

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105408	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2025
NAME OF PROVIDER OR SUPPLIER Treasure Isle Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1735 N Treasure Drive North Bay Village, FL 33141	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>Based on observations, records reviewed and interviews, the facility failed to ensure privacy of confidential information on three (units three, four and five) out of five nursing stations as evidenced by an unattended unlocked computer screen with information visible and information was on top of a treatment cart. The findings included: Observation on 7/23/25 at 6:50 AM of the unit three nursing station revealed an unattended unlocked computer screen with visible resident information. (Photographic evidence). The surveyor notified Staff C, Licensed Practical Nurse (LPN) who was on the unit away from the computer at the time of observation. Staff C, LPN was asked about the facility's protocol for protecting resident information and stated: When I am away from the computer the screen should be turned off to protect residents' information. On 7/23/25 at 6:55 AM an observation on unit four nursing station revealed a document with Resident information was left on top of a treatment cart in the hallway unattended. (Photographic evidence). The surveyor notified Staff D, LPN and asked about the facility's protocol for protecting residents' information; Staff D, LPN stated: All information is to be kept private, and I don't know who left that on top of the cart. On 7/23/25 at 7:01 AM an observation on unit five nursing station revealed an unattended unlocked computer screen with visible resident formation. (Photographic evidence). The surveyor notified Staff E, LPN and asked was asked about the facility's protocol for protecting resident information and stated, I left it open because I was helping a resident. The screen should be off for privacy. Record review of a policy titled: Health Information Management: Privacy effective date: January 2013 revised dates: July 2016; August 2017; April 2018; May 2018; May 2020 indicate: It is the policy of the Facility that compliance with the Privacy Rule is maintained to assure that individual's health information is properly protected while allowing the flow of personal and health information needed to promote the highest quality of health care and to protect the public's health and well-being. The Facility will protect individually identifiable health information held or transmitted, in any form or media whether electronic, paper, or oral.</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 105408
		If continuation sheet Page 1 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105408	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2025
NAME OF PROVIDER OR SUPPLIER Treasure Isle Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1735 N Treasure Drive North Bay Village, FL 33141	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105408	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2025
NAME OF PROVIDER OR SUPPLIER Treasure Isle Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1735 N Treasure Drive North Bay Village, FL 33141	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews facility failed to protect one (Resident #1) out of three sampled residents' right to be free from abuse and neglect, as evidenced by a staff member witnessed Resident #1 being physically abused (slapped on the buttocks) during hygiene. The findings included: On 7/14/25 a federal report of allegation of abuse was received. The facility reported an incident of Staff B, Licensed Practical Nurse witnessing Staff A, Certified Nursing Assistant (CNA) slap Resident #1 on the buttocks during hygiene care. The facility suspended the alleged perpetrator, investigated and notified the required government authorities, physician and family member of Resident #1. The facility concluded that the incident was verified. On 7/23/25 at 7:30 AM Resident #1 in bed, eyes closed, no apparent distress; at 1:00 PM Resident#1 observed in a recliner in room speaking incoherently. Record review of a demographic sheet revealed Resident #1 was admitted on [DATE] with diagnosis that included: Cerebral infarction, Cognitive communication deficit and Alzheimer's disease. Record review of a Quarterly Minimum data Set reference dated 4/15/25 revealed Resident#1 had Brief Interview of Mental Status score of 00, indicating severe cognitive impairment, was dependent for all hygiene care, speech unclear, and rarely/ never understood or understands. Record review of revealed Resident #1 had a care plan for Activities of daily living Self Care Performance Deficit initiated on 6/19/23 and revised on 12/05/24 with interventions that included: Converse with resident while providing care, explain tasks to be performed including what resident will do and what staff will do, provide assistance as needed to perform ADL functions. Record review of the electronic health record revealed a nursing note dated 7/14/25 at 1:25 PM written by Staff B, Registered Nurse revealed: I saw the CNA hit [Resident #1] with open right hand very hard to the resident on the right gluteus. I made noise because I was in shock and the CNA did not expect me behind her and she turn around told me Do not talk with her finger too. she left the room. Nurse in charge was reported immediately. Responsible party reported. MD (Medical Doctor) aware. Interview on 7/23/25 at 4:37 PM. the Director of Nursing (DON) stated: On 7/14/25 around 10:00 AM, I was in the morning clinical meeting and I was notified by [Staff B, RN] that she witnessed [Staff A, CNA] slap [Resident #1]. I immediately went to the room, removed the [Staff A] CNA from the room. At that time, [Staff A, CNA] was interviewed and revealed she slapped [Resident #1] on the right buttocks because the resident would not stop crying and she had other stresses and didn't know what came over her. [Staff A, CNA] was suspended pending investigation. A skin and pain evaluation for [Resident #1] and the family was notified. We also interviewed residents and staff and completed a full house in-service on Abuse and Neglect. Our conclusion was that no other residents were harmed, and no other staff witnessed any incidents. The incident was verified. [Staff A, CNA] received a disciplinary write up due to not accepting the assignment because she said she arrived first and should be able to keep her assignment State community-based agency department police were notified. The incident was verified due to the nurses and CNA statements. I followed up with the family to let them know the process. The nurses completed a full skin check for all the residents that the CNA may have come in contact with. The CNA is currently suspended and has not returned for active duty. Record review of a Policy titled, Topic: Abuse Prevention Program Effective: 2012 Change Date(s): December 2016; May 2019; January 2020; August 2020; January 2021; March 2021; March 2022; August 2022; November 2024 POLICY: The facility has designated and implemented processes, which strive to reduce the risk of abuse, neglect, exploitation, mistreatment, and misappropriation of resident's property. These policies guide the identification, management, and reporting of suspected, or alleged, abuse, neglect, mistreatment, and exploitation. It is expected that these policies will assist the facility with reducing the risk of abuse, neglect, exploitation, and misappropriation of resident's property through education of staff and residents, as well as early identification of staff burn out, or resident behavior which may increase the likelihood of such events.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105408	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2025
NAME OF PROVIDER OR SUPPLIER Treasure Isle Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1735 N Treasure Drive North Bay Village, FL 33141	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observations, records reviewed and interviews, the facility failed to properly secure medications on two (Units 1 and 5 out of five Nursing Units as evidenced by an unattended unlocked medication cart on Unit one and medication left on top of an unattended medication cart on Unit five. There were 162 residents residing in the facility at the time of the survey The findings included: On 7/23/25 at 6:58 am An observation was made on Nursing unit 1 of an unlocked unattended medication cart on (photographic evidence). The Surveyor notified Staff F, supervisor Registered Nurse (RN) who was in the hallway away from cart. The surveyor asked Staff F, supervisor Registered Nurse (RN) about the facility's protocol for storing medication and Staff F, RN replied, The cart should be locked when I am not in front of it. On 7/23/25 at an observation was made on Nursing Unit five unattended medication cart on top of the medication cart (photographic evidence). The Surveyor notified Staff E, Licensed Practical Nurse (LPN) and asked about the facility's protocol for storing medication and Staff E, Licensed Practical Nurse (LPN) stated, Medications should be inside the medication cart but I got nervous. Record review of a policy titled Medication storage 2007 revealed Policy: Medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.</p>		