STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105761	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Lake Healthcare and Rehabilitation Center	832 Sunset Lake Boulevard Venice, FL 34292

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30599 46824 Based on record review, review of facility's policies and procedures, residents and staff interviews, the facility failed to protect residents' right to be free from neglect by failing to ensure the safety of residents during emergency evacuation ahead of hurricane [NAME] landfall, a major category 3 hurricane with winds of 120 miles per hour. On 10/8/24 the facility evacuated 112 residents. Due to heavy traffic related to the large scale evacuation, 96 residents traveled approximately 197 miles for eight hours to two receiving facilities. The facility neglected to ensure residents on the buses/vans received necessary medications, food, or hydration, during the transfer to receiving facilities and failed ensure staff were available during transport. Resident #19, who was receiving rehabilitation services by the facility for multiple fractures, and wore a neck brace, suffered serious harm during the evacuation when she was improperly laid by staff across two seats on a coach bus. During the approximately seven hours it took to transfer the resident to the receiving facility nursing staff were not available to administer physician's ordered pain medication causing resident #19 to experience unnecessary, excruciating pain and suffering. Resident #7 suffered serious injury upon arrival to receiving facility when she was physically carried off the bus and sustained an open fracture of the ankle requiring emergent transfer to the hospital. Resident #9 had a diagnosis of Chronic Obstructive Pulmonary Disease, used oxygen, a Continuous Positive Airway Pressure (CPAP) machine and required the head of the bed elevated. Resident #9 had not been receiving the ordered oxygen or provided her CPAP machine. On 10/11/24 the resident suffered serious harm when she was improperly laid flat on a mattress on the floor. Resident #9 was found unresponsive, was emergently transferred to a local hospital, admitted and diagnosed with acute hypoxemic (low blood oxygen level) respiratory failure. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Random record reviews for residents #7, #9, #19, #12, #23 and #24 revealed the residents did not receive necessary medications, including insulin, intravenous antibiotics, anticonvulsants, narcotics and/or other necessary medications during transport and at the receiving facilities. The facility failure to prevent the neglect of residents during emergency evacuation resulted in the determination of widespread Immediate Jeopardy (IJ), scope and severity of L. On 12/6/24 at 10:30 p.m., the Administrator was notified of the determination of Immediate Jeopardy. The findings included: Cross reference to F689, F835 and F867. Review of the undated facility's policy and procedure titled, Abuse Protection and Response Policy noted, The health center Administrator is responsible for assuring that patient safety . holds the highest priority . Neglect: Is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . A review of the facility's Comprehensive Emergency Management Plan (CEMP) revealed the Executive Director developed the plan and was responsible for the implementation of the plan in accordance with policies, procedures and in accordance with applicable rules, laws and regulations. The plan noted the Incident commander (Executive Director/designee) will implement emergency staffing. Management personnel will be staffed according to the A and B Team profile. Staff members, as defined by positions within the facility, are assigned to either A or B teams prior to, during, and after an emergency or disaster situation. The Medical Director was included in the A team and was responsible to oversee medical care upon activation of the plan and provide medical guidance. The Director of Clinical Services (Director of Nursing) was responsible to monitor resident condition and coordinate care with Unit Managers and Staff. In the event an evacuation is ordered for the facility, the Incident Commander or Administrator oversees the evacuation procedure upon declaration of evacuation and prepares residents and supplies for transit. The Unit Managers were responsible to ensure residents are prepared for transit and ensure residents are safely loaded into transportation. The plan noted in the event of an evacuation, facility staff will remain with the residents through the entire evacuation process until released by the Incident Commander or Executive Director. Facility staff will accompany evacuating residents to their destination through the same modes of transportation utilized in evacuating the residents. The plan noted supplies will be packed for transit. Medications will be with the resident. The facility had mutual aid agreements with two transport companies (Transport Companies A and B) and two facility owned vans (van #1: 12 seats; van #2: 5 seats). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Transport company A agreement the facility Administrator signed on 4/22/24 noted, It is understood that (Transport Company A) is under contract with Sarasota county Department of Emergency Management and that in the event of a disaster or emergency, Sarasota County Department of Emergency Management has the authority to direct all evacuation procedures. Transport company B agreement the facility Administrator signed on 4/24/24 noted, (Transport company B) will attempt to provide Sunset Lake Health and Rehabilitation Center with transportation service in the event of an emergency or disaster . The agreement noted, Total number of seats: 8 wheelchair, 4 Stretcher, 11 Ambulatory or 15 wheelchair, 11 ambulatory. The plan did not include contingency planning in the event the contracted transport companies could not fulfill the agreement. Key workers (Departmental Managers) will be responsible for understanding their roles in an emergency, as outlined in the CEMP. A hurricane preparedness in-service will be held with residents and staff just prior to hurricane season to review and prepare in the event of a hurricane. A comprehensive disaster preparedness education will be held annually and is mandatory for employees. In addition, disaster preparedness training is a key part of the orientation for new hires. Training is provided by department managers, each concentrating on their specific areas of responsibility. A general review of the facility's comprehensive emergency management plan is given to all new employees during their orientation. Department/Role specific training is completed during the employee's first week of orientation. Staffing for evacuation. Facility staff will accompany evacuating residents to their destination. Staff will accompany residents through the same modes of transportation utilized in evacuating the residents. Supplies will be packed for transit. Medications will be with the resident. Any residents deemed unable to transport in a non-emergent vehicle or Sunset Lake vehicle, will be reviewed by the Medical Director or designee, and may by physician order be transferred via ambulance to a local hospital. Review of a facility documentation related to the mandatory hurricane [NAME] evacuation revealed that on 10/8/24 at 9:30 a.m., the Nursing Home Administrator notified the management team that the Sarasota County Emergency Services issued a mandatory evacuation order which required all residents be transferred to a safe location by midnight. The facility secured evacuation locations at three different facilities, transportation services were obtained by contracted providers and from sister facilities. The facility secured trucks to transport ancillary equipment such as medication carts, oxygen concentrators, wheelchairs etc. The undercarriage of the coach buses was utilized for personal belongings, emergency food etc. Resident's families and/or responsible parties were notified via the facility's emergency notification system that an evacuation order was issued and preparations were underway to transfer residents. Residents were also verbally informed. By 6:00 p.m. the last bus transferring residents left the facility and facility staff conducted a facility wide sweep of the facility to ensure all residents had been transferred out. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of the facility's incident investigation revealed that after the Sarasota County issued an emergency evacuation the contracted buses arrived without mechanical lifts to assist with transfer of dependent residents on to buses/vans from wheelchairs or beds. Efforts to obtain accessible buses were unsuccessful due to the extended turnaround time for the replacement buses to arrive. The facility contacted local Emergency Management [NAME] (EMS) to assist in the transfer of residents to the buses/vans. The buses left the facility at approximately 6:00 p.m. However, due to heavy evacuation traffic, the buses did not begin to arrive at receiving facilities until the following morning on 10/9/24 at approximately 2:00 a.m. to 3:00 a.m., approximately 6 to 7 hours after the buses left the facility. Resident #7 Further review of the facility's incident investigation revealed that as Resident #7 was being unloaded from the bus at the receiving facility, a therapist reported that her foot came in contact with the ground and a fracture was suspected. EMS arrived and transported Resident #7 to a local hospital. On 11/18/24 at 12:30 p.m., in an interview the Administrator stated that Resident #7 required a full body mechanical lift for transfer but there was no space for Resident #7 on the stretcher transportation van. They had EMTs (Emergency Medical Technicians) manually lift the resident and place her in a seat on a bus that was not equipped with a lift. Therapy staff from the receiving facility took the resident off the bus. The Administrator said, I would assume the injury is what they said, the foot came in contact with the ground. There was no way to get a mechanical lift on the bus because it was not a transport bus. She was on the last bus. On 11/19/24 at 12:59 p.m., in a telephone interview Resident #7's daughter said the facility notified her of the emergency evacuation and said her mother was being transferred by stretcher to a local receiving facility. The daughter said the next message she received was that her mother had been sent to the hospital for a broken leg she sustained when staff was getting her off a coach bus. The resident's daughter said her mother underwent emergency surgery and was discharged to a local skilled nursing facility. The daughter further reported that her mother (Resident #7) had not received her seizure medications, had a seizure, went back to the hospital and had passed away. Clinical record review for Resident #7 revealed a Quarterly Minimum Data Set (MDS) Assessment with a target date of 9/3/24 which noted Resident #7 required substantial/maximal assistance with chair to bed transfer (Helper does more than half the effort). The care plan initiated on 9/5/23 noted the resident required a mechanical lift with two person assist for all transfers. On 5/13/24 the care plan intervention specified to use care during transfers and during activities of daily living due to fragile condition, osteoporosis (weak, brittle bones) with frail bones. On 12/4/24 at 2:15 p.m., in an interview the Director of Rehabilitation (DOR) said Resident #7 was totally dependent for mobility and confirmed Resident #7 should have evacuated by stretcher but was not. The DOR said staff used a mechanical lift sling to physically carry Resident #7 off the bus. The DOR stated that she had yelled as staff carried the resident off the bus to watch her foot, then realized it was bleeding. Resident #19 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Clinical record review revealed Resident #19 had an admitted [DATE]. Diagnoses included, Diabetes Mellitus, nondisplaced fracture of second cervical vertebra and multiple right rib fractures, fracture of the right tibia (lower leg bone), and weakness. The resident's care plan initiated on 9/12/24 noted Resident #19 had self-care deficit with grooming, bathing related to impaired mobility, chronic pain, alteration in comfort related to generalized discomfort, recent right tibia surgery, recent fracture of cervical vertebra, right tibia, and chronic pain syndrome. The interventions noted a cervical (neck) collar as ordered, mechanical lift with two person assist, a sling to the right upper extremity, back brace as ordered and administer medication for discomfort as ordered; observe for effectiveness and for side effects. The Admission MDS assessment with a target date of 9/15/24 noted the resident's cognition was moderately impaired with a Brief Interview for Mental Status (BIMS) score of 12. Resident #19 was dependent on staff for mobility, including rolling left and right, moving from sitting on side of the bed to lying flat on the bed. Resident #19 frequently experienced pain which occasionally effected sleep and interfered with activities of daily living. The physician's orders as of 9/11/24 included Dilaudid (narcotic used to treat severe pain) 4 milligrams (mg) three times a day for pain, and Dilaudid 4 mg one tablet by mouth every 4 hours as needed for pain level of 4 to 10. On 12/3/24 at 3:00 p.m., in an interview Licensed Practical Nurse (LPN) Staff CC said Resident #19 was evacuated on a coach bus and was in severe pain when she arrived at the receiving facility, and throughout her stay. She said on 10/11/24 they were going to bring her back on a coach bus. She told the Administrator she would not have the resident travel on a coach and would pay out of her own pocket to bring the resident back on a stretcher. Review of the Medication Administration Record (MAR) for October 2024 lacked documentation Resident #19 received the scheduled Dilaudid on 10/8/24 at 6:00 p.m. during transport to the receiving facility, or during her stay at the receiving facility on 10/10/24 at 6:00 p.m.,10/11/24 at 6:00 a.m., 10:00 a.m., and 6:00 p. m. Further review of the MAR revealed that Resident #19 did not receive the following physician ordered medications: Methocarbamol 750 mg one tablet by mouth for pain, on 10/8/24 at 2:00 p.m., 10/11/24 at 6:00 a.m., and 2:00 p.m. Magnesium Oxide 400 mg for low magnesium on 10/8/24, and 10/10/24 at 6:00 p.m. Metoprolol Tartrate 25 mg for hypertension on 10/8/24, 10/9/24, and 10/11/24 at 8:00 p.m. Enoxaparin Sodium injection to prevent blood clots on 10/8/24, 10/9/24, 10/10/24 at 9:00 p.m., and 10/11/24 9:00 a.m., and 9:00 p.m. Sennoside tablet 8.5 mg for constipation, Atorvastatin Calcium for hyperlipidemia, Insulin Glargine 10 units subcutaneously, and Lyrical 25 mg for neuropathic pain was not documented as given on 10/9/24 at 9:00 p. m., 10/11/24 at 9:00 a.m., and 9:00 p.m. Pantoprazole sodium 40 mg for Gastroesophageal reflux on 10/11/24 at 6:00 a.m. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	MiraLAX powder 17 grams for constipation on 10/8/24 and 10/10/24 at 5:00 p.m., 10/11/24 at 9:00 a.m., and 5:00 p.m. Buspirone 5 mg, 0.5 tablet for depression/anxiety on 10/8/24 at 2:00 p.m., 10/9/24 at 10:00 p.m., 10/11/24 at 6:00 a.m., 2:00 p.m., and 10:00 p.m. There was no documentation the resident's blood glucose was obtained as ordered to determine the need for insulin Lispro according to the sliding scale starting with blood glucose of 201 milligrams per deciliter (mg/dl) on 10/8/24 at 11:30 a.m., 4:30 p.m., and 9:00 p.m., 10/9/24 at 9:00 p.m., 10/10/24 at 4:30 p.m., and 10/11/24 at 6:30 a.m., 11:30 a.m., 4:30 p.m., and 9:00 p.m. On 12/4/24 at 10:15 a.m., an interview was conducted with Resident #19 who reported that staff carried her on a sling to a seat on the bus. The resident said, I bumped into every seat on the way to the back of the bus. I was screaming in pain the entire time. I bounced onto every chair, I hurt my knee and hip. They laid me across two seats toward the back of the bus. Resident #19 said there were no nurses on the bus to help her reposition, administer pain medication or offer food or water during the nearly eight hours bus trip to the receiving facility. On 12/4/24 at 2:15 p.m., in an interview the DOR said Resident #19 was totally dependent for mobility. She said Resident #19 should have been evacuated by stretcher but was not. She verified Resident #19 was physically carried off the bus when she arrived at the receiving facility. Resident #9 Clinical record review for Resident #9 revealed an admitted [DATE]. Diagnoses included morbid obesity, anxiety disorder, sleep apnea, chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure. Resident #9 required oxygen at 3 liters per minute and a CPAP machine. The Admission MDS with a target date of 9/29/23 noted Resident #9's cognition was intact with a BIMs score of 15. The resident required partial/moderate assistance to safely move from lying on the back to sitting on the side of the bed with no back support. On 10/5/24 the physician documented, Discussed with patient the absolute necessity to utilize her CPAP at night and during daytime when sleeping. Patient has all necessary items at bedside. Reminded patient that her respiratory status was concerning for multiple staff, particularly with her need for pain medication following her orthopedic surgery. On 10/5/24 a nursing progress note documented the resident experienced shortness of breath while lying flat or attempting to lie flat. Oxygen as ordered. Head of bed elevated to prevent/avoid shortness of breath while lying flat. On 10/7/24 a physician progress note documented, on 2-liters of oxygen nasal cannula. The physician's orders included Benzonatate capsule 100 mg, two capsules daily at bedtime, Omeprazole 40 mg, one capsule by mouth in the morning for acid reflux, Budesonide suspension 0.25 mg/2 ml, inhale orally every 12 hours for COPD, Fluticasone Propionate nasal suspension 50 micrograms, one spray in both nostrils twice a day, Gabapentin 600 mg, one tablet by mouth three times a day for nerve pain, Ibuprofen 800 mg, one tablet by mouth every six hours for pain. On 10/8/24 Resident #9 evacuated approximately 197 miles to a receiving facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the MAR for October 2024 failed to show documentation Resident #9 received the following physician ordered medication during evacuation: Benzonatate capsule100 mg for cough on 10/8/24 and 10/9/24 at 9:00 p.m. Omeprazole 40 mg for acid reflux on 10/9/24 and 10/11/24 at 6:00 a.m. Quetiapine Fumarate at bedtime for anxiety disorder on 10/8/24 and 10/9/24 at 9:00 p.m. Budesonide suspension for COPD on 10/8/24, 10/9/24 at 9:00 p.m., and 10/11/24 at 9:00 a.m., and 9:00 p.m. Fluticasone Propionate nasal suspension on /8/24, 10/9/24 at 9:00 p.m., and 10/11/24 at 9:00 a.m., and 9:00 p.m. Gabapentin 600 mg for nerve pain on 10/8/24 at 1:00 p.m., and 9:00 p.m., 10/9/24 at 9:00 p.m., to 11/24 at 9:00 a.m., 1:00 p.m., and 9:00 p.m. Ibuprofen 800 mg for pain, on 10/8/24 at 12:00 p.m., 6:00 p.m., 10/9/24 at 12:00 a.m., 6:00 a.m., 10/10/24 at 12:00 a.m., and 10/11/24 at 6:00 a.m., 12:00 p.m., and 6:00 p.m. Review of the nursing progress notes revealed a late entry dated 10/11/24 at 12:30 p.m. which noted the resident was presenting respiratory failure, respiratory distress, and altered mental status while at the evacuation center. The resident was transferred to a local emergency room . On 11/19/24 at 11:00 a.m., in a telephone interview LPN Staff J said Resident #9 was supposed to have the head of the bed elevated but on 10/11/24 she was lying flat on a mat. Staff J said Resident #9 was not evacuated with her CPAP machine. When she notified the Director of Nursing, he said he forgot the machine. On 11/19/24 at 12:00 p.m., in an interview the Administrator verified nursing requested a bed for Resident #9 but did not receive one. On 11/19/24 at 1:00 p.m., in a telephone interview former Unit Manager Registered Nurse (RN) staff I said she was concerned about Resident #9's respiratory status. She told the Administrator and the DON several times during the evacuation that Resident #9 needed to sleep in a bed to elevate the head of the bed as per physician's order. She said on 10/11/24 everyone was asked to wake up at 4:30 a.m. Resident #9 had to be on oxygen via nasal cannula with the head of the bed elevated. She was one of the residents placed on a flat floor mattress. She was difficult to arouse, she wasn't able to breathe, her head was not elevated. She called 911. She said some of her residents were missing medications so they received what they had. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 12/4/24 at 4:00 p.m., in a telephone interview Resident #9 said they did not bring her CPAP machine when she evacuated. The oxygen concentrator kept beeping. She told the DON about the oxygen, and the CPAP machine and that she couldn't breathe when lying flat. The DON told her to, Lay down, we will figure it out in the morning. Resident #9 said on 10/8/24 the facility had them sit in their wheelchairs for hours, since 8:00 a.m., until they arrived at the receiving facility. She said they did not provide water, food or medications for 24 hours. On 10/11/24 she woke up gasping for air. Staff told her they will be loading soon to go back to [NAME]. She said she did not remember anything else. She was unconscious and was transported by ambulance to a local hospital. On 12/3/24 at 3:00 p.m., in an interview Licensed Practical Nurse (LPN) Staff CC said she evacuated with approximately 20 to 25 residents on a bus to a receiving facility. She said she did not know the residents and did not administer any medication since the residents were not evacuated with their MARS and she did not want to give the wrong medication to the residents. Review of the MARs for randomly selected Residents #12, #23 and #24 showed the residents did not receive their medications as ordered during the evacuation on 10/8/24 through 10/11/24. The following is a review of their records: Resident #24 Review of the clinical record for Resident #24 revealed a diagnosis of dysphagia (impaired swallowing ability), and malignant neoplasm (cancer) of the esophagus, non Alzheimer's dementia. Resident #24 received nutrition through a feeding tube inserted through the abdomen into the stomach. Review of the MAR for the month of October 2024, revealed the resident was ordered to receive Jevity 1.2 one carton (237 milliliters) via PEG (Percutaneous Endoscopic Gastrostomy) tube gravity bolus one time a day at 2pm. Further review of the MAR failed to reveal documentation that the resident received the tube feeding as ordered by the physician on 10/8/24, 10/10/24 and 10/11/24 at 2:00 p.m The physician's orders included to administer Glucerna 1.5 (nutritional meal replacement) via PEG by pump at 75 ml per hour for 12 hours (900 ml total volume). The order specified to start the tube feeding at 6:00 p. m. There was no documentation on the MAR the resident received the Glucerna as ordered on 10/8/24, 10/9/24, 10/10/24, and 10/11/24 at 6:00 p.m. The physician's orders also included to flush the tube four times a day with 250 ml of water bolus gravity. The flushes were scheduled to be administered at 6:00 a.m., 2:00 p.m., 6:00 p.m., and 9:00 p.m. The MAR lacked documentation the water flushes were administered as ordered on 10/8/24 at 2:00 p.m., 6:00 p.m., 9:00 p.m., on 10/9/24 at 6:00 a.m., on 10/11/24 at 2:00 p.m., and 6:00 p.m. Review of the MAR for October 2024 failed to reveal documentation the resident received the following physician ordered medications: Kapspargo ER (Extended Release) sprinkle 50 mg capsule, one capsule via the feeding tube for hypertension on 10/8/24 at 9:00 a.m. Omeprazole 20 mg via feeding tube for GERD (Gastroesophageal reflux disease) on 10/8/24 at 9:00 a.m. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Eliquis oral tablet 5 mg for atrial fibrillation (irregular, rapid heart rate) on 10/8/24 at 9:00 a.m., and 5:00 p.m., and 10/11/24 at 5:00 p.m. Gabapentin 250 mg/ml, 2.5 ml via tube for neuropathic pain on 10/8/24, 10/10/24, 10/11/24 at 6:00 p.m., 10/9/24, and 10/11/24 at 6:00 a.m.: Metoclopramide 5 mg for impaired gastric emptying on 10/8/24, 10/11/24 at 6:00 p.m., 10/9/24 at 6:00 a.m. Tramadol 50 mg, one tablet via gastric tube for pain on 10/8/24 at 8:00 a.m., and 4:00 p.m., 10/10/24 at 4:00 p.m., and 10/11/24 at 4:00 p.m. Depakote oral tablet delayed release 125 mg via gastric tube for mood stabilization on 10/8/24 at 2:00 p.m., and 10:00 p.m., on 10/9/24 at 6:00 a.m. Resident #23 Review of the clinical record for Resident #23 revealed an admitted [DATE]. Diagnoses included Osteomyelitis (bone infection) of the left ankle and foot, Methicillin resistant staphylococcus aureus infection, Diabetes Mellitus, Bipolar Disorder. Review of the Admission MDS with a target date of 9/7/24 revealed the resident's cognition was intact with a BIMs score of 15. Resident #23 was evacuated on 10/8/24. Review of the MAR for October 2024 failed to reveal documentation the resident received the following physician ordered medications: Insulin Glargine 20 units subcutaneously for Diabetes Mellitus, on 10/8/24 and 10/9/24 at 9:00 p.m., Seroquel 50 mg by mouth for Bipolar Disorder on 10/9/24 at 9:00 p.m. Famotidine 20 mg, one tablet by mouth for GERD, on 10/8/24, 10/11/24 at 5:00 p.m. Cefepime (antibiotic) solution 2 grams Intravenously for gangrene (dead tissue), on 10/8/24 at 2:00 p.m., and 10:00 p.m., 10/9/24 at 6:00 a.m., and 10:00 p.m., 10/10/24 at 6:00 a.m., 2:00 p.m., and 10:00 p.m., 10/11/24 at 6:00 a.m. Metronidazole (antibiotic) tablet 500 mg, one tablet by mouth every eight hours related to gangrene on 10/8/24 at 2:00 p.m., and 10:00 p.m., 10/9/24 at 6:00 a.m., and 10:00 p.m., 10/10/24 at 2:00 p.m., and 10/11/24 at 6:00 a.m., and 10:00 p.m. On 12/4/24 at 9:30 a.m., in an interview Resident #23 said she did not receive her scheduled medications during transportation to the receiving facility. The resident said, I was supposed to get Cefepime three times a day but only received it twice during the entire evacuation. It was just chaos. There were no medication on the bus. Resident #12 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the clinical record for Resident #12 revealed an admitted [DATE]. Diagnoses included Diabetes Mellitus, cirrhosis of the liver, left leg above knee amputation, stage 3 chronic kidney disease. Review of the Quarterly Minimum Data Set (MDS) assessment with a target date of 8/17/24 revealed the resident's cognition was intact with a Brief Interview for Mental Status score of 14. Review of the MAR for October 2024 failed to show documentation the resident received the following physician ordered medications: Bumetanide (diuretic) 2.5 mg for edema (swelling due to accumulation of fluid in the tissues), on 10/9/24, 10/10/24 and 10/1124 at 9:00 a.m. Spironolactone 25 mg for edema, on 10/8/24, 10/9/24, 10/10/24, 10/11/24 at 5:00 p.m., 10/9/24, 10/10/24 and 10/11/24 at 9:00 a.m. Fentanyl (narcotic analgesic) patch 12 micrograms per hour for pain on 10/9/24. MiraLAX powder 17 grams for constipation on 10/10/24 at 6:00 a.m. Basaglar (insulin glargine) 6 units for Diabetes Mellitus on 10/9/24 and 10/10/24 at 6:00 a.m. Gabapentin 300 mg, one capsule by mouth for neuropathic pain on 10/8/24, 10/9/24 and 10/10/24 at 9:00 p.m., 10/9/24, 10/10/24 and 10/11/24 at 9:00 a.m. MagOx 400, one tablet by mouth for leg cramps on 10/8/24 and 10/9/24 at 9:00 p.m., 10/9/24, 10/10/24, 10/11/24 at 9:00 a.m. Methocarbamol 750 mg, two tablets by mouth for neuropathic pain on 10/8/24, 10/9/24, 10/10/24 at 9:00 p.m., and 10/9/24, 10/10/24 and 10/11/24 at 9:00 a.m. There was no documentation the resident's blood glucose was measured to determine the need for insulin coverage per sliding scale as ordered before meals and at bedtime on 10/8/24, 10/9/24, 10/10/24, 10/11/24 at 4:30 p.m., 10/8/24, 10/10/24 at 6:30 a.m., 10/8/24, 10/9/24 at 9:00 p.m. On 12/3/24 at 10:15 a.m., in an interview Resident #12 said, The evacuation was a screwed up mess. She said the receiving facility did not have her medications, including her pain medications. The resident stated, The pain got so severe, I had to take Morphine twice to get it under control. On 11/18/24 at 2:50 p.m., in an interview related to the neglect of residents during the emergency evacuation, the Administrator said the evacuation locations listed on their Emergency Plan were in Bradenton, Port [NAME] and [NAME] Acres. He confirmed he was in charge of the evacuation and the decision was made to not evacuate to the local facilities but to facilities in Fort [NAME]. He said, We had to take what we could, there was no space on the stretcher transport. He verified the facility evacuated 112 residents and said he was not aware of any residents who did not receive their medications. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 11/19/23 at 1:00 p.m., in a telephone interview former Unit Manager Registered Nurse (RN) Staff I said she drove her car to the receiving facility in Fort [NAME]. She said residents were improperly assigned to coach buses instead of stretcher transportation. She functioned as a medication nurse at the receiving facility and documented, whatever I was able to do for the residents which wasn't a lot. Not all of their medications arrived so they missed some, they received what they had. On 11/19/24 at 3:00 p.m., in an interview CNA Staff L verified she was working on 10/8/24 when the decision was made to evacuate. She said she did not go on the bus with the residents, she drove her car to the receiving facility in Fort [NAME]. There was only one other CNA at the receiving facility to provide care to the residents. On 12/2/24 at 4:26 p.m., in an interview the Administrator said he made the decision on the back end to evacuate the residents 197 miles to Fort [NAME]. He said he did not know which staff members went on the buses with the residents and did not know if food or drinks were available for the residents on the buses and did not know who administered medications to the residents. On 12/3/24 at 10:37 a.m., in an interview Resident #27 said she slept in a chair and put her feet up, the bus ride was seven hours. She said, It was the worst thing I've been through. There was a bus driver. There were no snacks and we were not given any food or water. They did not take any precaution. They picked me up and took me off. Someone threw up but there was no one to help her. I never saw anyone clean up the vomit. On 12/3/24 at 12:00 p.m., in an interview the Administrator said he did not have specifics of which staff went on the buses with the residents, and did not know who went where. He said he did not keep documentation of nurses or CNAs who went with the residents on the buses. He said, My concern was getting the residents on the bus. I don't know if there is documentation of patient care during the bus trip. On 12/3/24 at 2:25 p.m., in a joint interview with the Administrator and the scheduler, the scheduler said CNAs Staff EE, Staff L, and Staff FF evacuated with the residents on the buses/vans. The Administrator said the former Director of Nursing (DON) and the former Assistant Director of Nursing (ADON) were responsible to ensure nursing staff were on the buses with the residents to administer medications and provide care. He said he did not verify with the DON or the ADON complied with their responsibilities and ensured staff traveled to the receiving facilities with the residents. Several calls were placed to the former DON for an interview but he did not return the calls. On 12/3/24 at 3:28 p.m., in an interview CNA Staff EE said she helped to load the residents on the buses then drove her own car to the receiving facility. On 12/4/24 at 2:50 p.m., in an interview CNA Staff FF she said she brought her child to the facility and rode on a coach bus with residents. She said many of the residents on the coach bus required maximum assistance or two person assistance. She asked th[TRUNCATED]

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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** 46824 Based on record review, review of facility's policy and procedure, and staff interviews, the facility failed to immediately report an alleged violation involving neglect for 1 (Resident #7) of 3 residents reviewed for accident to the appropriate officials, including to the State Survey and Certification agency (The Agency for Health Care Administration), and Adult Protective Services in accordance with State law. The findings included: Review of the facility's incident investigations revealed on 11/7/24 the facility Administrator initiated an investigation related to fracture and transfer of Resident #7 to a more acute level of care. The investigation noted on 10/8/24 at approximately 9:30 a.m., the Sarasota County issued an evacuation order ahead of category 3 hurricane [NAME] landfall. When the coach buses arrived, they did not have the necessary mechanical lifts for wheelchair bound residents. Due to the turnaround time to get replacement buses, time became a factor, as did the safety of the residents, due to the travel time and evacuation destination of Fort [NAME]. The local Emergency Medical Services department was contacted to assist in loading the residents, including Resident #7. Upon arrival to Fort [NAME], two highly skilled rehabilitation therapy staff from the receiving facility physically lifted Resident #7 off the bus. The resident's foot, came in contact with the ground surface, injuring the right foot. The facility Administrator documented on the incident investigation, The event was isolated and accidental without intention . No identified events required reporting as a 1/5 day . On 11/18/24 at 10:00 a.m., in an interview related to Resident #7's incident resulting in a fracture the Administrator said the resident used a full body mechanical lift for transfer. He verified Resident #7 did not evacuate on a stretcher transportation and said, It was the only thing we could do to get her out. He said therapy staff from the receiving facility physically carried Resident #7 off the bus caused the injury. He said it was, a matter of her foot coming in contact with the ground. On 11/18/24 at 12:30 p.m., in a follow up interview the Administrator said there was no space for Resident #7 on the stretcher transportation. They had EMTs (Emergency Medical Technicians) lift the resident and place her in a seat on a bus that was not equipped with a lift. Therapy staff from the receiving facility took the resident off the bus. The Administrator said, I would assume the injury is what they said, the foot came in contact with the ground. There was no way to get a mechanical lift on the bus because it was not a transport bus. She was on the last bus. The Administrator verified he did not immediately report the incident resulting in Resident #7's fractured ankle which could constitute neglect to the State Survey Agency and Adult Protective Services as required.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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** 46824 Based on record review and interviews with residents, residents representative and staff, the facility failed to ensure appropriate transportation, availability of assistive devices, and adequate supervision of dependent residents during emergency evacuation related to hurricane [NAME] a major category 3 storm. This failure affected all 112 residents evacuated from the facility and resulted in the emergency transfer of 2 residents (#7 and #9) to the hospital and unaddressed excruciating pain for 1 resident (#19). Resident #19 had multiple fractures and wore a neck brace. Facility staff inappropriately laid the resident across two seats on a coach bus for a 197 miles trip that lasted approximately seven hours, causing excruciating pain and suffering. Resident #7 was wheelchair bound and required a full body mechanical lift for transfers. She was inappropriately transported approximately 197 miles for seven hours on a coach bus. She sustained an open fracture of the ankle when two staff members physically carried her off the bus. Resident #9 was oxygen dependent, used a continuous positive airway pressure machine and required the head of the bed elevated. On [DATE] the resident was improperly laid flat on a mattress on the floor. The resident was found unresponsive and emergently transferred to a local hospital. The facility's failure to have processes in place to ensure the safety of residents during emergency evacuation created a likelihood of serious harm, injury, impairment or death of dependent residents and resulted in the determination of a pattern of Immediate Jeopardy (IJ) at a scope and severity of L. On [DATE] at 10:30 p.m., the Administrator was informed of the determination of Immediate Jeopardy. The findings included: Cross reference F600, F835 and F867. The facility assessment reviewed and updated [DATE] noted a facility wide assessment was completed to determine resources necessary to care for residents during day to day operations and emergencies. The facility assessment noted as of [DATE], 18 residents were independent for transfer, 73 residents required assistance of one to two staff and 29 residents were dependent. 44 residents were independent for mobility, 58 used an assistive device to ambulate and 18 residents were in chair most of the time. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility's Emergency Plan noted: Staffing for evacuation. Facility staff will accompany evacuating residents to their destination. Staff will accompany residents through the same modes of transportation utilized in evacuating the residents. Supplies will be packed for transit. Medications will be with the resident. Any residents deemed unable to transport in a non-emergent vehicle or Sunset Lake vehicle, will be reviewed by the Medical Director or designee, and may by physician order be transferred via ambulance to a local hospital. 1. On [DATE] at 10:00 a.m., in an interview the Administrator said on [DATE] at approximately 9:30 a.m., Sarasota County said the facility had to evacuate. The police came in person and told them they had to leave. 16 residents were transported via stretcher to a receiving facility in [NAME] Acres. 96 residents were transported via motorcoach buses to two facilities in Fort [NAME]. The Administrator said the trip lasted three hours plus evacuation traffic. He said, It was probably one of the worst experiences of my life. The Administrator said the former Director of Nursing (DON) was responsible for residents medication. He said, Could it have been better? Yes. Orders were in the electronic medical record when the residents arrived in Fort [NAME] therefore there was no interruption in care. When asked if residents missed any of their medications, the Administrator said, Not to my knowledge. When asked about Resident #7's fractured ankle the Administrator said the incident was transfer related. He said, When you just touch her she almost breaks. The therapist told him the resident's foot came in contact with the ground and it fractured. He said Resident #7 required a full body mechanical lift. On [DATE] Emergency Medical Technicians physically lifted the resident with a mechanical lift sling and put her on a bus. He verified Resident #7 was not transported via stretcher and said, It was the only thing we could do to get her out. The Administrator said Resident #7 sustained the fracture when trained therapists from the receiving facility physically lifted the resident to get her off the bus. The Administrator said there was one other resident who was transferred to the hospital during the evacuation, she was not in good shape. He could not remember what happened to the residents hospitalized during the evacuation and would have to look it up. Review of the facility's incident investigations revealed on [DATE] the Sarasota County issued an emergency evacuation order with the requirement to be out by midnight. The ordered buses arrived but did not have lifts for those needing assistance for wheelchairs. Due to the turnaround time to get replacement buses, time became a factor, as did the safety of the residents, due to the travel time and distance to Fort [NAME]. To safely assist in loading the residents, the local skilled Emergency Management Services was contacted. The buses left the facility at approximately 6:00 p.m. Due to heavy evacuation traffic, the buses arrived on [DATE] at approximately 2:00 a.m. to 3:00 a.m. As Resident #7 was being unloaded, the therapists recounted that her foot came in contact with the ground and a fracture was suspected. EMS arrived and transported Resident #7 to a local hospital. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Clinical record review for Resident #7 revealed a Quarterly Minimum Data Set (MDS) Assessment with a target date of [DATE] which noted Resident #7 required substantial/maximal assistance with chair to bed transfer (Helper does more than half the effort). The care plan initiated on [DATE] noted the resident required a mechanical lift with two person assist for all transfers. On [DATE] the care plan intervention specified to use care during transfers and during activities of daily living due to fragile condition, osteoporosis (weak, brittle bones) with frail bones. On [DATE] at 12:59 p.m., in a telephone interview Resident #7's daughter said the facility notified her of the emergency evacuation and said her mother was being transferred by stretcher to a local receiving facility. The daughter said the next message she received was that her mother was sent to the hospital for a broken leg she sustained when staff was getting her off a coach bus. The resident's daughter said her mother underwent emergency surgery and was discharged to a local skilled nursing facility. She said Resident #7 did not receive her seizure medications, had a seizure, went back to the hospital and died . On [DATE] at 2:15 p.m., in an interview the Director of Rehabilitation (DOR) said Resident #7 was totally dependent for mobility and confirmed Resident #7 should have evacuated by stretcher but was not. The DOR said staff used a mechanical lift sling to physically carry Resident #7 off the bus. She yelled to staff carrying the resident to watch her foot, then realized it was bleeding. 2. On [DATE] at 3:00 p.m., in an interview Licensed Practical Nurse (LPN) Staff CC said Resident #19 was evacuated in a coach bus and was in severe pain when she arrived at the receiving facility, and throughout her stay. She said on [DATE] they were going to bring her back on a coach bus. She told the Administrator she would not have the resident travel on a coach bus and would pay out of her own pocket if necessary to bring the resident back on a stretcher. On [DATE] at 10:15 a.m., in an interview Resident #19 said staff carried her on a sling to a seat on the bus. The resident said, I bumped into every seat on the way to the back of the bus. I was screaming in pain the entire time. I bounced onto every chair, I hurt my knee and hip. They laid me across two seats toward the back of the bus. Resident #19 said there were no nurses on the bus to help her reposition, administer pain medication or offer food or water during the nearly eight hours bus trip to the receiving facility. On [DATE] at 2:15 p.m., in an interview the Director of Rehab (DOR) said Resident #19 was totally dependent for mobility. She said Resident #19 should have been evacuated by stretcher but was not. She verified Resident #19 was physically carried off the bus when she arrived at the receiving facility. Clinical record review revealed Resident #19 had an admitted [DATE]. Diagnoses included, Diabetes Mellitus, nondisplaced fracture of second cervical vertebra and multiple right rib fractures, fracture of the right tibia (lower leg bone), and weakness. The Admission Minimum Data Set (MDS) assessment with a target date of [DATE] noted the resident's cognition was moderately impaired with a Brief Interview for Mental Status score of 12. Resident #19 was dependent on staff for mobility, including rolling left and right, moving from sitting on side of the bed to lying flat on the bed. Resident #19 frequently experienced pain which occasionally effected sleep and interfered with activities of daily living. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The physician's orders as of [DATE] included Dilaudid (narcotic) 4 milligrams (mg) three times a day for pain, and Dilaudid 4 mg one tablet by mouth every 4 hours as needed for pain level of 4 to 10. Review of the Medication Administration Record (MAR) for [DATE] lacked documentation Resident #19 received the scheduled Dilaudid on [DATE] at 6:00 p.m. during transport to the receiving facility, on [DATE] at 6:00 p.m., and on [DATE] at 6:00 a.m., 10:00 a.m., and 6:00 p.m. 3. On [DATE] at 11:00 a.m., in a telephone interview related to the emergency evacuation, LPN Staff J said Resident #9 was supposed to have the head of the bed elevated but on [DATE] she was lying flat on a mat. Staff J said Resident #9 was not evacuated with her CPAP (Continuous Positive Air Pressure) machine. When she notified the Director of Nursing, he said he forgot the machine. Clinical record review for Resident #9 revealed an admitted [DATE]. Diagnoses included morbid obesity, anxiety disorder, sleep apnea, chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure. Resident #9 required oxygen at 3 liters per minute and a CPAP machine. The Admission MDS with a target date of [DATE] noted Resident #9's cognition was intact with a Brief Interview for Mental Status (BIMS) score of 15. The resident required partial/moderate assistance to safely move from lying on the back to sitting on the side of the bed with no back support. Review of the nursing progress notes revealed a late entry dated [DATE] at 12:30 p.m. which noted the resident was presenting respiratory failure, respiratory distress, and altered mental status while at the evacuation center. The resident was transferred to a local emergency room . On [DATE] at 12:00 p.m., in an interview the Administrator verified nursing requested a bed for Resident #9 but did not receive one. On [DATE] at 1:00 p.m., in an interview Registered Nurse (RN) staff I said she was concerned about Resident #9's respiratory status. She told the Administrator and the DON several times during the evacuation that Resident #9 needed to sleep in a bed to elevate the head of the bed as per physician's order. On [DATE] at 4:00 p.m., in a telephone interview Resident #9 said they did not bring her CPAP machine when she evacuated. The oxygen concentrator kept beeping. She told the DON about the oxygen, and the CPAP machine and that she couldn't breathe when lying flat. The DON told her to, Lay down, we will figure it out in the morning. Resident #9 said on [DATE] the facility had them sit in their wheelchairs for hours, since 8:00 a.m., until they arrived at the receiving facility. She said they did not provide water, food or medications for 24 hours. On [DATE] she woke up gasping for air. Staff told her they will be loading soon to go back to [NAME]. She said she did not remember anything else. She was unconscious and was transported by ambulance to a local hospital. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	4. On [DATE] at 9:51 a.m., the Medical Director said she was not specifically asked to review any residents that may not be safe to evacuate to another facility or may have to go to the hospital in lieu of an evacuation site. She said she sent a message to all staff to let them know it was a low threshold to send anyone to the hospital. I had three lists of people to evacuate. One was for wheelchair, one by stretcher and one was for ambulatory residents. I didn't know how long it took them to get to Fort [NAME]. That was a big surprise to me and big shock that it took that long. This evacuation was a big warning we had some work to do going forward. No one told me about the residents having missed medications. No one told me about Resident #7's injury and having to be transferred to the hospital, or Resident #9 having respiratory distress. 5. On [DATE] at approximately 5:30 p.m., in an interview the Administrator said there were no concerns identified during the evacuation warranting a discussion in QAPI (Quality Assurance and Performance Improvement) or any corrective actions.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30599 Based on observation, record review and interviews, the facility failed to ensure 3 (Licensed Nurses N, HH, and I) of 5 sampled nurses reviewed received training and were competent in checking the function of the wander alert bands (alert staff when a resident leaves a designated safe area) to prevent cognitively impaired residents unsafe wandering and elopement. The findings included: Clinical record review for Resident #16 revealed an admitted [DATE]. Diagnoses included Encephalopathy, Anxiety Disorder, Adult Failure to Thrive and generalized weakness. The elopement risk evaluation dated 10/11/23 noted an elopement risk score of 16. The form noted a score of 15 or above indicated a high risk for elopement. Review of facility's incident investigations showed on 7/6/23 at approximately 7:30 p.m., Resident #16 was found outside of facility doors. A staff member quickly discovered her and returned her safely back to her room. The investigation noted Resident #16's cognition was moderately impaired with a Brief Interview for Mental Status score of 07. The resident was wearing a wander alert bracelet at the time of the elopement. The wander alert bracelet was checked every shift to ensure placement and functioning. The facility's investigation noted the wander alert bracelet was sounding when staff brought the resident back into the facility. The resident's care plan initiated on 6/7/24 noted staff was to verify placement and check the functioning of the wander alert bracelet daily. On 12/4/24 at 10:35 a.m., Resident #16 was observed lying in her bed. The resident had a wander alert bracelet to her left ankle. When asked how she checked the function of the wander alert bracelet, Registered Nurse (RN) Staff N said the device had a green light. Observation of the wander alert with Staff N did not show a green light. Staff N said she was not able to check the function of the wander alert bracelet and said she's never checked the device for anything, except that it was in place on her ankle. Review of the Treatment Administration Record (TAR) for November of 2024 showed Staff N documented on 11/1/24, 11/5/24, 11/7/24, 11/8/24, 11/ 14/24, 11/17/24, 11/18/24, 11/20/24, 11/23/24, 11/26/24, 11/28/24, and 11/29/24 she had checked the function of the Resident #16's Wander alert bracelet. On 12/4/24 at 11:00 a.m., in an interview Registered Nurse, Staff HH said she only checks placement of the wander alert bracelets. She said she did not know how to check the functioning of the device. Review of the TAR for November and December 2024 showed Staff HH documented she checked the function of the wander alert bracelet on 11/20/24 and 12/4/24. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/4/24 at 11:20 a.m., the Assistant Director of Nursing (ADON) was asked to provide documentation of training and competency on checking the functioning of wander alert devices for Staff N, Staff HH, and Staff I. On 12/4/24 at 12:45 p.m., in an interview the ADON verified she had no documentation of training or competency related to verifying the function of the wander alert devices for Staff N, Staff HH, and Staff I. On 12/4/24 at 1:15 p.m., in an interview the DON said the facility did not have a policy and procedure for checking the function of the wander alert bracelets. The DON said she was currently working on an in-service for the nurses.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46824 Based on observation, interviews, and record review, the facility's administration failed to utilize its resources effectively to prevent the neglect of residents by failing to develop and implement an effective Emergency Plan emergency plan, including contingency planning for evacuation transportation and failing to adequately train and verify competency of staff to respond to natural disasters including emergency evacuation procedures in a safe and orderly manner. This failure resulted in avoidable serious harm of residents #7, #9 and #19 and created a likelihood of serious injury of 112 residents during emergency evacuation on 10/8/24 ahead of category 3 hurricane [NAME] landfall. Resident #19 had multiple fractures and suffered excruciating pain when staff inappropriately laid her across two seats for approximately 197 miles and seven hours during transport to the receiving facility. Resident #7 was evacuated in a coach bus instead of necessary transportation equipped with a lift. She suffered a fractured ankle when receiving facility staff physically carried her off the bus. Resident #9 had a diagnosis of Chronic Obstructive Pulmonary Disease and required the use of oxygen, a continuous positive air pressure (CPAP) machine and the head of the bed elevated. She suffered serious harm when she was not evacuated with the CPAP machine and was improperly laid flat on a mattress on the floor. The resident went unresponsive and was emergently transferred to a local hospital. On 12/6/24 at 10:30 p.m., the Administrator was notified of the determination of ongoing widespread Immediate Jeopardy (IJ). The findings included: Cross reference to F600, F689, F867 The Administrator's job description signed on 8/10/22 noted the primary purpose of the position is to direct the day-to-day functions of the facility in accordance with current federal, state and local standards guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to the residents at all times. The Director of Nursing job description signed on 11/6/23 noted the primary purpose of the position is to plan, organize, develop, and direct the overall operation of the nursing service department in accordance with current federal, state and local standards, guidelines, and regulations that govern the facility and as may be directed by the Administrator to ensure that the highest degree of quality care is maintained at all times. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 11/18/24 the facility's Comprehensive Emergency Management Plan (CEMP) was reviewed. The plan noted the Executive Director developed the plan and was responsible for the implementation of the plan in accordance with policies, procedures and in accordance with applicable rules, laws and regulations. The plan noted the Incident commander (Executive Director/designee) will implement emergency staffing. Management personnel will be staffed according to the A and B Team profile. Staff members, as defined by positions within the facility, are assigned to either A or B teams prior to, during, and after an emergency or disaster situation. The Medical Director was included in the A team and was responsible to oversee medical care upon activation of the plan and provide medical guidance. The Director of Clinical Services (Director of Nursing) was responsible to monitor resident condition and coordinate care with Unit Managers and Staff. In the event an evacuation is ordered for the facility, the Incident Commander or Administrator oversees the evacuation procedure upon declaration of evacuation and prepares residents and supplies for transit. The Unit Managers were responsible to ensure residents are prepared for transit and ensure residents are safely loaded into transportation. The plan noted in the event of an evacuation, facility staff will remain with the residents through the entire evacuation process until released by the Incident Commander or Executive Director. Facility staff will accompany evacuating residents to their destination through the same modes of transportation utilized in evacuating the residents. The plan noted supplies will be packed for transit. Medications will be with the resident. The facility had mutual aid agreements with two transport companies (Transport Companies A and B) and two facility owned vans (van #1: 12 seats; van #2: 5 seats). Transport company A agreement the facility Administrator signed on 4/22/24 noted, It is understood that (Transport Company A) is under contract with Sarasota county Department of Emergency Management and that in the event of a disaster or emergency, Sarasota County Department of Emergency Management has the authority to direct all evacuation procedures. Transport company B agreement the facility Administrator signed on 4/24/24 noted, (Transport company B) will attempt to provide Sunset Lake Health and Rehabilitation Center with transportation service in the event of an emergency or disaster . The agreement noted, Total number of seats: 8 wheelchair, 4 Stretcher, 11 Ambulatory or 15 wheelchair, 11 ambulatory. The plan did not include contingency planning in the event the contracted transport companies could not fulfill the agreement. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Key workers (Departmental Managers) will be responsible for understanding their roles in an emergency, as outlined in the CEMP. A hurricane preparedness in-service will be held with residents and staff just prior to hurricane season to review and prepare in the event of a hurricane. A comprehensive disaster preparedness education will be held annually and is mandatory for employees. In addition, disaster preparedness training is a key part of the orientation for new hires. Training is provided by department managers, each concentrating on their specific areas of responsibility. A general review of the facility's comprehensive emergency management plan is given to all new employees during their orientation. Department/Role specific training is completed during the employee's first week of orientation. On 11/18/24 at 10:00 a.m., in an interview the Administrator said on 10/8/24 at approximately 9:30 a.m., the Sarasota County issued an evacuation order for the facility and the police told them in person that they had to leave. One of the receiving facilities listed on their plan had already evacuated to one of the receiving facilities listed on their plan. They were only able to accommodate 16 residents. It looked like the storm was going to make landfall in Bradenton where the third receiving facility was located. He made the decision to evacuate 96 residents approximately 197 miles to two facilities in Fort [NAME] and had to use coach buses to transport the residents. When asked about Resident #7's fracture, the Administrator said the resident used a full body mechanical lift for transfer. He verified Resident #7 did not evacuate on a stretcher transportation and said, It was the only thing we could do to get her out. He said therapy staff from the receiving facility physically carried Resident #7 off the bus caused the injury. He said it was, a matter of her foot coming in contact with the ground. When asked about implementation of the Emergency Plan and ensure a safe evacuation of the residents the Administrator said he was not aware of any serious complaint. Residents mostly complained about being put on the floor and other inconveniences. There were a few missing personal items which he replaced. The Administrator said he was not aware of residents not receiving care, food, hydration or medications during the evacuation. He was not able to provide a list of staff who accompanied the residents on the transport buses or vans. The Administrator was asked but was not able to provide how the list of management and direct care staff assigned to Team A or Team B per the evacuation plan. On 11/19/23 at 1:00 p.m., in a telephone interview former Unit Manager Registered Nurse (RN) Staff I said she drove her car to the receiving facility in Fort [NAME]. She said residents were improperly assigned to coach buses instead of stretcher transportation. She functioned as a medication nurse at the receiving facility and documented, whatever I was able to do for the residents which wasn't a lot. Not all of their medications arrived so they missed some, they received what they had. On 11/19/24 at 3:00 p.m., in an interview CNA Staff L verified she was working on 10/8/24 when the decision was made to evacuate. She said she did not go on the bus with the residents, she drove her car to the receiving facility in Fort [NAME]. There was only one other CNA at the receiving facility to provide care to the residents. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 12/2/24 at 4:26 p.m., in an interview the Administrator said he made the decision on the back end to evacuate the residents 197 miles to Fort [NAME]. He said he did not know which staff members went on the buses with the residents and did not know if food or drinks were available for the residents on the buses and did not know who administered medications to the residents. On 12/3/24 at 10:37 a.m., in an interview Resident #27 said she slept in a chair and put her feet up, the bus ride was seven hours. She said, It was the worst thing I've been through. There was a bus driver. There were no snacks and we were not given any food or water. They did not take any precaution. They picked me up and took me off. Someone threw up but there was no one to help her. I never saw anyone clean up the vomit. On 12/3/24 at 12:00 p.m., in an interview the Administrator said he did not have specifics of which staff went on the buses with the residents, and did not know who went where. He said he did not keep documentation of nurses or CNAs who went with the residents on the buses. He said, My concern was getting the residents on the bus. I don't know if there is documentation of patient care during the bus trip. On 12/3/24 at 2:25 p.m., in a joint interview with the Administrator and the scheduler, the scheduler said CNAs Staff EE, Staff L, and Staff FF evacuated with the residents on the buses/vans. The Administrator said the former Director of Nursing (DON) and the former Assistant Director of Nursing (ADON) were responsible to ensure nursing staff were on the buses with the residents to administer medications and provide care. He said he did not verify with the DON or the ADON complied with their responsibilities and ensured staff traveled to the receiving facilities with the residents. Random record review for residents #7, #9, #19, #12, #23 and #24 showed the residents did not receive necessary medications, including insulin, intravenous antibiotics, anticonvulsants, narcotics and/or other necessary medications during transport and at the receiving facilities. Several calls were placed to the former DON for an interview but he did not return the calls. On 12/3/24 at 3:28 p.m., in an interview CNA Staff EE said she helped to load the residents on the buses then drove her own car to the receiving facility. On 12/4/24 at 2:50 p.m., in an interview CNA Staff FF she said she brought her child to the facility and rode on a coach bus with residents. She said many of the residents on the coach bus required maximum assistance or two person assistance. She asked the Administrator about the many residents who did not belong on the coach bus. The Administrator said there was no other choice. She said at the receiving facility the residents who slept on mattresses on the floor did not have a way to sit up for meals. She worked over 24 hours with no one to relieve her. The Administrator said there was no Team A or Team B to rotate staff because there were not enough staff to have teams. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 12/5/24 at 9:51 a.m., in an interview the Medical Director said she was not asked to review residents who may not be safe to evacuate to another facility or may have to go to the hospital in lieu of an evacuation site. She said there were three residents lists, including one for wheelchair bound resident and one for residents requiring transportation via stretcher. She said she didn't know how long it took for the residents to get to Fort [NAME]. The Medical Director said it was a big surprise and big shock that it took that long. A big warning that we had a lot of work to do for our emergency planning. The Medical Director said she was not informed until a week after the evacuation of residents who did not receive their medications and was never informed of Resident #7's injury. On 12/6/24 at 5:20 p.m., in an interview the Administrator said there was no documentation staff and residents were in-serviced just prior to hurricane season as per their Emergency Preparedness Plan to review and prepare in the event of a hurricane. The Administrator said, I can stop looking for training as it is not going to help. He said there were no concerns identified related to the emergency evacuation of the residents on 10/8/24 warranting a discussion or corrective actions. On 12/6/24 at 5:45 p.m., in an interview the Maintenance Director said the whole evacuation was chaotic. He had an informal conversation with the Administrator about residents left sitting in wheelchairs for at least two hours before getting on the buses/vans for the drive to the receiving facilities. He said he recommended residents stay in their room for comfort until ready to get on the bus. 6. Random staff and resident interviews revealed: On 11/18/24 at 11:47 a.m., in an interview Registered Nurse (RN) Staff N said it didn't seem like there was any protocol. If called to evacuate there should be a concrete plan. She said the residents returned to the facility, then the mattresses came back, then the medications came back. On 11/18/24 at 12:15 p.m., Licensed Practical Nurse (LPN) Staff O said she has been employed at the facility for one month and had not received any training on emergency planning or evacuation. On 11/18/24 at 12:30 p.m., in an interview LPN Staff GG said she was at the facility on 10/11/24 to receive the residents from the evacuating facilities. She said it was haphazard. Residents came back without medications or mattresses. The medications and mattresses came back within a day after the residents' arrival. She said residents were exhausted. It didn't seem like there is any protocol if you're called to evacuate. It should be ok, a, b, c, d, e, it really felt that there should be a plan in place. On 11/19/24 at 9:15 a.m., in a follow up interview the Maintenance Director verified there was no resident or staff training just prior to the start of the hurricane season. On 11/19/24 at 10:07 a.m., in an interview the Admission Director said, I am not familiar with the facility assessment. I was not part of any facility drills for evacuation from January through September. He said he drove facility and resident equipment and supplies in a truck and did not remain at the facility with the residents. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 11/19/24 at 11:00 a.m., in an interview Unit Manager LPN Staff J said when they arrived at the receiving facility, residents medications and narcotics were still missing and they reported it to the Administrator. She said they used mostly pillows to prop residents up but they really didn't work that well. When asked about providing residents their usual medications Staff J said I was able to do what I always do. I would borrow. I wouldn't let them go without unless they didn't have the medications available. She said several residents including Residents #17 and #18 sustained skin tears from the transport. She said they were rushing and removing residents from the bus improperly. She used bandages to care for the injuries, there was no one there to evaluate the residents. Staff J said she did not think there was any staff on one of the buses. On 11/19/24 at 5:00 p.m., in a telephone interview with the former Assistant Director of Nursing (ADON), and RN Staff FF, the ADON said with the help of the Director of Rehab, they prepared a list of residents, ambulatory, wheelchair bound and stretcher required. The Administrator decided we could walk and carry the residents on the bus. He said he was not going to pay for another bus and to, get them on whatever bus you can. She said Resident #7 was on the stretcher transport list but evacuated on a coach bus. She did not have the trunk control to sit on a bus. She suffered a compound fracture when she was physically carried off the bus. On 11/21/24 at 11:00 a.m., in a telephone interview RN Staff W said on 10/11/24 she received residents from the evacuation sites. She said one of the buses from Fort [NAME] did not have any staff. It was a bus full of residents. When she walked into the bus, the residents looked dehydrated, distressed and started to cry. Every oxygen tank was empty. One resident had defecated on the seat. The bus driver was irate that no one accompanied the residents on the bus. She said residents were dirty, covered in urine, feces and food. The entire bus had no alert and oriented residents on it. Many residents had skin tears; they had to do a skin sweep for the entire building. On 12/2/24 at 10:00 a.m., in an interview Resident #25 said he fell getting on the coach bus and scrapped his leg. The DON helped him up. He did not receive his medications during the trip to the receiving facility. He said there was an assistant on the bus coming back to the facility but no food or water.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 30599 Based on interview, record review the facility failed to ensure the Facility Assessment was complete and involved input from facility staff and ensured documentation of how the facility informed staff of the current Comprehensive Emergency Management Plan (CEMP) The findings included: Review of the Facility Assessment provided by the facility last updated on 1/11/24 listed the Activities Director, The Director of Housekeeping, the Social Service Director and Resident #28 as contributors to the assessment. On 11/19/24 at 8:45 a.m., in an interview the Activities Director said she wasn't sure what the facility assessment was and did not participate in the development and did not provide any feedback on the development of the assessment. On 11/19/24 at 10:00 a.m., in an interview the Director of Housekeeping and the Assistant Director of Housekeeping said they were not familiar with the facility assessment, did not attend any meetings or provide any input about the facility assessment. On 11/19/24 at 10:07 a.m., in an interview the Admissions Director said, I am not familiar with the facility assessment. On 12/5/24 at 9:37 a.m., in an interview Resident #28 said she did not have any input or involvement with the facility assessment. She was not aware of any planning or discussion regarding facility needs, evacuation planning or supplies that would be necessary to take during a disaster. Review of the Facility Assessment last updated 1/11/24 showed no documentation of how staff were informed of the facility's Comprehensive Emergency Management Plan. On 12/4/24 at 3:10 p.m., in an interview the Administrator verified the current facility assessment did not document how staff would be instructed on the facility's Comprehensive Emergency Management Plan.

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46824 Based on record review and staff interviews the facility failed to implement corrective actions for identified quality deficiencies related to staff training and competency to respond appropriately to natural disasters to prevent the neglect of residents during natural disasters and emergency evacuation of residents. On 10/8/24 the facility did not ensure the safety of 112 residents during emergency evacuation ahead of category 3 hurricane [NAME] landfall. The facility did not ensure transportation to meet the needs of wheelchair and stretcher bound residents and failed to staff each transport bus or van with nursing staff to ensure residents safety, provision of care and administration of necessary physician ordered medications. Resident #19 had multiple fractures and suffered excruciating pain when staff inappropriately laid her across two seats for approximately 197 miles and seven hours during transport to the receiving facility. Resident #7 was evacuated in a coach bus instead of necessary transportation equipped with a lift. She suffered a fractured ankle when receiving facility staff physically carried her off the bus. Resident #9 had a diagnosis of Chronic Obstructive Pulmonary Disease and required the use of oxygen, a continuous positive air pressure (CPAP) machine and the head of the bed elevated. She suffered serious harm when she was not evacuated with the CPAP machine and was improperly laid flat on a mattress on the floor. The resident went unresponsive and was emergently transferred to a local hospital. Random record review for residents #7, #9, #19, #12, #23 and #24 showed the residents did not receive necessary medications, including insulin, intravenous antibiotics, anticonvulsants, narcotics and/or other necessary medications during transport and at the receiving facilities. The facility failure to have an effective Quality Assurance and Performance Improvement program that identify quality deficiencies and implement appropriate corrective actions created a likelihood of serious harm, serious injury or death of other residents and resulted in the determination of widespread ongoing Immediate Jeopardy (IJ). On 12/6/24 at 10:30 p.m., the Administrator was notified of the determination of Immediate Jeopardy (IJ). The findings included: Cross reference to F600, F689, F835 (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility's Emergency Preparedness Plan noted the facility Administrator will review the drill critiques or after-action reports upon completion of drills or actual emergency events where the CEMP (Comprehensive Emergency Management Plan) has been activated. Areas identified as being deficient or needing approval upon, the facility Administrator will ensure that new staff education is created, and staff receive the new education. The new education will be added to the Annual Disaster education and the New Hire Orientation for Disaster education. On 11/18/24 at 10:00 a.m., in an interview the Administrator said on 10/8/24 at approximately 9:30 a.m., the Sarasota County issued an evacuation order for the facility and the police told them in person that they had to leave. One of the receiving facilities listed on their plan had already evacuated to one of the receiving facilities listed on their plan. They were only able to accommodate 16 residents. It looked like the storm was going to make landfall in Bradenton where the third receiving facility was located. He made the decision to evacuate 96 residents approximately 197 miles to two facilities in Fort [NAME] and had to use coach buses to transport the residents. When asked about the list of staff who accompanied residents on the transport buses or vans to ensure residents received necessary care, food, hydration and medications, the Administrator said he was not able to provide documentation showing which nursing staff members traveled with the residents on the buses or vans. He said he was not aware of residents not receiving care, food, hydration or medications. He said he was not aware of serious complaints. When asked about Resident #7's fracture, the Administrator said the resident used a full body mechanical lift for transfer. He verified Resident #7 did not evacuate on a stretcher transportation and said, It was the only thing we could do to get her out. He said therapy staff from the receiving facility physically carried Resident #7 off the bus caused the injury. He said it was, a matter of her foot coming in contact with the ground. Review of the incident investigation related to Resident #7's fracture completed by the Administrator showed the facility did not consider neglect. The Administrator documented, No other injuries occurred during the evacuation. The event was isolated and accidental without intention. On 11/18/24 at 12:30 p.m., in an interview the Administrator said Resident #7 used a full body mechanical lift for transfer. There was no space for Resident #7 on the stretcher transportation. They had EMTs (Emergency Medical Technicians) lift the resident and place her in a seat on a bus that was not equipped with a lift. Therapy staff from the receiving facility took the resident off the bus. The Administrator said, I would assume the injury is what they said, the foot came in contact with the ground. There was no way to get a mechanical lift on the bus because it was not a transport bus. She was on the last bus. Clinical record review of Resident #7 noted documentation in the care plan initiated on 9/5/23 Resident #7 required a mechanical lift with two person assist for all transfers. On 5/13/24 the care plan intervention specified to use care during transfers and during activities of daily living due to fragile condition, osteoporosis (weak, brittle bones) with frail bones. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105761	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Lake Healthcare and Rehabilitation Center	832 Sunset Lake Boulevard Venice, FL 34292

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 12/3/24 at 3:00 p.m., in an interview Licensed Practical Nurse (LPN) Staff CC said Resident #19 was evacuated in a coach bus and was in severe pain when she arrived at the receiving facility, and throughout her stay. She said on 10/11/24 they were going to bring her back on a coach bus. She told the Administrator she would not have the resident travel on a coach bus and would pay out of her own pocket to bring the resident back on a stretcher. On 12/4/24 at 10:15 a.m., in an interview Resident #19 said staff carried her on a sling to a seat on the bus. The resident said, I bumped into every seat on the way to the back of the bus. I was screaming in pain the entire time. I bounced onto every chair, I hurt my knee and hip. They laid me across two seats toward the back of the bus. Resident #19 said there were no nurses on the bus to help her reposition, administer pain medication or offer food or water during the nearly eight hours bus trip to the receiving facility. Clinical record review lacked documentation Resident #19 received physician ordered medications, including narcotic analgesics for pain and other medications during the evacuation and at the receiving facility. On 11/19/24 at 11:00 a.m., in a telephone interview related to care of residents during the evacuation, LPN Staff J said Resident #9 was supposed to have the head of the bed elevated but on 10/11/24 she was lying flat on a mat. Staff J said Resident #9 was not evacuated with her CPAP machine. When she notified the Director of Nursing, he said he forgot the machine. On 11/19/24 at 12:00 p.m., in an interview the Administrator verified nursing requested a bed for Resident #9 but did not receive one. On 11/19/24 at 1:00 p.m., in an interview Registered Nurse (RN) staff I said she was concerned about Resident #9's respiratory status. She told the Administrator and the DON several times during the evacuation that Resident #9 needed to sleep in a bed to elevate the head of the bed as per physician's order. On 12/4/24 at 4:00 p.m., in a telephone interview Resident #9 said they did not bring her CPAP machine when she evacuated. The oxygen concentrator kept beeping. She told the DON about the oxygen, and the CPAP machine and that she couldn't breathe when lying flat. The DON told her to, Lay down, we will figure it out in the morning. Resident #9 said on 10/8/24 the facility had them sit in their wheelchairs for hours, since 8:00 a.m., until they arrived at the receiving facility. She said they did not provide water, food or medications for 24 hours. On 10/11/24 she woke up gasping for air. Staff told her they will be loading soon to go back to [NAME]. She said she did not remember anything else. She was unconscious and was transported by ambulance to a local hospital. Review of Resident #9's clinical record revealed a late entry nursing progress note dated 10/11/24 at 12:30 p. m. which noted the resident was presenting respiratory failure, respiratory distress, and altered mental status while at the evacuation center. The resident was transferred to a local emergency room . During random staff interviews on 11/18/24 with Licensed Practical Nurse (LPN) Staff O, Staff GG, Staff J said they had not received training on the facility's Emergency Plan or evacuation process. (continued on next page)

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	105761	A. Building B. Wing	12/06/2024

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 11/21/24 at 11:00 a.m., in a telephone interview Registered Nurse Staff W said on 10/11/24 she received residents from the evacuation sites. She said no staff accompanied residents in one of the buses from Fort [NAME]. She said it was a bus full of residents. When she walked into the bus, the residents looked dehydrated, distressed and started to cry. Every oxygen tank was empty. One resident had defecated on the seat. The bus driver was irate that no one accompanied the residents on the bus. She said residents were dirty, covered in urine, feces and food. The entire bus had no alert and oriented residents on it. Many residents had skin tears; they had to do a skin sweep for the entire building. On 12/3/24 at 2:25 p.m., in an interview the Administrator said the former Director of Nursing (DON) and the former Assistant Director of Nursing (ADON) were responsible to ensure nursing staff were on the buses with the residents to administer medications and provide care. He said he did not verify with the DON or the ADON complied with their responsibilities and ensured staff traveled to the receiving facilities with the residents. On 12/5/24 at approximately 5:30 p.m., in an interview the Administrator said there were no concerns identified during the evacuation warranting a discussion in QAPI (Quality Assurance and Performance Improvement) or any corrective actions. The Administrator said since the hurricane the facility held a QAPI meeting in November, but the items discussed did not include a review of the evacuation for hurricane [NAME]. The Administrator refused to share the items discussed during the QAPI meeting but said they did not include a review of the emergency evacuation.