STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105982	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sun Harbor Healthcare	18480 Cochran Blvd Port Charlotte, FL 33948

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on observation, record review, resident representative and staff interviews, the facility failed to act on the designated Health Care Surrogate request for a change of treatment for 1 (Resident #118) of 2 residents reviewed for choices and representative involvement in care plan and decision making. The findings included: Review of the clinical record revealed Resident #118 was admitted to the facility on [DATE]. Diagnoses included Dementia with psychotic disturbance, Alzheimer's disease, Atrial Fibrillation (irregular heartbeat), and cardiac pacemaker (implanted device that regulated the heart's rhythm). The Advance Health Care Directive in the clinical record revealed on November 20, 1995, Resident #118 designated her husband to be her healthcare surrogate. If her husband was unable or unwilling to serve in this capacity, the resident designated her daughter to serve as her healthcare surrogate. Review of the Admission Minimum Data Set (MDS) assessment with a target date of 8/29/24 noted Resident #118 was a widow. On 8/26/24 the Attending Physician evaluated Resident #118 and determined she lacked capacity to give informed consent and make health care decisions. On 9/16/24 at 1:46 p.m., in a telephone interview the designated Health Care Surrogate said Resident #118 had a diagnosis of dementia and needed long term placement. She said she did not want to prolong her life is her heart stopped or she stopped breathing. The Health Care Surrogate said she requested several times to have the pacemaker deactivated. She said she also spoke with the Social Worker and requested to have the pacemaker deactivated, and they have not arranged for it to be done. The clinical record lacked documentation the Health Care Surrogate's request was communicated to the physician to address the request to have the cardiac pacemaker deactivated. On 9/18/24 at 9:40 a.m., in an interview the Social Service Director verified Resident #118's Health Care Surrogate told her she wanted to have the cardiac pacemaker deactivated. She said she communicated the request to the Unit Manager, Licensed Practical Nurse Staff B but did not document the Health Care Surrogate's request or her conversation with the Unit Manager. She said she should have notified the Attending Physician of the request to get the process started but she did not. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105982	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24 at 10:06 a.m., in an interview Unit Manager Staff B said she was not aware of the Health Care Surrogate's request to have the pacemaker deactivated. She said she would have notified the physician. On 9/18/24 at 10:07 a.m., in an interview the Director of Nursing no one informed her of the designated Health Care Surrogate's request to have the cardiac pacemaker deactivated. She said the facility did not have a policy for pacemakers but the process would be to schedule a cardiology appointment to have the pacemaker deactivated.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30599 Based on observation, record review and Interview, the facility failed to ensure the resident's right to include representative in care planning for 1 (Resident #47) of 2 cognitively impaired residents reviewed for choices and care planning. The findings included: Review of the clinical record revealed Resident #47 was admitted to the facility on [DATE]. Diagnoses included Malnutrition and Dementia. Review of the Notification & Consent for Medical Services & Medications form dated 7/26/24 showed Resident #47 signed the form authorizing medical services and medications. The Admission Minimum Data Set (MDS) Assessment with a target date of 8/2/24 noted Resident #47 scored a 06 on the Brief Interview for Mental Status, indicating severe cognitive impairment. On 8/2/24 Resident #47 signed a consent for wound care. The resident's signature was witnessed by a facility staff. On 8/7/24 the Medical Director documented Resident #47 was alert and oriented to 1-2 (Person and place). On 9/16/24 at 10:44 a.m., and 9/18/24 at 8:59 a.m., Resident #47 was observed lying in bed. He was not able to respond appropriately to interview questions. On 9/18/24 at 10:36 a.m., in an interview the Social Service Director said Resident #47 was not completely alert and oriented. She said Resident #47 told her he did not have any family but some family members have contacted her expressing concerns about his well-being. She said she did not get back in touch with them to discuss advocacy for his care. Review of the Admission Record Information revealed two family members and a friend were listed as emergency contacts. On 9/18/24 at 11:38 a.m., in an interview the Regional Business Office Manager said the Business Office would be responsible to ensure steps were being taken to obtain a guardian to ensure the residents rights were being honored. The Business Office Manager would contact an attorney with legal aid and the facility would pay for the services. On 9/18/24 at 12:33 p.m., in an interview the Medical Director said Resident #47 was not capable of making his own medical decisions but had not yet documented the information in the clinical record.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on observation, record review, resident representative and staff interviews, the facility failed to make prompt efforts to resolve a grievance related to missing personal property for 1 (Resident #118) of 3 residents reviewed for resolution of grievances. The findings included: Review of the clinical record revealed Resident #118 was admitted to the facility on [DATE]. Diagnoses included Dementia. On 9/16/24 at 9:50 a.m., Resident #118 was observed wandering in her bedroom. Resident #118 was not able to answer interview questions. An empty eyeglass case was observed in a drawer in the resident's dresser. Resident #118 was not able to say where her glasses were. Review of the personal items inventory list signed by Resident #118, and dated 8/25/24 showed an X next to glasses, indicating Resident #118 was admitted to the facility with a pair of glasses. Review of Resident #118's Inventory of Personal Effects dated 8/25/24, there is an X mark next to glasses indicating the resident was admitted with a pair of glasses. The resident signed the inventory sheet, but the space for the staff member's signature was blank. The care plan initiated on 8/26/24 noted Resident #118 had a Health Care Surrogate. On 9/16/24 at 1:46 p.m., in a telephone interview the Health Care Surrogate said Resident #118 was admitted to the facility with prescription lenses. She said she visits Resident #118 every day and her prescription glasses have been missing the day after her admission. The Health Care Surrogate said she did not file a written grievance but has asked several staff members numerous times to find the glasses. She said the glasses were still missing. Review of the grievance log for August and September 2024 revealed no documentation of a grievance for Resident #118's missing prescription eyeglasses. On 9/17/24 at 3:38 p.m., in an interview Certified Nursing Assistant, CNA Staff A said Resident #118 was transferred from a different room without eyeglasses. On 9/17/24 at 3:41 p.m., Resident #118 was observed in the bedroom doorway. The resident was not wearing eyeglasses. The empty eyeglass case remained in a drawer of the resident's dresser. On 9/18/24 at 8:59 a.m., in a follow up telephone interview the Health Care Surrogate said Resident #118's vision was very poor and she needed to wear her prescription glasses every day. On 9/18/24 at 9:40 a.m., in an interview the Social Service Director said she was responsible for filing grievances and address concerns for missing personal property but no one told her Resident #118's glasses were missing. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24 at 10:07 a.m., in an interview the Director of Nursing (DON) said no one told her Resident #118's prescription glasses were missing. On 9/18/24 at 12:26 p.m., the DON said the missing eyeglasses were found in a drawer at the nurse's station and returned to the resident. On 9/19/24 10:20 a.m., in a telephone interview Resident #118's Health Care Surrogate verified the prescription eyeglasses were found and returned to her.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, review of the clinical record, review of facility policy and procedures, resident and staff interviews, the facility failed to provide the necessary care and services to maintain personal hygiene for 4 (Resident #8, #17, #95, and #47) of 4 sampled residents who required assistance with activities of daily living (ADL's). The findings included: The facility policy Activities of Daily Living documented, The facility shall ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living . A resident who is unable to carry out activities of daily living shall receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene . 1. Review of the clinical record revealed Resident #8 had an admitted [DATE] with diagnoses including anxiety, depression, hypothyroidism and adult failure to thrive. Review of the Admission Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) dated 6/14/24 documented resident #8 required partial to moderate assistance with personal hygiene. The MDS noted Resident #8's cognitive skills for daily decision making were intact. On 9/16/24 at 11:33 a.m., Resident #8 was observed sitting in her wheelchair at bedside. She had a black beard extending from the corners of her mouth and under her chin, approximately one inch growth. In an interview she said she did not like it, but no one had shaved her when she asked. Resident #8 said, I'm beginning to look like a circus performer. She said, My arm pits and legs need shaving as well. I told the certified nursing assistant (CNA) but she does not do it. On 9/17/24 at 11:43 a.m., Resident #8 was observed in her bed. She remained with a beard. The resident's legs were observed to be very hairy. Resident #8 said she told the nurse about the CNA not shaving her. Review of the progress notes showed no documentation the resident refused care including shaving. A review of the CNA documented the resident received personal hygiene care each shift from 9/1/24 through 9/17/24. On 9/17/24 at 3:58 p.m., in an interview Unit Manager Licensed Practical Nurse (LPN) Staff H said Resident #8 refuses to be shaved. She said when she works in the evenings she offers to shave her and she says no. Staff H was then observed asking Resident #8 if she wanted to be shaved. Resident #8 readily agreed and requested the facial hair and her legs shaved. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/18/24 at 9:03 a.m., Resident #8 was in bed and was observed with no facial hair. She said, The nurse shaved me last night. I feel better without that beard. I was feeling like the bearded lady at the circus. 2. Review of the clinical record revealed Resident #17 had an admitted [DATE] with diagnoses including type 2 diabetes, anxiety, left breast neoplasm and dementia. The Quarterly MDS dated [DATE] documented, Resident #17 was dependent on staff for all her care needs. The MDS noted Resident #17's cognitive skills for daily decision making were severely impaired. Review of the care plan initiated on 5/31/24 documented, Right hand splint as ordered, nursing to monitor skin integrity and circulation. Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. During random observations on 9/16/24 at 1:49 p.m., and 9/17/24 at 10:30 a.m., Resident #17 was observed in bed. Her right-hand fingernails extended over 1/2 inch in length past the tip of the fingers with a brown substance under the nails. The righ hand fifth fingernail extended approximately two inches in length from the tip of the finger. Resident #17 had bilateral hand contractures (fixed deformity) and kept her hands in a tight fist. Resident #17 was observed slightly opening her hands periodically. The left thumb fingernail extended approximately one inch past the fingertip. The remaining fingernails of the left hand extended approximately half inch. A brown substance was observed under the nails. Resident #118 was not observed wearing any positioning device to her hands. On 9/17/24 at 10:34 a.m., in an interview, CNA Staff F said she was aware the resident's fingernails were very long. She said, I'm afraid I will hurt her. She pulls her hand back and I don't want to cut her. I tried to trim the nails for her, but she won't let me. I'm afraid I might hurt her. On 9/18/24 at 12:17 p.m., a joint observation of Resident #17's fingernails was done with Unit Manager Staff H. In an interview Staff H said some of the resident's fingernails were very thick and she did not know if they could cut them. She said she'll see if the podiatrist could come in and do the nail care. Review of the clinical record for Resident #17 revealed a physician's order with a start date of 8/6/24 to apply a splint to the right hand in the monring and remove in the afternoon. The order specified the resident may wear the splint for up to six hours a day. Nursing was to check for skin integrity. Review of the Treatment Administration Record (TAR) showed the splint was applied to the resident's right hand on 9/1/24 to 9/3/24, 9/5/24, 9/6/24, 9/9/24, 9/11/24, 9/12/24, 9/13/24, 9/16/24, and 9/17/24. On 9/18/24 the TAR documented not applicable for the right hand splint. On 9/18/24 at 12:07 p.m., in an interview Unit Manager Staff H said she was not aware Resident #17 had an order for a right hand splint. Staff H reviewed the clinical record and confirmed Resident #17 had an order for a right hand splint. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/18/24 at 12:47 p.m., in an interview Registered Nurse (RN) Staff M said she did not know if Resident #17 had a splint. Staff M searched the resident's room and was not able to locate a splint. RN Staff M confirmed Resident #17 had an order for a right hand splint that was not applied. Review of the CNA Kardex (Provides instructions for care) revealed to apply a splint or brace to the right hand in the morning and remove at bed time, wear up to four hours as tolerated. Review of the CNA task documentation for September 2024 showed on 9/3/24, 9/4/24, 9/5/24, 9/6/24, 9/9/24, 9/10/24, 9/11/24, 9/12/24, 9/13/24, 8/14/24, 9/16/24, 9/17/24, and 9/18/24 Staff F documented applying the splint to the resident's right hand. On 9/18/24 at 12:55 p.m., in an interview CNA Staff F said she had not seen a splint for the resident. She said if she had known Resident #17 had an order for a right hand splint, she would have applied it for her. Staff F verified she signed the CNA documentation indicating the splint was applied. 3. Review of the clinical record revealed Resident #95 had an admitted [DATE] with diagnoses including hemiparesis (weakness) and hemiplegia (paralysis) of the left side, cerebral infarction, and contracture of left and right hand. The Admission MDS dated [DATE] documented the resident required staff assistance with all care needs. The MDS noted the residents' cognitive skills for daily decision making were moderately impaired. Review of the CNA Care Kardex showed, The resident is totally dependent on 1 staff for personal hygiene and oral care. On 9/16/24 at 10:22 a.m., Resident #95 was observed in bed with approximately three days of facial hair growth. In an interview Resident #95 said sometimes the staff shave him and sometimes they don't. Resident #95 said he would ask the staff to shave him today. Review of the CNA documentation for September 2024 showed Resident #95 was bathed on 9/16/24 during the 3:00 p.m., to 11:00 p.m. shift. On 9/17/24 at 10:51 a.m., and 9/18/24 at 11:16 a.m., Resident #95 was observed unshaven. On 9/18/24 at 11:16 a.m., in an interview Resident #95 said no one had shaved him and he does not refuse care when offered. On 9/18/24 at 1:34 p.m., in an interview Unit Manager Staff H said residents are shaved on shower days and when needed. Staff H said she would see that the resident was shaved today. On 9/19/24 at 10:48 a.m., in an interview CNA Staff I was asked how often she shaved her residents and how she identified the resident care needs. The CNA was not able to answer the questions. 30599 4. Review of the clinical record revealed Resident #47 was admitted to the facility on [DATE]. Diagnoses included Dementia. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Admission MDS with a target date of 8/2/24 noted the resident's cognitive skills for daily decision making were severely impaired with a Brief Interview for Mental Status score of 03. The MDS noted the resident was dependent on staff for personal hygiene,(Helper does all of the effort. Resident does none of the effort to complete the activity). The CNA Kardex noted the resident preferred to be bathed on Tuesdays and Fridays during the 3:00 p.m. to 11:00 p.m. shift. The Kardex specified to check nail length and clean on bath days as necessary. On 9/16/24 at 10:44 a.m., Resident #47 was observed in bed. The resident looked unkempt with long, dull hair covering his ears. Long strands of hair were protruding through the resident's nose and ears. The resident's fingernails on both hands extended approximately a quarter of an inch from the tip of the fingers with brown film like residue under the nails. Review of the CNA electronic documentation showed Resident #47 received a bed bath on 9/17/24. On 9/18/24 at 8:59 a.m., Resident #47's hair remained long, uncombed, covering his ears, and strands of hair protruding out of his nose and ears. His fingernails remained uncut with the brown film residue under all his nails. On 9/18/24 at 10:54 a.m., in a joint observation, CNA Staff M verified Resident #47's hair remained long, uncombed, covering his ears, and strands of hair protruding out of his nose and ears. His fingernails remained uncut with the brown film residue under all his nails. She said CNAs did not cut residents hair. She said she would trim his nails on shower days and whenever they needed to be cleaned or cut. On 9/18/24 at 11:18 a.m., in an interview Licensed Practical Nurse Staff L said Resident #47 needed a hair cut and needed to have the hair protruding from his nose and ears trimmed. She said the Social worker would be the one to arrange for the haircut if the resident did not have the funds to pay for it. On 9/18/24 at 11:25 a.m., in an interview the Social Worker said Resident #47 could not get his hair cut if he did not have the funds to pay for it. On 9/18/24 at 11:38 a.m., in an interview the Regional Business Office Manager said if the resident needed a hair cut and did not have the money to pay for the services, the facility would pay for the haircut.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, review of the clinical record, review of the facility policy and procedure and resident and staff interviews, the facility failed to ensure appropriate treatment, equipment and services to maintain mobility for 2 (Resident #17 and #95) of 5 residents reviewed with contractures and splinting devices. The findings included: Review of the facility policy Assistive Devices and Equipment documented, Our facility provides, maintains, and supervises the use of assistive devices and equipment for residents. Devices and equipment that assist with resident mobility, safety and independence are provided for residents. Recommendations for the use of devices and equipment are based on the comprehensive assessment and documented in the resident's plan of care. 1. Review of the clinical record revealed Resident #17 had an admitted [DATE] with diagnoses including type 2 diabetes, anxiety, left breast neoplasm and dementia. The Quarterly Minimum Data Set (MDS) dated [DATE] documented, Resident #17 was dependent on staff for all her care needs. Resident #17's cognitive skills for daily decision making were severely impaired. Review of the care plan initiated on 5/31/24 documented Right hand splint as ordered, nursing to monitor skin integrity and circulation. Review of the physician order dated 8/6/20 documented, Right-hand splint on in a.m., off in p.m. may wear up to six hours a day. Nursing to check for skin integrity every day shift for restorative. During random observations on 9/16/24 at 11:00 a.m., 9/17/24 at 10:30 a.m., and 9/18/24 at 9:58 a.m., Resident #17 was in bed holding both hands in a tight fist. She was nonverbal and did not respond to verbal stimuli. The resident was holding both hands in fisted position and there were no splinting devices on her hands. Review of the nursing Treatment Administration Record (TAR) revealed the licensed nurses documented the splint was applied to the resident's right hand on 9/1/24, 9/2/24, 9/3/24, 9/5/24, 9/6/24, 9/9/24, 9/10/24, 9/12/24, 9/13/24, 9/14/24, 9/16/24 and 9/17/24. On 9/1/24 and 9/18/24 the TAR documented N/A (not applicable). On 9/18/24 at 12:07 p.m., in an interview Unit Manager Staff H said she was not aware Resident #17 had an order for a right hand splint. Staff H reviewed the clinical record and confirmed Resident #17 had an order for a right hand splint. On 9/18/24 at 12:47 p.m., in an interview Registered Nurse (RN) Staff M said she did not know if Resident #17 had a splint. Staff M searched the resident's room and was not able to locate a splint. RN Staff M confirmed Resident #17 had an order for a right hand splint that was not applied. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the CNA Kardex (Provides instructions for care) revealed to apply a splint or brace to the right hand in the morning and remove at bedtime, wear up to four hours as tolerated. Review of the CNA task documentation for September 2024 showed on 9/3/24, 9/4/24, 9/5/24, 9/6/24, 9/9/24, 9/10/24, 9/11/24, 9/12/24, 9/13/24, 8/14/24, 9/16/24, 9/17/24, and 9/18/24 Certified Nursing Assistant (CNA) Staff F documented applying the splint to the resident's right hand. On 9/18/24 at 12:55 p.m., in an interview CNA Staff F said she had not seen a splint for the resident. She said if she had known Resident #17 had an order for a right hand splint, she would have applied it for her. Staff F verified she signed the CNA documentation indicating the splint was applied. On 9/19/24 at 11:14 a.m., in an interview the Director of Rehab said Resident #17 had not been on caseload for quite a while and she did not know about a right-hand splint. On 9/19/24 at 11:35 a.m., in a follow up interview the Director of Rehab said the company she works for took over six months ago and she did not have access to the previous therapy records. She said she could not find any information for a right hand splint for Resident #17 . The Director of Rehab said she spoke with the staff and is aware of the order for a right-hand splint. She said since she did not have access to the previous records, Occupational Therapy will put the resident on caseload to address the contractures and the use of the splint to the right hand. 2. Review of the clinical record revealed Resident #95 had an admitted [DATE]. Diagnoses included with diagnoses including hemiparesis (weakness) and hemiplegia (paralysis) of the left side, and contracture of the left and right hands. The Admission MDS dated [DATE] documented the resident required staff assistance with all care needs. The MDS noted the residents' cognitive skills for daily decision making were moderately impaired. Review of the CNA Care Kardex documented, Contractures, the resident to wear bilateral palm guards as ordered to manage contractures of the (bilateral hands). Provide skin care to keep clean. On 9/16/24 at 10:25 a.m., during an observation Resident #95 was noted to have a contracture of the left hand. There were two splints observed on the nightstand. The resident said both of his hands were contracted and no one had applied the splints in a while. During random observations on 9/17/24 at 10:58 a.m., and 9/18/24 at 12:00 p.m., Resident #95 was observed without the splints on his hands. Both splints remained on the nightstand. On 9/17/24 at 10:53 a.m., in an interview Rehab Tech CNA Staff O said Resident #95 was on caseload for the splints but he had been discharged to the care of the unit staff. He said if a resident refuses to wear the ordered splint, he would let therapy know. He said he had not heard Resident #95 had been refusing to wear the splints. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105982	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sun Harbor Healthcare	18480 Cochran Blvd Port Charlotte, FL 33948

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Occupational Therapy (OT) discharge summary dated 9/13/24 documented Manual Tx (treatment) stretching of shortened connective tissue and joint mobilization techniques to prepare for application of palm guards, techniques included soft tissue manipulation, slow sustained stretching to increase wrist and digit extension and PROM (passive range of motion) at digits. Application of palm guards post manual therapy with skin checks. Pt (patient) and caregiver training instructed patient and primary care givers in positioning maneuvers, self-care/skin checks and splinting/orthotic schedule to order with 100% carryover demonstrated by primary caregivers. On 9/18/24 at 12:37 p.m., in an interview Unit Manager Licensed Practical Nurse Staff H confirmed Resident #95 had two splints on the nightstand. Staff H said she was not aware the resident had any splints and said she would check his record and see if he has an order for them. The Unit Manager said she checked the clinical record and the resident did not have an order for the splints. She said she will check with therapy and see if he is supposed to wear splints. On 9/18/24 at 1:46 p.m., in an interview Resident #95 said he was not able to open his hands, he could move his fingers, but had difficulty moving the right shoulder and arm. The splints were observed on the nightstand. Resident #95 said no one tried to put them on for him. On 9/18/24 a physician order was written for the splints: Pt (patient) to wear bilateral palm guards during the day as tolerated for contracture management. On 9/19/24 at 11:18 a.m., in an interview the Rehab Director said Resident #95 recently came off Occupational Therapy (OT) services for the hand contractures. She said the Occupational Therapist developed a functional maintenance program for Resident #95's hand contractures, the resident needed to wear the splints to both hands for contractures. On 9/19/24 at 11:38 a.m., in a follow up interview Resident #95 said no one has placed the palm guards in his hands. He said both his hands were contracted, the left hand was worse. He said the nurse came in the day before and told him he had to wear the splints (palm guards). He said they might help but he won't know until they are applied.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105982	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER: Sun Harbor Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE: 18480 Cochran Blvd Port Charlotte, FL 33948	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50970 Based on observations, staff and resident interview and record review the facility failed to safely store medication to prevent unauthorized access for 3 (Resident #6, #24, and #94) of 3 residents observed with unsecured medications at bedside. The findings included: Review of the facility's policy titled, Administering medications with a revision date of 2/21/24 revealed Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. Review of facility policy titled: 5.0 Medication Storage noted, Medications will be stored in a manner that maintains the integrity of the product and ensures the safety of the residents and is in accordance with Florida Department of Health guidelines. With the exception of Emergency Drug Kits, all medications will be stored in a locked cabinet, cart, or medication room that is accessible only to authorized personnel, as defined by facility policy. 1. On 9/16/24 at 9:22 a.m., a bottle of Flonase nasal spray was observed unsecured on Resident #6's bedside table. In an interview, Resident #6 said the Unit Manager gave her permission to keep the spray at bedside. Photographic evidence obtained. On 9/17/24 at 9:44 a.m., in an interview,Certified Nursing Assistant (CNA) Staff K stated Resident #6 has had the nasal spray out on bedside table previously. On 9/18/24 at 10:35 a.m., Licensed Practical Nurse Staff G verified Resident #6 had an unsecured bottle of Flonase stored at the bedside. She said Resident #6 had a new order to keep the medication at the bedside and was provided a locked box to store the medication. 41155 2. On 9/16/24 at 11:21 a.m., a clear plastic medication cup with six unidentified pills were observed on Resident #24's bedside table. In an interview, Resident #24 said the pills were antacid tablets. He used them for his stomach. On 9/17/24 at 9:03 a.m., the medication cup with the six pills remained unlabeled and unsecured on Resident #24's bedside table. Review of the physician orders dated 6/25/21 documented Cal-Gest Antacid Tablet Chewable 500 milligrams (Calcium Carbonate Antacid) give 1 tablet by mouth at bedtime for acid reflux / indigestion. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Sun Harbor Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 18480 Cochran Blvd Port Charlotte, FL 33948	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/17/24 at 3:41 p.m., in an interview Unit Manager Licensed Practical Nurse Staff H said Resident #24 had an order for antacid tablets but not to keep them at bedside. Staff H said she will go and remove the medication from the resident's room and explain to him that he could not have them at bedside. 41905 3. On 9/17/24 at 11:13 a.m., a small clear plastic medication cup with several pills of different colors and sizes were observed unsecured on Resident #94's bedside table. In an interview, Resident #94 said the nurse gave her the cup of medications but she fell asleep and did not take them. On 9/17/24 at approximately 11:15 a.m., in an interview LPN Staff D verified the observation of the unsecured medications at the resident's bedside. She said she gave the resident the cup of pills but was called to another room before she could observe Resident #94 take the medications. She said the expectation was to observe the resident take the medications then document in the Medication Administration Record (MAR). Staff D said she did not come back to the room to make sure the resident took the medications. On 9/19/24 at 9:22 a.m., in an interview the Director of Nursing (DON) said she was not sure which medications were found at Resident #94's bedside but the expectation was to make sure the resident swallows the medication before they sign it off on the MAR.