STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105567	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springs at Lake Pointe Woods	3280 Lake Pointe Blvd 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility's policies and procedures and staff interviews, the facility failed to protect the resident's rights to be free from neglect by failing to follow safety precautions specified in the care plan to prevent avoidable accident with injury for 1 (Resident #1) of 3 dependent residents reviewed. The findings included: Review of facility Policy titled Abuse, Neglect, Exploitation, Misappropriation, not dated, indicated: Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect occurs when the facility is aware of or should be aware of goods and services that a resident requires, but the facility fails to provide them to the resident resulting in or may result in physical harm. Review of facility Policy titled Mechanical Lifts, not dated, indicated: The facility will encourage the use of mechanical lifts with resident transfers. Using mechanical lifts helps to minimize the risk of injury to the resident due to mishandling and serves to reduce the risk of injury to the caregiver as well. Policy also indicates: 3. The resident's level of assistance needed with transfers and repositioning along with lift type and sling size when applicable should be included in the resident's plan of care. Review of medical records revealed Resident #1 was admitted to the facility on [DATE] for short term rehab with diagnosis including Chronic Obstructive Pulmonary Disease, kidney disease and neuropathy (damage or disease to the nerves). Skin assessment noted resident had fragile skin. The admission Minimum Data Set (MDS) with a target date of 4/30/25 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 11 indicating moderate cognitive impairment. Review of the care plan revealed Resident #1 required assistance with Activities of Daily Living (ADL) related to decreased mobility and generalized weakness. Resident #1 required Full-body lift for transfers with 2 staff Hoyer (mechanical lift for transfer) and had Bilateral 1/4 assist bars to promote independence and mobility. Review of Kardex (an electronic system used to summarize resident information) revealed Resident #1 required full body mechanical lift with assist of 2 staff for transfers. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Change in Condition Form dated 4/8/25 indicated Resident #1 obtained a skin tear to the left lateral leg during transfer, steri-strips applied. A Physician Progress note dated 4/9/25 indicated: called last night, laceration left leg. Patient refused emergency room (ER). A Nursing progress note on 4/9/25 indicated Deep laceration to left lower extremity, steri-strips in place. A Nursing progress notes on 4/10/25 indicated Resident #1 previously refused to go to ER, was now agreeable to go to ER and was sent out. Patient returned the same day with 7 sutures to close left leg wound. On 6/26/25 at 12:00 p.m., Resident #1 said she had received a cut to her leg from the transfer. She said they didn't use the Hoyer to transfer. She said Staff B had put her arms around her with her leg between her knees to transfer her, but it wasn't far enough away from the enabler bar and when they turned, her leg scraped against it and caused the injury. Resident #1 said the enabler bar had a gap in it which was rough and caused the tear and she had needed 7 stitches to close the wound. She said there were 2 people in the room at the time, but Staff B chose to do it herself. She said since the injury, she had continued working with physical therapy and no longer required the Hoyer lift to transfer. Record Review of Resident #3's Kardex indicated she was a full body mechanical lift for transfers with 2 assist. On 6/26/25 at 12:19 p.m., the Resident said she is transferred using a Hoyer lift. She said they use 2 people to transfer with the Hoyer, but not always, especially on the evening shift. She said it hurt and was not safe. She said she had not sustained any injuries during transfers. Record review of Resident #2 Kardex indicated she requires full body mechanical lift with assist of 2 staff. On 6/26/25 at 2:20 p.m., Resident #2 said she is transferred using a Hoyer lift. She said they don't use 2 people, it's always one person, and it was not safe. Resident #2 said she felt they needed more help. She said she had not sustained any injuries during transfer. On 6/26/25 at 2:28 p.m., Staff A Certified Nurse Assistant (CNA) said on 4/8/25 Resident #1 wanted to go back to bed. Staff A said she went to get Staff B (CNA) to assist. Staff A said she noticed the Hoyer pad wasn't under Resident #1 and she told Resident #1 they would scoot the pad under her to transfer her. Resident #1 told us we didn't have to because therapy had gotten her up without it. Staff A said she said to Staff B let's get her up together, but Staff B said No, I got it. And positioned herself in front of Resident #1, put her arms around her waist and stood her up to guide her to the bed. Resident #1 said ouch and they looked down and saw blood on her leg. There was some kind of thing on the side that wasn't covered, and her leg had scraped across and caused the injury. Staff A said now the first thing she does is check the Kardex and see if the person is a Hoyer lift and always uses 2 people. Per the facility investigation, Staff B said Staff A had asked for help to transfer Resident #1. Staff B said Resident #1 didn't have the Hoyer pad underneath because therapy had gotten her up, so they put her in bed. (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 0600 Level of Harm - Actual harm Residents Affected - Few	On 6/26/25 at 3:44 p.m., Staff C Licensed Practical Nurse (LPN) evening supervisor said Staff A came to her upset about Resident #1, saying Staff B came in to assist to transfer, but moved her out of the way and transferred Resident #1 by herself and caused an injury. Staff C said she went to Resident #1's room and Resident #1 was screaming that she was not going to the hospital. Staff C said she tried to calm Resident #1 down and explained she may need stitches. Resident #1 was adamant about not going, so the wound was cleaned and steri-stripped. Staff C said she saw the Hoyer pad and asked about it and Resident #1 said therapy had got her up that morning and never put it in the chair. Staff C said she then asked why the staff didn't put the pad back under her and Resident #1 said she told them not to and started saying again she would not go to the hospital. Staff A was saying Staff B had just moved her out of the way and said I got it and lifted Resident #1 and Staff B kept saying there were 2 people in the room. Staff C said she asked Staff A and Staff B to leave the room. Staff C said as Resident#1 was talking she said she didn't want to get anyone in trouble and that Staff B had moved her by herself. On 6/26/25 at 3:50 p.m., the Director of Nursing said the staff had not followed Resident #1's Plan of Care for transfer. She said staff re-education had been in process and provided documentation of what they are trained. The documentation provided indicated: Kardex must be verified for all transfer status, any full body lift transfer must have the mechanical lift utilized for transfers and 2-person assistance for all full body lift transfers.

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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 - Actual harm Residents Affected - Few	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** Based on record review, review of facility's policies and procedures and staff interviews, the facility failed to protect the resident's rights to be free from accidents by failing to follow safety precautions specified in the care plan resulting in an injury for 1 (Resident #1) of 3 dependent residents reviewed. The findings included: Review of facility Policy titled Abuse, Neglect, Exploitation, Misappropriation, not dated, indicated: Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect occurs when the facility is aware of or should be aware of goods and services that a resident requires, but the facility fails to provide them to the resident resulting in or may result in physical harm. Review of facility Policy titled Mechanical Lifts, not dated, indicated: The facility will encourage the use of mechanical lifts with resident transfers. Using mechanical lifts helps to minimize the risk of injury to the resident due to mishandling and serves to reduce the risk of injury to the caregiver as well. Policy also indicates: 3. The resident's level of assistance needed with transfers and repositioning along with lift type and sling size when applicable should be included in the resident's plan of care. Review of medical records revealed Resident #1 was admitted to the facility on [DATE] for short term rehab with diagnosis including Chronic Obstructive Pulmonary Disease, kidney disease and neuropathy (damage or disease to the nerves). Skin assessment noted resident had fragile skin. The admission Minimum Data Set (MDS) with a target date of 4/30/25 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 11 indicating moderate cognitive impairment. Review of the care plan revealed Resident #1 required assistance with Activities of Daily Living (ADL) related to decreased mobility and generalized weakness. Resident #1 required Full-body lift for transfers with 2 staff Hoyer (mechanical lift for transfer) and had Bilateral 1/4 assist bars to promote independence and mobility. Review of Kardex (an electronic system used to summarize resident information) revealed Resident #1 required full body mechanical lift with assist of 2 staff for transfers. Review of Change in Condition Form dated 4/8/25 indicated Resident #1 obtained a skin tear to the left lateral leg during transfer, steri-strips applied. A Physician Progress note dated 4/9/25 indicated: called last night, laceration left leg. Patient refused emergency room (ER). A Nursing progress note on 4/9/25 indicated Deep laceration to left lower extremity, steri-strips in place. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A Nursing progress notes on 4/10/25 indicated Resident #1 previously refused to go to ER, was now agreeable to go to ER and was sent out. Patient returned the same day with 7 sutures to close left leg wound. On 6/26/25 at 12:00 p.m., Resident #1 said she had received a cut to her leg from the transfer. She said they didn't use the Hoyer to transfer. She said Staff B had put her arms around her with her leg between her knees to transfer her, but it wasn't far enough away from the enabler bar and when they turned, her leg scraped against it and caused the injury. Resident #1 said the enabler bar had a gap in it which was rough and caused the tear and she had needed 7 stitches to close the wound. She said there were 2 people in the room at the time, but Staff B chose to do it herself. She said since the injury, she had continued working with physical therapy and no longer required the Hoyer lift to transfer. Record Review of Resident #3's Kardex indicated she was a full body mechanical lift for transfers with 2 assist. On 6/26/25 at 12:19 p.m., the Resident said she is transferred using a Hoyer lift. She said they use 2 people to transfer with the Hoyer, but not always, especially on the evening shift. She said it hurt and was not safe. She said she had not sustained any injuries during transfers. Record review of Resident #2 Kardex indicated she requires full body mechanical lift with assist of 2 staff. On 6/26/25 at 2:20 p.m., Resident #2 said she is transferred using a Hoyer lift. She said they don't use 2 people, it's always one person, and it was not safe. Resident #2 said she felt they needed more help. She said she had not sustained any injuries during transfer. On 6/26/25 at 2:28 p.m., Staff A Certified Nurse Assistant (CNA) said on 4/8/25 Resident #1 wanted to go back to bed. Staff A said she went to get Staff B (CNA) to assist. Staff A said she noticed the Hoyer pad wasn't under Resident #1 and she told Resident #1 they would scoot the pad under her to transfer her. Resident #1 told us we didn't have to because therapy had gotten her up without it. Staff A said she said to Staff B let's get her up together, but Staff B said No, I got it. And positioned herself in front of Resident #1, put her arms around her waist and stood her up to guide her to the bed. Resident #1 said ouch and they looked down and saw blood on her leg. There was some kind of thing on the side that wasn't covered, and her leg had scraped across and caused the injury. Staff A said now the first thing she does is check the Kardex and see if the person is a Hoyer lift and always uses 2 people. Per the facility investigation, Staff B said Staff A had asked for help to transfer Resident #1. Staff B said Resident #1 didn't have the Hoyer pad underneath because therapy had gotten her up, so they put her in bed. (continued on next page)

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