

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106025	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/18/2025
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Sarasota		STREET ADDRESS, CITY, STATE, ZIP CODE  8104 Tuttle Ave Sarasota, FL 34243	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews and record review, the facility failed to provide one resident (#100) of thirty-nine sampled residents with a bed that met his height needs and comfort during three days (9/8/2025, 9/9/2025 and 9/10/2025) of four days observed. Findings included: On 9/8/2025 at 10:45 a.m. and 1:00 p.m. Resident #100 was visited while in his room. Both times observed, he was noted lying flat in bed with his head on a pillow. Further observations revealed Resident #100 was utilizing a mechanical air loss mattress system with bolsters on each side of the bed. The residents both feet were either pressed up against the end of the foot board or positioned on top of the foot board. Photographic evidence was taken with permission from Resident #100's wife, who was his decision maker. On 9/9/2025 at 8:30 a.m. and at 9:40 a.m., Resident #100's feet were observed propped up and pressed up against the end of the foot board. It appeared Resident #100 was tall in stature and not fitting comfortably in the bed. On 9/9/2025 at 9:40 a.m. an interview with Resident #100's family member who revealed they visited the resident daily. The family member Resident #100 was six feet four inches and that he lies in bed all day, by choice and his feet are always scrunched up against or positioned on top of the foot board. The family member revealed the resident had wounds on his heels and are being treated but did not think having his feet pressed up against or placed on top of the hard wooden foot board helped with healing and comfort. The family member stated having notified facility staff and assumed there was nothing that could be done. Resident #100 who had cognitive deficiencies with dementia was not interviewable and could not express if the bed was too short and if he had any discomfort or pain related to his feet placed on the foot board. During multiple tours on 9/9/2025 and on 9/10/2025 Resident #100 was observed in the same condition, his feet pressed against the foot of the bed. On 9/10/2025 at 10:00 a.m. an interview with Staff T, Registered Nurse (RN)/Unit Manager (UM) revealed she was knowledgeable of Resident #100 and his care and service needs. Staff T revealed the resident has dementia and does not get out of bed. Staff T revealed Resident #100 had wounds on his heels that is being treated for by the wound care team, and that he utilizes a mechanical air loss mattress with bolsters for comfort as well as decreasing risk for further pressure ulcers. Staff T confirmed Resident #100 was tall but could not say exactly how tall he was. Staff T went to Resident #100's room and confirmed his feet were pressed up against the foot board with a portion of one of his feet positioned on top of the wooden foot board. Staff revealed the foot board was bordering and placed against the end of the mattress. She revealed the foot board could be adjusted out but had not been done. Staff T confirmed Resident #100's feet were not placed properly and should not be positioned on the foot board due to him already having foot ulcers. Staff T stated Resident #100 should be wearing foot heel protector boots and was not aware why he was not wearing them. She confirmed he does not refuse the use of the protector boots, and stated staff should have been aware of the resident's feet pressing on the board. Review of Resident #100's medical record revealed he was admitted to the facility on [DATE] with diagnoses to include but not limited to: Alzheimer's, dementia, depression, restlessness and agitation, seizures, and need for personal assistance. Review of the current physician's orders for the month of 9/2025 revealed the following but not limited to orders:- Wound treatment for Right heel: clean with n/s, apply silver alginate to wound bed, cover with gauze island w/bdr (with a bordered dressing), every night shift (order date 8/11/2025).- Air mattress with bilateral bolsters check placement and function, every shift (order date 8/2/2024).- Skin prep to heels for skin protection every night shift (order date 6/6/2024).- Elevate heels when in bed to alleviate pressure as tolerated every shift (order date 9/16/2022). Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #100 had a Brief Interview Mental Status (BIMS) score of 3 of 15 indicating the resident was severely impaired. Section GG revealed the resident had impairment on both sides with upper extremities, impairment on one side with lower extremity and was dependent on staff for ADLs (activities of daily living). Review of the current care plans with a next review date 10/19/2025 revealed the resident was at risk for break in skin integrity r/t (related to) impaired mobility, incontinence, dx. (diagnosis) of anemia, PVD (Peripheral Vascular Disease), history of pressure ulcers and arterial ulcers, with interventions in place to include air mattress with bilateral bolsters, check placement and function, heel elevating boots per current MD (medical doctor) order, pressure reducing mattress. On 9/11/2025 at 1:00 p.m. an interview was conducted with the Nursing Home Administrator (NHA) and the Director of Nursing (DON). They provided the Bed Inspection &amp; Bed Maintenance and Bed Rail Installation policy and procedure with a last review date of 1/17/2025 for review</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, interviews and policy review, the facility failed to report an injury of unknown origin for one resident (#11) of two residents sampled. Findings Included: On 09/09/2025 at 03:05 p.m. an interview was conducted with Staff M Licensed Practical Nurse (LPN) and Unit Manager (UM), of the Manatee unit. Staff M stated Resident #11 experienced a fall on 09/06/2025. Staff M stated the fall was not observed by staff. Staff M stated resident #11 went to the hospital on [DATE] after the resident complained of pain and an x-ray showed the resident had a hip fracture. On 09/10/2025 at 04:18 p.m. an interview was conducted with Staff R, Certified Nursing Assistant (CNA). Staff R explained seeing Resident #11 on the floor on the right side of the resident's bed and laying on their right side. Staff R stated Resident #11 was not seen falling to the floor. Staff R stated Resident #11 complained of pain while receiving a bed bath. On 09/10/2025 at 04:39 p.m. an interview was conducted with Staff S, Licensed Practical Nurse (LPN). Staff S stated how or why the resident fell was unknown. On 09/11/2025 at 10:40 a.m. an interview was conducted with Staff P, Registered Nurse (RN), and Staff I, CNA. Staff I explained walking by Resident #11's room and observing Resident #11 on the floor and having notified the nurse. Staff I, stated Resident #11 expressed pain in the right hip, while being picked up off the floor. On 09/18/2025 at 12:46 p.m., an interview was conducted with Staff W Physical Therapy Assistant (PTA). Staff W stated Resident #11's family member/decision maker reported the resident was in pain due to a fall over the weekend. Staff W stated one of Resident #11's legs was moved slightly and the resident expressed pain. Staff W stated a nurse was notified. Review of Resident #11's medical record revealed the resident was admitted to the facility on [DATE] and was readmitted on [DATE] with a primary diagnosis of displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing. Other diagnoses included encounter for other orthopedic aftercare, muscle weakness, need for assistance with personal care, end stage renal disease, history of falling, and repeated falls. Review of a hospital history and physical for Resident #11 dated 09/09/2025 showed .the patient presented from nursing facility after having an outpatient X-ray that showed a femoral neck fracture. It was reported the patient had a fall on Saturday and had evaluation outpatient. Patient was complaining of hip pain while at dialysis. The X-ray showed a fracture. Patient does not appear in any discomfort or pain at this time. On arrival patient had a CT (Computed Tomography) of pelvis that showed a comminuted intertrochanteric fracture of the right femur with impaction; healed sacral and left pubic rami fractures. Compression screw noted within the left femoral neck per urology read. Review of a quarterly Minimum data Set (MDS) for Resident #11 dated 06/30/2025 revealed in section B the resident had impaired vision and sometimes understands verbal content. section C revealed the resident had a Brief Interview Mental Status score of 04, which meant severe cognitive impairment. Section GG revealed the resident used a wheelchair and walker for mobility and was dependent on staff for activities of daily living (ADLs) to include toileting hygiene, personal hygiene, and lower body dressing. Resident #11 required partial to moderate assistance for toilet transfers. Review of a progress note dated 09/06/2025 at 4:21 p.m. revealed, nurse alerted to the room. Pt (patient) was found on the floor on her right side, on the right side of the bed. Bed was in the lowest position. Neuros initiated . Nurse helped the CNA (Certified Nursing Assistant) put the patient back in her bed. Nurse cleansed the skin tear RUE (right upper extremity) with normal saline, Zeroform and clean, dry dressing. Physician made aware. POA (power of Attorney) made aware. On 09/18/2025 at 01:23 p.m. an interview was conducted with the Director of Nursing (DON) and the Risk manager (RM)/Assistant Director of Nursing (ADON). The DON stated how the resident fell was unknown. The DON stated the resident experienced a fall and the injury sustained by Resident #11 was unwitnessed. The DON stated a five-day adverse should have been completed. The DON stated the incident should have been reported. Review of a facility policy titled Abuse-protection of Residents, reviewed 06/17/2024 revealed a policy - the facility will ensure that all residents are protected from physical and psychosocial harm during and after the investigation. Procedure: The following methods to ensure the protection of residents during an investigation may include but are not limited to: 5. Notification of the alleged violation to other agencies or law enforcement authorities.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews and record review, the facility failed to implement care plan interventions related to the use of orthotics for one resident (#100) of two residents reviewed during three days (9/8/2025, 9/9/2025, and 9/10/2025) of four days observed. Findings included: During multiple tours conducted on 9/8/2025 between 10:45 a.m. and 2:45 p.m., and on 9/10/2025 at 7:30 a.m. and at 9:50 a.m., Resident #100 was observed in his room lying in bed with no Right-hand splint/brace/hand carrot on and no heel protector boots on either of his feet. On 9/9/2025 at 9:40 a.m. an interview with Resident #100's family member who revealed they visited the resident daily. The family member Resident #100 was six feet four inches and that he lies in bed all day, by choice and his feet are always scrunched up against or positioned on top of the foot board. The family member revealed the resident had wounds on his heels and are being treated but did not think having his feet pressed up against or placed on top of the hard wooden foot board helped with healing and comfort. The family member stated having notified facility staff and assumed there was nothing that could be done. Resident #100 who had cognitive deficiencies with dementia was not interviewable and could not express if the bed was too short and if he had any discomfort or pain related to his feet placed on the foot board. The family member revealed not being aware of Resident #100's heel protector boots or a Right-hand splint/hand carrot device and having not seen them applied to the resident. An interview was conducted on 9/10/2025 at 10:00 a.m. with Staff T, Registered Nurse (RN)/Unit Manager in 100 hall. Staff T revealed she was aware and knowledgeable of Resident #100's care and services. Staff T stated not being aware Resident #100 had orders to utilize heel protector boots and stated they would look at the orders to get clarification. She reviewed the record and confirmed he was care planned and ordered for use of heel protector boots while in bed, and with feet to be elevated. Staff T went to Resident #100's room and confirmed Resident #100 was not wearing any type of Right-hand splint/brace or hand carrot device. Staff T revealed she believed it was the responsibility of Physical Therapy (PT) department to maintain the use and donning and doffing of the Heel protective boots and Right-hand splint/ hand carrot device on a daily basis. Staff T stated having reviewed Resident #100's medical record to include the Treatment Administration Record (TAR) for the month of 9/2025 and found there was no documentation of application of the orthotics. Staff T confirmed Resident #100 should be assisted with the heel protector boots and a Right-hand splint/hand carrot device. Review of Resident #100's medical record revealed he was admitted to the facility on [DATE] with diagnoses to include but not limited to: Alzheimer's, dementia, depression, restlessness and agitation, seizures, and need for personal assistance. Review of the current physician orders for the month of 9/2025 revealed the following orders:a . Monitor Splint/Brace/Medical device to R (right) hand. Check skin integrity around or under device, pain and circulation x shift and document any changes in progress notes (order date 8/27/2025).b . Splint/Brace/Medical device: Allmed therapy Carrot Hand Contracture Orthotics. Apply to R hand for at least 1 hour. On during the day and off at night. Assess pain level, circulation and skin integrity, every shift document in progress note any changes (order date 8/27/2025).c . Wound treatment for R heel: clean with n/s, apply silver alginate to wound bed, cover with gauze Island w/bdr, every night shift (order date 8/11/2025).d . Elevate heels when in bed to alleviate pressure as tolerated every shift (order date 9/16/2022). Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #100 had a Brief Interview Mental Status (BIMS) score of 3 of 15 indicating the resident was severely impaired. Section GG revealed the resident had impairment on both sides with upper extremities, impairment on one side with lower extremity and was dependent on staff for ADLs (activities of daily living). Review of the nurse's progress notes dated 6/1/2025 through 9/10/2025 revealed there was no documentation related to the use of orthotics or refusals. Review of a physician's progress note dated 8/25/2025 revealed Resident #100 was seen today for monthly follow up. Resident with Pressure ulcer right heel stage 4, Pressure ulcer left heel stage 3, Wound care onboard managing treatments to include Encourage off-loading of pressure from the affected areas using specialized footwear or heel protectors. Review of Resident #100's Medication Administration Record (MAR)dated 9/2025 revealed:- Monitor splint/brace/medical device to Right hand. Check skin integrity around or under device, pain and circulation every shift document any changes in progress notes and notify MD (medical doctor) if appropriate (order date 8/27/2025). - Splint/Brace/Medical device: Allmed therapy carrot hand contracture orthosis. Apply to R hand for at least one hour. On during the day and off at night. Assess pain level, circulation, and skin integrity. Every shift document in progress notes</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>(continued on next page)</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews and record review, the facility failed to ensure care was provided in accordance with professional standards related to the use of orthotics for one resident (#100) of two residents reviewed during three days (9/8/2025, 9/9/2025, and 9/10/2025) of four days observed. Findings included: During multiple tours conducted on 9/8/2025 between 10:45 a.m. and 2:45 p.m., and on 9/10/2025 at 7:30 a.m. and at 9:50 a.m., Resident #100 was observed in his room lying in bed with no Right-hand splint/brace/hand carrot on and no heel protector boots on either of his feet. On 9/9/2025 at 9:40 a.m. an interview with Resident #100's family member who revealed they visited the resident daily. The family member Resident #100 was six feet four inches and that he lies in bed all day, by choice and his feet are always crunched up against or positioned on top of the foot board. The family member revealed the resident had wounds on his heels and are being treated but did not think having his feet pressed up against or placed on top of the hard wooden foot board helped with healing and comfort. The family member stated having notified facility staff and assumed there was nothing that could be done. Resident #100 who had cognitive deficiencies with dementia was not interviewable and could not express if the bed was too short and if he had any discomfort or pain related to his feet placed on the foot board. The family member revealed not being aware of Resident #100's heel protector boots or a Right-hand splint/hand carrot device and having not seen them applied to the resident. An interview was conducted on 9/10/2025 at 10:00 a.m. with Staff T, Registered Nurse (RN)/Unit Manager in 100 hall. Staff T revealed she was aware and knowledgeable of Resident #100's care and services. Staff T revealed she would follow up with the missing heel protector boots and Right-hand splint/brace. Staff T searched in the resident's room and confirmed both of his feet were without heel protector boots on and were positioned up against the footboard and he was not wearing a Right-hand splint/hand carrot. Staff T confirmed Resident #100's feet should not have been pressed up against the foot board. Staff T left the room and was observed walking down the hallway with a clear plastic bag with contents to include heel protector boots. Staff T and another staff member entered the room with the bag of heel protector boots and donned them on the resident. A follow-up interview with Staff T confirmed she had to get boots from the therapy department. Staff T revealed the resident showed no behaviors or discomfort when placing the boots on. She confirmed the resident had not been assisted with the heel protector boots. Staff T confirmed not having observed the resident with the orthotics prior to this day. Review of Resident #100's medical record revealed he was admitted to the facility on [DATE] with diagnoses to include but not limited to: Alzheimer's, dementia, depression, restlessness and agitation, seizures, and need for personal assistance. Review of the current physician orders for the month of 9/2025 revealed the following orders: a . Monitor Splint/Brace/Medical device to R (right) hand. Check skin integrity around or under device, pain and circulation x shift and document any changes in progress notes (order date 8/27/2025). b . Splint/Brace/Medical device: Allmed therapy Carrot Hand Contracture Orthotics. Apply to R hand for at least 1 hour. On during the day and off at night. Assess pain level, circulation and skin integrity, every shift document in progress note any changes (order date 8/27/2025). c . Wound treatment for R heel: clean with n/s, apply silver alginate to wound bed, cover with gauze Island w/bdr, every night shift (order date 8/11/2025). d . Elevate heels when in bed to alleviate pressure as tolerated every shift (order date 9/16/2022). Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #100 had a Brief Interview Mental Status (BIMS) score of 3 of 15 indicating the resident was severely impaired. Section GG revealed the resident had impairment on both sides with upper extremities, impairment on one side with lower extremity and was dependent on staff for ADLs (activities of daily living). Review of the nurse's progress notes dated 6/1/2025 through 9/10/2025 revealed there was no documentation related to the use of orthotics or refusals. 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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review, and interviews, the facility failed to provide adequate supervision to prevent a fall resulting in major injury and hospitalization for one resident (#11) of two residents reviewed. Findings Included: Review of Resident #11's medical record revealed the resident was admitted to the facility on [DATE] and was readmitted on [DATE] with a primary diagnosis of displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing. Other diagnoses included encounter for other orthopedic aftercare, muscle weakness, need for assistance with personal care, end stage renal disease, history of falling, and repeated falls. Review of a hospital history and physical for Resident #11 dated 09/09/2025 showed .the patient presented from nursing facility after having an outpatient X-ray that showed a femoral neck fracture. It was reported the patient had a fall on Saturday and had evaluation outpatient. Patient was complaining of hip pain while at dialysis. The X-ray showed a fracture. Patient does not appear in any discomfort or pain at this time. On arrival patient had a CT (Computed Tomography) of pelvis that showed a comminuted intertrochanteric fracture of the right femur with impaction; healed sacral and left pubic rami fractures. Compression screw noted within the left femoral neck per urology read. Review of a quarterly Minimum data Set (MDS) for Resident #11 dated 06/30/2025 revealed in section B the resident had impaired vision and sometimes understands verbal content. section C revealed the resident had a Brief Interview Mental Status score of 04, which meant severe cognitive impairment. Section GG revealed the resident used a wheelchair and walker for mobility and was dependent on staff for activities of daily living (ADLs) to include toileting hygiene, personal hygiene, and lower body dressing. Resident #11 required partial to moderate assistance for toilet transfers. Review of progress notes for Resident #11 dated 09/04/2025 revealed Resident #11 who resided in the memory care (Serenity) unit was readmitted to the facility following Covid diagnosis and was moved from the unit for isolation. The progress note dated 09/04/2025 at 4:56 p.m. showed, family member aware [Resident #11] will return to Serenity unit once she is finished with isolation. Review of a physician note dated 09/04/2025 at 4 p.m. revealed under assessment plan, family member stated demented [Resident #11] is confused and demands a UA (urinalysis) . Continue above medications and fall precautions. Review of a progress note dated 09/06/2025 at 4:21 p.m. revealed, nurse alerted to the room. Pt (patient) was found on the floor on her right side, on the right side of the bed. Bed was in the lowest position. Neuros initiated . Nurse helped the CNA (Certified Nursing Assistant) put the patient back in her bed. Nurse cleansed the skin tear RUE (right upper extremity) with normal saline, Zeroform and clean, dry dressing. Physician made aware. POA (power of Attorney) made aware. Review of a progress note dated 09/06/2025 at 9:21 p.m. revealed the resident was given Acetaminophen 325 MG (milligram), Give 2 tablets by mouth as needed for mild pain (1-3). Review of a skilled note dated 09/09/2025 revealed .Resident is a fall risk and assisted with all ADLs by CNA. Resident pain and medications are managed by nursing staff. Review of a physician progress note dated 09/09/2025 at 12:51 p.m. showed, Fall out of bed on 9/6, found on right side, minimum pain-now with increased pain. X-ray ordered, found to have acute left femoral neck fracture. Review of a progress note dated 09/09/2025 at 1:52 p.m. revealed, doctor called from hospital and resident will be admitted to the hospital at this time. On 09/10/2025 at 04:39 p.m. an interview was conducted with Staff S, Licensed Practical Nurse (LPN). Staff S stated Resident #11 experienced a fall on 09/06/2025 and reported being alerted by the CNA of Resident #11's fall. Staff S stated Resident #11 was observed on the floor, after which the resident was assisted to bed, then evaluations were completed for the resident. During an interview on 09/11/2025 at 10:40 a.m. with Staff I, CNA and Staff P, Registered Nurse (RN), Staff I, CNA explained assisting Staff R, CNA and Staff S, LPN in response to Resident #11's fall. Staff I, CNA stated Staff S, LPN looked at the resident and stated the resident was fine and instructed the CNAs to pick the resident up. Staff I, CNA stated the resident expressed pain in the right hip and grabbed the right hip. On 09/09/2025 at 3:05 p.m. an interview was conducted with Staff M, LPN/Unit Manager (UM) who explained Resident #11 went to a local hospital due to a fall on 09/06/2025. The Unit Manager stated Resident #11 was a long-term care resident residing in the Serenity wing. The resident had a respiratory infection, went to a hospital, was diagnosed with Covid and returned to the facility on [DATE]. Staff M stated the resident went to the Manatee/Cardiac wing, away from the Walkie Talkie residents in the Serenity wing. Staff M stated the resident was placed in the Manatee Wing for isolation and was planning to return to the Serenity wing on 09/09/2025. Staff M stated the resident was found on the floor and skin and pain assessments were</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106025	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/18/2025
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Sarasota		STREET ADDRESS, CITY, STATE, ZIP CODE  8104 Tuttle Ave Sarasota, FL 34243	

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)
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>(continued on next page)</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record reviews, and interviews, the facility failed to ensure the medication error rate was less than 5%. Thirty medication opportunities were observed, and four errors were identified for our residents (#39, #41, #71 and #88) out of eight residents resulting in an error rate of 13.33%. Findings included: On 9/9/25 at 8:32 a.m., Staff D, Registered Nurse (RN) was observed administering medication to Resident #39. Staff D, RN administered the following medications: Xanax 0.5mg (milligrams), Lexapro 20mg, losartan potassium 50mg, tamsulosin 0.4 mg and Lantus SoloStar pen injector. Staff D, RN dialed the dosage selector to 20 units on the Lantus SoloStar pen injector, cleaned the needle injector port with alcohol and inserted the needle into the injector port. Staff D, RN entered Resident #39's room prepared the injection site and administered the medication. When asked about priming the insulin injector pen Staff D, RN said, I don't do that. Review of Resident #39's admission record showed the resident was originally admitted on [DATE] and re-admitted on [DATE] with diagnoses not limited to Type 2 Diabetes Mellitus. On 9/9/25 at approximately 9:15 a.m., Staff V, Licensed Practical Nurse (LPN) was observed administering medication to Resident #71. Staff V, LPN crushed and administered the following medications: aspirin 81mg, cholecalciferol 1000 units, polysaccharide iron complex 150 mg, famotidine 20 mg, calcium citrate + vitamin D3 (calcium and vitamin D3 supplement). Review of Resident #71's admission record showed the resident was admitted on [DATE] with diagnoses to include fracture of the right femur, iron deficiency anemia and vitamin D deficiency. Review of Resident #71's orders showed orders including calcium citrate +oral tablet (multiple vitamins with minerals) Give 1 tablet two times daily for supplement, ordered date 2/25/25 and discontinued date 9/10/25. On 9/10/25 at 9:18 a.m. during an interview with the Director on Nursing (DON) and review of resident #71's Medication Administration Record (MAR), the DON said she recognized What's wrong and will contact Resident #71's Primary Care Physician (PCP) immediately. On 9/10/25 at 11:30 a.m., Staff A, LPN was observed administering medication to Resident #88. Staff A, LPN obtained fingerstick blood glucose and Resident #88's result was 251. Staff A, LPN reviewed the insulin orders and dialed the dosage selector to 6 units on the insulin Aspart, human pen injector, cleaned the needle injector port with alcohol and inserted the needle into the injector port. Staff A, LPN entered Resident #88's room prepared the injection site and administered insulin Aspart 6 units. Review of Resident #88's admission record showed the resident was originally admitted on [DATE] and re-admitted on [DATE]. The record include diagnoses of Diabetes Mellitus. On 9/10/25 at 11:38 a.m., Staff A, LPN was observed administering medication to Resident #41. Staff A, RN obtained fingerstick blood glucose, Resident #41's result was 396. Staff A, LPN reviewed the insulin orders and dialed the dosage selector to 13 units on the insulin lispro pen injector, cleaned the needle injector port with alcohol and inserted the needle into the injector port Staff A, LPN entered Resident #41's room prepared the injection site and administered 13 units of insulin lispro. During an interview after the medications were administered, Staff A, LPN said, I forgot when asked about priming the insulin pen injectors. Review of Resident #41's admission record showed the resident was originally admitted on [DATE] and re-admitted on [DATE] with diagnoses to include Type 2 Diabetes Mellitus. During an interview on 9/10/25 at 12:50 p.m. the DON said insulin training was recently provided for the staff, and they were told to prime the pen. She said she expects staff to follow the training that was provided. Review of the facility's policy titled, Insulin Pen Administration, revised date 5/27/25 showed the following: Policy- The facility will ensure residents with orders for Insulin administration through the use of a pen delivery device is performed in accordance with current standards or practice and manufacturer's guidance. Procedure .4 The insulin pen should be primed prior to each use (in accordance with manufacturer's guidelines) to prevent the collection of air in the insulin reservoir.a. General guidance on priming an insulin pen in the absence of manufacturer's guidance.i). Dial 2 units by turning the dose selector clockwise ii. With the needle pointing up, push on the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat this procedure until at least one drop of insulin appears. Review of the facility's policy titled, General dose preparation and medication administration, revised date 11/15/24, revealed the following: Applicability- the procedures relating to general dose preparation and medication administration. Procedure . 3. Prior to administration of medication, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: 3.1 Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct</p>		