending small and large group activities and preferred going to activities in the afternoon. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She reviewed Resident #24's documentation/data for April 2024 and confirmed the record revealed the resident had pet therapy on April 11 and 25 at 7:15 a.m. and 7:17 a.m. On April 1, 2, 3, 8, 9, 10, 11, 12,15, 16, 17, 19, 22, 24, 25, 26, 29, and 30, Resident #24 was documented as watching television between 7:00 a. m. and 7:17 a.m. Review of the activity daily tracking for May 2024 revealed Resident #24 had pet therapy on May 2, 16 and 23 between 7:15 a.m. and 7:20 a.m. On May 1, 2, 3, 6, 7, 8, 9, 10, 15, 16, 17, 20, 21, 22, 23, 28, 29, 30, and 31, Resident #24's documentation/data revealed the documentation for the activity being completed that day for watching television was completed between 7:00 a.m. and 7:20 a.m. The DOA said the on the days she documented Resident #24 had watched television she did not observe the activity been completed that day. She stated she had assumed staff would turn on the television for Resident #24 at some time during the day. She further said there was no documentation in-room one-on-one activity visits had occurred on a weekly basis as noted in the quarterly activity assessment dated [DATE] as required. 2. On 6/2/24, at 10:36 a.m., 11:26 a.m., 12:29 p.m., and 3:10 p.m., Resident #106 was observed in her room, in bed without the television or radio on and was not observed in a facility activity program during the day. On 6/3/24 at 9:10 a.m., 11:40 a.m., 1:45 p.m., and 4:15 p.m., Resident #106 was observed in her room, in bed without the television or radio on. The resident was not observed in a facility activity program during the day. Review of Resident #106's clinical record revealed an initial admitted to the facility on [DATE] and readmission on 5/17/24 with diagnoses of anxiety, aphasia following cerebral infarction, cognitive communication deficit, displaced fracture of the right femur neck, and unsteadiness on her feet. Review of the activity daily tracking for April 2024 revealed Resident #106 had pet therapy on April 11 and 25 at 7:11 a.m. and 7:15 a.m. On April 1, 2, 3, 8, 9, 10, 11, 12, 15, 16, 17, 19, 22, 24, 25, 26, 29, and 30, Resident #106 was documented as watching television, socialization with peers, and outdoors between 7:00 a.m. and 7:27 a.m. Review of the activity daily tracking for May 2024 revealed Resident #106 had pet therapy on May 2, and 23 between 7:13 a.m. and 7:18 a.m. On May 1, 2, 3, 6, 7, 8, 9, 10, 20, 21, 22, 23, 28, 29, 30, and 31 Resident #106 was documented as watching television, being outdoors, and socialization with peers, between 7:00 a.m. and 7:18 a.m. Resident #106's activity progress note dated 2/23/24 stated the DOA met with Resident #106 regarding leisure pursuits and determined Resident #106 could not make her activity needs known. The DOA wrote Resident #106 enjoyed sitting outside on the patio and staff would encourage participation in group activities of choice in order to promote socialization and stimulation. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Activity Admission assessment dated [DATE] stated Resident #106 preferred activities in the afternoon, preferred small and large group activities, and preferred in room and general activity programs. The assessment also stated Resident #106 liked to watch television, and movies. On the readmission Activity assessment dated [DATE] the documentation stated Resident #106 liked to watch television and movies, listen to music, and pet interaction. On 6/5/24 at 3:25 p.m., in an interview the DOA confirmed Resident #106 initial admission on 2/20/24 and readmission on 5/17/24 with diagnoses of anxiety, aphasia following cerebral infarction, cognitive communication deficit, displace fracture of the right femur neck, and unsteadiness on feet. She confirmed Activity Admission Assessments dated 2/23/24 and 5/20/24 stated Resident #106 likes to watch television, and movies. On the readmission Activity assessment dated [DATE] stated Resident #106 likes to watch television and movies, listening to music and pet interaction. The DOA confirmed the documentation on the activity daily tracking form for April 2024, Resident #106 had pet therapy on April 11 and 25 at 7:11 a.m. and 7:15 a.m. On April 1, 2, 3, 8, 9, 10, 11, 12, 15, 16, 17, 19, 22, 24, 25, 26, 29, and 30 Resident #106 was documented as watching television, socialization with peers, and outdoors between 7:00 a.m. and 7:27 a.m. The DOA confirmed the documentation on the activity daily tracking form for May 2024 revealed Resident #106 had pet therapy on May 2, and 23 between 7:13 a.m. and 7:18 a.m. On May 1, 2, 3, 6, 7, 8, 9, 10, 20, 21, 22, 23, 28, 29, 30, and 31, Resident #106 was documented as watching television, being outdoors, and socializing with peers, between 7:00 a.m. and 7:18 a.m. The DOA said she did not observe and/or confirm the activities she documented as having occurred in April and May 2024 because she assumed the facility staff would have turned on Resident #106's television at some point during the day and assisted the resident to an outdoor activity and socialization with her peers. The DOA said she did not have documentation that these activities had occurred as noted on the daily activity tracking documentation/data for April and May 2024.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49527 Based on observations, record review, review of facility's policy and procedure, resident and staff interviews, the facility failed to provide timely assistance to address lost prescription glasses for 1 (Resident #94) of 2 residents reviewed for vision services. The findings included: Review of the facility's policy and procedures titled, Vision/Hearing Services with an effective date of February 2021 noted, The facility will assist residents in obtaining routine and prompt vision/hearing care. The Social Services department will work to assist and /or coordinate services, such as . Prompt referrals (i. e. glasses, etc.) 3. Identify those residents who require a prompt referral . Lost . glasses, or other assisted devices. Review of the clinical record for Resident #94 revealed an admitted [DATE]. The Admission Minimum Data Set (MDS) assessment with a target date of 11/8/23 noted Resident #94's ability to see in adequate light (with glasses or other visual appliances) was impaired. Resident #94 was able to see large print but not regular print in newspapers/books. Resident #94's cognition was moderately impaired with Brief Interview for Mental Status score of 12. The Quarterly MDS assessment with a target date of 5/8/24 noted Resident #94's ability to see in adequate light (with glasses or other visual appliances) was adequate. The resident was able to see fine detail, including regular print in newspapers/books. The undated Inventory Changes sheet noted Resident #94's personal possession included eyeglasses. The care plan initiated on 11/2/23 noted Resident #94 had impaired visual function related to glaucoma. The interventions included as of 11/2/23 to assist with cleaning or placing glasses as needed and report any damage to nurse/social service. The care plan was updated on 5/10/24 to, Assist with cleaning glasses as needed. On 6/2/24 at 11:00 a.m., Resident #94 was observed without glasses. In an interview the resident said her glasses went missing. She could not say how long the glasses have been missing but said, I haven't had my glasses for a while. They were trifolds. Resident #94 said she reported the missing glasses to the staff. Review of the Social Services progress notes showed the last entry related to the resident's vision was dated 2/2/24 and read, No issues with vision reported at this time. SSD (Social Service Director) to follow up as needed. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/24 at 9:23 a.m., in an interview Resident #94 said she liked artwork but needed her glasses to be able to read. On 6/4/24 at 10:35 a.m., Resident #94 was observed watching television. She was not wearing her prescription glasses. On 6/5/24 at 10:04 a.m., Resident #94 was observed holding a magazine. She said her glasses went missing and she could not read without them. Review of the grievance log from October 2023 to May 2024 failed to show a written grievance for Resident #94's missing glasses and steps taken to assist the resident with appointments to replace the lost glasses. On 6/5/24 review of the eye doctor's progress notes provided by the Director of Nursing showed: On 12/18/23 the eye doctor documented, Diagnosis and plan: new glasses; patient understands they will have a line. Monitor condition. On 3/18/24 the eye doctor documented, Diagnosis and Plan: monitor condition and continue current glasses. On 6/5/24 at 10:09 a.m., in an interview the Social Service Director said she was not aware Resident #94's glasses were missing. She did not arrange any appointment to assist the resident replace the missing glasses. On 6/5/24 at 1:15 p.m., in an interview the Clinical Reimbursement Director said she contacted the eye doctor to replace Resident #94's missing glasses.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49527 Based on observations, interviews, and record reviews, the facility failed to provide care and services to prevent a decline in range of motion for 1(Resident #23) of 3 sampled residents with limited range of motion. The findings included: Review of the facility's policy titled, Restorative Nursing Programs with a revision date of October 2017 showed, The facility provides Restorative Nursing Programs that involve interventions to improve or maintain the optimal physical, mental and psychological functioning. The Interdisciplinary Team (IDT), resident, and or family identify the needs of the resident, and collaboratively determine appropriate Restorative Nursing Programs to achieve the resident's goals. The programs include: Contracture Management and Prevention-This program includes the provision of active, and or passive range of motion exercises/movements to maintain or improve joint flexibility as well as strength. This program also involves splint/brace assistance to protect joint and skin integrity. Combinations to consider that may enhance the Restorative Nursing Process: Passive Range of Motion (PROM) plus splint/brace assist. PROM/AROM (Active range of motion) plus splint/brace assist. Review of the clinical record for Resident #23 revealed an admitted [DATE]. The Annual Minimum Data Set (MDS) assessment with a target date of 2/16/24, and the Quarterly MDS assessment with a target date of 5/16/24 noted Resident #23's cognition was severely impaired with a Brief Interview for Mental Status score of 03. The resident functional range of motion was impaired on both upper extremities. Resident #23 required substantial/maximal assistance of staff for upper and lower body dressing. Both assessments noted Resident #23 did not receive passive or active range of motion or assistance with brace or splint for at least 15 minutes in the last seven calendar days. Resident #23 did not receive Occupational Therapy in the seven days preceding the target date. The care plan initiated on 12/17/2020 and revised on 5/20/24 noted Resident #23 has a risk or actual limitation in range of motion to bilateral hands as evidenced by risk for contractures (permanent stiffness of joints). The goal was to improve the range of motion. The interventions included to apply an orthotic device (splint) to the resident's hands after morning care and remove for care and meals. If the resident removed the splints, staff was to encourage the resident to maintain the splint application per recommended duration and inform the resident of the benefits and negative outcomes of removing the splints. The Kardex (Provides instructions for care) noted in the Restorative section to apply hand/wrist orthotic (splint) to bilateral upper extremities in the morning after washing and drying the resident's hands and remove in the afternoon. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/2/24 at 10:33 a.m., observed Resident #23 in a wheelchair, with bilateral hand contractures. Resident #23 was not wearing splints to both hands. Two splints were observed on the nightstand. Photographic Evidence Obtained On 6/2/24 the Licensed Nurse placed an X on the Treatment Administration Record (TAR) noting the splints were not applied to the resident's hands after morning care. There was no documentation the resident refused the application of the splints. On 6/3/24 at 9:41 a.m., a Certified Nursing Assistant (CNA) was observed trimming Resident #23's nails. The CNA said she had just showered the resident and she checks her nails after her showers. On 6/3/24 at 9:55 a.m., 11:33 a.m., and 4:34 p.m., Resident #23 was observed in the dining/activity area. She was not wearing the splints to her hands as per the care plan. Review of the Treatment Administration Record for 6/3/24 showed the nurse placed her initials and a check mark indicating the splints were applied to the residents hands after morning care. On 6/4/24 at 8:58 a.m., and 9:41 a.m., Resident #23 was observed in the dining/activity area. She was not wearing the splints to her hands as per the care plan. On 6/4/24 at 4:32 p.m., in an interview Restorative CNAs Staff P and Staff A said they were not currently working with Resident #23 since she was receiving occupational therapy. On 6/4/24 at 4:51 p.m., in an interview Licensed Practical Nurse Staff N said the splints were not always applied to Resident #23's hands. She said it was the nurse's responsibility to apply the splints. She said if the splinting devices were not in place, the resident wouldn't get better and prevent further decline in range of motion. She verified on Sunday 6/2/24 she documented on the TAR the splints were not applied to the resident's hands. Review of the Occupational Therapy Progress for Resident #23 dated 6/4/24 noted a start of care date of 4/2/24. The therapist documented the resident had functional deficit on both upper extremities. The analysis of functional outcome, skilled services provided, patient/caregiver training, the short term and long term goals did not address the resident's bilateral hand contractures, or the use of splints to prevent further decline in range of motion of the resident's hands. On 6/4/24 at 5:56 p.m., in an interview the therapy Program Manager said Resident #23 was not receiving therapy and had no goals for the bilateral hand contractures. On 6/5/24 at 5:19 p.m., in an interview the Director of Nursing said she did not know when Resident #23 developed the contractures and was not able to provide notes related to the resident's bilateral hand contractures.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25618 Based on record review, and staff interviews, the facility failed to ensure they maintained communication between the nursing facility and the dialysis center related to the ongoing assessment of a dialysis resident before and after each dialysis treatment for 1 (Resident #24) of 1 resident who was receiving dialysis. The findings included: The facility's undated policy titled, Dialysis Management (Hemodialysis) stated the facility would coordinate care and services for hemodialysis residents . Complete the Dialysis Communication Tool before and after dialysis and follow up on any special instructions from the dialysis center. The Dialysis Communication Tool form instruction stated the purpose of the form was to maintain communication between the dialysis provider and the facility clinical staff. The nurse assigned to the resident scheduled for dialysis would ensure a dialysis communication tool was completed and sent with the resident to the dialysis center. Nursing would ensure sections 1, 2 and 3 were completed and the clinician would sign/date/time the bottom of the dialysis communication form and place it in the resident's permanent medical record. The Dialysis Communication Tool used by the facility noted the facility nurse was to complete section 1 before sending the resident to dialysis which included: Medication given in the six hours prior to sending the resident for dialysis treatment. The presence of bruit/thrill (audible sound and palpable vibratory sensation of the dialysis access site). Signs of infection. Bleeding after the last treatment. Time of last meal. Any change in condition or information. Isolation precautions and personal protective equipment required. Transfer wheelchair cushion to dialysis center. If elopement risk identified, escort accompanied? Section 3 was to be completed by the facility nurse upon return of the resident from the dialysis center and included: Vital signs (Temperature, pulse, respiration and blood pressure). (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Evaluation of the access site for bruit and thrill. Evaluation of the dressing to the access site. Any changes in condition of the resident. Review of the clinical record for Resident #24 revealed an admitted to the facility of 1/11/24 with diagnoses of anemia, end stage renal disease, heart failure, history of falling, gastroenteritis, and colitis. Resident #24 had physician order to attend hemodialysis every Monday, Wednesday and Friday. Review of Resident #24's Dialysis Communication Tool form binder noted the form was missing for April 3, 5, 8, 12, 22, 24, 26, 29, May 1, 6, 8, 10, 13, 15, 17, 24, 31, June 3 and 5 of 2024. Review of the Dialysis Communication Tool form in Resident #24's dialysis binder noted the completed forms dated April 1, 10, 15, 17, 19, 22, May 3, 20, 22, 27, and 29, were missing required information in Section 1 and 3 and were not signed, timed and dated as required in the dialysis communication tool form instruction procedure. On 6/5/24 at 9:45 a.m., in an interview Registered Nurse (RN) Staff G, a Registered Nurse confirmed Resident #24 was admitted to the facility on [DATE] and currently went to dialysis every Monday, Wednesday and Friday in the morning and returned to the facility prior to dinner. Staff G reviewed Resident #24's dialysis logbook and medical record and stated he was unable to find the Dialysis Communication Tool forms for April 3, 5, 8, 12, 22, 24, 26, 29, May 1, 6, 8, 10, 13, 15, 17, 24, 31, June 3 and 5 of 2024. He further said the Dialysis Communication Tool form in Resident #24's dialysis binder noted the forms dated April 1, 10, 15, 17, 19, 22, May 3, 20, 22, 27, and 29 were missing required information in Section 1 and 3 and were not signed, timed and dated as required by the nurse as required as per the dialysis communication tool form instruction procedure. He said nursing would send a dialysis resident to the dialysis center and was required to complete Section 1 prior to the resident leaving the facility and complete Section 3 when the resident returned to the facility to ensure the dialysis resident was stable upon return to the facility. Staff G said the nurse was to assess the resident's dialysis access port to ensure it was in good condition. On 6/5/24 at 3:36 p.m., Unit Manager Staff K said their facility policy stated the nurse was required to complete a Dialysis Communication Tool form Section 1 every time a dialysis resident went to the dialysis center for hemodialysis. When the dialysis resident returned to the facility, the nurse was required to review Section 2, which was filled out by the dialysis center for communication from the dialysis center to the facility, and complete Section 3 of the form, and sign, date and time the form and place the completed form in the resident's permanent medical record. Staff K reviewed Resident#24's medical record and confirmed it was missing the Dialysis Communication Tool forms for April 3, 5, 8, 12, 22, 24, 26, 29, May 1, 6, 8, 10, 13, 15, 17, 24, 31, June 3 and 5 of 2024. She further said the Dialysis Communication Tool form in Resident #24's dialysis binder noted the forms dated April 1, 10, 15, 17, 19, 22, May 3, 20, 22, 27, and 29 were missing required information in Section 1 and 3 and were not signed, timed and dated as required by the nurse as required as per the dialysis communication tool form instruction procedure. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She said the facility would start conducting education with the nursing staff to ensure they understood they were required to complete and ensure all sections of the Dialysis Communication Tool form was completed, signed, dated and timed prior to putting the form in the resident's permanent medical record.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 38570 Based on observations, record review and staff interview the facility failed to ensure the required nursing staff information was posted daily and failed to maintain the posted daily nurse staffing data for 18 months as required. The findings included: On 6/2/24, 6/3/24 and 6/4/24, during random observations, the daily nurse staffing with the required information was not posted or readily available to residents and visitors. On 6/4/24 at 12:30 p.m., in an interview the Administrator stated that the facility had not posted the required daily staffing with the required information since 2/29/24. The Administrator provided one daily nursing staff posting dated 2/29/24. He acknowledged that the Federal Staffing should be posted daily in a prominent place in the facility.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44824 Based on observation, record review, review of facility's policies and procedures, residents and staff interviews, the facility failed to provide or obtain dental services to meet the needs of 4 (Resident #25, #44, #45, #94) of 6 residents reviewed for dental services. The findings included: The facility Dental Services Policy and Procedure effective March 2023 stated, The facility will assist residents in obtaining routine care, 24-hour emergency dental care and denture replacement in the case of loss, damage, or ill-fitting dentures. This dental care may be provided in-facility or by scheduling and transporting to a dental provider. In case of an emergency the resident will be transported to a facility that provides emergency dental services. Whenever possible the facility will secure a dental contract to provide in-house dental services; If an in-house dental contract is not available, the facility will maintain a dental provider list in the community that will provide dental services to the residents; The facility will maintain a list of emergency dental care providers in the community for resident use; The facility will identify dental needs of the residents through interview, assessment, and observation; Any resident identified needing dental services will be referred to the dental provider within 3 days of the identification; The Care Plan and Kardex will be updated as needed. 1. Review of Resident #45's clinical record revealed an admitted [DATE]. The Admission MDS assessment with a target date of 12/19/17, and the Annual MDS assessment with a target date of 1/11/24 noted Resident #45 was edentulous (toothless). The Quarterly MDS assessment with a target date of 4/11/24 noted the resident's cognition was moderately impaired with a BIMS score of 9. The care plan initiated on 12/12/17 noted the resident was edentulous, required monitoring for potential oral discomfort and/or difficulty chewing. The care plan noted the resident said she has full dentures at home. Review of the Social Service progress notes revealed on 12/13/2017, the resident was offered dental services. Resident #45 accepted and a referral was faxed to the dental company for review. On 6/5/2024 at 4:00 p.m., Resident #45 was interviewed. She was pleasant and able to answer questions appropriately. Observation of the resident's mouth with her permission showed she was edentulous. Resident #45 said she has not seen a dentist or had dentures since her admission to the facility. She said she would like to have dentures but no one at the facility has ever spoken to her about dentures. On 6/5/2024 at 4:15 p.m., in an interview Registered Nurse (RN) Staff F said she has been employed at the facility for approximately four months. The nurses make all the appointments for the residents. She said she has never seen Resident #45 with dentures and has never spoken to her about her teeth. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/5/2024 at 4:20 p.m., in an interview Licensed Practical Nurse (LPN) Staff U said she does not have enough time to schedule appointments for the residents. She said when she make appointments the providers' offices will call the day before and cancel the appointment because, they don't take their insurance. She said the facility needed to have someone dedicated to making and tracking appointments for the residents. She said there was no way to track the appointments made as they were not documented anywhere. LPN Staff U said there was no way to tell which resident needed what services. On 6/5/24 at 4:45 p.m., a joint interview was conducted with the Interim Administrator, the Director of Nursing (DON), and the new Administrator. The DON said the Social Service department only arranges for in-house dentistry. The nurses make all other appointments. All appointments are documented on the Medication Administration Record. The DON said if Resident #45 saw the dentist, the dental notes should be in the hard chart. She said she could not find documentation of dental appointments in the clinical record of Resident #45. She said someone should have asked the resident if she wanted or needed to see a dentist. The new Administrator said, Having teeth makes you feel better. It probably should have been addressed before now if even for her dignity. No additional documentation related to assisting Resident #45 with appointments for evaluation for dentures was provided as requested during the survey. 25618 2. On 6/2/24 at 10:55 a.m., via observation, Resident #25 was noted to have multiple missing and broken teeth. Resident #25 said she was admitted to the facility with multiple missing, and broken teeth. She said she had told multiple nursing staff she would like to have all her teeth extracted so she could get upper and lower dentures. She said someone told her due to the type of insurance she had, she would have to see an out of facility dentist. She said no one had gotten back to her about a dentist who would take her insurance to extract her remaining teeth so she could receive upper and lower dentures. Review of the Minimum Data Set (MDS), a resident assessment and care screening tool, dated 2/15/24, coded Resident #25's Brief Interview for Mental Status (BIMS) score as 14 out of 15. with a BIMS score of 13 to 15 meaning the resident is cognitively intact and capable of daily decision making. Section L (Oral/Dental Status) stated Resident #25 had natural teeth which were not broken, cracked, uncleaned, or loose. Nursing Admission Data Collection and Baseline Care Plan form dated 2/13/24 stated the resident had natural teeth which were not broken or carious. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/4/24 at 5:58 p.m., in an interview with the Social Service Director (SSD), she said when a resident was admitted to the facility each department did a full resident assessment. She said all resident's dental status were assessed and documented in the medical record. If a resident's teeth were noted to be missing, broken, cracked and/or discolored the facility staff would arrange for a dental consult as needed and/or requested by the resident or their legal representative. She said if a resident had insurance, the social service department would arrange for the resident to be seen by the facility's dental service and any follow-up services recommended by the dental service or if the resident had Medicaid as their insurance, nursing was responsible to arrange for the dental service and any follow up service recommended by the dental service. The SSD reviewed Resident #25's medical record and confirmed the resident was admitted to the facility on [DATE]. The SSD said Resident #25 was currently not receiving dental services. On 6/4/24 at 6:30 p.m., the SSD and this surveyor conducted an interview with Resident #25. Resident #25 told the SSD she was admitted to the facility with broken, missing, and cracked teeth and she told multiple people in nursing she would like her remaining teeth pulled so she could get a full set of dentures. Resident #25 proceeded to show the SSD her missing, broken, cracked and discolored teeth. In an interview with the SSD on 6/5/24 at 6:40 p.m., the SSD confirmed Resident had missing, broken, cracked and discolored teeth. She said she would talk with nursing related to setting up a dental service visit for Resident #25 to evaluate and treat any dental concerns identified during the dental service assessment. On 6/5/24 at 11:05 a.m., in an interview with the MDS Coordinator said when a resident was admitted to the facility each department did their resident assessment. She stated the initial dental assessment was completed by nursing as part of their admission assessment. The MDS Coordinator confirmed the nursing dental assessment did not note Resident #25 had missing, broken, cracked and discolored teeth. She said after reviewing Resident #25's medical record, no dental visits had been conducted and no appointments scheduled by nursing for the dental concerns reported by Resident #25. The MDS coordinator said if a resident had Medicaid as their primary insurance, the nursing department was responsible to set up the initial dental service appointment and any follow-up appointments. On 6/5/24 at 11:35 a.m., MDS Coordinator and this surveyor conducted an interview with Resident #25. Resident #25 told the MDS Coordinator she was admitted to the facility with broken, missing, and cracked teeth and she told multiple people in nursing she would like her remaining teeth pulled so she could get a full set of dentures. Resident #25 proceeded to show the MDS Coordinator her missing, broken, cracked and discolored teeth. In an interview with the MDS Coordinator on 6/5/24 at 11:45 a.m., she confirmed Resident #25 had missing, broken, cracked and discolored teeth that had not been addressed by the facility. 49527 3. Review of the clinical record for Resident #94 revealed an admitted [DATE]. (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	06/05/2024

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

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Admission Minimum Data Set (MDS) assessment with an assessment reference date of 11/8/23 noted Resident #94 did not have any broken or missing teeth. The resident's cognition was moderately impaired with a Brief Interview for Mental Status score of 12. On 6/2/24 at 10:59 a.m., Resident #94 was observed with broken front upper teeth. Resident #94 was able to respond appropriately to interview questions. Resident #94 said she would like to know how much it would cost to have her teeth fixed. On 6/3/24 at 9:19 a.m., Resident #94's teeth were observed with her permission. The upper front teeth were broken at the gum line and the resident had missing teeth to the back. Resident #94's care plan initiated on 11/1/23 noted the resident had self-care performance deficit for activities of daily living. The interventions noted Resident #94 was independent with oral care daily and as needed, brush teeth, clean gums with toothette (disposable oral care swabs), rinse mouth with wash. Staff was to encourage the resident to observe and report broken/chip denture/teeth, bleeding, pain and mouth sores and report to the nurse. The care plan did not reflect the resident's dental status and interventions to address the resident's broken upper teeth. On 6/5/24 at 10:40 a.m., in an interview Licensed Practical Nurse (LPN) Staff K, Unit Manager, said she would notify the physician and schedule a dental visit if a resident had dental issues. They would reassess the mouth for pain with chewing and swallowing. On 6/5/24 at approximately 10:45 a.m., LPN Staff K was observed asking Resident #94 if she had any pain or chewing issues. Resident #94 said she would like her teeth fixed but was concerned about the cost. LPN Staff K said she would schedule a speech evaluation and find out from the Social Service Director about the resident seeing a dentist. On 6/5/24 at 1:15 p.m., Licensed Practical Nurse Staff M observed Resident #94's mouth and verified Resident #94's front upper teeth were broken at the gum line. When asked about the broken upper front teeth, Resident #94 said, They have been bad for a long time. In an interview Staff M reviewed the resident's clinical record and said there were no issues with the resident's teeth when she completed the Admission MDS. Staff M verified the care plan was not updated to reflect the resident's dental status. She said she was not consistent in asking each resident about their dental status and only documented if a resident complained about dental issues. 38570 (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of Resident #44's clinical record revealed an admitted [DATE]. Diagnoses included dementia, muscle weakness, depression and gastrostomy status (feeding tube surgically inserted into the stomach through the abdomen). The Significant Change in Status Minimum Data Set (MDS) assessment dated [DATE] noted Resident #44 scored 10 on the BIMS (Brief Interview for Mental Status), indicative of moderate cognitive impairment. Resident #44's range of motion was impaired on upper and lower extremities on one side. The resident required maximal assistance or was dependent on staff for care such as personal, oral hygiene. Resident #44 was six feet tall and weighed 122 pounds. The assessment noted the resident had no teeth, had a 5% weight loss in the last month or 10% or more in the last six months. On 6/2/24 at 10:40 a.m., in an interview Resident #44 said he needed assistance with showering and dressing. Resident #44 appeared very thin. His upper dentures were loose and moving around as he spoke. On 6/3/24 at 9:33 a.m., Resident #44 was observed in bed. In an interview, Resident #44 said his top dentures were, flopping up and down in his mouth. Review of Resident #44's care plan for activities of daily living initiated on 1/31/23 noted the resident wore full upper dentures and needed assistance of one staff member for personal hygiene. Staff was to observe, document and report to the physician signs and symptoms of oral, dental problems needing attention. On 6/4/24 at 8:35 a.m., in an interview the Registered Dietitian (RD) said she was not aware of Resident #44's loose dentures. She said the resident had not been eating sufficiently and had lost some weight. The RD said she had to increase the feeding the resident receives through the feeding tube to increase his calories and nutrition. The RD said the loose dentures may be causing a problem with the resident's food consumption. On 6/4/24 at 1:25 p.m., in an interview Certified Nursing Assistant Staff O said she assists Resident #44 with mouth care, including cleaning his dentures. She said Resident #44 does not talk too much, she did not notice the dentures were loose or did not fit well. Staff O said she did not know if denture adhesive was available for the residents and would have to ask the nurse. On 6/4/24 at 4:10 p.m., in an interview the Social Service Director said she was not aware of Resident #44's loose dentures and would have to research and find a dentist who accepts the resident's insurance. On 6/4/24 at 4:40 p.m., in an interview the Director of Nursing said she was not aware of Resident #44's loose dentures. On 6/5/24 at 12:19 p.m., in an interview the Speech Therapist said he evaluated Resident #44 the previous week and did not notice the resident's dentures were loose or moving around during the evaluation. On 6/5/24 at 2:40 p.m., in an interview Licensed Practical Nurse Staff M said when she completed the oral assessment for the Significant Change in Status MDS on 5/7/24 she was not aware the resident's upper dentures were loose therefore she did not code it on the assessment.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. 41905 Based on a review of the facility's policy and procedure and staff interview, the facility licensed for 169 beds failed to ensure the full-time social worker had the required qualifications. The findings included: On 6/1/124, review of the daily census showed 119 current residents. Review of the facility Policy and Procedure for Social Services effective February 2021 noted, The facility strives to ensure the Social Services staff have qualifications that are commensurate with State and Federal regulations, defined job responsibilities, applicable licensure law, regulation and applicable certification to meet the residents/patient's needs . On 6/4/24 at 9:10 a.m., the Social Service Director said she became the full-time Social Worker at the facility in March 2024 when the previous Social Worker left. She said she held a bachelor's degree in social work; however, she did not have one year of supervised social work experience in a health care setting working directly with individuals. On 6/4/24 at 6:00 p.m., in an interview the Regional Consultant said the previous social worker left in March and has not returned. She said the facility did not have a qualified regional social worker to fill-in until they hire a qualified social worker. The Regional Consultant and the Human Resources Assistant said they could not locate a signed job description on file for the current social worker.