STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105859	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solaris Healthcare Charlotte Harbor	4000 Kings Hwy Port Charlotte, FL 33980

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record review, review of facility policy, resident and staff interviews, the facility failed to ensure staff provided care and services with respect and dignity to 1 (Resident #999) of 4 sampled residents.The findings included:Review of the undated facility policy Resident Mistreatment, Neglect and Abuse Prohibition Guidelines documented, The facility is committed to protecting the physical and emotional well-being and personal possessions of every resident. Each facility has systems procedures and a program of employee training and supervision in place to foster dignified treatment, respect and compassion for residents .On 3/18/26 at 9:01 a.m., Resident #999 was observed in his room in bed. In an interview, the resident said he recalled an incident when he was sleeping soundly and a Certified Nursing Assistant (CNA) woke him up to change him. He asked her to wait 30 minutes, she said no and said she had to change him right now. Resident #999 said the CNA kept insisting and he kept refusing. She left the room and came back with a nurse and another CNA. The nurse told him he was wet, filthy and laying in his own urine. They told him it was the change of shift, and they needed to change him. Resident #999 said he felt they could have waited for 30 minutes as he asked, but it was a big deal so they started holding him down. Two staff were on the left side and one was on the right side. Resident #999 said he was yelling, No. Stop, stop, stop. The staff did not seem to be angry but they were not going to leave without changing him. He said, They were determined to do their own thing. I felt helpless, not afraid. I was angry about the fact that they could do that. I'm a patient they should not treat a patient that way. He sustained a skin tear to his left hand and the nurse bandaged it.Review of the clinical record of Resident #999 revealed an admission date of 12/12/24. Diagnoses included recent low back pain, opioid dependence, major depressive disorder and vertebrogenic low back pain.Review of the Quarterly Minimum Data Set (MDS) with an assessment reference date of 3/10/26 documented Resident #999 scored 15 on the Brief Interview for Mental Status, indicating intact cognition. Resident #999 had no behavior or mood problems. The MDS noted the resident required substantial/maximum assistance with toileting hygiene, dressing, bathing and personal hygiene.Review of the care plan revealed Resident #999 refuses care at times and is combative during care at times. The approaches included to value the resident's input for the care being provided. If the resident is resistive to care, ensure safety, and reapproach at a later time. Ensure preferences of resident are honored and ensure a calming approach when assisting resident.Review of the nursing progress notes revealed Registered Nurse (RN) Staff D documented on 3/15/26 at 3:11 a.m., that the assigned CNA made her aware that the resident had been refusing care and to be changed during the shift. The nurse spoke with the resident about care. The resident became argumentative about this bullshit about my skin breaking down and it hasn't yet. The progress note documented the resident then said, do what you will, I don't care. Care was provided by the nurse and assigned CNA. The resident's brief was saturated with urine and feces. The resident was made aware that he was in need of incontinence care and the resident was made aware of findings.Review of the facility provided grievance dated 3/15/26 revealed the nurse noticed a skin tear on Resident #999's hand. Resident #999 said that earlier that night, he was woken up by a CNA who said she needed to change him because he was wet. He did not want to be changed so he told (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her no. She came back with another CNA and a nurse. Two of them held him down while the other one changed him.Review of the facility provided statements revealed:On 3/16/26, Licensed Practical Nurse (LPN) Staff C documented in a statement that two CNAs requested assistance with a patient requiring incontinent care. The patient was observed with feces, urine and drainage from the J-tube (feeding tube inserted into the small intestine) on the bedding and his clothes. The patient was informed of the need for hygiene care due to soiling and the risk for skin breakdown. The patient initially stated that he wanted to return to sleep and declined care. The patient was educated that remaining in soiled linens could lead to skin complications. The CNAs reported a history of similar noncompliant behavior during care. With staff assistance, the patient was gently repositioned and incontinent care was completed. The patient was visibly upset but did not physically resist during care. After repositioning, skin tears were noted. Plan was to initiate wound care. However, the primary nurse returned to the room and assumed care of the wounds and further treatment.On 3/16/26, CNA Staff B provided a statement via telephone that she was asked to assist CNA Staff A to provide care to Resident #999. She was gently asking the resident to allow staff to care for him. The resident denied care but would go back and forth on consenting to care. Resident #999 was rolled on his side and cleaned. After care was provided, a skin tear was found on his hand and treated.On 3/16/26, CNA Staff A provided a statement via telephone that she entered Resident #999's room after dinner because his bed was so wet. The resident refused care so she requested assistance from CNA Staff B, and LPN Staff C. They all entered the room. Resident #999 was rolled over and cleaned. After care was provided, a skin tear was found on his hand and treated. On 3/18/26 at 1:19 p.m., in a telephone interview CNA Staff B said on 3/14/26 CNA Staff A asked her to help with Resident #999. Staff A told her that the resident said no when she tried to change him. She said when she went in the room, the tube feeding was open and wet the bed, everything was wet. She explained it to the resident and said he needed to be changed but Resident #999 said no. She went to get LPN Staff C to speak to the resident. Resident #999 agreed to be changed. They turned him with the nurse. When they started touching him, he said no. He was already rolled over and the pads rolled under him. She said they can't stop while they are providing care. CNA Staff B said that Resident #999 was not fighting, he was just saying don't touch me, leave me like that, leave my room. She said everything was wet from head to toe. We would talk to him, he would say yes again then no.On 3/18/26 at 3:33 p.m., in an interview LPN Staff C said that CNA Staff A and CNA Staff B asked him to explain to Resident #999 why he needed to be changed. He explained to the resident the skin concerns from lying in urine and feces but the resident said no. The CNAs said that Resident #999 refused care a lot so, let's just change him. The CNAs said the resident would say yes to care, then say no. He said, at the time, Resident #999 was saying no. The CNAs said, let's just get it done. LPN Staff C said he had his hands on the resident's hips and back while the CNAs worked. He said they were not restraining the resident at all. When they were done, he told the resident, see it was over quick. The resident then showed him the skin tear on his hand.On 3/18/26 at 4:15 p.m., in an interview, the Administrator said they came to the conclusion that Resident #999 would say no/yes but he was not resisting physically. The staff's actions were truly to do what was best for the resident. She said that Resident #999 was not fighting, he was saying no. The resident said they held him down and they could not substantiate that. The staff all said they never held him down. He was not combative and went along with the care. She said the resident ultimately cooperated. The intention was to prevent harm not to cause harm. She said they were currently in-servicing staff on the resident's right to refuse care.