STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105497	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Venice Health and Rehabilitation Center	1240 Pinebrook Road Venice, FL 34292

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on record review and staff interviews, the facility failed to protect residents' right to be free from neglect by failing to ensure staff consistently provide safe nursing care to prevent avoidable accidents and serious physical harm for 1 (Resident #1) of 3 dependent residents reviewed.Resident #1 had a history of cerebral infarction (stroke) with resultant hemiplegia (paralysis) of his right dominant side and was dependent on the assistance of 2 staff for bed mobility.On 6/19/25 the Certified Nurse Assistant (CNA) chose to not follow safety precautions of 2 staff assistance listed on the care plan to provide incontinent care, causing Resident #1 to fall out of bed.Resident #1 sustained a serious head injury from the avoidable fall, requiring an emergency transfer to an acute care hospital for evaluation and treatment.Resident #1 was diagnosed with a subarachnoid and subdural hematoma (collection of blood between the skull, brain membrane and brain surface). The facility failure to prevent the neglect resulted in serious injury to Resident #1 and created a likelihood of further incidents of neglect for all 15 residents care planned for the assistance of 2 staff for bed mobility.This failure resulted in the determination of Immediate Jeopardy.The findings included:Cross reference to F689.Review of the facility's policy titled Abuse, Neglect and Exploitation last revised 11/16/23 noted, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent . neglect .The policy noted the facility will implement policies and procedure to prevent and prohibit all types of neglect that achieves the identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to neglect.Review of the facility's incidents investigations revealed on 6/19/25 the facility initiated a neglect investigation related to Resident #1 falling out of bed while receiving care.Review of the facility provided investigation revealed:On 6/19/25 at 11:15 a.m. , Resident #1 had a witnessed fall from his bed while receiving care from his assigned Certified Nursing Assistant (CNA). A bump was noted on the resident's right forehead. The physician issued an order to transfer Resident #1 to the local Emergency Department (ED) for evaluation.CNA Staff A provided a statement that on 6/19/25 she changed Resident #1's incontinent brief. The resident had a bowel movement. She turned Resident #1 to his left side to wipe him. While attempting to change the resident, she was holding him with one hand and reaching for wipes with the other. The resident slipped from her hold.Registered Nurse (RN) Staff B provided a statement that on 6/19/25 she was called into Resident #1's room and saw him on the floor. She noted the bed was in a higher position. Resident #1 was on his right side with a hematoma to his right temple. Resident #1 was assessed and 911 was called. RN Staff B stated she applied ice to the resident's head and waited with him until 911 arrived.Licensed Practical Nurse (LPN) Staff C assessed Resident #1 after the fall. A bump was noted to the resident's right forehead. The physician was notified and gave an order to transfer the resident to the ED for further evaluation.The Director of Nursing (DON) interviewed CNA Staff A about the resident's fall from the bed. CNA Staff A performed a reenactment with the DON present. CNA Staff A said that she was providing incontinent care, she reached for wipes that were placed at the resident's knees, and he rolled out of bed onto the floor.The DON asked CNA Staff A if there was anyone else in the room to help her. CNA Staff A stated, No, we usually do two people, but everyone is busy, so I did it myself.The DON asked CNA Staff A if she was aware that the resident was care planned for 2 staff assistance with toileting and bed mobility needs. CNA Staff A stated, Yes, we usually use two, but we are busy, and I needed to clean him up, so I did it myself.The DON asked CNA Staff A if she checks the Kardex (provides essential information for care) first when she comes to work and starts her assignment. CNA Staff A replied, No, I can't do that there is no time.The DON asked CNA Staff A how she knew how to take care of Resident #1. CNA Staff A responded, I know from the last time I worked.The DON asked CNA Staff A if she knew how to find the Kardex and she stated, Yes. The DON and CNA Staff A walked to the kiosk and CNA Staff A was able to locate the Kardex.The investigation noted 9 licensed nurses and 8 CNAs who were present and working on 6/19/25 at the time of the fall were interviewed. All 17 staff interviewed said that they were not asked to assist with Resident #1's care.On 6/25/25, the hospital provided the facility with a diagnosis of traumatic subarachnoid hemorrhage and subdural hematoma.On 6/25/25, the facility verified the allegation of neglect and noted CNA Staff A demonstrated her decision to act independently of the guidance provided by the facility's education and practices when she chose to not review and follow the Kardex prior to providing care to Resident #1. The resident's Kardex was available, up to date, and accurate at the time of the resident's fall.On 7/7/25, review of the clinical record revealed

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on record review, review of facility's policy and procedure, and staff interviews, the facility failed to ensure effective processes were in place to protect 1 (Resident #1) of 3 residents reviewed from avoidable fall and fall related major injury.Resident #1 had a history of cerebral infarction (stroke) with resultant hemiplegia (paralysis) of his right dominant side and was dependent on the assistance of 2 staff for bed mobility.On 6/19/25 the Certified Nurse Assistant (CNA) chose to not follow safety precautions of 2 staff assistance listed on the care plan to provide incontinent care, causing Resident #1 to fall out of bed.Resident #1 sustained a serious head injury from the avoidable fall, requiring an emergency transfer to an acute care hospital for evaluation and treatment.Resident #1 was diagnosed with a subarachnoid and subdural hematoma (collection of blood between the skull, brain membrane and brain surface). The facility failure to ensure residents safety during care resulted in serious injury to Resident #1 and created a likelihood of serious harm, serious injury or death from avoidable falls for all 15 residents care planned for the assistance of 2 staff during care and resulted in the determination of Immediate Jeopardy (IJ).The findings included:Cross reference to F600. Review of the facility's policy titled, Accidents and Supervision with a date reviewed/Revised of 10/18/2022 revealed, Each resident will receive adequate supervision and assistive devices to prevent accidents . Implementation of interventions. Using specific interventions to try to reduce a resident's risk from hazards in the environment. The process includes: . Ensuring that the interventions are put into action .Resident-directed approaches may include: Implementing specific interventions as part of the plan of care. Supervising staff and residents . Monitoring and Modification . Ensuring that interventions are implemented correctly and consistently .Review of the clinical record for Resident #1 revealed a re-admission date of 1/25/25. Diagnoses included Cerebral infarction with resultant hemiplegia affecting the resident's right dominant side.Review of the discharge Minimum Data Set (MDS) Assessment with a target date of 6/19/25 noted Resident #1 was dependent on staff for rolling left and right, personal hygiene, and toileting.Review of the care plan created on 5/10/25 revealed Resident #1 had Activities of Daily Living self-care performance deficit. The interventions included Dependent Assist of 2 for toileting, and Dependent Assist of 2 with bed mobility (repositioning self in bed).Review of the Kardex revealed Resident #1 required dependent assistance by 2 staff to turn and reposition in bed as necessary.Review of the progress notes revealed:On 6/19/25 at 12:41 p.m., a nursing progress note read, Resident fell off the bed while the CNA was attempting to change him at 11:20 AM. A large bump was observed on the resident's right side head . Resident was sent to emergency room for further evaluation.Review of the facility provided fall investigation for Resident #1revealed:On 6/19/25 at 11:15 a.m., Resident #1 had a witnessed fall from his bed while receiving care from his assigned Certified Nursing Assistant (CNA) Staff A. A bump was noted on the resident's right forehead. The physician issued an order to transfer Resident #1 to the local Emergency Department (ED) for evaluation.CNA Staff A provided a statement that on 6/19/25 she changed Resident #1's incontinent brief. The resident had a bowel movement. She turned Resident #1 to his left side wipe him. While attempting to change the resident, she was holding him with one hand and reaching for wipes with the other. The resident slipped from her hold.Registered Nurse (RN) Staff B provided a statement that on 6/19/25 she was called into Resident #1's room and saw him on the floor. She noted the bed was in a higher position. Resident #1 was on his right side with a hematoma to his right temple.The Director of Nursing (DON) interviewed CNA Staff A about Resident #1's fall from the bed. 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