STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105817	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plymouth Harbor Incorporated	700 John Ringling Blvd Sarasota, FL 34236

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on clinical record review, resident representative and staff interviews, the facility failed to ensure the clinical record accurately reflected the residents' advance directives for 2 (Residents #5 and #8) of 2 residents reviewed for advance directives. The findings included: Review of the facility's Advance Directive Policy (revised [DATE]) revealed prior to or upon admission of a resident, the Social Services Director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. Upon admission the interdisciplinary team assesses the resident's decision-making capacity and identifies the primary decision-maker if the resident is determined not to have decision-making capacity. 1. Review of the clinical record for Resident #5 revealed an admitted [DATE]. Diagnoses included but were not limited to, cerebral infarction (stroke) and dementia. Review of the Minimum Data Set (MDS) Assessment with a target date of [DATE] revealed Resident #5 scored a six (6) on the Brief Interview for Mental Status (BIMS), indicating severe impaired cognition. Review of the physician's order dated [DATE] revealed Resident #5 had a full code status, meaning cardiopulmonary resuscitation (CPR) would be initiated if the resident had no pulse or respirations. Review of the Resident #5's care plan initiated on [DATE] revealed an Advance Directive Care Plan which noted Resident #5 had a full code status. Review of the incapacity statement signed by the attending physician and dated [DATE] showed Resident #5 was unable to make informed health care decisions or provide informed consent. Review of the progress note written on [DATE] by Registered Nurse (RN) MDS Coordinator revealed a plan of care meeting was conducted for Resident #5. The legal representative's preference for code status was DNR, do not resuscitate. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:10 a.m., in a telephone interview the legal representative said he told the nurse at the plan of care meeting Resident #5's code status was Do Not Resuscitate (DNR) meaning CPR would not be initiated if the resident had no pulse or respirations. On [DATE] at 5:28 p.m., in an interview the MDS coordinator said that Resident #5's medical record was incorrect and the code status should be DNR. She said she did not correct the code status when she wrote the note on [DATE]. On [DATE] at 5:47 p.m., in an interview the Director of Nursing (DON) said if the resident is incapacitated the legal representative is asked for code status preference and the record checked for accuracy. On [DATE] at 6:12 p.m., the Nursing Home Administrator (NHA) reviewed the entire medical record including the paper chart. The NHA said there was no Florida DNR order in the record, which is required for DNR status. She said after the facility was aware the representative wanted DNR status, the facility should have obtained the required document and changed the medical record to DNR. On [DATE] at 7:18 a.m., in an interview the Assistant Director of Nursing (ADON) said she contacted Resident #5's legal representative, and the preference is DNR. She said the facility had the incorrect code status in the medical record. 2. Review of the clinical record for Resident #8 revealed an admitted [DATE]. Diagnoses included pelvic fracture, acute pain and history of falling. Review of the Minimum Data Set (MDS) Assessment with a target date of [DATE] revealed Resident #8 scored a 13 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. Review of the physician's order dated [DATE] revealed Resident #8 had a full code status. Review of the care plan revealed no care plan for Advance Directives. Review of the clinical record including electronic and paper records revealed Resident #8 was full code status and CPR would be performed. Review of the hospital record dated [DATE] for Resident #8 revealed wishes to defer code status decision to the son. On [DATE] at 3:04 p.m., in a telephone interview the resident's son and power of attorney said Resident #8 does not comprehend informed health care decisions consistently and is often confused. He said the code status should be DNR. He said the resident signed a Florida DNR yellow form last year on [DATE] when the resident went to the same facility for rehabilitation. He said he thought it would carry over. He said the facility staff did not ask him about code preference. He assumed Resident #8 was DNR. On [DATE] 5:05 p.m., during an interview with Resident #8 and the son at the facility, the son said Resident #8 is a DNR. Resident #8 said she did not want CPR. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On ,d+[DATE] 25 at 5:48 p.m., during an interview with Resident #8 in the bedroom, the resident told the DON she wanted DNR status in the facility. On [DATE] 6:29 p.m., the DON said she did not know the resident was undecided on code status when she was admitted , or she would have included the son in the decision. She obtained the old chart from the medical records file cabinet, which contained the DNR order dated [DATE]. On [DATE] 7:40 a.m., in an interview the Assistant Director of Nursing (ADON) said she did not consult the son with Resident #8's code status at any time during this admission. On [DATE] at 10:16 p.m. in a telephone interview Licensed Practical Nurse (LPN) Staff C said she admitted Resident #8 on [DATE]. She said the resident was undecided on code status and wanted to ask her son. The resident did not have a yellow DNR form, so she documented the resident would be full code. She said she did not write a progress note about the discussion. She thought someone else would follow up. In an interview with the DON on [DATE] at 12:23 p.m., she said she was not aware the resident was undecided on the code status because there was no documentation about it, and no one told her. The DON confirmed they had the hospital note indicating the resident deferred to her son for code status. The DON obtained the Florida DNR order the resident signed on [DATE] from the previous admission.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on observation, interview and record review, the facility failed to develop, implement and revise the care plan to meet the needs and preferences of 3 (Residents #5, #8 and #12) of 3 reviewed for care plans. The findings included: 1. Review of Resident #5's clinical record revealed an admitted [DATE]. Diagnoses included cerebral infarction and dementia. Review of the Minimum Data Set (MDS) Assessment with a target date of [DATE] revealed Resident #5's cognition was severely impaired with a Brief Interview for Mental Status (BIMS) score of 06. Review of the incapacity statement signed by the attending physician and dated [DATE] showed Resident #5 was unable to make informed health care decisions or provide informed consent. On [DATE] at 12:37 p.m., Certified Nursing Assistant (CNA) Staff D was observed assisting Resident #5 with her lunch. In an interview during the observation, CNA Staff D said Resident #5 did not speak. Resident #5 stared straight ahead and did not respond to several attempts to interview. On [DATE] at 10:10 a.m., in a telephone interview the resident's Power of Attorney (POA) for health care said he was one of the resident's sons and made all health care decisions because Resident #5 was unable. He said he discussed the code status with the nurse. Resident #5's code status was DNR (Do not resuscitate) and the facility should not perform CPR (cardiopulmonary resuscitation). Review of nursing progress notes revealed on [DATE] MDS coordinator Registered Nurse (RN) Staff A documented the resident's healthcare representative decided Resident #5 would be Do Not Resuscitate (DNR). Review of the care plan for Advance Directives initiated on [DATE] and reviewed on [DATE] revealed Resident #5's code status was full code meaning cardiopulmonary resuscitation (CPR) would be initiated if the resident's heart or breathing would stop. Record review of the electronic and paper clinical record revealed no Florida DNR on file. On /,d+[DATE] at 9:20 a.m., in an interview the MDS coordinator RN Staff A said she wrote the progress note on [DATE] that Resident #5 should be DNR status. She said she was responsible to update the care plan but she did not change the code status on the care plan. She said the Social Services Director should have caught and correct the mistake. On [DATE] at 5:46 p.m., in an interview the Director of Nursing (DON) verified Resident #5's care plan was not accurate and did not reflect the resident's representative wishes for code status. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 92:0 a.m., in an interview the MDS coordinator said the resident's code status was not updated during the quarterly review in [DATE]. 2. Review of the clinical record for Resident # 8 revealed admitted on [DATE]. Diagnoses included but were not limited to pelvis stress fracture, acute pain, and history of falling. Review of the MDS Assessment with a target date of [DATE] revealed Resident #8 scored a 13 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. On [DATE] at 2:47 p.m., in a telephone interview the resident's son said Resident #8 does not consistently comprehend informed health care decisions and is often confused. He attended one care conference this admission and no one asked him about the resident's code status. He said He said the resident is a DNR and CPR should not be performed. On [DATE] at 5:05 p.m., in an interview Resident #8 said she did not want CPR and defers to her son for decisions regarding her code status. Resident #8's son was present during the interview and said the resident code status was DNR. He said Resident #8 signed a DNR form last year and he thought the DNR from the [DATE] admission would have carried over to this admission. He said no one spoke with him about the code status. Review of the baseline care plan for admission [DATE] revealed a code status for full code. Review of the physician's order summary revealed an active order dated [DATE] for full code status. Review of the comprehensive care plans on [DATE] at 3:19 p.m. revealed no comprehensive care plan for code status. Review of the record including progress notes and social services assessment dated [DATE] failed to reveal documentation the resident's son was included in the development of the resident's care plan for advance directives. 3. Review of the clinical record for Resident #12 revealed an admitted [DATE]. Diagnoses included Dementia and Pelvic fracture due to multiple falls. Review of the Admission Minimum Data Set (MDS) assessment with a target date of [DATE] revealed the resident's cognition was moderately impaired with a BIMS score of 07. The assessment noted the resident was totally dependent on staff for toileting (with the helper doing all the effort). Toilet transfer was not attempted due to safety concerns. Review of the care plan for Activities of Daily Living (ADLs) initiated on [DATE] revealed the resident was dependent on 2 staff for toilet use. Review of the ADL Toilet Record for Support Provided revealed each day from [DATE] through [DATE] the facility used only 1 staff for toileting Resident #12. Review of the progress note dated [DATE] revealed the facility initiated falls mats on each side of the bed at the request of the resident's daughter and responsible party. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan did not contain the use of fall mats to minimize fall related injury. On [DATE] the facility added a care plan intervention for bowel and bladder training. The care plan did not include instructions on the bowel and bladder training. On [DATE] at 12:55 p.m., Certified Nursing Assistant (CNA) Staff B was observed assisting Resident #12 with toileting in the bathroom. The resident was standing in front of the toilet, and the CNA was standing next to the resident. There was no other staff assisting CNA Staff B with the toileting. On [DATE] at 12:58 p.m., in an interview CNA Staff B said she works for an agency and has been working at the facility for six months. She said she was not familiar with the Kardex (provides instructions for safe care) and the assignment sheet did not say the resident required the assistance of 2 for toileting. She said Resident #12 had multiple falls and was usually in the activity room due to the falls. On [DATE] at 1:26 p.m., CNA Staff B said she was not trained in using the Kardex to get resident information. She stated, Maybe you get trained when you are staff here, but no one ever really sat down and trained me on the Kardex. On [DATE] at 2:02 p.m., in an interview the Assistant Director of Nursing (ADON) said the bowel and bladder training was added to the care plan on [DATE] but not implemented. She said it involves a bowel and bladder assessment by the nurse and then checking the resident every hour. On [DATE] at 9:21 a.m., in an interview Registered Nurse (RN) MDS Coordinator Staff A confirmed the fall mats were not on the care plan. She said if staff used them, they should be on the care plan. She said two staff for toileting was added to prevent accidents, including falls. The resident's ability fluctuates and there should have been two. The MDS coordinator said bowel and bladder training should have been implemented because the resident was falling when she tried to get to the bathroom without assistance. On [DATE] at 11:48 a.m., the ADON said Staff B should have had a second CNA on [DATE] when she was toileting the resident to prevent a possible accident/fall. She said she found out on [DATE] that Staff B did not know how to access the Kardex.

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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. 41905 Based on observation, record review and staff interview, the facility failed to provide care and services in accordance with professional standards of practice by failing to administer medications in accordance with the physician's orders for 1 (Resident #22) of 4 residents reviewed for compliance with physician's orders. The findings included: On 3/26/25 at 8:34 a.m., Licensed Practical Nurse (LPN) Staff A was observed preparing to administer medications to Resident #22, including Vitamin D3. LPN Staff A said she needed to clarify the order for the Vitamin D3 before administering it to the resident. Review of the Medication Administration Record (MAR) for March 2025 revealed the nurses signed off they administered one capsule of Vitamin D3 1000 International Units (IU) daily to Resident #22 as per the physician's orders. On 3/26/25 at 8:34 a.m., observation of Resident #22's medications revealed two blister cards of 30 tablets of Vitamin D3 of 2000 IU. One blister card was filled on 2/20/25. 29 tablets had been removed from the card. One blister card was filled on 3/24/25. None of the tablets were removed. On 3/26/25 at 11:57 a.m., in an interview LPN Staff A said the physician's order in the electronic clinical record for the Vitamin D3 was to administer 1000 IU. The Vitamin D3 2000 IU that she had available and that was being given was different from the physician's orders. She said she gave the incorrect dose of Vitamin D3 to the resident on 3/3/25, 3/4/25, 3/5/25, 3/6/25, 3/10/25, 3/17/25, 3/18/25, and 3/24/25. On 3/26/25 at 5:35 p.m., in an interview LPN Staff C said on 3/21/25 she was the nurse assigned to Resident #22 and administered the Vitamin D3 2000 IU that was in the medication cart to the resident. She said she never altered the medication, and the resident took the tablet of Vitamin D3 2000 IU whole. She did not crush or cut the tablet of Vitamin D3 2000 IU. On 3/27/25 at 12:30 p.m., in an interview the Director of Nursing (DON), she said she was made aware the incorrect dose of Vitamin D3 has been administered to Resident #22. She said she expects the nurses to follow the physician's orders.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on observation, record review, and interviews, the facility failed to implement care plan interventions to prevent falls and fall related injuries for 1 (Resident #12) with multiple falls of 2 residents reviewed for fall prevention. The findings included: Review of the clinical record for Resident #12 revealed an admitted [DATE]. Diagnoses included Dementia and Pelvic fracture due to multiple falls. Review of the Admission Minimum Data Set (MDS) assessment with a target date of 1/24/25 revealed Resident #12's cognition was severely impaired with a Brief Interview for Mental Status score of 7. The assessment noted the resident was dependent on staff for toileting (Helper does all the effort). Toilet transfer was not attempted due to safety concerns. Review of the care plan for Activities of Daily Living (ADL) initiated on 1/17/25 revealed the resident was totally dependent on two staff for toilet use. On 3/26/25 at 12:55 p.m., Certified Nursing Assistant (CNA) Staff B was observed assisting Resident #12 with toileting in the bathroom. The resident was standing in front of the toilet, and the CNA was standing next to the resident. There was no other staff assisting CNA Staff B with the toileting. On 3/26/25 at 12:58 p.m., in an interview CNA Staff B said she works for an agency and has been working at the facility for six months. She said she was not familiar with the Kardex (provides instructions for safe care) and the assignment sheet did not say the resident required the assistance of 2 for toileting. She said Resident #12 had multiple falls and was usually in the activity room due to the falls. On 3/26/25 at 1:26 p.m., CNA Staff B said she was not trained in using the Kardex to get resident information. She stated, Maybe you get trained when you are staff here, but no one ever really sat down and trained me on the Kardex. On 3/27/25 at 9:21 a.m., in an interview Registered Nurse (RN) MDS Coordinator Staff A said two staff for toileting was added to prevent accidents, including falls. The resident's ability fluctuates and there should have been two. On 3/27/25 at 11:48 a.m., the Assistant Director of Nursing (ADON) said Staff B should have had a second CNA on 3/26/25 when she was toileting the resident to prevent a possible accident/fall. She said she found out on 3/26/25 that Staff B did not know how to access the Kardex. Review of the care plan revealed Resident #12 sustained multiple falls at the facility as follows: 2/12/25: Fall with no injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/16/25: Fall with minor injury. 2/24/25: Fall with no injury 3/1/25: Fall with minor injury 3/11/25: Fall with minor injury. Resident #12 was sent to the emergency room and returned to the facility. Fall #1: Review of the progress note dated 2/12/25 revealed Resident #12 was observed on the floor near the bed facing the bathroom at 3:30 a.m. The resident said she forgot she had a urinary catheter and was trying to go to the bathroom. On 2/12/25 the facility updated the care plan for frequent checks. Fall #2: The nursing progress notes did not include the circumstances of Resident #12's fall on 2/16/25. On 2/18/25 the facility updated the care plan to Place sign to remind the resident to call for assistance. On 2/19/25, the practitioner entered a progress note indicating the resident had a fall and will monitor closely, fall precautions. The practitioner added, dementia is stable, pleasantly confused, can speak and answer but not always accurate, obtained collateral information from family present. On 2/20/25 the facility added the following diagnoses to the resident's clinical record: muscle weakness, abnormality of gait and mobility, history of falling, and need for assistance with personal care. Fall #3 On 2/24/25 at 12:31p.m. the facility entered a fall progress note. The resident was on the floor at the foot of the bed. The resident told the staff at the time, I don't know what I was trying to do. I just wanted to go to the bathroom. On 3/24/25 at 3:22 p.m., Resident #12 was observed sitting in a wheelchair in the activity room. When asked about the care at the facility and the multiple falls, she said she gives them pluses. The resident could not explain what she meant and said we should call her daughter. Fall #4 On 3/1/25 at 3:15 a.m., an incident note documented the nurse heard a loud scream and walked into the resident's room. She found the resident on the bathroom floor. The resident stated she needed to use the bathroom. The resident had a skin tear to the left hand that reopened. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the progress note dated 3/2/25 revealed the facility placed falls mats on each side of the bed at the request of the resident's daughter and responsible party. The care plans did not identify the use of the fall mats use to prevent fall injury. On 3/27/25 at 9:21 a.m., in an interview Registered Nurse (RN) MDS Coordinator Staff A confirmed the fall mats were not on the care plan. She said if staff used them, they should be on the care plan. On 3/3/25 the facility updated the care plan with an intervention for bowel and bladder training. The clinical record lacked documentation of a bowel and bladder training program. On 3/26/25 at 2:02 p.m., in an interview the Assistant Director of Nursing (ADON) said the bowel and bladder training was added to the care plan on 3/3/25 but not implemented. She said it involves a bowel and bladder assessment by the nurse and then checking the resident every hour. On 3/27/25 at 9:21 a.m., in an interview the MDS coordinator said bowel and bladder training should have been implemented because the resident was falling when she tried to get to the bathroom without assistance. Fall #5 On 3/11/25 at 4:50 p.m., the alert progress note indicated an unwitnessed fall after for the resident after toileting herself and falling. The resident could not remember if she hit her head. 911 was called and the resident was transported to the hospital. The facility updated the fall care plan on 3/17/25 to include a medication review. On 3/24/25 at 11:03 a.m., in a telephone interview, Resident #12's daughter and responsible party said her mother had multiple falls at the facility in a short time and the facility's efforts have not prevented them. She said she was worried the resident will fall and sustain another fracture or worse. She said the resident has dementia and periods of confusion. On 3/27/25 at 9:21 a.m., in an interview Registered Nurse (RN) Minimum Data Set Assessment Coordinator (MDS) Staff A said all falls are reviewed with the Interdisciplinary team IDT and the team decides which new interventions are added to the care plan. She verified fall mats did not get added to the care plan. She said fall mats do not prevent falls and are not appropriate for all residents and can contribute to falls because of tripping. She said providing assistance of 2 staff for toileting was added to prevent accidents including falls. She said the resident's ability fluctuates from day to day. She said there should have been 2 CNAs toileting Resident #12, if not used to support the resident, to be there for assistance if the resident should lose balance and begin to fall. The MDS coordinator said the bowel and bladder training intervention was added because the resident fell multiple times while trying to get to the bathroom. The IDT team decided on the intervention, and it should have been implemented by the IDT, which included the ADON.