

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 02/20/2025
NAME OF PROVIDER OR SUPPLIER Creekside Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155</p> <p>Based on observation, record review, residents and staff interviews, the facility failed to ensure a safe, clean, comfortable and homelike environment for 9 (Rooms #238, #240, #243, Residents #75's room, #103's room, #109's room, and #81's room)of 22 residents' rooms observed, and 2 (Unit 2A and 2B) of 2 shower rooms observed.</p> <p>The findings included:</p> <p>On 2/17/25 at 9:46 a.m., during the initial tour the following observations were made:</p> <p>1. room [ROOM NUMBER]:</p> <p>A shampoo bottle, and a spray bottle were stored on the floor next to bed B.</p> <p>15 unrefrigerated yogurts and a carton of milk were stored on the air-conditioning unit and the windowsill.</p> <p>The shared bathroom had a pile of soiled towels on the floor. Unlabeled dishes and washbasins were stored on a shelf above the toilet. An unlabeled urine measuring container was stored on the toilet tank.</p> <p>Photographic evidence obtained.</p> <p>2. Resident #108's room:</p> <p>Resident #108 was observed in bed. Her urinary catheter drainage bag was on the floor.</p> <p>3. room [ROOM NUMBER] A:</p> <p>The mattress on the bed was frayed, torn and soiled covering 50% of the upper portion of the mattress.</p> <p>4. Resident #75's room:</p> <p>(continued on next page)</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
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #75 was observed in bed. The urinary catheter drainage bag was on the floor. Garbage was scattered on the floor and the trashcan was not within the residents reach.</p> <p>Photographic evidence obtained.</p> <p>There was damage to one of the walls in the room.</p> <p>A ceiling tile was missing from the shared bathroom, exposing the ceiling pipes.</p> <p>An unlabeled wash basin was stored on top of the sharp container.</p> <p>An unlabeled wash basin was stored on the toilet seat.</p> <p>Photographic evidence obtained.</p> <p>Outside of room [ROOM NUMBER] there was a fire extinguisher holder with red scattered, unknown substance on the side of the holder.</p> <p>Photographic evidence obtained.</p> <p>5. Resident #103's shared room and bathroom:</p> <p>Soiled gloves were observed on the floor, next to a pile of unbagged soiled linen.</p> <p>Uncovered and unlabeled wash basins were stored on top of the sharps container.</p> <p>Photographic evidence obtained.</p> <p>The room had a pungent smell of urine and feces.</p> <p>6. room [ROOM NUMBER]'s shared bathroom:</p> <p>An unlabeled and uncovered wash basin was stored on the toilet tank.</p> <p>7. Resident #109's room:</p> <p>Snacks foods, and bottles of lemon-aid stored were stored on the floor.</p> <p>A nebulizer (a small machine that turns liquid medication into a mist that is inhaled) was stored uncovered on the floor under the bed.</p> <p>In an interview, Resident #109 said she was using the nebulizer to treat her cough and shortness of breath. The resident said the showers on Unit 2 B and Unit 2 A were broken. There was only one shower that did not always work.</p> <p>Photographic evidence obtained.</p> <p>8. Resident #107's room:</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #107 was observed sitting in bed with books piled at end of bed. The resident's clothes were hanging from the privacy curtains, and from a broken television unit on the wall.</p> <p>A urinal 75% full of urine was on the bedside table. Two empty urinals were observed hanging inside of the trash can.</p> <p>In an interview during the observation, Resident #107 said the closet was too small and did not hold all of his clothing.</p> <p>In the shared bathroom:</p> <p>Resident #107's dentures and toothbrush were stored on the back of the toilet tank.</p> <p>The resident said he stored his items on the back of the toilet because there was no storage or shelving in the bathroom. He said he did not receive showers since the showers in the shower room on the unit were broken.</p> <p>Photographic evidence obtained.</p> <p>On 2/18/25 at 2:45 p.m., the Director of Nursing (DON) observed Resident #107's room and confirmed his clothing was hanging from the privacy curtain. She said the resident liked his things a certain way. She said the resident had too much stuff.</p> <p>The DON said the staff have been working with him to reduce the amount of items he has. The DON said the resident's clothing hanging from the wall where the television was once attached was not an issue or concern. She said the clothing hanging from the privacy curtain was not a safety issue and was ok to be there because the curtain was able to be opened and closed.</p> <p>The DON confirmed the resident's personal care items stored on the back of the toilet tank including dentures and toothbrush was not acceptable. She said they should be stored in a wash basin and placed in the nightstand. She confirmed there were three urinals in the trash can and they would have to come up with a plan for that.</p> <p>9. On 2/17/25 at 11:00 a.m., Resident #74 was observed in the television room on unit seated in his wheelchair with a towel covering his laps. The resident's shirt was dirty, he had no pants, briefs or underwear on. His sides and back visible through wheelchair gaps. In an interview, Resident #74 said he was not able to find any of his pants.</p> <p>A female resident sat at a table in the room looking at a magazine.</p> <p>10. On 2/17/25 at 11:27 a.m., Resident #81 was observed in his room. A urinal filled with approximately 25% with urine was sitting on the nightstand. There were dirty linen scattered on the floor.</p> <p>Photographic evidence obtained.</p> <p>11. On 2/17/25 at 11:42 a.m., observation of the shower room on Unit 2 A revealed a broken and missing shower head in the first stall.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Photographic evidence obtained.</p> <p>On 2/17/25 at 11:45 a.m., in an interview Licensed Practical Nurse (LPN) Staff K confirmed the showers on Unit 2 A were not functioning. Staff K said the showers had been broken for a long time.</p> <p>On 2/18/25 at 10:16 a.m., in an interview Certified Nursing Assistant (CNA) Staff O said the showers on Unit 2 A and 2 B have been broken for months.</p> <p>Observation of the shower room on Unit 2 B the 2 B revealed 2 functioning showers. The CNA said she did not know exactly how long the showers had not been working but said Maintenance knew about the problem. She said the facility had no maintenance person for several months, so things did not get repaired.</p> <p>On 2/18/25 at 2:45 p.m., in an interview the DON said she was aware the showers on Unit 2 A were not working and confirmed there were only two functioning showers on the 2nd floor.</p> <p>On 2/18/25 at 3:30 p.m., in an interview Resident #109, the Resident Council President said Today was my shower day and I was not offered a shower. Just a little longer and I will go outside and use a hose. The situation with the showers has been going on for a long time, for months. The staff get to go home, and they get to take a shower. This is our home, and we can't get a shower. They give a sponge bath and I'm sorry, but a sponge bath is not a shower. I need a shower, and the shower situation has got to be resolved. I can go into the bathroom and wash myself up, so they don't even offer me a sponge bath. No one here ever offered me a shower. I can tell you, We, as in the Resident Council and other residents who can express themselves feel like we are being ignored. This is our last stop in life for most of us and they need to treat us with respect. No one ever offers me a shower. It is not right.</p> <p>Review of the facility Maintenance Logs revealed on 12/4/24, both showers on unit 2 A are flooded and unable to use. On 1/8/25, Staff report the showers are not working on unit 2 A. On 1/8/25 a maintenance request documented, shower not working, or draining on the 2nd floor unit 2 B. The Maintenance Requests were still marked as open requests and not completed.</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155</p> <p>Based on resident and staff interviews, the facility failed to support the resident's right to voice a grievance without fear of discrimination or reprisal for 1(Resident #103) of 2 residents reviewed for grievances.</p> <p>The findings included:</p> <p>The facility policy Abuse, Neglect, Exploitation, Misappropriation, Mistreatment and Injury of Unknown Origin issued 8/2022, defined Mental abuse: the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame.</p> <p>Review of the clinical record revealed Resident #103 had a readmitted [DATE] with diagnoses including multiple sclerosis, anxiety and major depressive disorder.</p> <p>Review of the Quarterly Minimum Data Set (MDS) with a target date of 2/2/25. The MDS noted the resident's cognitive skills for daily decision making were intact with a BIMS score of 15. Resident #103 had an indwelling urinary catheter and was always incontinent of stool. Resident #103 was dependent on staff for toileting and required substantial/maximal assistance to shower/bathe self.</p> <p>On 2/17/25 at 10:00 a.m., Resident #103 was observed in her room in bed. She said she was bedbound and not able to stand. The room had a strong, pungent odor of urine and feces. Resident #103 said she had not received incontinent care since last night. The resident said, I know I smell right now; I can smell myself.</p> <p>On 2/19/25 at 9:13 a.m., in an interview Resident #103 said she valued her privacy. Two staff members from the management team came to speak with her immediately after her interview with a member of the survey team on 2/17/25 at 10:00 a.m. They wanted to know what was discussed during the interview and made her feel guilty. Resident #103 said she felt insecure about it now.</p> <p>On 2/20/24 at 11:15 a.m., in an interview the Assistant Director of Nursing (ADON) verified she did ask Resident #103 about her interview with a member of the survey team but did not file a grievance for the resident.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905</p> <p>Based on interview and record review, the facility failed to develop a care plan to meet the needs of 1 (Resident #51) of 4 residents reviewed for comprehensive care plan.</p> <p>The findings included:</p> <p>Review of the clinical record for Resident #51 revealed an admitted [DATE]. Diagnoses included Chronic Obstructive Pulmonary Disease.</p> <p>Review of the smoking evaluation dated 1/20/25 at 8:27 a.m., revealed Resident #51 was a smoker, used cigarettes and agreed to the smoking policy. Resident #51 also agreed to remove oxygen source before smoking.</p> <p>Review of the care plan failed to reveal a care plan for smoking with goals and interventions to meet the resident's needs.</p> <p>On 2/18/25 at 3:36 p.m., in an interview Resident #51 said she's been smoking for a long time. She said when her sister visits, she goes outside with her to smoke.</p> <p>On 2/18/25 at 4:06 p.m., in an interview Minimum Data Set (MDS) Licensed Practical Nurse (LPN) Staff R said there should be a smoking care plan if the resident was smoking while residing at the facility.</p> <p>On 2/20/25 at 12:11 p.m., in an interview Registered Nurse (RN) MDS Staff S said he was not sure why a care plan was not developed to address Resident #51's smoking.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51818</p> <p>Based on observation, interview, and record review, the facility failed to ensure 8 (Residents #109, #346, #196, #108, #138, #103, #9, and #65) of 9 residents dependent upon staff for care received the necessary care and assistance for activities of daily living.</p> <p>The findings included:</p> <p>1. Review of the Clinical Record Review for Resident #109 revealed an Annual Minimum Data Set (MDS) assessment with a target date of 3/14/24. The assessment noted the resident felt it was very important to choose a shower, bed bath, tub bath or sponge bath.</p> <p>The Quarterly MDS with a target date of 1/2/25 revealed Resident #109's cognitive skills for daily decision making was intact with a Brief Interview for Mental Status (BIMS) score of 15. Resident #109 required set-up or clean-up assistance with showers or bathing and supervision or touching assistance to get in and out of a tub/shower.</p> <p>On 2/17/25 at 10:00 a.m., in an interview Resident #109 stated, Staff do not offer to shower me and no, I did not receive my shower yesterday. The resident said the showers on this side were broken. The shower that is working does not have a grab bar, so she can't use it. Resident #109 said, I'll just have to keep taking a sink bath until they get the showers fixed.</p> <p>On 2/18/25 at 3:15 p.m., in an interview Resident #109 said no one offered to shower her today. The resident said she was afraid to go in the shower because there was no ramp and no grab bar. The resident said she will continue to wash up in the sink, or they can help me find a hose outside until the 2A unit showers are repaired. Resident stated the showers on Unit 2A have been an issue for several months. The issue had been discussed in Resident Council meetings. She has gone months without a shower.</p> <p>Record review of the Certified Nursing Assistant (CNA) bathing documentation failed to reveal documentation Resident #109 received a shower in January 2025 and February 2025.</p> <p>The documentation showed Resident #109 received a sponge bath on 1/2/2025 1/4/2025, 1/6/2025, 1/9/2025, 1/16/2025, 1/20/2025, 1/22/2025, 1/23/2025, 1/24/2025, 1/29/2025, 1/30/2025, 2/1/2025, 2/6/2025, 2/8/2025, 2/12/2025, 2/13/2025, 2/14/2025, 2/15/2025, 2/17/2025.</p> <p>2. Review of the clinical record for Resident #346 revealed an admitted [DATE]. Diagnoses included Traumatic Brain Injury, Seizures, Spastic Hemiplegia affecting the left side and muscle weakness.</p> <p>The Annual Minimum Data Set (MDS) assessment with a target date of 1/30/25 revealed Resident #346 had no impairment in functional range of motion in bilateral upper and lower extremities and required supervision with meals and oral hygiene. The MDS noted the residents' cognitive skills for daily decision making were moderately impaired with a Brief Interview for Mental Status (BIMS) score of 06.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Kardex (Provides instructions for safe care) for Resident #346 revealed to encourage, offer assist fluids at meals. Encourage and assist with all ADL tasks as indicated and as tolerated by resident, including meals.</p> <p>On 2/17/25 at 12:00 p.m., Dietary Aide Staff G was observed serving the noon meal to the residents in the dining room. In an interview, Dietary Aide Staff G said no one from the nursing department comes to assist the residents with dining. Staff G said someone from the kitchen or a dietary aid are in the dining room. In an emergency, he would run down the hallway to the nursing desk for assistance. He confirmed no other staff were in the dining room during the meal.</p> <p>On 2/17/25 at 12:30 p.m., Resident #346 was observed in the dining room. A family member was assisting the resident with his lunch. No staff were observed in the dining room to assist resident #346 with his meal.</p> <p>On 2/17/25 at 1:30 p.m., in an interview Resident #346's family member stated that the nursing staff were not providing ADL care or supervision during mealtime. She said, There is not enough staff. Things have changed with the new ownership. The family member said there was an increased use of agency nursing and the CNAs (Certified Nursing Assistants), They don't care the same way that the regular staff does and I feel the care has really declined here. They don't help him at mealtime and I am afraid that he could choke. I feel that he is declining.</p> <p>The family member said Resident #346 had not received a shower in five weeks. Any type of bathing the resident gets is if she provides it.</p> <p>On 2/18/25 at 9:35 a.m., CNA Staff H said Resident #346 was independent with meals and she did not feed him.</p> <p>On 2/18/25 continuous observation from 12:00 p.m., to 12:15 p.m., revealed Resident #346 in the dining area during the lunch meal. Resident #346's eyes were closed. He appeared to be sleeping. Resident #346 had no napkin or silverware. Resident #346 did not start eating until CNA Staff M held the resident's soup container and placed a glass of juice in the resident's hand and guided it towards his mouth. Resident #346 required Staff M's cueing and encouragement throughout the meal.</p> <p>On 2/18/25 at 3:10 p.m., in an interview the Director of Nursing (DON) said that the dining room on the first floor was intended for residents who are independent diners or need staff cueing.</p> <p>On 2/20/25 at 11:30 a.m., Resident #346 was observed sitting at a table in the dining area. Resident #346 was holding a fork but was not eating his meal. No staff was observed in the dining area assisting or cueing Resident #346.</p> <p>On 2/20/25 at 11:40 a.m., the Assistant Director of Nursing (ADON) arrived in the dining area. The ADON verified that there was no nursing staff in the dining room. She said the kitchen staff could go find a nurse down the hall if there was a need. She said if the facility policy states that a member of the nursing team is to be in the dining area during mealtime, then it was not ok not to have someone there. During the observation and interview, kitchen staff were observed walking through the dining room and back to the kitchen with little interaction with the residents.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the CNA documentation for January 2025 and February 2025 failed to reveal Resident #346 received assistance with meals during the 3:00 p.m., to 11:00 p.m. shift on 1/1/2025, 1/2/2025, 1/3/2025, 1/4/2025, 1/5/2025, 1/6/2025, 1/7/2025, 1/8/2025, 1/9/2025, 1/10/2025, 1/11/2025, 1/12/2025, 1/13/2025, 1/14/2025, 1/15/2025, 1/16/2025, 1/17/2025, 1/18/2025, 1/19/2025, 1/20/2025, 1/21/2025, 1/22/2025, 1/23/2025, 1/24/2025, 1/25/2025, 1/26/2025, 1/27/2025, 1/28/2025, 1/29/2025, 1/30/2025, 1/31/2025, 2/1/2025, 2/2/2025, or 2/3/2025.</p> <p>There was no documentation Resident #346 received a shower on 1/2/2025, 1/3/2025, 1/4/2025, 1/5/2025, 1/6/2025, 1/7/2025, 1/8/2025, 1/9/2025, 1/10/2025, 1/11/2025, 1/12/2025, 1/13/2025, 1/14/2025, 1/16/2025, 1/17/2025, 1/18/2025, 1/18/2025, 1/19/2025, 1/20/2025, 1/21/2025, 1/23/2025, 1/24/2025, 1/25/2025, 1/26/2025, 1/27/2025, 1/28/2025, 1/30/2025, 1/31/2025, 2/1/2025, 2/2/2025, 2/3/2025, or 2/4/2025.</p> <p>3. Review of the clinical record for Resident #108 revealed a re-entry date of 12/29/24.</p> <p>Review of the Quarterly MDS with a target date of 12/11/24 revealed Resident #108's cognitive skills for daily decision making were intact with a BIMS score of 15. The resident was dependent on staff to get in and out of a tub/shower and to showers and bathe self.</p> <p>On 2/17/25 at 9:15 a.m., in an interview Resident #108 stated the showers have been broken for at least one month and she has not been able to get a shower.</p> <p>On 2/19/25 at 9:00 a.m., in an interview Resident #108 said her shower days were Tuesdays and Thursdays on the evening shift. She said no one offered her to shower the previous evening (Tuesday 2/18/25). Resident #108 said they do not offer her showers. She has to remember her shower days and track down an aide to ask for a shower.</p> <p>Review of Resident #108's Kardex revealed the resident was independent to supervision, able to transfer in and out of shower and complete the bathing task.</p> <p>Review of the CNA Activities of Daily Living documentation report failed to show Resident #108 received a shower on 1/2/2025, 1/4/2025, 1/7/2025, 1/9/2025, 1/11/2025, 1/14/2025, 1/16/2025, 1/18/2025, 1/21/2025, 1/23/2025, 1/28/2025, 2/1/2025, 2/4/2025, 2/6/2025, 2/11/2025, 2/13/2025, 2/15/2025 and 2/18/2025.</p> <p>The resident received a sponge bath on 2/8/25.</p> <p>4. Review of the clinical record for Resident #103 revealed a Quarterly MDS with a target date of 2/2/25. The MDS noted the resident's cognitive skills for daily decision making were intact with a BIMS score of 15. Resident #103 had an indwelling urinary catheter and was always incontinent of stool. Resident #103 was dependent on staff for toileting and required substantial/maximal assistance to shower/bathe self.</p> <p>Review of Resident #103's Kardex revealed staff was to encourage and assist with all ADL as indicated and as tolerated by resident, including bathing, and toileting.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/17/25 at 9:15 a.m., Resident #103 was observed in bed. The room had a strong urine odor. The resident's hair was uncombed and greasy. In an interview during the observation, Resident #103 said no one changed her incontinent briefs since the previous night.</p> <p>Resident #103 stated, I can tell that I smell. I did not get changed last night.</p> <p>The CNA ADL documentation for January 2025 and February 2025 lacked documentation of bathing on 1/2/2025, 1/4/2025, 1/7/2025, 1/9/2025, 1/14/2025, 1/16/2025, 1/18/2025, 1/28/2025, 1/30/2025, 2/4/2025, 2/6/2025, 2/8/2025, and 2/11/2025.</p> <p>There was no documentation Resident #108 received personal hygiene care on 1/4/2025, 1/6/2025, 1/7/2025, 1/9/2025, 1/10/2025, 1/16/2025, 1/17/2025, 1/21/2025, 2/4/2025, and 2/8/2025.</p> <p>30599</p> <p>5. Review of the clinical record for Resident #9 revealed an admitted [DATE]. Diagnoses included Osteomyelitis, Major Depressive Disorder, Arthritis and Anxiety Disorder.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment with a target date of 12/9/24 revealed the resident's cognitive skills for daily decision making were intact with a BIMS score of 14. Resident #9 was dependent on staff for showering and did not reject care.</p> <p>Review of the care plan for activities of daily living initiated on 3/10/24 and revised on 9/13/24 revealed Resident #9 was dependent on staff for bathing needs, including transfer in and out of the shower.</p> <p>On 2/20/25 at 10:45 a.m., in an interview Resident #9 said she does not get a shower when she wants one. She said she would like to shower twice a week but it has been a while since she's had a shower.</p> <p>Review of Resident #9's Kardex showed no scheduled days for showers.</p> <p>On 2/20/25 at 12:30 p.m., in an interview the Director of Nursing (DON) said the Kardex is used to communicate the residents' needs to the CNAs and the shower schedule should be listed on the Kardex.</p> <p>A Shower Schedule list observed hanging behind the B Nursing Station showed Resident #9's showers were scheduled on Tuesdays and Fridays.</p> <p>On 2/20/25 at 1:15 p.m., in an interview Resident #9 said she did not know when she was scheduled to have a shower.</p> <p>Review of the electronic Shower/bathing Task schedule for January 2025 and February 2025 showed documentation of bathing or showers five times in the past 30 days. The most recent documentation of bathing was on 2/15/25.</p> <p>6. Review of the clinical record for Resident #65 revealed an admitted [DATE]. Diagnoses included Diabetes, Epilepsy, Psychotic Disorder, Traumatic Brain Injury, and Depressive Disorder.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Quarterly MDS with a target date of 12/30/24 revealed Resident #65's cognition for daily decision making was severely impaired with a BIMS score of 7. Resident #65 was dependent on staff for bathing and did not reject care.</p> <p>Review of the resident's care plan revised on 7/17/24 revealed Resident #65 had self-care deficit for activities of daily living and was dependent on staff to transfer him in and out of the shower. The care plan did not include a shower schedule.</p> <p>On 2/19/25 at 3:49 p.m., Resident #65 was observed in the dining room on the [NAME] unit watching television. The resident's hair was uncombed and greasy.</p> <p>Review of the shower schedule list hanging behind the nursing station on the [NAME] Unit showed Resident #65 was scheduled for showers on Tuesdays and Fridays.</p> <p>Review of the electronic Shower/Bathing checklist for January 2025 and February 2025 showed Resident #65 received a shower/bath three times in the last 30 days, on 2/7/25, 2/14/25 and 2/18/25.</p> <p>On 2/20/25 at 12:15 p.m., in an interview the Assistant Director of Nursing verified there was no documentation Resident #65 received his scheduled showers twice weekly.</p> <p>7. Review of the clinical record for Resident #138 revealed an admitted [DATE]. Diagnoses included Hemiplegia (paralysis of one side of the body), Malnutrition, Cerebral Infarction, and Seizures.</p> <p>Review of the Quarterly MDS with a target date of 2/1/25 showed Resident #138's cognitive ability for daily decision making were moderately impaired with a BIMS score of 08. Resident #138 was dependent on staff for showering and did not refuse care.</p> <p>Review of the care plan for Activities of Daily Living initiated on 11/30/24 revealed the resident was dependent on staff for bathing needs, including to transfer in and out of the shower.</p> <p>Review of the electronic Kardex revealed no documentation of a shower schedule for Resident #138.</p> <p>Review of the unit's shower book revealed shower days were listed for each room. Resident #138's room was not included on the list.</p> <p>Review of the electronic Shower/Bathing checklist from 1/20/25 through 2/18/25 revealed Resident #138 received a bath/shower twice in the last 30 days, on 1/21/25 and 2/17/25.</p> <p>On 2/18/25 at 9:43 a.m., Resident #138 was observed in his room, in bed. The resident had a full beard. In an interview, Resident #138 was asked if he liked having a beard. The resident shook his head and said, No.</p> <p>On 2/19/25 at 12:30 p.m., in an interview Registered Nurse (RN) Staff D verified Resident #138 was not included in the book with the shower schedule. Staff D said he did not know why the resident was not included in the shower schedule.</p> <p>On 2/19/25 at 12:46 p.m., in an interview CNA Staff C said she did not know Resident #138's shower schedule.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/19/25 12:45 p.m., in an interview the ADON said Resident #138 had not been listed on the shower schedule since 3/8/24. She said she could only find documentation the resident received a shower twice in the last 30 days, on 1/21/25 and 2/17/25.</p> <p>8. Review of the clinical record revealed Resident #196 had an admitted [DATE] and resided in the memory care unit. Diagnoses included Hemiplegia (Weakness on one side of the body), Traumatic Brain Injury and Obesity.</p> <p>Review of the Admission MDS with a target date of 2/8/25 revealed the resident's cognition was severely impaired with a BIMS score of 04. Resident #196 did not reject care. Resident #196 required substantial/maximum assistance to shower/ bathe self, and supervision for eating.</p> <p>On 2/18/25 at 11:14 a.m., Resident #196 was observed in bed, sleeping. The resident's hair was uncombed and greasy. The lunch tray in front of the resident was untouched.</p> <p>On 2/19/24 at 1:43 p.m., Resident #196 was observed bed sleeping. The resident's hair remained greasy.</p> <p>On 2/19/25 at 1:45 p.m., in an interview Licensed Practical Nurse (LPN) Staff N said Resident #196's showers were scheduled for the night shift (11:00 p.m., to 7:00 a.m.).</p> <p>Review of the electronic Shower/Bathing checklist revealed since admission of 2/5/25, Resident #196 received one shower on 2/18/25.</p> <p>On 2/20/25 at 12:15 p.m., in an interview the Assistant Director of Nursing verified there was no documentation Resident #196 received his scheduled showers twice a week as scheduled.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905</p> <p>Based on observation, record review and interviews, the facility failed to ensure 2 (Residents #6 and #123) of 3 sampled residents received care in accordance with the established plan of care.</p> <p>The findings included:</p> <p>1. Review of Resident #6's clinical record revealed an admitted [DATE]. Diagnoses included chronic diastolic congestive heart failure, a condition in which the heart doesn't pump blood as well as it should.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment with a target date of 1/7/25 revealed Resident #6's cognition was intact with a Brief Interview for Mental Status score of 15.</p> <p>Review of the Treatment Administration Record (TAR) for February 2025 revealed a physician's order dated 1/30/25 for TED hose (compression stockings) on during the day and off at night to Bilateral Lower Extremities (BLE), every day and evening for BLE edema (swelling caused by excess fluid buildup in tissues) and orthostatic hypotension (sudden drop in blood pressure upon standing up).</p> <p>On 2/17/25 at 3:55 p.m., Resident #6 was observed sitting in a wheelchair. Observation of the resident's lower legs revealed she was wearing tennis shoes and socks rolled down to the ankle. The resident's lower legs were clearly visible. She was not wearing the compression stockings.</p> <p>On 2/18/25 at 11:00 a.m., Resident #6 was observed in the therapy gym. The resident's lower legs were clearly visible. She was not wearing the compression stockings.</p> <p>On 2/18/25 at 4:39 p.m., Resident #6 was observed sitting in a wheelchair. The resident's lower legs were visible. She was not wearing the compression stockings. In an interview, Resident #6 said she did not own a pair of compression stockings. She said the staff have not given her compression stockings and have never applied compression stockings to her legs. Resident #6 said, I wonder if I am being charged for them.</p> <p>On 2/18/25, review of the TAR for February 2025 revealed on 2/1/25 through 2/18/25, each day the nurses placed their initials on the TAR verifying Resident #6 had the compression stockings on during the day and the stockings were removed in the evening. On 2/6/25, the TAR showed the compression stockings were applied in the morning but lacked documentation the stockings were removed in the evening.</p> <p>On 2/18/25 at 4:45 p.m., in an interview Registered Nurse (RN) Staff P verified she documented the compression stockings were applied on 2/18/25 without verifying Resident #6 had them on.</p> <p>On 2/18/25 at 4:52 p.m., the DON was observed in Resident #6's room. In an interview she said she could not find compression stockings or any wraps in Resident #6's room. Resident #6 said she's never worn compression stockings since her admission to the facility, no one had offered or asked her to apply compression stockings. The DON said she would expect the nurses to verify the compression stockings were applied before documenting on the TAR.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/19/25 at 9:57 a.m., in an interview RN Staff D verified he signed on the TAR the compression stockings were applied on 2/1/25, 2/2/25, 2/3/25, 2/5/25, 2/6/25, 2/7/25, 2/10/25, 2/11/25, 2/12/25, 2/13/25, 2/15/25, 2/16/25 and 2/17/25. He said Resident #6 began refusing the compression stockings but he kept documenting on the TAR they were applied to the resident's legs. He said he never verified the resident was wearing the compression stockings when he signed the TAR.</p> <p>2. Review of the clinical record for Resident #123 revealed an admitted [DATE]. Diagnoses included fracture of the lower end of the right femur (thigh bone).</p> <p>Review of the Admission MDS with a target date of 12/21/24 revealed the resident's cognition was intact with a BIMS score of 14.</p> <p>Review of the MAR for February 2025 revealed an order dated 2/5/25 for a compression sock to the right leg, on in am (morning) and off at HS (hour of sleep/bedtime).</p> <p>On 2/17/25 at 10:30 a.m., Resident #123 was observed in her room sitting in a wheelchair. The resident's lower legs were clearly visible. She was not wearing a compression sock to the right leg.</p> <p>On 2/18/25 at 5:13 p.m., Resident #123 was observed sitting in a wheelchair in her room. Her lower legs were clearly visible. She was not wearing a compression sock to the right lower extremity as ordered. The DON was present during the observation and verified Resident #123 was not wearing the compression sock to the right lower leg. In an interview during the observation, Resident #123 said the compression sock was in her drawer but no one has asked her to wear the compression sock or applied it for her.</p> <p>On 2/18/25 at 5:15 p.m., the DON found a package of compression stocking in the drawer of the resident's bedside table.</p> <p>Review of the MAR for February 2025 revealed each day on 2/6/25 through 2/11/25 and 2/13/25 through 2/18/25 the licensed nurses signed the MAR verifying the compression sock was applied to the resident's right leg and removed in the evening.</p> <p>On 2/18/25 at 5:20 p.m., in an interview, Licensed Practical Nurse (LPN) Staff J verified she signed on the MAR the compression sock was applied to the resident's right leg on 2/6/25, 2/8/25, 2/9/25, 2/10/25, 2/11/25, 2/13/25, 2/14/25, and 2/18/25. LPN Staff J said she never applied the compression sock to Resident #123's right leg and did not verify the compression sock was applied before signing the TAR.</p>		

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<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>51818</p> <p>Based on observation, clinical record review, review of facility Standards and Guidelines, resident and staff interviews, the facility failed to ensure proper storage of medication for 2 (Residents #107 and #81) of 2 residents observed with unsecured over the counter medications at bedside and 1 (Unit 1A) of 3 units observed with medication left unsecured and unattended.</p> <p>The findings included:</p> <p>The facility Standards and Guidelines: Medication Storage and Labeling documented, The facility stores all drugs and biologicals in a safe, secure and orderly manner . Drugs used in the facility are stored in locked compartments . Only persons authorized to prepare and administer medications have access to locked medications .</p> <p>On 2/17/25 at 10:43 a.m., an unsecured bottle of acetaminophen 500 milligrams (mg) tablets was observed at Resident #107's bedside.</p> <p>In an interview, Resident #107 said he took the acetaminophen as needed for headaches.</p> <p>Photographic evidence obtained.</p> <p>Review of Resident #107's clinical record failed to show documentation that the Interdisciplinary Team (IDT) determined the resident was able to safely self-administer the medication and ensure the medication was stored safely and securely.</p> <p>On 2/17/25 at 1:57 p.m., in an interview Licensed Practical Nurse (LPN) Staff K confirmed the bottle of acetaminophen at the resident's bedside was not stored safely and securely. LPN Staff K reviewed Resident #107's clinical record and said there was no evaluation indicating the resident was able to keep the medication at the bedside and was able to ensure the acetaminophen was stored safely.</p> <p>2. On 2/17/25 at 11:27 a.m., Resident #81 was observed in his room at his computer desk. A large, half full bottle of antacid tablets was observed on the desk and one full bottle of antacid tablets was observed on the floor next to his wheelchair. Resident #81 said the medications were his.</p> <p>Photographic evidence obtained.</p> <p>On 2/17/25 at 2:00 p.m., LPN Staff L confirmed Resident #81 had two unsecured bottles of antacids in his room. LPN Staff L reviewed Resident #81's clinical record and confirmed he had no physician order or assessment to self-administer the medication.</p> <p>3. On 2/18/25 at 2:20 p.m., during an observation at the 1A unit nursing desk there was a box of Ipratropium Bromide (relaxes the airway) belonging to Resident #116, sitting on top of the desk. There were no staff present for several minutes. Residents and visitors were in the hallways.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Photographic evidence obtained.</p> <p>On 2/18/25 at 2:40 p.m., in an interview the Director of Nursing (DON) said she was informed of the unsecured medication at the bedside of Residents #107 and #81. She said she was not aware of the unsecured medication left at the 1 A nursing station today.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44824</p> <p>Based on observation, staff interviews, and record reviews, the facility failed to follow proper sanitation and cleaning practices in the kitchen to prevent the outbreak of foodborne illness.</p> <p>The findings included:</p> <p>On 2/17/25 at 9:20 a.m., an initial tour of the kitchen was completed with the Certified Dietary Manager (CDM).</p> <p>The ice machine was observed first. It had a monthly maintenance check sheet attached to the front. The last month signed on the maintenance log for the ice machine was checked by maintenance was August of 2024.</p> <p>Photographic evidence obtained</p> <p>In an interview the CDM said to her knowledge no one had checked it since she had been she had been employed at the facility, approximately three months.</p> <p>Dietary Aide Staff E was observed using the 3-compartment sink. The third sink was empty. A metal bin with a sanitizing solution was observed in the third sink. Dietary Aide Staff E was observed washing and rinsing a pan. Staff E dunked the pan and left it floating on the sanitizing solution in the metal bin. Staff E did not ensure the pan was completely submerged in the solution.</p> <p>Photographic evidence obtained</p> <p>In an interview Dietary Aide Staff E said the dishes were supposed to be in the sanitizing solution for 10 seconds.</p> <p>Review of the instructions affixed to the wall for use of the sanitizer revealed the dishes had to stay submerged for 1-2 minutes in the sanitizing solution. Staff E said he was not aware the dishes had to be submerged for 1-3 minutes in the sanitizing solution. Staff E said the third compartment used for the sanitizer had been leaking for the past 4-5 days which is why he was using the metal bin. The CDM and Dietary Aide Staff E said they had notified the Maintenance Department that the third sink was leaking.</p> <p>In an interview the CDM said Dietary Aide Staff E was hired after she started employment at the facility three months ago. She could not provide documentation Dietary Aide Staff E was trained on the proper use of the 3 compartment sink.</p> <p>During the tour, a staff member was observed entering and walking through the kitchen without a hair restraint. When asked about hair restraint she said there were no hairnet at the entrance so she walked through the other entrance to get one.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>There were also multiple areas of black bio growth noted throughout the kitchen, on the ceiling and vents with dust/debris.</p> <p>Photographic evidence obtained.</p> <p>In an interview the CDM said that maintenance has not cleaned the air-conditioning vents or the ceiling since she started employment at the facility three months ago.</p> <p>On 2/18/25 at 9:15 a.m., in a follow up tour of the kitchen, the 3 compartment sink was observed. The 3rd sink containing the sanitizing solution was full of dishes. Not all the dishes were completely submerged in the sanitizing solution. The CDM was present during the observation.</p> <p>In an interview, when asked if this was proper use of the sanitizer sink, the CDM replied no.</p> <p>On 2/18/25 at 9:30 a.m., in an interview the Maintenance Director said he has been employed at the facility for only 3 weeks and has been putting out fires. He said he has taken care of a drainage issue for the steam table and affixed an appliance to the wall for the kitchen.</p> <p>On 2/18/25 The CDM Provided the Three Compartment Sink Operation Manual which stated, The ware is then immersed for 60 seconds in the third sink, which contains the sanitizing solution. It must stay immersed for 60 seconds to comply with the Environmental Protection Agency's (EPA) requirements.</p> <p>On 2/20/25 at 11:15 a.m., the Maintenance Director provided a TELS (Web-based building management platform) printout of closed work orders for July 1, 2024, to [DATE]. Included on this list was to clean bio growth off ceiling, paint falling from ceiling, ceiling vents dirty, ceiling needs repair and paint. None of the listed items had a completion date.</p> <p>On 2/20/2025 at 11:30 a.m., in an interview the Administrator said kitchen ceilings should be cleaned monthly. He also agreed that if there was a monthly sign-in sheet on an appliance, that would indicate it required a monthly servicing.</p> <p>He also said that no employee should enter the kitchen (other than the designated area at the main entrance) without wearing a hair net.</p>		

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 02/20/2025
NAME OF PROVIDER OR SUPPLIER Creekside Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>51818</p> <p>Based on observations, record reviews and staff interviews, the facility failed to ensure licensed nurses followed infection prevention practices during blood glucose monitoring for 2 (Residents #447 and #131) of 2 residents observed.</p> <p>The facility failed to ensure urinary catheter drainage bags were stored in a safe and sanitary manner for 2 (Residents #103 and #75) of 2 residents observed with urinary catheter drainage bags stored on the floor.</p> <p>The findings included:</p> <p>1. Review of the policy for Hand Hygiene and Infection Control last revised on 6/2023 revealed that the facility shall require facility personnel use accepted hand hygiene after each direct resident contact for which hand hygiene is indicated. Situations that require hand hygiene include but are not limited to: Before and after performing any invasive procedure (e.g. fingerstick blood sampling) and after removing gloves or aprons.</p> <p>On 2/19/25 at 11:30 a.m., Registered Nurse (RN) Staff D was observed doing a fingerstick to measure Resident #447's blood glucose.</p> <p>RN Staff D donned a pair of gloves that he removed from his pocket. Staff D did not perform hand hygiene before donning the gloves.</p> <p>RN Staff D removed a glucometer (machine to measure blood glucose) from a plastic container in the medication cart and placed it on the resident's bedside. RN Staff D did not clean/disinfect the glucometer before taking it to the resident's room.</p> <p>RN Staff D performed the fingerstick and measured the resident's blood glucose.</p> <p>RN Staff D removed the gloves and did not perform hand hygiene.</p> <p>He took the glucometer back to the medication cart at the nurse's station, accessed the computer and medication in the cart.</p> <p>RN Staff D did not perform hand hygiene, donned a pair of gloves and prepared insulin for the resident.</p> <p>RN Staff D returned to the resident's room and administered insulin to Resident #447.</p> <p>He removed the gloves and did not perform hand hygiene before leaving the resident's room and walking down the hallway.</p> <p>Staff D RN took a telephone call at the nurse's station and returned to the medication cart.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>RN Staff D did not perform hand hygiene and placed the cleaned glucometer and supplies back in the plastic container.</p> <p>2. On 2/19/25 at 11:40 a.m., RN Staff D was observed preparing to monitor Resident #131's blood glucose. He did not perform hand hygiene and donned a pair of gloves.</p> <p>RN Staff D removed a glucometer from a plastic container in the medication cart and took it to the resident's room. RN Staff D did not clean or sanitize the glucometer before using it to monitor the resident's blood glucose.</p> <p>RN Staff D obtained a drop of blood via fingerstick and measured Resident #131's blood glucose.</p> <p>RN Staff D removed the gloves and did not perform hand hygiene before leaving the resident's room.</p> <p>RN Staff D removed and prepared insulin to administer to Resident #131.</p> <p>RN Staff D donned gloves and administered insulin subcutaneously to Resident #131.</p> <p>RN Staff D removed the gloves and did not perform hand hygiene before leaving the resident's room.</p> <p>RN Staff D sanitized the glucometer and placed it back in the plastic container. He did not perform hand hygiene and accessed the computer.</p> <p>On 2/19/25 at 2:00 p.m., in an interview RN Staff D said he was not aware that he needed to perform hand hygiene before donning gloves and after doffing gloves. He said he believed that using a sanitizing wipe for the glucometer was a sufficient form of hand sanitizing. He said he believed he may have picked up bad habits.</p> <p>On 2/20/25 at 9:00 a.m., the observation of lack of hand hygiene before donning gloved and after doffing gloves were shared with the Director of Nursing (DON). She said the facility provides handwashing training.</p> <p>3. Review of the Catheter Care policy last revised on 1/2024 revealed that the facility will maintain infection control guidelines related to catheter use and catheter care to minimize catheter associated infections. 1. Ensure the retainage spigot (flow valve) is not touching the floor, the tubing is free of kinks and the catheter is kept at an appropriate level to promote urine flow.</p> <p>On 2/17/25 at 9:15 a.m., Resident #103 was observed in bed. The bed was in the low position. Resident #103 had an indwelling urinary catheter (catheter inserted in the bladder to drain urine). The urinary catheter drainage bag was touching the floor.</p> <p>On 2/17/25 at approximately 9:30 a.m., Resident #75 was observed in bed. The resident had an indwelling urinary catheter. The catheter drainage bag was not secured to the bed and was laying on the floor.</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37256</p> <p>Based on record review and interview, the facility failed to ensure that resident or resident representative had the opportunity to accept or refuse a COVID-19 vaccine and that the resident's medical record includes documentation that the resident or resident representative were provided education regarding the benefits and potential risks associated with COVID-19 vaccine, documentation of COVID-19 vaccine administered to the resident; or documentation the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal for 5 (Residents #97, #67, #133, #104, #108) of 5 residents reviewed for vaccinations.</p> <p>The findings included:</p> <p>Facility policy for Infection Control COVID 19 Revised 6/24/24 indicated under section titled Vaccination 1. COVID 19 Vaccines are offered to residents and staff in accordance with CDC (Centers for Disease Control) guidance Stay Up to Date with COVID-19 Vaccines.</p> <p>CDC guidance Stay Up to Date with COVID-19 Vaccines indicates: It is especially important to get your 2024-2025 COVID-19 vaccine if you are ages 65 and older, are at high risk for severe COVID-19, or have never received a COVID-19 vaccine. Vaccine protection decreases over time, so it is important to get your 2024-2025 COVID-19 vaccine.</p> <p>*Getting the 2024-2025 COVID-19 vaccine is especially important if you:</p> <ul style="list-style-type: none"> *Are ages [AGE] years and older *Are at high risk for severe COVID-19 *Are living in a long-term care facility <p>On 2/20/25 at 10:00 a.m., the Regional Nurse provided documentation regarding COVID vaccination status for Residents #97, #67, #133, #104, and #108. This documentation indicated the following as status of vaccination:</p> <p>Resident #97 historical 4/29/21, historical 5/21/21, complete Left Deltoid 10/26/2</p> <p>Resident #67 historical 5/24/21, historical 3/8/22</p> <p>Resident #133 not eligible</p> <p>Resident #104 not eligible</p> <p>Resident #108 complete 10/26/21</p> <p>(continued on next page)</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/20/25 at 10:40 a.m., the Director of Nursing (DON) said residents were asked if they've had the COVID vaccine before and if they wanted it again. She said the residents just tell them yes or no. The DON was unaware if there was any form or documentation for this.</p> <p>On 2/20/25 at 12:00 p.m., the Assistant Director of Nursing (ADON) acknowledged she was the Infection Preventionist for the facility. The ADON said if they have had the vaccination in the past, she enters it as historic, as opposed to a declination that they had it before. ADON agrees the way it is currently handled she cannot verify resident/representative education or acceptance/refusal was discussed. She said they had not been using consent forms for COVID vaccinations.</p>		