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SARASOTA CENTER FOR NURSING & REHABILITATION	4783 FRUITVILLE ROAD SARASOTA, FL 34232

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F 000	INITIAL COMMENTS An unannounced complaint survey for complaint #2025005758, #2025005908 and #2025005863 was conducted on through at Sarasota Center for Nursing and Rehabilitation, a skilled nursing facility in Sarasota, Florida. Complaint #2025005758 was substantiated with citation at F600. Complaint #2025005908 was substantiated with citation at F686. Complaint #2025005863 was substantiated with citation at F600. Sarasota Center for Nursing and Rehabilitation is not in compliance with 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 600 SS=G	Free from and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from , Neglect, and , The resident has the right to be free from , neglect, misappropriation of resident property, and , as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary and any physical or chemical not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, , or	F 600		

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 600	Continued From page 1 , , , corporal punishment, or involuntary ; This REQUIREMENT is not met as evidenced by: Based on review of the clinical record, review of policy and procedures and resident and staff interviews, the facility failed to protect residents' rights to be free from by failing to ensure residents were protected from mental and for 4 (Residents #699, # 700, #800 and #850) of 4 residents reviewed for allegations of . The findings included: The facility policy " , Neglect and , " implemented (revised) documented, "It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent , neglect, , and misappropriation of resident property." " means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, , or mental anguish, which can include staff to resident . . ." "Instances of of all residents irrespective of any mental or physical condition, cause physical harm, , or mental anguish. It includes and mental . . ." Mental includes but is not limited to humiliation, harassment, threats of punishment or deprivation." Review of the facility investigation documented an allegation was made by Resident #699 and	F 600	Tag Cited: F-600 Free from and Neglect CFR(s): 483.12(a)(1) 1. Immediate action(s) taken for the resident(s) found to have been affected include: • CNA Staff A and CNA Staff B were immediately removed from the schedule and terminated from employment and reported to board. • Affected residents (R699, R700, R800, R850) received , , assessments from Social Services and were offered ongoing emotional support. • The facility formally notified residents R699, R700, R800, and R850 (and/or their representatives) that CNA Staff A and B were no longer employed. 2. The Identification of other residents having the potential to be affected was accomplished by: • Starting A facility-wide audit of grievance reports and residents with of 12 or higher was conducted by Social Services to identify any other concerns related to or neglect and was completed by . 3. Actions taken/systems put into place to reduce the risk of future occurrence include: • On Human Resources	

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F 600	Continued From page 2 Resident #700 involving concerns about inappropriate verbal interactions and improper care practices by a certified nursing assistant (CNA) Staff A during evening care period the allegation includes potential and verbal threats and failure to follow proper hygiene procedures. The allegation occurred on at 3:29 p.m. Review of the clinical record revealed Resident #699 a female (YOF) readmitted on with diagnoses including , failure with , , and . The Quarterly Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date (ARD) of documented Resident #699's skills for daily decision making were intact. On at 9:00 a.m., in an interview Resident #699 said, "Certified Nursing Assistant (CNA) Staff A, was nasty and she was big, and I was afraid of her. She would not listen to me when I tried to tell her about the steps for my shower. She said to me, "Shut up or I will leave you in this chair and not come ." She did not use the lift like she should have to get me up. She just picked me up out of bed and was rough and put me in the wheelchair (w/c). I told her I needed to use the bathroom, that is how they always do it, but she was nasty. She did not hit me, but she was rough. I couldn't stand and she grabbed me and put me in the w/c. I was afraid she would leave me in the w/c. I had a movement (BM) in my brief during the shower; and she did not take it off. The CNA washed me in the w/c	F 600	re-conducted Prevention Training and Customer Service education for all staff to be completed by . Any staff who are unable to meet the compliance date will be educated prior to their next working shift. All new hires must complete Prevention and Customer Service modules in Relias during orientation. The facility doesn't currently utilize agency staffing at this time 4. How the corrective action(s) will be monitored to ensure the practice will not recur: • The Administrator or designee will complete 10 resident interviews weekly for 2 weeks, and then 5 residents weekly for 4 weeks to monitor any concerns about staff behavior or . • With any allegation of or neglect a licensed psychologist/social Worker will conduct an initial interview and determine plan for resident(s) emotional or , needs. • Customer service satisfaction rounds will be completed 5x weekly by the Department Heads for a total of 80 residents by the end of the week and submitted to the Administrator and/or Designee for review by the end of each day 5 x weekly for 6 weeks. • The Administrator will bring the findings to the QAPI meeting monthly starting to evaluate effectiveness and recommend changes. 5. Corrective action completion date: ____6/3/25.	

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with the dirty brief on. I tried to tell her how to do it to make it easier for her and she told me, "I know what I'm doing," she did not listen to me. I was shaking and afraid she would do something to me. She did not want to put me in the shower chair, and she washed me with the BM diaper on and in my w/c. She ruined my w/c cushion and the w/c. There was BM all over it and it was wet. The CNA brought me to the room full of BM and picked me up and put me in bed. She was mean and rough. She told me again if I said anything she would leave me in the w/c and not come . She made me shut up. She was a big lady. I was afraid of her, and I did not want to see her again." Resident #699 said, " About a week later the police came in and asked me about it and took my statement. He told me the CNA had been fired. I think the facility should have told me, because every time the door opened, I was afraid she was , or she would retaliate against me or have someone else do it. That was my biggest fear that she would come . It would have made me feel more comfortable if I knew the CNA was not here anymore. I was afraid she was going to come , and they should have told me she was not here anymore. They left me feeling afraid for a week. I was very upset."

Review of the clinical record revealed Resident #700 a admitted on with diagnoses including , and major .

The Quarterly MDS dated documented the resident was independent with her care needs. The MDS noted Resident #700's skills for daily decision making were intact.

On at 8:30 a.m., in an interview Resident

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#700 said, "I was very respectful and nice to CNA Staff A. I don't remember her name but for a week prior to the incident she would come in the room to bring ice and what not and did not really bother us but she was not friendly or nice. You could tell she was not happy with the job, but she never said anything."
Resident #700 said, "On on 3 p.m., to 11 p.m., shift, I don't know the exact time, the CNA came into the room and my roommate Resident #699 had asked for a shower. The CNA got mad and said it was not her time. We explained to her that they changed our showers to p.m. The CNA was thick, strong and built like a linebacker. She looked mean like she would hurt you. I tried to explain to her, and she looked right at me in the , like she wanted to hurt me and said, "Shut up." I was a social worker and I'm mostly independent so I help my roommate out when I can. My roommate was telling her how she usually gets her shower, they bring the shower chair in, and they take her to the bathroom for a BM and then wheel her to the shower room. The CNA said, "Don't tell me how to do my job, I know what I'm doing." I watched her pick my roommate up out of bed without the lift and she was rough and slammed her into the w/c. My roommate was shaking, and I could see she was afraid and getting . She left the room without toileting her and returned a while later. My roommate had a BM in the brief because she did not toilet her. The CNA gave her a shower in the w/c in the soiled brief. It took her 45 minutes to get her in bed and clean her up. I was watching her with my roommate, and she was rough and mean. She was moving her around in bed like a bag of wet cement. My roommate was saying "stop" but she kept up. There was BM everywhere on the cushion in the w/c and it stunk. I told my

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roommate we need to report it, but she was afraid of retaliation, so I called her daughter and told her. The next morning, I told the nurse. Then the Management Team came in and spoke to us about it.
They had the police in about a week after that to get our statements and I told him everything. The facility did not tell us the CNA was no longer working here. My poor roommate was afraid, and they should have told us she was no longer employed here. I saw how she was handling my roommate, and I tried to tell her how to do it, but she was not listening to me and she turned and glared at me with a look that said she would hurt me. We have been roommates for years and we look out for each other, so I was watching how she got her in and out of the bed. She was very rough with her, and she was shaking, she was afraid. I think the facility did what they were supposed to do because that first week we had so many people here asking us about it and we told them just like we are telling you. The story did not change, and it will not change because it is the truth."

On at 9:45 a.m., in an interview with Licensed Practical Nurse (LPN) Staff C said, "I was not here the night it happened with CNA Staff A. I work the 7 a.m., to 3 p.m., shift and this occurred on the shift. Resident #700 told me what had happened, and I had her fill out a grievance form and I assisted Resident #699 to fill hers out. I went right to the Administrator and gave her the grievance forms and told her what they said had happened. That is all I know, really. Like I said, I was not here when it happened."

Further review of the facility investigation documented "The allegation was determined to

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be unsubstantiated based on the investigation findings; the CNA's behavior was found inconsistent with facility standards.". . "The CNA was found to have violated the facilities Code of Conduct and Resident Rights policies through the use of inappropriate and unprofessional communication."

The facility reported a second allegation of to the State Agency involving Resident #800 and #850. The report documented on at 5:00 a.m., two residents have raised concerns alleging a staff member, CNA Staff B, displayed aggressive behavior toward them in their shared room. In addition, Staff D reported witnessing concerning interactions involving CNA Staff B and the residents. The residents have voiced concerns regarding their comfort and feelings of safety within their room. Supportive measures have been initiated, including increased monitoring and emotional support.

Review of the clinical record revealed Resident #850 was an with an admission date of . Diagnoses included a of the right and

The Admission MDS dated indicated the resident required substantial to with toileting, showers, bed mobility and personal hygiene.
The MDS noted Resident #850's skills for daily decision making were intact.

On at 8:30 a.m., in an interview Resident #850 said on the CNA that night came in to change her and her roommate Resident #800. CNA Staff B pulled my covers and moved

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my gown up, then said she would be right . The CNA did not come for 45 minutes. I was at that point covered in and . I had taken my wet gown off and thrown it in the corner. I was in a position and so . The CNA began mumbling things in a different language and was rough when pulling the wet , out from under me. She was mumbling something in a different language the whole time. She then sprayed me with water to clean me, and I said, "please don't do that" but she continued to do it. I felt abused, hurt and I don't think I was being taken care of. I was so scared to say something. If I had said something, who knows what she would have done the next night. Resident #850 said being left uncovered for 45 minutes felt demeaning and hurtful. She said she was never physically hit; the CNA was just rough when changing me and mumbling things. Resident #850 was observed tearful and emotional during the interview. Resident #850 said the same thing happened similarly the week before with this CNA, but she did not report it. Prior to that incident, the resident said the CNA came in and yelled, "it's 12:00 a.m., turn the television off". Resident #850 said, "She then pulled my curtain shut and put my remote out of reach so I couldn't turn it on."

Resident #800, an with an admission date of and diagnoses including , Hypertensive , Type 2 , and major , .

The Medicare 5-day MDS dated documented the resident's skills for daily decision making were moderately .

On at 11:27 a.m., in interview with

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Resident #800, said she did not know about the incident on with CNA Staff B. She said she was probably sleeping at the time and did not remember the incident. The resident said, "I just felt uncomfortable when she was around me, she was not nice."

On at 9;30 a.m., in an interview, Central Supply Staff D, said, "on at around 5 a.m., I was doing rounds, and I was in Resident #800 and #850's room. I felt the CNA Staff B was verbally , she was just very short with Resident #850. These folks are here in our care and if we don't care we shouldn't be here. CNA Staff B was very short the way she was talking with her and I saw her be rough with her. I saw her. She jerked Resident #850's arm when she was trying to get her arm in her sweater. She was rough and I had been told by Resident #850 that the CNA was mean to her all the time.
About a week ago I was taking with Resident #850 on the way to a doctor's , , because I also drive the facility van. The resident said I'm afraid of my night aid, she is very mean, and she said it was Staff B.
CNA Staff B was very big and intimidating, she gave me a look when I said something to her about what I saw, but she did not say anything to me. Resident #850 said she was intimidated, she never said Staff B hit her. I reported it to the nurse on duty at the time because the Director of Nursing (DON) was not here. The DON did speak with me about what I saw. That is what I observed, I felt like the CNA treated Resident #850 worse when I was not in the room because I could call her on it and the resident could not. I visit the room most every day."

Further review of the facility investigation

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F 600	Continued From page 9 documented, "Due to a lack of definitive evidence to confirm or disprove the allegation, the findings are classified as inconclusive. However, based on administration concerns related to customer service, CNA Staff B's employment has been terminated." On at 10:50 a.m., in an interview the Administrator said she had reposted her phone number and spoke with everyone about , not really but customer service. "We reach out to family and residents to make sure they are ok. This company is all about customer service and right now it is not acceptable. We have a new leadership team, and we are not tolerating it." The Administrator confirmed there was no documentation of the increased monitoring after the allegations. The Administrator said, "I spoke with the residents; skin sweeps were done and there were no injuries. I re-educated the staff on customer service. I think that is the problem, customer service is not where it needs to be." On at 8:45 a.m., in an interview the Administrator said regarding the /neglect allegations, "I have done education, and the Regional Nurse Consultant is reviewing that now because it is on-going and we want to make sure everyone is on the list. I did education and we have online learning and there is a lot of things about customer service. I have told the staff to take care of themselves and not work a lot of overtime because that can lead to issues."	F 600		
F 686 SS=D	Treatment/Svcs to Prevent/Heal CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1)	F 686		

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F 686	Continued From page 10 Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent and does not develop , unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with , receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent and prevent new from developing. This REQUIREMENT is not met as evidenced by: Based on review of policies and procedures, clinical record review, and staff interview, the facility failed to provide the necessary interventions to prevent the development of avoidable , for 1(Resident #799) of 3 residents identified as at risk for developing , . The findings included: The facility policy "Pressure Injury Prevention and Management" initiated (revised) documented, "this facility is committed to the prevention of avoidable pressure injuries unless clinically unavoidable and to provide treatment and services to heal the pressure injury, prevent and the development of additional pressure injuries. injury refers to localized damage to the skin and or underlying soft tissue usually over a Bony prominence or related to a medical or other device. The facility shall establish and utilize a systematic approach for pressure injury prevention and management including prompt assessment and	F 686	Tag Cited: F686 Treatment/Svcs to Prevent/Heal CFR(s): 483.25(b)(1)(i)(ii) 1. Immediate action(s) taken for the resident(s) found to have been affected include: • The facility failed to implement skin integrity interventions for Resident R799. Resident R799 was transferred to hospital and didn't return to the facility. 2. Identification of other residents having the potential to be affected was accomplished by: • On the Director of Nursing, Assistant Director of Nursing, and Unit Manager conducted a 100% skin sweep audit for current residents to establish a baseline skin assessment by completed by . • On a 100% audit for Braden Assessments was completed for	

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treatment intervening to stabilize reduce or remove underlying risk factors monitoring the impact of the interventions and modifying the interventions as appropriate."

Review of the clinical record revealed Resident #799 was and admitted to the facility on . Diagnoses included: , and of the left .

The Admission Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date of documented Resident #799 was dependent for bed mobility, transfers, toileting and bathing. The MDS documented that the resident was not at risk for pressure injury and had no pressure injuries at admission.
The MDS noted Resident #799's skills for daily decision making were moderately .

The care plan initiated did not address the resident's skin condition including the potential/risk for pressure injury.
Review of the Admission Assessment completed on documented a surgical to the left , and no pressure injuries. The assessment documented that the resident was not at risk for pressure injury/ .

The clinical record showed no documentation of preventive measures to decrease the risk of for Resident #799.

The weekly skin assessment dated documented "admission, no open areas."

current residents to address moderate to high-risk Braden Scores. This audit was conducted by the Director of Nursing, Assistant Director of Nursing, and Unit Manager completed by .

3. Actions taken/systems put into place to reduce the risk of future occurrence include:
• On the Director of Nursing conducted an audit of all current residents to review and identify those with and/or Braden scores of moderate to high risk by and completed by . Any resident with or Braden Scores of moderate to high had care plans initiated or revised care plan focusing on skin integrity and , prevention needs.

• All new admissions are ordered skin prep to heels for the first 14 days of admission and then reassessed by nurse for further skin integrity needs.

• A designated treatment nurse was hired on .

• Starting the Assistance Director of Nursing began re-education for Licensed Nursing staff (RN and LPN) on Care Best Practices including timely documentation. All licensed nursing staff will be educated by , anyone not in compliance with this date will be educated prior to the next working shift. All newly hired licensed nursing staff (RN and LPN) will complete this education during orientation. The facility is not

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	105983	A. BUILDING _____ B. WING _____	C 05/08/2025

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SARASOTA CENTER FOR NURSING & REHABILITATION	4783 FRUITVILLE ROAD SARASOTA, FL 34232

(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 686	Continued From page 12 A (used to determine a resident's risk for) was completed on and documented a score of 14 indicating moderate risk for . On at 6:10 p.m., a nursing progress note documented the resident was transferred to the local emergency department at the request of the family. The resident did not return to the facility. On at 9:39 a.m., a Progress note written after transfer to the hospital documented, "Darkened area to of resident's left heel identified as , , , . POA (power of attorney) aware of identification and treatment plan consisting of the addition of , while in bed and skin prep to heel q (every) shift." Review of the Treatment Administration Record did not show documentation the skin prep was ordered or applied to the left heel. A late entry progress note dated at 2:43 p.m., documented: Late entry. Interdisciplinary Team (IDT) reviewed skin issue. Resident was sent to the hospital shortly after identification and is still at the hospital. New order for skin prep and a to the heel. When returns from the hospital we will assess the at that time and involve care physician and dietician if appropriate. On at 9:38 a.m., in an interview the Administrator said, "We have a new company and a new Director of Nursing (DON), we are all new and working together. We have weekly and daily meetings for and the new company will start next week."	F 686	currently utilizing agency staffing 4. How the corrective action(s) will be monitored to ensure the practice will not recur: • Starting the Care Nurse or designee will audit new admissions five times a week for 2 weeks, and 5 new admission records weekly for 4 weeks, to ensure residents with high-risk Braden Scores have appropriate interventions in place for skin integrity. • The Care Nurse will bring the findings to the QAPI meeting monthly starting to evaluate effectiveness and recommend changes. 5. Corrective action completion date: _____6/3/25	

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F 686	Continued From page 13 On at 10:50 a.m., in an interview the DON said she was hired 2 weeks ago as the Care Nurse and on , she took the position of the DON. The DON said, "We are just starting this new process of weekly skin sweeps, and ensuring a skin assessment is completed at admission. With all new admissions the plan is for myself, the Assistant Director of Nursing (ADON) and the Unit Manager will follow up in 24 hours to assess the skin and complete another skin assessment." Review of the facility investigation dated documented, "Resident was noted to have developed a pressure injury during her stay, which was documented and treated. The pressure injury that developed during the residents stay was assessed and treated according to facility protocol."	F 686		

Agency for Health Care Administration

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N 000	INITIAL COMMENTS An unannounced complaint survey for complaint #2025005758, #2025005908 and #2025005863 was conducted on through at Sarasota Center for Nursing and Rehabilitation, a skilled nursing facility in Sarasota, Florida. Complaint #2025005758 was substantiated with citation at N204. Complaint #2025005908 was substantiated with citation at N201. Complaint #2025005863 was substantiated with citation at N204. The following is the description of the deficiencies.	N 000		
N 201	400.022(1)(l), FS Right to Adequate and Appropriate Health Care (l) 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 review of policies and procedures, clinical record review, and staff interview, the facility failed to provide the necessary care and services to prevent the development of avoidable , for 1(Resident #799) of 3 residents identified as at risk for developing , . The findings included:	N 201	Tag Cited: F686 Treatment/Svcs to Prevent/Heal CFR(s): 483.25(b)(1)(i)(ii) 1. Immediate action(s) taken for the resident(s) found to have been affected include: • The facility failed to implement skin	

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/25

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N 201	Continued From page 1 The facility policy "Pressure Injury Prevention and Management" initiated (revised) documented, "this facility is committed to the prevention of avoidable pressure injuries unless clinically unavoidable and to provide treatment and services to heal the pressure injury, prevent and the development of additional pressure injuries. injury refers to localized damage to the skin and or underlying soft tissue usually over a Bony prominence or related to a medical or other device. The facility shall establish, and utilize a systematic approach for pressure injury prevention and management including prompt assessment and treatment intervening to stabilize reduce or remove underlying risk factors monitoring the impact of the interventions and modifying the interventions as appropriate." Review of the clinical record revealed Resident #799 was and admitted to the facility on . Diagnoses included: , , , and of the left . The Admission Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date of documented Resident #799 was dependent for bed mobility, transfers, toileting and bathing. The MDS documented the resident was not at risk for pressure injury and had no pressure injuries at admission. The MDS noted Resident #799's skills for daily decision making were moderately , .	N 201	integrity interventions for Resident R799. Resident R799 was transferred to hospital and didn't return to the facility. 2. Identification of other residents having the potential to be affected was accomplished by: • On the Director of Nursing, Assistant Director of Nursing, and Unit Manager conducted a 100% skin sweep audit for current residents to establish a baseline skin assessment by completed by . • On a 100% audit for Braden Assessments was completed for current residents to address moderate to high-risk Braden Scores. This audit was conducted by the Director of Nursing, Assistant Director of Nursing, and Unit Manager completed by . 3. Actions taken/systems put into place to reduce the risk of future occurrence include: • On the Director of Nursing conducted an audit of all current residents to review and identify those with and/or Braden scores of moderate to high risk by and completed by . Any resident with or Braden Scores of moderate to high had care plans initiated or revised care plan focusing on skin integrity and , prevention needs. • All new admissions are ordered skin prep to heels for the first 14 days of admission and then reassessed by nurse for further skin integrity needs.	

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N 201	Continued From page 2 The care plan initiated did not address the residents skin condition including the potential/risk for pressure injury. Review of the Admission Assessment completed on documented a surgical to left , and no pressure injuries. The assessment documented that the resident was not at risk for pressure injury/ . The weekly skin assessment dated documented admission, no open areas. A (used to determine a resident's risk for) was completed on and documented a score of 14 indicating moderate risk for . On at 6:10 p.m., a nursing progress note documented the resident was transferred to the local emergency department at the request of the family. The resident did not return to the facility. On at 9:39 a.m., a Progress note documented "Darkened area to of resident's left heel identified as , , . POA (power of attorney) aware of identification and treatment plan consisting of the addition of , while in bed and skin prep to heel q shift. Review of Treatment Administration Record did not show documentation the skin prep was ordered or applied to the left heel. A late entry progress note dated at 2:43 p.m., documented: Late entry. Interdisciplinary Team (IDT) reviewed skin issue. Resident was sent to the hospital shortly after identification and is still at the hospital. New order for skin prep and a to the heel. When returns from the hospital we will assess the at that time and involve	N 201	• A designated treatment nurse was hired on . • Starting the Assistance Director of Nursing began re-education for Licensed Nursing staff (RN and LPN) on Care Best Practices including timely documentation. All licensed nursing staff will be educated by , anyone not in compliance with this date will be educated prior to the next working shift. All newly hired licensed nursing staff (RN and LPN) will complete this education during orientation. The facility is not currently utilizing agency staffing 4. How the corrective action(s) will be monitored to ensure the practice will not recur: • Starting the Care Nurse or designee will audit new admissions five times a week for 2 weeks, and 5 new admission records weekly for 4 weeks, to ensure residents with high-risk Braden Scores have appropriate interventions in place for skin integrity. • The Care Nurse will bring the findings to the QAPI meeting monthly starting to evaluate effectiveness and recommend changes. 5. Corrective action completion date: _____6/3/25	

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N 201	Continued From page 3 care physician and dietician if appropriate. On at 9:38 a.m., in an interview the Administrator said we have a new company and a new Director of Nursing (DON), we are all new and working together. We have weekly and daily meetings for and the new company will start next week. On at 10:50 a.m., in an interview the DON said she was hired 2 weeks ago as the care Nurse and on she took the position of the DON. The DON said we are just starting this new process of weekly skin sweeps, and ensuring a skin assessment is completed at admission. With all new admissions the plan is for myself, the Assistant Director of Nursing (ADON) and the Unit Manager will follow up in 24 hours to assess the skin and complete another skin assessment. Review of the facility investigation dated documented "Resident was noted to have developed a pressure injury during her stay, which was documented and treated. The pressure injury that developed during the residents stay was assessed and treated according to facility protocol." Class II	N 201		
N 204	400.022(1)(o), FS Right to be Free from , , etc 400.022, F. S. (1)(o) All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with	N 204		

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N 204	Continued From page 4 the provisions of that statement. The statement shall assure each resident the following: (o) The right to be free from mental and , , , neglect, , , corporal punishment, extended involuntary , and , , corporal punishment, extended involuntary , and physical and chemical , except those authorized in writing by a physician for a specified and limited period of time or as are necessitated by an emergency. In case of an emergency, may be applied only by a qualified licensed nurse who shall set forth in writing the circumstances requiring the use of , and, in the case of use of a chemical , a physician shall be consulted immediately thereafter. may not be used in lieu of staff supervision or merely for staff convenience, for punishment, or for reasons other than resident protection or safety. This Statute or Rule is not met as evidenced by: Based on review of the clinical record, review of policy and procedures and resident and staff interviews, the facility failed to protect residents' rights to be free from by failing to ensure residents were protected from mental and for 4 (Residents #699, # 700, #800 and #850) of 4 residents reviewed for allegations of . The findings included: The facility policy " , Neglect and , " implemented (revised) documented, "It is the policy of this facility to provide protection for the health, welfare and	N 204	Tag Cited: F-600 Free from and Neglect CFR(s): 483.12(a)(1) 1. Immediate action(s) taken for the resident(s) found to have been affected include: • CNA Staff A and CNA Staff B were immediately removed from the schedule and terminated from employment and reported to board. • Affected residents (R699, R700, R800, R850) received , assessments from Social Services and were offered ongoing emotional support.	

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N 204	Continued From page 5 rights of each resident by developing and implementing written policies and procedures that prohibit and prevent , neglect, , and misappropriation of resident property." " means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, , or mental anguish, which can include staff to resident . . ." "Instances of of all residents irrespective of any mental or physical condition, cause physical harm, , or mental anguish. It includes and mental . . ." Mental includes but is not limited to humiliation, harassment, threats of punishment or deprivation." Review of the facility investigation documented an allegation was made by Resident #699 and Resident #700 involving concerns about inappropriate verbal interactions and improper care practices by a certified nursing assistant (CNA) Staff A during evening care period the allegation includes potential and verbal threats and failure to follow proper hygiene procedures. The allegation occurred on at 3:29 p.m. Review of the clinical record revealed Resident #699 a female (YOF) readmitted on with diagnoses including , failure with , , and . The Quarterly Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date (ARD) of documented Resident #699's skills for daily decision making were intact.	N 204	• The facility formally notified residents R699, R700, R800, and R850 (and/or their representatives) that CNA Staff A and B were no longer employed. 2. The Identification of other residents having the potential to be affected was accomplished by: • Starting A facility-wide audit of grievance reports and residents with of 12 or higher was conducted by Social Services to identify any other concerns related to or neglect and was completed by . 3. Actions taken/systems put into place to reduce the risk of future occurrence include: • On Human Resources re-conducted Prevention Training and Customer Service education for all staff to be completed by . Any staff who are unable to meet the compliance date will be educated prior to their next working shift. All new hires must complete Prevention and Customer Service modules in Relias during orientation. The facility doesn't currently utilize agency staffing at this time 4. How the corrective action(s) will be monitored to ensure the practice will not recur: • The Administrator or designee will complete 10 resident interviews weekly for 2 weeks, and then 5 residents weekly for 4 weeks to monitor any concerns about staff behavior or .	

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N 204	Continued From page 6 On at 9:00 a.m., in an interview Resident #699 said, "Certified Nursing Assistant (CNA) Staff A, was nasty and she was big, and I was afraid of her. She would not listen to me when I tried to tell her about the steps for my shower. She said to me, "Shut up or I will leave you in this chair and not come ." She did not use the lift like she should have to get me up. She just picked me up out of bed and was rough and put me in the wheelchair (w/c). I told her I needed to use the bathroom, that is how they always do it, but she was nasty. She did not hit me, but she was rough. I couldn't stand and she grabbed me and put me in the w/c. I was afraid she would leave me in the w/c. I had a movement (BM) in my brief during the shower; and she did not take it off. The CNA washed me in the w/c with the dirty brief on. I tried to tell her how to do it to make it easier for her and she told me, "I know what I'm doing," she did not listen to me. I was shaking and afraid she would do something to me. She did not want to put me in the shower chair, and she washed me with the BM diaper on and in my w/c. She ruined my w/c cushion and the w/c. There was BM all over it and it was wet. The CNA brought me to the room full of BM and picked me up and put me in bed. She was mean and rough. She told me again if I said anything she would leave me in the w/c and not come . She made me shut up. She was a big lady. I was afraid of her, and I did not want to see her again." Resident #699 said, " About a week later the police came in and asked me about it and took my statement. He told me the CNA had been fired. I think the facility should have told me, because every time the door opened, I was afraid she was , or she would retaliate against me or have someone else do it. That was my biggest	N 204	• With any allegation of or neglect a licensed psychologist/social Worker will conduct an initial interview and determine plan for resident(s) emotional or needs. • Customer service satisfaction rounds will be completed 5x weekly by the Department Heads for a total of 80 residents by the end of the week and submitted to the Administrator and/or Designee for review by the end of each day 5 x weekly for 6 weeks. • The Administrator will bring the findings to the QAPI meeting monthly starting to evaluate effectiveness and recommend changes. 5. Corrective action completion date: 6/3/25.	

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N 204	Continued From page 7 fear that she would come . It would have made me feel more comfortable if I knew the CNA was not here anymore. I was afraid she was going to come , and they should have told me she was not here anymore. They left me feeling afraid for a week. I was very upset." Review of the clinical record revealed Resident #700 a admitted on with diagnoses including , and major The Quarterly MDS dated documented the resident was independent with her care needs. The MDS noted Resident #700's skills for daily decision making were intact. On at 8:30 a.m., in an interview Resident #700 said, "I was very respectful and nice to CNA Staff A. I don't remember her name but for a week prior to the incident she would come in the room to bring ice and what not and did not really bother us but she was not friendly or nice. You could tell she was not happy with the job, but she never said anything." Resident #700 said, "On on 3 p.m., to 11 p.m., shift, I don't know the exact time, the CNA came into the room and my roommate Resident #699 had asked for a shower. The CNA got mad and said it was not her time. We explained to her that they changed our showers to p.m. The CNA was thick, strong and built like a linebacker. She looked mean like she would hurt you. I tried to explain to her, and she looked right at me in the like she wanted to hurt me and said, "Shut up." I was a social worker and I'm mostly independent so I help my roommate out when I can. My roommate was telling her how she usually gets her shower, they bring the shower chair in, and they take her to the bathroom for a	N 204		

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N 204	Continued From page 8 BM and then wheel her to the shower room. The CNA said, "Don't tell me how to do my job, I know what I'm doing." I watched her pick my roommate up out of bed without the lift and she was rough and slammed her into the w/c. My roommate was shaking, and I could see she was afraid and getting . She left the room without toileting her and returned a while later. My roommate had a BM in the brief because she did not toilet her. The CNA gave her a shower in the w/c in the soiled brief. It took her 45 minutes to get her in bed and clean her up. I was watching her with my roommate, and she was rough and mean. She was moving her around in bed like a bag of wet cement. My roommate was saying "stop" but she kept up. There was BM everywhere on the cushion in the w/c and it stunk. I told my roommate we need to report it, but she was afraid of retaliation, so I called her daughter and told her. The next morning, I told the nurse. Then the Management Team came in and spoke to us about it. They had the police in about a week after that to get our statements and I told him everything. The facility did not tell us the CNA was no longer working here. My poor roommate was afraid, and they should have told us she was no longer employed here. I saw how she was handling my roommate, and I tried to tell her how to do it, but she was not listening to me and she turned and glared at me with a look that said she would hurt me. We have been roommates for years and we look out for each other, so I was watching how she got her in and out of the bed. She was very rough with her, and she was shaking, she was afraid. I think the facility did what they were supposed to do because that first week we had so many people here asking us about it and we told them just like we are telling you. The story did not change, and it will not change because it is	N 204		

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N 204	Continued From page 9 the truth." On at 9:45 a.m., in an interview with Licensed Practical Nurse (LPN) Staff C said, "I was not here the night it happened with CNA Staff A. I work the 7 a.m., to 3 p.m., shift and this occurred on the shift. Resident #700 told me what had happened, and I had her fill out a grievance form and I assisted Resident #699 to fill hers out. I went right to the Administrator and gave her the grievance forms and told her what they said had happened. That is all I know, really. Like I said, I was not here when it happened." Further review of the facility investigation documented "The allegation was determined to be unsubstantiated based on the investigation findings; the CNA's behavior was found inconsistent with facility standards.". . "The CNA was found to have violated the facilities Code of Conduct and Resident Rights policies through the use of inappropriate and unprofessional communication." The facility reported a second allegation of to the State Agency involving Resident #800 and #850. The report documented on at 5:00 a.m., two residents have raised concerns alleging a staff member, CNA Staff B, displayed aggressive behavior toward them in their shared room. In addition, Staff D reported witnessing concerning interactions involving CNA Staff B and the residents. The residents have voiced concerns regarding their comfort and feelings of safety within their room. Supportive measures have been initiated, including increased monitoring and emotional support. Review of the clinical record revealed Resident	N 204		

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	35960915	A. BUILDING: _____ B. WING _____	C 05/08/2025

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N	Continued From page 10 #850 was an with an admission date of . Diagnoses included a of the right , and , , . The Admission MDS dated indicated the resident required substantial to with toileting, showers, bed mobility and personal hygiene. The MDS noted Resident #850's skills for daily decision making were intact. On at 8:30 a.m., in an interview Resident #850 said on the CNA that night came in to change her and her roommate Resident #800. CNA Staff B pulled my covers and moved my gown up, then said she would be right . The CNA did not come for 45 minutes. I was at that point covered in and . I had taken my wet gown off and thrown it in the corner. I was in a position and so . The CNA began mumbling things in a different language and was rough when pulling the wet out from under me. She was mumbling something in a different language the whole time. She then sprayed me with water to clean me, and I said, "please don't do that" but she continued to do it. I felt abused, hurt and I don't think I was being taken care of. I was so scared to say something. If I had said something, who knows what she would have done the next night. Resident #850 said being left uncovered for 45 minutes felt demeaning and hurtful. She said she was never physically hit; the CNA was just rough when changing me and mumbling things. Resident #850 was observed tearful and emotional during the interview. Resident #850 said the same thing happened similarly the week before with this CNA, but she did not report it. Prior to that incident, the resident said the CNA came in and yelled, "it's 12:00 a.m., turn the	N 204		

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N 204	Continued From page 11 television off". Resident #850 said, "She then pulled my curtain shut and put my remote out of reach so I couldn't turn it on." Resident #800, an with an admission date of and diagnoses including , Hypertensive , Type 2 , and major The Medicare 5-day MDS dated documented the resident's skills for daily decision making were moderately . On at 11:27 a.m., in interview with Resident #800, said she did not know about the incident on with CNA Staff B. She said she was probably sleeping at the time and did not remember the incident. The resident said, "I just felt uncomfortable when she was around me, she was not nice." On at 9:30 a.m., in an interview, Central Supply Staff D, said, "on at around 5 a.m., I was doing rounds, and I was in Resident #800 and #850's room. I felt the CNA Staff B was verbally , she was just very short with Resident #850. These folks are here in our care and if we don't care we shouldn't be here. CNA Staff B was very short the way she was talking with her and I saw her be rough with her. I saw her. She jerked Resident #850's arm when she was trying to get her arm in her sweater. She was rough and I had been told by Resident #850 that the CNA was mean to her all the time. About a week ago I was taking with Resident #850 on the way to a doctor's , because I also drive the facility van. The resident said I'm afraid of my night aid, she is very mean, and she said it was Staff B. CNA Staff B was very big and intimidating, she	N 204		

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N 204	Continued From page 12 gave me a look when I said something to her about what I saw, but she did not say anything to me. Resident #850 said she was intimidated, she never said Staff B hit her. I reported it to the nurse on duty at the time because the Director of Nursing (DON) was not here. The DON did speak with me about what I saw. That is what I observed, I felt like the CNA treated Resident #850 worse when I was not in the room because I could call her on it and the resident could not. I visit the room most every day." Further review of the facility investigation documented, "Due to a lack of definitive evidence to confirm or disprove the allegation, the findings are classified as inconclusive. However, based on administration concerns related to customer service, CNA Staff B's employment has been terminated." On at 10:50 a.m., in an interview the Administrator said she had reposted her phone number and spoke with everyone about , not really but customer service. "We reach out to family and residents to make sure they are ok. This company is all about customer service and right now it is not acceptable. We have a new leadership team, and we are not tolerating it." The Administrator confirmed there was no documentation of the increased monitoring after the allegations. The Administrator said, "I spoke with the residents; skin sweeps were done and there were no injuries. I re-educated the staff on customer service. I think that is the problem, customer service is not where it needs to be." On at 8:45 a.m., in an interview the Administrator said regarding the /neglect allegations, "I have done education, and the Regional Nurse Consultant is reviewing that now	N 204		

Agency for Health Care Administration

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N 204	Continued From page 13 because it is on-going and we want to make sure everyone is on the list. I did education and we have online learning and there is a lot of things about customer service. I have told the staff to take care of themselves and not work a lot of overtime because that can lead to issues." Class II	N 204		