

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>85827</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/27/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PLYMOUTH HARBOR INCORPORATED</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 JOHN RINGLING BLVD SARASOTA, FL 34236</b>
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(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
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N 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced relicensure survey was conducted on _____ through _____ at Plymouth Harbor Incorporated, a skilled nursing facility in Sarasota, Florida.</p> <p>The following is the description of the deficiencies.</p>	N 000		
N 054 SS=E	<p>59A-4.107(5), FAC Follow Physician Orders</p> <p>All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident's medical record during that shift.</p> <p>This Statute or Rule is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to provide care and services in accordance with professional standards of practice by failing to administer medications in accordance with the physician's orders for 1 (Resident #22) of 4 residents reviewed for compliance with physician's orders.</p> <p>The findings included:</p> <p>On _____ at 8:34 a.m., Licensed Practical Nurse (LPN) Staff A was observed preparing to administer medications to Resident #22, including D3. LPN Staff A said she needed to clarify the order for the _____ D3 before administering it to the resident.</p> <p>Review of the Medication Administration Record (MAR) for _____ revealed the nurses signed off they administered one capsule of _____ D3 1000 International Units (IU) daily to Resident #22 as per the physician's orders.</p> <p>On _____ at 8:34 a.m., observation of Resident #22's medications revealed two _____ cards of</p>	N 054	<ol style="list-style-type: none"> <li>1. Physician order was clarified and updated to reflect 2000 units, consistent with the original dosage on _____. The dosage was administered on _____. MARs audited facility-wide for compliance with physician orders initiated and completed</li> <li>2. Medication administration training initiated for licensed nurses projected completion date _____</li> <li>3. Random audits twice weekly for 30 days led by DON or designee; pharmacy consultant monthly reviews, change in pharmacy services provider beginning _____. Reviewed in QAPI</li> <li>4. Report to QA committee will continue monthly for recommendations and or revisions. Completion Date: _____</li> </ol>	

AHCA Form 3020-0001  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X8) DATE \_\_\_\_\_

Electronically Signed \_\_\_\_\_ /25

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N 054	<p>Continued From page 1</p> <p>30 tablets of D3 of 2000 IU. One card was filled on . 29 tablets had been removed from the card. One card was filled on . None of the tablets were removed. On at 11:57 a.m., in an interview LPN Staff A said the physician's order in the electronic clinical record for the D3 was to administer 1000 IU. The D3 2000 IU that she had available and that was being given was different from the physician's orders. She said she gave the incorrect dose of D3 to the resident on , , and .</p> <p>On at 5:35 p.m., in an interview LPN Staff C said on she was the nurse assigned to Resident #22 and administered the D3 2000 IU that was in the medication cart to the resident. She said she never altered the medication, and the resident took the tablet of D3 2000 IU whole. She did not crush or cut the tablet of D3 2000 IU.</p> <p>On at 12:30 p.m., in an interview the Director of Nursing (DON), she said she was made aware the incorrect dose of D3 has been administered to Resident #22. She said she expects the nurses to follow the physician's orders.</p> <p>Class III</p>	N 054		
N 201 SS=E	<p>400.022(1)(i), FS Right to Adequate and Appropriate Health Care</p> <p>(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</p>	N 201		

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N 201	<p>Continued From page 2</p> <p>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.</p> <p>This Statute or Rule is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to implement care plan interventions to prevent and related injuries for 1 (Resident #12) with multiple of 2 residents reviewed for prevention.</p> <p>The findings included:</p> <p>Review of the clinical record for Resident #12 revealed an admission date of . . . Diagnoses included and due to multiple</p> <p>Review of the Admission Minimum Data Set (MDS) assessment with a target date of revealed Resident #12's cognition was severely with a score of "7". The assessment noted the resident was dependent on staff for toileting (Helper does all the effort). Toilet transfer was not attempted due to safety concerns.</p> <p>Review of the care plan for Activities of Daily Living (ADL) initiated on revealed the resident was totally dependent on two staff for toilet use.</p> <p>On at 12:55 p.m., Certified Nursing Assistant (CNA) Staff B was observed assisting Resident #12 with toileting in the bathroom. The resident was standing in front of the toilet, and the CNA was standing next to the resident. There was no other staff assisting CNA Staff B with the</p>	N 201	<ol style="list-style-type: none"> <li>1. Resident #12's care plan updated with two-person assist, mats, and, implemented programing</li> <li>2. All high-risk residents' care plans reviewed, referrals made, and care plans updated as necessary initiated completed</li> <li>3. Staff re-educated on use of Kardex, interventions, and toileting support initiated with projected completion</li> <li>4. Daily review in clinical meeting, weekly audit at risk meeting ongoing and reported to QA committee monthly. Reviewed in QAPI</li> <li>5. Report to QA committee will continue monthly for recommendations and or revisions. Completion Date: . . .</li> </ol>	
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N 201	<p>Continued From page 3</p> <p>toileting.</p> <p>On _____ at 12:58 p.m., in an interview CNA Staff B said she works for an agency and has been working at the facility for six months. She said she was not familiar with the Kardex (provides instructions for safe care) and the assignment sheet did not say the resident required the assistance of 2 for toileting. She said Resident #12 had multiple _____ and was usually in the activity room due to the _____.</p> <p>On _____ at 1:26 p.m., CNA Staff B said she was not trained in using the Kardex to get resident information. She stated, "Maybe you get trained when you are staff here, but no one ever really sat down and trained me on the Kardex."</p> <p>On _____ at 9:21 a.m., in an interview Registered Nurse (RN) MDS Coordinator Staff A said two staff for toileting was added to prevent accidents, including _____. The resident's ability fluctuates and there should have been two.</p> <p>On _____ at 11:48 a.m., the Assistant Director of Nursing (ADON) said Staff B should have had a second CNA on _____ when she was toileting the resident to prevent a possible accident/_____. She said she found out on _____ that Staff B did not know how to access the Kardex.</p> <p>Review of the care plan revealed Resident #12 sustained multiple _____ at the facility as follows:</p> <ul style="list-style-type: none"> <li>: with no injury.</li> <li>: with minor injury.</li> <li>: with no injury</li> <li>: with minor injury</li> <li>: with minor injury. Resident #12 was sent to the Emergency Room and returned to the facility.</li> </ul>	N 201		

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N 201	<p>Continued From page 4</p> <p>#1: Review of the progress note dated revealed Resident #12 was observed on the floor near the bed facing the bathroom at 3:30 a.m. The resident said she forgot she had a _____ and was trying to go to the bathroom. On _____ the facility updated the care plan for frequent checks.</p> <p>#2: The nursing progress notes did not include the circumstances of Resident #12's on _____. On _____ the facility updated the care plan to "Place sign to remind the resident to call for assistance." On _____, the practitioner entered a progress note indicating the resident had a _____ and "will monitor closely, _____ precautions." The practitioner added, "_____ is stable, pleasantly _____ can speak and answer but not always accurate, obtained collateral information from family present." On _____ the facility added the following diagnoses to the resident's clinical record: _____, abnormality of gait and mobility, history of falling, and need for assistance with personal care.</p> <p>#3 On _____ at 12:31p.m. the facility entered a progress note. The resident was on the floor at the _____ of the bed. The resident told the staff at the time, "I don't know what I was trying to do. I just wanted to go to the bathroom." On _____ at 3:22 p.m., Resident #12 was observed sitting in a wheelchair in the activity room. When asked about the care at the facility and the multiple _____, she said she "gives them pluses." The resident could not explain what she</p>	N 201		
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N 201	<p>Continued From page 5</p> <p>meant and said we should call her daughter.</p> <p><b>#4</b></p> <p>On _____ at 3:15 a.m., an incident note documented the nurse heard a loud scream and walked into the resident's room. She found the resident on the bathroom floor. The resident stated she needed to use the bathroom. The resident had a _____ to the left that reopened.</p> <p>Review of the progress note dated _____ revealed the facility placed _____ mats on each side of the bed at the request of the resident's daughter and responsible party.</p> <p>The care plans did not identify the use of the mats use to prevent _____ injury.</p> <p>On _____ at 9:21 a.m., in an interview Registered Nurse (RN) MDS Coordinator Staff A confirmed the _____ mats were not on the care plan. She said if staff used them, they should be on the care plan.</p> <p>On _____ the facility updated the care plan with an intervention for _____ and _____ training.</p> <p>The clinical record lacked documentation of a _____ and _____ training program.</p> <p>On _____ at 2:02 p.m., in an interview the Assistant Director of Nursing (ADON) said the _____ and _____ training was added to the care plan on _____ but not implemented. She said it involves a _____ and _____ assessment by the nurse and then checking the resident every hour.</p> <p>On _____ at 9:21 a.m., in an interview the MDS coordinator said _____ and _____ training should have been implemented because the resident was falling when she tried to get to the bathroom without assistance.</p> <p><b>#5</b></p> <p>On _____ at 4:50 p.m., the alert progress note indicated an unwitnessed _____ after for the resident</p>	N 201		
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N 201	<p>Continued From page 6</p> <p>after toileting herself and falling. The resident could not remember if she hit her . 911 was called and the resident was transported to the hospital.</p> <p>The facility updated the care plan on to include a medication review.</p> <p>On at 11:03 a.m., in a telephone interview, Resident #12's daughter and responsible party said her mother had multiple at the facility in a short time and the facility's efforts have not prevented them. She said she was worried the resident will and sustain another or worse. She said the resident has and periods of . . .</p> <p>On at 9:21 a.m., in an interview Registered Nurse (RN) Minimum Data Set Assessment Coordinator (MDS) Staff A said all are reviewed with the interdisciplinary team IDT and the team decides which new interventions are added to the care plan. She verified . mats did not get added to the care plan. She said mats do not prevent and are not appropriate for all residents and can contribute to because of tripping. She said providing assistance of 2 staff for toileting was added to prevent accidents including . She said the resident's ability fluctuates from day to day. She said there should have been 2 CNAs toileting Resident #12, if not used to support the resident, to be there for assistance if the resident should lose balance and begin to . The MDS coordinator said the and training intervention was added because the resident multiple times while trying to get to the bathroom. The IDT team decided on the intervention, and it should have been implemented by the IDT, which included the ADON.</p>	N 201		
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N 201	Continued From page 7 Class III	N 201		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

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F 000	INITIAL COMMENTS  An unannounced recertification survey was conducted on _____ through 3/27/25 at Plymouth Harbor Incorporated, a skilled nursing facility in Sarasota, Florida.  Plymouth Harbor Incorporated is 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 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)  §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.  §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.  §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 578		

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.

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F 578	<p>Continued From page 1</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>( ) If an adult individual is _____ at the time of admission and is unable to receive information or _____ whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.</p> <p>(v) The facility is not relieved of its _____ to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on clinical record review, resident representative and staff interviews, the facility failed to ensure the clinical record accurately reflected the residents' advance directives for 2 (Residents #5 and #8) of 2 residents reviewed for advance directives.</p> <p>The findings included:</p> <p>Review of the facility's Advance Directive Policy (revised _____) revealed prior to or upon admission of a resident, the Social Services Director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. Upon admission the interdisciplinary team assesses the resident's decision-making capacity and identifies the primary decision-maker if the resident is determined not to have decision-making capacity.</p>	F 578	<ol style="list-style-type: none"> <li>1 Resident #5 and #8 records updated to accurately reflect status and valid Florida yellow forms obtained.</li> <li>2 Facility-wide audit of advanced directives completed</li> <li>3 Education commenced _____ and completed on _____ for clinical staff on federal and Florida requirements for advance directives.</li> <li>4 Weekly audits for 4 weeks, then monthly for 3 months; reviewed in QAPI _____, led by Social Worker or designee.</li> <li>5 Report to QA committee will continue monthly for recommendations and or revisions. Reviewed in QAPI _____</li> </ol> <p>Correction completion date:</p>		

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F 578	<p>Continued From page 2</p> <p>1. Review of the clinical record for Resident #5 revealed an admission date of _____ Diagnoses included but were not limited to, _____ ( ) and _____ Review of the Minimum Data Set (MDS) Assessment with a target date of _____ revealed Resident #5 scored a six (6) on the _____ ( ), indicating severe _____ cognition. Review of the physician's order dated _____ revealed Resident #5 had a full code status, meaning _____ ( ) or _____ would be initiated if the resident had no _____ or _____ Review of the Resident #5's care plan initiated on _____ revealed an Advance Directive Care Plan which noted Resident #5 had a full code status. Review of the incapacity statement signed by the attending physician and dated _____ showed Resident #5 was unable to make informed health care decisions or provide informed consent. Review of the progress note written on _____ by _____ Registered Nurse (RN) MDS Coordinator revealed a plan of care meeting was conducted for Resident #5. The legal representative's preference for code status was _____ On _____ at 10:10 a.m., in a telephone interview the legal representative said he told the nurse at the plan of care meeting Resident #5's code status was _____ ( ) meaning _____ would not be initiated if the resident had no _____ or _____ On _____ at 5:28 p.m., in an interview the MDS coordinator said that Resident #5's medical record was incorrect and the code status should be _____. She said she did not correct the code</p>	F 578			

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F 578	<p>Continued From page 3</p> <p>status when she wrote the note on</p> <p>On . . . at 5:47 p.m., in an interview the Director of Nursing (DON) said if the resident is . . . the legal representative is asked for code status preference and the record checked for accuracy.</p> <p>On . . . at 6:12 p.m., the Nursing Home Administrator (NHA) reviewed the entire medical record including the paper chart. The NHA said there was no Florida . . . order in the record, which is required for . . . status. She said after the facility was aware the representative wanted . . . status, the facility should have obtained the required document and changed the medical record to . . .</p> <p>On . . . at 7:18 a.m., in an interview the Assistant Director of Nursing (ADON) said she contacted Resident #5's legal representative, and the preference is . . . She said the facility had the incorrect code status in the medical record.</p> <p>2. Review of the clinical record for Resident #8 revealed an admission date of . . .</p> <p>Diagnoses included , . . . , acute , . . . , and history of falling.</p> <p>Review of the Minimum Data Set (MDS) Assessment with a target date of . . . revealed Resident #8 scored a "13" on the . . . ( . . . ), indicating intact cognition.</p> <p>Review of the physician's order dated . . . revealed Resident #8 had a full code status.</p> <p>Review of the care plan revealed no care plan for Advance Directives.</p> <p>Review of the clinical record including electronic and paper records revealed Resident #8 was full code status and . . . would be performed.</p> <p>Review of the hospital record dated . . . for Resident #8 revealed wishes to defer code status</p>	F 578		

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F 578	<p>Continued From page 4 decision to the son.</p> <p>On _____ at 3:04 p.m., in a telephone interview the resident's son and power of attorney said Resident #8 does not comprehend informed health care decisions consistently and is often _____. He said the code status should be _____. He said the resident signed a Florida yellow form last year on _____ when the resident went to the same facility for rehabilitation. He said he thought it would carry over. He said the facility staff did not ask him about code preference. He assumed Resident #8 was _____. On _____ 5:05 p.m., during an interview with Resident #8 and the son at the facility, the son said Resident #8 is a _____. Resident #8 said she did not want _____. On _____ 25 at 5:48 p.m., during an interview with Resident #8 in the bedroom, the resident told the DON she wanted _____ status in the facility. On _____ 6:29 p.m., the DON said she did not know the resident was undecided on code status when she was admitted, or she would have included the son in the decision. She obtained the old chart from the medical records file cabinet, which contained the _____ order dated _____.</p> <p>On _____ 7:40 a.m., in an interview the Assistant Director of Nursing (ADON) said she did not consult the son with Resident #8's code status at any time during this admission.</p> <p>On _____ at 10:16 p.m. in a telephone interview Licensed Practical Nurse (LPN) Staff C said she admitted Resident #8 on _____. She said the resident was undecided on code status and wanted to ask her son. The resident did not have a yellow _____ form, so she documented the resident would be full code. She said she did not write a progress note about the discussion. She</p>	F 578		

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F 578	Continued From page 5 thought someone else would follow up.  In an interview with the DON on _____ at 12:23 p.m., she said she was not aware the resident was undecided on the code status because there was no documentation about it, and no one told her. The DON confirmed they had the hospital note indicating the resident deferred to her son for code status. The DON obtained the Florida order the resident signed on _____ from the previous admission.	F 578			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)  §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary	F 657			

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F 657	<p>Continued From page 6</p> <p>team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to develop, implement and revise the care plan to meet the needs and preferences of 3 (Residents #5, #8 and #12) of 3 reviewed for care plans.</p> <p>The findings included:</p> <p>1. Review of Resident #5's clinical record revealed an admission date of _____ and Diagnoses included _____ and _____</p> <p>Review of the Minimum Data Set (MDS) Assessment with a target date of _____ revealed Resident #5's cognition was severely _____ with a _____ ( _____ ) score of "06".</p> <p>Review of the incapacity statement signed by the attending physician and dated _____ showed Resident #5 was unable to make informed health care decisions or provide informed consent.</p> <p>On _____ at 12:37 p.m., Certified Nursing Assistant (CNA) Staff D was observed assisting Resident #5 with her lunch. In an interview during the observation, CNA Staff D said Resident #5 did not speak. Resident #5 stared straight ahead and did not respond to several attempts to interview.</p> <p>On _____ at 10:10 a.m., in a telephone interview the resident's Power of Attorney (POA) for health care said he was one of the resident's sons and made all health care decisions because Resident #5 was unable. He said he discussed the code status with the nurse. Resident #5's code status</p>	F 657	<p>1. Resident #5, #8, and #12 care plans were updated to reflect code status, ADL needs, precautions, and toileting protocols.</p> <p>2. Audit of all care plans initiated _____ and completed _____</p> <p>3. IDT members re-educated on timely care plan development and revisions</p> <p>4. Weekly audits for 4 weeks, then monthly for 3 months; reviewed in QAPI _____, led by MDS Coordinator or designee.</p> <p>5. Report to QA committee will continue monthly for recommendations and or revisions.</p> <p>Correction completion date:</p>		

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F 657	<p>Continued From page 7</p> <p>was ( ) and the facility should not perform ( ).</p> <p>Review of nursing progress notes revealed on MDS coordinator Registered Nurse (RN) Staff A documented the resident's healthcare representative decided Resident #5 would be ( ).</p> <p>Review of the care plan for Advance Directives initiated on and reviewed on revealed Resident #5's code status was "full code" meaning ( ) would be initiated if the resident's or breathing would stop.</p> <p>Record review of the electronic and paper clinical record revealed no Florida on file.</p> <p>On /27/25 at 9:20 a.m., in an interview the MDS coordinator RN Staff A said she wrote the progress note on that Resident #5 should be status. She said she was responsible to update the care plan but she did not change the code status on the care plan. She said the Social Services Director should have caught and correct the mistake.</p> <p>On at 5:46 p.m., in an interview the Director of Nursing (DON) verified Resident #5's care plan was not accurate and did not reflect the resident's representative wishes for code status.</p> <p>On at 9:20 a.m., in an interview the MDS coordinator said the resident's code status was not updated during the quarterly review in</p> <p>2. Review of the clinical record for Resident # 8 revealed admission date of on</p> <p>Diagnoses included but were not limited to , stress , acute , and history of falling.</p> <p>Review of the MDS Assessment with a target</p>	F 657			

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F 657	<p>Continued From page 8</p> <p>date of . . . revealed Resident #8 scored a "13" on the ( ), indicating intact cognition.</p> <p>On . . . at 2:47 p.m., in a telephone interview the resident's son said Resident #8 does not consistently comprehend informed health care decisions and is often . . . . . He attended one care conference this admission and no one asked him about the resident's code status. He said He said the resident is a . . . and . . . should not be performed.</p> <p>On . . . at 5:05 p.m., in an interview Resident #8 said she did not want . . . and defers to her son for decisions regarding her code status. Resident #8's son was present during the interview and said the resident code status was . . . He said Resident #8 signed a . . . form last year and he thought the . . . from the . . . admission would have carried over to this admission. He said no one spoke with him about the code status.</p> <p>Review of the baseline care plan for admission . . . . . revealed a code status for "full code".</p> <p>Review of the physician's order summary revealed an active order dated . . . for full code status.</p> <p>Review of the comprehensive care plans on . . . at 3:19 p.m. revealed no comprehensive care plan for code status.</p> <p>Review of the record including progress notes and social services assessment dated . . . failed to reveal documentation the resident's son was included in the development of the resident's care plan for advance directives.</p> <p>3. Review of the clinical record for Resident #12 revealed an admission date of . . . . . Diagnoses included . . . and . . . due to multiple . . .</p>	F 657			

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F 657	<p>Continued From page 9</p> <p>Review of the Admission Minimum Data Set (MDS) assessment with a target date of revealed the resident's cognition was moderately with a score of "07". The assessment noted the resident was totally dependent on staff for toileting (with the helper doing all the effort). Toilet transfer was not attempted due to safety concerns.</p> <p>Review of the care plan for Activities of Daily Living (ADLs) initiated on revealed the resident was dependent on 2 staff for toilet use.</p> <p>Review of the ADL Toilet Record for Support Provided revealed each day from through the facility used only 1 staff for toileting Resident #12.</p> <p>Review of the progress note dated revealed the facility initiated mats on each side of the bed at the request of the resident's daughter and responsible party.</p> <p>The care plan did not contain the use of mats to minimize related injury.</p> <p>On the facility added a care plan intervention for " and training." The care plan did not include instructions on the and training.</p> <p>On at 12:55 p.m., Certified Nursing Assistant (CNA) Staff B was observed assisting Resident #12 with toileting in the bathroom. The resident was standing in front of the toilet, and the CNA was standing next to the resident. There was no other staff assisting CNA Staff B with the toileting.</p> <p>On at 12:58 p.m., in an interview CNA Staff B said she works for an agency and has been working at the facility for six months. She said she was not familiar with the Kardex (provides instructions for safe care) and the assignment sheet did not say the resident required the assistance of 2 for toileting. She said</p>	F 657		

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F 657	Continued From page 10 Resident #12 had multiple _____ and was usually in the activity room due to the _____. On _____ at 1:26 p.m., CNA Staff B said she was not trained in using the Kardex to get resident information. She stated, "Maybe you get trained when you are staff here, but no one ever really sat down and trained me on the Kardex." On _____ at 2:02 p.m., in an interview the Assistant Director of Nursing (ADON) said the _____ and _____ training was added to the care plan on _____ but not implemented. She said it involves a _____ and _____ assessment by the nurse and then checking the resident every hour. On _____ at 9:21 a.m., in an interview Registered Nurse (RN) MDS Coordinator Staff A confirmed the _____ mats were not on the care plan. She said if staff used them, they should be on the care plan. She said two staff for toileting was added to prevent accidents, including _____. The resident's ability fluctuates and there should have been two. The MDS coordinator said _____ and _____ training should have been implemented because the resident was falling when she tried to get to the bathroom without assistance.  On _____ at 11:48 a.m., the ADON said Staff B should have had a second CNA on _____ when she was toileting the resident to prevent a possible accident/ _____. She said she found out on _____ that Staff B did not know how to access the Kardex.	F 657		
F 684 SS-E	Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684		

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F 684	<p>Continued From page 11</p> <p>assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and staff interview, the facility failed to provide care and services in accordance with professional standards of practice by failing to administer medications in accordance with the physician's orders for 1 (Resident #22) of 4 residents reviewed for compliance with physician's orders.</p> <p>The findings included:</p> <p>On at 8:34 a.m., Licensed Practical Nurse (LPN) Staff A was observed preparing to administer medications to Resident #22, including D3. LPN Staff A said she needed to clarify the order for the D3 before administering it to the resident.</p> <p>Review of the Medication Administration Record (MAR) for revealed the nurses signed off they administered one capsule of D3 1000 International Units (IU) daily to Resident #22 as per the physician's orders.</p> <p>On at 8:34 a.m., observation of Resident #22's medications revealed two cards of 30 tablets of D3 of 2000 IU.</p> <p>One card was filled on .29 tablets had been removed from the card.</p> <p>One card was filled on . None of the tablets were removed.</p> <p>On at 11:57 a.m., in an interview LPN Staff A said the physician's order in the electronic clinical record for the D3 was to administer 1000 IU. The D3 2000 IU that</p>	F 684	<ol style="list-style-type: none"> <li>Physician order was clarified and updated to reflect 2000 units, consistent with the original dosage on . The dosage was administered on . MARs audited facility-wide for compliance with physician orders initiated and completed</li> <li>Medication administration training initiated for licensed nurses projected completion date</li> <li>Random audits twice weekly for 30 days led by DON or designee; pharmacy consult monthly reviews, change in pharmacy services provider beginning . Reviewed in QAPI</li> <li>Report to QA committee will continue monthly for recommendations and or revisions. Completion Date: .</li> </ol>	

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F 684	Continued From page 12 she had available and that was being given was different from the physician's orders. She said she gave the incorrect dose of D3 to the resident on _____, and _____  On _____ at 5:35 p.m., in an interview LPN Staff C said on _____ she was the nurse assigned to Resident #22 and administered the D3 2000 IU that was in the medication cart to the resident. She said she never altered the medication, and the resident took the tablet of D3 2000 IU whole. She did not crush or cut the tablet of D3 2000 IU. On _____ at 12:30 p.m., in an interview the Director of Nursing (DON), she said she was made aware the incorrect dose of D3 has been administered to Resident #22. She said she expects the nurses to follow the physician's orders.	F 684		
F 689 SS=E	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 observation, record review, and interviews, the facility failed to implement care plan interventions to prevent _____ and related injuries for 1 (Resident #12) with multiple _____ of 2 residents reviewed for _____ prevention.	F 689	1. Resident #12s care plan updated with two-person assist, _____ mats, and _____ implemented _____ programing  2. All high-risk residents care plans	

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F 689	<p>Continued From page 13</p> <p>The findings included:</p> <p>Review of the clinical record for Resident #12 revealed an admission date of _____ and _____ due to multiple _____</p> <p>Review of the Admission Minimum Data Set (MDS) assessment with a target date of _____ revealed Resident #12's cognition was severely _____ with a score of "7". The assessment noted the resident was dependent on staff for toileting (Helper does all the effort). Toilet transfer was not attempted due to safety concerns.</p> <p>Review of the care plan for Activities of Daily Living (ADL) initiated on _____ revealed the resident was totally dependent on two staff for toilet use.</p> <p>On _____ at 12:55 p.m., Certified Nursing Assistant (CNA) Staff B was observed assisting Resident #12 with toileting in the bathroom. The resident was standing in front of the toilet, and the CNA was standing next to the resident. There was no other staff assisting CNA Staff B with the toileting.</p> <p>On _____ at 12:58 p.m., in an interview CNA Staff B said she works for an agency and has been working at the facility for six months. She said she was not familiar with the Kardex (provides instructions for safe care) and the assignment sheet did not say the resident required the assistance of 2 for toileting. She said Resident #12 had multiple _____ and was usually in the activity room due to the _____</p>	F 689	<p>reviewed, referrals made, and care plans updated as necessary initiated completed</p> <p>3. Staff re-educated on use of Kardex, interventions, and toileting support initiated _____ with projected completion _____</p> <p>4. Daily review in clinical meeting, weekly audit at risk meeting ongoing and reported to QA committee monthly. Reviewed in QAPI</p> <p>5. Report to QA committee will continue monthly for recommendations and or revisions. Completion Date: _____</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>105817</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/27/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>PLYMOUTH HARBOR INCORPORATED</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 JOHN RINGLING BLVD SARASOTA, FL 34236</b>		
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F 689	<p>Continued From page 14</p> <p>On at 1:26 p.m., CNA Staff B said she was not trained in using the Kardex to get resident information. She stated, "Maybe you get trained when you are staff here, but no one ever really sat down and trained me on the Kardex."</p> <p>On at 9:21 a.m., in an interview Registered Nurse (RN) MDS Coordinator Staff A said two staff for toileting was added to prevent accidents, including . . . The resident's ability fluctuates and there should have been two.</p> <p>On at 11:48 a.m., the Assistant Director of Nursing (ADON) said Staff B should have had a second CNA on when she was toileting the resident to prevent a possible accident/ . She said she found out on that Staff B did not know how to access the Kardex.</p> <p>Review of the care plan revealed Resident #12 sustained multiple at the facility as follows:</p> <ul style="list-style-type: none"> <li>: with no injury.</li> <li>: with minor injury.</li> <li>: with no injury</li> <li>: with minor injury</li> <li>: with minor injury. Resident #12 was sent to the Emergency Room and returned to the facility.</li> </ul> <p>#1: Review of the progress note dated revealed Resident #12 was observed on the floor near the bed facing the bathroom at 3:30 a.m. The resident said she forgot she had a and was trying to go to the bathroom. On the facility updated the care plan for frequent checks.</p>	F 689			

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F 689	<p>Continued From page 15</p> <p>#2:</p> <p>The nursing progress notes did not include the circumstances of Resident #12's . . . on . . . . .</p> <p>On . . . . . the facility updated the care plan to "Place sign to remind the resident to call for assistance."</p> <p>On . . . . ., the practitioner entered a progress note indicating the resident had a . . . and "will monitor closely, . . . precautions." The practitioner added, " . . . is stable, pleasantly . . . can speak and answer but not always accurate, . . . obtained collateral information from family present."</p> <p>On . . . . . the facility added the following diagnoses to the resident's clinical record: . . . abnormality of gait and mobility, history of falling, and need for assistance with personal care.</p> <p>#3</p> <p>On . . . . . at 12:31p.m. the facility entered a progress note. The resident was on the floor at the . . . of the bed. The resident told the staff at the time, "I don't know what I was trying to do. I just wanted to go to the bathroom."</p> <p>On . . . . . at 3:22 p.m., Resident #12 was observed sitting in a wheelchair in the activity room. When asked about the care at the facility and the multiple . . ., she said she "gives them pluses." The resident could not explain what she meant and said we should call her daughter.</p> <p>#4</p> <p>On . . . . . at 3:15 a.m., an incident note documented the nurse heard a loud scream and walked into the resident's room. She found the resident on the bathroom floor. The resident stated she needed to use the bathroom. The resident had a . . . to the left that</p>	F 689			

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F 689	<p>Continued From page 16 reopened.</p> <p>Review of the progress note dated revealed the facility placed mats on each side of the bed at the request of the resident's daughter and responsible party. The care plans did not identify the use of the mats use to prevent injury.</p> <p>On at 9:21 a.m., in an interview Registered Nurse (RN) MDS Coordinator Staff A confirmed the mats were not on the care plan. She said if staff used them, they should be on the care plan.</p> <p>On the facility updated the care plan with an intervention for and training. The clinical record lacked documentation of a and training program.</p> <p>On at 2:02 p.m., in an interview the Assistant Director of Nursing (ADON) said the and training was added to the care plan on but not implemented. She said it involves a and assessment by the nurse and then checking the resident every hour.</p> <p>On at 9:21 a.m., in an interview the MDS coordinator said and training should have been implemented because the resident was falling when she tried to get to the bathroom without assistance.</p> <p>#5</p> <p>On at 4:50 p.m., the alert progress note indicated an unwitnessed after for the resident after toileting herself and falling. The resident could not remember if she hit her . 911 was called and the resident was transported to the hospital.</p> <p>The facility updated the care plan on to include a medication review.</p> <p>On at 11:03 a.m., in a telephone</p>	F 689			

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F 689	<p>Continued From page 17</p> <p>interview, Resident #12's daughter and responsible party said her mother had multiple at the facility in a short time and the facility's efforts have not prevented them. She said she was worried the resident will and sustain another or worse. She said the resident has and periods of . . . . .</p> <p>On . . . . . at 9:21 a.m., in an interview Registered Nurse (RN) Minimum Data Set Assessment Coordinator (MDS) Staff A said all are reviewed with the interdisciplinary team IDT and the team decides which new interventions are added to the care plan. She verified mats did not get added to the care plan. She said mats do not prevent and are not appropriate for all residents and can contribute to because of tripping. She said providing assistance of 2 staff for toileting was added to prevent accidents including . . . . . She said the resident's ability fluctuates from day to day. She said there should have been 2 CNAs toileting Resident #12, if not used to support the resident, to be there for assistance if the resident should lose balance and begin to . . . . . The MDS coordinator said the and training intervention was added because the resident multiple times while trying to get to the bathroom. The IDT team decided on the intervention, and it should have been implemented by the IDT, which included the ADON.</p>	F 689			