

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/27/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER Charlotte Bay Rehab and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4033 Beaver Lane Port Charlotte, FL 33952	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observations, review of the clinical record, resident and staff interviews and review of facility policy and procedures, the facility failed to provide the necessary care and services to maintain personal hygiene for 2 (Residents #252 and #61) of 3 residents reviewed for activities of daily living (ADL's). The findings included: Review of the facility's policy, Activities of Daily Living effective 4/1/22 documented Purpose: To ensure all residents needs are met in a manner that promotes their quality of life and preferences . A resident who is unable to carry out activities of daily living shall receive the necessary services to maintain good . grooming, and personal and oral hygiene . Review of the clinical record revealed Resident #252 had an initial admitted [DATE] with readmissions on 1/11/25 and 1/23/25 following hospitalization . The Admission Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with a target date of 1/11/25 documented Resident #252 required substantial to maximum assistance with showers and personal hygiene. The MDS noted Resident #252's cognitive skills for daily decision making were intact with a Brief Interview for Mental Status Score of 15. The care plan initiated on 1/15/25 identified Resident #252 had an ADL self-care deficit related to overall functional decline. The interventions for Resident #252 specified the resident requires substantial to maximum assistance by one staff with personal hygiene. The care plan instructed to Check nail length and trim and clean on bath day and as necessary. On 1/27/25 at 3:49 p.m., Resident #252 was observed in bed. He was unshaven with approximately seven days of facial hair growth. In an interview during the observation, Resident #252 said before he went into the hospital, he had a mustache and goatee. He said a Certified Nursing Assistant (CNA) shaved him once in the last four weeks. The resident said, I could use a shave, but I have not told anyone. He said he had not received any showers recently, They washed me up in the bed. Resident #252 said he would enjoy a shower and did not know why he had not received his scheduled showers. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 105363	Facility ID: 105363 If continuation sheet Page 1 of 13

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/28/25 at 10:35 a.m., Resident #252 was observed in his room in bed. The resident remained unshaved and had approximately one inch of beard growth. His fingernails were observed to extend approximately 1/2 inch from the fingertips. They were jagged and with a brown substance under the nails. The resident said, someone came in and said they would take care of it today. Review of the CNA documentation revealed Resident #252 preferred showers and was scheduled for showers on Tuesdays and Fridays on the 7:00 a.m., to 3:00 p.m., shift. The documentation from 1/4/25 through 1/28/25 revealed the resident received bed baths on 1/4/25, 1/11/25, 1/14/25, 1/15/25, 1/17/25, 1/18/25, 1/19/25, 1/23/25, 1/24/25 and 1/28/25. The only documented shower was on 1/13/25. On 1/29/25 at 11:22 a.m., in an interview CNA Staff C said resident care information including showers, splints and care needs was documented in the CNA Kardex (provides information for safe care) in the electronic record and that is how she gets resident information. The CNA said she checks residents' daily, shaves and provides fingernails care as needed. On 1/29/25 at 12:31 p.m., Resident #252 was observed in his room in a recliner chair. He had a full beard and mustache of approximately one inch growth. He said he was waiting for someone to shave him. On 1/29/25 at 3:48 p.m., Resident #252's facial hair growth (beard and mustache) was observed with Unit Manager Licensed Practical Nurse (LPN) Staff A. LPN Staff A said Resident #252 was readmitted with the beard and mustache on 1/3/25. She verified the resident had requested to be shaved. Staff A said she would have staff shave him. On 1/30/25 at 8:48 a.m., Resident #252 was observed in his bed. He was not shaved. His fingernails remained long and jagged, extending approximately half an inch. In an interview during the observation, Resident #252 said, Last night someone came in the room and said they were going to shave me, and they would get what they needed and left. They never came back so I don't know what is going on. Review of the clinical record revealed Resident #61 had a readmitted [DATE]. Diagnoses included dementia. Resident #61 required assistance with personal care. The Quarterly MDS with a target date of 12/15/24 documented Resident #61 was dependent on staff for all ADL's. The MDS noted Resident #61's cognitive skills for daily decision making were intact with a Brief Interview for Mental Status score of 14. The care plan initiated 9/23/24 and revised 11/1/24 identified Resident #61 had an ADL self-care performance deficit related to weakness, functional decline, and dementia. The care plan specified resident was totally dependent on 2 staff for showering/bathing per schedule and as needed. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/27/25 at 12:34 p.m., Resident #61 was observed sleeping in bed. Her fingernails extended approximately 1/2 inch. An accumulation of brown/black substance was observed under the nails. Facial hair was observed under her chin and the neck area. On 1/28/25 at 10:57 a.m., Resident #61 was observed with Unit Manager LPN Staff A. Resident #61 was in bed. The left and right hand fingernails extended approximately 1/2 inch from the fingertips and remained with a black/brown substance under the nails. The resident's left hand was curled in a fist. In an interview during the observation, she said she was not able to open her left hand and it was starting to hurt. The resident's lips were dry. The lower lip was peeling. Resident #61 said no one had cleaned her teeth for her. She said she did not get out of bed and did not know why. LPN Staff A observed the resident's left hand and verified the fingernails extended approximately 1/2 inch from the fingertips and were curled into a fist. Staff A said Resident #61 was supposed to wear a splint to the left hand. On 1/29/25 at 11:21 a.m., CNA Staff B was observed providing care to Resident #61 in her room. In an interview CNA Staff B said she cleans the resident in bed, provides range of motion to her legs and fixes the resident's her hair. CNA Staff B said, I do mouth care for her and I speak with her. CNA Staff B said with two person assist, they use a shower bed to take Resident #61 to the shower room. Staff B said some days the resident refuses her shower and she cleans her in bed and fixes her hair. Review of the CNA documentation revealed Resident #61 was scheduled for showers on Wednesdays and Saturdays during the 3:00 p.m., to 11:00 p.m., shift. The documentation showed on 1/8/25, 1/11/25, 1/18/25 and 1/22/25 Resident #61 did not receive her scheduled showers.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observations, review of the facility policy and procedures, resident and staff interviews, and review of the clinical record, the facility failed to ensure a resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion (ROM) for 1 (Resident #61) of 1 resident reviewed for limitation in ROM. The findings included: The facility policy Nursing-Mobility and Range of Motion with an effective date of 4/1/2022 documented, Residents with limited ROM should receive treatment and services to increase and or prevent a further decrease in ROM. As part of the resident's comprehensive assessment the nurse should identify the resident's limitations in movement or mobility. The nurse should also identify conditions that place the resident at risk for complications related to ROM. including contractures. The care plan should include specific interventions, exercises and therapies to maintain, prevent avoidable decline in or improve mobility and ROM. Review of the clinical record revealed Resident #61 had a readmitted [DATE]. Diagnoses included dementia. Resident #61 required assistance with personal care. The Quarterly MDS with a target date of 12/20/24 documented Resident #61 was dependent on staff for all activities of daily living. Resident #61 had limitation in ROM to one side of the upper body and both sides of the lower body. The MDS noted Resident #61's cognitive skills for daily decision making were intact with a Brief Interview for Mental Status score of 14. The care plan initiated 9/23/24 and revised 11/1/24 identified Resident #61 had an ADL (activities of daily living) self-care performance deficit related to weakness, functional decline, and dementia. The care plan interventions specified, Resident to wear a palm guard (protective device) to left hand as tolerated/as ordered, remove for hygiene and skin checks. On 1/27/25 at 12:31 p.m., in an interview Resident #61 said she was not able to open her left hand. The fingers of the left hand were observed curled into a tight fist. Resident #61 was not wearing the palm guard specified in the care plan to the left hand. A hand splint was observed on the residents' nightstand. (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/28/25 at 10:57 a.m., Resident #61 was observed with Unit Manager LPN Staff A. Resident #61 was in bed and was not wearing the palm guard to the left hand. The left hand fingernails extended approximately 1/2 inch from the fingertips. The resident's left hand was curled in a fist. In an interview during the observation, Resident #61 said she was not able to open her left hand and it was starting to hurt. Resident #61 said she did not know if she had a splint for her hand. Unit Manager Staff A said Resident #61 was supposed to wear a splint to the left hand. On 1/29/25 at 12:35 p.m., in an interview Certified Nursing Assistant (CNA) Staff B said she often took care of Resident #61. Staff B said the resident had a splint for her left hand. She said the therapist shows the staff how to put apply and remove the splint and how to take care of the splint. She said the information was on the Kardex (Provides instructions for safe care). Review of the CNA Kardex revealed, Resident to wear palm guard to left hand as tolerated/as ordered, remove for hygiene and skin checks.		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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** 44824 Based on clinical record review, review of facility's policies and procedures, and staff interviews, the facility failed to ensure staff followed safety precautions in the care plan while providing care to prevent avoidable fall and fall related fracture for 1 (Resident #50) of 3 residents reviewed for accidents. The findings included: Review of the facility's policy for Falls and Fall Risk-Managing with effective date of 4/1/2022 revealed, Based on previous evaluations and current data, the staff should identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling . Review of the clinical record for Resident #50 revealed an admitted [DATE]. Diagnoses included Chronic Kidney Disease, and anemia. Review of the Quarterly Minimum Data Set (MDS) assessment with a target date of 12/2/24 noted the resident's cognition was intact with a Brief Interview for Mental Status score of 15. The assessment noted the resident was dependent (Helper does all of the effort. Resident does none of the effort to complete the activity) for toileting, shower, bathing, upper and lower body dressing. The resident required substantial/maximal assistance to roll left and right. Review of the Care Plan for Resident #50 revealed the resident was dependent on staff for activities of daily living care, transfers and mobility, related to physical limitations. The care plan noted Resident #50 was at risk for falls related to general weakness, decreased mobility, anemia, Hypertension, Thyroid disorder, insomnia, and potential side effects of medications. The care plan specified, The resident requires assist (assistance) of 2 staff to turn and reposition in bed. Review of the facility's incident investigations revealed on 1/21/25 at approximately 6:30 p.m., Resident #50 rolled out of her bed during patient care, resulting in a fracture of the right distal femur (thigh bone) proximal to the knee joint. The investigation noted Certified Nursing Assistant (CNA) Staff F was providing a bed bath to the resident independently. After review of the resident's care profile, it was identified that the resident was a two person assist for bed mobility. The investigation noted CNA Staff F failed to follow Resident #50's Kardex (Provides instructions for safe care) by assisting the resident with bed mobility by herself and not with the assistance of another staff member as indicated in Resident #50's medical record. The investigation noted, The facility concludes from this investigation that this injury to (Resident #50) could potentially have been avoided had CNA Staff F followed Resident #50's Kardex as indicated in her medical record. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Certified Nursing Assistant Kardex howed Resident #50 required dependent assistance of two staff to turn and reposition in bed and used bulateral enablers to maximize independence with turning and repositioning in bed. The investigation included an interview with Resident #50 who said CNA Staff F gave her a bed bath. The CNA was drying her off and changing the sheets. CNA Staff F was standing on the left side of the bed. Resident #50 said she used the assist bar to roll to the right side of the bed while the CNA changed her sheets. She did not know what happened. The resident stated one of her legs must have gone too far and her legs slid off the bed, her right knee hit the floor and then she slid off the bed. Resident #50 stated her knee hurt and the nurses were providing her with pain medication. Review of CNA Staff F witness statement revealed Resident #50 asked for a bed bath. When she was finishing up drying the resident's back while making the bed, Resident #50 used her side rail to pull herself on her side by herself. She was facing away from me holding the side rail her legs went off the bed. Her knee hit the floor then I call the nurse ect [sic]. On 1/22/25, Resident #50 was emergently transferred to a local hospital and admitted . On 1/28/25 at 11:40 a.m., in an interview the Administrator said Resident #50 received a bed bath in her room. The resident turned herself using the enabler bars. Her legs shifted and she rolled off the bed. CNA Staff F was changing sheets and drying her off. The Administrator said CNA Staff F did not follow the requirements outlined in the Kardex, she was still suspended pending investigation. On 1/30/25 at 9:30 a.m., a joint interview was conducted with the Regional Director of Nursing, the Administrator, and the Director of Nursing. They all agreed that CNA Staff F failed to provide the required two person care during a bed bath which resulted in Resident #50 falling out of bed and sustaining a major injury. They said CNA Staff F was suspended and remains on suspension.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on observation, interview and record review, the facility failed to ensure a resident admitted with a urinary catheter was assessed for removal of the catheter as soon as possible, received services to prevent urinary tract infections, and had the proper securing device to prevent friction and movement at the insertion site for 1 (Resident #305) of 2 residents reviewed for urinary catheters. The findings included: Review of the facility Policy for Urinary Catheter Care revised 2/21/23 included instructions for infection control: Be sure the catheter tubing and drainage bag are kept off the floor. Catheter changing instructions included: Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh.) Review of the clinical record for Resident #305 revealed an admitted [DATE] for rehabilitation after pacemaker surgery. Diagnoses included vascular implant infection, diabetes, and chronic kidney disease. Resident #305 was admitted with a urinary catheter. The hospital record dated 1/7/25 noted the resident had a recent surgery for infected pacemaker. During the hospital course, a urinary catheter had been removed shortly before discharge. The bladder scan showed full bladder; therefore, Foley catheter will be placed. The hospital records did not include a diagnosis of obstructive uropathy. The Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form (Agency for Health Care Administration form 3008) showed Resident #305 was incontinent, with a urinary catheter placed on 1/12/25. The reason for the urinary catheter was urinary retention. The physician's order dated 1/14/25 included to secure the catheter once every seven days and as needed. The physician's order dated 1/15/25 gave instructions to administer Myrbetriq 50 milligrams once a day for overactive bladder. The facility's comprehensive assessment dated [DATE] listed an active diagnosis of obstructive uropathy. On 1/27/25 at 3:48 p.m., Resident #305 was observed sitting in the wheelchair in her room. The urinary catheter drainage bag tubing was on the floor. The catheter was not secured to the resident's thigh resident to prevent irritation or friction. In an interview during the observation, Resident #305 said the tubing was uncomfortable, pulls in her crotch and digs in her skin. The resident said she really just wants the catheter out. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25 at 12:36 p.m., Resident #305's catheter was observed. It was not secured to the resident's thigh to prevent movement or friction. On 1/29/25 at 4:19 p.m., in an interview Resident #305 said she never had a urinary catheter before. She said it was uncomfortable, and she wanted it out. The catheter tubing was not secured to the resident's thigh. The drainage bag was under the wheelchair and resting on the floor. On 1/29/25 at 4:26 p.m., in an interview Registered Nurse (RN) Staff G said she was taking care of Resident #305. She said she did not know why the resident had the urinary catheter. The resident's catheter was observed with the RN Staff G. RN Staff G verified the catheter was not secured to the resident's thigh to prevent pulling and friction and verified the urinary catheter drainage bag was stored on the floor. Staff G said the bag and tubing should not be on the floor and the catheter should be secured to the resident's thigh for comfort. On 1/29/25 at 4:40 p.m., in an interview Unit Manager Staff A said the resident has not had a voiding trial or urology follow-up since being admitted to the facility. She said upon the resident's admission, she consulted with the Advanced Practice Registered Nurse who gave the obstructive uropathy diagnosis. On 1/30/25 at 9:06 a.m., in an interview Certified Nursing Assistant Staff K said the floor was covered with germs, the urinary catheter bag and tubing should be off the floor at all times. She said the catheter should be secured with a leg strap. On 1/30/25 at 9:43 a.m., in an interview Resident #305 said she retained urine and took medication for it. The resident said she never needed a urinary catheter before and wanted this one out. The resident said at the hospital they told her she needed it. Resident #305 said she was able to void. On 1/30/25 at 9:52 a.m., in an interview RN Staff H said when a resident is admitted with a urinary catheter, the nurse should obtain a thorough medical history to determine whether the resident really needs the catheter. Too many times, hospitals insert urinary catheters for convenience. On 1/30/25 at 9:57 a.m., Unit Manager Staff A said the Advanced Practice Registered Nurse gave orders to discontinue the Myrbetriq for Resident #305 and for bladder retraining. She said they would be contacting the urologist. On 1/30/25 at 10:09 a.m., in an interview, Minimum Data Set (MDS) Coordinator RN Staff I said she reviewed the resident's medical record and did not see a diagnosis justifying the use of the urinary catheter. She said she consulted with the Unit Manager and Advanced Practice Registered Nurse who gave the diagnosis of obstructive uropathy.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, review of the clinical record, facility policy and procedure and resident and staff interviews, the facility failed to maintain urinary catheters in a sanitary manner for 4 (Residents #61, # 249, #252, and #305) of 4 residents observed with urinary catheters. The facility also failed to ensure intravenous (IV) access devices were dated and secured properly for 2 (Resident #252, and #305) of 3 residents reviewed. The findings included: The facility policy Nursing- Catheter Care- Urinary. The purpose of this procedure is to prevent catheter associated urinary tract infections (UTI's). Infection Control) . Maintain clean technique when handling or manipulating the catheter, tubing or drainage bag . Be sure the catheter tubing and drainage bag are kept off the floor. Review of the clinical record revealed Resident #61 had a readmitted [DATE] with diagnoses including obstructive, reflux uropathy and urinary tract infection. Record Review documented the resident's labs results were positive for a UTI (Urinary Tract Infection) on 11/6/24 and 10/21/24 and required the use of antibiotics. The Quarterly Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with a target date of 12/15/24 documented Resident #61 was dependent on staff for all ADL's. The MDS noted Resident #61's cognitive skills for daily decision making were intact. The care plan initiated 9/15/24 and revised 11/1/24 identified Resident #61 had an indwelling urinary catheter The goals for Resident #61 specified she would be/remain from catheter related trauma and the residents risk for urinary infections will be minimized. The interventions included to report any signs or symptoms of UTI to the physician, provide catheter care as ordered, and position catheter bag and tubing below the level of the bladder. On 1/27/25 at 1:14 p.m., Resident #61 was observed in bed, and catheter drainage bag was on the floor. Photographic evidence obtained. On 1/28/25 at 9:35 a.m., Resident #61 was sleeping in her bed, and the catheter drainage bag was on the floor. Photographic evidence obtained. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/28/25 at 9:37 a.m., the Registered Nurse, Staff Development Coordinator confirmed Resident #61's drainage bag was on the floor. Review of the clinical record revealed Resident #249 had an admitted [DATE] with diagnoses including chronic kidney disease. The care plan initiated on 1/21/25 identified the resident has Indwelling catheter. The goals for Resident #249 specified the resident will show no signs or symptoms of urinary infection. The resident will be/remain free from catheter-related trauma through review date. On 1/27/25 at 11:32 a.m., Resident #249 was observed in bed with the bed in the low position. The catheter tubing and drainage bag were in contact with the floor. Photographic evidence obtained. On 1/27/25 at 00:00 Resident #249 was sent to the local emergency department and did not return to the facility. Review of the clinical record revealed Resident #252 had an initial admitted [DATE] with readmissions on 1/11/25 and 1/23/25 following hospitalization . Admitting diagnoses included ileostomy (surgical opening in the abdominal wall in which part of the small intestine is brought to the surface) and dependence on renal dialysis. The Admission MDS with a target date of 1/11/25 documented Resident #252 required substantial to maximum assistance personal hygiene and was dependent for toileting. The MDS noted Resident #252's cognitive skills for daily decision making were intact. On 1/27/25 at 12:12 p.m., during an observation Resident #252's ileostomy drainage bag was attached to the side of the bed facing the open door. There was no privacy bag, and the catheter system was visible to anyone passing by the resident's room. The drainage bag spout was touching the metal frame of the beds wheels. Photographic evidence obtained. On 1/30/25 at 10:50 a.m., in an interview Certified Nursing Assistant (CNA) Staff F said catheter drainage bags are attached to the bed frame and the tubing and drainage bag should never be on the floor. CNA Staff F said if the bed is in the low position, the drainage bag is placed in a wash basin to keep it off the floor. Review of the clinical record revealed Resident #305 was admitted to the facility on [DATE] with an indwelling urinary catheter. On 1/27/25 at 3:48 p.m., Resident #305 was observed in the bedroom sitting in the wheelchair. The urinary catheter tubing was observed under the seat of the wheelchair, touching the floor. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER Charlotte Bay Rehab and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4033 Beaver Lane Port Charlotte, FL 33952	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/29/25 at 4:19 p.m., Resident #305 was observed in the bedroom sitting in the wheelchair. The urinary catheter tubing and drainage bag were observed below the seat of the wheelchair and touching the floor. Registered Nurse Staff G confirmed the tubing and bag were on the floor. Staff G said the tubing and drainage bag should not be in contact with the floor. On 1/30/25 at 9:06 a.m., CNA Staff K said the floor was covered with germs, and the urinary catheter drainage bag and tubing should not be in contact with the floor. The facility policy Guidelines for Preventing Intravenous Catheter -Related Infections documented The purpose of this procedure is to maximally reduce the risk of infection associated with indwelling intravenous (IV) catheters.Catheter Site Dressing Regimens. Change initial dressing after placement within 24 hours. Use sterile transparent dressing.Change the transparent dressing every 5 to 7 days or as needed if . loosened. On 1/27/25 at 12:12 p.m., Resident #252 was observed with an IV access catheter in his left antecubital. In an interview the resident said he thinks he was receiving antibiotics in the hospital prior to his admission at the facility. There was no date on the dressing. The transparent dressing was rolled up on the edges. Photographic evidence obtained. On 1/27/25 at 4:04 p.m., the Infection Preventionist observed Resident #252's intravenous insertion site dressing and said she was not able to tell when the dressing was changed because there was no date on it. The Infection Preventionist said the policy for IV dressings to be changed was weekly and as needed. Review of the clinical record revealed Resident #305 was admitted to the facility on [DATE] for rehabilitation following surgery for an infected pacemaker. The physician ordered an IV antibiotic on 1/14/25 to be given daily every 2 days until 2/20/25. On 1/14/25, the physician ordered a dressing change to the IV catheter insertion cite to be completed on admission or 24 hours after insertion and weekly thereafter and as needed. Review of the medication administration record revealed the nurse signed off the IV cover dressing was changed on 1/21/25. On 1/27/25 at 3:48 p.m., during an observation of Resident #305's IV cover dressing, the date handwritten on the dressing was 1/17/25. Photographic Evidence Obtained On 1/27/25 at 4:05 p.m., in an interview the Infection Preventionist, verified the IV cover dressing was dated 1/17/25 and was outdated. She said the IV dressing should be changed every seven days to prevent infection. On 1/27/25 at 5:10 p.m. during an interview RN Staff J said she administered the IV antibiotic to Resident #305 today with the outdated cover dressing. She said the Medication Administration Record did not trigger her to check the date and she did not notice it was outdated. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/27/2025
Form Approved OMB
No. 0938-0391

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NAME OF PROVIDER OR SUPPLIER Charlotte Bay Rehab and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4033 Beaver Lane Port Charlotte, FL 33952	
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/30/25 at 11:50 a.m., in an interview the Infection Preventionist said the nurse who signed off the dressing change was completed on 1/21/25 should not have signed off something that was not done. She said the IV dressing was outdated.		