STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105523	A. BUILDING _____ B. WING _____	C 11/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PORT REHABILITATION AND NURSING CENTER	6940 OUTREACH WAY NORTH PORT, FL 34287

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint survey for #2023017140 was conducted on through at North Port Rehabilitation and Nursing Center, a skilled nursing facility in North Port, Florida. This survey was conducted in conjunction with a complaint revisit survey. Complaint #2023017140 was substantiated with a citation at F607, and F609. North Port Rehabilitation and Nursing Center is not in compliance with the Code of Federal Regulations (CFR) 42, Part 483, Subparts B-F, Requirements for Long-Term Care Facilities. The following is the description of the noncompliance.	F 000		
F 607 SS=D	Develop/Implement /Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent , neglect, and , of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75.	F 607		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/2023

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

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F 607	Continued From page 1 §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility's policy and procedure, resident representative and staff interview, the facility failed to implement their policies and procedures, and immediately address an allegation of staff to resident for 1 (Resident #1) of 3 residents reviewed for . The findings included: Review of the facility's policy, " , Neglect, , , Misappropriation, Mistreatment, and injury of unknown origin(ANEMMI)" revision noted , included, "Hitting, slapping, pinching, and kicking." The policy listed several criterias, including "any resident or family complaint of physical harm, , or mental anguish resulting from willful infliction from others," will be considered as possible ANEMMI. The policy specified any employee having either direct or indirect knowledge of any event that mighty consitute , Neglect, , , Misappropriation, Mistreatment, and injury of	F 607	1. LPN Staff S was re-educated on , by the Administrator/Designee on the components of F607 with an emphasis on reporting allegations of ANEMI to the administrator per the federal regulation and facility policy. LPN Staff T was re-educated on , by the Administrator/Designee on the components of F607 with an emphasis on reporting allegations of ANEMI to the administrator per the federal regulation and facility policy. 2.By the Administrator/Designee completed an audit on the past 60 days of reportables to ensure timely reporting was completed per the federal regulation and facility policy. No like incidents were noted. 3.On , the Administrator and the Director of Nursing were educated by the Regional Nurse Consultant on the	

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F 607	Continued From page 2 unknown origin must report the event promptly. Residents will be protected from harm during an investigation. Staff person or persons suspected of ANEMM will be suspended immediately pending result of the investigation. Review of the facility's . . . . . investigations revealed on (Monday) at approximately 3:20 p.m., a police officer came to the facility to interview Resident #1. Resident #1 stated, "sometimes yesterday [Sunday . . . . .] someone punched him in the . . . " Review of the clinical record revealed Resident #1 was admitted to the facility on . . . . . . Diagnoses included , , Major . . . . . , Restlessness and Agitation, , Acute , . Resident #1 required total assistance for personal care. On Monday . . . . . , Licensed Practical Nurse (LPN) Staff T documented a statement noting on "Sunday afternoon" the nurse told her Resident #1's friend said someone hit him. She went to Resident #1 and asked what had happened. Resident #1 replied "nothing." The resident's friend again said Resident #1 told her someone hit him. LPN Staff T documented when she asked Resident #1 where he was hit, he said to the left side of his cheek. LPN Staff T documented she spoke to the Certified Nursing Assistant (CNA) who was taking care of the resident. The CNA said Resident #1 refused to be changed, was kicking at them, cursing them, kicking one of the CNAs on her . . . . . , damaging her glasses. On Monday . . . . . , LPN Staff S wrote a statement noting the nurse for the 3:00 p.m., to 11:00 p.m., shift stated Resident #1's visitor said	F 607	systematic process of reporting allegations of ANEMI per the federal regulation. By , current staff were educated by the Director of Nursing/Designee on the components of F607 with an emphasis on reporting allegations of ANEMI per the federal regulation and the facilities policy. Newly hired staff will be educated on the components of F607 with an emphasis on reporting allegations of ANEMI to the administrator per the federal regulation by the Director of Nursing/Designee at orientation as a part of the systematic changes. 4. The Administrator/Designee will conduct a weekly audit on 5 residents to ensure no allegations of ANEMI were pending reporting weekly x4 weeks then monthly for 2 months or until substantial compliance is achieved. The Administrator/Designee will conduct a weekly audit with 5 employees to ensure no allegations of ANEMI were reported to them, weekly x4 weeks then monthly for 2 months or until substantial compliance is achieved. Findings will be reported monthly at the QAPI Committee meeting until such a time substantial compliance has been determined.	

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F 607	Continued From page 3 that someone had hurt him on the ....., but she did not observe any injury. On at 1:20 p.m., in a telephone interview, Resident #1's friend said on Sunday when she walked into the resident's room, two CNAs were providing care. He has on his . His got bumped causing a lot of , and agitated him. He was yelling and cursing at the CNAs and said that she had hit him in the left , and pointed to just below the left . One of the CNAs said Resident #1 had hit her in the as she was bending over. The CNA did not say that she hit him, but she did not deny hitting him either. She did not say anything either way. She said she was concerned about it because he had never accused anyone of hitting him ever. She reported the incident to LPN Staff S who works on Sundays. LPN Staff S said she would notify the supervisor. Shortly after, the supervisor came in, she looked at Resident #1's , and said she did not see any redness. She tended to side with the aides because the resident tended to get upset. She said she would go to the CNAs and get their side of the story. Resident #1's visitor said she never heard from anyone after that, the supervisor never came in the room. On at 2:30 p.m., in a telephone interview, LPN Staff S said on Resident #1's friend said last weekend the resident's friend reported to her two CNAs were providing care, and one of them hit him in the . The friend described the staff to her, and what they were wearing. She reported the incident to the desk nurse, LPN Staff T who got up right away and looked for the staff described.	F 607		

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F 607	Continued From page 4	F 607		

On at 2:45 p.m., in an interview LPN Staff T said when LPN Staff S reported the alleged incident to her, she went in the room to speak to Resident #1. At first, the resident said, "nothing happened." When asked again, he pointed to his and said someone hit him. She said she did not see any marks or . She said Resident #1 would kick or punch when he is being changed. She identified the two CNAs who were providing care to the resident but did not notify anyone about the allegation until the police came to the facility a day or two later.

On at 11:40 a.m., CNA Staff W said on she was assisting CNA Staff V changing Resident #1. When they turned Resident #1 to his side, CNA Staff V was in front ho him. He grabbed CNA Staff V's and kicked her in the . Her glasses were hanging on her shirt, and he broke them.

On at 11:46 a.m., CNA Staff V verified on she helped CNA Staff W providing care for Resident #1. She said Resident #1 was violent and required two CNAs and two nurses when providing care to him. She said, "I do not people." CNA Staff W said she rolled Resident #1 to one side, he does not like that, he wants it done quickly. She said she turned to him and put her on his . Resident #1 then hit her in the and broke her glasses. She said she reported the incident to LPN Staff S. The CNA said the resident's friend was in the room, behind the privacy curtain when they were providing care and did not say anything.

There was no documentation of steps taken by

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F 607	Continued From page 5 the facility on [redacted] to immediately report, investigate and protect Resident #1 from harm during the investigation. On [redacted] at 11:00 a.m., the Director of Nursing (DON) said she was not aware of the allegation of staff to resident [redacted] until 11/20/23 when the police officer came to the facility. She said no one called her that Sunday. On [redacted] at 1:25 p.m., the Administrator said no one called her on [redacted] to report the allegation of [redacted]. She said she reported it to the appropriate authorities on [redacted], "Once the police came."	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of [redacted], neglect, [redacted], or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving [redacted], neglect, [redacted] or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve [redacted] or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve [redacted] and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		

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F 609	Continued From page 6 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility's policy and procedure, resident and staff interview, the facility failed to ensure the reporting of an allegation of staff to resident to the State Survey Agency, and Adult Protective Services within the specified timeframe for 1 resident (Resident #1) of 3 residents reviewed for . . . . . The findings included: Review of the facility's policy, " . . . . , Neglect, , , Misappropriation, Mistreatment, and injury of unknown origin(ANEMMI)" revision noted, "with response to allegations of . . . . , neglect, . , ... , or mistreatment, the facility must: Ensure that all alleged violations involving . . . . , neglect . . . are reported immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve OR result in bodily injury . . . " The facility procedure noted, "any and all staff observing or hearing about such events must report the event immediately to the Administrator, immediate Supervisor AND one of the following: Director of Nursing, ANEMMI Prevention Coordinator, or Risk Manager so that appropriate reporting and investigation procedures take place immediately . . ."	F 609	1. LPN Staff S was re-educated on . . . . . , by the Administrator/Designee on the components of F609 with an emphasis on reporting allegations of ANEMI to the administrator per the federal regulation. LPN Staff T was re-educated on , by the Administrator/Designee on the components of F609 with an emphasis on reporting allegations of ANEMI to the administrator per the federal regulation. 2.By the Administrator/Designee completed an audit on the past 60 days of reportables to ensure timely reporting was completed per the federal regulation. No like incidents were noted. 3.On . . . . . , the Administrator and the Director of Nursing were educated by the Regional Nurse Consultant on the systematic process of reporting allegations of ANEMI per the federal regulation. By . . . . . , current staff were educated by the Director of Nursing/Designee on the components of	

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F 609	Continued From page 7 Review of the facility's investigations revealed on (Monday) at approximately 3:20 p.m., a police officer came to the facility to interview Resident #1. Resident #1 stated, "sometimes yesterday [Sunday] someone punched him in the ." On Monday , Licensed Practical Nurse (LPN) Staff T documented a statement noting on "Sunday afternoon" the nurse told her Resident #1's friend said someone hit him. She went to Resident #1 and asked what had happened. Resident #1 replied "nothing." The resident's friend again said Resident #1 told her someone hit him. LPN Staff T documented when she asked Resident #1 where he was hit, he said to the left side of his cheek. LPN Staff T documented she spoke to the Certified Nursing Assistant (CNA) who was taking care of the resident. The CNA said Resident #1 refused to be changed, was kicking at them, cursing them, kicking one of the CNAs on her , damaging her glasses. On at 1:20 p.m., in a telephone interview, Resident #1's friend said on Sunday when she walked into the resident's room, two CNAs were providing care. He has on his . His got bumped causing a lot of , and agitated him. He was yelling and cursing at the CNAs and said that she had hit him in the left , and pointed to just below the left , . One of the CNAs said Resident #1 had hit her in the as she was bending over. The CNA did not say that she hit him, but she did not deny hitting him either. She did not say anything either way. She said she was concerned about it because he had never accused anyone of hitting him ever. She reported	F 609	F609 with an emphasis on reporting allegations of ANEMI per the federal regulation. Newly hired staff will be educated on the components of F609 with an emphasis on reporting allegations of ANEMI to the administrator per the federal regulation by the Director of Nursing/Designee at orientation as a part of the systematic changes. 4. The Administrator/Designee will conduct a weekly audit on reportables to ensure timely reporting was completed x 4 weeks; then monthly for 2 months or until substantial compliance is achieved. Findings will be reported monthly at the QAPI Committee meeting until such a time substantial compliance has been determined.	

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F 609	Continued From page 8	F 609		

the incident to LPN Staff S who works on Sundays. LPN Staff S said she would notify the supervisor.
Shortly after, the supervisor came in, she looked at Resident #1's , and said she did not see any redness. She tended to side with the aides because the resident tended to get upset. She said she would go to the CNAs and get their side of the story. Resident #1's visitor said she never heard from anyone after that, the supervisor never came in the room.

On at 2:30 p.m., in a telephone interview LPN Staff S verified she worked on Sunday . She verified Resident #1's friend reported to her Resident #1 said two CNAs were providing care, and one of them hit him in the . She reported the incident to the desk nurse, LPN Staff T who got up right away and looked for the staff described.

On at 2:45 p.m., in an interview LPN Staff T verified on LPN Staff S reported to her Resident #1's friend said two CNAs were providing care, and one of them hit him in the . She verified she did not notify anybody until the police came to the facility another day or maybe a couple of days later.

There was no documentation that the allegation of staff to resident was reported to the State Survey Agency or Adult Protective Services on within the required time frame. The investigation noted the allegation was reported to the State Survey Agency and the Registry on .

On at 11:00 a.m., the Director of Nursing (DON) said she was not aware of the allegation of

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F 609	Continued From page 9 staff to resident until 11/20/23 when the police officer came to the facility. She said no one called her that Sunday. On at 1:25 p.m., the Administrator said apparently on when two CNAs were taking care of Resident #1, he hit CNA Staff V in the . She said Resident #1's friend visited every Sunday and mentioned the resident reported to the staff nurse that someone hit him. She said no one called her on to report the allegation of . She said she reported it to the appropriate authorities on , "Once the police came."	F 609		

Agency for Health Care Administration

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	85810	A. BUILDING: _____ B. WING _____	C 11/27/2023

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N 000	INITIAL COMMENTS An unannounced complaint survey for #2023017140 was conducted on . . . . . through at North Port Rehabilitation and Nursing Center, a skilled nursing facility in North Port, Florida. This survey was conducted in conjunction with a complaint revisit survey. Complaint #2023017140 was substantiated with a citation at N0040. The following is a description of the deficiencies.	N 000		
N 040 SS=D	59A-4.106( ) FAC Facility Policies Required (2) Each nursing home licensee must adopt, implement, and maintain written policies and procedures governing all services provided in the facility. (3) All policies and procedures must be reviewed at least annually and revised as needed with input from the facility Administrator, Medical Director, and Director of Nursing. This Statute or Rule is not met as evidenced by: Based on record review, review of facility's policy and procedure, resident representative and staff interview, the facility failed to implement their policies and procedures, and immediately address an allegation of staff to resident for 1 (Resident #1) of 3 residents reviewed for . The findings included: Review of the facility's policy, " , Neglect, , ... , Misappropriation, Mistreatment, and injury of unknown origin(ANEMMI)" revision	N 040	1. LPN Staff S was re-educated on . . . . . , by the Administrator/Designee on the components of N040 with an emphasis on reporting allegations of ANEMI to the administrator per the federal regulation and facility policy. LPN Staff T was re-educated on , by the Administrator/Designee on the components of N040 with an emphasis on reporting allegations of ANEMI to the administrator per the federal/state regulations and facility policy.	

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/23

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NORTH PORT REHABILITATION AND NURSING CENT	6940 OUTREACH WAY NORTH PORT, FL 34287

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N 040	Continued From page 1 noted , included, "Hitting, slapping, pinching, and kicking." The policy listed several criterias, including "any resident or family complaint of physical harm, or mental anguish resulting from willful infliction from others," will be considered as possible ANEMMI. The policy specified any employee having either direct or indirect knowledge of any event that mighty consitute , Neglect, , , Misappropriation, Mistreatment, and injury of unknown origin must report the event promptly. Residents will be protected from harm during an investigation. Staff person or persons suspected of ANEMM will be suspended immediately pending result of the investigation. Review of the facility's investigations revealed on (Monday) at approximately 3:20 p.m., a police officer came to the facility to interview Resident #1. Resident #1 stated, "sometimes yesterday [Sunday] someone punched him in the ." Review of the clinical record revealed Resident #1 was admitted to the facility on . Diagnoses included , , Major , Restlessness and Agitation, , Acute , . Resident #1 required total assistance for personal care. On Monday , Licensed Practical Nurse (LPN) Staff T documented a statement noting on "Sunday afternoon" the nurse told her Resident #1's friend said someone hit him. She went to Resident #1 and asked what had happened. Resident #1 replied "nothing." The resident's friend again said Resident #1 told her someone hit him. LPN Staff T documented when she asked Resident #1 where he was hit, he said to the left	N 040	2.By the Administrator/Designee completed an audit on the past 60 days of reportables to ensure timely reporting was completed per the federal/state regulations and facility policy. No like incidents were noted. 3.On , the Administrator and the Director of Nursing were educated by the Regional Nurse Consultant on the systematic process of reporting allegations of ANEMI per the federal/state regulations. By , current staff were educated by the Director of Nursing/Designee on the components of N040 with an emphasis on reporting allegations of ANEMI per the federal regulation and the facilities policy. Newly hired staff will be educated on the components of N040 with an emphasis on reporting allegations of ANEMI to the administrator per the federal regulation by the Director of Nursing/Designee at orientation as a part of the systematic changes. 4. The Administrator/Designee will conduct a weekly audit on 5 residents to ensure no allegations of ANEMI were pending reporting weekly x4 weeks then monthly for 2 months or until substantial compliance is achieved. The Administrator/Designee will conduct a weekly audit with 5 employees to ensure no allegations of ANEMI were reported to them, weekly x4 weeks then monthly for 2 months or until substantial compliance is achieved. Findings will be reported monthly at the QAPI Committee meeting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	85810	A. BUILDING: _____ B. WING _____	C 11/27/2023

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N 040	Continued From page 2 side of his cheek. LPN Staff T documented she spoke to the Certified Nursing Assistant (CNA) who was taking care of the resident. The CNA said Resident #1 refused to be changed, was kicking at them, cursing them, kicking one of the CNAs on her , damaging her glasses. On Monday , LPN Staff S wrote a statement noting the nurse for the 3:00 p.m., to 11:00 p.m., shift stated Resident #1's visitor said that someone had hurt him on the , but she did not observe any injury. On at 1:20 p.m., in a telephone interview, Resident #1's friend said on Sunday when she walked into the resident's room, two CNAs were providing care. He has on his . His got bumped causing a lot of and agitated him. He was yelling and cursing at the CNAs and said that she had hit him in the left and pointed to just below the left . One of the CNAs said Resident #1 had hit her in the as she was bending over. The CNA did not say that she hit him, but she did not deny hitting him either. She did not say anything either way. She said she was concerned about it because he had never accused anyone of hitting him ever. She reported the incident to LPN Staff S who works on Sundays. LPN Staff S said she would notify the supervisor. Shortly after, the supervisor came in, she looked at Resident #1's and said she did not see any redness. She tended to side with the aides because the resident tended to get upset. She said she would go to the CNAs and get their side of the story. Resident #1's visitor said she never heard from anyone after that, the supervisor never came in the room.	N 040	until such a time substantial compliance has been determined.	

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N 040	Continued From page 3 On [redacted] at 2:30 p.m., in a telephone interview, LPN Staff S said on [redacted] Resident #1's friend said last weekend the resident's friend reported to her two CNAs were providing care, and one of them hit him in the [redacted]. The friend described the staff to her, and what they were wearing. She reported the incident to the desk nurse, LPN Staff T who got up right away and looked for the staff described. On [redacted] at 2:45 p.m., in an interview LPN Staff T said when LPN Staff S reported the alleged incident to her, she went in the room to speak to Resident #1. At first, the resident said, "nothing happened." When asked again, he pointed to his [redacted] and said someone hit him. She said she did not see any marks or [redacted]. She said Resident #1 would kick or punch when he is being changed. She identified the two CNAs who were providing care to the resident but did not notify anyone about the allegation until the police came to the facility a day or two later. On [redacted] at 11:40 a.m., CNA Staff W said on [redacted] she was assisting CNA Staff V changing Resident #1. When they turned Resident #1 to his side, CNA Staff V was in front ho him. He grabbed CNA Staff V's [redacted] and kicked her in the [redacted]. Her glasses were hanging on her shirt, and he broke them. On [redacted] at 11:46 a.m., CNA Staff V verified on [redacted] she helped CNA Staff W providing [redacted] care for Resident #1. She said Resident #1 was violent and required two CNAs and two nurses when providing care to him. She said, "I do not [redacted] people." CNA Staff W said she rolled Resident #1 to one side, he does not like that, he wants it done quickly. She said she turned to him and put her [redacted] on his [redacted].	N 040		

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N 040	Continued From page 4 Resident #1 then hit her in the . . . and broke her glasses. She said she reported the incident to LPN Staff S. The CNA said the resident's friend was in the room, behind the privacy curtain when they were providing care and did not say anything. There was no documentation of steps taken by the facility on . . . . . to immediately report, investigate and protect Resident #1 from harm during the investigation. On . . . . . at 11:00 a.m., the Director of Nursing (DON) said she was not aware of the allegation of staff to resident . . . . until 11/20/23 when the police officer came to the facility. She said no one called her that Sunday. On . . . . . at 1:25 p.m., the Administrator said no one called her on . . to report the allegation of . . . . . She said she reported it to the appropriate authorities on , "Once the police came." Class III	N 040		