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	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springs at Lake Pointe Woods	3280 Lake Pointe Blvd Sarasota, FL 34231

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility's policy and procedure, and staff interviews, the facility failed to store and distribute food in accordance with professional standards for food service safety. This has the potential to affect 91 residents who consume the food made on the premises.The findings Included:Review of the facility policy on Food Receiving and Storage dated 6/2025 revealed that all foods stored in the refrigerator or freezer will be covered, labeled and dated.On 4/20/26 at 9:35 a.m., observations during the initial tour of the kitchen revealed:The following food items in the reach in refrigerator were not date-marked to indicate when the food must be consumed or discarded: 5 Apple Juice cups; 12 Cranberry Juice cups; 23 Orange Juice cups; a plate of tomato slices; a dish of an unknown white food item; a cup of fresh fruit; a container of Oat milk. The date on what appeared to be tapioca pudding was not legible and read either 4/4/ or 4/14; a dish of a white food item was dated 4/4; a container of (brand name) vanilla nutritional drink with an opened date of 3/2.Observation of the walk-in refrigerator revealed: A container of shredded cheese with a label that was illegible; 2 zip lock bags of sliced cheese that were not sealed; a bag of grated cheese that was opened, sealed, but not dated; a partially used block of butter or margarine that was sealed, but not dated; a container of maraschino cherries that was undated; a beverage pitcher that was undated with what appeared to be tea; a pastry bag with an unidentified substance partially used was stored in a plastic bag, with a label indicating it was opened on 4/5; an unlabeled and undated filled beverage pitcher; a beverage pitcher with fruit punch that had a prep date of 4/11 and disposal date of 4/15; a beverage pitcher with what appeared to be orange juice that was undated; an undated beverage pitcher with what appeared to be fruit punch; an opened and undated carton of (brand name) thickened lemon water; 2 cartons of (brand name) thickened cranberry juice dated 4/13/26; a tray of cups with a pudding consistency food item and cups of pineapple chunks that were undated; Observation of the walk-in freezer revealed: An open bag of what appeared to be individual sized, pre-prepared cookie dough that was not dated or properly sealed; 2 trays of biscuits that were not dated; 2 opened sleeves of waffles that were not dated.Observation of the food preparation area revealed: A bin of thickener that was dated 2/23 and disposal date of 3/23; a container of brown sugar that was dated 3/11 with a dispose of date of 4/11; an opened and undated container of ground oregano.On 4/20/26 at 10:00 a.m., in an interview the Dietary Manager verified the observation of the unlabeled, undated food items in the refrigerators, the freezer and the food preparation area. He said that all food items should be sealed, resealed, labeled and dated with a receipt date, an open date, and a dispose of date.On 4/20/26 at approximately 10:05 a.m., Dietary Staff O provided a list of food items specifying that all labels must include product name, open date, expiration date, and initials of person making the label. All wrapped items must be wrapped tight. The list specified the days given for the following food items: Prepared and leftover food, 3 days; Opened product (Mayo, BBQ, Peanut Butter), 30 days; Dry product (Sugar, flour, rice) 90 days, cut fruit and vegetables, 3 days, dairy (cottage cheese, sour cream, milk), 7 days, cheese products, 7 days; spices on food station, 1 year.On 4/20/26 at 12:20 p.m., observation of the assisted dining room lunch food cart on the [NAME] Unit revealed a tray of a resident's leftover (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	breakfast food items stored on the bottom rack of the cart of, underneath the residents' lunch trays to be served. Photographic evidence obtainedOn 4/23/26 at 1:51 p.m., in an interview, the Dietary Manager said that left over breakfast trays should not be stored with fresh lunch trays. He said that it was crossing clean with dirty/contaminated and it should not occur.

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview and record review the facility failed to ensure garbage and refuse were properly contained in dumpsters and failed to ensure the surrounding area was maintained in a sanitary condition, free of trash and debris.The findings included:On 4/20/26 at 10:15 a.m., observation of the surrounding ground of the facility with the Dietary Manager revealed four dumpsters used for disposal of the facility trash and refuse. Each dumpster had two lids. Two of the dumpsters were not fully closed with one of the lids opened. A plastic bag of food waste, a Styrofoam container, loose trash, including used gloves and plastic utensils were observed scattered on the ground surrounding the dumpsters. In an interview during the observation, the Dietary Manager said that the lids of the dumpsters were supposed to remain closed. Photographic evidence obtained

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, review of facility policies and procedures, residents and staff interviews, the facility failed to ensure that 2 (Residents #11 and #74) of 3 residents reviewed for non-pressure wounds received appropriate care and services in accordance with physician's orders. The facility failed to ensure that 1 (Resident #48) of 3 residents reviewed had preventive measures in place to prevent new skin injuries. The findings included:1. Review of the undated Facility Policy, Skin Care & Wound Management- Manage Wound Care revealed: The interdisciplinary team will develop a Care Plan to address identified skin impairment(s) which will include at a minimum, effort to stabilize, reduce or remove risk factors and describes treatment protocol. Interventions will be communicated to the caregiving team. The policy noted that treatment will be changed based on physician order and documented. On 4/20/26 at 9:52 a.m., Resident #48 was observed in bed with a wound vac (a medical device that uses negative pressure to promote healing in acute, chronic, and complex wounds) connected to the resident's back. In an interview, Resident #48 said that she developed a wound on her back at the facility but did not remember how she got it. Review of the clinical record for Resident #48 revealed an admission date of 10/17/23. Diagnoses included unspecified dementia, hypertensive heart disease, and major depressive disorder. Review of the Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date of 3/20/26 revealed that Resident #48 scored 05 of 15 on the Brief Interview for Mental Status, indicating severe cognitive impairment. The resident required substantial/maximal assist with toileting, bathing and transfers. A nursing progress note dated 2/17/26 documented that during a routine skin sweep, a skin abrasion was noted on the resident's right buttock with superficial skin loss, scant drainage and no active bleeding. The surrounding skin was intact with no erythema (redness), warmth, swelling, or signs of infection. An Interdisciplinary Team (IDT) note dated 2/20/26 revealed that the IDT met to discuss the resident's abrasion to her right buttocks. The note documented that the wound appears to be trauma possibly from bedside commode over the toilet for lift and safety. The recommendation was that the resident would benefit from a bariatric bedside commode so that the resident has room to sit. The plan included to consult wound care for treatment and Physical Therapy (PT) and Occupational Therapy (OT) for evaluation of a bedside commode. A Wound Physician Progress Note dated 2/24/26 revealed that the wound appeared to be a large area of ecchymosis (bruising), possibly trauma from the commode seat. The tissue type by percentage is 90% epithelial tissue (layer of cells covering body surface) and 10% dermal. The size was 6 centimeters(cm) by 6 cm with a depth of 0.1cm and a total wound area of 36 square cm. A Nursing Progress Note dated 3/2/26 documented that a Certified Nursing Assistant (CNA) was toileting Resident #48 when she noticed a change to the resident's right buttock wound and notified the nurse. Black necrotic (dead) tissue was noted to coccyx with surrounding erythema and the area was warm and tender to touch with some scant blood drainage noted. The wound care physician was notified and ordered antibiotics. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Wound Physician Progress Note dated 4/14/26 revealed that the wound had declined with excessive exudate (secretion) and a foul odor. A wound VAC was recommended. A Nursing Progress Note dated 4/14/26 at 5:03 p.m., revealed that a wound vac was applied to the right buttock wound per physician's order. On 4/21/26 at 10:00 a.m., in an interview, Wound Care Nurse, Staff A said that Resident #48's wound to the right buttock started as a trauma. She said that Resident #48 was sitting sideways on a commode and cut herself on the commode. The wound opened up a week later. Wound Care Nurse Staff A said that Physical Therapy evaluated the resident a week after the wound opened. On 4/23/26 at 11:17a.m., in an interview, the Risk Manager said that her investigation showed the wound occurred when the resident was being placed onto the commode in the bathroom. She said Resident #48 would regularly flop to one side as she was sitting on the commode. She said that she did not know how long the resident was on the commode, it was not timed or noted. She did not ask the CNA how long the Resident had been on the commode. She said Physical Therapy evaluated her for a new commode and for positioning onto the commode. They tried a larger commode, but the resident was very short and it was not a good fit for her. Physical Therapy spoke with the CNAs about how to position the resident on the commode. She said Resident #48 was still using the same commode. The Risk Manager said her investigation showed that the injury was not caused by the commode but how she was positioned on the commode. On 4/23/26 at 11:32 a.m., in an interview, the Director of Rehabilitation (DOR) said she was unable to provide documentation showing that the Resident was seen by Physical or Occupational Therapy at any time after the wound occurred or that Resident #48 was evaluated for a new commode. She said she had no documentation that training was provided to the CNAs on how to position the resident on the commode to prevent injury. Review of Resident #48's care plan revealed that on 3/3/26, a care plan was initiated for a trauma wound to the resident's right buttock. The goal was for the wound to show signs of healing by the next review date. The interventions did not include necessary precautions to prevent further skin injuries or worsening of the existing wound from improper positioning of the resident on the commode. 2. Review of the clinical record for Resident #11 revealed an admission date of 11/24/25. Diagnoses included peripheral vascular disease (blood vessels become blocked), venous insufficiency (poor circulation), and hypertensive (high blood pressure) heart disease with heart failure. Review of the Quarterly MDS Assessment with an Assessment Reference Date of 2/2/26 revealed that Resident #11 required substantial/maximal assistance to dependent on staff for Activities of Daily Living (ADLs). The MDS documented the resident's cognitive status moderately impaired. The care plan initiated on 12/1/25 and revised on 2/2/25 documented Resident #11 was at risk for further impairment to skin integrity related to generalized weakness, decreased mobility, incontinence, fragile skin and advanced age. The goal was for the resident to have interventions in place to minimize the risk of skin breakdown. The intervention initiated on 2/23/26 and revised on 4/9/26 included treatment to right upper arm malignant (cancerous) neoplasm growth (abnormal growth) as ordered. Review of the Progress Note dated 3/5/26 revealed that Resident #11 was seen by dermatology (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/5/26 for right upper arm. New order obtained. Review of the Dermatology Consult dated 3/5/26 revealed that Resident #11 was seen for a growth: unspecified malignant neoplasm of skin. Location: Right medial tricep (large muscles on the back of the upper arm). The note documented an Electronic Prescription for Efudex (fluorouracil 5% topical cream. A paper prescription was left with the nurse to enter into Medication Administration Record. The Skin/Wound Weekly Evaluation dated 3/11/26 documented Resident #11 had other wound to right proximal medial arm. Following Dermatology, received topical fluorouracil daily. Calcium Alginate and dry dressing. Review of the Treatment Administration Record for March 2026 revealed: An order dated 3/10/26 for fluorouracil external cream 5% (topical). Apply to right inner tricep topically one time a day for malignant neoplasm growth cover with dry dressing. An order dated 3/5/26 to clean the right proximal medial arm with normal saline/wound cleanser, pat dry, apply calcium alginate, cover with dry dressing one time a day. The treatment was discontinued on 4/1/26. Review of the Dermatology Consult dated 4/2/26 revealed that Resident #11 was seen for unspecified malignant neoplasm of skin. Location: right middle mid medial tricep. Electronic prescription: Electronic Prescription: Efudex (fluorouracil 5% topical cream. Paper prescription left with nurse to enter into Medication Administration Record. Dermatologist documented that the wound care nurse said the order was never given to her and medication was never applied. She will get order in today. 3. Review of the clinical record revealed Resident #74 was admitted to the facility on [DATE]. Diagnoses included hypertensive heart disease without heart failure, unspecified dementia, and encephalopathy (brain dysfunction). Review of the Quarterly MDS Assessment with an Assessment Reference Date of 3/24/26 revealed that Resident #74 required substantial/maximal staff assistance for Activities of Daily Living (ADLs). The MDS documented that the resident's cognitive status was intact. The care plan initiated 9/18/24, revised on 1/3/25 documented Resident #74 is at risk for skin breakdown related to decreased mobility, incontinence, and fragile skin due to advanced age, admitted with a cancer lesion. Intervention initiated 12/2/24 included treatments as orders. The Dermatology Consult dated 2/5/26 documented Resident #74 was diagnosed with malignant neoplasm to the left buttock. Prescription: Mupirocin (antibiotic) 2% ointment. Apply topically to left gluteus (buttock) and cover with bandage. Review of the Progress note dated 2/12/26 revealed that Resident #74 was reviewed for wound care to cancerous lesion left buttock. Treatment is Mupirocin. Followed by dermatologist. Review of the Dermatology Consult dated 3/5/26 revealed that Resident #74 was seen for growth (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	follow-up. Unspecified malignant neoplasm of skin left superior gluteus maximus (the upper, outer portion of the largest buttock muscle). Electronic prescription: Bactroban (mupirocin 2% topical ointment). Paper prescription left with nurse to enter into Medication Administration Record. Dermatologist documented that staff continued to use Efudex even though mupirocin was ordered last month. Nurse will make sure wound care nurse knows to apply mupirocin. Review of the Progress Note dated 3/5/26 revealed that Resident #74 was reviewed for wound care to cancerous lesion on left buttock. Treatment changes as of 3/3/26 to Santyl (prescription ointment to remove dead tissue) /dry dressing. Resident is also followed by Dermatologist. Review of the Skin/Wound Weekly Evaluation dated 3/13/26 revealed the wound did not appear infected at this time. Santyl and dry dressing. Review of the Dermatology Consult dated 4/2/26 revealed that Resident #74 was seen for Unspecified malignant neoplasm of skin left superior lateral gluteus maximus. Electronic prescription: Bactroban (mupirocin 2% topical ointment. Paper prescription left with nurse to enter into Medication Administration Record. Dermatologist documented wound care nurse said order was never given to her and medication was never applied. She will get order in today. Review of the Treatment Administration Record (TAR) for February 2026 for Resident #74 revealed that the treatment order to the left gluteus to cleanse the wound, pat dry, apply fluorouracil external cream 5% to the left gluteus topically every night shift was discontinued on 2/5/26. No other treatment was entered for the wound to the left gluteus for February 2026. Review of the TAR for March 2026 revealed the treatment to Resident #74's left buttock to cleanse with normal saline or wound cleanser, pat dry, apply Santyl and cover with dry dressing one time a day for wound care started on 3/5/26 and was discontinued on 4/1/26. Review of the TAR for April 2026 for Resident #74 revealed the treatment to cleanse the cancerous lesion to the left buttock with normal saline/wound cleanser, pat dry, apply mupirocin ointment, cover with dry dressing one time a day was not signed as completed on 4/9/26, 4/14/26, and 4/17/26. On 4/23/26 at 10:00 a.m., in an interview, Licensed Practical Nurse (LPN) Staff B said that the Dermatologist saw Residents #11 and #74 once a month for cancerous lesions. LPN Staff B, said they receive orders from the dermatologist monthly and enter them into the Treatment Administration Record. On 4/23/26 at 11:43 a.m., in an interview, LPN Staff A, said she no longer did wound care for Residents #11 and #74 since they were being followed by the dermatologist. LPN Staff A said she did not remember seeing the Dermatologist in March 2026 and could not explain why the orders were not entered. She said Residents #11 and #74 should have received the treatments ordered by the Dermatologist. LPN Staff A said the blank for wound care because they are being followed by the dermatologist. She said she does not remember seeing the dermatologist is March 2026. Staff B, LPN could not explain why the orders were not entered. Staff A, LPN said the residents should have been receiving the treatments ordered by the dermatologist. She said blanks on the TAR for Resident #74 for 4/9/26, 4/14/26, and 4/17/26 meant that the nurse did not sign off the treatment was done. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/23/26 at 1:06 p.m. in an interview, the Director of Nursing (DON) said the nurses should enter any new orders from the physician into the electronic medical record. The DON could not explain why the Dermatologist's orders were not entered in the electronic medical record for Residents #11 and #74. She said she could not explain what happened to the paper prescriptions the Dermatologist gave to the nurse. She said she would have to follow up with the Dermatologist.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility's policy and procedure and staff interviews, the facility failed to provide necessary repair and store residents' personal care items in a sanitary manner in 7 (Rooms 101, 104, 106, 107, 108, 110 and 111) of 17 rooms of the [NAME] Unit observed.The findings included: Review of the undated facility policy and procedure titled, Environmental Services - Safe Environment revealed, In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment . This includes ensuring that the resident can receive care and services safely . Orderly is defined as an uncluttered physical environment that is neat and well kept. Sanitary includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes, but is not limited to, equipment used in the completion of the activities of daily living .On 4/20/26 at 9:37 a.m., during an initial tour of the [NAME] Unit (rooms 100 to 116), the following was observed:1. room [ROOM NUMBER] shared bathroom: 2 emesis basins containing residents' care items were stored uncovered on the sink with personal items in each.An unlabeled bed pan was stored unbagged behind the shared toilet.Photographic evidence obtained.2. room [ROOM NUMBER] shared bathroom: An unbagged urinal labeled 101-1 was hanging on the handrail next to a towel. An unlabeled and unbagged urinal was observed hanging from the handrail in the shared shower.Two unbagged bed pans, a towel and a bedside commode bucket were stacked on the shower seat.Photographic evidence obtained. 3. Private room [ROOM NUMBER]: An unlabeled and uncovered bedpan was stored on the floor under the toilet.Photographic evidence obtained.4. room [ROOM NUMBER] shared bathroom: An unlabeled and unbagged urinal was hanging from the arm rest of a bedside commode in the shared shower. A wash basin, a used towel and an unlabeled deodorant stick were stored on the shared shower seat. A large crawling insect was observed in the bathroom.Photographic evidence obtained.5. room [ROOM NUMBER] shared bathroom: An unlabeled and unbagged cup containing a toothbrush and toothpaste was observed stored on the shared sink. An unlabeled and unbagged washbasin containing resident care items, a bottle of mouth wash, a bottle of aftershave, a pack of wipes and other residents' care items were stored unlabeled and unbagged on the shower seat. Photographic evidence obtained.6. room [ROOM NUMBER] shared bathroom: 2 unlabeled and unbagged washed basins were stacked and stored on the shared sink. Photographic evidence obtained.7. room [ROOM NUMBER] shared bathroom: An unlabeled and unbagged wash basin was stored on the floor under the sink. Scuff marks were observed on the wall next to the sink with peeling paint and discoloration. Photographic evidence obtained.On 4/22/26 at 8:30 a.m., in an interview, when asked about the storage of residents' personal care items, such as urinals, the Director of Nursing replied, Is it in a private or shared bathroom?

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, record review, review of facility's policy and procedures, and staff interviews, the facility failed to implement the comprehensive person-centered care plan to meet the needs for communication for 1 (Resident #5) of 3 residents reviewed for implementation of care plan interventions.The findings included:Review of the facility policy for Resident Assessment Instrument Comprehensive Care Plan Policy with an effective date of September 2024 revealed:Developing the Care Plan:The care plan will address physical, emotional, social, and cognitive needs, as well as any other relevant areas (e.g., nutritional, safety, mobility, medication management).Interdisciplinary Team (IDT) Collaboration:The IDT, consisting of nursing, dietary, therapy, social services, and other relevant staff, will collaborate to create and review the care plan.Family members and resident will be involved in care planning to the greatest extent possible, ensuring their preferences and choices are reflected in the plan.Review of the clinical record for Resident #5 revealed an admission date of 1/17/25. Diagnoses included: Cerebral Infarction (a stroke caused by a blocked blood vessel); Hemiplegia and Hemiparesis of right side (paralysis and weakness on one side of the body); Dementia; and Cognitive Communication Deficit.Review of the Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 3/16/26 revealed Resident #5 scored 3 of 15 in the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. The MDS noted that the resident was sometimes understood and her ability to express ideas and wants was limited to making concrete requests. Resident #5's ability to understand others was Sometimes understands-responds adequately to simple, direct communication only. Review of Resident #5's Care Plan with a review date of 3/19/26 revealed:Resident #5 was alert and oriented, able to make needs and wants known. A communication book was at bedside and in the activity room. The goal was for the resident to maintain involvement in cognitive stimulation and social activities as desired through review date.The care plan noted that Resident #5 had a communication problem related to Spanish speaking and neurological symptoms. The goal was for the resident to maintain current level of communication function and be able to make basic needs known on a daily basis.On 4/21/26 at 11:16 a.m., Resident #5 was observed in the activity room. In an interview, Registered Nurse (RN) Staff G, stated that Resident #5 only spoke Spanish. RN Staff G said she was not aware that Resident #5 used a communication book.On 4/21/26 at 10:30 a.m., and at 1:32 p.m., Resident #5 was observed in her room without a communication book at bedside. On 4/21/26 at 10:35 a.m., Resident #5 was observed in an activity. No communication book was observed with the resident or available to the resident in the activity room. On 4/21/26 at 1:35 p.m., Resident #5 was observed in the small activity room. No communication book was observed available to the resident.On 4/22/26 at 10:02 a.m. Resident #5 was observed in her bed. No communication book was visible in room.On 4/22/26 at 12:30 p.m., in an interview, Certified Nursing Assistant (CNA) Staff N stated that lately, she has not seen a communication book in Resident #5's room. She said she didn't see the communication book yesterday or today. On 4/22/26 at 12:35 p.m., in an interview, CNA Staff J stated that he wasn't aware that Resident #5 used a communication book and has not seen one. He said that he did not work directly with the resident but does help to supervise the activity room while she is present. He stated that he does not speak Spanish.On 4/22/26 at 3:10 p.m., in an interview, CNA Staff L said he did not take care of Resident #5 except when he is supervising the activity room. He said he didn't know that Resident #5 used a communication book. He said that he didn't speak Spanish, but there were staff who spoke Spanish.On 4/22/26 at 3:13 p.m., in an interview, Licensed Practical Nurse (LPN) Staff M stated that Resident #5 had a communication book in her room when she first came, but she had not seen it recently and did not know if she still had it. LPN Staff M said she spoke Spanish and was able to communicate with Resident #5.On 4/23/26 at 9:45 a.m., in an interview, the Director of Nursing (DON) said that she was not aware Resident #5 used a communication book. The (continued on next page)

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	105567	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springs at Lake Pointe Woods	3280 Lake Pointe Blvd Sarasota, FL 34231

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON said they usually assigned a staff member who speaks Spanish to the resident. The DON did not answer when asked how staff communicated with Resident #5 when she's in the activity room and the staff assigned to supervise the residents did not speak Spanish.On 4/23/26 at 10:02 a.m., the DON brought in a communication book which she said belonged to Resident #5. She said that she found the book in the resident's closet. She said she did not know the specific locations for the communication book listed in the resident's care plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, review of clinical records and resident and staff interviews the facility failed to provide the necessary care to maintain personal hygiene for 2 (Resident #86 and #56) of 5 residents who required staff assistance with activities of daily living (ADLs).The findings included:1. Review of the clinical record for Resident #86 revealed an admission date of 8/20/25. Diagnoses included dementia, repeated falls, anxiety and major depressive disorder.Review of the Significant Change Minimum Data Set (MDS) with an assessment reference date (ARD) of 2/05/26 revealed Resident #86 scored 09 of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment for daily decision making.Review of the care plan revealed that Resident #86 required assistance with Activities of Daily Living (ADLs) related to decreased mobility, generalized weakness and impaired cognition.The goal was for Resident #86 to have his ADL needs met as evidence by presenting in a clean, well-groomed manner. The interventions included to check nail length, trim and clean them on bath day and as necessary. Report any changes to the nurse. Provide sponge bath when a full bath or shower cannot be tolerated.Review of the CNA Kardex (contains instructions for care) revealed to keep Resident #86's fingernails short.On 4/20/26 at 2:10 p.m., Resident #86 was observed with 3 to 4 days of facial growth. The resident's fingernails extended approximately 1/2 inch with a brown substance underneath the nails. The resident's hair was not combed and looked greasy.On 4/21/26 at 11:28 a.m., Resident #86 remained unshaven. His fingernails remained untrimmed with a black substance under the nails. Resident #86 was not able to answer interview questions.Review of the shower schedule revealed that Resident #86's shower days were on Tuesdays and Fridays during the day shift. The shower schedule noted, Shower sheets MUST be turned in to nurse before end of shift!Review of the Certified Nursing Assistants (CNAs) logbook revealed individual shower sheets to be completed on shower days by the CNAs. The instructions on the form specified to turn in the form to the Unit Manager daily for shower confirmation.On 4/22/26, review of the shower sheets for Resident #86 revealed the resident had a shower on 4/1/26 and a bed bath on 4/8/26 and 4/15/26. On 4/8/26, Resident #86 refused a shower. Each shower sheet was signed by a licensed nurse. No other shower sheets were found for Resident #86 in the logbook. The shower sheets did not include documentation of nail care. Review of the electronic health record revealed that the CNA documentation for bathing for Resident #86 differed from the information entered in the shower sheets. The CNA documentation in the electronic health record documented that Resident #86 received a bed bath on 4/1/26 and 4/18/26 and a shower on 4/8/26. On 4/4/26 and 4/11/26, the CNA documented N/A (Not applicable) for bathing. Review of the nursing progress notes failed to provide documentation for the bed bath documented on shower days.2. Review of the clinical record for Resident #56 revealed and admission date of 3/27/26. Diagnoses included severe protein calorie malnutrition, anxiety disorder and difficulty walking.Review of the care plan initiated on 7/30/25 revealed that Resident #56 required assistance with ADLs related to decreased mobility and generalized weakness. The goal was for the resident to continue to have his ADL needs met as evidenced by presenting in a clean, well-groomed manner.The interventions specified that Resident #56 required assistance of 1 staff member with bathing/showering and dressing.The care plan initiated on 7/25/25 revealed that Resident #56 had a behavior problem related to refusing care and speaking inappropriately, yelling at staff. The goal was for the resident to have fewer episodes of refusing care, yelling at staff daily/weekly.Review of the CNA Kardex revealed Resident #56 required assistance of 1 staff member with bathing/showering.On 4/20/26 at 9:48 a.m., Resident #56 was observed in bed. He had approximately 4 days of facial hair growth. His fingernails extended approximately 1/2 inch with a brown substance under the nails.In an interview during the observation, Resident #56 said that he needed to see a podiatrist to have his toenails cut. He removed his socks. The resident's toenails were thick and beginning to curl over his toes. A brown substance was observed under the resident's nails. On 4/21/26 at 10:30 a.m., Resident #56 was observed in his bed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #56 was wearing the same shirt he had on the day before. He remained unshaven and his nails remained untrimmed with an accumulation of a brown substance under the nails.On 4/22/26 at 9:48 a.m., in an interview, Unit Manager Registered Nurse (RN) Staff G said Resident #56 was alert and oriented and did a lot of his own care. RN Staff G said that Resident #56 refuses care. The CNA's shave the men and do nail care on shower days and when needed.On 4/22/26 at 8:30 a.m., in an interview, the Director of Nursing (DON) said, We do not have a specific time to do nail care, I can't say it is done weekly or on this day. It should be once a week and men should be shaved. If you see it, you should do it.On 4/22/26 at 9:30 a.m., in an interview, CNA Staff H said nail care is completed daily, nails are cut and cleaned. The CNA said, If a resident refuses a shower, I try to encourage them and if they still refuse, I let the nurse know. If the resident continues to refuse, I tell the nurse, document it and give a bed bath.Review of the shower schedule documented revealed that Resident #56 showers were scheduled on Wednesdays and Saturdays on the day shift.Review of the CNA documentation for April 2026 revealed N/A (Not applicable) was documented on the scheduled shower days on 4/2/26, 4/6/26, 4/9/26, 4/13/26, 4/16/26, and 4/20/26. There was no documentation of nail care.On 4/22/26 at 3:20 p.m., in an interview, Unit Manager RN Staff G said she did not know what the CNAs meant by documenting N/A for showers. On 4/22/26 at 9:36 a.m., in an interview Licensed Practical Nurse (LPN) Staff C said the CNAs clean and file the residents' nails on shower days. Activities also do nail care.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations, resident and staff interviews, the facility failed to ensure the safe storage of medications for 3 (Residents #56, #24, and #97) of 3 residents observed with unsecured medications at the bedside. The findings included: On 4/20/26 at 9:48 a.m., a prefilled syringe of normal saline was observed in Resident #56' bed. In an interview, Resident #56 said that the nurse was in his room and had left the syringe of saline on his bed. On 4/20/26 at 11:52 a.m., observation of Resident #24's room revealed a bottle of nasal spray, 1 tube of anti-fungal cream and 2 bottles of eye lubricant stored unsecured at the resident's bedside. Photographic evidence obtained.On 4/20/26 at 12:01 p.m., a bottle of salicylic acid 17% (wart remover) was observed stored unsecured at Resident #97's bedside. Photographic evidence obtained.On 4/21/26 at 10:23 a.m., in an interview, Licensed Practical Nurse (LPN) Staff K verified the unsafe and unsecured storage of the medications at Residents #24, #97, and #56's bedside.