

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105319	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/20/2026
NAME OF PROVIDER OR SUPPLIER Sun Terrace Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 105 Trinity Lakes Dr Sun City Center, FL 33573	
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 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** Based on observation, interview, and record review, the facility failed to follow the comprehensive care plan and physician-ordered toileting schedule for one (#4) out of four sampled. As a result, Resident #4 experienced overnight incontinence without timely care, and scheduled toileting was not consistently implemented or documented. Findings Include: During an observation and interview on 7/20/26 at 7:15 a.m., Resident #4 was seated in a wheelchair, well groomed and dressed in street clothing. During the interview, the resident became tearful, appeared stressed, and reported having a bad night. Resident #4 stated she was incontinent during the night and staff did not provide incontinent care until she was assisted with getting dressed for the day. Record review showed Resident #4 was admitted on [DATE] with diagnoses including left hemiplegia and hemiparesis, type 2 diabetes mellitus with chronic kidney disease, a need for assistance with personal care, and osteoarthritis of the knee. Review of the quarterly Minimum Data Set (MDS) dated [DATE] showed the following: Cognitive Patterns: Resident #4 had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. Functional Abilities: Resident #4 required substantial/maximal assistance with toilet transfer and artrial/moderate assistance with toileting hygiene. Bowel and Bladder: Resident #4 was frequently incontinent of bladder. Record review showed physician orders dated 2/25/26 directing staff to toilet the resident after each meal, upon rising, and prior to bed. Review of the care plan showed the following focus areas: Resident #4 has impaired visual function related to glaucoma and legal blindness. Resident #4 has bowel and bladder incontinence related to weakness and urinary frequency. Interventions included assessing and anticipating the resident's toileting needs and assisting the resident frequently with toileting. Review of nursing skilled evaluation notes, including a note dated 7/20/26, showed documentation indicating Resident #4 was continent of bladder. Review of Resident #4's Documentation Survey Report V2 showed the ordered toileting schedule of toileting the resident after each meal, upon rising, and prior to bed. Record review found missing documentation indicating the ordered toileting schedule was not consistently implemented or recorded: May 2026: Documentation was missing for 7 of 99 shifts. June 2026: Documentation was missing for 12 of 90 shifts. July 2026: A documentation report was requested by the survey team but was not provided by the facility. During an interview on 7/20/26 at 4:45 p.m., Staff B, Certified Nursing Assistant (CNA), stated that when toileting assistance is provided, it should be documented in the medical record. During an interview and record review on 7/20/26 at 3:28 p.m., the Director of Nursing (DON) stated that toileting documentation was missing and that missing documentation should be assumed to mean the task was not done. She stated she expects staff to complete documentation of assigned tasks each shift. Review of facility policy titled, Activities of Daily Living (ADLs), Supporting, revised March 2018 showed the following: Policy Statement: Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 105319	Facility ID: 105319 If continuation sheet Page 1 of 6

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	out activities of daily living (ADLs).Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.Policy Interpretation and Implementation:Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable.The existence of a clinical diagnosis or condition does not alone justify a decline in a resident's ability to perform ADLs .Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with:Hygiene (bathing, dressing, grooming, and oral care); .Mobility (transfer and ambulation, including walking);Elimination (toileting);Dining (meals and snacks); andCommunication (speech, language, and any functional communication systems).Care and services to prevent and/or minimize functional decline will include appropriate pain management, as well as treatment for depression and symptoms of depression A resident's ability to perform ADLs will be measured using clinical tools, including the MDS. Functional decline or improvement will be evaluated in reference to the Assessment Reference Date (ARD) and the following MDS definitions:Independent - Resident completed activity with no help or staff oversight at any time during the last 7 days.Supervision -Oversight, encouragement or cueing provided 3 or more times during the last 7 days. continues on next pageLimited Assistance - Resident highly involved in activity and received physical help in guided maneuvering of limb(s) or other non-weight bearing assistance 3 or more times during the last 7 days.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on record review, and interviews, the facility failed to ensure that effective supervision and fall prevention interventions were implemented to prevent an avoidable fall with injury for one (Resident #6) out of three residents sampled. Review of Resident #6's Resident Information Record showed she was originally admitted on [DATE] and readmitted on [DATE]. Her diagnoses included: periprosthetic fracture around an internal prosthetic left knee joint (subsequent encounter) dated 04/30/2026; unspecified fracture of the upper end of the left humerus (subsequent encounter with routine healing) dated 02/20/2026; Type 2 Diabetes Mellitus with diabetic polyneuropathy dated 02/20/2026; fracture of the left shoulder girdle (subsequent encounter with routine healing) dated 02/20/2026; need for assistance with personal care dated 02/20/2026; fall on same level (subsequent encounter) dated 02/20/2026; and mild cognitive impairment of uncertain or unknown etiology. Review of Resident #6's Baseline Care Plan dated 02/20/2026 showed Resident #6 was admitted following hospitalization for a fall resulting in fractures of the left humerus and femur. She required skilled nursing services including physical, occupational, and speech therapy related to gait training, strengthening, and cognition. Review of Resident #6's admission assessment dated [DATE] showed Resident #6 had a history of falls and demonstrated balance problems while standing, sitting, and walking. Review of Resident #6's change in condition note dated 04/27/2026 showed she was found on the bathroom floor after having a bowel movement. Resident #6 sustained a small skin tear on the left shin. Skin prep and thin sterile adhesive skin closures were applied. Resident #6 complained of right knee pain, and an x-ray was ordered. The x-ray showed an acute distal femur fracture. Resident #6 was sent to the hospital for further evaluation. Review of Resident #6's Activity of Daily Living (ADL) care plan, initiated on 02/21/2026 and revised on 03/03/2026, showed Resident #6 was assessed as having an ADL self-care performance deficit related to a fall resulting in fractures of the left femur and left humerus, limited mobility, decreased range of motion, and pain. Review of Resident #6's ADL goals, initiated on 02/21/2026 and revised on 02/27/2026, showed the goal was for her to maintain the current level of function through the review period, with a target date of 07/29/2026. Interventions initiated on 02/21/2026 directed staff to encourage Resident #6 to use the call bell to request assistance and to provide the level of assistance and supervision needed to safely complete ADLs. During an interview on 07/20/2026 at 1:00 PM, Staff D, Certified Nursing Assistant (CNA) stated she cared for Resident #6 on 04/27/2026. Staff D reported the resident had periods of confusion, required two person assistance, and was incontinent. Staff D stated she got Resident #6 dressed and out of bed and then left to assist another resident. When returning down the hall, she saw Resident #6 attempting to wheel herself to her room to use the bathroom. Staff D stated she assisted the resident to the toilet, placed her on it, and instructed her to pull the call light when finished. Staff D stated another CNA later found Resident #6 on the bathroom floor. Staff D could not recall whether the resident used the call light. Staff D, CNA said Resident #6 was not typically left alone in the bathroom. On 07/20/2026 at 2:00 PM, Staff E, Licensed Practical Nurse (LPN) stated Resident #6 was a vulnerable and a high fall risk resident. Staff E, LPN stated she conducted the follow up assessment when Resident #6 complained of leg pain in April. Staff E stated she notified the physician and obtained orders for an x-ray. The x-ray showed an acute fracture, and the resident was transferred to the hospital. Resident #6 returned back to the facility on [DATE] with non-weight bearing orders. During an interview on 07/20/2026 at 2:40 PM, the Director of Nursing (DON) stated (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she was not present when Resident #6 was originally admitted . The DON stated the facility recently discussed proper mechanical lift and toileting procedures, with the staff. The DON acknowledged Resident #6 was found sitting on the bathroom floor on 04/27/2026 with a skin tear and later complained of knee pain, after which an x`ray confirmed an acute distal knee fracture. The DON stated Resident #6 required extensive two`person assistance on 02/21/2026, limited one`person assistance on 04/22/2026, and mechanical lift use on 05/21/2026 following the fall. The DON stated the care plan was updated on 04/27/2026 after the fall to indicate Resident #6 should not be left alone in the bathroom. The DON stated the facility did not have a fall or supervision policy.		

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure ostomy care was provided and documented according to the physician's orders for one (Resident #5) out of three residents reviewed for ostomy care. This failure resulted in the inability to determine whether the resident received required ostomy care and hygiene support. Findings include: Record review showed Resident #5 was admitted in October 2021 with multiple diagnoses including partial intestinal obstruction, ileostomy status, Type 2 diabetes mellitus with chronic kidney disease, vascular dementia (moderate), muscle weakness, need for assistance with personal care, hypertensive heart and chronic kidney disease with heart failure, and obstructive sleep apnea. A review of the quarterly Minimum Data Set (MDS), dated [DATE], showed Section C Brief Interview for Mental Status (BIMS) score was 06, indicating impaired cognition. Section GG showed the resident required full assistance from staff for toileting, showering/bathing, and personal hygiene. Section H documented the resident was always incontinent of urine, and bowel continence was marked Not rated; resident has an ostomy. A review of Tasks documentation for Resident #5 from 06/21/2026 through 07/20/2026 showed 19 out of 90 expected toileting hygiene tasks were not documented as completed. Record review of the resident's orders showed: Ileostomy care every shift, every day (initiated 05/26/2026). Change ileostomy wafer and pouch using prescribed pouch type. Barrier paste, powder, and skin prep may be used as needed to ensure adhesion of wafer. Change as needed for leaking or non-adhering wafer (order dated 05/26/2026). During an interview on 07/20/2026 at 4:13 PM, Staff F, Licensed Practical Nurse (LPN), stated Certified Nursing Assistants (CNAs) are responsible for emptying a resident's ostomy, and nurses are responsible for assessing the ostomy, maintaining cleanliness, and replacing the ostomy appliance as ordered or when issues occur. Staff F stated that assessment and replacement of an ostomy should be documented in the Treatment Administration Record (TAR) or in a progress note. Staff F confirmed Resident #5, and two other residents on the unit, had ostomies. During an interview on 07/20/2026 at 5:17 PM, Staff G, CNA, stated CNAs empty ostomies and check them at least every two hours during toileting or incontinence rounds. Staff G reported they document emptying of ostomies in the Tasks section of the electronic record but do not document each time the ostomy is checked. During an interview on 07/20/2026 at 5:19 PM, the Director of Nursing (DON) stated documentation of ostomy care was completed appropriately in May; however, for June and July, no ostomy care documentation was completed in the Treatment Administration Record (TAR) for Resident #5 on any shift reviewed. The DON confirmed that without documentation of ostomy care or appliance changes, there was no way to determine whether care was completed according to the physician's orders. The DON stated she attempted to locate the documentation but was unable to produce any records by the end of the survey. A review of the May Treatment Administration Record (TAR) for Resident #5 showed order Ileostomy care every shift was documented appropriately for every shift every day with the exception of 2 shifts. A review of the TAR for the months of June and July showed no checks (meaning administered/completed) for any ileostomy care or replacements. The followed to follow their policy Ostomy Care which states: Purpose: To maintain ostomy site integrity Procedure: Assemble equipment. Explain the process and provide privacy. Wash hands. Position the resident in a comfortable position. Expose the abdominal area. Don gloves. Remove sealed bag/appliance & discard appropriately. Remove and discard gloves. Perform hand hygiene and don second gloves. Cleanse stoma and skin surrounding stoma with soap and water (use specific (continued on next page)		

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cleanse ordered). Rinse and gently pat dry. Apply bag/appliance. Remove and discard gloves. Reposition for comfort with call light in reach. Wash hands. Discard trash. Documentation: Document in the resident's electronic health record (HER).		