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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105454	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Health and Rehabilitation Center	5511 Swift Road Sarasota, FL 34231

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on record review and interview, the facility failed to protect the resident's right to be free from misappropriation of property for 1 (Resident #1) of 3 residents reviewed.The findings included:Review of the facility policy titled Abuse, Neglect, Exploitation, Misappropriation, Mistreatment and Injury of Unknown Origin (ANEMMI), revision date 3/2025 revealed Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.On 2/3/26 at 10:30 a.m., the Regional Director of Operations provided incident investigations for November 2025 which included an investigation into an allegation of misappropriation of resident's property. Review of the facility provided investigations revealed that on 11/13/25, the facility initiated an investigation into an allegation of unauthorized transfer of money from Resident #1's bank account to Certified Nursing Assistant (CNA) Staff A's money transfer application. The facility's investigation included documentation from local law enforcement indicating that the bank statement from 10/6/25 to 10/31/25 showed transactions totaling $13,250.00 went from Resident #1's bank account to CNA Staff A's (brand name) money transfer application. On 2/6/26 at 10:42 a.m., in an interview the Business Office Manager (BOM) said she wrote a statement that on 11/13/25 she was doing her rounds and entered Resident #1's room. She said after asking Resident #1 a few questions, he asked why he was being charged $14,000 per month for his stay at the facility. The BOM said she explained to the resident that the Veterans Administration paid for his stay and the facility did not receive any funds from him. Resident #1 asked her to look at his bank account statements and explain the charges to him. The BOM said she noted transfers made to CNA Staff A through (brand name), a mobile application that allows users to send and receive money instantly. She said Resident #1 asked her to help him and call the police. BOM said she told Resident #1 that she would notify the Administrator and an investigation ensued.On 2/5/26 at 12:12 p.m., in an interview the Director of Nursing (DON) confirmed he wrote a statement which indicated that on 11/13/25 he interviewed Resident #1. The DON said Resident #1 gave him permission to look at his cell phone and bedside computer with his assistance. The DON said Resident #1 and himself validated that he did not have the (brand name) application used to transfer the money from his bank account linked to his phone or computer. When asked, Resident #1 said he kept his debit card in his room in his bedside dresser. Resident #1 said he did not give anyone permission to use his debit card. He said he could have given his debit card to CNA Staff A once to purchase items for him, but he could not remember for sure. Resident #1 stated that he had called his bank and cancelled the debit card. Review of Resident #1's bank statements provided by the facility from October 2025 showed multiple transfers made to CNA Staff A through (brand name) application.

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: 105454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER: Creekside Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 5511 Swift Road, Sarasota, FL 34231	

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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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). Based on observation, record review and interview, the facility failed to protect the right to be free from involuntary seclusion for 1 (Resident #2) or 4 residents reviewed.The findings included:Review of the facility policy titled Abuse, Neglect, Exploitation, Misappropriation, Mistreatment and Injury of Unknown Origin (ANEMMI), revision date 3/2025 indicated the resident has the right to be free from abuse, neglect, exploitation, misappropriation of resident property, mistreatment and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Abuse is defined at 483.5 as the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish.On 2/4/26 at 11:39 a.m., Resident #2 was observed in the secured memory care unit. Resident #2 said, They moved me back here against my will. He said they taped the door up saying do not enter and he was locked in his room for 3 days.Clinical Record review for Resident #2 revealed Power of Attorney paperwork allowing his children to make decisions about his healthcare if he could not decide for himself anymore. The clinical record lacked documentation of a physician's incapacity statement that Resident #2 was not able to make his own health care decisions. Record review also indicated Resident #2 had a BIMS score (Brief Interview for Mental Status) of 15 indicating he was cognitively intact.On 2/4/26 at 12:04 p.m., in an interview the Director of Regional Operations said for the safety of female residents Resident #2 was moved to the secured memory care unit as he had made inappropriate statements and behaviors. She said Resident #2 had confusion, but he made that decision himself. She said it was documented throughout the progress notes that the resident made the decision to move to the secured unit. The Director of Regional Operations said there was nothing signed by the resident that he agreed to move to the secured unit. She verified that Resident #2 did not have a lacks capacity statement from a physician. She said Resident #2 was concerned about people coming in his room. They had placed a stop sign across the door as an intervention so no one would enter his room.Review of a psychology progress note dated 1/22/26 revealed that Resident #2 reported making statements related to self-harm following distress about being moved to a different room within the facility. He did not articulate a specific plan or intent and stated that his comments were directly related to feeling upset about the room change. Resident #2 reported that if he were moved back to his previous room, he would not engage in self-harm statements. Social Service Administration was advised of Resident #2's behavior.On 2/5/26 at 1:04 p.m., in an interview the Social Services Director (SSD) said Resident #2 had reached out to the VA (Veterans Administration) suicide hotline and they in turn notified her. She said she notified the psychiatry provider. She said Resident #2 did not make any attempts and when interviewed he denied wanting to harm himself. On 2/5/26 at 1:10 p.m., in an interview the Regional Nuse said they had just completed an audit on 2/2/26 on what residents have as far as advanced directives, including incapacity statements. The audit didn't indicate if they need it, just if they currently have one. He said the next step would be to review whether they need one.