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	01/16/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on record review, review of facility's policies and procedures, and staff interviews, the facility failed to protect residents' rights to be free from abuse by failing to honor the residents' right to refuse care for 1 (Resident #999) of 3 sampled residents when the resident displayed agitated and aggressive behaviors during care. The findings included: The facility policy Abuse Policy and Procedure Manual with a review date of 3/24/23 noted, Each person served has the right to be free from abuse and mistreatment . Some examples, rough handling a resident. Prevention. Appropriate supervision of staff to maintain the mission of caring for, serving and satisfying all residents is provided .Signs and Symptoms Dementia residents in distress may exhibit the following: Aggressiveness, agitation, yelling out, delusions, wandering etc. Be aware of risk factors (age, cognitive and or physician limitations, etc.) . Listen to residents . If they say stop, stop! The facility Employee Agreements signed upon hire specified, If a resident refuses care at any time, I will inform the nurse and or supervisor of the refusal of care. I will respect the residents wishes and reapproach with the nurses' help to offer care at a later time. Review of the clinical record revealed Resident #999 had an admitted [DATE]. Diagnoses included dementia, and major depressive disorder. The Quarterly Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with a reference date of 11/27/24 documented Resident #999 required substantial/maximum assistance with toileting. The MDS noted Resident #999's brief interview for mental status score was 03, indicating her skills for daily decision making were severely impaired. The care plan initiated 11/26/24 noted Resident #999 had a behavior problem and, exhibits periods of anxious behavior and physical aggression toward staff due to a diagnosis of Dementia. Resident can become combative, spitting on staff/throwing feces. The care plan also noted Resident #999 at times, resists/refuses care (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The interventions for Resident #999 included: Approach in a calm manner, make eye contact and reassure the resident. Use a pleasant voice and identify self when approaching resident. Offer friendly nonverbal cues by smiling and using friendly tone of voice when speaking to resident. If resident refuses/resists care, reapproach and reintroduce care or task to be performed at a later time. Further review of the clinical record revealed an initial psychiatric note dated 9/3/24 documented new patient with dementia and depression. Patient has been confused and combative with care, impulsive. Arrived on Paxil and Trazadone (antidepressants). Per sitter gets fearful with care and agitated. Will decrease Paxil to 10 milligrams (mg) and add Depakote 125 mg twice a day for impulse control. Review of the Psychiatric note dated 12/20/24 documented [AGE] year-old lady with a history of dementia has been smearing feces, combative and throwing things . I am going to substitute current medications with Seroquel (an antipsychotic) 25 mg twice a day and re-evaluate. Review of the facility's incident investigation revealed on 12/19/24 the facility initiated an investigation of abuse related to observation of bruising , redness and swelling of Resident #999's left hand. Resident #999 had voiced pain in the thumb and finger. The resident was unable to describe how the injury occurred. The resident was assessed and sent to the emergency room for evaluation. An x-ray of the left hand revealed no fracture or acute process. The investigation findings revealed Licensed Practical Nurse (LPN) Staff D in the shift -to -shift reported the incident occurred on 12/18/24 on the evening shift. The nursing progress dated 12/19/24 at 7:09 a.m., by Staff D documented, Resident #999 was fighting, biting, kicking with her legs and hands. The resident required three staff members to change her. The facility investigative findings noted statements were obtained from the staff. The Interviews Conducted revealed the following: LPN Staff D indicated Resident #999 had two episodes of combativeness during the evening shift. During the second episode at approximately 9:00 p.m., Certified Nursing Assistant (CNA) Staff E called him to come to Resident #999's room because they were trying to clean her up and she was combative. LPN Staff D said he walked into the room and the resident was kicking, swinging her arms in the air. LPN Staff D said he held Resident #999's legs down while CNA Staff E changed. He said CNA Staff C was trying to hold Resident #999's arms. LPN Staff D said when they were done, CNA Staff E had asked him to do a skin check on Resident #999 because she did not want anyone to say the resident had an injury. CNA Staff E said Resident #999 was combative when trying to clean her, so she asked CNA Staff C and CNA Staff B to assist her. Staff E said they were not able to clean Resident #999 and she asked one of the CNA's to get LPN Staff D to help. CNA Staff E said she cleaned the resident but did not remember where the other staff were. CNA Staff E asked LPN Staff D to check the resident's skin because she didn't want anyone saying the resident had bruising. CNA Staff C revealed that she went with another staff member to assist CNA Staff E to clean Resident #999. CNA Staff C said when CNA Staff E was trying to clean Resident #999 was kicking and swinging her arms in the air. CNA Staff C said she observed Resident #999 hitting the bed with her hand. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	CNA Staff B said on 12/18/24 at approximately 9:00 p.m., LPN Staff D asked her to assist CNA Staff E to change Resident #999's bed linen because she was combative. CNA Staff B said when she walked into the room CNA Staff E and CNA Staff C had already cleaned the resident. CNA Staff B said she assisted with changing the bed linens but did not touch Resident #999. On 1/16/25 at 11:15 a.m., during an interview with Resident #999 said she was fine and had no problems with the staff. She said everyone was good to her and she had no recall of the event of 12/18/24. On 1/16/25 at 10:55 a.m., in an interview LPN Staff A said, I was here the next day on 12/19/24. I sent her (Resident #999) out to the emergency room , and I was the one who noticed her hands when I helped to toilet her. Her left hand was not like that the day before. The left hand was just different, swollen and bruised. I spoke with my supervisor and had her assess her (Resident #999) as well. I did not know how it occurred. I don't know how it happened. The night before I worked with her and she was ok, her hand was not like that when I had her. I notified her family. I notified the physician. LPN Staff A said If the resident refuses care, we re-approach, redirect and speak with the resident. We try to make them as comfortable as we can. They have a right to refuse, but most of the residents on this unit do not understand. We just try and take care of them as they allow us. I speak with the family and the provider to see what we can do. On 1/16/25 at 12:15 p.m., in a telephone interview CNA Staff B said she was working on 12/18/24 on the secured unit. She said, I was on my break when the nurse (LPN Staff D) called me into the room to help them. He told me to change the sheet, so I pulled the sheets off the bed. The resident was in the bed and I put new sheets on. I did not see anything. I did not observe anyone holding the resident, that is the only thing I can tell you. I was called to change the sheets, and I did it and left the room. That is it. I did not see anything. The resident was in bed on her side, and I took the dirty sheets off the bed and I left the room. I never saw anyone holding the resident or touching her. I did not see anything. On 1/16/25 at 5:18 p.m., in a telephone interview CNA Staff E said on 12/18/24 Resident #999 was in the dining room about 8:00 or 8:30 p.m., and she was playing in feces. Resident #999 had all of her clothes off and they were on the floor. She took the resident to her room, o the bed to clean her up. Resident #999 started fighting me and I tried to speak to her very nicely and explained to her that she had feces all over her and I needed to change her. That night she was agitated, so I left her in bed for 30 minutes and I came back, and she was still agitated with me. I explained to her what I needed to do but she tried to hit me. She was yelling and tried to hit me. I put the call light on, and I asked CNA Staff C and LPN Staff D to help me because we are told to always use two people. I asked them to stand there and make sure Resident #999 did not roll onto the floor, and I cleaned her. She was fine when I left that night, there was nothing on her hands. I never told anyone to hold her. I just asked them to stay on either side of the bed, so she does not fall out of the bed. I never saw them holding Resident #999 by her arms or her hands. I work with Alzheimer's residents, and I know you have to be patient. Resident #999 always wants to fight you. She could have hit her hand in the dining room before I found her. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 1/17/25 at 2:30 p.m., in a phone interview LPN Staff D said on 12/18/24 I had just received the change of shift report. It was approximately 7:30 p.m., and Resident #999 was in the dining room, and she had blood running from her ankle. She had scratched her ankle, and she had no clothes on. Everything was off and on the floor. She had her hand in her brief, and she had feces all over her. It was everywhere and on both of her hands. The other nurse was still there, LPN Staff A. I asked her what happened, and she did not know. I told her to go, I would take care of it. I cleaned the wound and put a dressing on it. I asked CNA Staff E to come and get Resident #999, to take her to her room and take care of her and she did. Staff E came to me and said the resident was combative, hitting and throwing feces, so I told her to wait a bit and go back. At approximately 8:00 p.m., Staff E went back to the room to help Resident #999, and she asked CNA Staff C to help her. The resident accepted the care. Staff C came to get me approximately 8:30 p.m., to tell me the dressing to the ankle needed to be changed because there was feces on it. I went into the room and changed the dressing. The resident had already been cleaned by CNA Staff E. I put the dressing on the wound, I never held her legs down. I did not say that in my witness statement. CNA Staff B came into the room and took the dirty linen out, she never touched the resident. No one did that, no one was holding her. She had nothing, no bruising or nothing that I saw on her all night. On 1/16/25 at 12:00 p.m., in an interview the Chief Nursing Officer (CNO) said CNA (Staff E) felt the resident required changing because she had soiled herself and she wanted to clean her. In the end her decision to ask someone to hold her down was not appropriate and the staff were terminated. It may not be in the best interest of the residents to leave them soiled, but sometimes you have to do it and you keep trying. Resident #999 can be combative, but she has the right to refuse if she wants to, all we can do is to continue to try to provide her care. The CNO said the root cause of the event was the staff did not respect the resident's rights. On 12/24/24 the facility completed the investigation of abuse and documented The facility verifies that the injuries to Resident #999's hand was a result of physical abuse committed jointly by CNA Staff E, CNA Staff C and LPN Staff D. Their actions of holding Resident #999 down to provide care was a physical restraint of resident #999 as well as violated her right to refuse care.