

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  12/17/2025
NAME OF PROVIDER OR SUPPLIER  Indian Beach Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0602  Level of Harm - Actual harm  Residents Affected - Many	Protect each resident from the wrongful use of the resident's belongings or money.  (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0602  Level of Harm - Actual harm  Residents Affected - Many	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, record review and facility policy the facility failed to protect the residents' rights to be free from misappropriation of residents' property for 6 (Residents #1, #2, #3, #4, #5 and #6) of 6 residents reviewed out of 51 residents whose personal funds are managed by the facility. The findings included: Review of the Facility's Policy titled Abuse, Neglect, Exploitation &amp; Misappropriation with an effective date of [DATE], and a revision date of [DATE] documented: It is inherent in the nature and dignity of each resident at the center the he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property. The management of the facility recognizes these rights and hereby establishes the following statements, policies, and procedures to protect these rights and to establish a disciplinary policy, which results in the fair and timely treatment of occurrences of resident abuse. Employees of the center are charged with a continuing obligation to treat residents so they are free from abuse, neglect, mistreatment, and/or misappropriation of property. No employee may at any time commit an act of physical, psychological, or emotional abuse, neglect, mistreatment, and/or misappropriation of property against any resident. Violation of this standard will subject employees to disciplinary action, including dismissal, provided herein. Definition: Misappropriation of resident property is the deliberate misplacement, exploitation, or wrongful, temporary, permanent use of a resident's belongings or money without the resident's consent. Misappropriation includes but it not limited to theft of money from bank accounts and a resident who provides monetary assistance to staff, after staff had made the resident believe that staff was in a financial crisis. Review of the clinical record revealed Resident #1 was admitted to the facility [DATE]. Diagnoses included atherosclerotic heart disease, unspecified dementia, chronic kidney disease stage 3, and chronic pain. Review of the Quarterly Minimum Data Set (MDS) with an assessment reference date of [DATE] documented resident was independent with Activities of Daily Living (ADLs). The MDS noted the residents' cognitive status was intact. Review of the Resident Fund Management Authorization Service Authorization and Agreement Form to handle resident funds documented Resident #1 signed the form [DATE]. Review of Resident #1 Resident Fund Statement documented the resident made the following withdrawals: [DATE] personal needs items \$150.00XXX[DATE] personal needs items \$150.00XXX[DATE] tobacco \$150.00XXX[DATE] personal needs items \$150.00XXX[DATE] personal needs items \$100.00XXX[DATE] personal needs items \$100.00XXX[DATE] personal needs items \$300.00XXX[DATE] tobacco \$100.00XXX[DATE] clothing \$100.00XXX[DATE] tobacco \$200.00XXX[DATE] tobacco \$100.00. Review of accounting records for petty cash disbursements for the month of [DATE] revealed no receipts for Resident #1 for personal needs items. Review of the accounting records for petty cash disbursements for the month of [DATE] revealed no receipts for tobacco, personal needs items, or clothing. On [DATE] at 11:55 a.m., in an interview with Resident #1 said the facility manages her finances. Resident #1 said, I am missing a lot of money. She said the facility gave her financial statements, but no one explained them to her. She said she only gets \$40 each time she can. Resident #1 looked at the facility provided financial statements for [DATE], and [DATE] and said, Look at me, do you think I buy new clothes?. Resident #1 said she does not smoke and was being charged for tobacco. She said she never drew out that much money for personal care needs. Resident #1 said she was only able to withdraw \$100 once so she could buy the former Business Office Manager (BOM) a gift. She said the former BOM said she had lost her car and was living with a friend. She felt bad for the former (BOM), but it turns out she was stealing from me this whole time. She said the former (BOM) would also do weird stuff when she would withdraw money. She said the former BOM would grab money from the safe and would always go to her purse before handing over the money. She said she was furious because, I only have so much. She said that her family took the house and now the facility has taken everything else. Resident #1 was crying and said, This is all I have. Review of the clinical record revealed Resident #2 was admitted to the facility [DATE]. Diagnoses included hypertensive encephalopathy, major depressive disorder, unspecified dementia, and depression. Review of the Quarterly MDS with an assessment reference date of [DATE] documented the resident was independent with Activities of Daily Living (ADLs). The MDS noted the residents' cognitive status was intact. Review of the Resident Fund Management Authorization Service Authorization and Agreement Form to handle resident funds documented Resident #2 signed the form [DATE]. Review of Resident #2 Resident Fund Statement for [DATE], documented the resident made the following withdrawals: [DATE] telephone charges \$200.00XXX[DATE]</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on record review, review of facility policy and procedure and staff interview, the facility failed to report an allegation of misappropriation of resident property within required timeframe for 1 of 3 incidents reviewed. The findings included: Review of the Facility's Policy Abuse, Neglect, Exploitation &amp; Misappropriation effective date 11/30/2014, revision date 11/28/2017 documented Policy: It is inherent in the nature and dignity of each resident at the center the he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property. The management of the facility recognizes these rights and hereby establishes the following statements, policies, and procedures to protect these rights and to establish a disciplinary policy, which results in the fair and timely treatment of occurrences of resident abuse. Employees of the center are charged with a continuing obligation to treat residents so they are free from abuse, neglect, mistreatment, and/or misappropriation of property. No employee may at any time commit an act of physical, psychological, or emotional abuse, neglect, mistreatment, and/or misappropriation of property against any resident. Violation of this standard will subject employees to disciplinary action, including dismissal, provided herein. Investigation: The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse, neglect, misappropriation and exploitation. A Social Service representative may be offered in the role of resident advocate during any questioning or of interviewing of residents. Reporting: Any employee or contracted service provider who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident is obligated to report such information immediately, but no later than 2 hours after the allegation is made. Review of the facility's allegations of abuse, neglect, exploitation and misappropriation of residents property reports to the Agency for Healthcare Administration revealed that on 10/24/25 at 1:40 p.m., the facility reported an allegation of misappropriation of resident's property to law enforcement. The allegation of misappropriation of resident's property was reported to Agency for Healthcare Administration on 10/24/25 at 3:34 p.m., and to the Abuse registry on 10/28/25. Review of the facility provided investigation revealed that 10/22/25 at approximately 10:30 a.m., the [NAME] President of Finance was contacted and made aware that the former Business Office Manager (BOM) had called off via text message for the second day and there was only \$125.00 in the Resident Fund Management System (RFMS) cash box for residents. The cash amount was verified by Human Resources. The [NAME] President of Finances notified the Nursing Home Administrator (NHA) on 10/22/25 and informed him that the residents' cash box should have more funds available since the former BOM cashed a petty cash check on 10/20/25. On 12/16/25 at 1:04 p.m., in an interview the Nursing Home Administrator (NHA) said he was investigating missing money from the petty cash box on 10/22/25 in the amount of \$905.00. He said he looked and could not find any receipts for the missing money. He said the previous BOM was terminated and verified the facility filed a report for the allegation of misappropriation of residents' property report with the Agency for Healthcare Administration and law enforcement on 10/24/25, and the Department of Children and Families on 10/28/25.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, review of the facility's policy and procedure, residents and staff interviews, the facility failed to thoroughly investigate an allegation of misappropriation of residents' property for 1 of 1 incident investigation related to misappropriation of residents' personal funds reviewed. The findings included: Review of the facility's policy and procedure titled, Abuse, Neglect, Exploitation &amp; Misappropriation with an effective date of [DATE] and a revision date of [DATE] revealed, It is inherent in the nature and dignity of each resident at the center he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property. Employees of the center are charged with a continuing obligation to treat residents so they are free from abuse, neglect, mistreatment, and/or misappropriation of property. No employee may at any time commit an act of physical, psychological, or emotional abuse, neglect, mistreatment, and/or misappropriation of property against any resident. Misappropriation of resident property is the deliberate misplacement, exploitation, or wrongful, temporary, permanent use of a resident's belongings or money without the resident's consent. Misappropriation includes but is not limited to: Theft of money from bank accounts. Unauthorized or coerced purchases from residents' funds. A resident who provides monetary assistance to staff, after staff had made the resident believe that staff was in a financial crisis. Procedure. Investigation. The Abuse Coordinator or his/her designee shall investigate all reports or allegations of misappropriation and exploitation. A Social Service representative may be offered in the role of resident advocate during any questioning of or interviewing of residents. Review of the facility provided incident investigations revealed on [DATE] the facility initiated an investigation of misappropriation of Resident Property. The investigation noted that on [DATE] the Nursing Home Administrator (NHA) was made aware of an alleged misappropriation of resident funds from the Resident Fund Management Service (RFMS) account. When dispersing resident funds to residents, the cash box contained only \$125.00. The facility cash box should have contained \$1030.00. The facility investigation noted former Business Office Manager (BOM) was the alleged perpetrator. The investigation documented on [DATE] at approximately 10:30 a.m. the [NAME] President of Finance was contacted and made aware that the former BOM had called off via text message for the second day and there was only \$125.00 in the Resident Fund Management System (RFMS) cash box for residents. The cash amount was verified by Human Resources. The [NAME] President of Finances notified the Nursing Home Administrator (NHA) on [DATE] and informed him the residents cash box should have more funds available due to the former BOM cashing a petty cash check on [DATE]. On [DATE] at 1:04 p.m., in an interview the Nursing Home Administrator (NHA) said he was investigating missing money from the petty cash box on [DATE] in the amount of \$905.00. He said he looked and could not find any of the missing receipts. He said the former BOM was terminated and he filed a report with Agency for Healthcare Administration, the Sarasota Police and the Department of Children and Families. The NHA said the former BOM was hired on [DATE]. He said the facility did not go back and investigate to see if other monies were missing. A review of a sample of 6 of 51 residents who chose to have the facility manage their personal funds revealed: Resident #1 signed an authorization for the facility to handle her funds on [DATE]. Review of the Resident Fund Statements revealed in [DATE], and [DATE], Resident #1 withdrew a total of \$950.00 for personal needs items, \$100.00 for clothing and \$550.00 for tobacco. Review of the accounting record revealed no receipts for the withdrawals. On [DATE] at 11:55 a.m., in an interview with Resident #1 said the facility manages her finances. Resident #1 said, I am missing a lot of money. She said the facility gave her financial statements, but no one explained them to her. She said she only gets \$40 each time she can. Resident #1 looked at the facility provided financial statements for [DATE], and [DATE] and said, Look at me, do you think I buy new clothes?. Resident #1 said she does not smoke and was being charged for tobacco. She said she never drew out that much money for personal care needs. Resident #1 said she was only able to withdraw \$100 once so she could buy the former Business Office Manager (BOM) a gift. She said the former BOM said she had lost her car and was living with a friend. She felt bad for the former (BOM), but it turns out she was stealing from me this whole time. She said the former (BOM) would also do weird stuff when she would withdraw money. She said the former BOM would grab money from the safe and would always go to her purse before handing over the money. She said she was furious because, I only have so much. She said that her family took the house and now the facility has taken everything else. Resident #1 was crying and said</p>		

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F 0835  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently.  (continued on next page)

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, review of the facility's policies and procedures, residents and staff interviews, the facility administration failed to utilize its resources effectively and provide the necessary oversight to prevent the misappropriation of residents' personal funds for 6 (Residents #1, #2, #3, #4, #5 and #6) of 6 of 51 residents whose funds are managed by the facility. The findings included: Review of the Business Office Manager's job description revealed the duties and responsibilities included to maintain current and accurate computer data including documentation of all account activity performed in A/R (Account Receivable) systems. Complete cash log as required. Maintain compliance with all state, federal, and government agencies. Perform all other business-related duties as assigned. Review of the facility's policy and procedure titled, Abuse, Neglect, Exploitation &amp; Misappropriation with an effective date of [DATE] and a revision date of [DATE] revealed, The center is committed to the prevention of . misappropriation of resident property, and exploitation. The following systems have been implemented . Department Heads and supervisors that monitor staff to identify inappropriate behavior. Review of the facility provided investigations revealed on [DATE] the facility initiated an investigation for an allegation of misappropriation of Resident Property/Exploitation. The investigation noted that on [DATE] the Nursing Home Administrator (NHA) was notified that the cash box contained \$125.00. The residents' cash box should have more funds available due to the former Business Office Manager (BOM) cashing a resident petty cash check on [DATE] for \$1,030.00. The alleged perpetrator was the former Business Office Manager. The former Business Office Manager was not able to provide receipts or an explanation for the missing money. A total of \$905.00 was unaccounted for. The investigation noted that Quarterly statements for [DATE] through [DATE] were printed and provided to residents or responsible parties. The investigation noted that on [DATE] the facility verified the allegation of misappropriation of residents property and noted, Based on the findings of this investigation and reviewing of resident's statements it appears [name] Business Office Manager removed \$905.00 from the RFMS (Resident Fund Management Service) petty cash account box and could not provide receipts or an explanation of the location of the missing funds. The event was verified after the audit of the cash box. Interviewed with residents revealed no concerns with accounts. On [DATE], a review of a sample of 6 of 51 residents who chose to have the facility manage their personal funds revealed: Resident #1 signed an authorization for the facility to handle her funds on [DATE]. Review of the Resident Fund Statements revealed in [DATE], and [DATE], Resident #1 withdrew a total of \$950.00 for personal needs items, \$100.00 for clothing and \$550.00 for tobacco. Review of the accounting record revealed no receipts for the withdrawals. On [DATE] at 11:55 a. m., in an interview with Resident #1 said the facility manages her finances. Resident #1 said, I am missing a lot of money. She said the facility gave her financial statements, but no one explained them to her. She said she only gets \$40 each time she can. Resident #1 looked at the facility provided financial statements for [DATE], and [DATE] and said, Look at me, do you think I buy new clothes?. Resident #1 said she does not smoke and was being charged for tobacco. She said she never drew out that much money for personal care needs. Resident #1 said she was only able to withdraw \$100 once so she could buy the former Business Office Manager (BOM) a gift. She said the former BOM said she had lost her car and was living with a friend. She felt bad for the former (BOM), but it turns out she was stealing from me this whole time. She said the former (BOM) would also do weird stuff when she would withdraw money. She said the former BOM would grab money from the safe and would always go to her purse before handing over the money. She said she was furious because, I only have so much. She said that her family took the house and now the facility has taken everything else. Resident #1 was crying and said, This is all I have. Resident #3 signed an authorization on [DATE] for the facility to handle his personal funds. Review of the resident's funds statements for [DATE], [DATE] and [DATE] revealed Resident #3 withdrew a total of \$260.00 for tobacco and \$700.00 for personal care items. Review of the accounting records for petty cash disbursement revealed no receipts for the withdrawals for tobacco and personal care items for Resident #3. On [DATE] at 1:34 p.m., in an interview Resident #3 said the facility manages his money and he gets about \$250 a month. He said he gets \$40 every time he gets money out, never more than that. He said most of the time he has to sign something when he gets his money, but not every time. Resident #2 signed an authorization for the facility to handle his personal funds on [DATE]. Review of the Resident Fund Statements revealed in [DATE], Resident #2 withdrew \$200.00 for telephone charges and a total of \$400.00 for personal needs items. Review of the</p>		