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 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Treasure Isle Care Center	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39177 Based on observation, record review and staff interview, the facility failed to ensure 3 residents (Resident # 131, Resident #27 and Resident #473) out of 33 sampled residents were treated in a dignified manner as evidenced by the facility's staff was observed standing while feeding Resident #131. Furthermore Resident # 27 and Resident #473 were not dressed in their own clothing, rather than hospital gowns, to promote dignity. The findings included. Resident #131 On 06/10/2024 at 8:50 AM, during an observation, Resident #131 was observed in bed slouched leaning to the left while Staff L, a Certified Nursing Assistant (CNA) was standing while feeding Resident # 131. There was a chair on the left side of the bed with a plastic bag containing linen and other items, there were individual storage areas in the room for each resident occupying room At 9:00 AM Staff B entered the room and assisted Staff L to pull Resident #131 up in the bed. At 9:05 AM Staff L was asked about her standing while feeding the resident, Staff L stated, I shouldn't. and quickly left the room. Staff B revealed that Staff L is not a regular on the floor and was only assisting with feeding the residents. Resident #131 was admitted to the facility on [DATE]. Clinical diagnoses include but not limited to Cerebral infarction, Type 2 Diabetes Mellitus, Dysphagia and Aphasia. Review of the Minimum Data Set (MDS) quarterly review dated 03/10/2024 Section C for Cognitive Pattern indicates a brief interview for Mental Status score (BIMS) score of 03 out of 15 this suggests severe cognitive impairment. Section GG for Functional Abilities and Goals indicate: Resident #131 is dependent on staff for all ADLs (Activities of Daily Living). Resident # 27 On 06/10/2024 at 8:45 AM Resident #27 was observed on 06/10/2024 at 8:45 AM wearing a hospital gown while eating breakfast. At 9:36 am Resident #27 was sitting in the dining area speaking with another resident and still wearing a hospital gown. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105408	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Treasure Isle Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1735 N Treasure Drive North Bay Village, FL 33141	

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/11/2024 at 8:25 AM resident #27 was observed at the doorway to his room wearing a hospital type gown. On 6/11/2024 at 8:40 AM Resident #27 was observed in the dining area wearing a hospital gown while eating breakfast. On 06/11/2024 at 8:30 AM 9:30 AM Resident #27 was observed eating breakfast in the dining area eating breakfast wearing a hospital gown. Record review revealed Resident #27's initial admission to the facility was 03/06/2008; and was re admitted on [DATE]. Clinical diagnoses include but not limited to Hemiplegia, Hemiparesis, Type 2 Diabetes Mellitus, and Hypertension Review of the Minimum Data Set (MDS) annual assessment dated [DATE] Section C for Cognitive Pattern indicates a brief interview for Mental Status score (BIMS) score of 14 out of 15 this suggests the resident's cognition is intact. Section GG for Functional Abilities and Goals indicate: For upper body dressing Resident #27 has the ability to dress and undress above the waist; including fasteners, with supervision. For Lower body dressing Resident #27 has the ability to dress and undress below the waist, including fasteners; does not include footwear, with partial/moderate assistance During an interview on 6/13/2024 at 8:15 AM, Resident #27 was asked about wearing the hospital gown to breakfast. Resident #27 stated I always go in the gown because they are always late to dress me and bring breakfast to my room, so I go out to the dining room because it is faster, Today the nurse told me wait in my room and get dressed because state is here. Further review of Resident #27's medical record revealed no documentation to indicate it was the resident's preference to wear a hospital gown. Resident #473 On 06/11/2024 at 6:30 AM Resident #473 was observed at 6:30 AM in the dining area wearing a hospital gown. Resident # 473 was admitted to the facility on [DATE] with an original admitted [DATE]. Resident # 473 clinical diagnoses include but not limited to Cerebral Infarction, Respiratory Failure, difficulty walking, Dysphagia, Cognitive communication deficit, slurred speech and Alzheimer's Disease. Review of the Minimum Data Set (MDS) quarterly review dated 03/08/2024 Section C for Cognitive Pattern indicates a brief interview for Mental Status score (BIMS) score of 5 out of 15 this suggests severe cognitive impairment. Section GG for Functional Abilities and Goals indicate: For upper and lower body dressing, putting on and taking off footwear; Resident #473 requires supervision and assistance with verbal ques steadying from assistant while performing activities. (continued on next page)

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	105408	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/2024 at 9:07 AM, Staff B was asked about the resident wearing a gown and spending most of the time in the dining area Staff B revealed; we don't have enough help, it is too much, we can hardly finish taking care of our residents. Staff A explained that if the resident is awake the night shift leaves the resident in the gown. 06/13/2024 07:05 AM, Resident #473 was observed in the dining area wearing a hospital gown. On 06/13/2024 at 07:18 AM the administrator and Assistant NHA apprised of the concerns.

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F 0576

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure residents have reasonable access to and privacy in their use of communication methods.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 31581

Based on interview and record review, the facility failed to ensure a delivered package for one resident (Resident #118) out of one resident reviewed was received by the resident in a timely manner. The delivered package contained frozen foods and they were defrosted and spoiled when delivered to the resident. This has the potential to affect 169 residents residing in the facility at the time of this survey.

The findings included:

Record review of the Mail Resident/Patient/Employee Policy and Procedure (effective dated June 2013); Policy-Mail, flowers, gifts and packages are delivered unopened daily to individual resident/patient rooms; Procedure: 5) Deliver mail, flowers, gifts and packages unopened to the resident/patient's room in a timely manner.

Review of the Safe Handling, Storage and Reheating for Food From Visitors or Outside Source Policy and Procedure (effective date March 2022); Policy Statement-Residents will be assisted in properly storing and safely consuming food items brought into the facility for residents by visitors; Procedure: 1) The facility staff will request that visitors bringing in food, and/or residents that receive food, must notify a member of the nursing or activities departments. This information is located in the resident handbook, 2) The nursing staff member will determine whether the food items are appropriate for resident's diet and is for immediate consumption or to be stored for later use; Later Consumption: When food items are intended for later consumption, the nursing staff will: 1) Ensure the food item(s) are in a sealed container, stored in the nourishment room/pantry refrigerator label with the current date and name of the resident.

Review of the Demographic Face Sheet for Resident #118 documented the resident was admitted on [DATE] with a diagnosis of gout, end stage renal disease, diabetes mellitus, chronic obstructive pulmonary disease, major depressive disorder, congestive heart failure, hypertension and dependence on renal dialysis.

Review of the Minimum Data Set (MDS) Annual Assessment for Resident #118 dated 4/17/2024 documented the resident's Mental Status (BIMS) Summary Score had a BIMS Summary Score of 13 out of 15 indicating no cognitive impairment, he was able to make his own decisions and make his needs known and required partial/moderate assistance for ADLs (Activities of Daily Living).

On 6/11/24 at 7:58 AM observation and interview with Resident #118 via Spanish translator, revealed the resident sitting in a wheelchair in Section 1 dining room, watching television. He revealed he placed a grievance about a box of food that was sent to him by his family and the staff threw away his food. He placed a grievance about it and nothing was done about it. He referred to the social worker throwing away his food.

Review of the grievance log for Resident #118 dated March 2024 documented the resident was listed on the grievance log for March 19, 2024, the concern category was listed as other and the grievance was resolved on March 19, 2024.

(continued on next page)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/24 at 10:45 AM, interview and record review with the Social Services Director. She stated, For the March 19, 20024 grievance, his family had sent him frozen foods that was delivered over the weekend. The food was delivered in a box. It sat there over the weekend, unopened. The food was spoiled by the time it was given to him. If a package is delivered, it is supposed to be delivered to the resident. We are to let the residents know they have a package at the front in a timely manner. I think the kitchen threw it away. Review of the Statement Documents documented the following: 1) Dated 3/19/24; Written by the Administrator: Writer contacted family regarding frozen foods being delivered to the facility. Family member was encouraged to pick-up the huge box of frozen food as the facility did not have a big enough freezer to place foods and 2) Dated 3/19/24; Written by the [ ] Activities Assistant: Resident had food delivery here that he cannot keep in his food and his family was aware of it. On 6/13/24 at 12:29 PM, interview with the Director of Nursing (DON). She stated, I came back from the weekend and I was told the food was delivered on the outside of the door and when located it had already gone bad. He was notified and the family was notified. On 6/13/24 at 12:31 PM, interview with the Administrator. She stated, [ ] A local delivery service, delivered the package inside the facility in the back of the building. When I saw the box, it was wet. Once I walked around the building on that weekend, I saw who it was for and I opened the box. The huge box contained frozen food and it was defrosted. On 6/13/24 at 2:26 PM, interview with the Activities Assistant. She stated, When I came into work on that weekend, the box was sitting at the front desk in the lobby. I heard that he couldn't have that type of food here.

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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** 39177 Based on observation record review and staff interviews, the facility failed to ensure one (Resident #131) out of 33 sampled resident Minimum Data Set (MDS) assessment was accurately coded as evidence by Resident #131 use of a splint device was not accurately coded on the MDS. There were nine residents in the facility that required splint devices. The findings included. Review of clinical records revealed Resident # 131 a vulnerable resident was admitted to the facility on [DATE]. Clinical diagnoses include but not limited to Osteomyelitis of the vertebrae and communication deficit. Record review of orders and the Medication Administration Records for June 2024 revealed active orders for Right hand Range of Motion and mobility. Order dated 5/25/2023, Splinting: Ensure right hand splint is applied daily as tolerated. May remove for care or skin sweep. On before breakfast time, off after lunch time. Review of Resident #131's Quarterly MDS (Minimum Data Set, dated dated dated [DATE] Section O for Special Treatments, Procedures, Programs; documented in the section for number of days each item were performed coded for item A-Passive Range Of Motion=0, Active Range Of Motion =3 and Splint Device=0. splint device. Review of Resident #131's Quarterly MDS (Minimum Data Set, dated dated dated [DATE] Section C for Cognitive Pattern indicates a score of 00 out of 15 to suggests severe cognitive impairment. Review of Resident #131's Quarterly MDS (Minimum Data Set, dated dated dated [DATE] Section GG for Functional Abilities and Goal revealed Resident #131 is dependent on staff for ADLs (Activities of Daily Living). Review of the Care Plans with focus indicate Range of motion [Resident #131] has a risk limitation in range of motion date initiated 05/26/2023, Revision 07/12/2023. Goal: will maintain range of motion: Date initiated 05/26/2023. Revision on 10/11/2023. Target date: 09/07/2024. Interventions/Task Reposition for comfort (position with pillows needed). Refer to therapy to evaluate and treat per MD (Medical Doctor) .If resident removes splint encourage resident to maintain splint application per recommended duration and inform of benefits and negative outcome of removal. Apply right and splint daily as tolerated. May remove for care or skin sweep. Before breakfast. Off after lunch. On 6/13/2024 at 9:08 AM, the Rehabilitation Director: stated: He is on OT [Occupational Therapy] since 6/11/2024 the occupational therapist did the evaluation and saw him on 6/12/2024 the plan of care will be for ROM [Range Of Motion], Therapeutic self-care such as grooming upper body dressing we try and to see if it is successful. He has splints on the right hand only.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42532 Based on observations, interview, and record review the facility failed to ensure the Preadmission Screening and Resident Review (PASRR) Level I PASRR was not completed for residents (Resident # 103, Resident # 108) and Level II PASRR was not requested for Resident # 164, out of five residents investigated. This deficiency had the potential to affect 168 residents residing in the facility at the time of the survey. The findings included: Resident # 108 During multiple observations starting on 06/11/2024-06/13/2024, Resident #108 was in the room in bed sleeping, or awake. Call light was always in reach, and distress or anxiety was noted. The resident never responded to questions asked. Record review of the clinical records for Resident # 108 revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE]. Clinical diagnoses include, but not limited to, Other intervertebral Disk Degeneration, Lumbar Region; Unspecified Dementia, Unspecified Severity with Other Behavioral Disturbance; Schizophrenia, Unspecified; Other Specified Depressive Episodes; Major Depressive Disorders, Recurrent, Unspecified. Record review of Admission Minimum Data Set (MDS) Section A Identification dated 05/10/2021 revealed the section 1500 Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? NO. Record review of PASRR Level I dated 05/21/2021 revealed no identification of serious mental diagnosis illness (schizophrenia) under 1A. Section 1B was not checked for Serious Mental Illness (SMI). Section 2,3 (A/B) and 4 (A/B) were checked No. Section II Part A & B were checked No. Section IV, V and VI were not completed. Record review of Annual MDS Section C Cognitive Patterns dated 05/08/2024 revealed the resident Brief Intervention for Mental Status (BIMS) summary score was 12 out of 15. Review of Annual MDS section I Active Diagnosis the resident's diagnosis were depression and Schizophrenia. Review of Annual MDS section N Medications revealed the resident was receiving antipsychotic and antidepressants medication. Review of Psychiatrist Consultation dated 03/25/2024 revealed the Chief complaint of the resident # 108 was Schizophrenia/Dementia. Continued with same medications. Follow-up in one month, earlier if necessary. Interview with Staff D Licensed Practical Nurse (LPN) on 06/13/24 at 09: 24 AM. She stated the resident is not agitated or anxious, not aggressive. She stated the resident prefers to be in his room. She stated the resident is legally blind, and the staff helped him for all ADLs. She stated the resident tolerates well all medications. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident # 164 During multiple observations starting on 06/11/2024-06/13/2024, Resident # 164 was in her room in bed sleeping. Call light was always in reach, and distress or anxiety was noted. Record review of the clinical records for Resident # 164 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses include, but not limited to, Major Depressive Disorder, Recurrent, Unspecified; Unspecified Psychosis Not Due to a Substance or Known Physiological Condition; Unspecified Dementia, Unspecified Severity Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety. Record review of Admission Minimum Data Set (MDS) Section A Identification dated 03/27/2024 revealed the section 1500 Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? NO. Review of Level I PASRR dated 02/29/2024 Section II-Other indications for PASRR Screen Decision-Making: 1- Is there an indication the individual has or may have had a disorder resulting in functional limitations in major life activities that would otherwise be appropriate for the individual's developmental stage? YES 3- Is there and indication that the individual has received recent treatment for mental illness with indication that the individual has experienced at least one of the following? A- Psychiatrist treatment more intensive than outpatient care (e.g. partial hospitalization s or inpatient hospitalization s) YES. Record review of Admission MDS Section C Cognitive Patterns dated 03/27/2024 revealed the resident Brief Intervention for Mental Status (BIMS) summary score was 13 out of 15. Review of Admission MDS Section I Active Diagnosis the resident's diagnosis were Depression and Psychotic Disorder. Review of Admission MDS Section N Medications revealed the resident was receiving antipsychotic and antidepressants medications. Review of Psychiatrist Consultation dated 04/19/2024 revealed the reason for follow-up: Mood changes/Activities/Medication effectiveness/Modifying treatment plan. Recommendations: Continue to monitor and make changes as indicated. Nursing staff continue to monitor for any acute change in mood and behaviors. Interview with Staff E Registered Nurse (RN) on 06/13/24 09:15 AM She stated the resident was alert and oriented but confused. She stated the resident is not aggressive, she cooperates with staff at the time of care. She stated the resident likes to wander but not seeking for an exit. She stated she tolerates the medication very well. She stated the family is very involved. Interview with Social Services Director on 06/13/24 at 10:28 AM She stated the process for PASRR is as follows: The resident was admitted from the hospital and the Level I PASRR was reviewed and redo it, because the hospital never completed it. She stated she sent it again to the State agency with the corrected resident's diagnosis. She stated for resident # 164 she couldn't review her Level I PASRR because she was hired in March when the resident was admitted , and she did not have access to the State agency website. She stated for Resident # 108 was before she was hired, and it was not reviewed. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Policy and Procedures Topic: PASRR Requirements Level I and Level II-Florida. Policy Pre-Admission Screening and Resident Review (PASRR) Preadmission screening for mental illness and intellectual disability is required to be completed prior to admission to a Nursing Home. The screening is reviewed by Admission to ensure appropriate placement in the least restrictive environment and to identify any specialized services the applicant may need. Procedure: PASRR Level I 2-Social Services or Registered Nurse will review to determine if a Serious mental Illness (SMI) and Intellectual disability (ID) or both exits while reviewing the PASRR form. The existence of either, or both, condition (s) triggers the requirement for Level II review and will be provided to the appropriate state agency by the Social Services Director upon admission. The Social Services Director /Nursing Administration will review for completion and accuracy during the clinical meeting process. PASRR Level II 3- Level II PASRR must be completed if the below are listed but not limited to: Is there an indication the resident has or may have had a disorder resulting in functional limitations in major life activities that would otherwise be appropriate for the individual developmental stage, the resident has a primary or secondary diagnosis of dementia or related Neurocognitive disorder, and a suspicion, or diagnosis of, SMI, ID or both and, are currently exhibiting interpersonal issues, an indication that the resident has received treatment for a mental illness with indication that they have experienced at least one of the following: -psychiatrist treatment more intensive than outpatient care (partial hospitalization or inpatient hospitalization). 48906 2) Record review of Level I Pre-Admission Screening and Resident Review (PASRR) for resident#103 Section I: PASRR Screen Decision Making A. MI or suspected MI (check all that apply): no diagnosis checked. Electronically signed on 8/18/2023 by Registered Nurse from a hospital. Record review of demographic sheet for Resident#103 (Resident #103) revealed an admitted [DATE] and readmitted d 3/29/2024 with diagnosis that included Generalized Anxiety Disorder and Major Depressive Disorder. Record review of Admission Minimum Data Set (MDS) dated [DATE], Section A for identification revealed resident was not currently considered by the state for level II Pre-Admission Screening and Resident Review (PASRR) process to have serious mental illness and/or intellectual disability or a related condition. Record review of Quarterly MDS dated [DATE] Section C for cognitive status revealed a Brief Interview for Mental Status (BIMS) score of 14 out of a scale of 0-15 indicated no cognitive impairment. Section I for diagnosis revealed anxiety disorder and Depression. Section N for medications revealed no antianxiety or antidepressants received. Section O for psychological therapy revealed no psychological therapy received. Record review of physician orders revealed an order dated 3/29/2024 for Lexapro Tablet (Escitalopram Oxalate) Give 15 milligrams by mouth one time a day for Depression. On 6/13/2024 at 1:45 pm an interview was conducted with the Social Services Director who stated: PASRR are updated the next day after admission. The PASSR for Resident#103 is incomplete because at the time of admission I didn't have access to the website to create a new Level I PASRR and I haven't had a chance yet. This PASRR needs to be updated to reflect current diagnosis.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39177 Based on observation record review and interviews, the facility's staff failed to implement the care plan to prevent further decline in the resident's range of motion and maintain skin integrity as evidence by failure to ensure splint devices is in place for one resident (Resident #131) out of one resident reviewed for splint devices and range of motion. There were nine residents in the facility that required splint devices, and failed to reposition Resident #131 at a minimum of two hours. The findings include. On 06/10/24 at 8:12 AM Resident #131 was observed in bed on his left side. There was a blue hand splint device on the side table and the resident had a rolled washcloth in his left hand. The resident is non-verbal. On 6/10/2024 at 10:23 AM Resident #131 was observed in bed on his left side. On 06/10/2024 at 11:07 AM Resident #131 was observed in bed on his left side with the splint device on the left hand. On/6/10/2024 at 12:15 PM Resident # 131 was observed in bed on his left side. On 06/11/2024 at 8:02 AM Resident on his left side with one rolled wash cloth in the left hand. On 6/11/2024 at 10:05 AM, Staff B a Certified Nursing Assistant was asked how frequently the resident should be repositioned, Staff H revealed the resident should be turned every two hours. Staff B also revealed the splint is for the left hand. On 6/11/2024 at 11:25 AM Resident #13 was observed in bed on his left side with rolled wash cloths in both hand On 06/12/24 at 8:15 AM Resident #131 was in bed on his back. The splint devise was on his left hand. On 06/12/24 at 10:11 AM Resident #131 was observed in bed on his back with the splint devise on the left hand. Review of the clinical records revealed Resident # 131 a vulnerable resident was admitted to the facility on [DATE]. Clinical diagnoses include but not limited to Cerebral infarction, type 2 Diabetes Mellitus, Dysphagia, Muscle wasting, Osteomyelitis of the vertebrae and communication deficit. Review of Resident # 131's [NAME] MDS (Minimum Data Set, dated dated dated [DATE] Section C for Cognitive Pattern indicates a score of 00 out of 15 to suggests severe cognitive impairment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident # 131's [NAME] MDS (Minimum Data Set, dated dated dated [DATE] Section GG for Functional Abilities and Goal revealed Resident # 131 is dependent on staff for ADLs (Activities of Daily Living). Review of Resident # 131's [NAME] MDS (Minimum Data Set, dated dated dated [DATE] Section O for Special Treatments, Procedures, Programs; documented in the section for number of days each item were performed coded for item A-Passive Range Of Motion=0, Active Range Of Motion =3 and Splint Device=0. splint device. Review of the Care Plans with focus indicate Range of motion [Resident #131] has a risk limitation in range of motion date initiated 05/26/2023, Revision 07/12/2023. Goal: will maintain range of motion: Date initiated 05/26/2023. Revision on 10/11/2023. Target date: 09/07/24. Interventions/Task Reposition for comfort (position with pillows needed). Refer to therapy to evaluate and treat per MD (Medical Doctor) .If resident removes splint encourage resident to maintain splint application per recommended duration and inform of benefits and negative outcome of removal. Apply right and splint daily as tolerated. May remove for care or skin sweep. On before breakfast and off after lunch. Record review of orders and the Medication Administration Records for June 2024 revealed active orders for Right hand Range of Motion and mobility. Order dated 5/25/2023, Splinting: Ensure right hand splint is applied daily as tolerated. May remove for care or skin sweep. On before breakfast time, off after lunch time. On 6/13/2024 at 9:08 AM, the concerns were discussed with the Rehabilitation Director: she stated: He is on OT [Occupational Therapy] since 6/11/24 the occupational therapist did the evaluation and saw him on 6/12/2024 the plan of care will be for ROM [Range Of Motion], Therapeutic self-care such as grooming upper body dressing we try and to see if it is successful. He has splints on the right hand only. During an observation on 6/13/2024 at 9:22 AM with the Rehabilitation Director in Resident #131's room, it was observed that Resident #131 was on his left side and the splint device was the resident's left hand. The rehabilitation Director confirmed the splint was on the wrong hand. She then proceeded to remove the splint device and placed it on the residents' right hand and repositioned the resident.

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 06/13/2024
NAME OF PROVIDER OR SUPPLIER: Treasure Isle Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1735 N Treasure Drive, North Bay Village, FL 33141	

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48906 Based on observations, interviews and record review the facility failed to provide the necessary interventions, consistent with professional standards of practice, to promote healing of pressure ulcers for one resident (Resident #146) out of eight sampled residents as evidenced by observations of Resident#146 in supine position for more than 2 hours. There were 27 Residents with wounds residing in the facility. The findings included: On 06/10/2024 at 10:38 AM Resident#146 was observed in supine position on an air mattress. On 06/10/2024 at 12:25 AM, Resident #146 was observed in a supine position on an air mattress. On 06/12/2024 at 8:06 AM Resident #146 was observed in supine position on an air mattress. 06/12/2024 10:02 AM, the wound care nurse entered Resident #146's room to perform wound care. Upon entering the room Resident #146 was observed in supine in bed. The wound care nurse performed the wound care as per physician's order assisted by Staff I, Certified Nursing assistant (CNA). The resident was returned to supine position in bed by Staff I, CNA. On 06/12/2024 at 11:50 AM , the wound care nurse and surveyor entered the room of Resident #146 upon request of surveyor. Resident #146 supine in bed. no pillow was observed under Resident #146 to assist with offloading his buttocks. Record review of demographic sheet for Resident#146 (R#146) revealed an admitted [DATE] and discharge date to hospital on 4/12/2024 and readmitted [DATE] with diagnosis that included: Encounter for surgical aftercare following surgery on the skin and subcutaneous tissue. Record review of Significant Change Minimum Data Set (MDS) dated [DATE] Section C for cognitive status revealed a Brief Interview for Mental Status (BIMS) score was undetermined and Section M for Skin revealed two Stage 2 pressure ulcers present upon admission, three Stage three pressure ulcers present upon admission and one Stage four pressure ulcer present upon admission. Record review of Care Plan initiated on 5/5/2024 for Actual Wounds: Location: status post sacral flap, mid abdomen, left BKA (Below Knee Amputation). Interventions included: Encourage/remind/assist to turn/reposition as needed or requested. On 06/12/2024 at 11:59 AM, The wound care nurse stated: The CNA should have repositioned [Resident#146] off his back using a pillow to offload the buttocks. On 06/12/2024 at 12:22 PM, Staff I, CNA stated: I reposition the residents every 2 hours. I was not able to reposition this resident today due not having enough pillows in the room. I will ask the unit manager for an extra pillow. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Policy effective date October 2021. Topic: Prevention Protocols Policy: Prevention Protocols assist clinicians to identify those who are at risk of skin breakdown by measuring key areas & other individualized factors that put the resident/patient at risk. Early identification will assist the facility in developing an individualized plan of care. The nurse will utilize the tools presented in the procedure below. Procedure: 2. An initial Care plan will be initiated by selecting interventions to reduce risk. These interventions will be selected on this same tool. The initial interventions will serve as the Interim plan of Care. Topic: Prevention Protocols. 3. Skin Protection a. Use a Glide sheet to reposition the resident/ patient in bed

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	105408	A. Building B. Wing	06/13/2024

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39177 Based on observations record review and interview the facility failed to provide foot care according to professional standard for one (Resident #35) out of eight residents sampled. The findings included. On 06/10/2024 at 7:10 AM Resident #35 was observed in bed, his toenails were observed long and curling over the top of his toes. On 06/11/2024 at 9:02 AM Resident #35 was observed in bed awake with no socks or shoes on; his toenails were long and curved over. Resident # 35 was asked if he had seen the podiatrist for his feet and had his toenails been trimmed since his admission into facility. Resident #35 stated: No never done here. Review of his clinical records revealed Resident #35 was admitted to the facility on [DATE]. With diagnoses that include but not limited to type two diabetes, difficulty walking and acute bilateral embolism and thrombosis of unspecified deep vein lower extremity. Review of Resident #35 Admission Minimum Data Set (MDS) dated [DATE] Section C for Cognitive Pattern documented the resident's Brief Interview of Mental Status (BIMS) score of 8 out of 15 to suggest moderate cognitive impairment. Section GG for Self-Care: indicated the resident needs assistance with ADLs (Activities of Daily Living) and nail care should be provided by the Certified Nursing Assistant (CNA) as necessary On 06/13/2024 at 09:42 AM the unit manager was asked about the Resident' nail care. She revealed that the Certified Nursing Assistants (CNAs) do the fingernails and the Podiatrist comes weekly on Fridays to cut toenails. When asked how the Podiatrist knows which resident to see, she revealed the residents' names are placed on a list for the Podiatrist. Review of the Podiatrist list for June,2024 did not show resident #35's name listed. On 06/13/2024 at 9:57 AM during observation of Resident #35's feet with the unit manager; she confirmed that the resident's toenails needed to be trimmed. The unit manager asked the resident if she could cut his nails and the resident said yes she then proceeded to cut his nails. On 6/13/2024 at 3:45 PM the Director of Nursing (DON) revealed for residents with Diabetes the Podiatrist does the cutting of the toenails on Fridays. Staff are not allowed to cut the resident's toenails especially the diabetics. The DON was apprised of the observation with the Nurse Manager of Resident #35 and the Resident's toenails being cut by the Nurse Manager. The DON reported she will speak to the staff. The requested Facility Policy for foot care was not received.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 39177 Based on observation record review and staff interviews, the facility failed to ensure a splint device was in place for one resident (Resident #131) out of one resident reviewed for splint devices and range of motion. There were nine residents in the facility that required splint devices. The findings include. On 06/10/24 at 8:12 AM Resident #131 was observed in bed on his left side. There was a blue hand splint device on the side table and the resident had a rolled washcloth in his left hand. The resident is non-verbal. On 6/10/2024 at 10:23 AM Resident #131 was observed in bed on his left no splint device in place. On 06/10/2024 at 11:07 AM Resident #131 was observed in bed on his left side with the splint device on the left hand. On 06/10/2024 at 12:15 PM Resident # 131 was observed in bed on his left side a rolled was cloth was in his left hand. On 06/11/2024 at 8:02 AM Resident on his left side with one rolled wash cloth in the left hand. On 06/11/2024 at 10:05 AM, Staff B a Certified Nursing Assistant was asked how frequently the resident should be repositioned, Staff H revealed the resident should be turned every 2 hours. Staff B also revealed the splint is for the left hand. On 6/11/2024 at 11:25 AM Resident #13 was observed in bed on his left side with a rolled wash cloths in both hand On 06/12/24 at 8:15 AM Resident #131 was in bed on his back. The splint was on his left hand. On 06/12/24 at 10:11 AM Resident #131 was observed in bed on his back with the splint on the left hand. Review of clinical records revealed Resident # 131 a vulnerable resident was admitted to the facility on [DATE]. Clinical diagnoses include but not limited to Cerebral Infarction, Type 2 Diabetes Mellitus, Dysphagia, Muscle wasting, Osteomyelitis of the vertebrae and communication deficit. Review of Resident #131's Quarterly MDS (Minimum Data Set, dated dated dated [DATE] Section C for Cognitive Pattern indicates a score of 00 out of 15 to suggests severe cognitive impairment. Review of Resident # 131's Quarterly MDS (Minimum Data Set, dated dated dated [DATE] Section GG for Functional Abilities and Goal revealed Resident # 131 is dependent on staff for ADLs (Activities of Daily Living). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident # 131's Quarterly MDS (Minimum Data Set, dated dated dated [DATE] Section O for Special Treatments, Procedures, Programs; documented in the section for number of days each item were performed coded for item A-Passive Range Of Motion=0, Active Range Of Motion =3 and Splint Device=0. Review of the Care Plans with focus indicate Range of motion [Resident #131] has a risk limitation in range of motion date initiated 05/26/2023, Revision 07/12/2023. Goal: will maintain range of motion: Date initiated 05/26/2023. Revision on 10/11/2023. Target date: 09/07/24. Interventions/Task Reposition for comfort (position with pillows needed). Refer to therapy to evaluate and treat per MD (Medical Doctor) .If resident removes splint encourage resident to maintain splint application per recommended duration and inform of benefits and negative outcome of removal. Apply right and splint daily as tolerated. May remove for care or skin sweep. On before breakfast. Off after lunch. Record review of orders and the Medication Administration Records for June 2024 revealed active orders for Right hand Range of Motion and mobility. Order dated 5/25/2023, Splinting: Ensure right hand splint is applied daily as tolerated. May remove for care or skin sweep. On before breakfast time, off after lunch time. On 6/13/2024 at 9:08 AM, the concerns were discussed with the Rehabilitation Director: she stated: He is on OT [Occupational Therapy] since 6/11/24 the occupational therapist did the evaluation and saw him on 6/12/2024 the plan of care will be for ROM [Range Of Motion], Therapeutic self-care such as grooming upper body dressing we try and to see if it is successful. He has splints to the right hand only. During an observation on 6/13/2024 at 9:22 AM with the Rehabilitation Director in Resident #131's room, it was observed that Resident #131 was on his left side and the splint device was the resident's left hand. The rehabilitation Director confirmed the splint was on the wrong hand. She reported the resident should be repositioned every two hours. She then proceeded to remove the splint device and placed it on the resident's right hand and repositioned the resident.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 39177 Based on observations, record review and interview, the facility failed to ensure safety for all residents the residents in the facility as evidence by a knife was observed in one (Resident #46) out of eight residents sampled. Staff failed to intervene in a timely manner during an argument between two residents (Resident #128 and Resident #170) that enabled Resident #170 to strike Resident #128, which led to Resident #170 being arrested by local law enforcement. The facility's incidents by incident types report from January 2023 to June 10, 2024 revealed there were six alleged abuse incidents and nine incidents of resident-to-resident altercation. There were 136 residents residing in the facility at the time of this survey. 1) During initial observation on 6/10/2024 at 9:15 AM in the room shared between Resident #115, Resident # 46, Resident # 130 and Resident #138, it was noted upon entrance that a small white pill was on the floor (photo taken). observation of Resident # 46's top drawer that was noted open showed a long knife in the drawer with a blade approximately four inches long (photo taken). Resident # 46 was not in the room but her three roommates were. The survey's Team Coordinator (TC) was immediately notified. The Director of Nursing (DON) and the Administrator (NHA) were informed of the findings by the team and an observation was made with the DON and the NHA who acknowledged the knife in the resident's drawer. The DON and NHA were informed of the seriousness of any resident possessing a knife in the facility. The DON and NHA immediately had staff check all the resident's rooms and drawers for any prohibited items. The knife was immediately removed from the room. The pill on the floor was also removed and disposed of by the DON and NHA. Record review of Resident #46s clinical records revealed an initial admission of 12/17/2010 and most recent readmitted [DATE]. Diagnoses include but not limited to Type 2 Diabetes Mellitus, Anxiety Disorder and Insomnia. Review of Resident #46's Annual Minimum Data Set (MDS) dated [DATE] section C for Cognitive Pattern documented a Brief Interview of Mental status of 13 out of 15 this suggests the Resident's cognition is intact. Section D for mood document rarely for social isolation Section E for Behaviors showed no behavioral symptoms. On 06/10/2024 at 9:45 AM the DON called an emergency Resident Council meeting. In attendance at the meeting were the Assistant NHA, DON, NHA, Resident Counsel President, Activities Director and 15 residents. The DON asked if anyone had knives in their belongings and if knives are allowed, the residents responded no. One resident commented that a knife can be used to harm another person and verbalized understanding why no knives are allowed. The Residents Counsel President (Resident #46) then revealed she has a knife in her room to cut mangoes and she knew knives are not allowed. There were residents engaging in conversation and made statements such as: Why do I need a knife when I have these (showing his fist). The DON again announced that knives and sharp objects are not allowed. The meeting was adjourned at 10:21 AM. On 06/10/2024 at 10:25 AM the Resident #46 approached the surveyor and revealed I feel bad about what I did. Resident #46 stated I will be fasting until 11:00 AM tomorrow (10/11/2024) and I am going to church the following day (10/12/2024) and you can speak with me after. (continued on next page)

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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 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Interview On 06/13/2024 at 9:04 AM, Resident #46 revealed: I took the knife from my sister's house on Sunday to peel my mangoes. I know I should not have the knife and they (DON and NHA) told me because of me they are getting a tag. I feel bad about it. I was not going to hurt anybody with it. When my son comes next week he can get it. My son said mom, you know you should not have a knife. my family is mad with me too and I feel bad. Resident # 46 then asked: Do you know where the knife is, who took it, where did they put it? Resident #46 was asked why she is asking where the knife is and who has it. Resident #46 stated: I need it for when my son comes next week, so he can get it. Resident # 46 was informed that when her son comes for it the facility's staff will speak with him and give the knife to him to take home.

Resident #46 has three roommates that reported they had no concerns and get along with each other. Resident #115 was admitted to the facility on [DATE] and is bedbound. Clinical diagnoses include Hemiplegia and Hemiparesis and Major Depressive Disorder., according to the quarterly MDS dated [DATE] in section C for cognitive Pattern indicates a Brief Interview of Mental Status (BIMS) score of 13 out of 15 this suggests the resident's cognition is intact. Resident # 138 was admitted to the facility on [DATE], Resident #138 is ambulatory and also uses a wheelchair to get around. Clinical diagnoses include unspecified Mood Affective Disorder. Review of the quarterly MDS dated [DATE] indicates a BIMS score of 15 out of 15 this suggests Resident #138 cognition is intact. Resident #130 was initially admitted to the facility on ,d+[DATE] 2023 and readmitted on [DATE], Resident #130 is ambulatory. The clinical diagnoses include but not limited to Conduct Disorder unspecified, Bipolar disorder, Major Depressive and Anxiety disorder. Review of the quarterly MDS dated [DATE] in Section C for Cognitive Pattern the resident has a BIMS score of 14 out of 15 to indicate Resident #130 cognition is intact.

On 06/12/2024 at 9:15 AM during an interview with the DON and NHA; the DON reported that the staff did a sweep and looked at all residents draws and rooms for any sharp items that are not allowed. The DON stated: I don't think she would use the knife inappropriately she is alert and oriented and has no history both past and present of harming anyone. She is a hoarder; her side of the room is cluttered. We check back and forth we check her draw, and it is now locked she was educated, and she has been given a food peeler and she is in agreement and area to keep locked. her room mates are alert, and oriented [Resident #115] is non ambulatory and has history of checking to see who is entering the room. The concierge will be checking their assigned area each day for the block assigned if residents refuse to have drawers checked based on policy if resident refuse we can call law enforcement. The NHA and DON were informed that the food peeler is a sharp object. They both revealed other option will be considered such as informing the resident to ask staff to peel her mangoes. The DON and NHA were asked if they understood that the knife found could be used by anyone to inflict harm both accidentally and intentionally. The DON stated: As far as harm goes, no harm was done. Possibility of harm, no because this resident would not cause any harm. When the resident went out on pass Sunday she took it back and based on residents' rights it is dignity and residents rights to search them when the return from pass. We are going to develop something for safety, we spoke to the sister, and she stated that the resident took the knife back to the facility to peel mangoes. During the resident Council meeting with about 15 residents and concierge we told the other residents not to take anything that can cause harm and when the sweep was done we found nothing.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The DON and NHA were asked what if another resident, staff or visitor had found or knew about the knife. The DON stated: The other residents in room would not allow any other resident to pass. The NHA and DON were reminded that the drawer was open, and the knife was visible when they checked the room with the surveyor and only one resident (Resident #115) was in the room. The DON stated no harm was done and the possibility exist for any resident or staff. The DON and NHA were asked how the facility could have prevented this situation, based on the fact that three out of four residents residing in the room is capable of using a knife; and the possibility exist because Resident # 115 was in the room, and she is not ambulatory to stop anyone from harming her; also, a staff member could have gone in the room and harm themselves while checking the drawer. The DON and NHA agreed and reported that the possibility existed for the residents, any staff member and anyone visiting the facility could have been harmed if the knife somehow got into the hands of anyone with bad intentions. The resident who had the knife may be alert and oriented, but it cannot be predicted that the resident would never do any harm with the knife but at the same time the resident could harm herself either intentionally or accidentally. When asked what the facility did and will do to prevent this incident from reoccurring? The NHA stated: The system in place would violate the resident's rights to check the residents' drawers. The resident took the knife in on Sunday night, she knew that she should not bring the knife and no sharp objects. The DON and NHA revealed the facility has a sign posted indicating NO GUNS ALLOWED and nothing indicating no knives, so moving forward the sign will be updated to include knives and sharp objects. The DON and NHA revealed the admission records had nothing indicating that no knives are allowed in personal items or in possession of any resident. Also, the facility's policy did not indicate that knives are not allowed. The NHA and DON indicated that the policy will be revised. The DON and NHA acknowledged that this is a major Safety issue. 2) Observation and interview on 06/13/2024 at 9:22 AM Resident #128 was alert and oriented with no sign of distress. Resident # 128 agreed to be interviewed. When asked about the incident on 04/17/2024, Resident #128 reported Resident #170 picked on him before, but he ignored him. It was dinner time went to sit with some women, he told me to move from the table, I did not move from the table, he punched me in the face and busted my lip. Review of Resident # 128's clinical records revealed, Resident # 128 was admitted to the facility on [DATE]; clinical diagnoses include but not limited to cerebral infarction, dysphagia, type 2 diabetes mellitus, schizophrenia, bipolar disorder, current episode manic severe with psychotic features. Review of Resident #128's Quarterly Minimum Data Set (MDS) dated [DATE] Section C for Cognitive Pattern, Brief Interview of Mental Status (BIMS) documented a score of 15 out of 15 indicating the resident is cognitively intact. Section D for Moods and Section E for Behaviors did not indicate the resident having any moods and behaviors. Review of Resident #170's clinical records documented an admitted [DATE] with an initial admitted [DATE]. Clinical diagnoses include but not limited to type 2 diabetes mellitus, Post Traumatic Stress Disorder (PTSD) and Paranoid Schizophrenia. Resident # 170 was discharged from the facility on 04/17/2024. Review of Resident #170's quarterly MDS dated [DATE] Section C for Cognitive Pattern BIMS documented a BIMS score of 15 out of 15 indicating the resident is cognitively intact. Section D for Moods and Section E for Behaviors did not indicate the resident had any moods or behaviors. Record review revealed both residents did not have any change in medications. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the Nursing Home Federal Report revealed that on 04/17/2024 at 5:55 PM Resident #128 reported an allegation of abuse to Registered Nurse (RN) Staff K, who then reported this to the Director of Nursing (DON). The DON immediately reported to the Nursing Home Administrator (NHA) at 6:30 PM. The NHA reported the incident. The incident was reported but did not reach the criteria to be accepted for further investigation. The reported documented: [Resident #128] reported that [Resident # 170] told him to move from the table and then hit him on the face after he refused to leave the dining room table where he was sitting. [Resident #128] sustained a skin tear to the upper lip. With no pain concerns. He remains at his usual behavioral baseline participating in usual activities with no distress. Further review revealed Resident #170 was arrested by law enforcement due to aggressive behavior. Case number provided. Steps were taken to ensure residents are protected and included emotional support provided confirming [Resident #128] felt safe. Skin and pain assessment completed with no concerns. The resident's Physician was notified, and orders were received for facial x-ray and neuro checks. The resident's responsible party was notified. Review of interviews of others that may have knowledge of the alleged incident documented indicated that three Certified Nursing Assistants, one Licensed Practical Nurse and one Registered Nurse and the supervisor confirmed the incident and interviews with four residents indicated one resident was sitting at the table and witnessed the incident and other resident heard loud voices. On 04/17/2024 Certified Nursing Assistant [] confirmed that while passing trays for dinner, she heard the residents arguing and immediately assisted in separating the two individuals. On 06/12/2024 at 11:20 AM the report was reviewed with the Administrator regarding the incident. Several Attempts to interview staff that witnessed the incident by phone with no success. Review of the facility's policies and procedures with most recent change date August 2022 document: the facility has 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.

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NAME OF PROVIDER OR SUPPLIER Treasure Isle Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1735 N Treasure Drive North Bay Village, FL 33141	

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42532 Based on observations, interviews and record review facility failed to provide sufficient staffing to provide services to residents. This deficient practice has potential to affect 168 residents residing in the facility at the time of the survey. The findings included: During multiple observations starting on 06/11/2024-06/13/2024, residents were observed sitting in the activity area, with urine odor and residents wearing the night gowns at the time for breakfast. It was observed resident in bed waiting to be bathed and dressed around mid-morning. During multiples observations starting on 06/11/2024 through 06/13/2024, the nursing boards were posted with enough nursing staffing for current census following regulations. Interview with Staff A Certified Nursing Assistant (CNA) on 06/13/24 at 11:40 AM She stated she has been working in the facility for [AGE] years. She stated she is not happy with the workload that she had, she had 15 residents almost every day. She stated she had 3 or 4 residents they care for themselves, but she must supervise them, the rest of the residents needed total care. She stated her workload that she had to provide care to the residents in a day was hard to finished. She stated the staff had in-services training very frequently in abuse/neglect, hand washing, to prevent falls and to prevent pressure ulcers. The protocol to call out sick is to call two or three hours ahead of the shift. Interview with Staff B Certified Nursing Assistant (CNA) on 06/13/2024 at 11:45 AM. She revealed today has 14 residents and it is too many, she can hardly finish with all residents; and only 2 residents did not need total care. The staff had in-services education often especially abuse/neglect training, infection control, resident rights, etc. The facility protocol to call out sick was two or three hours before the shift. Interview with Staff C Certified Nursing Assistant (CNA) on 06/13/2024 at 11:55 AM She stated she had 15 residents today to take care, it is too many residents. She has in-services education frequently such as abuse/neglect, hand washing, resident rights, etc. She stated that to call out sick they must call three hours ahead of time. Interview with the Staffing Coordinator on 06/13/2024 at 11:11 AM. She reported she was hired three (3) weeks ago. The schedule is based on the census. There is a master schedule to follow for CNAs and nurses. The facility has a Registered Nurse in a 24-hour schedule. The protocol for staff to call out sick is to call 2 hours ahead of the shift. The protocol is to call staff that we have in a list for staff that want to be called to work. the nurses are in charge of the CNAs assignments. The facility does not use employees from agencies, they worked with the facility employees. The staff has in-services education on a regular basis for Abuse/Neglect/Exploitation, Residents Rights, Dementia Care, Infection Control such as hand washing, etc. she stated when she prepared the schedule for weekends she added extra staff for the weekend admissions. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Nursing on 06/13/2024 at 01:26 PM. She reported the Staff Coordinator prepared the schedule based on the census. The nurses were responsible for the CNAs assignments, but she made sure the CNA had no more than 8 or 10 residents to take care of, even the regulations stated 20 residents for CNAs. She stated the facility had enough staff on every shift to take care of the residents. Record review of Policy and Procedures for Staffing Effective April 2024 revealed Policy: Each nursing center has sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable, physical, mental, and psychosocial well-being of each resident, as required by federal law and sufficient staff to meet applicable state law requirements (including minimum staffing ratios). Procedure: Establish Facility Projected Staffing Levels. 1-Monitor the census and resident special care needs daily. 3-adjust staffing throughout the day based on census and resident special care needs changes.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48906 Based on observations, record review and interviews facility failed to dispose of medication as per policy for one resident (Resident #50) and facility failed to keep an accurate reconciliation of controlled narcotics for two residents (Resident #141 and Resident #99) out of eight residents sampled as evidenced by an observation of staff member disposing of a medicated patch into the trash can in a resident's room and review of two narcotic count sheets with totals that did not match amount of pills in the corresponding bingo cards. There were 136 residents residing in the facility at the time of survey. The findings included: On 06/10/2024 at 9:00 AM a medication administration observation was conducted with Staff F, Registered Nurse (RN) in nursing section five Staff F, RN removed a previous patch from Resident 50's skin and disposed of it in the trash can in the room. Staff F, RN completed the medication pass with Resident #50 and left the room. The surveyor asked Staff F, RN if disposing of patch in the resident's trash can was within the policy and procedure and Staff F, RN replied No, and stated I should have disposed of the patch in the sharps container. Record review of demographic sheet for Resident #50 revealed a physician's order dated 2/23/2024 for Scopolamine Patch 72 Hour directions: Apply 1 patch on the skin every 72 hours for Increased Secretions and remove per schedule. Record review of the facility's Policy and Procedure Disposal of medications, Syringes, Needles Disposal of Medications dated 7/19 revealed medications not listed on Schedule II, III, IV and V (non-controlled medications) shall be destroyed by the nursing care center in the presence of a pharmacist or nurse, and other witness as per state regulations. A. For the State of Florida, the appropriate method non-controlled medication destruction is as follows: Transfer to a container for release to a pharmaceutical waste contractor, transfer medication to trash receptacle following destruction to unusable consistency. On 06/13/2024 at 11:28 AM a medication storage check was done with Staff J, Licensed Practical Nurse (LPN) on nursing unit two, medication cart two. Upon record review of a Controlled Drug Declining Inventory sheet for Resident #141 Lacosamide 200 mg revealed amount remaining 29. Observation of the bingo card for Resident #141 Lacosamide 200 mg tablet revealed 28 tablets. (see photo evidence) Continued review of a Controlled Drug Declining Inventory sheets revealed for Resident #99 Oxycodone HCL (IR) 50 mg tablet amount remaining 50 and an observation of corresponding bingo card for Resident #99 revealed 49 tablets. (see photo evidence) Record review of Electronic Medication Administration Record revealed that medications were given on 6/13/2024. Staff J, LPN stated I administered the medications but got sidetracked and forgot to sign it out in the narcotic sign out sheet. On 06/13/2024 at 11:38 AM Assistant Director of Nursing stated nurses are sign out any controlled medication immediately after taking the pill from the bingo card. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Policy and Procedure for Medication Administration Controlled Substances dated 11/17 Controlled Substances Policy: Controlled Medications are substances that have an accepted medical use (medications which fall under U.S. Drug Enforcement Agency (DEA) schedules II-V), have a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence. These medications are subject to special handling, storage, disposal, and record keeping at the nursing care center, in accordance with federal and state laws and regulations. Procedures: 4. When a controlled substance is administered the licensed nurse administering the medication immediately enters the following information on the accountability record when removing dose from controlled storage: (Note: Refer to state regulations for particulars regarding Scheduled Classes and proper storage.) a. Date of Administration b. Amount administered c. Signature f nurse administering the dose.

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F 0761

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48906

Based on observations and interviews facility failed to properly store drugs and biologics, as evidenced by an observation of unattended normal saline filled syringes in one resident's room (Resident #131) out of one resident observed for Intravenous (IV) medication administration. The facility failed to ensure expired treatment and biological supplies were discarded in one out of one medication storage room. The facility has only one medication storage room.

The findings included:

1) On [DATE] at 9:43 AM a medication administration observation was conducted with Staff H, Registered Nurse, (RN) in nursing section two on medication cart one.

On [DATE] at 9:48 AM Staff H, RN entered Resident#131's room and placed the Intravenous (IV) medication on the side table next to the resident, then entered bathroom and performed hand hygiene, leaving the IV medication on the side table out of direct vision.

On [DATE] at 9:49 AM Staff H, RN returned to resident's bedside and surveyor asked if medication can be left out of sight and staff H, RN replied: No, the medication should not have been out of my sight.

[DATE] at 09:58 AM Staff H started the IV.

On [DATE] at 10:04 AM Staff stated to surveyor: I am done with the resident and will return after medication is completed. Staff exited the room with the surveyor. Three Normal Saline filled syringes remained on the resident's side table. (see photo evidence)

On [DATE] at 10:05 AM surveyor asked Staff H, RN if it is within protocol to leave normal saline solution syringes on side table Staff H, RN replied; no I should have taken it with me. I will take it with me.

39177

2.) On [DATE] at 7:15 AM during an observation of the facility's Medication Storage room with Registered Nurse (RN) Staff K; the following expired items were observed in the medication storage room. (Photos taken)

3 specimen collection swab and transport kits that had an expiration date of [DATE],

4 packs of Covid-19 test kits with expiration dated [DATE]

2 expired bottles with saline: 1 had an expiration dated [DATE] and 1 had an expiration dated [DATE].

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1 package hypodermic needles with expiration date [DATE] 1 IV (Intravenous) start kit with expiration date of [DATE]. Review of the Facility's Medication Storage Policy Section 4.1 dated ,d+[DATE] documented: Medication and biologicals are stored properly, following manufacturers or provider pharmacy recommendations to maintain their integrity and to support safe effective drug administration. On [DATE] at 07:44 AM, Staff K and the Director of Nursing (DON) acknowledged the identified concerns. The Don revealed, all shifts are responsible for checking the med room to ensure it is in order. Further more the pharmacy comes monthly and checks the med room, carts and drug disposal.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 31581 Based on observation, interview and record review the facility failed to ensure the pantry refrigerator in Section 1 used exclusively for all resident's food contained foods that were labeled with the resident's name and dated. This has the potential to affect one-hundred and forty-five residents out of one hundred and sixty-nine residents who eat orally residing in the facility. The findings included: Record review of the Safe Handling, Storage and Reheating for Food From Visitors or Outside Source Policy and Procedure (effective date March 2022); Policy Statement-Residents will be assisted in properly storing and safely consuming food items brought into the facility for residents by visitors; Procedure: 1) The facility staff will request that visitors bringing in food, and/or residents that receive food, must notify a member of the nursing or activities departments. This information is located in the resident handbook; Later Consumption: When food items are intended for later consumption, the nursing staff will: 1) Ensure the food item(s) are in a sealed container, stored in the nourishment room/pantry refrigerator label with the current date and name of the resident. Observation of the Pantry Refrigerator in Section 1 on 6/12/24 at 9:27 AM revealed two plastic bags with food in them that were not labeled with the resident's name nor dated. One plastic bag contained a package of string cheese and the second plastic bag contained sugar cane and a protein drink. Photographic evidence submitted. Observation and interview with the Assistant Director of Nursing (ADON) on 6/12/24 at 9:28 AM. She confirmed that the bags of food belonged to two residents, were not labeled with the resident's name and were not dated. She stated, The resident's food should be labeled and dated when in the refrigerator.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 39177 Based on observations interview and record review, the facility failed to their Quality Assurance Performance Improvement policy and demonstrate effective plan of actions were implemented to correct identified quality deficiencies in the problem area related to repeated deficient practices for F550-Resident Rights/Exercise of Rights and F725 Sufficient Nursing Staff. The findings included: Review of the facility's survey history revealed, during a recertification survey with exit dated January 12, 2023 the facility was cited F550-Resident Rights/Exercise of Rights based on staff failure to ensure dignity during dining and F725 Sufficient Nursing Staff. During this survey with exit date of June 13, 2024, the facility was cited F550-Resident Rights/Exercise of Rights related to staff standing while feeding a resident (Resident #131) and observation of two residents (Resident #27 and Resident #473) wearing hospital type gowns in dining area and F725 Sufficient Nursing Staff. On 6/13/2024 at 3:02 PM Quality Assurance and Performance Improvement (QAPI) overview was conducted with the NHA, DON and Assistant NHA. It was reported that the last meeting was held on 5/21/2024. The DON reported the meetings are held monthly and all department heads attends the meetings. For concerns with dignity the DON reported education is ongoing. Anything that occurs we educate the staff. For staffing concerns the NHA and DON reported the facility does not use Agency staff. The DON revealed: On weekends we add the unit manager but from Monday to Friday a unit manager on each unit. On the weekends we only have one supervisor because during the weekend we have more nurses. The NHA, Assistant NHA and DON were informed that there are concerns with the facility's Quality Assurance and Performance Improvement based on the identified concerns.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48906 Based on observations, record review and interviews, the facility failed to follow infection control standards and transmission-based precautions to prevent the spread of infections as evidenced by observations of trash in hallways and Staff not donning appropriate Protective Equipment before entering Resident #136's room. There were 136 residents residing in the facility at the time of survey. The findings included: On 06/10/2024 at 6:41 AM, a bag of trash was observed on the floor in nursing section four in front of a residen's room. (see photo evidence) On 6/11/2024 at 9:45 AM Staff F, Registered Nurse (RN) was observed entering room without donning appropriate personal protective equipment (PPE). Staff F, RN stopped by surveyor and asked if it was according to protocol to enter without donning gloves for a resident under contact precaution and Staff F, RN replied: No, according to the sign I am supposed to don gloves before I enter the room. On 6/11/2024 at 10:00 AM Staff G, charge nurse revealed, staff should perform hand hygiene and then don all appropriate PPE before entering any room with signs for Contact Precaution. On 6/11/2024 at 12:18 PM A bag of trash was observed on floor in the hallway. (see photo evidence) Record review of demographic sheet for Resident #136 revealed an admitted [DATE] with diagnosis that included: Candidiasis. Record review of Quarterly Minimum Data Set (MDS) dated [DATE] Section C for cognitive status revealed a Brief Interview for Mental Status (BIMS) score was undetermined and section GG for Functional status revealed dependent for Activities of Daily Living (ADL). Record review of Care Plan revised on 10/05/2023 and initiated on 01/10/2023 for ADL self-care performance deficit cannot. Interventions that included: Contact Precaution. Record review of physician orders dated 12/16/2022 revealed Contact Precaution every shift for History of candida auris. On 6/13/2024 at 10:24 AM Staff G, charge nurse/ Infection Control Preventionist reported staff are required to take trash out of room in a tied plastic bag, holding it away from their body, not touching the floor and then place it in the bin located in the Soiled Utility room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Policy effective date October 2021 Topic: Infection Prevention and control Program Policy: The infection Prevention and Control Program is comprehensive program that addresses detection, prevention and control of infections and communicable diseases among residents, visitors, volunteers, those individuals providing services under contractual agreement and personnel. The Infection Prevention and Control Program, in addition, will facilitate activities to improve antibiotic use to reduce adverse events, prevent emergence of antibiotic resistance, and promote better outcomes for residents. Procedure: c. Implementation of Infection control and prevention measures. Prevention of spread of infections is accomplished by use of Standard Precautions, organism specific precautions, and other barriers, appropriate treatment and follow up, and employee work restrictions for illness.