STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105655	A. Building B. Wing	03/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inn at Freedom Village, The	6410 21st Ave W Bradenton, FL 34209

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews the facility failed to ensure staff were competent to provide direct care to a resident with behaviors due to dementia for one (Resident #1) out of three residents sampled.Findings include: Review of Resident #1's admission Record dated 03/09/2026 showed Resident #1 was admitted to the facility on [DATE] with diagnoses to include but not limited to Parkinsonism, anxiety disorder, unspecified dementia with other behavioral disturbance. Resident #1 was admitted to the facility for short term rehabilitation. Resident #1 was successfully discharged home according to the plan on 3/3/2026. Review of a Minimum Data Set, dated [DATE] showed a Brief Interview for Mental Status Score of 09 which indicated Moderate cognitive impairment. Review of Resident #1's care plan did not reveal a plan of care to deal with Resident #1's behaviors related to dementia. Review of a nursing progress note dated 2/20/2026 showed, Patient combative with care tonight. Bowel movement smeared all over himself and bed. On 03/09/2026 at 12:02 PM, an interview was conducted with Staff G, Certified Nursing Assistant (CNA). Staff G said Staff H, CNA asked for assistance with Resident #1 as Resident #1 was agitated and she was having a hard time with him. Staff G, CNA said Resident # 1 was covered in feces. Staff G, CNA stated while trying to assist Resident #1, he grabbed her hands and bent her fingers. As they continued to care for him, when we rolled him over, he was trying to hit Staff H, CNA. Staff H took the pillow and put it over his arms telling him he was not going to be combative today. Staff G, CNA stated she was trying to explain to him that they were trying to clean him up. Staff G, CNA stated Resident #1 continuing to fight them. Staff H, CNA used the pillow to move the resident's arm out of the way. Staff H told him he was not going to be combative today while holding the pillow on his arms and proceeded to clean the resident up. Resident #1 told them he was not trying to be mean. Staff G stated this was her first time working with Resident # 1, so she was not familiar with his behavior. After Staff H held up the pillow Resident #1 calmed down. Staff G, CNA stated not being sure of what she had just witnessed. Staff G stated she had not seen this happen before with a pillow so she asked another CNA. The other CNA told her they must report the event to the nurse. Staff G stated she did not think she had to report the event to her nurse because she planned on asking the Director of Nurse (DON) when she arrived at work the next morning. Staff G stated the other CNA told her she had to follow chain of command. Staff G stated prior to the event she did not know if what Staff H did was right or not. Staff G stated the other CNA reported the situation to a nurse. O 03/09/2026 at 1:14 PM, an interview was conducted with Staff B, Registered Nurse, (RN)/Nurse Manager. Staff B, RN stated being notified by one of the nurses that Staff H, CNA used a pillow to lean on Resident #1 to prevent him from striking her. Staff B stated he had Staff H, CNA write a statement about what happened. Then Staff H, CNA was told to go to the administrator's office. Staff H, CNA reported that she used a pillow to hold Resident #1 arm down to prevent him from hitting her during care. Staff B stated certified nursing assistants are trained to notify the nurse, step away and reattempt if redirection is not successful when a resident is combative during care. Staff B stated the approach Staff H took was not according to training. On 03/09/2026 at 1:50 PM, an interview was conducted with Staff H, CNA. Staff H stated it was her first (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105655	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/09/2026
NAME OF PROVIDER OR SUPPLIER: Inn at Freedom Village, The		STREET ADDRESS, CITY, STATE, ZIP CODE: 6410 21st Ave W Bradenton, FL 34209	

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time taking care of Resident #1, so she was not aware of his behavior. Staff H stated she did not get a full report from the CNA who had him prior to her taking the assignment. She said she checked his Kardex. Staff H stated she changed Resident #1 at 1:00 AM. When checking on him later in the shift, around 3:00 AM, Resident #1 was covered in feces. Staff H stated she left the room to get Staff G to assist her with changing Resident #1. Staff H stated Resident #1 grabbed Staff G's wrist and was trying to hurt her, while we were trying to change him. Staff H stated that's why she went to get Staff G because when she went to change Resident #1 the first time he grabbed her wrist. This time as soon as he let go of Staff G's wrists, he swung at her with both of his arms, trying to hit her. Staff H stated that's when she took a pillow and leaned her right arm on Resident #1 to keep him from hitting them. She said she asked Resident #1 to stop hitting them. After a few seconds she tried to wipe Resident #1 using her left hand while at the same time using her right arm to hold the pillow against him, so he would not hit her. Staff H stated she held the Resident with the pillow for about 30 seconds. Then Staff G was able to put his pants on, and then she was able to put on his shirt. Then they assisted him to his chair. Staff H stated she did not know that she was not able to use a pillow to stop Resident #1 from hitting them, because she had always used this technique in other states. On 03/09/2026 at 2:25 PM, an interview was conducted with Staff I, CNA. Staff I stated Staff G and Staff H worked with her on the same unit. Staff G told her that she was in the room assisting Staff H with Resident #1. Resident #1 was being combative during care and Staff H took a pillow and to prevent him from hitting them. After they finished changing Resident #1. Staff I stated she told staff G they needed to report the event to the nurse immediately. On 03/09/2026 at 2:44 PM, an interview was conducted with the Nursing Home Administrator (NHA) and DON. The NHA stated the Assistant Director of Nurses (ADON) came to his office to tell him there was an event with a CNA and Resident #1. Based on his investigation when he interviewed Staff H, it was all clear she said that she put a pillow on the resident and she leaned on the pillow to keep him from hitting her. The NHA said they gave Staff H education on how to handle resident with behaviors properly and told her she should have stepped away to get the nurse. The NHA stated staff are provided with dementia education upon hire and annually. Review of the facility policy titled, Dementia Care: Managing Challenging Behaviors, not dated, showed: Section 3: Behavior Problems in People Living with Dementia Behaviors in Dementia. Interventions for Aggression: Agitation and aggression usually happen for a reason. If you can find the cause, you may be able to stop it. Some causes of aggression are: . Being pushed to complete ADLs . These things may lead to aggressive behaviors, such as hitting, biting, angry outbursts, yelling, screaming, and throwing things. You may choose to intervene by: . Reassuring and speaking calmly . Do not use restraints unless safety is an issue and then do so only according to your organization's policy. Always check with your supervisor before using restraints.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interviews and record review, the facility did not ensure a controlled prescribed medication was available for one (#1) out of three residents.Findings included: A record review of Resident #1's admission Record showed an admit date of 02/14/2026 and a discharge date of 03/03/2026 to home. Upon further review, Resident #1 had diagnoses to include but not limited to Parkinsonism unspecified, anxiety disorder unspecified and unspecified dementia unspecified severity, with other behavioral disturbance. A record review of Resident #1's hospital discharge medications include the following but not limited to Clonazepam 0.5 mg (milligram) oral tablet one tablet by mouth daily as needed for anxiety. A record review of Resident #1's physician orders include but not limited to Clonazepam tablet 0.5 mg give one tablet by mouth every 24 hours as needed for anxiousness related to anxiety disorder unspecified for 14 days, ordered 02/14/2026. A record review of Resident #1's MDS (Minimum Data Set) dated 02/21/2026, Section C-Cognition showed a BIMS (Brief Interview for Mental Status) of 09 which indicated the resident had moderate impairment with thinking and memory. In Section I- Active Diagnoses, the MDS showed non-Alzheimer's dementia and anxiety disorder as active diagnoses. A record review of Resident 1's progress notes, dated 02/18/2026 at 16:52 (4:52 p.m.), showed the following entry: New Behavior Noted. Please see POC documentation. No new behavior noted, Staff A, RN/ADON (Registered Nurse/Assistant Director of Nursing). On 03/09/2026 at 1:37 p.m., an interview was conducted with Staff A, RN/ADON regarding progress note entry. Staff A, RN/ADON stated during their daily morning clinical meetings, the dashboard from the electronic medical records will display events from the night before such as orders for labs, new medications, vital signs, and many more. Staff A, RN/ADON stated the dashboard alert was initiated from a Certified Nursing Assistant (CNA) note dated 02/17/2026 at 02:00 a.m., in which Resident #1 was noted as agitated and hitting others. When asked what others meant, Staff A, RN/ADON stated staff members. Staff A, RN/ADON stated a follow-up would be warranted from the clinical team. Staff A stated they would talk to the CNAs and ask if there were any behaviors. Staff A stated the physician, maybe psych services would be notified and/or consulted if there were continued behaviors. Staff A stated the CNAs during the day shift were interviewed and the resident had no agitated/combative behaviors. A record review of Resident #1's progress notes, dated 02/20/2026 at 03:33 a.m. showed the following entry: Patient combative with cares [SIC] tonight. BM [bowl movement] smeared all over himself and bed. Does have an order for Clonazepam 0.5 mg prn but no script. Pharmacy called, awaiting call back [primary physician] made aware, entered by Staff F, RN. On 03/09/2026 at 2:25 p.m., a telephone interview was conducted with the facility's contracted pharmaceutical services. A pharmacist on staff for the pharmacy stated an electronic prescription for Clonazepam 0.5 mg to dispense 10 tablets was received on 02/20/2026 and the facility received the tablets on 02/21/2026. The pharmacist stated there were no earlier prescriptions for Clonazepam received/faxed/called to the pharmacy before 02/20/2026. A record review of the psychiatric advance nurse practitioner (ARNP) with a date of service of 02/20/2026 showed the following: Reason for referral/chief complaint: Dementia inappropriate behavior, resistive to receive care and/or treatment. History of present illness: Resident #1 presents being followed for psychotropic medication management. He has been struggling with resisting ADL (activities of daily living) care at HS (at night). He presents alert in NAD (no abnormality detected). He has no recollection of last night other than not wanting to be changed. A medication intervention may help to comfort him. Treatment plan- continue klonopin 0.5 mg po (oral) q (every) 24 hours PRN (as needed) x (for) 14 days as currently prescribed. On 3/09/2026 at 2:47 p.m., a telephone interview was conducted with Resident #1's psychiatric ARNP. The ARNP stated she had a telehealth visit with the resident on 02/20/2026 with a follow-up visit on 02/27/2026. The psych ARNP stated the resident may have benefited from the Clonazepam but overall stated, he did not like to be changed. The psych ARNP stated she ordered the Clonazepam on (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/21/2026. The ARNP stated she believes the discharging hospital would send the prescription over with the resident upon discharge but ultimately the facility should follow up with the orders. The ARNP stated the facility should try non- medicated interventions as well to calm the resident. On 3/09/2026 at 5:20 p.m., an interview was conducted with Staff B, RN/Nurse Manager of A wing and Staff C, LPN (Licensed Practical Nurse)/Staff Manager C wing. Both staff members stated, when a prescription for a controlled substance arrives with for a new admit or readmit, they would fax the prescription to the pharmacy, call the pharmacy to confirm the prescription was received and package up the prescriptions to be delivered to the pharmacy via the delivery representative upon arrival to the facility. Both Staff B, RN and Staff C, LPN stated they do not make a copy of the original prescription or the confirmation fax receipt in the resident's medical record. On 3/09/2026 at 5:26 p.m., an interview was conducted with Staff D, RN/weekend supervisor. Staff D, RN stated her normal process for new admits/readmits would be to fax controlled prescription(s) to the pharmacy, confirm pharmacy had received the fax and would make a copy of the resident's face sheet, prescription and confirmed fax receipt and place behind the physician orders in the hard chart. Staff D, RN reviewed Resident #1's medical record documents. Staff D, RN recalled signing the basic care plan with the resident's family member and showed the document for observation. However, Staff D, RN could not show a copy of the hard script (prescription) or a copy of the confirmed fax to pharmacy. Staff D, RN stated during morning clinical meetings, all new admits and readmits are screened for a secondary chart check by utilization of a clinical admission check list. On 3/09/2026 at 6:09 p.m., an interview was conducted with Staff E, RN. Staff E, RN confirmed she was assigned to the admission of Resident #1. Staff E, RN stated her normal process would be to fax the script over to the pharmacy, wait 30-45 minutes, call the pharmacy to verify confirmation script was received, the hard copy would be provided to the pharmacy delivery representative and put a copy of the script in the resident's chart. Staff E, RN stated if a prescription was not provided by the discharging hospital, she would contact the admitting physician a prescription would be needed. Staff E, RN stated the physician can send a prescription over via e-script. From there, Staff E, RN stated she would call the pharmacy to confirm the prescription was received and could get an authorization to pull the medication, if available, from their [electronic medication dispensing machine]. On 3/09/2026 at 4:16 p.m., an interview was conducted with Resident #1's primary attending physician (MD). The MD stated with Resident #1's behavior during the time of the event (02/20/2026), may not have benefitted from administering Clonazepam. The MD stated the resident may not have been receptive to taking an oral medication at the moment the behavior was present. The MD does not recall receiving a call from pharmacy regarding this medication of Clonazepam. The MD stated he would not hesitate to prescribe a controlled medication or any medication if needed. The MD stated he does not know why the medication was not available. The MD stated the nurses would contact him if a prescription was needed. The MD stated for Resident #1 he could not state what happened but added it would be a matter of minutes for him to place the prescription. A record review of the discharging hospital's history and physical showed a list of Resident #1's home medications with Clonazepam 0.5 mg one tablet as needed for anxiety listed. On 3/09/2026 at 3:30 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated when a new admit, the hospital may send the hard prescription for a controlled substance or if not, the nurses should contact the admitting physician to inform if a prescription would be needed. The DON stated the Clonazepam was appropriately reconciled by evidence of the medication in the Medication Administration Record and would contact the pharmacy to verify when the prescription was received. The DON returned to state the pharmacy had not originally received the prescription/order for Clonazepam. A record review of the Resident #1's progress notes showed the following: Resident discharged home today with family at side. All belongings and copy of discharge forms (including upcoming appt on Thursday) provided to resident. Signed discharge forms placed in resident's chart. Medication was also provided to resident along with the PRN Klonopin. Staff B, RN The facility provided a policy titled, Controlled Substances revised (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	December 2012 which showed the following policy statement: The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of scheduled II and other controlled substances.