STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105499	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solaris Healthcare Lely Palms	6135 Rattlesnake Hammock Road Naples, FL 34113

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 - Actual harm 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 - Actual harm Residents Affected - Few	Based on record review, review of facility's policies and procedures, and staff interviews, the facility failed to protect residents' rights to be free from neglect by failing to follow safety precautions during transfers resulting in an avoidable fall for 1 (Resident #999) of 3 residents reviewed for accidents and failure to ensure timely post-fall evaluation.The findings includedReview of the facility's policy #60.41 Alleged Abuse /Potential Neglect/ Exploitation revealed, It is the policy of this facility to provide an environment that promotes dignity and respect for all residents and one that prohibits abuse and/or neglect. Neglect is a failure or omission on the part of a care giver/facility to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.Review of the facility's policy Assessing Falls and Their Causes documented with a review date of 12/10/2024 revealed, Steps in the Procedure after a Fall: If a resident has just fallen, or is found on the floor without a witness to the event, nursing staff will record vital signs and evaluate for possible injuries to the head, neck spine and extremities . If there is evidence of a significant injury such as a fracture or bleeding, nursing staff will provide appropriate first aid . Notify the following individuals when a resident has a fall: The Director of Nursing (DON), the Nursing Supervisor on duty .Review of the clinical record for Resident #999 revealed an admission date of 5/9/24. Diagnoses included dementia with behavioral disturbance, heart failure, restlessness and agitation.Review of the Annual Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with a target date of 5/16/25 documented Resident #999 was dependent for transfers. The MDS noted Resident #999's cognitive skills for daily decision making were severely impaired. The resident rarely/never made decisions.Review of the Fall Risk Assessment form dated 6/27/25 noted Resident #999's risk score was 07. The form documented a score of 10 or greater, the resident should be considered at high risk for potential falls. Prevention protocol should be initiated immediately and documented on the care plan. Review of the certified nursing assistant (CNA) care Kardex (provides information and instructions on the resident's care needs) and the residents care plan revealed Resident #999 required a two person assist with a mechanical lift for all transfers.Review of the facility provided incident investigations revealed on 6/27/25 at 8:01 a.m., Certified Nursing Assistant (CNA) Staff A was transferring Resident #999 from the bed to the wheelchair (w/c) without assistance or without using the mechanical lift. Resident #999 slid from the bed to the floor. CNA Staff A noticed CNA Staff B passing by the room and asked for help. CNA Staff B noticed the resident on the floor and told CNA Staff A that if the resident had fallen, she needed to call the nurse. CNA Staff A denied a fall had occurred. CNA Staff B left the room for additional help from CNA Staff D. CNAs Staff A, Staff B and Staff D manually lifted Resident #999 from the floor and placed her in a wheelchair. CNA Staff A then took the resident to the dining room for breakfast.CNAs Staff A, Staff B or Staff D did not report Resident #999's fall to the nurse on duty to ensure timely post-fall evaluation for possible injuries to the head, neck spine and extremities.The investigation noted on 6/27/25 at 10:00 a.m., (2 hours after the fall), CNA Staff A informed Licensed Practical Nurse (LPN) Staff C that Resident #999 had slid to the floor. Licensed Practical Nurse (LPN) Staff C assessed the resident who complained of right leg pain. LPN Staff C notified the physician who ordered an x-ray of the right leg.The X-ray results documented a proximal tibia (larger bone of the lower leg) fracture.The physician was notified of the X-ray results and instructed LPN Staff C to send Resident #999 to the local emergency room (ER) for evaluation.The facility interviewed CNA Staff A who confirmed she did not look at Resident #999's Kardex for her transfer status. She did not ask any other staff member and just attempted a one person transfer.CNA Staff A provided a statement that around 8:00 a.m., while transferring Resident #999 from bed to chair, the resident slid to the ground. She saw another CNA passing in the hallway and she called her to assist her to get the resident off the floor. Her and another CNA picked up the resident and another CNA helped position the resident into the wheelchair.CNA Staff B provided a statement that on 6/27/25 at around 8:00 a.m., she was passing Resident #999's room and CNA Staff A called her into the room. As she entered the room, she saw Resident #999 on the floor. She told CNA Staff A to call the nurse if Resident #999 had fallen. She denied that Resident #999 had fallen, so she got another CNA to help them and they got her up.LPN Staff C provided a statement that at around 10:00 a.m., the CNA notified her that while transferring Resident #999 from bed, she slid down in front of the bed. The CNA had another CNA assist her to get the resident off the floor into the chair. When she was notified, she performed an assessment. Resident #999 reported pain in the right lower leg. She administered pain medication. She notified the Nurse Practitioner and got an order for an X-ray.The facility's investigation

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F 0689 Level of Harm - Actual harm 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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility's policies and procedures, the facility failed to ensure staff followed safety precautions while transferring 1 (Resident #999) of 3 residents reviewed for accidents, resulting in an avoidable with major injury requiring emergency transfer to an acute care hospital.The findings included:Review of the facility policy Assessing Falls and Their Causes revealed, Steps in the Procedure after a Fall: If a resident has just fallen, or is found on the floor without a witness to the event, nursing staff will record vital signs and evaluate for possible injuries to the head, neck spine and extremities. If there is evidence of a significant injury such as a fracture or bleeding, nursing staff will provide appropriate first aid. Notify the following individuals when a resident has a fall: The Director of Nursing (DON), the Nursing Supervisor on duty.Review of the clinical record revealed Resident #900 had a date of admission of 5/9/24was a [AGE] year-old female admitted on [DATE]. Diagnoses included dementia with behavioral disturbance, heart failure, restlessness and agitation.Review of the Annual Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with a target date of 5/16/25 documented Resident #999 was dependent for transfers. The MDS noted Resident #900s cognitive skills for daily decision making were severely impaired.Review of the resident's Kardex (Provides instructions for safe care) revealed, Special needs. Transfer with mechanical lift, medium yellow size sling. Transfers: Provide two persons for supervision/physical assistance with mechanical aid (brand name full body mechanical lift).Review of the progress notes revealed a nursing progress note dated 6/27/25 at 2:46 p.m., that read, Around 10 AM CNA notified me that while transferring patient from bed to wheelchair, the patient slid down in front of the bed. The CNA ten had other care staff assist her in transferring the patient from floor back into wheelchair. After the CNA notified me, I went and took vitals, performed body assessment no injuries noted but patient reported pain in right lower leg. Administered Tylenol for pain NP (Nurse Practitioner) gave orders for Xray of right lower leg 2 views.Review of the facility provided incident investigations revealed on 6/27/25 at 8:01 a.m., Certified Nursing Assistant (CNA) Staff A was transferring Resident #999 from the bed to the wheelchair (w/c) without assistance or without using the mechanical lift. Resident #999 slid from the bed to the floor. CNA Staff A noticed CNA Staff B passing by the room and asked for help. CNA Staff B noticed the resident on the floor and told CNA Staff A that if the resident had fallen, she needed to call the nurse. CNA Staff A denied a fall had occurred. CNA Staff B left the room for additional help from CNA Staff D. CNAs Staff A, Staff B and Staff D manually lifted Resident #999 from the floor and placed her in a wheelchair. CNA Staff A then took the resident to the dining room for breakfast.The investigation noted on 6/27/25 at 10:00 a.m., (2 hours after the fall), CNA Staff A informed Licensed Practical Nurse (LPN) Staff C that Resident #999 had slid to the floor. Licensed Practical Nurse (LPN) Staff C assessed the resident who complained of right leg pain. LPN Staff C notified the physician who ordered an x-ray of the right leg.The X-ray results documented a proximal tibia (larger bone of the lower leg) fracture. Resident #999 was emergently transferred to a local hospital for further evaluation and treatment and has not returned to the facility.CNA Staff A provided a statement that around 8:00 a.m., while transferring Resident #999 from bed to chair, the resident slid to the ground. She saw another CNA (Staff B) passing in the hallway and she called her to assist her to get the resident off the floor. She and another CNA picked up the resident and another CNA (Staff C) helped position the resident into the wheelchair.CNA Staff B provided a statement that on 6/27/25 at around 8:00 a.m., she was passing Resident #999's room and CNA Staff A called her into the room. As she entered the room, she saw Resident #999 on the floor. She told CNA Staff A to call the nurse if Resident #999 had fallen. She denied that Resident #999 had fallen, so she got another CNA to help them and they got her up.LPN Staff C provided a statement that at around 10:00 a.m., the CNA notified her that while transferring Resident #999 from bed, she slid down in front of the bed. The CNA had another CNA assist her to get the resident off the floor into the chair. When she was notified, she performed an assessment. Resident #999 reported pain in the right lower leg. She administered pain medication. She notified the Nurse Practitioner and got an order for an X-ray.The incident investigation documented the root cause was, Resident's Kardex for transfer status was not followed by the CNA. She stated she did not check to see how she transferred, she made the choice to transfer her as a one person. She made the choice not to report the fall to the nurse and had another CNA to help her get the resident off the floor and into the wheelchair because she did not think she was hurt. CNA informed nurse approximately 2 hours after fall