STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106035	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inn at Sarasota Bay Club	1303 North Tamiami Trail Sarasota, FL 34236

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50970 Based on observation, clinical record review, review of facility policy, resident and staff interviews, the facility failed to maintain a sanitary environment for 1 (Resident # 22) of 20 residents' rooms observed by failure to ensure the resident's room was free from foul odor. The findings included: The facility's policy and procedure for Housekeeping Expectations revealed to clean all resident bathrooms daily; Clean resident occupied rooms, a minimum of once weekly and as directed or deemed necessary; Clean vacated rooms as directed to prepare for admission ready. A complete room cleaning is performed, please speak with Admissions for any special cleaning requirements. The policy and procedure for the (Brand name) Urine Collection Systems (non-invasive urine collection system for women with urinary incontinence) with and effective date of 10/01/2018 stated, The facility does not provide any [Brand name] Collection systems, parts or supplies. Should a resident be clinically appropriate for the use of this type of urine collection system, the resident understands that they accept the responsibility of the cost and maintenance of the collection system machine, parts and supplies. Residents using a urine collection system such as a [Brand name], agree to hold The Inn harmless for any negative outcomes as a result of the use of this type of system and they are exercising their choice to use the system against the recommendation of The Inn. Information and understanding is provided to the resident prior to use of the urine collection system. Review of Resident #22's clinical record revealed an admitted [DATE]. Diagnoses included Osteoporosis. The Admission Minimum Data Set (MDS) Assessment (Federally mandated evaluation of resident's health needs and functional capabilities) with a target date of 3/6/24 noted Resident #22's cognition was intact with a Brief Interview for Mental Status Score of 14. The Assessment noted the resident was frequently incontinent of urine (inability to control urine from the bladder). On 8/12/24 at 10:00 a.m., Resident #22 was observed in her room. The room had a strong foul odor of urine. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/12/24 at 1:05 p.m., in an interview Resident #22 said she has been a resident at the facility for over a year. She said she was incontinent and used a (brand name) urine suction system at night (draws urine away from the body into a sealed collection canister). A urine suction machine was observed on the floor next to the resident's bed with urine in the collection canister. Resident #22's room remained with a strong foul odor of urine. On 8/13/24 at 11:00 a.m., Resident #22 was observed sitting in a lounge chair at her bedside. An empty urine collection canister was stored on the floor next to the resident's bed. The room remained with a strong foul odor of urine. On 8/13/24 at 3:10 p.m., in a joint interview Licensed Practical Nurse (LPN) Staff C and Registered Nurse (RN) Staff L said they were aware of the foul smell of urine in Resident #22's room. They said the facility tried multiple interventions such as daily baths, testing for urinary tract infection, cleaning the room, and washing with vinegar but nothing improved the foul smell of urine. Staff C and Staff L said Resident #22 was admitted with the urine collection system in February 2024 and the room had the foul urine smell ever since. They said the Administrator and the Director of Nursing (DON) were aware of the issue. On 8/14/24 at 10:57 a.m., in a telephone interview Resident #22's daughter said she visited her mother from out of State this past weekend. When asked about the strong foul smell of urine in the resident's room, she stated, I can smell it at times; her room has had the odor since admission in February. She stated, Mom does not know how to use her [brand name urine collection system] or if it is right. The daughter added, I do not think they know how to use it. The staff used to open her windows when the weather was cooler to air out the room. She said her mother has had the urine collection system since her admission to the facility. Review of the clinical record for Resident #22, including physician's orders, progress notes, care plans failed to show documentation of interventions to address the urine odor in the resident's room. The clinical record lacked documentation the facility provided information to Resident #22 about the use of the urine collection system and verified the resident's understanding prior to use of the system. On 8/14/24 at 2:15 p.m., in an interview Certified Nursing Assistant (CNA) Staff M said she noticed the urine smell in Resident #22's room since her admission in February. She said in the morning, she removes and discards the urine collection sponge before washing the resident's peri area. She cleans the urine collection canister with soap and hot water, rinses it with hot water, and wipes it with sanitary wipes. She also wipes the tubing with alcohol and allows the canister to air dry in a basin in the resident's shower. Staff M said the urine smell is so strong, she has to hold her breath. She has to send the resident's bedding and reusable pad to be laundered at least three times a week and sometimes daily. She reported it to the nurse. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24 at 3:30 p.m., in an interview the DON said she was aware of the urine odor in Resident #22's room. She said the facility started to pay for the supplies for the urine collection system to replace them more frequently. The DON verified Resident #22's room had the foul smell of urine since her admission. She said the urine collection system was causing the odor but it was the resident's choice to use the machine. The DON said the interdisciplinary team had several discussion about the continuing issue with the smell of the resident's room. The DON was asked but was not able to provide documentation of interventions attempted to address the ongoing foul smell of urine in Resident #22's room.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on observation, interview and record review, the facility failed to develop a person-centered comprehensive care plan to meet the needs of 1 (Resident #11) of 3 residents reviewed for care plans. The findings included: Review of the clinical record for Resident #11 revealed an admitted [DATE]. The nursing progress note dated 3/5/24 at 4:43 p.m., noted Resident #11 had a cardiac pacemaker (implanted device to help control the heart's rhythm and rate). The physician's order summary documented the presence of a cardiac pacemaker. The Admission Minimum Data Set (MDS) assessment dated [DATE] noted Resident #11's cardiac diagnoses included abnormal heart rhythm. The MDS did not document the presence of the cardiac pacemaker in the active diagnoses, or cardiopulmonary procedures. The assessment noted Resident #11's cognition was intact with a Brief Interview for Mental Status score of 15. The comprehensive care plan initiated on 3/21/24 did not address the presence of the cardiac pacemaker with goals, interventions, precautions, and follow up as appropriate. On 8/14/24 at 4:06 p.m., in an interview the MDS coordinator verified the lack of care plan for the pacemaker. She said she was responsible to ensure care plans were in place. She said she should have developed a care plan with goals and interventions for the pacemaker but she missed it. On 8/14/24 at 5:25 p.m., in an interview the Director of Nursing (DON) said the normal process is to have a care plan for the pacemaker with interventions.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on observation, interview and record review, the facility failed to ensure 3 (Residents #21, #25, and #180) of 5 residents reviewed received care in accordance with professional standards of practice. The findings included: 1. Review of the clinical record for Resident #21 revealed an admitted [DATE]. The physician's orders dated 7/27/24 included to weigh Resident #21 weekly on Tuesdays starting on 8/1/24 for a diagnosis of malnutrition. The physician's orders dated 7/27/24 also included to obtain the resident's vital signs (Temperature, pulse, respiration, blood pressure) and weight monthly. The clinical record lacked documentation the facility clarified the physician's orders related to the frequency of monitoring the resident's weight. On 8/14/24, review of the weight summary showed Resident #21's weight was obtained on 8/2/24. No other weight was documented after 8/2/24. The clinical record lacked documentation of the reason for the missing weekly weights. On 8/14/24 at 5:09 p.m., in an interview the DON verified the last weight for Resident #21 was obtained on 8/2/24. She said she personally entered the order for the weekly weight and staff should have obtained the weekly weight as ordered. On 8/15/24 at 8:35 a.m., in an interview the Administrator said the order for weekly weights on Tuesdays at 6:00 a.m., was on the Medication Administration Record (MAR) for August 2024. She said the night shift nurse should have obtained the weight or document in a progress note the reason why the physician's order for the weekly weight was not followed. 2. Review of the clinical record for Resident #25 revealed a physician's order dated 8/7/24 to apply a Lidoderm Patch 5% (local anesthetic) to the resident's right shoulder topically for pain. The patch was to be on for 12 hours and off for 12 hours. Review of the MARs for August 2024 revealed the patch was scheduled to be applied each day at 9:00 a.m., and removed each day at 9:00 p.m. The MAR showed the Licensed Nurse placed her initials on 8/12/24 at 9:00 p.m., indicating the Lidoderm patch was removed. On 8/13/24 at 8:17 a.m., LPN Staff C was observed preparing to administer medications to Resident #25, including a Lidoderm patch 5%. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the resident's right shoulder revealed a Lidoderm patch dated 8/12/24. LPN Staff C said the Lidoderm patch applied on 8/12/24 at 9:00 a.m., was not removed on 8/12/24 at 9:00 p. m., as ordered. On 8/13/24 at 8:28 a.m., LPN Staff C documented in a progress note the previous Lidocaine (Lidoderm) patch not removed at hours of sleep. On 8/14/24 5:17 p.m., in an interview the Director of Nursing (DON) said staff should not sign off something they did not do. The nurse was not following the physician's order. On 8/15/24 at 8:50 a.m., the Administrator said the nurse did not follow the physician's orders for the Lidoderm Patch. 25618 3. On 8/12/24 review of Resident #180's medical record revealed she was admitted to the facility on [DATE] with a diagnosis of failure to thrive and on hospice services. Review of the Baseline Care Plan did not identify services which Hospice was to provide for Resident #180 in order to coordinate care between the facility and Hospice. On 8/13/24 at 1:19 p.m., in an interview with Resident #180's Hospice Aid K said today was her first time working with Resident #180. She said when she reviewed Resident #180's medical record she was unable to find Resident #180's Hospice Care Plan which would let her know what care she needed to provide for Resident #180. She said when she was unable to find Resident #180's Hospice Plan of Care she called the main office, they told her she should ask Resident #180's nurse what they needed her to do for Resident #180 today. She said she used each Hospice resident's Hospice Plan of Care to determine what care she needed to provide to the resident, so there is not a duplication of care between the Hospice aid and the facility staff. On 8/13/24 at 1:46 p.m., in an interview with Staff F, Resident #180's nurse said Resident #180 was admitted to the facility on [DATE] under Hospice services. She said Hospice provided a Hospice Plan of Care for each resident which they keep in the resident's medical record. She said the Hospice Plan of Care was used to coordinate the care between Hospice staff and facility staff to ensure there was no duplication of care and the Hospice resident received the best care possible. She confirmed after reviewing Resident #180's medical record, Resident #180's Hospice Care Plan was not in her medical record as required. On 8/13/24 at 1:59 p.m., in an interview with the Minimum Data Set (MDS) Coordinator, she confirmed Resident #180 was admitted to the facility on [DATE] under Hospice care. She said she did not do a full comprehensive plan of care until day 21 after a resident was admitted to the facility, and Resident #180's comprehensive care has not been completed as of today. She confirmed Resident 180's Baseline Care Plan did not identify services that Hospice would provide in order to coordinate care between the facility and Hospice. She said Hospice was required to put their plan of care in each Hospice resident's medical record when a resident has been admitted to Hospice services to ensure coordination of care between Hospice and the facility staff. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MDS Coordinator reviewed Resident's 180's medical record and confirmed it did not contain the required Hospice Plan of Care and/or Hospice staff visit weekly documentation of the care they provided Resident #180 since her admission to the facility 7/24/24. On 8/15/24 at 11:00 a.m., in an interview with the Director of Nursing (DON), she said Hospice did not provide the facility with Resident #180's Hospice Plan of Care which reflected the resident and family goals with interventions addressing the patient's needs, services to be provided by Hospice, and problems identified by the Hospice Interdisciplinary Group as noted in the Hospice contract.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 41905 Based on observation, interview and record review, the facility failed to ensure the error rate was less than 5%. 25 opportunities were observed, two medication errors were identified resulting in a medication error rate of 8%. The findings included: 1. On 8/13/24 at 8:00 a.m., observed Registered Nurse (RN) Staff H administer 1 tablet of Vitamin B12 - 500 micrograms (mcg) to Resident #21. On 8/14/24 at 8:50 a.m., review of the physician's order summary for Resident #21 revealed a current order to give 2 tablets of Vitamin B12 - 500 mcg one time a day for B12 deficiency. On 8/14/24 at 9:01 a.m., review of the Medication Administration Record (MAR) for August 2024 revealed Staff H signed off she administered 2 tablets of Vitamin B12 500 mcg. on 8/13/24. On 8/14/24 at 11:33 a.m., during an interview with Staff H she said she thought Resident #21's order for B12 was for 1 tablet, so she gave her one tablet during the observation on 8/13/24. Staff H looked at the order on her computer screen and said, you're correct, the order is for two tablets; my error. Review of the physician's order summary and MAR for Resident #3 revealed an order with a start date of 8/1/24 for Cholecalciferol (Vitamin D) 400 units, 2 tablets one time a day for bone health. 2. On 8/13/24 at 8:57 a.m., Licensed Practical Nurse (LPN) Staff F was observed preparing several medications to administer to Resident #3, including Vitamin D. LPN Staff F placed two tablets of Vitamin D (400 units/each) from a stock bottle into the medication cup. LPN Staff F also placed one tablet of Vitamin D (400) units from a bubble pack into the medication cup. LPN Staff F walked into Resident #3's room to administer the medications to the resident, including 1200 units of Vitamin D instead of 800 units as per the physician's order. LPN Staff F was asked to stop the medication administration and verify the dosage of the Vitamin D she was about to administer to the resident. On 8/13/24 at approximately 9:15 a.m., LPN Staff F verified the physician's order was to administer Vitamin D (400 units) 2 tablets orally one time a day. LPN Staff F verified she placed Vitamin D (400 units) 3 tablets into the cup.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 38570 Based on record review and resident and staff interview, the facility failed to ensure the facilities binding arbitration agreement explicitly informed the residents of their rights to have it explained to them in a manner that was understood, that the agreement could be rescinded within 30 calendar days of signing, that the agreement did not have to be signed or that it was not a condition of admission or continued care in the facility, and that the resident would be allowed to communicate with federal, state or local ombudsman for 3 (Resident #10, #12 and #330) of 13 resident reviewed who had signed the facility binding arbitration agreement. The findings included: On review of Facilities binding arbitration agreement, it did not indicate the following: Explained in a from and manner that the resident understood. That the agreement may be rescinded within 30 calendar days of signing. That the agreement was not required to be signed or that it was a condition of admission or continued care in the facility. The resident or their representative could still communicate with federal, state or local officials such as federal and state surveyors, health department or long-term care ombudsman. During an interview on 8/14/24 at 9:07 a.m., the administrator stated that all resident are presented with the binding arbitration agreement on admission. She said she believed that all 30 resident in the facility had signed the agreement. She said that resident are given an admission packet and a separate packet of contracts and are asked to sign all the items in the packet and the arbitration agreement is in that packet. Administrator said she was unaware if the admission person pointed out the arbitration agreement or discussed it to be sure the resident or representation understood what it was or if they were aware that they do not have to sign it as a condition for being admitted . During an interview on 8/14/24 at 10:34 a.m., the Community Liaison Staff stated that he had not ever explained to a resident or their representative about the Binding Arbitration agreement. He said he usually has a stack of things from the admission paperwork and contracts that need to be signed on admission or before admission and he lays it on the resident bedside table before they arrive at the facility. He said that he highlights all the lines that have to be signed. He said, I admit that I have not gone over the form with them or told them it is voluntary and they did not have to sign or that it was not contingent on admission or receiving care here. He acknowledged the language in the form or agreement did not indicate that the signing of the form was voluntary or that it would not keep them for admission or care if they did not sign it. He acknowledged that that the agreement did not indicate that they could rescind it within 30 days after signing the arbitration agreement if they wanted to. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a second interview on 8/14/24 at 10:49 a.m., the Administrator acknowledged that the binding Arbitration Agreement did not inform resident or their represented that they could rescind the agreement within 30 days if they wanted to do so. She verified the agreement did not indicate that the whole agreement was voluntary and was not contingent of admission or continuing care in the facility, and did not indicate if resident could contact state or local agency or ombudsman. or that the resident could have a neutral arbitrator that they agreed on or that they could choose the venue for the meeting if having one. During an interview on 8/14/24 at 2:01 p.m., Resident #10 stated she did remember the paperwork left for her to sign on admission but could not say that she even knew what a binding Arbitration agreement statement was. She said no one came in to explain anything or go over the binding arbitration agreement. she said she just thought it was things for admission. On review of Resident #10 medical record and Minimum Data Set (MDS) Assessment the resident has a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact and was her own responsible party. During an interview on 8/14/24 at 2:15 p.m., Resident #330 stated that she did remember the stack of papers to sign laying on her bedside table when she came in and she remembered the lines to be signed were highlighted in yellow. She just figured it was stuff for admission and did not even know what this was. She said no one came in and went over the paperwork with her. She said when she got there she had just been in the hospital for over two weeks and really could not read all those contracts and comprehend everything. Resident said she thinks someone should go over admission paperwork upon admission. On review of Resident #330 medical record and Minimum Data Set (MDS) Assessment the resident has a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact and is her own responsible party. During an interview on 8/15/24 at 9:50 a.m., Resident #12 said that he remembers the stack of contracts in his room that he was supposed to sign. he said that he signed them but he did not remember seeing the Binding Arbitration agreement. He said that each of the contracts had an (X) mark or highlighted line to sign. The resident said he signed the line and figured it was just admission stuff. He said that on admission he was tired and there was no staff to go over the items with him, so he just signed them. On review of Resident #12 medical record and Minimum Data Set (MDS) Assessment the resident has a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was cognitively intact and is her own responsible party.

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide a neutral and fair arbitration process and agree to arbitrator and venue. 38570 Based on record review and resident and staff interview, the facility failed to ensure the facility's binding arbitration agreement signed by 3 (Residents #10, #12 and #330) of 13 resident reviewed explicitly informed residents of their rights to select a neutral arbitrator and participate in the select of venue for dispute resolution that both parties agreed upon. The findings included: Review of the clinical record for Residents #10, #12, and #330 revealed the residents signed the facility's binding agreement upon admission. On review of Facilities binding arbitration agreement, it did not indicate the following: 1. That the resident has a right to be included in selecting a neutral arbitrator agreed upon by both parties 2. That the resident has the right to be included in selecting a venue that is convenient to both parties. During an interview on 8/14/24 at 10:34 a.m., Community Liaison (admission person) stated that he has not ever explained to a resident or their representative about the Binding Arbitration agreement. He said he usually has a stack of things from the admission paperwork and contracts that need to be signed on admission or before admission and he lays it on the resident bedside table before they arrive at the facility. He said that he high lights all the lines that have to be sign. During a second interview on 8/14/24 at 10:49 a.m., Administrator verified that the binding Arbitration Agreement did not inform resident or their represented that the resident could have a neutral arbitrator that they agreed on or that they could choose the venue for the meeting if having one.