STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105634	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gulfside Health and Rehabilitation Center	1100 N Pine St Clearwater, FL 33756

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on record reviews and interviews the facility failed to report an injury of unknown origin following an unwitnessed fall for one (#5) out of two residents sampled. Findings included: Review of Resident #5's Admission Record revealed the resident was admitted on [DATE]. The resident's record included admission diagnoses not limited to unspecified severity unspecified dementia with other behavioral disturbance, delirium due to known physiological condition, other encephalopathy, generalized muscle weakness, and need for assistance with personal care. Review of the facility's Incident Log, revealed Resident #5 had unwitnessed falls on 9/23/24 at 11:45 p.m. and 9/28/24 at 8:30 p.m. Review of Resident #5's Situation, Background, Appearance, and Recommendation (SBAR) Change in Condition, dated 9/23/24 at 11:30 p.m. revealed the resident was observe(d) walking across the hall from her room the the [sic]) room across the hall. Resident was seen one minute then she was not seen. When staff walked around the nurses cart resident was seen sitting on the floor. When staff got closer to resident, she had blood on her face and there was blood on the wall. Resident has a 2 centimeter (cm) by 1/4 cm laceration to the right of her right eye. Residents left eye swollen shut. Resident never lost consciousness. The primary care providers recommendation was to send to emergency room (ER) for evaluation and treatment. Review of Resident #5's hospital records dated 9/24/24 revealed a C-spine computed Tomography scan (CT) result examination demonstrates within the posterior wall of the right maxillary sinus there is a minimally displaced fracture. A CT scan of facial bones revealed Examination demonstrates a displaced fracture within the posterior wall of the left maxillary sinus. Within the right orbital floor, there is a communicated inferiorly displaced fracture. This involves the infraorbital foramen. There is herniation of infraorbital fat into the superior sinus. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105634	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gulfside Health and Rehabilitation Center	1100 N Pine St Clearwater, FL 33756

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #5's Admission Minimum Data Set (MDS), dated [DATE], revealed the resident's Brief Interview of Mental Status score was 3 of 15, indicative of severe cognitive impairment. The assessment revealed the resident required supervision or touching assistance for rolling left and right, partial/moderate assist with chair/bed-to-chair transfers and ambulating 10 feet. The MDS showed the resident had no fall in the previous 6 months to admission and had one fall with major injury since admission or prior assessment. An interview was conducted on 12/17/24 at 3:42 p.m. with the Nursing Home Administrator (NHA), Director of Nursing (DON), and Social Service Director (SSD). The SSD stated Resident #5 did not do much, was sundowning, was a different resident at night. The DON reported the resident had a fall, was unsteady, very new to the facility, was up at night, sometimes coming to the nursing station, and wandering the halls. On 9/23/24 the resident had dementia and was impulsive, the staff monitored her, doing rounds and checking on her. The DON stated generally we have an aide who stays down on that end of hall, and the resident had just been seen in hallway then was seen sitting on floor in room, staff noticed blood on face and laceration above right eye. The physician was notified, and resident was transferred to the emergency room around 12:05 a.m., returning at approximately 5:45 a.m. The NHA stated drawing a blank on whether the incident had been reported. Review of the facility's Reportable Event Tracking Log did not reveal Resident #5's fall with major injury had been reported.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105634	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gulfside Health and Rehabilitation Center	1100 N Pine St Clearwater, FL 33756

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on observation, record review, and interview, the facility failed to provide adequate supervision for four (#5, #6, #3, and #7) of four residents in a manner that protected them from falls resulting in injuries. Findings included: 1. Review of the facility's Incident Log, revealed Resident #5 had unwitnessed falls on 9/23/24 at 11:45 p.m. and 9/28/24 at 8:30 p.m. Review of Resident #5's Admission Record revealed the resident was admitted on [DATE]. The resident's record included admission diagnoses not limited to unspecified severity unspecified dementia with other behavioral disturbance, delirium due to known physiological condition, other encephalopathy, generalized muscle weakness, and need for assistance with personal care. Review of Resident #5's Admit/Readmit Screener, dated 9/17/24, revealed the resident was admitted due to Urinary Tract Infection (UTI), Altered Mental Status (AMS), and dementia. The evaluation showed the resident was alert to person only, required supervision or touching assistance for toilet transfers, chair/bed-to-chair transfers, and walking 10 feet, and was independent with rolling left and right in bed. The screening revealed the resident had a history of falling, ambulated with either crutches, cane, or walker, had an impaired gait, overestimated or forgot limits to ambulate safely, and was at risk for elopement. The evaluation revealed the resident was a High Risk for Falling with a Morse Fall Scale score of 90 out of a possible 125. The Morse Fall scale showed a score of greater than 45 which indicated the person was a high risk for falling. Review of Resident #5's care plan revealed the following: - Resident was at risk for falls and fall-related injury (due to) behaviors, cognitive loss/decline, medication usage, (and) weakness. The focus was created and revised on 9/19/24. The goal was to minimize risk for falls and fall-related injuries through next review date, initiated 9/19/24 with a target date of 1/3/25. The interventions instructed for staff to assist with toileting and transfers as needed (initiated 9/19/24), to ensure call light was within reach and encourage use for assist with standing/transferring and ambulation (initiated 9/19/24), report falls to physician and responsible party (initiated 9/19/24), to observe for side effects of any drugs that can cause: (if noted, report to nurse) gait disturbance, orthostatic hypotension, weakness, sedation, Lightheadedness, dizziness, (and) change in mental status. Report to physician if abnormal findings (initiated 9/19/24). - (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105634	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gulfside Health and Rehabilitation Center	1100 N Pine St Clearwater, FL 33756

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #5's Admission Minimum Data Set (MDS), dated [DATE], revealed the resident's Brief Interview of Mental Status score was 3 of 15, indicative of severe cognitive impairment. The assessment revealed the resident required supervision or touching assistance for rolling left and right, partial/moderate assist with chair/bed-to-chair transfers and ambulating 10 feet. The MDS showed the resident had no fall in the previous 6 months to admission and had one fall with major injury since admission or prior assessment. Review of Resident #5's progress notes revealed the following: - Order Administration note, effective 9/19/24 at 1:12 a.m., Resident continues to come into the hallway, unassisted with an unsteady gait and at one point untied long shoelaces. Resident thinks she is visiting the woman in the door bed, and she keeps coming up to the nurses station because she believes it's her job to take care of the woman in the door bed. Resident has been oriented to reality multiple times without success. Resident states that she is only going (to) stay a while longer than [sic] go home. Resident educated that she was going to sleep here tonight and she was encouraged to try and get some rest. Will medicate resident in hopes to elicit cooperation and resident will get some sleep so she can participate in therapy and community activities. - Situation, Background, Appearance, Recommendation (SBAR), effective 9/19/24 at 3:00 a.m., revealed a change in condition evaluation was reported due to behavioral symptoms (e.g. agitation, psychosis). The Psych physician ordered a one time dose of Haldol, to start Depakote 375 milligram twice daily and for lab tests in one week. - Behavior note, effective 9/19/24 at 6:00 a.m., revealed Resident #5's behaviors escalated through out the shift (7:00 p.m. to 7:00 a.m.). The nurse documented the resident's family member was unable to re-orient her to reality or assist with de-escalating resident or her behavior. The psych physician had been notified as alternative therapies of 1:1 with staff, medications, family intervention and re-orientation was unsuccessful. The note revealed the resident rested for approximately 30 minutes after an injection of Haldol then was again ambulating unassisted in the hallway. - SBAR Change in Condition, 9/23/24 at 11:30 p.m., showed the evaluation was due to Falls and the resident had been started on Depakote then the dosage had been decreased. Resident observe(d) walking across the hall from her room the (the) room across the hall. Resident was seen one minute then she was not seen. When staff walked around the nurses cart resident was seen sitting on the floor. When staff got closer to resident, she had blood on her face and there was blood on the wall. Resident has a 2 centimeter (cm) by 1/4 cm laceration to the right of her right eye. Residents left eye swollen shut. Resident never lost consciousness. The primary care providers recommendation was to send to emergency room (ER) for evaluation and treatment. - Behavior note, effective 9/24/24 at 6:00 a.m., 9/23 7 p.m.-7 a.m. shift: Resident medication compliant but does not follow the directives of calling for help, waiting for staff to assist, and not to walk alone as her gait is unsteady. Resident impulsive and suffers from dementia and overestimates her own abilities. Resident has been redirected back to bed several times, away from walking in her room, and trying to walk down the hallway. The note revealed the resident had an unwitnessed fall resulting in a laceration to the right of the right eye and left eye swollen shut. The resident was sent out to the ER and returned on 9/24/24 at approximately 5:45 a.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105634	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gulfside Health and Rehabilitation Center	1100 N Pine St Clearwater, FL 33756

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #5's hospital records dated 9/24/24 revealed a C-spine computed Tomography scan (CT) result examination demonstrates within the posterior wall of the right maxillary sinus there is a minimally displaced fracture. A CT scan of facial bones revealed Examination demonstrates a displaced fracture within the posterior wall of the left maxillary sinus. Within the right orbital floor, there is a communicated inferiorly displaced fracture. This involves the infraorbital foramen. There is herniation of infraorbital fat into the superior sinus. Review of Resident #5's care plan showed the resident continued to be at risk for falls and fall related injuries and the intervention of Increased monitoring instituted. Medications reviewed was initiated on 9/24/24. Review of Resident #5's progress notes showed (as previously documented) the resident returned to the facility on [DATE] at approximately 5:45 a.m. The notes did not reveal the resident was evaluated after returning from the acute care facility. A note on 9/24/24 at 1:16 p.m. showed an order for the pain medication, Tramadol was entered into the resident's profile. A sequential note, effective 9/24/24 at 10:42 p. m., revealed Resident unable to swallow whole pills. Unable open mouth and swallow the medications. Medications crushed in pudding. The note did not reveal why the resident was unable to swallow whole pills, unable to open mouth, and/or if the provider was notified of this change. Review of a note on 9/25/24 at 12:07 p.m. revealed the Resident is sedated. The note did not reveal the physician was notified of the resident's sedation. A note on 9/25/24 at 10:18 p.m. revealed the resident was administered 1 milligram of Lorazepam as needed due to showing signs of anxiety and agitation, attempting to self-ambulate, was unable to be redirected and able to stand. Review of the facility's Neuro Check Assessment Form revealed Neuro checks were to be completed every 15 minutes for 1 hour, every 30 minutes for 1 hour, every 1 hour for 4 hours, every 4 hours for 24 hours, and every shift until 72 hours. Review of Resident #5's Neuro Check Form dated 9/24/24 showed the assessments began at 8:15 a.m., approximately 2.5 hours after the resident returned from the hospital following an unwitnessed fall with injury. The assessments should have concluded on 9/27 at 5:45 a.m. (72 hours after return). The form showed staff had completed two of the six opportunities for every 4 hours times 24-hour checks (24/4 = 6 opportunities), and no neuro checks had been completed on 9/26/24. Review of the Interdisciplinary (IDT) Post-Fall Review, effective 9/24/24 at 5:05 p.m. revealed Resident #5 had a fall on 9/23/24 at 11:45 p.m. The predisposing diseases included dementia, with unsteady gait, muscle weakness, and cognitive deficits contributing to the fall. The IDT review revealed the resident received cardiovascular, anti-anxiety and anti-psychotic medications. The IDT recommendations was for a rehab screen, resident education, physician consult, and other which showed the resident was educated on call light use and staff to assist 1:1 supervision. Review of Resident #5's 30-minute checks showed the monitoring started at 12:00 a.m. on 9/27/24, two days and 7 hours after the IDT recommendation for staff to assist 1:1 supervision. The monitoring forms showed the resident was not monitored: 9/28: 11:00 a.m., 11:30 a.m., 12:00 p.m. to 12:30 a.m. on 9/29. 9/29: 10:30 a.m., 11:00 a.m., 11:30 a.m., 12:00 p.m. and 12:30 p.m. to 12:00 a.m. on 9/30. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105634	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gulfside Health and Rehabilitation Center	1100 N Pine St Clearwater, FL 33756

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/30: 12:30 p.m. to 12 a.m. on 10/1. 10/1: 7:30 a.m. to 3 p.m. 10/2: 12 a.m. to 12:30 a.m., 3:30 a.m. to 6:30 a.m., 12:00 p.m. to 3:30 p.m. and 11:30 p.m. to 12:00 a.m. on 10/3. 10/4: 12:00 a.m. to 3:00 p.m. and 11:30 p.m. 10/5: 7:30 a.m. to 12:00 a.m. on 10/6. 10/6: 7:30 a.m. to 8:05 p.m. on 10/7/24. Review of a progress note, effective 10/7/24 at 8:05 p.m., revealed the Nursing Home Administrator, Social Service Director, and Director of Nursing informed Resident #5's family member that the 1:1 monitoring had been discontinued and the resident was placed on every 15-minute checks. Review of Resident #5's progress note, effective 9/29/24 at 4:30 a.m. showed the resident had a fall in her room, found lying supine on the floor. Assessed and later transferred to ER for evaluation to rule out (R/O) hemorrhage. A progress notes, effective 9/29/24 at 4:57 a.m. revealed the resident had returned to the facility via ambulance, resident was sleepy, mumbling to self, bed was at lowest position, 15-minute (min) checks were initiated and neuro checks in place. Review of Resident #5's progress note, effective 9/29/24 at 2:36 p.m. showed the facility reported to the family member the resident was placed on 1:1 (supervision). Review of Resident #5's Neuro Check Assessment Form, dated 9/29/24, revealed neuro checks began at 5:00 a.m. and staff had completed 15 minute checks for 1 hour, 30 minute checks for 2 hours, 3 of 4 - 1 hour checks, and no further neuro checks had been completed. Instructions written at top of form showed staff were to complete checks every 4 hours for 24 hours and every shift until 72 hours (10/2/24 at 4:57 a.m.). Review of Resident #5's progress notes from 9/29 to 10/2/24 showed the staff did not document neuro checks electronically. The notes did reveal on 10/2/24 at 12:07 a.m. the resident continued on 1:1 supervision and currently very lethargic, resident's name called several times, light turned on and 1:1 aide attempted to touch resident to wake her up without any success. The note did not indicate a change in condition was completed or the physician notified. Review of Resident #5's care plan revealed the resident was at risk for falls and fall related injuries. The interventions included staff were to observe for side effects of any drugs that can cause: (if noted, report to nurse) gait disturbance, orthostatic hypotension, weakness, sedation, Lightheadedness, dizziness, change in mental status. Report to physician if abnormal findings (initiated 9/19/24). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105634	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gulfside Health and Rehabilitation Center	1100 N Pine St Clearwater, FL 33756

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 12/17/24 at 3:42 p.m. with the NHA, DON, and SSD. The SSD stated Resident #5 did not do much, was sundowning, was a different resident at night. The DON reported the resident had a fall, was unsteady, very new to the facility, was up at night, sometimes coming to the nursing station, and wandering the halls. On 9/23/24 the resident had dementia and was impulsive, the staff monitored her, doing rounds and checking on her. The DON stated generally we have an aide who stays down on that end of hall, and the resident had just been seen in hallway then was seen sitting on floor in room, staff noticed blood on her face and laceration above her right eye. The physician was notified and resident was transferred to the emergency room around 12:05 a.m., returning at approximately 5:45 a.m. 2. Review of the facility Incident Log from 9/1 to 12/18/24 showed Resident #6 had 8 unwitnessed falls (9/2, 9/4, 10/13, 11/8, 11/12, twice on 11/14, and one on 11/20/24) during that period. Review of Resident #6's Admission Record showed the resident was admitted on [DATE]. The record included diagnoses not limited to unspecified severity unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, history of falling, laceration without foreign body of scalp subsequent encounter, subsequent encounter contusion of scalp, restlessness and agitation, weakness, and repeated falls. An observation on 12/17/24 at 9:59 a.m. was made of Resident #6 lying in a [reclining chair]-chair with leg rests raised and back laid back. The resident was drowsy but able to answer simple questions, reporting a broken back and 2 broken legs. The observation made at 10:02 a.m. revealed Staff B, Certified Nursing Assistant (CNA) and another unknown staff member taking resident to room, where the resident was later observed lying in bed. Review of Resident #6's care plan included the following focuses and interventions: - Has impaired cognitive function/impaired thought processes related to (r/t) end-stage dementia (initiated 12/29/23 and revised 7/12/24). The interventions included: Ask yes/no questions in order to determine the resident's needs and to cue, reorient, and supervise resident as needed (initiated 12/29/23). - At risk for decreased ability to perform activities of daily living(ADLS) in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting related to chronic disease process, impaired mobility, (and) impaired cognition. Resident's need for assistance can vary with time of day, pain, and fatigue. The associated interventions revealed the resident was max to dependent for oral hygiene, Max to total assistance with toileting, dependent with bathing and personal hygiene, maximum assist with dressing, bed mobility, and transfers, and nursing was to provide cueing for safety and sequencing to maximize current level of function. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105634	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gulfside Health and Rehabilitation Center	1100 N Pine St Clearwater, FL 33756

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Is at risk for falls and fall related injury related to (r/t) change in cognitive loss/ decline, difficulty in walking, history of falls, impaired mobility, (and) weakness. Has episodes of increased agitation and restlessness and will repeatedly attempt to get out of bed without assistance. Noted as lying near edge of bed often (initiated 12/29/23 and revised 11/20/24). The interventions included assist resident out of bed in the early morning, ensure call light is within reach and encourage use for assist with standing/ transferring and ambulation (created 12/29/23), floor mat to both sides of the bed when resident is in bed (created 2/29/24 and revised 5/13/24), Use of [reclining chair] chair went out of bed due to positioning deficits and increased fall risks (created 11/18/24), Offer to keep that in lowest position when in bed (created 3/11/24), perimeter mattress to bed for safety (initiated 1/14/24), Review environment of room (initiated 11/15/24), Room move to be closer to nurse station (initiated 8/9/24). - Has the following behavior problem(s) easily agitated, resists care, (and) restlessness. Has confusion and when agitated will attempt to rise independently placing him at high fall risk. Becomes verbally aggressive and swears when attempts to redirect at times period when agitated he at times will spit out medications (initiated 1/1/24). Review of Resident #6's quarterly Minimum Data Set assessment, dated 9/26/24, revealed a Brief Interview of Mental Status score of 0 of 15, which indicated severe cognitive impairment. The assessment showed the resident had two or more falls without injuries since admission or the prior assessment. Review of the Morse Fall Scale, effective 7/1/24 at 4:41 p.m., showed Resident #6 had fallen before, had more than one diagnosis, exhibited an impaired gait, and overestimated or forgets limits. The scale determined the resident had a score of 75 of 125, which indicated a High Risk for Falling. Review of the Fall Scale, effective 8/8/24 showed the residents score of 75 was unchanged and continued to be a High Risk for Falling. Review of Resident #6's progress notes and evaluations revealed the following: - 9/2/2/24 at 3:00 p.m., Change in Condition: Falls. No observation was documented. o 9/2/24 at 3:15 p.m. Narrative note: Resident noted to have a fall from wheelchair (w/c) today without any observed injuries. The note described the resident appeared to have attempted to transfer self from w/c to bed without assistance. Denied pain, neuro checks, vital signs and range of motion (ROM) were within normal limits. The physician and resident (self-responsible) were notified. o Morse Fall Scale, effective 9/2/24 at 3:13 p.m. revealed the resident had fallen before, had more than one diagnosis, ambulatory aids used none/bedrest/wheelchair/nurse assist, normal/bedrest/wheelchair gait, and overestimated or forgot limits. The score was 55, indicating a High Risk for Falling. - 9/4/24 at 11:30 a.m., Narrative note: Resident noted to have had another fall from w/c to floor while in the dining room. Small skin tear noted to back of right hand. Therapy to screen for positioning in w/c or the use of anti-rollbacks d/t patient forgetting to lock w/c. The note did not reveal the primary care physician was notified of the fall or the injury (skin tear). The documentation did not show a change in condition was completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105634	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gulfside Health and Rehabilitation Center	1100 N Pine St Clearwater, FL 33756

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o Morse Fall Scale, effective 9/4/24 at 11:30 a.m. score of 55 indicating a High Risk for Falling. - 10/13/24 at 7:38 p.m., Change in Condition: Falls. No observations or evaluations were completed. Primary Care Provider recommended neuro checks. o 10/13/24 at 7:54 p.m. a narrative note showed the nurse was paged overhead for a fall at the smoking patio. The nurse observed Resident #6 on the floor and reported trying to spit and fell off wheelchair. The nurse assess resident, no complaint of pain or discomfort and vital signs were within normal limits (WNL). (No evidence of neuro checks had been completed for this unwitnessed fall.) o Morse Fall Scale, effective 10/14/24 at 4:32 a.m. revealed a score of 75 and a High Risk for Falling. The resident had fallen before, had more than one diagnosis, ambulatory aids were none/bedrest/wheelchair/nurse assist, impaired gait, and overestimated or forgot limits. o Interdisciplinary (IDT) Post Fall Review, effective 10/14/24 at 9:38 a.m. showed the resident had a fall on 10/13/24 at 7:48 p.m. The review showed the resident had a predisposing disease of Dementia/Alzheimer's, had an unsteady gait, history of falls, muscle weakness, and a cognitive deficit that contributing to the fall, received no medications on the day of the fall, and the IDT recommendation was for a Rehab Screen. - 11/8/2024 at 10:02 p.m. a narrative note revealed Certified Nursing Assistant (CNA) found resident on the floor, run to the nursing station and get the nurse. Nurse came in found resident laying on the floor, close to the bed, with bed at the lowest position. Resident is assessed by nurse; resident has two depressions on the right side of the face but refuses any pain. No wound or open spot found upon assessment. Neuro checks initiated, Bed maintained in lowest position and call light and frequently reached items placed within reach. DON and physician notified of fall. No new orders received at this time. o IDT Post Fall Review, effective 11/9/24 at 5:42 p.m. showed the resident had a fall on 11/8/24 at 8:00 p.m. - 11/12/2024 at 3:51 p.m., a narrative note revealed Resident (Res.) attempted to get himself out of bed and slid to the floor. Res. found lying on the floor next to the bed. Res. assessed for injuries. No injuries noted. Res. denied pain. Res. did not have slipper socks on. Call light was within reach, but not engaged at the time. Res. has poor safety awareness and overestimates his ability to complete tasks independently. Res. assisted back to bed by staff, cleaned up and placed in a w/c in an area of high visibility. MD notified of fall. Neuro checks initiated, and at res's baseline at this time. o IDT Post Fall Review, effective 11/13/24 at 9:45 a.m. showed the resident had a fall on 11/12/24 at 3:15 p. m. The IDT recommendation was for labs. o The facility provided a Neuro Check Assessment form, dated 11/12/24 started at 3:15 p.m. and continued to 11/12/24 at 9:15 p.m. despite instructions for the checks to be completed every 4 hours for 24 hours then every shift until 72 hours (after fall). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105634	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gulfside Health and Rehabilitation Center	1100 N Pine St Clearwater, FL 33756

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 11/14/2024 at 7:27 p.m. a narrative note revealed Resident fell from his bed with a head injury. Notified Advanced Registered Nurse Practitioner (ARNP) (proper name) and new orders to send resident (to) emergency room (ER) for evaluation and treatment. - 11/14/24 at 7:45 p.m. an incident note revealed Resident was found on the floor next to his bed. He was bleeding from his head and being a poor historian was not able to communicate how the incident happened. Roommate related that the resident was trying to get out of bed (OOB). Resident has a history (hx) of Dementia. ARNP (proper name) made aware of situation and new order to transfer Resident to ER for further evaluation due to head injury. All paperwork printed and send with Medics. o Review of hospital History & Physical revealed the chief complaint was unwitnessed fall, head injury, scalp wound, and aspiration with staples. o A note on 11/16/24 at 7:29 p.m. showed the resident had returned last evening with 2 staples in top of head and neuro checks were initiated. The bed was placed in lowest position with a fall mat next the bed. - 11/20/24 a change in condition note showed the resident was found on the floor next to the door. Bed was in lowest position with parameter mattress, and floor mats in place. Upon assessment there were no physical injuries noted. Resident was assisted with 2-assist back to bed. Hydrated and made comfortable. Check and change in place and 30 minutes watch had already been initiated. Resident's brief was dry. Vital signs stable to his baseline. Primary Care Physician (PCP) notified 11/20 at 4:15 a.m., continue to assess and report any changes. o IDT Post Fall Review effective 11/21/24 at 9:47 a.m. showed the resident had a fall on 12/20/24 at 4:00 a.m. the resident had received the antidepressant Trazodone on the day of the fall and the IDT's recommendation was for increased supervision. Review of a grievance filed on behalf of Resident #6 revealed the resident had an unwitnessed fall from bed resulting in a transfer to emergency room (ER). The investigation showed the resident fell from bed to floor. A perimeter mattress was not transferred to the resident's bed upon transfer to (a) new room. The plan to resolve the grievance was to review care plan and fall interventions, update safety apparatus as ordered. An interview was conducted on 12/17/24 at 3:21 p.m. with the Director of Nursing (DON) and Nursing Home Administrator (NHA). The staff members reported Resident #6 had a fall (on 11/14/24) and was transferred to the hospital. The care plan was for a perimeter mattress but during inspection there was no perimeter mattress on the resident's bed. The resident had a laceration to the back of head with 2 staples. The fall had been unwitnessed. The DON and NHA stated the resident had been previously care planned for fall mats and at the time of the fall there should have been one but (it) was not in place. The staff members reported the resident was moved from a 4-person room to a semi-private room to be closer to the nursing station due to falls, getting up in age and later stage of dementia. The DON and NHA reported the facility had completed education regarding abuse/neglect/exploitation and following the care plan/Kardex, also a fall program. The new fall program rolled out approximately 3-4 months ago and staff were to use a post-fall sheet to capture everything (details), environmental things, do a Guardian Angel rounds, and when a room change is done to make sure specialized equipment gets moved with the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105634	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gulfside Health and Rehabilitation Center	1100 N Pine St Clearwater, FL 33756

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A written request was made twice on 12/18/24 between 4 p.m. and 5 p.m. for Resident #6's progress notes September - current - the facility provided notes from 9/2 through 10/13/24 notes, Neuro checks for falls September (Sept) to current - the facility provided neuro checks for 11/8 to 11/12/24, no neuro checks were provided for September or October falls or for the fall suffered on 11/21/24, and IDT Post Fall Review(s) (no effective dates given) - the facility provided 8/12, 10/14, 11/9, 11/13, and 11/21/24, none were provided related to the falls suffered on 9/2 or 9/4/24. During an interview on 12/18/24 at 2:02 p.m. the DON stated neuro check documentation was in paper form and would require to be uploaded in the residents' records. On 12/18/24 at 2:15 p.m. the DON stated neuro checks would be initiated after the return from hospital if the fall was unwitnessed, depending on length of time at hospital. She stated the checks would have been initiated for Resident #6 if at the hospital for 24 hours. 34768 3. Resident #3 was admitted on [DATE], readmitted on [DATE] and discharged on [DATE]. Review of the Admission Record showed diagnoses included but not limited to dementia, , history of falls, dementia with mild mood disorder, attention and concentration deficit, cognitive communication deficit, muscle wasting and atrophy, restlessness and agitation, generalized anxiety, and Wernicke's encephalopathy. Review of the Minimum Data Set (MDS) dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 00 which indicated severe cognitive impairment. rely impaired). Section GG, Functional Abilities showed resident was dependent related to toileting and bathing. Review of the physician orders showed Every 30-minute checks every shift, document on 30-minute check sheets as of 09/11/2024; perimeter mattress as of 01/18/2024; OT (Occupational Therapy) to screen for wheelchair positioning on 02/22/2024; one fourth side rail on both sides as of 09/30/2024. Review of the nursing progress notes showed: On 10/29/2024 at 8:43 a.m. CNA (Certified Nursing Assistant) alerted nurse the patient had fallen out of bed during breakfast. Patient's vitals were stable, pulse elevated due to fall, no visible injuries noted, patient was alert with confusion but denies pain or discomfort. MD (Medical Doctor) was notified. Bed in low position, continue to monitor patient during shift for any neuro changes. On 10/29/2024 at 7:14 a.m. Change in Condition showed resident had a fall. Observed patient sitting next to bed, legs stretched out in front of patient, no injuries noted at time and no complaint of paint. Recommend bed in low position. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105634	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gulfside Health and Rehabilitation Center	1100 N Pine St Clearwater, FL 33756

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/07/2024 at 11:54 a.m. Nurse was coming out of the bathroom to find resident falling forward out of her wheelchair. fell to her knees and fell on to the floor with her face hitting the floor. Upon running over to resident, found her yelling out. She had a bloody nose and skin tear to the back of her left hand near her thumb. Bleeding controlled on both sites with gauze. Full assessment done. Resident was neurologically intact answering questions appropriately. Vital signs done and found to be B/P 109/64, Pulse 79, Resp 18, Temp 97.3, and SpO2 97% on room air. Resident was complaining of pain to both back and nose. Resident left on floor where she fell so as to not further injure resident. C-spine maintained. Fall star paged overhead. 911 called. Paperwork gathered and given to EMS (Emergency Medical Service) upon arrival at approximately 10:15 a.m. Resident was transported to hospital for further evaluation. On 12/07/2024 at 7:41 p.m. showed change in condition from fall. Resident had fallen form wheelchair where she hit her head on the floor. Bleeding noted from nose. C-spine held to prevent further damage. She also had a skin tear to the back of her left hand that was cleaned and dressed with foam dressing. Send to ER (emergency room) via ambulance. Review of the IDT (Interdisciplinary Team) Post Fall Review dated 10/29/2024 showed time of fall was 8:40 a. m. Recommendations were performing a medication regimen review. Review of the IDT Post Fall Review dated 12/09/2024 showed a fall on 12/07/2024 at 9:40 a.m. IDT recommendations: equipment (specify below) and rehab screen. Therapy evaluation / wheelchair reviewed. Wheelchair to change to hemi-height, pommel cushion trial for positioning. Review of Morse Fall Scale dated 10/04/2024 showed a score of 75 or high risk if 45 or higher. Review of Morse Fall Scale dated 10/29/2024 showed a score of 95; high risk if 45 or higher. Review of Morse Fall Scale dated 10/30/2024 showed a score of 95; high risk if 45 or higher. Review of Morse Fall Scale dated 12/07/2024 showed a score of 75; high risk if 45 or higher. Neuro checks were not provided for the 10/29/2024 fall. Review of the care plans showed Resident #3 was at risk for falls and fall related injury related to cognitive impairment, Impulsive behaviors, medications in use, impaired mobility, incontinence, history of falling, impaired vision revised on 01/30/2024. Interventions included but not limited to bed in lowest position initiated on 11/16/2024; perimeter mattress initiated on 11/16/2024. During an interview on 12/19/2024 the Director of Nursing (DON) stated Resident #3 had fallen on 12/07/2024 requiring the resident to go to the hospital. The resident had surgery for a C1 and C2 fusion. She had nasal fracture post fall also. She stated the resident would be returning to the facility post-surgery for fall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105634	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gulfside Health and Rehabilitation Center	1100 N Pine St Clearwater, FL 33756

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the interview on 12/18/2024 at 2:40 p.m. the DON and the MDS Coordinator reviewed the 10/29/2024 documentation. The DON stated the IDT Post Fall Review showed the recommendation was to have medication review. The DON stated a medication regimen review had not been performed. The MDS Coordinator reviewed the fall care plan and verified the interventions did not show an update post the 10/29/2024 fall. The DON stated she would have to check with medical records to find the neuro checks. The DON reviewed the 12/07/2024 fall documentation. The DON stated the nurse was coming down the hall. The resident was a very active patient. The DON stated the nurse saw the resident fall forward out of the wheelchair. The DON stated the documentation recommended a therapy evaluation and wheelchair review. The wheelchair was to be changed to hemi-height, pommel cushion trial for positioning based on the IDT Post Fall Review. The DON stated the care plan would not be updated until she the resident returned. 4. An observation on 12/17/2024 at 9:50 a.m. with Resident #7 was conducted. He was lying in bed, with an enabler on the left side of his bed. Wh