

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106102	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Sarasota Point Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 Courtland Street Sarasota, FL 34237	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905</p> <p>Based on observation, record review, resident and staff interview, the facility failed to update the care plan to accurately reflect safety precautions for 1 (Resident #30) of 2 sampled residents at risk for elopement.</p> <p>The findings included:</p> <p>Review of the clinical record revealed Resident #30 was admitted to the facility on [DATE]. Diagnoses included non-Alzheimer's dementia.</p> <p>The Elopement risk evaluations completed on 4/26/24, 5/21/24, and 10/14/24 noted Resident #30 scored 2, indicating the resident was at risk for elopement.</p> <p>Review of the care plan initiated on 5/21/24 and revised on 10/14/24 noted Resident #30 was at risk for elopement. The goal was Attempts to prevent resident from eloping from facility will be provided. The interventions included an alerting bracelet (alerts staff when the resident leaves a designated safe area) placed to the right ankle. The care plan specified to check the alerting bracelet function and placement every day.</p> <p>Review of the Order Summary Report revealed a physician's order dated 10/16/24 to, Check placement of Alerting Bracelet walker every shift for monitoring.</p> <p>The care plan was not updated to reflect the alerting bracelet to the resident's walker.</p> <p>On 10/21/24 at 3:30 p.m., on 10/22/24 at 11:00 a.m., and on 10/23/24 at 11:13 a.m., Resident #30 was observed in her bedroom. The resident was not wearing an alert bracelet to the right ankle. An alert bracelet was observed attached to the resident's rolling walker.</p> <p>On 10/22/24 at 11:02 a.m., in an interview Resident #30 said she used to have an alert bracelet to her right ankle but she used a butter knife to cut it off.</p> <p>On 10/23/24 at 4:57 p.m., in an interview Minimum Data Set Registered Nurse (RN) Staff F said the physician's order and the care plan should match. She verified on 10/16/24 the physician's order for the alert bracelet to the rolling walker. Staff F said the care plan should have been revised to reflect the alert bracelet on the rolling walker.</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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/23/24 5:14 p.m., the MDS coordinator said she verified Resident #30's alert bracelet was attached to the rolling walker and not to the resident's right ankle. She said the care plan was incorrect.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>41905</p> <p>Based on observation, record review, resident and staff interviews, the facility failed to provide care and services in accordance with physician's orders to meet the needs of 1 (Resident #30) of 1 resident observed with edema (swelling) of the legs.</p> <p>The findings included:</p> <p>Review of the clinical record for Resident #30 revealed an admission to the facility of 4/25/24. Diagnoses included heart failure.</p> <p>The physician's orders dated 6/10/24 noted to apply [NAME] hose (compression garment to legs to help circulation and lower swelling) in the morning and off in the evening for edema.</p> <p>The care plan initiated on 4/25/24 noted Resident #30 was at risk for altered cardiovascular status related to hypertension and congestive heart failure. The goal was for the resident to have decreased risk of signs and symptoms of cardiac complications. The interventions included to observe for changes in lung sounds, edema or changes in weight.</p> <p>The care plan initiated on 5/6/24 noted Resident #30 is resistive to care and medications related to adjustment to admission, and new environment, and on 6/10/24 refused to wear the [NAME] Hose. Interventions included to allow the resident to make decisions about treatment regime to provide sense of control, give clear explanation of all care activities prior to and as they occur during each contact.</p> <p>On 10/21/24 at 3:30 p.m., 10/22/24 at 10:53 a.m., and 10/23/24 at 11:13 a.m., Resident #30 was observed sitting in her room with her legs in dependent position. Resident #30 was not wearing the [NAME] Hose. Her legs were swollen.</p> <p>Review of the Treatment Administration Record (TAR) for October 2024 showed on 10/21/24, 10/22/24 and 10/23/24 the nurse placed her initials indicating the [NAME] hose were applied in the morning.</p> <p>On 10/22/24 at 10:53 a.m., in an interview Resident #30 said no one offered to apply the [NAME] hose on 10/21/24 or today (10/22/24).</p> <p>On 10/23/24 at 11:13 a.m., in an interview Resident #30 complained her legs were swollen. She said she has not refused to wear the [NAME] hose, but no one offered to apply them recently.</p> <p>Review of the Medication Administration Audit Report revealed the [NAME] hose were scheduled to be applied at 7:00 a.m. Licensed Practical Nurse (LPN) Staff D documented on the TAR the [NAME] hose were applied on 10/23/24 at 11:57 a.m.</p> <p>On 10/23/24 at 12:25 p.m., Resident #30 was observed in her room. She was not wearing the [NAME] Hose.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/23/24 at 1:09 p.m., in an interview Certified Nursing Assistant (CNA) Staff C said she was assigned to care for Resident #30. Staff C said she knew Resident #30 needed the [NAME] hose. The resident did not refuse the [NAME] hose but it slipped her mind and she did not offer to apply the [NAME] hose.</p> <p>On 10/23/24 at 1:23 p.m., in an interview LPN Staff D said the CNAs are supposed to apply the [NAME] hose. She said she did not verify Resident #30 had the [NAME] hose on before documenting on the TAR the [NAME] hose were applied as ordered.</p> <p>On 10/23/24 at 1:30 p.m., Resident #30 was observed in her room. She was not wearing the [NAME] hose to her legs as ordered. Unit Manager Registered Nurse Staff E verified Resident #30's legs were swollen and she did not have the [NAME] hose on. She said staff should not be documenting a treatment before confirming it was completed.</p> <p>On 10/24/24 at 10:30 a.m., in an interview the Director of Nursing said staff should not document a treatment was completed before they confirmed that it was done.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>37256</p> <p>Based on observation of medication administration, record review, staff and resident interviews, the facility failed to ensure 2 (Residents #74 and #38) of 3 sampled residents were free from significant medication error related to the administration of transdermal pain patches.</p> <p>The findings included:</p> <p>1. Review of the clinical record for Resident #74 revealed a physician's order dated 5/25/23 for Lidocaine (topical anesthetic) External Patch 4%, apply to hip topically in the morning for pain and remove per schedule.</p> <p>Review of the Medication Administration Record (MAR) for October 2024 revealed the Lidocaine Patch was scheduled to be applied every day at 6:00 a.m. and removed every day at 6:00 p.m.</p> <p>The MAR for October 2024 had an order dated 5/12/23 to validate the Lidocaine Patch to the right hip was present every shift. The diagnoses for the Lidocaine Patch was fracture of the right femur.</p> <p>On 10/22/24 at 9:10 a.m., Licensed Practical Nurse (LPN) Staff A was observed administering medications to Resident #74. An undated Lidocaine Patch was observed on the resident's right thigh, near his groin. LPN Staff A said the previous shift applied the Lidocaine Patch. She said the patch should have been applied to the resident's right hip, not his thigh and should have been dated.</p> <p>On 10/22/24 at 10:21 a.m., Resident #74 was observed with the Director of Nursing and the Regional Clinical Director. Resident #74 remained with the undated patch to the right thigh. A Lidocaine Patch dated 10/18/24 was observed to the resident's left thigh.</p> <p>Review of the packaging for the Lidocaine patch revealed a warning label that said, Do not use more than one patch on your body at a time . Do not use more than one patch in a 12-hour period. Maximum 2 patches per day.</p> <p>Photographic evidence obtained.</p> <p>2. On 10/22/24 review of the clinical record for Resident #38 revealed a physician's order dated 9/28/24 to apply a Lidocaine Patch 4% topically to the resident's right shoulder in the morning for pain and remove at bedtime, remove per schedule.</p> <p>Review of the MAR for October 2024 revealed the Lidocaine Patch was scheduled to be applied every day at 6:00 a.m., and removed at 5:59 p.m. The MAR noted the Lidocaine Patch was applied as ordered on 10/22/24 at 6:00 a.m.</p> <p>On 10/22/24 at 10:40 a.m., in an interview Resident #38 said she felt the Lidocaine Patch was just cold and did nothing to help her pain. She said she had not used the Lidocaine Patch in about 10 days. Resident #38 showed a patch to her right shoulder which she said was a Thermacare Patch. She said Physical Therapy applied the Thermacare patch to her right shoulder which worked better.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Director of Nursing and the Regional Clinical Director were present during the interview, and observation.</p> <p>Review of the facility policy and procedure titled Medication Pass and Med Pass with Medication Cart Updated 8/14/24 noted to, Complete documentation on the medication MAR. Record the name, dose, route, and time of medication on the Medication Administration Record. Initial the record after the medication is administered to the resident. Record the reason for not administering the medication.</p> <p>On 10/22/24 at 10:45 a.m., the DON said there was no separate policy for transdermal patches, but the process was patches should be dated on the day they are placed. She said she was not aware of an order for Resident #74 to have a patch on his left thigh and the Lidocaine Patch should not have been left in place for four days. She also agreed Resident #38's MAR documented the patch as given and it was not in place on Resident #38's shoulder. The Regional Clinical Director said transdermal patches should be dated when applied.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44824</p> <p>Based on observation, record review and staff interviews, the facility failed to ensure 1 (Dietary Staff B) of 1 dietary staff observed operating the dishwasher was trained, and competent to test the sanitizing solution of the low temp dishwasher to ensure dishes were properly sanitized to prevent foodborne illnesses of residents consuming an oral diet.</p> <p>The findings included:</p> <p>The facility's policy and procedure titled, Testing Sanitizer & Temperature in Low Temp Dish Machines revised 8/2023 noted, Test sanitizing solution and temperature before cleaning each meal's dishes . Test the sanitizer with chlorine test strips obtained by the chemical vendor or food distributor. A proper level is 50 ppm (part per million) chlorine in the rinse water. An appropriated temperature is 120 - 160 F (Fahrenheit) . Record water temperature and sanitizer levels on the Dishwashing Temperature/Sanitizer Record.</p> <p>On 10/24/2024 at 9:20 a.m., during a tour of the kitchen with the Certified Dietary Manager (CDM), Food and Nutrition Aide Staff B was observed using the low temp dishwasher. In an interview Staff B said she has been employed at the facility for 2.5 years and had not received any training or instructions on testing the sanitizing solution of the dishwasher. Staff B said she signed the Dishwashing Temperature/Sanitizer log every day she worked but did not know what the log was for. She said, I just sign it because I was told to. She said she filled in the blanks with numbers on the form but did not know what it was for.</p> <p>The CDM was present during the observation and interview She told Staff B her where the chlorine test strips were kept and began to instruct her on how to test the dishwasher sanitizer. The CDM said she did not know if Staff B had been trained to use the dishwasher. She said Staff B only uses it sometimes and she signs the logbook for the person who is doing the testing.</p> <p>On 10/24/24 review of the Dishwashing Temperature/Sanitizer Record for October 2024 showed Staff B signed the log for 64 of the 67 meals documented. No temperature or sanitizer level was documented for the dinner meal on 10/21/24, 10/22/24 and 10/23/24.</p> <p>On 10/24/2024 at 10:30 a.m., documentation of Staff B's training and competency to test the water temperature and sanitizing solution for the dishwasher was requested. The CDM said she began employment at the facility six months ago. She did not know what training the dietary staff had received but she was working on that.</p> <p>On 10/24/2024 at 12:00 p.m., in an interview the Administrator said Staff B had been trained on using the dishwasher upon hire but did not provide the requested documentation Staff B was trained upon hire and competent to use the dishwasher, including measuring the water temperature and the sanitizing solution level to ensure dishes were properly washed and sanitized.</p>		