

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  01/09/2025
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)
<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30599</p> <p>Based on record review and interview, the facility failed to complete a significant change in status assessment for 1 (Resident #17) of 1 sampled resident with a 9.41% weight loss over a six month period and developed an unstageable pressure ulcer.</p> <p>The findings included:</p> <p>Clinical record review for Resident #17 revealed an admitted [DATE]. Diagnoses included COPD (Chronic Obstructive Pulmonary Disease), Hypertension, Dysphagia (swallowing difficulties), Depression, Anxiety, and Bipolar Disorder (mood swings ranging from depressive lows to manic highs).</p> <p>The Quarterly Minimum Data Set (MDS) assessment with a target date of 11/14/24 noted Resident #17's cognition was moderately impaired with a Brief Interview for Mental Status score of 09. Resident #17 used a wheelchair for mobility and required substantial assistance from staff to roll from left to right, transfer, and going from a lying to sitting position. The assessment noted Resident #17 was not on a physician-prescribed weight-loss regimen and had a weight loss of 5% or more in the last month or 10% or more in the last six months. The assessment noted the resident was at risk for pressure ulcers but did not have one or more unhealed pressure ulcers.</p> <p>Review of the weight record showed Resident #17 lost 9.5 lbs. from 6/20/24 (101 lbs.) to 12/19/24 (91.5 lbs.).</p> <p>Review of the progress notes revealed documentation on 12/16/24 Resident #17 had a left buttock wound.</p> <p>On 12/18/24, the Wound Care Specialist documented Resident #17 had an unstageable pressure wound to left Ischium (back of hip bone) measuring 1.0 centimeter (cm) by 1.5 cm by 0.3 cm.</p> <p>Review of the care plan with a revision date of 11/20/24 revealed documentation Resident #17 has the potential for pressure ulcer development related to malnutrition, fragile skin, decreased mobility, bladder and bowel incontinence.</p> <p>On 1/7/25 at 1:42 p.m., in an interview the MDS coordinator verified Resident #17 had a significant weight loss from 6/20/24 to 12/19/24 and had developed an unstageable pressure ulcer on 12/18/24. She said a significant change in status MDS assessment should have been done.</p>

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
---	-------	-----------