

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

PRINTED: 06/27/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>106025</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/23/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF SARASOTA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8104 TUTTLE AVE</b> <b>SARASOTA, FL 34243</b>		
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>A complaint survey for complaint number 2025006220, was conducted on _____ and continued after supervisory review on _____ at Life Care Center of Sarasota. The facility was not in compliance with Code for Federal Regulations (CFR), Part 483, Requirements for Long-Term Care Facilities.</p> <p>Findings of Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, or _____ to a resident) related to complaint number 2025006220 was identified at F689 Scope and Severity of "J" (Immediate Jeopardy to resident health or safety which is _____).</p> <p>Substandard Quality of Care was identified at F689.</p> <p>A partial extended survey was completed on _____</p> <p>The Immediate Jeopardy started on _____</p> <p>The facility resident census at the beginning of the survey was 110.</p> <p>The facility was informed of, and provided the templates for, the Immediate Jeopardy on _____ at 9:25 a.m.</p> <p>It was determined that the Immediate Jeopardy was removed on _____ and the Scope and Severity for F689 was reduced to a "D" after verification of removal of immediacy of harm.</p>	F 000			
F 689	Free of Accident Hazards/Supervision/Devices	F 689			

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 689 SS=J	<p>Continued From page 1</p> <p>CFR(s): 483.25(d)(1)(2)</p> <p>§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</p> <p>§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 observations, interviews, and record review, the facility failed to provide adequate supervision to prevent one resident (#1) from exposure to the sun/heat, resulting in an _____ and skin damage to the _____, arms, and _____, out of three residents sampled for outdoor activities.</p> <p>On _____ Resident #1 was seated in a wheelchair in the courtyard area of the facility for approximately one hour from 2:45 p.m. to 3:45 p.m., during the hottest part of the day. Resident #1 was discovered to be unresponsive and had to be transferred to a higher level of care for treatment from sun/heat exposure.</p> <p>This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and or _____ to Resident #1 and resulted in the determination of Immediate Jeopardy on _____. The findings of Immediate Jeopardy were determined to be removed on _____ and the severity and scope was reduced to a "D" after verification of removal of immediacy of harm.</p> <p>Findings included:</p>	F 689	<p>This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope of severity regarding any of these deficiencies cited are correctly applied. In order to ensure that the services provided at Life Care Center of Sarasota meet the professional standards of quality, the team had initiated the following plan of correction:</p> <p>Resident #1 was discharged from the facility.</p> <p>Residents who enjoy outdoor activities have the potential to be affected by not providing adequate supervision to prevent exposure to the sun/heat. The facility</p>	

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F 689	<p>Continued From page 2</p> <p>Resident #1 was admitted to the facility in with diagnoses including:</p> <p>Type 2 _____ with _____ ( _____ ), _____ difficulty walking, _____ communication _____, and need for assistance with personal care.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated _____, revealed in Section C- _____ Patterns, a _____ ( _____ ) score of 14, indicating the resident was _____.</p> <p>A review of the Order Summary Report, dated /22025- _____, revealed the following:</p> <ul style="list-style-type: none"> <li>-Aloe Vera external gel apply to affected areas _____ every shift for sunburn for 7 days, initiated _____</li> <li>- _____ oral capsule ( _____ ) give 25 mg (milligrams) by every 8 hours as needed for possible _____ reaction to skin, initiated _____</li> <li>-Consult _____ care for _____ on top of _____ thighs, and left _____, initiated _____</li> <li>-Transfer out to hospital for evaluation, initiated _____</li> <li>- _____ oral tablet give 40 mg by _____ one time a day for empiric for 5 days, initiated _____</li> </ul> <p>A review of the Care Plan Report, initiated on _____, revealed the following:</p> <p>1-Focus area: Resident #1 is dependent on staff and family for meeting emotional, physical, and social needs related to physical limitations. (initiated _____; revised _____)</p>	F 689	<p>revised and implemented a new process for the courtyard that includes designated times in which the courtyards will be open and supervised pending inclement weather.</p> <p>The Executive Director and or designee will educate the facility staff on the courtyard process, courtyard hours, communication, supervision and sign out process for residents who enjoy outdoor activities.</p> <p>The Executive Director and or designee will complete 5 random audits per week on the facility courtyard process which will include communication and supervision. The results of the audits will be tracked, trended and reported to the monthly Quality Assurance and Performance Improvement meeting for a period of three months or until sustained compliance is achieved.</p>		

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F 689	<p>Continued From page 3</p> <p>Goal: The resident will maintain involvement in stimulation, social activities as desire through review date.</p> <p>Interventions included:</p> <ul style="list-style-type: none"> <li>-The resident needs assistance/escort to activity functions. Can propel self in wheelchair.</li> <li>-The resident preferred activities are ice cream time, eating in the main dining room, the outdoors, and visiting with family.</li> </ul> <p>2-Focus area: (initiated ; revised )</p> <p>Goal: The resident will have no complications related to through the review date.</p> <p>Interventions included:</p> <ul style="list-style-type: none"> <li>-Avoid exposure to extreme heat or</li> <li>-Observe and report PRN (as needed) any signs and symptoms of , sweating, tremor, increased rate, pallor, nervousness, , slurred speech, lack of coordination, staggering gait.</li> </ul> <p>A review of the Progress notes for Resident #1 revealed the following:</p> <ul style="list-style-type: none"> <li>- 16:38 Health Status Note</li> </ul> <p>Note Text: Patient [family member] notified of transfer to hospital.</p> <p>A review of the hospital Emergency Department (ED) Physician record from admission date for Resident #1 revealed the following:</p> <p>History of Present Illness:</p> <p>The patient presented to this ED for evaluation via from [Facility name].</p> <p>Caregivers at [Facility name] found the patient to be somnolent and minimally responsive after he was out sitting in the sun for a bit.</p> <p>They could not arouse him, so was called. No reported, no , no or</p> <p>On arrival here, the patient is awake and alert but</p>	F 689		

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F 689	<p>Continued From page 4</p> <p>poorly interactive, no droop, moving all 4 extremities.</p> <p>Medical Decision Making: The ER work up include ( ), routine labs, swab, CT imaging of the . All are found to be unremarkable, no acute findings.</p> <p>and Rhabdomyolysis have both been ruled out.</p> <p>Patient appears to be acting much better after receiving a liter of fluid.</p> <p>Impression and Plan: Altered mental state Heat exposure</p> <p>A review of the Progress notes for Resident #1 after the ED visit revealed the following</p> <ul style="list-style-type: none"> <li>- 06:47 Health Status Note</li> </ul> <p>Note Text: Resident brought from [local hospital] around 2130. [Family member] was with him at bedside. [Family member] brought in a bottle of Aloe Vera and . Aloe Vera orders are in system. New skin care integrity assessment initiated. 2 on top of and 2 on each upper thighs noted upon return. Redness to , and thighs.</p> <ul style="list-style-type: none"> <li>- 18:30 Health Status Note</li> </ul> <p>Note Text: (Patient) noted with a moderate amount of clear yellow drainage emitting from the top of the area. Area cleansed and covered.</p> <p>Spoke with NP (Nurse Practitioner) who gave orders for care to evaluate on Monday</p> <ul style="list-style-type: none"> <li>- 11:06 Health Status Note</li> </ul> <p>Note Text: Per orders from NP, stat (emergent) ( )/CMP (comprehensive profile), stat pharmacy delivery of 40 mg, and a hold on 's (patient's) cream that is applied have all been</p>	F 689		

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F 689	Continued From page 5 processed. order placed as well. - 15:52 Health Status Note Note Text: Upon further inspection by this RN (Registered Nurse) and weekend supervisor, appears to be decreasing. Wife present and agrees. NP notified of current - 08:55 Skin/ Note Late Entry: Note Text: seen by [ Care Consultant] ARNP [Advanced Registered Nurse Practitioner] today. alert & oriented to self, able to follow directions. noted with in BUE (upper extremities), thighs and top of . Other on top of has popped and dry out. No or open skin area. in R (right) side of jaw line and able to talk clearly, swallow his medication with water without difficulty. Primary ARNP in room at the same time to evaluate. MD (Medical Doctor) contacted at that time by ARNP. would not be followed by [ Care Consultant] group since, does not have any skin open area. Will continue to monitor. - 10:50 Provider Note Chief Complaint/History of Present Illness: Re-admit Patient found unresponsive and sent to ER (Emergency Room). CT (Computed , , ) imaging negative for acute findings ...Sent to facility. Patient then was reported to be outside and a couple days later reported that he had sporadic large fluid filled on , B/L ( ) arms, and B/L areas all where sun had been exposed. has opened, and care will follow for this. He is unsure how long he was outside for. Agree with care's diagnosis of sun exposure vs (versus) drug bulous pemphigoid (a skin primarily affecting older adults). He does have increased	F 689			

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F 689	Continued From page 6 <p>_____ on the right side that has worsened since starting _____ 40 mg po (by _____) QD (daily). Concern for airway protection and recommend to send to ER for ( _____ ) and eval ...</p> <p>- 16:53 Provider Note Chief Complaint/History of Present Illness: ...MD evaluated the patient today with POA (Power of Attorney) present. Concern was held regarding the patient's breathing and _____ around his _____ predominantly on the right side of his _____ were present on his arms and thighs. Per report and per MD revise of facility documentation, patient was outside the day before with normal daily activities for the patient. He was subsequently reported altered outside and was subsequently brought inside for evaluation. Patient typically spends significant time with his spouse in and out of the facility. MD recommended _____ (Emergency Medical Services) to be called and patient was transported to the hospital in stable condition. Plan: MD reviewed imaging and facility records extensively and conferred with additional board-certified physicians internal medicine physicians including a board-certified dermatologist. Per exam patient has darkened pigment on his anterior _____ as well as thighs. Dermatologist advised after serial imaging review that patient likely has a history of long-term photosensitivity reactions indicative of someone with _____ sun exposure. Facility documentation was reviewed by MD the patient was outside for less than an hour and became _____ ...Patient was sent to the ED for a higher level of care for airway protection ....</p> <p>- 16:53 Event Note Late Entry Note text: At approximately 3:46 p.m. this nurse</p>	F 689		

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F 689	<p>Continued From page 7</p> <p>was notified by other staff members that patient needed assistance, this nurse quickly went with staff members to assess resident. This nurse assessed resident, resident was noted to be responsive, awake and slowly responding. Other nurse helped to assess resident. Resident noted not to appear at baseline medical provider notified gave order to send out via . 911 called per order and resident sent out to hospital. Spouse notified of change in condition and hospital transfer ...</p> <p>- 1802 Transfer to Hospital Note Text: Alert and oriented X2, resting in bed ...MD was in to see . . regarding fluid filled , redness of skin and _ in right . 2:30 p.m. orders to sent to ER for evaluation, 911 was called and patient was transferred to hospital via stretcher with paramedics ....</p> <p>A review of the hospital Emergency Department (ED) Physician record from admission date . . . for Resident #1 revealed the following: History of Present Illness: Patient is an . . . male who 2 days ago was left out in the sun accidentally by the staff at [Facility name] patient was evaluated at our facility at that time he had some sunburn on both upper thighs and his arms. The redness is turned to on both upper thighs and on his arms. Patient also states he was sent here for evaluation of there was a lab order form from [Facility name]. Patient appears in no obvious distress at this time. Patient denies any . . . Impression and Plan: - (condition in which the white cell count is above normal and is frequently a sign of an . . . ).</p>	F 689		

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F 689	<p>Continued From page 8</p> <p>- . . . (condition that arises when the body's response to . . . causes injury to its own tissues and . . . ).</p> <p>An interview was conducted on . . . at 11:21 a.m. with Staff A, Registered Nurse (RN). Staff A, RN stated she was the primary nurse for Resident #1 on . . . She stated Resident #1's family member came to the facility around 9 to 10 a.m. and spent most of the day with the resident. She said the last time she had seen the resident was before lunch to record his . . . She stated it was around 11:00 a.m. She said the nursing assistant (Staff B, Certified Nursing Assistant, CNA) toileted the resident in the morning and took the resident to activities with the family member. She stated she did not know when the resident went outside or how long he had been outside. She said the family member left the facility around 1:45 to 2:00 p.m. Staff A, RN stated she was walking in the hallway, and she heard staff saying they needed assistance in the patio area around three something in the afternoon. She said she ran to the outside patio and saw Resident #1 in the ice cream parlor, sitting in the wheelchair. She said the resident's . . . were open and she checked for a . . . She said the resident had a . . . and she starting calling his name and doing a rub on his . . . but he was not able to state his name. She said he was just "moaning." She stated Resident #1 appeared tired and . . . Staff A, RN stated one of the other nurses (Staff C, Licensed Practical Nurse, LPN) came to help and took over the care for Resident #1 while she went to go get the paperwork to send Resident #1 to the hospital. She could not recall exactly what the resident was wearing at the time. She stated she did not put a progress note into the record at the</p>	F 689		

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F 689	<p>Continued From page 9</p> <p>time of the incident because she thought the other nurse was going to do it. She stated she put a note in the record a few days later when she found out no note was written. She stated the activities staff are supposed to check on the residents and give them water if they are outside. She stated the CNA's are supposed to go and check on their resident's if the resident is outside. She stated is a resident is alert and oriented, they can go outside.</p> <p>An interview was conducted on _____ at 11:56 a.m. with Staff C, LPN. Staff C, LPN stated Staff D, Physical _____ ( ) was walking near the court yard and found Resident #1 unresponsive. She stated around 3:30-3:45 p.m. a staff member was screaming her name to come and help a resident. She said when she arrived she noticed it was Resident #1. She stated Staff D, _____ was bringing the resident inside as she arrived in the ice cream parlor. Staff C, LPN stated they moved the resident to the private dining area, and he was "very warm" to the touch. She said they brought the resident to the ground and laid him on the floor. She stated they checked his _____, and it was okay, so she started putting wet cool rags on his _____ and _____ area. She said she instructed other staff members to call 911 and get paperwork ready for transfer. Staff C stated Resident #1 was responding by opening his _____ and opening his _____, but he was not able to speak. She stated it was warm outside that day, but it was not extremely hot. She stated the resident had on a pair of black basketball shorts, and a gray shirt with sneakers and no hat. She stated he had no obvious skin injuries or _____ injury at the time.</p> <p>An interview was conducted on _____ at _____</p>	F 689		

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F 689	<p>Continued From page 10</p> <p>12:07 p.m., with Staff D, . Staff D, stated she was finishing up her day and had clocked out around 3:40 p.m. She stated she went out to the courtyard to speak with another resident, and she saw Resident #1 sitting in the court yard. She stated she knew Resident #1 well and she went over to say hello. She said he appeared to be resting, and she tried to wake him up, but he was not responding. She said Resident #1 did not appear to be his usual self. She said she went inside the ice cream parlor and asked someone to call for help with a medical emergency. She said she went and brought Resident #1 inside in his wheelchair. She said the nursing staff took over providing care for the resident. She stated she had not seen him throughout the day on . She stated she did not know how long Resident #1 had been outside and she did not see any other staff members outside in the courtyard at the time.</p> <p>An interview was conducted on at 12:15 p.m. with Staff E, Activities Assistant (AA). Staff E, AA stated he saw Resident #1 at 2:15 p.m. and instructed the resident that he could not go outside at the time because the landscapers were working in the courtyard. He stated he brought Resident #1 to activities in the dining room and gave him some ice cream at 2:30 p.m. He stated that was the last time he saw Resident #1. He stated he had seen Resident #1 earlier in the day with his family member in the hallway. He stated he offers water or juice and sunscreen to residents who are outside. He stated there was some areas of shade in the courtyard and Resident #1 can move around freely in his wheelchair.</p> <p>An interview was conducted on at</p>	F 689		

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F 689	Continued From page 11 12:27 p.m. with the Director of Nursing (DON). The DON said there is a button for residents to use to go outside and enter the courtyard. She stated staff are responsible to do rounds and check on residents. She stated the CNA's check on residents, but they would not document in the record. She stated the CNA's are required to do two hour checks on the residents depending on their needs. She stated some residents may need more supervision. She stated Staff E, AA was the last one to see Resident #1 around 2:30-2:45 p.m. when the resident went outside to eat his ice cream. She said based on the investigation Resident #1 was outside from 2:45 p.m.-3:45 p.m. The DON stated at 3:45 p.m. Resident #1, "appeared he was sleeping in the court yard and the physical , stated he was not responsive." She said on Monday she spoke with Resident #1, and he was slow to respond and that is his baseline. She said, "He is low speaking." She said the resident told her he just " asleep out there." She said when Resident #1 came . . . to the facility they found a on the top of his , and his arm. She said the next day the resident had some on the right side of his , and some weeping from his . The DON said the resident was responding to the treatments ordered and all the lab results appeared in normal limits. She said the doctors were trying to rule out an or some type of reaction. She stated Resident #1 has always gone outside and has never had any type of problem related to heat or sun before. She stated Resident #1 is still hospitalized and doctors are still trying to figure out what is going on. She stated the activities staff were responsible for checking in on the residents outside and providing hydration and sunscreen.	F 689			

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F 689	Continued From page 12  An interview was conducted on _____ at 1:12 p.m. with the Activities Director (AD). The AD stated they are responsible for checking on residents who are outside and offering them water and sunscreen. She stated they are responsible to document resident participation in activities on a participation log. She stated Resident #1 was more independent and able to move around in his wheelchair. She stated he did not participate in all activities, and he would go outside a few times a day. She stated Resident #1 would come and get ice cream in the afternoon and take it outside in the courtyard to eat it. She said this was Resident #1's normal routine.  An interview was conducted on _____ at 2:23 p.m. with the Nursing Home Administrator (NHA) and the DON. The NHA stated the facility started an investigation into the incident with Resident #1 right away. The NHA stated based on their investigation they believe Resident #1 was outside for a little less than an hour when he was found. The NHA stated there had been no previous concerns with the resident related to being outside. He stated they are still working with the doctor to investigate this incident. He stated they started an Adhoc QAPI plan (Quality Assurance and Performance Improvement Plan).  An interview was conducted on _____ at 2:47 p.m. with the Primary Care Provider (PCP). The PCP stated he was very familiar with Resident #1. The PCP stated he came in to see the resident the day after the incident. He stated he consulted a Dermatologist to discuss the case. He stated Resident #1 has a history of sun exposure and likes to be outside. He stated the	F 689		

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F 689	<p>Continued From page 13</p> <p>Dermatologist believed this may be an reaction to the sun exposure or a drug illness. He stated they are providing treatment at the hospital and Resident #1's body reacted to something but there is no absolute cause at this time. He stated he did not believe the reaction was related to a sunburn, but the sun might have been the catalyst for the reaction. He stated they are still working on a definite diagnosis.</p> <p>An interview was conducted on at 3:15 p.m. with Staff B, CNA. Staff B stated she did not work with Resident #1 very often. Staff B stated she came in at 7:00 a.m. and worked a double that day. She stated she saw Resident #1 at 7:30 a.m. after breakfast. She stated she assisted the resident to the bathroom and took him to activities. She stated a family member came to see Resident #1 and she saw them walking around and then they went to lunch. She said she checked on him around 2:30 p.m. and he was in the activity room eating ice cream. She said that was the last time she saw him before the incident. Staff B stated she was there when Resident #1 returned from the hospital. She said he came from hospital around 9:00 p.m. She said she helped get him to his room. She stated his skin had "boils."</p> <p>A telephone interview was conducted on at 3:35 p.m. with Resident #1's POA. The POA stated Resident #1 was still in the hospital and was "not doing well." The POA stated the hospital was going to transfer the resident to another facility where they had a unit. She stated the doctors still do not know what exactly happened, but it was started by the sun exposure for some reason. The POA stated the</p>	F 689			

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F 689	<p>Continued From page 14</p> <p>have gone down some but now they think he may have a staph on his . She stated she arrived at the facility on around 11:30 a.m. and stayed until around 1:30 p.m. She stated she did not take the resident outside during her visit and when she left Resident #1 was doing fine. The POA stated she received a call around 4:30 p.m. stating the resident was being sent to the hospital. She said Resident #1 was dressed in shorts and a shirt. She stated Resident #1 was being seen by several , and care. She stated the resident likes to be outside, but he does have some , and he does not always know when to drink water or to get out of the sun. The POA stated she has never had the resident out in the sun for an hour, and she always gets him inside after about 20 minutes. She said 20 minutes is as long as she can stand in the heat. The POA stated the resident, "Can present better than he is, but he really does not have a concept of how long he was outside or if he needs to drink."</p> <p>A review of the facility's policy titled Inclement Weather Restrictions, Issued ; Revised , revealed the following:</p> <p>Policy: Most facilities have courtyards, porches, or secured patios that are available for resident use and for outdoor facility activities and events. These are subject to inclement weather restrictions.</p> <p>Procedure: 1. Courtyards, secured patios, and porches are available for use for residents except during inclement weather conditions. Guidelines to consider: a. Temperature &lt; 32 degrees or &gt;90 degrees</p>	F 689		

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F 689	<p>Continued From page 15</p> <p>b. Heat index &gt; 100 degrees c. Excessive wind chill d. Excessive humidity e. Precipitation f. Severe weather watches or warnings</p> <p>2. Resident should be dressed appropriately for weather conditions if outside.</p> <p>3. Each facility should provide for periodic monitoring of residents in courtyards, secured patios, or porches to provide hydration in warmer weather.</p> <p>4. Resident with moderate to severe _____ should be attended by staff or visitor when outside.</p> <p>Facility immediate actions to remove the Immediate Jeopardy included: F 689 Removal Plan On _____ - Courtyards were rounded on hourly, all who chose to go outside offered hydration, sunscreen and encouraged to wear sunblock. On _____ - Courtyard re-opened with 30 minutes checks between 10am and 4pm. Conducted by the Activities Director, Executive Director and/or designee. On _____ - 100% of staff provided education as to inclement weather policy and facility procedures for facility courtyards. Current facility practice of communication ensures nursing is made aware of residents leaving unit to participate in an outdoor activity On _____ - Ad Hoc QAPI completed with Medical Director involvement to review immediate interventions, training completed. PIP and future Ad Hoc Quality Assurance Performance Improvement (QAPI) meetings. Facility Performance Improvement Plan (PIP) included nursing and activity review of residents who have a preference to participate in outdoor activities,</p>	F 689			

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F 689	<p>Continued From page 16</p> <p>care plans updated as appropriate. The committee agreed that compliance had been achieved.</p> <p>On - Courtyard closed for renovations On - At the recommendation of the Ad Hoc QAPI committee, education regarding upcoming courtyard process change, sign in and sign-out process for front desk. On - Education regarding new courtyard process sent to residents/families, front desk/receptionist staff. On - Met informally with resident council president (informally at her request) to discuss courtyard process. She agreed. On - Courtyard re-opened with 3 distinct opportunities to utilize with 100% supervision. Hours are 10am-10:30am, 2:30-3:00pm, and 4pm- 4:30 pm. All dependent upon our inclement weather policy.</p> <p>Verification of the facility's removal plan was conducted by the survey team on</p> <p>-Interviews were conducted with twenty-five staff members, including licensed nurses, certified nursing assistants, and activity staff who worked various shifts. The staff members were able to state that they had been trained and were knowledgeable about the new policies and procedures initiated by the facility. A tour of the courtyard area verified the implementation of resident checks that are documented on a log every 30 minutes during peak hours of sun exposure between 10 a.m. and 4 p.m. A review of in-service documentation revealed 100% of staff had acknowledged education and training related to the weather policy and the new process for courtyard usage by residents.</p> <p>Based on verification of the facility's immediate</p>	F 689		

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F 689	Continued From page 17 Jeopardy removal plan the immediate jeopardy was determined to be removed on and the non-compliance was reduced to a scope and severity of D.	F 689			

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N 000	<p><b>INITIAL COMMENTS</b></p> <p>A complaint survey for complaint number 2025006220, was conducted on _____ and _____ at Life Care Center of Sarasota. Deficiencies were identified at the time of the survey.</p> <p>A Class I deficiency was identified at N201 related to complaint number 2025006220.</p> <p>Class I deficiencies are those which the agency determines present an imminent danger to the residents or guests of the facility or a substantial probability that _____ or serious physical harm would result therefrom.</p> <p>The facility resident census at the beginning of the survey was 110.</p> <p>The Class I started on _____.</p> <p>The facility administration was informed of the Class I deficiency on _____ at 9:25 a.m.</p>	N 000		
N 201 SS=J	<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 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 observations, interviews, and record review, the facility failed to provide adequate</p>	N 201	This plan of correction is submitted as required under Federal and State	

AHCA Form 3020-0001 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X8) DATE  /25
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N 201	<p>Continued From page 1</p> <p>supervision to prevent one resident (#1) from exposure to the sun/heat, resulting in an _____ and skin damage to the _____, arms, and _____ out of three residents sampled for outdoor activities.</p> <p>On _____ Resident #1 was seated in a wheelchair in the courtyard area of the facility for approximately one hour from 2:45 p.m. to 3:45 p.m., during the hottest part of the day. Resident #1 was discovered to be unresponsive and had to be transferred to a higher level of care for treatment from sun/heat exposure.</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility in _____ with diagnoses including: _____ ( _____ ), Type 2 _____ with _____ and _____, difficulty walking, _____ communication _____, and need for assistance with personal care.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated _____, revealed in Section C- _____ Patterns, a _____ ( _____ ) score of 14, indicating the resident was _____.</p> <p>A review of the Order Summary Report, dated _____ /2025-_____, revealed the following: -Aloe Vera external gel apply to affected areas _____ every shift for sunburn for 7 days, initiated _____ oral capsule ( _____ ) give 25 mg (milligrams) by _____ every 8 hours as needed for possible _____.</p>	N 201	<p>regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope of severity regarding any of these deficiencies cited are correctly applied. In order to ensure that the services provided at Life Care Center of Sarasota meet the professional standards of quality, the team has initiated the following plan or correction:</p> <p>Resident #1 was discharged from the facility.</p> <p>Residents who enjoy outdoor activities have the potential to be affected by not providing adequate supervision to prevent exposure to the sun/heat. The facility revised and implemented a new process for the courtyard that includes designated times in which the courtyards will be open and supervised pending inclement weather.</p> <p>The Executive Director and or designee will educate the facility staff on the courtyard process, courtyard hours, communication, supervision and sign out process for residents who enjoy outdoor activities.</p> <p>The Executive Director and or designee will complete 5 random audits per week</p>	
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N 201	<p>Continued From page 2</p> <p>reaction to skin, initiated -Consult care for on top of thighs, and left , initiated -Transfer out to hospital for evaluation, initiated  - oral tablet give 40 mg by one time a day for empiric for 5 days, initiated</p> <p>A review of the Care Plan Report, initiated on , revealed the following: 1-Focus area: Resident #1 is dependent on staff and family for meeting emotional, physical, and social needs related to physical limitations. (initiated ; revised ) Goal: The resident will maintain involvement in stimulation, social activities as desire through review date. Interventions included: -The resident needs assistance/escort to activity functions. Can propel self in wheelchair. -The resident preferred activities are ice cream time, eating in the main dining room, the outdoors, and visiting with family. 2-Focus area: (initiated ; revised ) Goal: The resident will have no complications related to through the review date. Interventions included: -Avoid exposure to extreme heat or -Observe and report PRN (as needed) any signs and symptoms of , sweating, tremor, increased rate, pallor, nervousness, , slurred speech, lack of coordination, staggering gait.</p> <p>A review of the Progress notes for Resident #1 revealed the following: - 16:38 Health Status Note Note Text: Patient [family member] notified of transfer to hospital.</p>	N 201	<p>on the facility courtyard process which will include communication and supervision. The results of the audits will be tracked, trended and reported to the monthly Quality Assurance and Performance Improvement meeting for a period of three months or until sustained compliance is achieved.</p>	
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N 201	<p>Continued From page 3</p> <p>A review of the hospital Emergency Department (ED) Physician record from admission date for Resident #1 revealed the following: History of Present Illness: The patient presented to this ER for evaluation via from [Facility name]. Caregivers at [Facility name] found the patient to be somnolent and minimally responsive after he was out sitting on the sun for a bit. They could not arouse him, so was called. No reported, no , no or On arrival here, the patient is awake and alert but poorly interactive, no droop, moving all 4 extremities. Medical Decision Making: The ER work up include ( , ), , routine labs, , , swab, CT imaging of the . All are found to be unremarkable, no acute findings.  and Rhabdomyolysis have both been ruled out. Patient appears to be acting much better after receiving a liter of fluid. Impression and Plan: Altered mental state Heat exposure</p> <p>A review of the Progress notes for Resident #1 after the ED visit revealed the following - 06:47 Health Status Note Note Text: Resident brought from [local hospital] around 2130. [Family member] was with him at bedside. [Family member] brought in a bottle of Aloe Vera and . Aloe Vera orders are in system. New skin care integrity assessment initiated. 2 on top of , and 2 on each upper thighs noted upon return. Redness to , , and thighs.</p>	N 201		
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Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>35960957</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF SARASOTA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8104 TUTTLE AVE SARASOTA, FL 34243</b>
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N 201	<p>Continued From page 4</p> <p>- 18:30 Health Status Note Note Text: (Patient) noted with a moderate amount of clear yellow drainage emitting from the top of the area. Area cleansed and covered. Spoke with NP (Nurse Practitioner) who gave orders for care to evaluate on Monday</p> <p>- 11:06 Health Status Note Note Text: Per orders from NP, stat (emergent) ( )/CMP (comprehensive profile), stat pharmacy delivery of 40 mg, and a hold on (patient's) cream that is applied have all been processed. order placed as well.</p> <p>- 15:52 Health Status Note Note Text: Upon further inspection by this RN (Registered Nurse) and weekend supervisor, appears to be decreasing. Wife present and agrees. NP notified of current</p> <p>- 08:55 Skin/ Note Late Entry: Note Text: seen by [ Care Consultant] ARNP [Advanced Registered Nurse Practitioner] today. alert &amp; oriented to self, able to follow directions. noted with in BUE ( upper extremities), thighs and top of . Other on top of has popped and dry out. No or open skin area. in R (right) side of jaw line and able to talk clearly, swallow his medication with water without difficulty. Primary ARNP in room at the same time to evaluate, MD (Medical Doctor) contacted at that time by ARNP. would not be followed by [ Care Consultant] group since, does not have any skin open area. Will continue to monitor.</p> <p>- 10:50 Provider Note Chief Complaint/History of Present Illness: Re-admit Patient found unresponsive and sent to ER (Emergency Room). CT (Computed ) imaging negative for acute findings ...Sent</p>	N 201		
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N 201	Continued From page 5  to facility. Patient then was reported to be outside and a couple days later reported that he had sporadic large fluid filled on B/L ( ) arms, and B/L areas all where sun had been exposed. has opened, and care will follow for this. He is unsure how long he was outside for. Agree with care's diagnosis of sun exposure vs (versus) drug bullous pemphigoid (a skin primarily affecting older adults). He does have increased on the right side that has worsened since starting 40 mg po (by ) QD (daily). Concern for airway protection and recommend to send to ER for ( ) and eval ...  - 16:53 Provider Note Chief Complaint/History of Present Illness: ...MD evaluated the patient today with POA (Power of Attorney) present. Concern was held regarding the patient's breathing and around his predominantly on the right side of his were present on his arms and thighs. Per report and per MD revise of facility documentation, patient was outside the day before with normal daily activities for the patient. He was subsequently reported altered outside and was subsequently brought inside for evaluation. Patient typically spends significant time with his spouse in and out of the facility. MD recommended (Emergency Medical Services) to be called and patient was transported to the hospital in stable condition. Plan: MD reviewed imaging and facility records extensively and conferred with additional board-certified physicians internal medicine physicians including a board-certified dermatologist. Per exam patient has darkened pigment on his anterior as well as	N 201		

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N 201	<p>Continued From page 6</p> <p>thighs. Dermatologist advised after serial imaging review that patient likely has a history of long-term photosensitivity reactions indicative of someone with sun exposure. Facility documentation was reviewed by MD the patient was outside for less than an hour and became ....Patient was sent to the ED for a higher level of care for airway protection ....</p> <p>- 16:53 Event Note Late Entry Note text: At approximately 3:46 p.m. this nurse was notified by other staff members that patient needed assistance, this nurse quickly went with staff members to assess resident. This nurse assessed resident, resident was noted to be responsive, awake and slowly responding. Other nurse helped to assess resident. Resident noted not to appear at baseline medical provider notified gave order to send out via 911 called per order and resident sent out to hospital. Spouse notified of change in condition and hospital transfer ...</p> <p>- 1802 Transfer to Hospital Note Text: Alert and oriented X2, resting in bed ...MD was in to see , regarding fluid filled , redness of skin and in right . 2:30 p.m. orders to sent to ER for evaluation, 911 was called and patient was transferred to hospital via stretcher with paramedics ....</p> <p>A review of the hospital Emergency Department (ED) Physician record from admission date for Resident #1 revealed the following: History of Present Illness: Patient is an , male who 2 days ago was left out in the sun accidentally by the staff at [Facility name] patient was evaluated at our facility at that time he had some sunburn on both upper thighs and his arms. The redness is turned to on both upper thighs and on his arms.</p>	N 201		

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N 201	<p>Continued From page 7</p> <p>Patient also states he was sent here for evaluation of                    there was a lab order form from [Facility name]. Patient appears in no obvious distress at this time. Patient denies any                    Impression and Plan:</p> <ul style="list-style-type: none"> <li>-                    (condition in which the white cell count is above normal and is frequently a sign of an                    ).</li> <li>-                    (condition that arises when the body's response to                    causes injury to its own tissues and                    ).</li> </ul> <p>An interview was conducted on                    at 11:21 a.m. with Staff A, Registered Nurse (RN). Staff A, RN stated she was the primary nurse for Resident #1 on                    . She stated Resident #1's family member came to the facility around 9 to 10 a.m. and spent most of the day with the resident. She said the last time she had seen the resident was before lunch to record his                    . She stated it was around 11:00 a.m. She said the nursing assistant (Staff B, Certified Nursing Assistant, CNA) toileted the resident in the morning and took the resident to activities with the family member. She stated she did not know when the resident went outside or how long he had been outside. She said the family member left the facility around 1:45 to 2:00 p.m. Staff A, RN stated she was walking in the hallway, and she heard staff saying they needed assistance in the patio area around three something in the afternoon. She said she ran to the outside patio and saw Resident #1 in the ice cream parlor, sitting in the wheelchair. She said the resident's                    were open and she checked for a                    . She said the resident had a                    and she starting calling his name and doing a rub on his                    , but he was not able to state his name. She said he was just "moaning." She stated</p>	N 201		
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N 201	<p>Continued From page 8</p> <p>Resident #1 appeared tired and _____, Staff A, RN stated one of the other nurses (Staff C, Licensed Practical Nurse, LPN) came to help and took over the care for Resident #1 while she went to go get the paperwork to send Resident #1 to the hospital. She could not recall exactly what the resident was wearing at the time. She stated she did not put a progress note into the record at the time of the incident because she thought the other nurse was going to do it. She stated she put a note in the record a few days later when she found out no note was written. She stated the activities staff are supposed to check on the residents and give them water if they are outside. She stated the CNA's are supposed to go and check on their resident's if the resident is outside. She stated is a resident is alert and oriented, they can go outside.</p> <p>An interview was conducted on _____ at 11:56 a.m. with Staff C, LPN. Staff C, LPN stated Staff D, Physical _____ ( ) was walking near the court yard and found Resident #1 unresponsive. She stated around 3:30-3:45 p.m. a staff member was screaming her name to come and help a resident. She said when she arrived she noticed it was Resident #1. She stated Staff D, _____ was bringing the resident inside as she arrived in the ice cream parlor. Staff C, LPN stated they moved the resident to the private dining area, and he was "very warm" to the touch. She said they brought the resident to the ground and laid him on the floor. She stated they checked his _____, and it was okay, so she started putting wet cool rags on his _____ and _____ area. She said she instructed other staff members to call 911 and get paperwork ready for transfer. Staff C stated Resident #1 was responding by opening his _____ and opening his _____, but he was not able to speak. She stated</p>	N 201		

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N 201	<p>Continued From page 9</p> <p>it was warm outside that day, but it was not extremely hot. She stated the resident had on a pair of black basketball shorts, and a gray shirt with sneakers and no hat. She stated he had no obvious skin injuries or injury at the time.</p> <p>An interview was conducted on . . . at 12:07 p.m., with Staff D. . . Staff D. stated she was finishing up her day and had clocked out around 3:40 p.m. She stated she went out to the courtyard to speak with another resident, and she saw a Resident #1 sitting in the court yard. She stated she knew Resident #1 well and she went over to say hello. She said he appeared to be resting, and she tried to wake him up, but he was not responding. She said Resident #1 did not appear to be his usual self. She said she went inside the ice cream parlor and asked someone to call for help with a medical emergency. She said she went and brought Resident #1 inside in his wheelchair. She said the nursing staff took over providing care for the resident. She stated she had not seen him throughout the day on . . . She stated she did not know how long Resident #1 had been outside and she did not see any other staff members outside in the courtyard at the time.</p> <p>An interview was conducted on . . . at 12:15 p.m. with Staff E, Activities Assistant (AA). Staff E, AA stated he saw Resident #1 at 2:15 p.m. and instructed the resident that he could not go outside at the time because the landscapers were working in the courtyard. He stated he brought Resident #1 to activities in the dining room and gave him some ice cream at 2:30 p.m. He stated that was the last time he saw Resident #1. He stated he had seen Resident #1 earlier in the day with his family member in the hallway. He stated he offers water or juice and sunscreen to</p>	N 201		
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N 201	<p>Continued From page 10</p> <p>residents who are outside. He stated there was some areas of shade in the courtyard and Resident #1 can move around freely in his wheelchair.</p> <p>An interview was conducted on _____ at 12:27 p.m. with the Director of Nursing (DON). The DON said there is a button for residents to use to go outside and enter the courtyard. She stated staff are responsible to do rounds and check on residents. She stated the CNA's check on residents, but they would not document in the record. She stated the CNA's are required to do two hour checks on the residents depending on their needs. She stated some residents may need more supervision. She stated Staff E, AA was the last one to see Resident #1 around 2:30-2:45 p.m. when the resident went outside to eat his ice cream. She said based on the investigation Resident #1 was outside from 2:45 p.m.-3:45 p.m. The DON stated at 3:45 p.m. Resident #1, "appeared he was sleeping in the court yard and the physical _____ stated he was not responsive." She said on Monday she spoke with Resident #1, and he was slow to respond and that is his baseline. She said, "He is low speaking." She said the resident told her he just " _____ asleep out there." She said when Resident #1 came _____ to the facility they found a _____ on the top of his _____, and his arm. She said the next day the resident had some _____ on the right side of his _____, and some weeping from his _____. The DON said the resident was responding to the treatments ordered and all the lab results appeared in normal limits. She said the doctors were trying to rule out an _____ or some type of reaction. She stated Resident #1 has always gone outside and has never had any type of problem related to heat or sun before. She stated Resident #1 is still</p>	N 201			

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N 201	<p>Continued From page 11</p> <p>hospitalized and doctors are still trying to figure out what is going on. She stated the activities staff were responsible for checking in on the residents outside and providing hydration and sunscreen.</p> <p>An interview was conducted on _____ at 1:12 p.m. with the Activities Director (AD). The AD stated they are responsible for checking on residents who are outside and offering them water and sunscreen. She stated they are responsible to document resident participation in activities on a participation log. She stated Resident #1 was more independent and able to move around in his wheelchair. She stated he did not participate in all activities, and he would go outside a few times a day. She stated Resident #1 would come and get ice cream in the afternoon and take it outside in the courtyard to eat it. She said this was Resident #1's normal routine.</p> <p>An interview was conducted on _____ at 2:23 p.m. with the Nursing Home Administrator (NHA) and the DON. The NHA stated the facility started an investigation into the incident with Resident #1 right away. The NHA stated based on their investigation they believe Resident #1 was outside for a little less than an hour when he was found. The NHA stated there had been no previous concerns with the resident related to being outside. He stated they are still working with the doctor to investigate this incident. He stated they started an Adhoc QAPI plan (Quality Assurance and Performance Improvement Plan).</p> <p>An interview was conducted on _____ at 2:47 p.m. with the Primary Care Provider (PCP). The PCP stated he was very familiar with Resident #1. The PCP stated he came in to see the resident</p>	N 201		
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N 201	<p>Continued From page 12</p> <p>the day after the incident. He stated he consulted a Dermatologist to discuss the case. He stated Resident #1 has a history of sun exposure and likes to be outside. He stated the Dermatologist believed this may be an reaction to the sun exposure or a drug illness. He stated they are providing treatment at the hospital and Resident #1's body reacted to something but there is no absolute cause at this time. He stated he did not believe the reaction was related to a sunburn, but the sun might have been the catalyst for the reaction. He stated they are still working on a definite diagnosis.</p> <p>An interview was conducted on at 3:15 p.m. with Staff B, CNA. Staff B stated she did not work with Resident #1 very often. Staff B stated she came in at 7:00 a.m. and worked a double that day. She stated she saw Resident #1 at 7:30 a.m. after breakfast. She stated she assisted the resident to the bathroom and took him to activities. She stated a family member came to see Resident #1 and she saw them walking around and then they went to lunch. She said she checked on him around 2:30 p.m. and he was in the activity room eating ice cream. She said that was the last time she saw him before the incident. Staff B stated she was there when Resident #1 returned from the hospital. She said he came from hospital around 9:00 p.m. She said she helped get him to his room. She stated his skin had "boils."</p> <p>A telephone interview was conducted on at 3:35 p.m. with Resident #1's POA. The POA stated Resident #1 was still in the hospital and was "not doing well." The POA stated the hospital was going to transfer the resident to another facility where they had a</p>	N 201		

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N 201	<p>Continued From page 13</p> <p>unit. She stated the doctors still do not know what exactly happened, but it was started by the sun exposure for some reason. The POA stated the have gone down some but now they think he may have a staph on his . She stated she arrived at the facility on around 11:30 a.m. and stayed until around 1:30 p.m. She stated she did not take the resident outside during her visit and when she left Resident #1 was doing fine. The POA stated she received a call around 4:30 p.m. stating the resident was being sent to the hospital. She said Resident #1 was dressed in shorts and a shirt. She stated Resident #1 was being seen by several , and care. She stated the resident likes to be outside, but he does have some , and he does not always know when to drink water or to get out of the sun. The POA stated she has never had the resident out in the sun for an hour, and she always gets him inside after about 20 minutes. She said 20 minutes is as long as she can stand in the heat. The POA stated the resident, "Can present better than he is, but he really does not have a concept of how long he was outside or if he needs to drink."</p> <p>A review of the facility's policy titled Incontinent Weather Restrictions, Issued ; Revised , revealed the following:</p> <p>Policy: Most facilities have courtyards, porches, or secured patios that are available for resident use and for outdoor facility activities and events. These are subject to inclement weather restrictions.</p> <p>Procedure: 1. Courtyards, secured patios, and porches are available for use for residents except during inclement weather conditions. Guidelines to</p>	N 201		
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N 201	<p>Continued From page 14</p> <p>consider:</p> <ol style="list-style-type: none"> <li>a. Temperature &lt; 32 degrees or &gt;90 degrees</li> <li>b. Heat index &gt; 100 degrees</li> <li>c. Excessive wind chill</li> <li>d. Excessive humidity</li> <li>e. Precipitation</li> <li>f. Severe weather watches or warnings</li> </ol> <ol style="list-style-type: none"> <li>2. Resident should be dressed appropriately for weather conditions if outside.</li> <li>3. Each facility should provide for periodic monitoring of residents in courtyards, secured patios, or porches to provide hydration in warmer weather.</li> <li>4. Resident with moderate to severe _____ should be attended by staff or visitor when outside.</li> </ol> <p>Class I</p>	N 201		

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>106025</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/23/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF SARASOTA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8104 TUTTLE AVE</b> <b>SARASOTA, FL 34243</b>	
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F 000	INITIAL COMMENTS  AMENDED  A complaint survey for complaint number 2025006220, was conducted on _____ and continued after supervisory review on _____ at Life Care Center of Sarasota. The facility was not in compliance with Code for Federal Regulations (CFR), Part 483, Requirements for Long-Term Care Facilities.  Complaint number 2025006220 was identified at F689 Scope and Severity of "D".  The facility resident census at the beginning of the survey was 110.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and  §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to provide adequate supervision to prevent one resident (#1) from exposure to the sun/heat, resulting in an _____ and skin damage to the _____, arms, and _____, out of three residents sampled for outdoor activities.  On _____ Resident #1 was seated in a _____	F 689	This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the	

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 689	<p>Continued From page 1</p> <p>wheelchair in the courtyard area of the facility for approximately one hour from 2:45 p.m. to 3:45 p.m., during the hottest part of the day. Resident #1 was discovered to be unresponsive and had to be transferred to a higher level of care for treatment from sun/heat exposure.</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility in with diagnoses including;</p> <p>Type 2 with _____ and _____, difficulty walking, _____ communication _____, and need for assistance with personal care.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated _____, revealed in Section C- _____ Patterns, a _____ ( _____ ) score of 14, indicating the resident was _____.</p> <p>A review of the Order Summary Report, dated _____ /22025- _____, revealed the following:</p> <ul style="list-style-type: none"> <li>-Aloe Vera external gel apply to affected areas _____ every shift for sunburn for 7 days, initiated _____</li> <li>- _____ oral capsule ( _____ ) give 25 mg (milligrams) by every 8 hours as needed for possible _____ reaction to skin, initiated _____</li> <li>-Consult _____ care for _____ on top of _____ thighs, and left _____, initiated _____</li> <li>-Transfer out to hospital for evaluation, initiated _____</li> <li>- _____ oral tablet give 40 mg by _____ one _____</li> </ul>	F 689	<p>facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope of severity regarding any of these deficiencies cited are correctly applied. In order to ensure that the services provided at Life Care Center of Sarasota meet the professional standards of quality, the team had initiated the following plan of correction:</p> <p>Resident #1 was discharged from the facility.</p> <p>Residents who enjoy outdoor activities have the potential to be affected by not providing adequate supervision to prevent exposure to the sun/heat. The facility revised and implemented a new process for the courtyard that includes designated times in which the courtyards will be open and supervised pending inclement weather.</p> <p>The Executive Director and or designee will educate the facility staff on the courtyard process, courtyard hours, communication, supervision and sign out process for residents who enjoy outdoor activities.</p> <p>The Executive Director and or designee will complete 5 random audits per week on the facility courtyard process which will include communication and supervision. The results of the audits will be tracked, trended and reported to the monthly Quality Assurance and Performance Improvement meeting for a period of three _____</p>		

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F 689	<p>Continued From page 2</p> <p>time a day for empiric for 5 days, initiated</p> <p>A review of the Care Plan Report, initiated on _____, revealed the following:</p> <p>1-Focus area: Resident #1 is dependent on staff and family for meeting emotional, physical, and social needs related to physical limitations. (initiated _____; revised _____)</p> <p>Goal: The resident will maintain involvement in stimulation, social activities as desire through review date.</p> <p>Interventions included:</p> <ul style="list-style-type: none"> <li>-The resident needs assistance/escort to activity functions. Can propel self in wheelchair.</li> <li>-The resident preferred activities are ice cream time, eating in the main dining room, the outdoors, and visiting with family.</li> </ul> <p>2-Focus area: _____ (initiated _____; revised _____)</p> <p>Goal: The resident will have no complications related to _____ through the review date.</p> <p>Interventions included:</p> <ul style="list-style-type: none"> <li>-Avoid exposure to extreme heat or _____</li> <li>-Observe and report PRN (as needed) any signs and symptoms of _____, sweating, tremor, increased _____ rate, pallor, nervousness, _____, slurred speech, lack of coordination, staggering gait.</li> </ul> <p>A review of the Progress notes for Resident #1 revealed the following:</p> <ul style="list-style-type: none"> <li>- _____ 16:38 Health Status Note</li> </ul> <p>Note Text: Patient [family member] notified of transfer to hospital.</p> <p>A review of the hospital Emergency Department (ED) Physician record from admission date _____ for Resident #1 revealed the following:</p> <p>History of Present Illness:</p>	F 689	<p>months or until sustained compliance is achieved.</p>		

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F 689	<p>Continued From page 3</p> <p>The patient presented to this ED for evaluation via from [Facility name]. Caregivers at [Facility name] found the patient to be somnolent and minimally responsive after he was out sitting in the sun for a bit. They could not arouse him, so was called. No reported, no no or</p> <p>On arrival here, the patient is awake and alert but poorly interactive, no droop, moving all 4 extremities.</p> <p>Medical Decision Making: The ER work up include ( ), routine labs, swab, CT imaging of the</p> <p>All are found to be unremarkable, no acute findings.</p> <p>and Rhabdomyolysis have both been ruled out.</p> <p>Patient appears to be acting much better after receiving a liter of fluid.</p> <p>Impression and Plan: Altered mental state Heat exposure</p> <p>A review of the Progress notes for Resident #1 after the ED visit revealed the following</p> <p>- 06:47 Health Status Note Note Text: Resident brought from [local hospital] around 2130. [Family member] was with him at bedside. [Family member] brought in a bottle of Aloe Vera and . Aloe Vera orders are in system. New skin care integrity assessment initiated. 2 on top of and 2 on each upper thighs noted upon return. Redness to , and thighs.</p> <p>- 18:30 Health Status Note Note Text: (Patient) noted with a moderate amount of clear yellow drainage emitting from the top of the , area. Area cleansed and covered.</p>	F 689		

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F 689	<p>Continued From page 4</p> <p>Spoke with NP (Nurse Practitioner) who gave orders for care to evaluate on Monday - 11:06 Health Status Note</p> <p>Note Text: Per orders from NP, stat (emergent) ( )/CMP (comprehensive profile), stat pharmacy delivery of 40 mg, and a hold on 's (patient's) cream that is applied have all been processed. order placed as well.</p> <p>- 15:52 Health Status Note</p> <p>Note Text: Upon further inspection by this RN (Registered Nurse) and weekend supervisor, appears to be decreasing. Wife present and agrees. NP notified of current</p> <p>- 08:55 Skin/ Note Late Entry:</p> <p>Note Text: seen by [ Care Consultant] ARNP [Advanced Registered Nurse Practitioner] today. alert &amp; oriented to self, able to follow directions. noted with in BUE ( upper extremities), thighs and top of . Other on top of has popped and dry out. No or open skin area. in R (right) side of jaw line and able to talk clearly, swallow his medication with water without difficulty. Primary ARNP in room at the same time to evaluate. MD (Medical Doctor) contacted at that time by ARNP. would not be followed by [ Care Consultant] group since, does not have any skin open area. Will continue to monitor.</p> <p>- 10:50 Provider Note</p> <p>Chief Complaint/History of Present Illness: Re-admit</p> <p>Patient found unresponsive and sent to ER (Emergency Room). CT (Computed ) imaging negative for acute findings ...Sent to facility. Patient then was reported to be outside and a couple days later reported that he had sporadic large fluid filled on , B/L</p>	F 689		

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F 689	<p>Continued From page 5</p> <p>( ) arms, and B/L areas all where sun had been exposed. has opened, and care will follow for this. He is unsure how long he was outside for. Agree with care's diagnosis of sun exposure vs (versus) drug bullous pemphigoid (a skin primarily affecting older adults). He does have increased on the right side that has worsened since starting 40 mg po (by ) QD (daily). Concern for airway protection and recommend to send to ER for ( ) and eval ...</p> <p>- 16:53 Provider Note</p> <p>Chief Complaint/History of Present Illness: ...MD evaluated the patient today with POA (Power of Attorney) present. Concern was held regarding the patient's breathing and around his predominantly on the right side of his were present on his arms and thighs. Per report and per MD revise of facility documentation, patient was outside the day before with normal daily activities for the patient. He was subsequentially reported altered outside and was subsequently brought inside for evaluation. Patient typically spends significant time with his spouse in and out of the facility. MD recommended (Emergency Medical Services) to be called and patient was transported to the hospital in stable condition.</p> <p>Plan: MD reviewed imaging and facility records extensively and conferred with additional board-certified physicians internal medicine physicians including a board-certified dermatologist. Per exam patient has darkened pigment on his anterior as well as thighs. Dermatologist advised after serial imaging review that patient likely has a history of</p>	F 689			

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F 689	<p>Continued From page 6</p> <p>long-term photosensitivity reactions indicative of someone with sun exposure. Facility documentation was reviewed by MD the patient was outside for less than an hour and became ....Patient was sent to the ED for a higher level of care for airway protection .... - 16:53 Event Note Late Entry Note text: At approximately 3:46 p.m. this nurse was notified by other staff members that patient needed assistance, this nurse quickly went with staff members to assess resident. This nurse assessed resident, resident was noted to be responsive, awake and slowly responding. Other nurse helped to assess resident. Resident noted not to appear at baseline medical provider notified gave order to send out via 911 called per order and resident sent out to hospital. Spouse notified of change in condition and hospital transfer ... - 1802 Transfer to Hospital Note Text: Alert and oriented X2, resting in bed ...MD was in to see regarding fluid filled redness of skin and in right 2:30 p.m. orders to sent to ER for evaluation, 911 was called and patient was transferred to hospital via stretcher with paramedics ....</p> <p>A review of the hospital Emergency Department (ED) Physician record from admission date for Resident #1 revealed the following: History of Present Illness: Patient is an male who 2 days ago was left out in the sun accidentally by the staff at [Facility name] patient was evaluated at our facility at that time he had some sunburn on both upper thighs and his arms. The redness is turned to on both upper thighs and on his arms. Patient also states he was sent here for</p>	F 689		



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F 689	<p>Continued From page 8</p> <p>Resident #1 appeared tired and _____, Staff A, RN stated one of the other nurses (Staff C, Licensed Practical Nurse, LPN) came to help and took over the care for Resident #1 while she went to go get the paperwork to send Resident #1 to the hospital. She could not recall exactly what the resident was wearing at the time. She stated she did not put a progress note into the record at the time of the incident because she thought the other nurse was going to do it. She stated she put a note in the record a few days later when she found out no note was written. She stated the activities staff are supposed to check on the residents and give them water if they are outside. She stated the CNA's are supposed to go and check on their resident's if the resident is outside. She stated is a resident is alert and oriented, they can go outside.</p> <p>An interview was conducted on _____ at 11:56 a.m. with Staff C, LPN. Staff C, LPN stated Staff D, Physical _____ ( ) was walking near the court yard and found Resident #1 unresponsive. She stated around 3:30-3:45 p.m. a staff member was screaming her name to come and help a resident. She said when she arrived she noticed it was Resident #1. She stated Staff D, _____ was bringing the resident inside as she arrived in the ice cream parlor. Staff C, LPN stated they moved the resident to the private dining area, and he was "very warm" to the touch. She said they brought the resident to the ground and laid him on the floor. She stated they checked his _____, and it was okay, so she started putting wet cool rags on his _____ and _____ area. She said she instructed other staff members to call 911 and get paperwork ready for transfer. Staff C stated Resident #1 was responding by opening his _____ and opening his _____</p>	F 689			

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F 689	<p>Continued From page 9</p> <p>, but he was not able to speak. She stated it was warm outside that day, but it was not extremely hot. She stated the resident had on a pair of black basketball shorts, and a gray shirt with sneakers and no hat. She stated he had no obvious skin injuries or injury at the time.</p> <p>An interview was conducted on at 12:07 p.m., with Staff D, . Staff D, stated she was finishing up her day and had clocked out around 3.40 p.m. She stated she went out to the courtyard to speak with another resident, and she saw Resident #1 sitting in the court yard. She stated she knew Resident #1 well and she went over to say hello. She said he appeared to be resting, and she tried to wake him up, but he was not responding. She said Resident #1 did not appear to be his usual self. She said she went inside the ice cream parlor and asked someone to call for help with a medical emergency. She said she went and brought Resident #1 inside in his wheelchair. She said the nursing staff took over providing care for the resident. She stated she had not seen him throughout the day on . She stated she did not know how long Resident #1 had been outside and she did not see any other staff members outside in the courtyard at the time.</p> <p>An interview was conducted on at 12:15 p.m. with Staff E, Activities Assistant (AA). Staff E, AA stated he saw Resident #1 at 2:15 p.m. and instructed the resident that he could not go outside at the time because the landscapers were working in the courtyard. He stated he brought Resident #1 to activities in the dining room and gave him some ice cream at 2:30 p.m. He stated that was the last time he saw Resident #1. He stated he had seen Resident #1 earlier in</p>	F 689			

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F 689	Continued From page 10  the day with his family member in the hallway. He stated he offers water or juice and sunscreen to residents who are outside. He stated there was some areas of shade in the courtyard and Resident #1 can move around freely in his wheelchair.  An interview was conducted on _____ at 12:27 p.m. with the Director of Nursing (DON). The DON said there is a button for residents to use to go outside and enter the courtyard. She stated staff are responsible to do rounds and check on residents. She stated the CNA's check on residents, but they would not document in the record. She stated the CNA's are required to do two hour checks on the residents depending on their needs. She stated some residents may need more supervision. She stated Staff E, AA was the last one to see Resident #1 around 2:30-2:45 p.m. when the resident went outside to eat his ice cream. She said based on the investigation Resident #1 was outside from 2:45 p.m.-3:45 p.m. The DON stated at 3:45 p.m. Resident #1, "appeared he was sleeping in the court yard and the physical _____ stated he was not responsive." She said on Monday she spoke with Resident #1, and he was slow to respond and that is his baseline. She said, "He is low speaking." She said the resident told her he just " _____ asleep out there." She said when Resident #1 came _____ to the facility they found a _____ on the top of his _____, and his arm. She said the next day the resident had some _____ on the right side of his _____, and some weeping from his _____. The DON said the resident was responding to the treatments ordered and all the lab results appeared in normal limits. She said the doctors were trying to rule out an _____ or some type of reaction. She stated	F 689		

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F 689	<p>Continued From page 11</p> <p>Resident #1 has always gone outside and has never had any type of problem related to heat or sun before. She stated Resident #1 is still hospitalized and doctors are still trying to figure out what is going on. She stated the activities staff were responsible for checking in on the residents outside and providing hydration and sunscreen.</p> <p>An interview was conducted on _____ at 1:12 p.m. with the Activities Director (AD). The AD stated they are responsible for checking on residents who are outside and offering them water and sunscreen. She stated they are responsible to document resident participation in activities on a participation log. She stated Resident #1 was more independent and able to move around in his wheelchair. She stated he did not participate in all activities, and he would go outside a few times a day. She stated Resident #1 would come and get ice cream in the afternoon and take it outside in the courtyard to eat it. She said this was Resident #1's normal routine.</p> <p>An interview was conducted on _____ at 2:23 p.m. with the Nursing Home Administrator (NHA) and the DON. The NHA stated the facility started an investigation into the incident with Resident #1 right away. The NHA stated based on their investigation they believe Resident #1 was outside for a little less than an hour when he was found. The NHA stated there had been no previous concerns with the resident related to being outside. He stated they are still working with the doctor to investigate this incident. He stated they started an Adhoc QAPI plan (Quality Assurance and Performance Improvement Plan).</p>	F 689		

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

PRINTED: 07/09/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>106025</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/23/2025</b>
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F 689	<p>Continued From page 12</p> <p>An interview was conducted on _____ at 2:47 p.m. with the Primary Care Provider (PCP). The PCP stated he was very familiar with Resident #1. The PCP stated he came in to see the resident the day after the incident. He stated he consulted a Dermatologist to discuss the case. He stated Resident #1 has a history of _____ sun exposure and likes to be outside. He stated the Dermatologist believed this may be an _____ reaction to the sun exposure or a drug _____ illness. He stated they are providing treatment at the hospital and Resident #1's body reacted to something but there is no absolute cause at this time. He stated he did not believe the reaction was related to a sunburn, but the sun might have been the catalyst for the reaction. He stated they are still working on a definite diagnosis.</p> <p>An interview was conducted on _____ at 3:15 p.m. with Staff B, CNA. Staff B stated she did not work with Resident #1 very often. Staff B stated she came in at 7:00 a.m. and worked a double that day. She stated she saw Resident #1 at 7:30 a.m. after breakfast. She stated she assisted the resident to the bathroom and took him to activities. She stated a family member came to see Resident #1 and she saw them walking around and then they went to lunch. She said she checked on him around 2:30 p.m. and he was in the activity room eating ice cream. She said that was the last time she saw him before the incident. Staff B stated she was there when Resident #1 returned from the hospital. She said he came from hospital around 9:00 p.m. She said she helped get him to his room. She stated his skin had "boils."</p> <p>A telephone interview was conducted on _____</p>	F 689		

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F 689	<p>Continued From page 13</p> <p>at 3:35 p.m. with Resident #1's POA. The POA stated Resident #1 was still in the hospital and was "not doing well." The POA stated the hospital was going to transfer the resident to another facility where they had a unit. She stated the doctors still do not know what exactly happened, but it was started by the sun exposure for some reason. The POA stated the _____ have gone down some but now they think he may have a staph _____ on his _____. She stated she arrived at the facility on _____ around 11:30 a.m. and stayed until around 1:30 p.m. She stated she did not take the resident outside during her visit and when she left Resident #1 was doing fine. The POA stated she received a call around 4:30 p.m. stating the resident was being sent to the hospital. She said Resident #1 was dressed in shorts and a shirt. She stated Resident #1 was being seen by several _____ and _____ care. She stated the resident likes to be outside, but he does have some _____, and he does not always know when to drink water or to get out of the sun. The POA stated she has never had the resident out in the sun for an hour, and she always gets him _____ inside after about 20 minutes. She said 20 minutes is as long as she can stand in the heat. The POA stated the resident, "Can present better than he is, but he really does not have a concept of how long he was outside or if he needs to drink."</p> <p>A review of the facility's policy titled Incontinent Weather Restrictions, Issued _____; Revised _____, revealed the following:</p> <p>Policy: Most facilities have courtyards, porches, or secured patios that are available for resident use and for outdoor facility activities and events.</p>	F 689		

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F 689	Continued From page 14 These are subject to inclement weather restrictions. Procedure: 1. Courtyards, secured patios, and porches are available for use for residents except during inclement weather conditions. Guidelines to consider: a. Temperature < 32 degrees or >90 degrees b. Heat index > 100 degrees c. Excessive wind chill d. Excessive humidity e. Precipitation f. Severe weather watches or warnings 2. Resident should be dressed appropriately for weather conditions if outside. 3. Each facility should provide for periodic monitoring of residents in courtyards, secured patios, or porches to provide hydration in warmer weather. 4. Resident with moderate to severe _____ should be attended by staff or visitor when outside.	F 689			

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N 000	<p><b>INITIAL COMMENTS</b></p> <p>A complaint survey for complaint number 2025006220, was conducted on _____ and _____ at Life Care Center of Sarasota. Deficiencies were identified at the time of the survey.</p> <p>A Class III deficiency was identified at N201 related to complaint number 2025006220.</p> <p>Class III deficiencies are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines indirectly or potentially threaten the physical or emotional health, safety, or security of clients.</p> <p>The facility resident census at the beginning of the survey was 110.</p>	N 000		
N 201 SS=D	<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 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 observations, interviews, and record review, the facility failed to provide adequate supervision to prevent one resident (#1) from exposure to the sun/heat, resulting in an _____ and skin damage to the _____, arms, and _____, out of three residents sampled for</p>	N 201	This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the	

AHCA Form 3020-0001 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE _____	(X8) DATE _____ /25
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N 201	<p>Continued From page 1</p> <p>outdoor activities.</p> <p>On Resident #1 was seated in a wheelchair in the courtyard area of the facility for approximately one hour from 2:45 p.m. to 3:45 p.m., during the hottest part of the day. Resident #1 was discovered to be unresponsive and had to be transferred to a higher level of care for treatment from sun/heat exposure.</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility in with diagnoses including;</p> <p>Type 2 with _____ and _____, difficulty walking, _____ communication _____ and need for assistance with personal care.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated _____, revealed in Section C- _____ Patterns, a _____ ( _____ ) score of 14, indicating the resident was _____.</p> <p>A review of the Order Summary Report, dated /22025- _____, revealed the following:</p> <ul style="list-style-type: none"> <li>-Aloe Vera external gel apply to affected areas _____ every shift for sunburn for 7 days, initiated _____</li> <li>- _____ oral capsule ( _____ ) give 25 mg (milligrams) by every 8 hours as needed for possible reaction to skin, initiated _____</li> <li>-Consult care for _____ on top of _____ thighs, and left _____, initiated _____</li> <li>-Transfer out to hospital for evaluation, initiated _____</li> </ul>	N 201	<p>facility, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope of severity regarding any of these deficiencies cited are correctly applied. In order to ensure that the services provided at Life Care Center of Sarasota meet the professional standards of quality, the team has initiated the following plan or correction:</p> <p>Resident #1 was discharged from the facility.</p> <p>Residents who enjoy outdoor activities have the potential to be affected by not providing adequate supervision to prevent exposure to the sun/heat. The facility revised and implemented a new process for the courtyard that includes designated times in which the courtyards will be open and supervised pending inclement weather.</p> <p>The Executive Director and or designee will educate the facility staff on the courtyard process, courtyard hours, communication, supervision and sign out process for residents who enjoy outdoor activities.</p> <p>The Executive Director and or designee will complete 5 random audits per week on the facility courtyard process which will include communication and supervision. The results of the audits will be tracked, trended and reported to the monthly</p>	
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N 201	<p>Continued From page 2</p> <p>- oral tablet give 40 mg by one time a day for empiric for 5 days, initiated</p> <p>A review of the Care Plan Report, initiated on , revealed the following:</p> <p>1-Focus area: Resident #1 is dependent on staff and family for meeting emotional, physical, and social needs related to physical limitations. (initiated ; revised )</p> <p>Goal: The resident will maintain involvement in stimulation, social activities as desire through review date.</p> <p>Interventions included:</p> <p>-The resident needs assistance/escort to activity functions. Can propel self in wheelchair.</p> <p>-The resident preferred activities are ice cream time, eating in the main dining room, the outdoors, and visiting with family.</p> <p>2-Focus area: (initiated ; revised )</p> <p>Goal: The resident will have no complications related to through the review date.</p> <p>Interventions included:</p> <p>-Avoid exposure to extreme heat or .</p> <p>-Observe and report PRN (as needed) any signs and symptoms of , sweating, tremor, increased rate, pallor, nervousness, , slurred speech, lack of coordination, staggering gait.</p> <p>A review of the Progress notes for Resident #1 revealed the following:</p> <p>- 16:38 Health Status Note Note Text: Patient [family member] notified of transfer to hospital.</p> <p>A review of the hospital Emergency Department (ED) Physician record from admission date for Resident #1 revealed the following:</p>	N 201	<p>Quality Assurance and Performance Improvement meeting for a period of three months or until sustained compliance is achieved.</p>	
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N 201	<p>Continued From page 4</p> <p>Spoke with NP (Nurse Practitioner) who gave orders for care to evaluate on Monday - 11:06 Health Status Note</p> <p>Note Text: Per orders from NP, stat (emergent) ( )/CMP (comprehensive profile), stat pharmacy delivery of 40 mg, and a hold on (patient's) cream that is applied have all been processed. order placed as well.</p> <p>- 15:52 Health Status Note</p> <p>Note Text: Upon further inspection by this RN (Registered Nurse) and weekend supervisor, appears to be decreasing. Wife present and agrees. NP notified of current - 08:55 Skin/ Note Late Entry:</p> <p>Note Text: seen by [ Care Consultant] ARNP [Advanced Registered Nurse Practitioner] today. alert &amp; oriented to self, able to follow directions. noted with in BLUE (upper extremities), thighs and top of . Other on top of has popped and dry out. No or open skin area. in R (right) side of jaw line and able to talk clearly, swallow his medication with water without difficulty. Primary ARNP in room at the same time to evaluate. MD (Medical Doctor) contacted at that time by ARNP. would not be followed by [ Care Consultant] group since, does not have any skin open area. Will continue to monitor.</p> <p>- 10:50 Provider Note</p> <p>Chief Complaint/History of Present Illness: Re-admit</p> <p>Patient found unresponsive and sent to ER (Emergency Room). CT (Computed , , ) imaging negative for acute findings ...Sent to facility. Patient then was reported to be outside and a couple days later reported that he had sporadic large fluid filled on , B/L ( ) arms, and B/L areas all where sun</p>	N 201		
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N 201	<p>Continued From page 5</p> <p>had been exposed. _____ has opened, and _____ care will follow for this. He is unsure how long he was outside for. Agree with _____ care's diagnosis of sun exposure vs (versus) drug bullous pemphigoid (a _____ skin _____ primarily affecting older adults). He does have increased _____ on the right side that has worsened since starting _____ 40 mg po (by _____) QD (daily). Concern for airway protection and recommend to send to ER for ( _____ ) and eval ...</p> <p>- 16:53 _____ Provider Note Chief Complaint/History of Present Illness: ...MD evaluated the patient today with POA (Power of Attorney) present. Concern was held regarding the patient's breathing and _____ around his _____ predominantly on the right side of his _____ were present on his arms and thighs. Per report and per MD revise of facility documentation, patient was outside the day before with normal daily activities for the patient. He was subsequently reported altered outside and was subsequently brought inside for evaluation. Patient typically spends significant time with his spouse in and out of the facility. MD recommended _____ (Emergency Medical Services) to be called and patient was transported to the hospital in stable condition. Plan: MD reviewed imaging and facility records extensively and conferred with additional board-certified physicians internal medicine physicians including a board-certified dermatologist. Per exam patient has darkened pigment on his anterior _____ as well as thighs. Dermatologist advised after serial imaging review that patient likely has a history of long-term photosensitivity reactions indicative of someone with _____ sun exposure. Facility</p>	N 201		
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N 201	<p>Continued From page 6</p> <p>documentation was reviewed by MD the patient was outside for less than an hour and became ...Patient was sent to the ED for a higher level of care for airway protection .... - 16:53 Event Note Late Entry Note text: At approximately 3:46 p.m. this nurse was notified by other staff members that patient needed assistance, this nurse quickly went with staff members to assess resident. This nurse assessed resident, resident was noted to be responsive, awake and slowly responding. Other nurse helped to assess resident. Resident noted not to appear at baseline medical provider notified gave order to send out via 911 called per order and resident sent out to hospital. Spouse notified of change in condition and hospital transfer ... - 1802 Transfer to Hospital Note Text: Alert and oriented X2, resting in bed ...MD was in to see . . regarding fluid filled . . redness of skin and . . in right . . 2:30 p.m. orders to sent to ER for evaluation, 911 was called and patient was transferred to hospital via stretcher with paramedics ....</p> <p>A review of the hospital Emergency Department (ED) Physician record from admission date for Resident #1 revealed the following: History of Present Illness: Patient is an . . male who 2 days ago was left out in the sun accidentally by the staff at [Facility name] patient was evaluated at our facility at that time he had some sunburn on both upper thighs and his arms. The redness is turned to . . on both upper thighs and on his arms. Patient also states he was sent here for evaluation of . . there was a lab order form from [Facility name]. Patient appears in no obvious distress at this time. Patient denies</p>	N 201		
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N 201	<p>Continued From page 7</p> <p>any Impression and Plan: - (condition in which the white cell count is above normal and is frequently a sign of an ). - (condition that arises when the body's response to causes injury to its own tissues and ).</p> <p>An interview was conducted on at 11:21 a.m. with Staff A, Registered Nurse (RN). Staff A, RN stated she was the primary nurse for Resident #1 on . She stated Resident #1's family member came to the facility around 9 to 10 a.m. and spent most of the day with the resident. She said the last time she had seen the resident was before lunch to record his . She stated it was around 11:00 a.m. She said the nursing assistant (Staff B, Certified Nursing Assistant, CNA) toileted the resident in the morning and took the resident to activities with the family member. She stated she did not know when the resident went outside or how long he had been outside. She said the family member left the facility around 1:45 to 2:00 p.m. Staff A, RN stated she was walking in the hallway, and she heard staff saying they needed assistance in the patio area around three something in the afternoon. She said she ran to the outside patio and saw Resident #1 in the ice cream parlor, sitting in the wheelchair. She said the resident's were open and she checked for a . She said the resident had a , and she starting calling his name and doing a rub on his , but he was not able to state his name. She said he was just "moaning." She stated Resident #1 appeared tired and . Staff A, RN stated one of the other nurses (Staff C, Licensed Practical Nurse, LPN) came to help and took over the care for Resident #1 while she went</p>	N 201		
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N 201	<p>Continued From page 8</p> <p>to go get the paperwork to send Resident #1 to the hospital. She could not recall exactly what the resident was wearing at the time. She stated she did not put a progress note into the record at the time of the incident because she thought the other nurse was going to do it. She stated she put a note in the record a few days later when she found out no note was written. She stated the activities staff are supposed to check on the residents and give them water if they are outside. She stated the CNA's are supposed to go and check on their resident's if the resident is outside. She stated is a resident is alert and oriented, they can go outside.</p> <p>An interview was conducted on _____ at 11:56 a.m. with Staff C, LPN. Staff C, LPN stated Staff D, Physical _____ ( ) was walking near the court yard and found Resident #1 unresponsive. She stated around 3:30-3:45 p.m. a staff member was screaming her name to come and help a resident. She said when she arrived she noticed it was Resident #1. She stated Staff D, _____ was bringing the resident inside as she arrived in the ice cream parlor. Staff C, LPN stated they moved the resident to the private dining area, and he was "very warm" to the touch. She said they brought the resident to the ground and laid him on the floor. She stated they checked his _____, and it was okay, so she started putting wet cool rags on his _____ and _____ area. She said she instructed other staff members to call 911 and get paperwork ready for transfer. Staff C stated Resident #1 was responding by opening his _____ and opening his _____, but he was not able to speak. She stated it was warm outside that day, but it was not extremely hot. She stated the resident had on a pair of black basketball shorts, and a gray shirt with sneakers and no hat. She stated he had no</p>	N 201		
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NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF SARASOTA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8104 TUTTLE AVE</b> <b>SARASOTA, FL 34243</b>		
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N 201	<p>Continued From page 9</p> <p>obvious skin injuries or injury at the time.</p> <p>An interview was conducted on _____ at 12:07 p.m., with Staff D, . Staff D, stated she was finishing up her day and had clocked out around 3:40 p.m. She stated she went out to the courtyard to speak with another resident, and she saw a Resident #1 sitting in the court yard. She stated she knew Resident #1 well and she went over to say hello. She said he appeared to be resting, and she tried to wake him up, but he was not responding. She said Resident #1 did not appear to be his usual self. She said she went inside the ice cream parlor and asked someone to call for help with a medical emergency. She said she went and brought Resident #1 inside in his wheelchair. She said the nursing staff took over providing care for the resident. She stated she had not seen him throughout the day on _____. She stated she did not know how long Resident #1 had been outside and she did not see any other staff members outside in the courtyard at the time.</p> <p>An interview was conducted on _____ at 12:15 p.m. with Staff E, Activities Assistant (AA). Staff E, AA stated he saw Resident #1 at 2:15 p.m. and instructed the resident that he could not go outside at the time because the landscapers were working in the courtyard. He stated he brought Resident #1 to activities in the dining room and gave him some ice cream at 2:30 p.m. He stated that was the last time he saw Resident #1. He stated he had seen Resident #1 earlier in the day with his family member in the hallway. He stated he offers water or juice and sunscreen to residents who are outside. He stated there was some areas of shade in the courtyard and Resident #1 can move around freely in his wheelchair.</p>	N 201			

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N 201	<p>Continued From page 10</p> <p>An interview was conducted on _____ at 12:27 p.m. with the Director of Nursing (DON). The DON said there is a button for residents to use to go outside and enter the courtyard. She stated staff are responsible to do rounds and check on residents. She stated the CNA's check on residents, but they would not document in the record. She stated the CNA's are required to do two hour checks on the residents depending on their needs. She stated some residents may need more supervision. She stated Staff E, AA was the last one to see Resident #1 around 2:30-2:45 p.m. when the resident went outside to eat his ice cream. She said based on the investigation Resident #1 was outside from 2:45 p.m.-3:45 p.m. The DON stated at 3:45 p.m. Resident #1, "appeared he was sleeping in the court yard and the physical _____ stated he was not responsive." She said on Monday she spoke with Resident #1, and he was slow to respond and that is his baseline. She said, "He is low speaking." She said the resident told her he just " _____ asleep out there." She said when Resident #1 came _____ to the facility they found a _____ on the top of his _____, and his arm. She said the next day the resident had some _____ on the right side of his _____, and some weeping from his _____. The DON said the resident was responding to the treatments ordered and all the lab results appeared in normal limits. She said the doctors were trying to rule out an _____ or some type of reaction. She stated Resident #1 has always gone outside and has never had any type of problem related to heat or sun before. She stated Resident #1 is still hospitalized and doctors are still trying to figure out what is going on. She stated the activities staff were responsible for checking in on the residents outside and providing hydration and</p>	N 201		
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N 201	<p>Continued From page 11</p> <p>sunscreen.</p> <p>An interview was conducted on _____ at 1:12 p.m. with the Activities Director (AD). The AD stated they are responsible for checking on residents who are outside and offering them water and sunscreen. She stated they are responsible to document resident participation in activities on a participation log. She stated Resident #1 was more independent and able to move around in his wheelchair. She stated he did not participate in all activities, and he would go outside a few times a day. She stated Resident #1 would come and get ice cream in the afternoon and take it outside in the courtyard to eat it. She said this was Resident #1's normal routine.</p> <p>An interview was conducted on _____ at 2:23 p.m. with the Nursing Home Administrator (NHA) and the DON. The NHA stated the facility started an investigation into the incident with Resident #1 right away. The NHA stated based on their investigation they believe Resident #1 was outside for a little less than an hour when he was found. The NHA stated there had been no previous concerns with the resident related to being outside. He stated they are still working with the doctor to investigate this incident. He stated they started an Adhoc QAPI plan (Quality Assurance and Performance Improvement Plan).</p> <p>An interview was conducted on _____ at 2:47 p.m. with the Primary Care Provider (PCP). The PCP stated he was very familiar with Resident #1. The PCP stated he came in to see the resident the day after the incident. He stated he consulted a Dermatologist to discuss the case. He stated Resident #1 has a history of _____ sun exposure and likes to be outside. He stated the</p>	N 201		

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N 201	<p>Continued From page 12</p> <p>Dermatologist believed this may be an reaction to the sun exposure or a drug illness. He stated they are providing treatment at the hospital and Resident #1's body reacted to something but there is no absolute cause at this time. He stated he did not believe the reaction was related to a sunburn, but the sun might have been the catalyst for the reaction. He stated they are still working on a definite diagnosis.</p> <p>An interview was conducted on at 3:15 p.m. with Staff B, CNA. Staff B stated she did not work with Resident #1 very often. Staff B stated she came in at 7:00 a.m. and worked a double that day. She stated she saw Resident #1 at 7:30 a.m. after breakfast. She stated she assisted the resident to the bathroom and took him to activities. She stated a family member came to see Resident #1 and she saw them walking around and then they went to lunch. She said she checked on him around 2:30 p.m. and he was in the activity room eating ice cream. She said that was the last time she saw him before the incident. Staff B stated she was there when Resident #1 returned from the hospital. She said he came from hospital around 9:00 p.m. She said she helped get him to his room. She stated his skin had "boils."</p> <p>A telephone interview was conducted on at 3:35 p.m. with Resident #1's POA. The POA stated Resident #1 was still in the hospital and was "not doing well." The POA stated the hospital was going to transfer the resident to another facility where they had a unit. She stated the doctors still do not know what exactly happened, but it was started by the sun exposure for some reason. The POA stated the have gone down some but now they think</p>	N 201			

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N 201	<p>Continued From page 13</p> <p>he may have a staph on his . She stated she arrived at the facility on around 11:30 a.m. and stayed until around 1:30 p.m. She stated she did not take the resident outside during her visit and when she left Resident #1 was doing fine. The POA stated she received a call around 4:30 p.m. stating the resident was being sent to the hospital. She said Resident #1 was dressed in shorts and a shirt. She stated Resident #1 was being seen by several , and care. She stated the resident likes to be outside, but he does have some , and he does not always know when to drink water or to get out of the sun. The POA stated she has never had the resident out in the sun for an hour, and she always gets him inside after about 20 minutes. She said 20 minutes is as long as she can stand in the heat. The POA stated the resident, "Can present better than he is, but he really does not have a concept of how long he was outside or if he needs to drink."</p> <p>A review of the facility's policy titled Inclement Weather Restrictions, Issued ; Revised , revealed the following:</p> <p>Policy: Most facilities have courtyards, porches, or secured patios that are available for resident use and for outdoor facility activities and events. These are subject to inclement weather restrictions.</p> <p>Procedure: 1. Courtyards, secured patios, and porches are available for use for residents except during inclement weather conditions. Guidelines to consider: a. Temperature &lt; 32 degrees or &gt;90 degrees b. Heat index &gt; 100 degrees c. Excessive wind chill</p>	N 201		

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N 201	<p>Continued From page 14</p> <p>d. Excessive humidity</p> <p>e. Precipitation</p> <p>f. Severe weather watches or warnings</p> <p>2. Resident should be dressed appropriately for weather conditions if outside.</p> <p>3. Each facility should provide for periodic monitoring of residents in courtyards, secured patios, or porches to provide hydration in warmer weather.</p> <p>4. Resident with moderate to severe _____ should be attended by staff or visitor when outside.</p> <p>Class III</p>	N 201		