STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105774	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Indian Beach Nursing and Rehab Center	1755 18th St Sarasota, FL 34230

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 21322 Based on observation, record review, residents and staff interviews, the facility failed to ensure timely repairs to maintain a safe and comfortable environment for 8 (Residents #1, #2, #6, #19, #20, #21, #22, and #23) of 15 residents of the [NAME] wing (300 hall). The findings included: On 9/25/24 at 6:15 a.m., during a tour the temperature in the 300 hallway felt warmer than the rest of the facility. The thermostat in the hallway next to room [ROOM NUMBER] did not display a temperature. Photographic evidence obtained. On 9/25/24 at 6:29 a.m., a hygrometer was used to measure the temperature in the room shared by four Residents, (Residents #1, #2, #19 and #20). The temperature was 82.4 degrees Fahrenheit (F). On 9/25/24 at 6:30 a.m., Resident #1 was observed in bed, uncovered, wearing a brief. In an interview, Resident #1 said, It's hot. A large fan was observed blowing warm air into the room. Certified Nursing Assistant (CNA) Staff A was observed in Resident #1's room. She said the room was hot. Staff A said when she came on duty the fan was already in the room and did not know who placed it there. On 9/25/24 at 6:31 a.m., Resident #2 was observed getting out of bed. The resident was visibly upset and complained about the temperature. In an interview Resident #2 said it was impossible to do anything here or even sleep as it was so hot. The resident said the air conditioning has not been working for a year in his room and it's been very hot. (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: 105774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER Indian Beach Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1755 18th St Sarasota, FL 34230	

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #2 wiped visible sweat from his forehead and showed the sweat he wiped from his forehead on his hand. He walked away while complaining about the facility not making efforts to fix the air conditioning. The Director of Nursing (DON) was present during the interview and observation. On 9/25/24 at 6:35 a.m., the Director of Nursing verified the thermostat controlling the temperature in the rooms in the 300 hallway was not working. On 9/25/24 at 6:38 a.m., in an interview Housekeeper Staff B said he has been employed at the facility for approximately [AGE] years. He said the air conditioning has not been working in the 300 hallway for at least two weeks. On 9/25/24 at 6:41 a.m., the temperature of the back hallway where the activity room is located was 82.4 degrees F. The thermostat was set at 75.0 degrees F. The temperature displayed on the thermostat screen was 82.0 degrees F. Photographic evidence obtained. On 9/25/24 at approximately 6:45 a.m., in an interview Maintenance Assistance Staff C said he has been employed at the facility for six months. He said the Air Conditioning (A/C) has not been working in the 300 hallway for at least 20 days. Staff C said the Administrator knew about the A/C not working. He said he was told to install a window A/C unit in rooms 302, 304, 306 and 308 which he did. He verified rooms [ROOM NUMBERS] did not have a window A/C unit. When asked about the reason a window A/C unit was not provided to the eight residents in rooms [ROOM NUMBERS], Staff C said he did as he was told. He was not told to install an A/C unit in rooms [ROOM NUMBERS]. On 9/25/24 at 6:50 a.m., in an interview Resident #3 said it's been very hot until they installed a small window A/C unit the week before. On 9/25/24 at 6:51 a.m., in an interview Resident #4 said it's been very hot. She said they gave them a fan that was just blowing hot air. They installed a small A/C unit the week before. On 9/25/24 at 6:53 a.m., in an interview Resident #5 said it has been very hot in her room until they installed a small window A/C unit two months ago. On 9/25/24 at 6:55 a.m., the temperature in the room shared by four Residents (Residents #6, #21, #22 and #23) was 83.4 degrees F. Resident #6 was observed lying in bed uncovered. On 9/25/24 at 7:00 a.m., the DON provided a temperature monitoring log for 9/23/24 and 9/24/24. The log did not include temperatures in residents' rooms. In an interview the DON said she started taking temperatures since the A/C was not working. She said she knew the temperature must remain between 71.0 F and 81.0 F but she did not measure the temperature in the residents' rooms to ensure it remained within the specified range of 71.0 F to 81.0 F. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/25/24 at 7:45 a.m., in an interview Staff D said he's been helping with the maintenance of the facility since the Maintenance Director resigned in August 2024. He said he's been spot checking the temperatures but has not kept a log showing the temperature remained within the range of 71.0 F to 81.0 F. Staff D provided estimates from an outside company dated 4/21/24 and 9/17/24 with the repairs needed to the A/C system. Staff D verified the repairs had not been made. On 9/25/24 at 8:39 a.m., Resident #6 was observed in his room in the 300 hallway. At the time of the observation, the temperature was 83.4 F. In an interview Resident #6 said it's been very hot in his room, the A/C has not been working for a while. He said maybe the facility was trying to save energy or money by turning off the A/C. Resident #6 said, This morning it got so warm here. He said the facility's administration was aware of the issue with the temperature but, nothing has been done. On 9/25/24 at 8:40 a.m., in an interview Licensed Practical Nurse (LPN) Staff E said she has been employed at the facility for eight months. She said at times it gets very hot in the 300 hallway and the residents sometimes complain about the heat. She said when the residents complain, she reports it to the administration. She said the A/C company came out. On 9/25/24 at 12:30 p.m., in an interview the DON verified the facility did not install a window air conditioning unit to keep the temperature within the specified range for Residents #1, #2, #6, #19, #20, #21, #22, and #23 who reside in the 300 hall where the air conditioning has not been functioning.

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F 0585

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 21322

Based on observation, record review, review of facility's policies and procedures, residents and staff interviews, the facility failed to demonstrate prompt efforts to address and resolve grievances related to comfortable temperature, pest control and staff treatment of residents for 10 (Residents #1, #2, #7, #6, #5, #8, #9, #10, #11 and #13) of 10 sampled residents who complained about unresolved grievances.

The findings included:

The facility's policy for Complaint/Grievance with an effective date of 9/7/23 noted, The Center will support each resident's right to voice a complaint/grievance without fear of discrimination or reprisal. The center will make prompt efforts to resolve the complaint/grievance and inform the resident of progress towards resolution . The resident should have reasonable expectations of care and services and the center should address those expectation in a timely, reasonable, and consistent manner . An employee receiving a complaint/grievance from a resident, family member and/or visitor will initiate a Complaint/Grievance Form . The Grievance Officer/designee shall act on the grievance and begin follow-up of the concern or submit it to the appropriate department director for follow-up . The grievance follow up should be completed in a reasonable time frame; this should not exceed 14 days. The findings of the grievance shall be recorded on the Complaint/Grievance Form . The Grievance Official will log complaints/grievances on a Monthly Grievance log. The individual voicing the grievance will receive follow up communication with the resolution, a copy of the grievance resolution will be provided to the resident upon request.

On 9/25/24 at 6:29 a.m., the temperature in the room shared by Residents #1, #2, #19 and #20 was 82.4 degrees Fahrenheit (F).

On 9/25/24 at 6:30 a.m., in an interview Resident #1 complained the room was hot. He said the air conditioning (A/C) has not been working. They have complained about it and it was still not fixed.

On 9/25/24 at 6:31 a.m., Resident #2 was observed visibly upset and complaining about the temperature in the room. In an interview Resident #2 said he's complained to staff about the temperature in the room. He said the air conditioning has not been working for a year and it's been very hot. Resident #2 said nothing was done to address his complaint related to the temperature.

On 9/25/24 at 6:45 a.m., in an interview Maintenance Assistant Staff C said he's been employed at the facility for six months. He said the A/C has not been working for at least 20 days in the 300 hallway (Rooms 301, 302, 303, 304, 306 and 308). He said the Administration knew the A/C was not working. He did as he was told and installed a small window A/C unit in rooms 302, 304, 306 and 308. He was not instructed to install a window A/C unit in rooms [ROOM NUMBERS].

On 9/25/24 at 6:55 a.m., the temperature in the room shared by Residents #6, #21, #22, and #23 in the 300 hallway was 83.4 F.

(continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/25/24 at 7:00 a.m., the Director of Nursing (DON) said she was aware of the residents' complaints related to the temperature and said she knew the temperature had to be maintained between 71.0 F and 81.0 F. The DON said she did not measure the temperature in the residents' rooms to address and resolve their complaints related to comfortable temperature. On 9/25/24 at 8:39 a.m., Resident #6 was observed in his room. The temperature was 83.4 F. In an interview Resident #6 said it's been very hot in his room. He said maybe the facility was trying to save energy or money by turning off the AC. Resident #6 said, This morning it got so warm here. He said the administrative team was aware of the complaints related to the temperature but, nothing has been done. On 9/25/24 at 8:40 a.m., in an interview Licensed Practical Nurse (LPN) Staff E said she's been employed at the facility for eight months. She said at times it gets very hot in the 300 hallway and the residents sometimes complain about the heat. She said when the residents complain about the temperature, she reports it to the administration. On 9/25/24 at 8:45 a.m., in an interview Resident #7 said the facility had roaches. The resident said despite the multiple complaints about the roaches, they're still there and it's not any better. Resident #7 said he also complained to the Director of Nursing a month ago how difficult it was to obtain assistance when certain staff were on duty, and how staff make him feel like he's an inconvenience to them. He said at times the air conditioning does not work and it gets hot. When he complains, they keep saying they'll get a new air conditioner, it doesn't work. Period! On 9/25/24 at 10:21 a.m., in an interview the DON said she was aware of the complaints related to the ongoing issue related to pest control. The facility was trying to secure a contract with a new pest control company. On 9/25/24 at 11:50 a.m., a tour of the facility and residents interviews were conducted with the Director of Nursing. On 9/25/24 at 11:53 a.m., Resident #5 said she complained about roaches in her room. She said they sprayed the room, but the roaches come back. On 9/25/24 at 11:56 a.m., in an interview Resident #8 said there are quite a few roaches in his room. He said he's killed quite a few roaches. Resident #8 said he's complained about the roaches, but nothing has improved. Resident #8 also said he's complained to the DON about a specific staff member as she does not clean him when he is incontinent of stool. He said his grievance was not addressed as the Certified Nursing Assistant (CNA) was assigned to work with him this past weekend. The DON present during the interview verified she was aware of Resident #8's grievances related to pest control and care issues. On 9/25/24 at 12:00 p.m., in an interview Resident #9 said he's complained about staff taking too long to answer call lights. He said it takes 45 minutes to one hour. He said it happens all the time, on all shifts but mainly the night shift. He's seen no improvement. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/25/24 at 12:04 p.m., in an interview Resident #10 said he sees water bugs in his room fairly often. He said they spray the room routinely once a month with no improvement. He said he's also complained about staff slow response to the call lights to request assistance. He said it took hours to answer to the call lights. He's seen no improvement since he complained. Resident #10 added, it's a waste of time to use the call light, they don't answer. He said he's complained to the nurses many times over the [AGE] years he's lived at the facility but there has been no improvement. On 9/25/24 at 12:07 p.m., in an interview Resident #11 said she sees roaches all the time in her bathroom. On 9/25/24 at 12:15 p.m., in an interview Resident #13 said she was very upset and tells the DON all the time about the CNAs not answering the call lights. She said, The aides are terrible. They do not answer the call lights. Resident #13 said she's also complained about roaches in her room all the time. Review of the grievance/complaint log for July 2024, August 2024 and September 2024 showed one documented grievance related to pests on 7/24/24, no grievances related to the room temperatures and no grievances related to call lights and staff treatment. Review of the Resident council meeting minutes with the resident council president's permission revealed: On 5/23/24 old business included, Call light. Under new business, Pest control log book, A/C unit being serviced and call light response improving were noted. Five residents attended the meeting and did not include Residents #1, #2, #7, #6, #5, #8, #9, #10, #11 and #13. On 6/30/24, 14 residents attended the resident council meeting. The minutes noted new business included A/C unit maintenance, check and fixing. Temperature needs to be between 71.0 F and 81.0 F. Pest control log west wing, weekly service continues. Report all pest sightings. The residents' rights to verbalize complaints and the right to file grievances were discussed. Residents #1, #2, #7, #6, #5, #8, #9, #10, #11 and #13 did not attend the meeting. On 7/26/24 new business discussed during the resident council meeting included A/C units being fixed in 500 and 300 halls, temperature regulations between 71.0 F and 81.0 F, pest control program: Spray in attic and throughout the building, report sightings to nurses and CNAs and document in pest control book. Residents #1, #2, #7, #6, #5, #8, #9, #10, #11 and #13 did not attend the meeting. On 8/22/24 new business discussed during the resident council meeting included air conditioning 300 hall partial, 700 hall are being serviced. Maintenance and A/C specialist needs new air handler and compressor. Residents #1, #2, #7, #6, #5, #8, #9, #10, #11 did not attend the meeting. Resident #13 attended the meeting. The topics discussed did not include Resident #13's grievance related to staff not answering the call lights and pest control. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/12/24 new business discussed in resident council meeting included AC units: 300 hall being serviced. Missing handler and condenser. Residents #1, #2, #7, #6, #5, #8, #9, #10, #11 and #13 did not attend the meeting. The DON provided an inservice/education record done on 9/18/24. The summary of content was, Be present at all times. Answer call bells in a timely manner and provide assist. [sic] requested. Not more than one staff member off unit at a time. Cover each other's breaks. Sixteen CNAs and eight licensed nurses attended the inservice. On 9/25/24 at 12:30 p.m., in an interview the DON verified she did not have documentation of the grievances voiced by Residents #1, #2, #7, #6, #5, #8, #9, #10, #11 and #13. She verified she did not follow up with the residents with steps taken to address their complaint and ensure the grievances were resolved to the residents' satisfaction.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21322 Based on observation, record review, resident and staff interviews, the facility failed to implement effective pest control measures to address ongoing sightings of roaches. The findings included: On 9/25/24 at 5:45 a.m., Licensed Practical Nurse (LPN) Staff E was observed swiping a live brown crawling insect from the top of the medication cart of the secured unit. LPN Staff E said it was a small roach. The live insect was observed crawling away on the floor. Staff E did not attempt to kill the insect. On 9/25/24 at 8:45 a.m., in an interview Resident #7 said the facility had roaches. The resident said despite the multiple complaints about the roaches, they're still there and it's not any better. On 9/25/24 at 10:05 a.m., LPN Staff F said she sees roaches at the facility but mostly when it rains. She was not sure on how often they spray for roaches. On 9/25/24 at 10:21 a.m., in an interview the DON said she was aware of the complaints related to the ongoing issue related to pest control. The facility was trying to secure a contract with a new pest control company. On 9/25/24 at 10:30 a.m., a live brown insect was observed crawling out of a dresser in room [ROOM NUMBER]. A review of the pest sighting log from November 2023 to present showed in addition to roaches observed in other areas of the facility, recurrent sighting of roaches documented included: 12/26/23: Roaches in rooms 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, nurses station. 1/06/24: Roaches in all 300, 400, and 500 rooms. 1/22/24: Roaches in room [ROOM NUMBER]. 2/01/24: Roaches in rooms 802, 804, 806, 808, and oxygen room. 2/20/24: Roaches in rooms 809, 807, 812, and private dining. 2/28/24: Roaches in room [ROOM NUMBER], and east nurse station. 3/01/24: Roaches rooms 809, 811, 807, 805, 803 and 801. 5/06/24: Roaches in rooms and bathrooms of 802, 804, 806, 808, 810, and 812. 5/20/24: Roaches in rooms 802, 804, 806, 808, 810, 812, 800, and supplies room. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/23/24: Roaches in rooms 801, 803, 805, 807, 809, and 811. 6/07/24: Roaches in rooms 802, 804, 808, 806, 801, and 812. 6/18/24: Roaches in rooms 801, 803, 805, 807, and 809. 6/29/24: Roaches [NAME] in every room. 6/29/24: Roaches split side in every room. 7/05/24: Roaches in rooms 802, 804, 806, 808, 810, 812, 801, 803, 809, 807, 809, and 811. 7/10/24: Large cockroach in rooms 802, 804, 806, 808, 810, and 812. 7/24/24: Roaches in rooms 801, 803, 805, 807, 809, 811, and drain in east wing shower. 7/25/24: Roaches in rooms 802, and 804. 8/13/24: Roaches in rooms 802, 804, 806, 808, 810, and 812. 8/13/24: Roaches in East Wing nourishment room, mattress room, medical records storage, rooms 301, 302, 303, 304, 306, 308, housekeeping closet, west wing soiled linen room, laundry and vending room. 8/15/24: Roaches west wing, nurses station, sink across station, and west wing med room 8/28/24: Winged bugs west nurse's station. 9/9/24: Roaches in rooms 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, and 400 hall especially around sink. 9/19/24: Roaches in the kitchen dish room. On 9/25/24 at 10:35 a.m., in a telephone interview the technician of the pest control company said he used to be assigned to this facility but had not been there for over a year. He said he made one visit to the facility on [DATE] to cover for the current technician. He said the facility's problem is American cockroaches. Last year he recommended the facility seal all the entry points for the roaches. He was surprised on 9/13/24 to find out they still had not done that. The technician said it did not matter what they sprayed or how often they sprayed for roaches. It was useless unless they sealed all the entry points. He said the problem was the doors of the 800 hallway. The outside was clearly visible between the doors and that was where the roaches came in. Review of the service inspection reports from the pest control company provided by the DON showed the most recent pest control company visits were on: 7/11/24, 7/18/24, 7/25/24, 8/1/24, 8/8/24, 8/19/24, 9/6/24, and 9/13/24. Each report noted, Weekly callback service for covered pest, (Resident Rooms per request/logbook) (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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Monthly Service for common areas, Kitchen/Dining areas, Housekeeping/Laundry, Activity/Therapy rooms, Dry food Storage, courtyard, Dumpster Area, EXT (exterior) perimeter. Previous pest control service inspection reports provided by the DON showed on 5/30/23, general comments/instructions noted, Having roach issues . Conditions: Cracks & crevices-unsealed. Action: Seal opening. The report noted the observation was reported on 5/11/22, and reviewed 5/30/23. The same recommendation was noted on the service inspection report for 6/7/23. On 9/25/24 at 11:50 a.m., a tour of the facility and resident interviews were conducted with the Director of Nursing. On 9/25/24 at 11:53 a.m., Resident #5 said she complained about roaches in her room. She said they sprayed the room but the roaches come back. On 9/25/24 at 11:56 a.m., in an interview Resident #8 said there are quite a few roaches in his room. He said he's killed quite a few roaches. Resident #8 said he's complained about the roaches but nothing has improved. On 9/25/24 at 12:00 p.m., Resident #9 from time to time there are quite a few roaches in his room. The resident said he thought it was normal to see roaches, it's Florida. On 9/25/24 at 12:04 p.m., in an interview Resident #10 said he sees water bugs in his room fairly often. He said they spray the room routinely once a month with no improvement. The DON who was present for each interview asked Resident #10 what water bugs were. Resident #10 said, large roaches. On 9/25/24 at 12:07 p.m., in an interview Resident #11 said she sees roaches all the time in her bathroom. On 9/25/24 at 12:15 p.m., in an interview Resident #13 said she's complained about roaches in her room all the time. On 9/25/24 at 12:18 p.m., observation of the doors of the 800 hallway with the DON showed they did not seal properly. The outside was clearly visible between the two doors. The DON verified the doors did not seal properly, leaving gaps where insects could easily crawl in the facility. Photographic evidence obtained.