STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105342	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehab & Healthcare Center of Cape Coral	2629 Del Prado Blvd Cape Coral, FL 33904

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 41155 Based on observation, residents and staff interviews, the facility failed to ensure reasonable accommodation of needs by failure to ensure the call light was within reach to request assistance as needed for 9 (Residents #900, #1000, #1001, #20, #12, #89, #10, #1002, and #1004) of 18 sampled residents The findings included: On 5/12/25 at 8:45 a.m., during an initial tour of the facility the following observations were made: 1. Resident #900's room. The call light was hooked to a metal bracket that contained a box of gloves, on the wall behind the head of the bed. In an interview, Resident #900 said he did not know where the call light was. Photographic evidence obtained. 2. Resident #1000's room. Resident #1000 was observed sleeping in bed. The call light was hooked to a metal bracket that contained a box of gloves. Photographic evidence obtained. 3. Resident #1001's room. Resident #1001 was observed in bed. The call light was on the floor near the head of the bed. 4. Resident #20's room. Resident #20 was observed in bed and did not respond to interview questions. The call light was hanging from the glove rack and not within the resident's reach. On 5/12/25 at 9:13 a.m., Registered Nurse (RN) Staff E verified Resident #20's call light was hanging from the glove rack on the wall behind the resident's bed and was not within the resident's reach. RN Staff E said, It should not be like that, it should be within the resident's reach. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Resident #12. Resident #12 was observed in bed yelling out repeatedly for help. The call light was on the floor, not within reach of the resident. 6. Resident #89. Resident #89 was observed in bed. The call light was on the floor and not within the resident's reach. In an interview Resident #89 said he did not know what happened to the call light and could not find it. He said, I just yell for someone. 7. Resident #10. Resident #10 was observed in bed. In an interview Resident #10 said he did not know where the call light was. He said, If I need anything believe me, I will call out for them. 8. Resident #1002. Resident #1002 was observed in bed. The call light was on the floor behind the headboard of the bed. In an interview Resident #1002 said it takes up to an hour at times before someone answers the call light. 10. Resident #1004. Resident #1004 was observed sitting in a wheelchair in her room. The call light was on the floor behind the wheelchair and not within reach of the resident. In an interview Resident #1004 said she could not reach the call light. She said sometimes it takes a while, more than 30 minutes for someone to answer the call light.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41155 Based on record review, review of facility's policies and procedures, and staff interviews, the facility failed to protect residents' rights to be free from neglect by failing to provide the necessary care and services to maintain personal hygiene for 3 (Resident #999, #89, and #27) of 5 sampled residents. The findings included: The facility policy Abuse Prevention Program documented The facility has designated and implemented processes, which strive to reduce the risk of . neglect . The policy defined neglect as, Failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. The facility Policy Documentation for CNA'S (Certified Nursing Assistants) instructed CNA's to Document what you did for the resident (assisting with ADL's). 1. Review of the clinical record revealed Resident #999 had an admitted [DATE]. Diagnoses included cerebral vascular accident with left hemiparesis (weakness of one side of the body) and chronic kidney disease stage 4. Review of the Discharge Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with a date of 4/22/25 documented Resident #999 required substantial to maximum assistance with showers and was dependent for transfers. Resident #999 was alert and oriented. Review of the shower schedule revealed the Resident was scheduled for showers on the 3:00 p.m., to 11:00 p.m., shift on Mondays and Thursdays. Review of the CNA documentation for April 2025 failed to reveal documentation Resident #999 received the scheduled showers on Mondays and Thursdays during the 3:00 p.m., to 11:00 p.m. shift. On 4/17/25 (Thursday) the CNA entered N/A (not applicable). On 4/18/25, 4/19/25, and 4/20/25 a bed bath was documented for the 7:00 a.m. to 3:00 p.m. shift. On 4/21/25, a partial bed bath was documented. Review of the CNA documentation for personal hygiene including oral care and shaving revealed Resident #999 was dependent for hygiene. There was no documentation Resident #999 received assistance with personal hygiene during the day shift on 4/21/25. No personal hygiene care was documented for the 3:00 p. m., to 11:00 p.m., shift on 4/18/25, 4/21/25 and 4/22/25. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the clinical record revealed Resident #89 had an admitted [DATE] with diagnoses including alcohol abuse, dementia and multiple sclerosis. Review of the significant change in status MDS assessment with a target date of 3/13/25 noted Resident #89's cognition was moderately impaired with a Brief Interview for Mental Status score of 07. The MDS noted the resident required partial/moderate assistance with personal hygiene. Resident #89 required supervision or touching assistance with oral hygiene and substantial to maximal assistance with showers. On 5/13/25 at 10:00 a.m., Resident #89 was observed in his room in bed. He was unshaven. He had had very foul breath and his teeth were coated with a white film. In an interview, Resident #89 said he could not remember the last time he had a shower and he would really like one. He added, I don't think I have ever had one. Review of the shower schedule revealed Resident #89's scheduled showers were on Tuesdays and Fridays during the 3:00 p.m., to 11:00 p.m., shift. Review of the CNA documentation for April 2025, and May 2025 failed to reveal documentation Resident #89 received his scheduled showers. On 4/1/25, 4/4/25, 4/8/25, 4/11/25, 4/15/25, 4/18/25, 4/22/25, 4/29/25, 5/6/25 and 5/9/25, a bed bath was documented. On 4/25/25, and 5/2/25, the shower documentation was blank. There was no documentation of personal hygiene for the 7:00 a.m., to 3:00 p.m. shift on 5/5/25, 5/10/25 and 5/13/25. No care was documented for the 3:00 p.m., to 11:00 shift on 5/1/25 through 5/5/25, and on 5/10/24. 3. Review of the clinical record revealed Resident #27 had an admitted [DATE] with diagnoses including end-stage renal disease, dependent on renal dialysis, diabetes mellitus, cerebral vascular accident, and malnutrition. On 5/13/25 at 9:51 a.m., in an interview Resident #27 said he only had four showers in the two years he has resided in the facility. He said he gets a bed bath but would prefer a shower. Review of the CNA documentation revealed Resident #27's showers were scheduled on Mondays and Thursdays during the 3:00 p.m., to 11:00 p.m. shift. There was no documentation Resident #27 received his scheduled showers on 4/24/25, 4/28/25, 5/1/25 and 5/5/25. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/13/25 at 11: 55 a.m., in an interview Unit Manager Registered Nurse Staff M said every room has an assigned day and shift for showers. She said showers are entered in the computer within 72 hours of admission. She said Resident #27 has refused a shower since he has been on this unit. She said the resident was very particular when he wants a shower. She said the care plan is normally updated if a resident frequently refuses care. She said Resident #27 has been on this unit for about a month and did not think he has had a shower. On 5/13/25 at 11:25 a.m., in an interview the Administrator said if a resident refused a shower, the next step was a bed bath. The CNA should document the shower refusal and let the nurse know. They document the resident refused the shower, and a bed bath was provided. The Administrator said there was no policy on ADL (Activities of Daily Living) care, only documentation for CNA's.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on review of the clinical record and staff interviews, the facility failed to provide specialized rehabilitative services as directed by the plan of care for 1(Resident #999) of 3 residents for rehabilitative services. The findings included: Review of the clinical record revealed Resident #999 had an admitted [DATE]. Diagnoses included cerebral vascular accident with left hemiparesis (weakness of one side of the body). On 5/12/25 at 1:35 p.m., in a telephone interview a family member said Resident #999 did not receive therapy during his stay at the facility. Review of the plan of care initiated 4/23/25 revealed Resident #999 had an activities of daily living self-care performance deficit. The goals for the resident included Occupational Therapy (OT) as ordered, goals are established per the OT plan of care. PT (Physical Therapy) is ordered and goals are established per the PT plan of care. Will improve level of self-performance by next review period. Review of the Physical Therapy (PT) evaluation dated 4/18/25 revealed, Resident to be seen 6 x's a week (six times a week) for 8 weeks. Focus on focus on therapy exercises, therapy activity, gait training, resident caregiver education, group treatment when appropriate and discharge planning one time only for eight weeks. Review of the Physical Therapy Missed Visit Details documented on 4/21/25 Withheld. On 4/22/25 withheld, patient kept his eyes closed and was not participating. Review of the OT evaluation completed 4/18/25 revealed a plan of treatment that included therapeutic exercises, neuromuscular reduction, occupational therapy evaluation, therapeutic activities, self-care management training, and wheelchair management and training period. The frequency for the occupational therapy was six times a week for eight weeks. A review of the OT documentation revealed a note dated 4/21/25 stating patient withheld from therapy. On 4/24/25 the Occupational Therapist documented Patient discharged to hospital. Progress limited due to short stay. There was no documentation Resident #999 received Occupational Therapy as ordered during his stay at the facility. On 5/12/25 at 12:12 p.m., in an interview the Rehab Director said Resident #999 received therapy but he was in the facility only for a few days. She said she would review the therapy notes. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/12/25 at 3:57 p.m., in a follow up interview the Rehab Director said the Occupational Therapist who treated Resident #999 was no longer employed at the facility. She said, I have looked and I can't find any other notes. He was evaluated by PT and OT on 3/18/25. He was a Monday to Friday case load. I know PT tried to work with him, but he documented the resident would not participate. All I have is the completed evaluations. He did not receive any therapy because he was here only a few days. He arrived on 4/17/25 in the evening and was discharged on [DATE].