STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105966	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Larsen Health Center	13880 Shell Point Plaza Fort Myers, FL 33908

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 0689 Level of Harm - Actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37256 Based on record review, and interview, the facility failed to ensure staff followed the individualized care plan to ensure the safe transfer of 3 (Residents #1, #2 and #3) of 3 residents reviewed, resulting in residents injury and transfer to a higher level of care. The findings included: The Facility Policy titled Transfer of Resident using support devices, revision date 11/17 indicated Under Procedure: The Therapy Department will screen residents and determine a level of assistance needed for transfers and movement. This determination will be incorporated into the plan of care for the resident and communicated to the staff by means of the care plan. Under bullet 2 (d) Total Assistance - resident is non-weight bearing and requires mechanical devices for lifting. The resident requires two (2) persons and a mechanical lift to facilitate resident movement and/or transfer. 1. Review of Resident #1's clinical record revealed the Resident Care Guide for Certified Nurse Assistants (CNA) indicated Resident #1 required two staff assistance for transfers. Resident #1's care plan with a start date of 10/21/24 indicated Transfer with 2 assist, weight bearing as tolerated. Review of progress notes revealed on 10/27/24 Resident #1 had been found the previous evening with blood coming from her left shin. The resident stated she didn't know what happened. Resident #1 was transferred to the local emergency room and returned with sutures in place to the left and right shin. Review of the incident investigation revealed Certified Nursing Assistant (CNA) Staff A transferred the resident from her recliner to her wheelchair and from the wheelchair to the bed with a one person transfer. The facility's investigation included direct care staff interviews. The incident investigation noted Resident #1 sustained the skin tears during the improper transfer with one staff assist. On 12/10/24 at 2:07 p.m., in a telephone interview, Staff A said the skin tears happened before she came on shift. Staff A said Resident #1 was a physical transfer and mostly everybody transferred her by themselves. Staff A said she told the former Administrator on paper Resident #1 is a two person assist, but she had never seen two staff transfer the resident, everyone transferred her by themselves. Staff A said sometimes the paper does not get updated and her transfer was perfect. (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 0689 Level of Harm - Actual harm Residents Affected - Some	2. Review of Resident #2's clinical record revealed the Resident Care Guide for CNAs indicated Resident #2 required the use of a mechanical lift with two staff assistance for transfers. The care plan noted the resident used a sit to stand lift with two person assist for all transfers. Review of progress notes for Resident #2 revealed a note dated 11/8/24 indicating resident had slipped out of the bed and was found sitting on a hoyer pad on the floor. Resident #2 had a laceration on his forehead and was sent out to the hospital. Returned to facility same day with no acute findings other than small 3 cm superficial laceration to the forehead, vertical midline. Review of the facility investigation revealed Staff B (CNA) was preparing to transfer Resident #2 from bed using they hoyer lift and had left him alone seated at the edge of the bed. Staff A then left the room to obtain the hoyer lift and Resident #2 fell off the edge of the bed. 3. On 12/10/24 at 1:09 p.m., during an interview, the Administrator said on 12/3/24 there was another reportable incident involving an improper transfer with Resident #3 and provided the investigation. Investigation indicated on 12/4/24 Resident #3 reported to her nurse the CNA who worked with her the previous day 12/3/24 was rough with her, grabbed her hand and it was painful. Resident #4 had 2 small bruises on her left hand. Administrator said through the course of the investigation she determined Staff C had improperly transferred Resident #3 in the bed using the hoyer lift alone. She said Staff C had told her the private duty had assisted but when she interviewed the private duty they said they had left that day at 5 pm. Administrator said she terminated Staff C's employment due to improper transfer and false information in her interview Record review of Resident #3's chart revealed the Resident Care Guide for CNA's indicated Resident #2 was total dependence hoyer with 2 staff needed for transfer. Resident #3's care plan indicated hoyer lift for transfers with 2 person assist. On 12/10/24 at 2:48 p.m., during an interview, Resident #3's private duty aide said she did not not help with a transfer and said she had left the facility that day around 5 p.m. and resident was still out of bed when she left. On 12/10/24 at 1:09 p.m., during an interview, the Administrator said the first two incidents happened under the prior administration, and she and the Director of Nursing were new. She said she had recognized follow through had been lacking and was in the process of basic education with Quality Assurance Performance Improvement (QAPI) and what it should be. She said Staff B and C had been terminated in regards to these incidents, but she does not have anything that will show any type of performance improvement or audits were documented or even done.

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F 0867 Level of Harm - Actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 37256 Based on record review, and interview, the facility, after identifying an adverse incident, failed to initiate actions aimed at performance improvement, implement action, measure success and track performance to ensure that improvements are realized and sustained for 1 (Resident #4) of 1 resident identified with a medication error and 3 (Residents #1,# 2 and #3) of 3 residents reviewed for improper transfer. The findings included: 1. On 8/9/24, the facility reported to the Agency for Healthcare Administration (Agency) an incident in which a Staff D Registered Nurse (RN) had falsified Resident #4's medical administration record (MAR) signing off that a controlled substance was given on 8/8/24 at 9 a.m. and 12 p.m. and controlled drug sign out sheet, when it had not been given. This was discovered by Staff E (RN) when she retrieved the medication to give the 4 p.m. dose and discovered the actual count of 24 capsules reflected the last dose removed was on 8/7/24 at 4 p.m. and the dose for 9 a.m. and 12 p.m. had not been removed from the punch card on 8/8/24. On 12/11/24 at 10:18 a.m., Staff E said she had been pulled to the med cart about 11:30 a.m. or so after Staff D had to leave. She said Staff D was an as needed employee and only slotted to work a few hours. Staff E said they didn't know Staff D was leaving, that she had given the keys to someone and just left. Staff E said its possible a narcotic count may not have been done as she'd already left. Staff E said she personally didn't notice the count was off until she went to pull the 4 p.m. dose and then noticed the 2 earlier in the day had been signed off on the MAR but were still in the pack. On 12/11/24 at 10:51 a.m., the Director of Nursing (DON) said when there is a change of staff on the med cart, there is supposed to be a count, by both nurses, of the narcotics. There is a sign off sheet they both will sign off on that it was done and the count is correct. At 11:25 a.m., the DON said she was not able to provide the narcotic sign off sheet for 8/8/24. She said Medical Records said they had been told in the past to hold it for a month and then to shred them. On 12/10/24 a review of the facility file for investigation revealed no documentation of presenting to Quality Assurance Performance Improvement (QAPI) committee, identifying a root cause, no improvements implemented and no auditing to measure success and track performance. 2. On 10/26/24, the facility reported to the Agency an incident whereby Resident # 1 sustained lacerations to both shins requiring transfer to the emergency room where they placed sutures to both shins. Facility investigation found Resident #1 had been evaluated as a 2 person assist for transfers and Staff A (CNA) had improperly transferred her alone resulting in skin tears to Resident #1's shins and an emergency room visit in which she received 7 stitches to her right leg and 6 stitches to her left leg. (continued on next page)

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F 0867 Level of Harm - Actual harm Residents Affected - Some	On 12/10/24 a review of the facility file for investigation revealed no documentation of presenting to Quality Assurance Performance Improvement (QAPI) committee, identifying a root cause, no improvements implemented and no auditing to measure success and track performance. 3. On 11/8/24, the facility reported to the Agency an incident whereby Resident #2 slipped off the edge of the bed onto the floor sustaining a laceration to his forehead resulting in a trip to the emergency room where CT scan and lab work were found to be negative and a 3 cm superficial laceration to the forehead. Resident #2 had been evaluated to be dependent on staff for Hoyer transfer from the bed to his wheelchair. Facility investigation found Staff B (CNA) failed to follow the plan of care of a 2 person assist with hoyer resulting in Resident #2 sustaining a fall while unattended at the edge of his bed while Staff B left the room to get the hoyer lift. On 12/10/24 a review of the facility file for investigation revealed no documentation of presenting to Quality Assurance Performance Improvement (QAPI) committee, identifying a root cause, no improvements implemented and no auditing to measure success and track performance. 4. On 12/5/24 the facility reported to the Agency an incident where on 12/4/24 Resident #3 complained to Staff F (RN) that the aide the previous night was rough and hurt her hand resulting in a small bruise on the resident's left pinky finger. Facility investigation found Staff C (CNA) had been assigned to Resident #3 on 12/3/24 and the injuries were a result of Staff C improperly transferring Resident #3 using the hoyer lift without the assistance of another staff member. On 12/10/24 at 12/10/24 1:09 p.m., the Administrator said the incidents with Residents #1, #2 and #4 were with the prior Administration and she personally had recently reported the incident with Resident #3. She said she had recognized follow up had been lacking and she was in the process of basic education with QAPI and what it should be. She said she could not provide any documentation of any follow through by the previous Administration, but was aware some of the employees involved had been terminated. On 12/11/24 at 10:55 a.m., the Administrator said upon discovering an incident there should be an investigation done, determine the cause, develop a performance improvement plan, monitor to track success/improvement and discuss in QAPI ad hoc, don't wait until the next month. She said she has identified this as an area that needs improvement and has begun QAPI education.