STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105389	A. BUILDING _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD HEALTH AND REHABILITATION CENTER	3250 12TH ST SARASOTA, FL 34237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint survey for #2025005155 and #2025005054 was conducted on at Birchwood Health and Rehabilitation Center, a skilled nursing facility in Sarasota, Florida. Complaint #2025005155 was unsubstantiated. Complaint #2025005054 was substantiated with a citation at F689. Birchwood Health and Rehabilitation Center was not in compliance with the Code of Federal Regulations (CFR) 42, Part 483, Subparts B-F, Requirements for Long-Term Care Facilities. The following is the description of the noncompliance.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility's policies and procedures, and staff interviews, the facility failed to provide adequate supervision and assistance to prevent for 1 (Resident #850) 3 residents reviewed with history of , including a with major injury requiring a transfer to a higher level of care.	F 689	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105389	A. BUILDING _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD HEALTH AND REHABILITATION CENTER	3250 12TH ST SARASOTA, FL 34237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 1 The findings included: The facility policy "Standards and Guidelines: - Managing, Preventing, and Documentation" initiated (revised) documented, "Each resident will have an individualized plan of care that will be reviewed and modified as needed to include preventions most appropriate to their individual needs and diagnosis.". . "The staff will implement a resident centered prevention plan to reduce the specific risk factor(s) of for each resident at risk or with a history of ." "Staff will identify and implement relevant interventions to try to minimize serious consequences of falling." "The residents care plan should be updated timely and with new interventions determined by the interdisciplinary team." Review of the clinical record revealed Resident #850 had an admission date of with diagnoses including , legally , hard of hearing (HOH) and a history of falling. The Quarterly Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) dated documented the resident was able to walk 10 ft with partial/ and required substantial to with toileting. The MDS noted the residents' skills for daily decision making were severely Review of the care plan initiated identified the resident was at risk for related to , history of falling, , hearing and , vision. The goal for the	F 689	(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On Resident #850 was immediately assessed by a licensed nurse. No concerns were noted related to the alleged deficient practice. On Resident #850□s care plan was reviewed with the Interdisciplinary Team and revised to reflect appropriate interventions to minimize risk of . (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken; On a quality review was completed by Director of Nursing/designee on Residents identified to be at increased risk for to ensure that appropriate interventions have been put into place and reflected on the care plan. Any issues identified were immediately corrected. (3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur; By , Licensed Nurses and Certified Nursing Assistants were educated on the components of F689 with an emphasis on identifying a change in condition and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105389	A. BUILDING _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD HEALTH AND REHABILITATION CENTER	3250 12TH ST SARASOTA, FL 34237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 2 resident was the potential for sustaining a related injury will be minimized by utilizing precautions/interventions. The care plan interventions included: Assist with toileting (as requested) or care upon rising, before and after meals, and prior to bedtime as tolerated. Encourage and assist resident to use bed in lowest position as tolerated. Encourage and remind resident to use call bell and to wait for staff assistance with transfers, ambulation, toileting, etc., as indicated. Obtained labs as ordered and notify physician. Encourage and assist the resident to wear appropriate footwear. The care plan noted the resident had behaviors including ␣ in halls, ␣ into other resident rooms and combative during care. The interventions instructed staff to acknowledge/commend the residents progress/improvement in behavior. Administer medications as ordered. Explain procedures to the resident before starting and allow the resident to adjust to changes as needed. Intervene and or redirect resident behavior as necessary. Approach/speak in a clam manner. Divert attention. Monitor behavior episodes and attempt to determine underlying cause. The nursing progress note dated "Late entry at 7:16 a.m., documented, When I arrived at work I made my morning rounds. When I got to the hallway I heard yelling from the resident. I immediately went to his room and noted him on the floor in front of the bathroom door on his with his pointing towards the room entrance. I assessed the resident and noted left ␣ . The call light was not engaged. He was attempting to go to the	F 689	providing increased supervision and interventions to minimize the risk for by the Director of Nursing/Designee. Newly hired licensed nurses and Certified Nursing Assistants will be educated on the components of F689 with an emphasis on identifying a change in condition and providing increased supervision and interventions to minimize the risk for by the Director of Nursing/Designee at orientation as a part of the systematic changes. (4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place: Director of Nursing/Designee to conduct audits of 5 resident□s care plans 2x a week for 4 weeks, then 1x a week for 4 weeks and then monthly for 1 month to ensure that appropriate interventions were put into place to minimize risk of The findings of these quality monitoring□s to be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105389	A. BUILDING _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD HEALTH AND REHABILITATION CENTER	3250 12TH ST SARASOTA, FL 34237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 3	F 689		

bathroom unassisted. New order to transfer to ER for evaluation."

The local emergency room identified Resident #850 sustained a of the left requiring hospital admission and surgical repair. The resident returned to the facility on .

On at 3:45 p.m., in an interview Registered Nurse Staff D said " I found him at 7 in the morning because I arrive early and I make a round every single day and I heard somebody screaming and I found him on the floor. He was very , and he walked by himself from the bed to the bathroom. He said, "I'm in , ." He did not say how he . He just kept saying he had to go to the bathroom, and he had , . He is not supposed to go the bathroom by himself, because he is . No one told me he was having issues with his that day or that he was up before I got to work. He did not have 1 to 1 supervision at the time.

On at 9:25 a.m., Resident #850 was observed in bed, he did not respond when spoken to. The room door was open slightly and the privacy curtain was pulled obscuring the resident from view from the doorway. The call light was not in reach, and was located on the floor behind an concentrator.

On at 1:09 p.m., in an interview the Director of Nursing (DON) said Resident #850 was legally and had no prior since his admission one year ago. The DON said we had interventions in place, toileting times for him were in place. He was known to be . The DON said the new interventions after the were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105389	A. BUILDING _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD HEALTH AND REHABILITATION CENTER	3250 12TH ST SARASOTA, FL 34237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 4	F 689		

discussed with him in an Interdisciplinary Team meeting. She said after the we could not assist him to the toilet because of the left , and so we initiated care. His room was at the end of the hall and now he is closer to the nursing station. After he returned, we had to notify the certified nursing assistants (CNA's) that he was no longer able to do that, we took away the toileting after the and it is just care now. We were keeping more frequent monitoring of him. I don't know if we have documentation of the frequency, there was no set times for someone to check on him. We moved him so everyone can keep him in view. He can physically use the call light, but he is and does not always have the cognition to use it. We did not have specific interventions added to the care plan when he returned, just better supervision and better surveillance as evidence by no further . We check on him as we go up and down the halls. We did education for prevention. He had a in another facility which is why the daughter brought him here. We don't have documentation of supervision or monitoring, there are no set times, everyone just looks in as they pass his room.

Review of the Quality Assurance Performance Improvement Plan provided by the DON for revealed 16 documented , this is the same number as the previous month. The DON said after the resident returned from the hospital we did education as part of Quality Assurance.

Review of the education in-service dated documented "We have too many !!! Please see attached education for decreasing and keeping residents safe.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105389	A. BUILDING _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD HEALTH AND REHABILITATION CENTER	3250 12TH ST SARASOTA, FL 34237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5	F 689		

23 employees sign the in-service education record that they received the " Prevention Intervention List."

On at 1:50 p.m., in an interview the Administrator said the resident was now bedbound and not able to get up. He said the number of was decreasing in the facility and they have reviewed the care plan for the resident. He said there is nothing else they can put into place to prevent for him because he is non ambulatory since the . When informed of the observation of the residents' call light on the floor today and not within the resident's reach, the Administrator said he did not believe the resident could roll out of bed or get up due to the left . He said we moved him closer to the nursing station, which is around the hall and ½ way down the hall, not in view the nurse's station. The Administrator agreed the roommate of Resident #850 likes the privacy curtain pulled and the room door closed making observation of Resident #850 difficult. The Administrator said you are right, I know the room mate wants the door closed and the curtain pulled.

On at 2:30 p.m., in an interview the DON said the root cause of Resident #850's was the resident had 2 movements. One at 4:45 a.m., and a second one at 5:15 a.m., he was cleaned up and assisted to bed, and we believe he was trying to go to the bathroom. He had issues, and we should have addressed it but we didn't.

A review of the CNA documentation revealed on the resident had no movement. On he was of at 1:17 a.m. and received care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105389	A. BUILDING _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD HEALTH AND REHABILITATION CENTER	3250 12TH ST SARASOTA, FL 34237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 6 On at 3:15 p.m., in an interview the Director of Rehab said Resident #850 was seen a year ago and was on services. She said at that time he was able to ambulate with supervision and guidance because he could not see. He needed minimum help going from lying to sitting on the side of bed. He was seen today, and he requires with everything. He is slow now due to , . He can roll over in bed from side to side with minimal assistance and he can get up from bed with assistance. On at 3:25 p.m., in an interview Licensed Practical Nurse Staff A said monitoring and supervision is every couple of hours. I peek in on Resident #850 when I walk by. He can get up and walk but he is not steady on his . On at 3:35 in an interview CNA Staff C said increased monitoring depends on the individual. The CNA said Resident #850 used to walk, and can see shadows. She said when he needed to use the toilet he would walk out of his room because he did not know where the bathroom was. Review of Resident #850's care plan confirmed no new care plan interventions had been put into place to prevent further for Resident #850.	F 689		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	85806	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD HEALTH AND REHABILITATION CENTE	3250 12TH ST SARASOTA, FL 34237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	INITIAL COMMENTS A complaint survey for #2025005155 and #2025005054 was conducted on at Birchwood Health and Rehabilitation Center, a skilled nursing facility in Sarasota, Florida. Complaint #2025005155 was unsubstantiated. Complaint #2025005054 was substantiated with a citation at N201. The following is the description of the deficiencies.	N 000		
N 201 SS=D	400.022(1)(i), FS Right to Adequate and Appropriate Health Care (I) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on record review, review of facility's policies and procedures, and staff interviews, the facility failed to provide adequate supervision and assistance to prevent for 1 (Resident #850) 3 residents reviewed with history of , including a with major injury requiring a transfer to a higher level of care. The findings included: The facility policy "Standards and Guidelines: - Managing, Preventing, and Documentation" initiated (revised) documented, "Each	N 201	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. (1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	85806	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD HEALTH AND REHABILITATION CENTE	3250 12TH ST SARASOTA, FL 34237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 201	Continued From page 1 resident will have an individualized plan of care that will be reviewed and modified as needed to include preventions most appropriate to their individual needs and diagnosis.". . "The staff will implement a resident centered prevention plan to reduce the specific risk factor(s) of for each resident at risk or with a history of ." "Staff will identify and implement relevant interventions to try to minimize serious consequences of falling." "The residents care plan should be updated timely and with new interventions determined by the interdisciplinary team." Review of the clinical record revealed Resident #850 had an admission date of with diagnoses including , legally , hard of hearing (HOH) and a history of falling. The Quarterly Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) dated documented the resident was able to walk 10 ft with partial/ and required substantial to with toileting. The MDS noted the residents' skills for daily decision making were severely . Review of the care plan initiated identified the resident was at risk for related to , history of falling, , hearing and , vision. The goal for the resident was the potential for sustaining a related injury will be minimized by utilizing precautions/interventions. The care plan interventions included: Assist with toileting (as requested) or care upon rising, before and after meals, and prior to bedtime as tolerated. Encourage and assist	N 201	On Resident #850 was immediately assessed by a licensed nurse. No concerns were noted related to the alleged deficient practice. On Resident #850's care plan was reviewed with the Interdisciplinary Team and revised to reflect appropriate interventions to minimize risk of . (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken; On a quality review was completed by Director of Nursing/designee on Residents identified to be at increased risk for to ensure that appropriate interventions have been put into place and reflected on the care plan. Any issues identified were immediately corrected. (3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur; By , Licensed Nurses and Certified Nursing Assistants were educated on the components of N201 with an emphasis on identifying a change in condition and providing increased supervision and interventions to minimize the risk for by the Director of Nursing/Designee. Newly hired licensed nurses and Certified Nursing Assistants will be educated on the components of N201 with an emphasis on identifying a change in condition and	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	85806	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD HEALTH AND REHABILITATION CENTE	3250 12TH ST SARASOTA, FL 34237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 201	Continued From page 2 resident to use bed in lowest position as tolerated. Encourage and remind resident to use call bell and to wait for staff assistance with transfers, ambulation, toileting, etc., as indicated. Obtained labs as ordered and notify physician. Encourage and assist the resident to wear appropriate footwear. The care plan noted the resident had behaviors including ⌣ in halls, ⌣ into other resident rooms and combative during care. The interventions instructed staff to acknowledge/commend the residents progress/improvement in behavior. Administer medications as ordered. Explain procedures to the resident before starting and allow the resident to adjust to changes as needed. Intervene and or redirect resident behavior as necessary. Approach/speak in a clam manner. Divert attention. Monitor behavior episodes and attempt to determine underlying cause. The nursing progress note dated "Late entry at 7:16 a.m., documented, When I arrived at work I made my morning rounds. When I got to the hallway I heard yelling from the resident. I immediately went to his room and noted him on the floor in front of the bathroom door on his with his pointing towards the room entrance. I assessed the resident and noted left ⌣ , . The call light was not engaged. He was attempting to go to the bathroom unassisted. New order to transfer to ER for evaluation." The local emergency room identified Resident #850 sustained a of the left requiring hospital admission and surgical repair. The resident returned to the facility on .	N 201	providing increased supervision and interventions to minimize the risk for by the Director of Nursing/Designee at orientation as a part of the systematic changes. (4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place: Director of Nursing/Designee to conduct audits of 5 resident□s care plans 2x a week for 4 weeks, then 1x a week for 4 weeks and then monthly for 1 month to ensure that appropriate interventions were put into place to minimize risk of . The findings of these quality monitoring□s to be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	85806	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD HEALTH AND REHABILITATION CENTE	3250 12TH ST SARASOTA, FL 34237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 201	Continued From page 3 On at 3:45 p.m., in an interview Registered Nurse Staff D said " I found him at 7 in the morning because I arrive early and I make a round every single day and I heard somebody screaming and I found him on the floor. He was very , and he walked by himself from the bed to the bathroom. He said, "I'm in , ." He did not say how he . He just kept saying he had to go to the bathroom, and he had , . He is not supposed to go the bathroom by himself, because he is . No one told me he was having issues with his that day or that he was up before I got to work. He did not have 1 to 1 supervision at the time. On at 9:25 a.m., Resident #850 was observed in bed, he did not respond when spoken to. The room door was open slightly and the privacy curtain was pulled obscuring the resident from view from the doorway. The call light was not in reach, and was located on the floor behind an concentrator. On at 1:09 p.m., in an interview the Director of Nursing (DON) said Resident #850 was legally and had no prior since his admission one year ago. The DON said we had interventions in place, toileting times for him were in place. He was known to be . The DON said the new interventions after the were discussed with him in an Interdisciplinary Team meeting. She said after the we could not assist him to the toilet because of the left , and so we initiated care. His room was at the end of the hall and now he is closer to the nursing station. After he returned, we had to notify the certified nursing assistants (CNA's) that he was no longer able to do that, we took away the toileting after the and it is just	N 201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	85806	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD HEALTH AND REHABILITATION CENTE	3250 12TH ST SARASOTA, FL 34237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 201	Continued From page 4 care now. We were keeping more frequent monitoring of him. I don't know if we have documentation of the frequency, there was no set times for someone to check on him. We moved him so everyone can keep him in view. He can physically use the call light, but he is and does not always have the cognition to use it. We did not have specific interventions added to the care plan when he returned, just better supervision and better surveillance as evidence by no further . We check on him as we go up and down the halls. We did education for prevention. He had a in another facility which is why the daughter brought him here. We don't have documentation of supervision or monitoring, there are no set times, everyone just looks in as they pass his room. Review of the Quality Assurance Performance Improvement Plan provided by the DON for revealed 16 documented , this is the same number as the previous month. The DON said after the resident returned from the hospital we did education as part of Quality Assurance. Review of the education in-service dated documented "We have too many !!! Please see attached education for decreasing and keeping residents safe. 23 employees sign the in-service education record that they received the " Prevention Intervention List." On at 1:50 p.m., in an interview the Administrator said the resident was now bedbound and not able to get up. He said the number of was decreasing in the facility and they have reviewed the care plan for the resident. He said there is nothing else they can put into	N 201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	85806	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD HEALTH AND REHABILITATION CENTE	3250 12TH ST SARASOTA, FL 34237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 201	Continued From page 5 place to prevent for him because he is non ambulatory since the . When informed of the observation of the residents' call light on the floor today and not within the resident's reach, the Administrator said he did not believe the resident could roll out of bed or get up due to the left . He said we moved him closer to the nursing station, which is around the hall and ½ way down the hall, not in view the nurse's station. The Administrator agreed the roommate of Resident #850 likes the privacy curtain pulled and the room door closed making observation of Resident #850 difficult. The Administrator said you are right, I know the room mate wants the door closed and the curtain pulled. On at 2:30 p.m., in an interview the DON said the root cause of Resident #850's was the resident had 2 movements. One at 4:45 a.m., and a second one at 5:15 a.m., he was cleaned up and assisted to bed, and we believe he was trying to go to the bathroom. He had issues, and we should have addressed it but we didn't. A review of the CNA documentation revealed on the resident had no movement. On he was of at 1:17 a.m. and received care. On at 3:15 p.m., in an interview the Director of Rehab said Resident #850 was seen a year ago and was on services. She said at that time he was able to ambulate with supervision and guidance because he could not see. He needed minimum help going from lying to sitting on the side of bed. He was seen today, and he requires with everything. He is slow now due to . He can roll over in bed from side to side with minimal assistance and he	N 201		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	85806	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD HEALTH AND REHABILITATION CENTE	3250 12TH ST SARASOTA, FL 34237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 201	Continued From page 6 can get up from bed with assistance. On at 3:25 p.m., in an interview Licensed Practical Nurse Staff A said monitoring and supervision is every couple of hours. I peek in on Resident #850 when I walk by. He can get up and walk but he is not steady on his . On at 3:35 in an interview CNA Staff C said increased monitoring depends on the individual. The CNA said Resident #850 used to walk, and can see shadows. She said when he needed to use the toilet he would walk out of his room because he did not know where the bathroom was. Review of Resident #850's care plan confirmed no new care plan interventions had been put into place to prevent further for Resident #850. Class III	N 201		