STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105983	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harborview Sarasota	4783 Fruitville Road Sarasota, FL 34232

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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 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** Based on observation, review of facility policy, resident and staff interview, and record review, the facility failed to provide the necessary assistance as outlined in the resident's care plan and according to residents' preferences for 4 (Residents #1, # 2, #55 and #90) of 7 residents reviewed for activities of daily living (ADL's).The findings included:The facility policy Activities of Daily Living implemented 3/1/22 (revised 3/1/25) specified, The facility will, based on a residence comprehensive assessment and consistent with the resident's needs and choices, ensure a residence abilities in ADL's do not deteriorate unless deterioration is unavoidable. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The facility will maintain individual objectives of the care plan and periodic review and evaluation. 1. On 3/30/26 at 1:27 p.m., Resident #1 was observed in his room in bed. In an interview, Resident #1 said he needed to have his nails trimmed and his facial hair shaved. He said he did not usually have a beard or mustache. Resident #1's nails were observed to extend approximately 1/2 inch with an accumulation of a brown substance under the nails. The resident was unshaven with approximately one week of facial hair growth. Review of the clinical record revealed Resident #1 had an admission date of 6/13/25 with diagnoses including chronic osteomyelitis (an infection in the bones), complete traumatic left ankle and foot amputation of two or more toes and chronic ulcer of part of the left foot. Review of the significant change Minimum Data Set (MDS) with an assessment reference date (ARD) of 2/2/26 documented a Brief Interview for Mental Status (BIMS) score of 14 indicating Resident #1 had no cognitive impairment. The MDS indicated the resident required substantial to maximum assistance with personal hygiene, dressing, bathing and partial to moderate assistance with oral hygiene. Review of the care plan initiated 3/27/26 identified the resident needed assistance with grooming, bathing, and personal hygiene related to (r/t) mobility impairment non weight bearing on the right foot due to hospitalization and amputation of the right mid foot. The care plan interventions instructed staff to assist up and out of bed for all meals, as tolerated via resident. Bathing assist of (1). Bed mobility assistance of (1). Call bell within reach and reminders to use it as needed. Dressing assistance of (1). Eating assist of 1. Encourage choices with care. Monitor and report changes in physical functioning ability. Nail care as needed. Personal Hygiene assistance of (1). On 3/31/26 at 12:34 p.m., Resident #1 was observed in bed sleeping. He was unshaven with over a (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	week of facial hair growth; His nails remained long with a black/brown substance under the nails. On 4/1/26 at 8:26 a.m., Resident #1 was observed sitting up in bed. A Certified Nursing Assistant (CNA) came in with the morning meal, set up the resident's tray up and left the room. On 4/1/26 at 8:29 a.m., a different CNA went into the resident's room and removed the untouched breakfast tray. Resident #1's roommate said they gave him a tray and then picked it back up. On 4/1/2026 at 8:32 a.m., in an interview, CNA Staff E, the resident's assigned said Resident #1 was able to feed himself and he ate very good today. CNA Staff E said residents are shaved once a week when they get a shower, the nails are cut and cleaned every week. On 4/1/26 at 9:45 a.m., in an interview, the Director of Nursing (DON) said some men want to be shaved every day, male residents should be shaved daily if needed and twice a week during showers. 2. On 3/30/26 at 12:00 p.m., Resident #55 was observed in his room in bed. The resident had approximately 3 days of facial hair growth. His fingernails extended approximately 1/4 inch with a black substance under the nails. In an interview, Resident #55 said he was not able to cut his own nails and the staff did not always come to help him; He lays in bed waiting. Review of the clinical record revealed Resident #55 was [AGE] years old with diagnoses including dementia, stage 3 chronic kidney disease, anxiety, edema, hypertensive heart disease, and major depressive disorder. Review of the Quarterly MDS with an ARD (Assessment Reference Date) of 12/29/25 revealed Resident #55 scored 05 on the BIMS, indicating severe cognitive impairment. The MDS noted the resident required substantial to maximum assistance with personal hygiene, bathing, and toileting. Review of Resident #55's care plan initiated on 11/2/21 identified he had an ADL self-care performance deficit related to fall with subacute hematoma, Dementia, unsteadiness on feet, history of visual hallucinations, immobility, history of repeated falls and incontinence. The care plan interventions included: Showers require substantial assistance.Dressing: Allow sufficient time for dressing and undressing. Dressing: Assist the resident to choose simple comfortable clothing that enhances the resident's ability to dress self. Personal hygiene/oral care: setup assist for oral care and substantial assist with personal hygiene. Review of the CNA documentation for March 2026 revealed Resident #55 received assistance with personal hygiene daily, including shaving. On 3/31/26 at 12:36 p.m., and on 4/1/26 at 9:01 a.m., observation of Resident #55 revealed he remained unshaven with 4 or more days of facial hair; his nails remained untrimmed, with a black substance under the nails. Resident #55's feet were observed to be dry, scaly and flaky. On 4/1/26 at 10:53 a.m., in an interview the Administrator said she was aware of the care concerns for Resident #1 but did not know about Resident #55. She said, We did nails yesterday but they could use cleaning. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 3/30/26 at 1:53 p.m., Resident #90 was observed in bed. The resident's fingernails extended approximately 1/2 inch with a black/ brown substance under the nails. The resident's right-hand fingers were curled in a partially closed fist. No splinting device was observed in the resident's right hand. Review of the clinical record revealed Resident #90 was [AGE] years old with diagnoses including hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) following cerebral infarction (stroke) affecting the right dominant side, dementia and aphasia (impaired ability with language). Review of the Quarterly MDS with an ARD of 1/23/26 revealed Resident #90 was dependent for all ADLs and resident's decision making ability regarding tasks of daily life was severely impaired. Review of the care plan initiated 10/20/25 identified Resident #90 needed assistance with grooming, bathing, and personal hygiene related to self-care impairment. The care plan interventions included: Bathing assist of (2). Bed mobility assistance of (2). Dressing assistance of (2). Palm guard to right hand (prevents fingers from digging into the palm). Personal Hygiene assistance of (1). On 3/31/26 at 8:44 a.m., Resident #90 was observed in bed. The resident did not answer to interview questions. Her fingernails remained untrimmed with a black substance under the nails. Resident #90's right hand fingers were curled into a fist. The palm guard was not in place to the right hand. A foul odor was noted coming from the right hand. On 4/1/26 at 8:54 a.m., observation of Resident #90 revealed her fingernails remained untrimmed with the black substance under the nails. A foul odor was noted coming from the resident's right hand from three feet away. On 4/1/26 at 9:56 a.m., in an interview, the DON said nail care should be completed weekly and as needed. On 4/2/26 at 10:06 a.m., in an interview, CNA Staff D said she was assigned to Resident #90. She said the resident required total care. On 4/2/26 at 10:18 a.m., CNA Staff D and the DON were observed in Resident #90's room. The resident's bottom lip was sticking out and was coated with a thick, dry, brown substance. The DON verified the observation of the resident's lips and said, Her lips are dry. The DON instructed CNA Staff D to provide oral care to the resident. Record review for Resident #2 revealed an admission date of 4/23/25. Diagnoses included: Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side. (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 Quarterly MDS dated [DATE], revealed Resident #2 scored 13 on the BIMS, indicating of intact cognition. The MDS noted that Resident #2 It also needed set-up for eating and oral hygiene. Resident #2 was dependent for grooming. On 3/30/26 at 10:38 a.m., in an interview, Resident #2 she that her left arm was paralyzed from a stroke. She said that she was unable to clip her fingernails. She has asked staff to have them clipped, but it has not been done. Resident #2 said that staff did not help her to brush her teeth. She said she could not remember the last time her teeth were brushed. Observation of the resident during the interview revealed her fingernails extended beyond her fingertips. A white substance was observed at the gumline of her lower front teeth. On 3/30/26 at 1:38 p.m., Resident #2 was observed in bed. Her fingernails remained untrimmed. The white substance remained at the gumline of her lower front teeth. A meal tray was observed on the Resident #2's bedside table. An open hot dog roll topped with shredded brown meat and melted cheese was observed untouched on the tray. In an interview, Resident #2 stated that she was not able to pick up and eat the sandwich with one hand without spilling it all over herself. A review of Resident #2's care plan revealed the resident needed assistance with grooming, bathing, and personal hygiene related to mobility impairment and self-care impairment. The care plan specified the resident required the assistance of 1 for eating, and personal hygiene. On 3/31/26 at 9:27 a.m., and 3/31/26 at 12:35 p.m., observation of Resident #2 revealed the resident's bottom front teeth remained with the white substance at the gum line. On 3/31/26 at 2:55 p.m., in an interview CNA Staff B stated that Resident #2 was able to brush her own teeth and eat independently. CNA Staff B stated that she didn't know if there was a Kardex (contains resident care instructions) for Resident #2. On 3/31/26 at approximately 3:00 p.m., in an interview the Assistant Director of Nursing (ADON) verified that Resident #2's Kardex specified she required the assistance of one for meals and oral care. The ADON said he spoke with Resident #2 and agreed that the resident's teeth needed to be brushed and her nails trimmed. The ADON stated that the resident was able to use her right hand to eat but he understood how some food items were difficult for her to manage. On 3/31/26 at 3:44 p.m., an interview was held with the Director of Rehab and the Regional Director of Rehab. The Director of Rehab said that Resident #2 was discharged from Occupational Therapy on 6/16/25 with recommendation to set up for eating. The Regional Director of Rehab said that set up included cutting sandwiches into small pieces. On 4/1/26 at 10:03 a.m., in an interview, the DON said Resident #2's teeth should be brushed at least twice a day, ideally in the morning, after every meal, and at bedtime. He said the staff should be doing nail care with showers/baths or have the hairdresser do them.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview, record review and facility policy the facility failed to ensure that 5 (Licensed Practical Nurses Staff H, Staff N, Staff O, Staff P, and Staff Q) of 5 Licensed Practical Nurses reviewed had appropriate skill sets, and certifications to administer intravenous antibiotic therapy (IV) for 2 (Residents #73 and #66) of 3 residents reviewed for IV Therapy.The findings included:Review of facility policy Intravenous Therapy date implemented 3/1/22, date reviewed/revised 3/1/25 documented: The facility will adhere to accepted standards of practice regarding infusion practices in accordance with state regulations. Definitions: Intravenous (IV) Therapy is the administration of parenteral fluids or medications through an IV catheter to treat a condition. Compliance Guidelines: (14) The Registered Nurse or certified Licensed Practical Nurse (LPN) will evaluate the associated risks due to IV fluid administration (15) IV documentation is recorded in the nurses' notes and/or Medication Administration Record. Continuous Infusion, IV push and intermittent medication infusion procedures to be completed by RN or certified LPN.Review of the clinical record for Resident #73 revealed an admission date of 2/27/26. Diagnoses included chronic osteomyelitis right foot and ankle (infection of the bone tissue), peripheral vascular disease, Type 2 diabetes mellitus, history of osteomyelitis left foot and ankle with below the knee amputation.Review of the admission Minimum Data Set (MDS) with an assessment reference date of 3/5/26 documented Resident #73 was receiving IV medications.Review of the Physician's Order dated 3/2/26 included to administer Meropenem (Antibiotic) Intravenous Solution Reconstituted, 1 gram intravenously every 8 hours for wound infection until 4/2/26.The care plan date initiated revised on 3/2/26 documented that Resident #73 required IV therapy and was at risk for complications. The interventions included to administer IV medication as ordered, monitor for side effects and report to physician.Review of Medication Administration Record (MAR) for March 2026 revealed:LPN Staff H administered the Meropenem IV to Resident #73 on 3/20/26 at 2:00 p.m., and 10:00 p.m.; On 3/21/26 at 10:00 p.m.LPN Staff N administered the Meropenem IV to Resident #73 on 3/9/26 at 10:00 p.m., 3/16/26 at 10:00 p.m.; 3/23/26 at 10:00 p.m.; 3/24/26 at 10:00 p.m.; 3/28/26 at 10:00 p.m.LPN Staff O administered the Meropenem IV to Resident #73 on 3/3/26 at 10:00 p.m.LPN Staff P administered the Meropenem IV to Resident #73 on 3/6/26 at 2:00 p.m.; 3/14/26 at 2:00 p.m.;3/15/26 at 2:00p.m.LPN Staff Q administered the Meropenem IV to Resident #73 on 3/3/26 at10:00 p.m.; 3/12/26 at 10:00 p.m.; 3/13/26 at 10:00 p.m.; 3/15/26 at 6:00 a.m.; 3/17/26 at 10:00 p.m.; 3/21/26 at 6:00 a.m.; 3/27/26 at 6:00 a.m.; 3/29/26 at 10:00 p.m.The facility was unable to provide documentation of IV therapy Certification for the intravenous antibiotic doses administered by the LPNs.Review of the clinical record for Resident #66 revealed an admission date of 2/10/26. Diagnoses included periprosthetic fracture around internal prosthetic (fractures around the joint replacement), presence of left artificial knee joint, infection and inflammatory reaction due to internal left knee prosthesis, age-related osteoporosis (thinner and weaker bones), and chronic pain.Review of the 5-Day Minimum Data Set (MDS) with an assessment date of 2/22/26 documented that Resident #66 was receiving IV medications.The Physician's order for 2/16/26 included to administer Meropenem Intravenous Solution Reconstituted 1 gram intravenously every 8 hours for infection related to infection and inflammatory reaction due to internal left knee prosthesis until 3/19/26.Review of the MAR for 3/2026 revealed:LPN Staff N administered the Meropenem IV on 3/2/26 at 10:00 p.m.; 3/9/26 at 10:00 p.m.; 3/16/26 at 10:00 p.m.LPN Staff O administered the Meropenem IV to Resident # 66 on 3/3/26 at 10:00 p.m.LPN Staff P administered the Meropenem IV to Resident # 66 on 3/6/26 at 2:00 p.m.; 3/14/26 at 2:00 p.m.; 3/15/26 at 2:00 p.m.LPN Staff Q administered the Meropenem IV to Resident # 66 on 3/12/26 at 10:00 p.m.; 3/13/26 at 10;00 p.m.; 3/14/26 at 6:00 a.m.; 3/15/26 at 6:00 a.m.; 3/17/26 at 10:00 p.m.; 3/18/26 at 10:00 p.m.On 4/2/26 at 11:20 a.m., in an interview, the Assistant Director of Nursing (ADON) said that LPNs should be IV Certified to administer IV medications.On (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/2/26 at 11:31 a.m., in an interview the Director of Nursing (DON) said LPNs have to be IV certified to administer IV medications. He said if the LPN is not IV certified, one of the Registered Nurses supervisors should administer the IV medication. The DON stated that administering IV medications fell outside of practice for LPNs who were not IV certified and that it was an issue.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on record review, review of facility's policy and procedure and staff interviews, the facility failed to have documentation that 2 (Residents #73 and #66) of 3 residents reviewed, received intravenous antibiotics as ordered. Missed dosages of antibiotics could jeopardize the residents' health and safety. The findings included:A review of the Facility's Policy Medication Administration with a date implemented of 3/1/22, documented, Medications are administered by licensed nurses or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice . 12b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. Sign MAR (Medication Administration Record) after administered. 22. Report and document any adverse side effects or refusals. 23. Correct any discrepancies and report to nurse manager.Review of the clinical record for Resident #73 revealed an admission date of 2/27/26. Diagnoses included chronic osteomyelitis right foot and ankle (infection of the bone tissue).Review of the physician's orders dated 3/2/26 revealed to administer Meropenem (antibiotic) Intravenous Solution, 1 gram intravenously every 8 hours for wound infection until 4/2/26.Review of the Medication Administration Record (MAR) for March 2023 revealed the Meropenem was scheduled to be administered at 6:00 a.m., 2:00 p.m., and 10:00 p.m. The MAR failed to show documentation that the Meropenem was administered as ordered to Resident #73 on 3/3/26 at 6:00 a.m., 3/3/26 at 2:00 p.m., 3/4/26 at 2:00 p.m., 3/6/26 at 6:00 a.m., 3/12/26 at 6:00 a.m., 3/13/26 at 6:00 a.m., 3/14/26 at 6:00 a.m., 3/22/26 at 2:00p.m., 3/24/26 at 2:00 p.m., 3/25/26 at 2:00p.m., 3/25/26 at 10:00 p.m., and 3/26/26 at 6:00 a.m.The progress notes for March 2023 failed to reveal an explanation for the doses of Meropenem not documented as administered or physician notification of missed doses.Review of the clinical record documented Resident #66 revealed an admission date of 2/10/26. Diagnoses included infection and inflammatory reaction due to internal left knee prosthesis, and chronic pain.Review of the physician's orders dated 2/16/26 revealed to administer Meropenem intravenous solution reconstituted, 1 gram intravenously every 8 hours for infection and inflammatory reaction due to internal left knee prosthesis until 3/19/26.Review of the MAR for March 2026 failed to show documentation that the intravenous Meropenem was administered as orders on 3/3/26 at 6:00 a.m., 3/3/26 at 2:00 p.m., 3/12/26 at 6:00 a.m., and 3/13/26 at 6:00 p.m.The progress notes for March 2023 failed to reveal an explanation for the doses of Meropenem not documented as administered or physician notification of missed doses.On 4/2/26 at 11:00 a.m., in an interview, Licensed Practical Nurse (LPN) Staff F said that the physician should be notified of missed or refused doses of medications and documented in the clinical record. LPN Staff E said that missed doses of antibiotics could cause the infection to worsen. On 4/2/26 at 11:10 a.m., in an interview, LPN Staff G said medications are documented as given on the MAR after the medication has been administered. LPN Staff G said that the physician should be notified of missed or refused doses of medications and documented on the MAR. LPN Staff G said that missed doses of antibiotics could cause the infection to worsen.On 4/2/26 at 11:21 a.m., in an interview, the Assistant Director of Nursing (ADON) said that if there are no initials on the MAR for the scheduled administration time, it is then assumed that the medication was not administered, but there is no way to know. He said that missed doses of medications should be addressed at the morning meeting and the physician should be notified of the missed doses of medications. The ADON said that the nurse who hangs the IV antibiotic should be signing on the MAR that the medication was given.On 4/2/26 at 11:32 a.m., during an interview, the Director of Nursing (DON) verified that the MAR for Residents #73 and #66 lacked documentation that multiple doses of intravenous antibiotics were administered. The DON said that not administering the antibiotics as ordered could cause the infection to worsen and the physician should be notified of missed/refused doses of antibiotics.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review and interview, the facility failed to offer and/or administer the flu and/or pneumonia vaccine for 5 (Residents #8, #2, #92, #49, and #66) of 5 residents reviewed for vaccinations. The findings included:Review of the facility's policy and procedure titled Infection Prevention and Control Program, with a revision date of 2/1/25 indicated: 7. Influenza and Pneumococcal Immunization a. Residents will be offered the influenza vaccine each year between October 1 and March 31, unless contraindicated or received the vaccine elsewhere. B. Residents will be offered the pneumococcal vaccines recommended by the Center for Disease Control (CDC), upon admission, unless contraindicated or received the vaccines elsewhere.On 3/31/26 review of Resident #8's clinical record revealed that the legal representative consented to the pneumococcal vaccine on 10/3/25. The clinical record lacked documentation that the vaccine was administered. There was no documentation of contraindication for the vaccine.On 3/31/26 review of Resident #2's clinical record revealed a consent form for the pneumococcal vaccine dated 10/3/25. The area to indicate whether the resident wanted to receive the vaccine or declined the vaccine was left blank. The clinical record lacked documentation that Resident #2 accepted or refused the vaccine or that the vaccine was contraindicated.On 3/31/26 review of the clinical record for Resident #92 revealed a consent form for the pneumococcal vaccine dated 10/3/25. The form was left blank and did not indicate whether the resident wanted to receive or declined the pneumococcal vaccine. There was no documentation of contraindication to the vaccine. On 3/31/26 review of the clinical record for Resident #49 revealed that on 10/26/25, the resident consented to receive the pneumococcal vaccine. The clinical record lacked documentation that the pneumococcal vaccine was administered. There was no documentation that the vaccine was contraindicated.On 3/31/26 review of the clinical record review for Resident #66 revealed a consent form for the pneumococcal vaccination dated 10/3/25. There was no documentation on the consent form that the resident accepted or refused the pneumococcal vaccination or that the vaccine was contraindicated.On 3/31/26 at 11:28 a.m., in an interview, the Infection Control Preventionist (ICP) said that on admission, all residents are offered the influenza, pneumococcal and COVID vaccine. The ICP said that the consent form was included in the admission packet. He said they explain the benefits of getting vaccinated to the resident. If the resident is alert and oriented, they sign the form indicating whether they wanted the vaccine or not. If not alert and oriented, it would be discussed with the resident's legal representative who would sign the consent. He said if a vaccine is received or refused it is documented on the immunizations tab. The ICP reviewed the clinical record of Residents #8, #2, #92, #49, and #66. He verified that Residents #8 and #49 consented to the pneumococcal vaccination but the clinical records lacked documentation the residents received the vaccine. He verified that the consent forms for pneumococcal vaccination for Residents #2, #92 and #66 were incomplete and did not indicate whether the residents accepted or refused the pneumococcal vaccination or that the vaccine was contraindicated. He said he had no explanation for the missed vaccines or the incomplete forms.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interview, the facility failed to ensure that 5 (Residents #8, #2, #92, #49, and #66) of 5 residents reviewed for vaccinations were offered and administered the COVID-19 vaccine unless the immunization was medically contraindicated.The findings included:On 3/31/26 clinical record review for Resident #8 revealed the resident's legal representative consented to the COVID-19 vaccine on 10/3/25. The clinical record lacked documentation that the vaccine was administered or that the vaccine was contraindicated.On 3/31/26, review of the clinical record review for Resident #2 revealed a COVID-19 consent form dated 10/3/25. The area to document whether the resident wanted to receive or declined the COVID-19 vaccine was left blank. The clinical record lacked documentation that the resident accepted or declined the vaccine or that the vaccine was contraindicated.On 3/31/26, clinical record review for Resident #92 revealed a COVID-19 consent form dated 10/3/25. The area to document whether the resident wanted to receive or declined the COVID-19 vaccine was left blank. The clinical record lacked documentation that the resident accepted or declined the vaccine or that the vaccine was contraindicated. On 3/31/26 clinical record review for Resident #49 revealed that on 10/26/25, the resident consented to the COVID-19 vaccination. The clinical record lacked documentation that the resident received the COVID-19 vaccine as requested or that the vaccine was contraindicated.On 3/31/26 clinical record review for Resident #66 revealed a COVID-19 consent form dated 10/3/25. The area to document whether the resident wanted to receive or declined the COVID-19 vaccine was left blank. The clinical record lacked documentation that the resident accepted or declined the vaccine or that the vaccine was contraindicated. On 3/31/26 at 11:28 a.m., in an interview, the Infection Control Preventionist (ICP) said that the consent form for the COVID-19 vaccine was included in the admission packet. He said that on admission, and annually, all residents are offered the COVID-19 vaccine. The benefits of the vaccine are explained to the residents. Residents who are alert and oriented sign the consent form, indicating whether they wanted or declined the vaccine. For the residents who are not alert and oriented, the vaccination is discussed with the legal representative who would then sign the consent form and indicate whether or not to administer the COVID-19 vaccine.The ICP reviewed the clinical records of Residents #8, #2, #92, #49, and #66. He verified that Residents #8 and #49 consented to the COVID-19 vaccine and the lack of documentation that the residents received the vaccine.The ICP verified that the consent form for the COVID-19 vaccine was incomplete for Residents #2, #92, and #66 and did not indicate whether the residents accepted or declined the vaccine or that the vaccine was contraindicated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105983	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harborview Sarasota	4783 Fruitville Road Sarasota, FL 34232

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policy and staff interviews, the facility failed to ensure a safe, clean, sanitary and homelike environment that emphasizes and enhances resident comfort for the residents in the 100, 200, and 400 halls.The findings included: Review of the facility policy Resident Personal Belongings implemented 3/1/22 (revised 1/1/26) documented It is the policy of this facility to protect the residents right to possess personal belongings, such as clothing and furnishings, for their use while in the facility. All resident possessions, regardless of their apparent value to others will be treated with respect. The facility will support the residents' right to retain and use personal possessions to promote a home-like environment and maintain their independence. The facility will ensure resident belongings are kept in a neat and orderly fashion and maintained in each residents room. On 3/30/26 at 10:00 a.m., during an initial tour of the 100 hall the following observations were noted: 1. In the shared bathroom of room [ROOM NUMBER], a box of disinfecting wipes was observed on the bathroom counter. Photographic evidence obtained 2. In the shared bathroom of room [ROOM NUMBER], two unlabeled wash basins were observed stacked on the counter. Wheelchair footrests were observed stored on the floor, under the counter. Trash was observed on the bathroom floor. Photographic evidence obtained. 3. In the shared bathroom of room104, an unlabeled bedpan and a wash basin were stored on the counter. A wheelchair cushion was stored on the floor under the counter. Photographic evidence obtained. A corroded tube feeding pole was observed in room [ROOM NUMBER]. Multiple yellow, dried stains were observed on the bottom of the pole. Photographic evidence obtained. 4. In room [ROOM NUMBER]'s shared bathroom, two unlabeled, uncovered wash basins, and two unlabeled bottles of soap and lotion were observed stored on the counter. 5. In the shared bathroom of room107, an unlabeled, uncovered washbasin, an unlabeled bottle of cleansing foam and an unlabeled, uncovered toothbrush were observed stored on the counter. An unlabeled, uncovered was basin was observed stored on the floor under the counter. An unlabeled bedpan was stacked in the wash basin. Photographic evidence obtained. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. In room [ROOM NUMBER]'s shared bathroom, the following was observed: Two stacked unlabeled and uncovered wash basins, an uncapped razor and an unlabeled wash basin with personal care items. Photographic evidence obtained. The call light in the room for bed A was clipped to the privacy curtain and out of the residents reach as he laid in the bed. Photographic evidence obtained. 6. In the shared bathroom of room [ROOM NUMBER], an unlabeled and uncovered bedpan was observed stored on a wash basin on the floor under the counter. Photographic evidence obtained. On 3/30/26 at 11:39 a.m., the Director of Nursing verified the observation that the call light for Resident #59 and Resident #55 were attached to the privacy curtain and were not within the residents reach. On 3/31/26 at 9:30 a.m., Resident #1's catheter drainage bag was attached to the bedframe and was touching the floor. On 4/1/26 at 9:15 a.m., in an interview, Licensed Practical Nurse Staff A said the facility was aware of concerns of personal items in shared bathrooms not labeled or stored properly. On 4/1/2026 at 9:50 a.m., in an interview the Administrator said that the facility did not have a policy on storage of personal items in shared bathrooms and said, We can do better than that. 7. On 3/30/26 at 10:00 a.m., during a tour, the walls near the air conditioning units in rooms [ROOM NUMBER] were observed to be stained, the paint was peeling and cracking. The baseboards were discolored and pulling from the wall. Black bio growth was observed on the wall where the paint had peeled. On 4/2/26 at 11:00 a.m., in an interview the Maintenance Director said he had been employed at the facility for 5 months and had been working through the repairs. 8. On 3/31/26 at 2:15 p.m., in an interview, Resident #66 said that approximately a month ago, the chairs were taken out of the room and never brought back. She said when her family visits, her sister has to sit on the bed, and her brother-in-law must stand. She said her visitors don't stay long since they must stand. On 3/31/26 at 3:00 p.m. revealed 6 of 11 rooms in the 400-hallway did not have a chair, rooms 402, 403, 406, 407, 410, and 411. room [ROOM NUMBER] was shared by two residents and had one chair.