STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105421	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodside Health and Rehabilitation Center	3601 Lakewood Blvd Naples, FL 34112

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37256 Based on observation, residents and staff interviews, the facility failed to provide maintenance services to maintain a clean, safe and comfortable environment in 15 (Rooms 314, 325, 418, 201, 203, 212, 307, 309, 314, 324, 328, 337, 407, 403, and 418) of 15 rooms observed and 3 ([NAME], Hibiscus and Heritage) of 4 hallways observed. The findings included: On 7/10/24 at 9:30 a.m., during a tour of the facility the following observations were made: Common hallways were being used as storage spaces for wheelchairs, walkers, supply carts, water carts, mechanical lifts, and mattresses. Photographic evidence obtained Common hallway floors with the tile cracked, missing or stained throughout the building. Photographic evidence obtained Common hallways with multiple areas of peeling wallpaper and warped/damaged cove base. Photographic evidence obtained Multiple resident bathrooms with black bio-growth on walls and/or ceiling including rooms 314, 324 and 418. Photographic evidence obtained Multiple resident rooms and bathrooms with peeled missing paint, holes in plaster, scrapes on wall, cove based damaged with ground in dirt, caulk missing around toilets, tile cracked and/or missing pieces and brown substances on toilets including rooms 201, 203, 212, 307, 309, 314, 324, 328, 337, 407 and 418. Photographic evidence obtained) In room [ROOM NUMBER], a corner where 2 walls meet was badly damaged with plaster missing and the corner bead exposed. The corner was duct taped together. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Photographic evidence obtained On 7/10/24 at 12:39 p.m., in an interview the Administrator said they had hired a plumber to fix the plumbing, but discovered an issue with root intrusion which has been an ongoing issue with no repair date. The Administrator said the Maintenance Director did not stay long and they had just hired a new Maintenance Director who will begin at the end of the month. She said the facility staff had been trained to enter repair issues into the system. They had been bringing maintenance personnel from other facilities to help with drywall repair, ceiling repair and floor repair. On 7/10/24 at 3:16 p.m., Resident #5 said she was visually impaired. She said the clutter in the hallways causes her problems and she had bumped into some of it. She said it hadn't caused her any injury because she would feel her walker hit something and she would back off. She said she spoke with the Administrator, and she moved stuff, I think to the right side, but I still bump into stuff. I wish it could be cleared, but I don't think they have anyplace to put all the stuff. On 7/11/24 at 9:49 a.m., Resident #7 said her bedroom wall had been damaged for quite a while. She said there had been chips hanging out of the hole and she pulled them out. She said it bothered her. On 7/11/24 at 10:06 a.m., Resident #8 said they had been really good to her there and she didn't want to make any waves, but she had bumped into things in the hallways. She said luckily it didn't cause injury because I'm a tough old person. She said the building repairs were bad, and it was , almost as if they'd had a flood or something because what else could cause that? She said no one had discussed making repairs but figured staff would see the areas in disrepair and fix them. On 7/11/24 at 10:46 a.m., during a walk through with the Administrator, she agreed the broken surfaces could not be thoroughly cleaned and the building was in need of repairs. She said the Chief Executive Officer planned to visit the facility the following week to assess the situation.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 37256 Based on record review, residents and staff interviews, the facility failed to ensure resolution of residents grievances related to call lights for 2 (Residents #5 and #6) of 4 residents interviewed who complained of staff not promptly responding when the call light is activated to request assistance. The findings included: On 7/11/23 at 10: 01 a.m., in an interview Resident #6 said depending on who is working, when he calls for help, staff does not come right away and sometimes they never come. Resident #6 said he's had to get up and go to the nurses station to request assistance. On 7/ 11/24 at 10:15 a.m., in an interview Resident #5 said the call bell system has been broken for a while and there was a temporary system in place. She says getting assistance could take a bit. She said when she pressed the button, she will wait 15 minutes then press it again. She said after waiting for 45 minutes she has to get out of her bed and go to the nurses station for assistance. Resident #5 said she was lucky that she could walk and did not know how residents who could not walk went to the nurse for assistance. Record review of the grievance log revealed concerns with call lights and timely response in January 2024, February 2024, March 2024, and June 2024. Review of the Resident Council meeting minutes for 6/25/24 revealed concerns related to call lights not being answered and ignored. On 7/10/24 at 12:47 p.m., in an interview the Administrator said on the 300 hall they had a wireless call bell in place. The residents were given a red button they needed to carry with them. When the button is pressed, it alerts the nurses station. She said the residents needed to carry the button with them for it to work. If the resident went to the bathroom and did not bring the button, they would not be able to request assistance as the old system in the bathroom did not work. She said the enunciator panel from the old system broke, they sent it out for repair.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37256 Based on record review and interview, the facility failed to ensure 1 (Resident #3) of 3 sampled residents was free from a significant medication error by failing to administer multiple doses of an ammonia reducing medication in accordance with the physician's order. The findings included: Facility policy titled Physicians Orders Revised 1/2024 indicated: 9. Physician orders should be followed as prescribed, and if not followed, this should be recorded in the resident's medical record during the shift. The physician should be notified and the responsible party if indicated. 10. The resident will be informed of medication changes as they occur. If the resident is deemed incapable of making health care decisions, the residents responsible party will be informed of medication changes as they occur. Review of the clinical record for Resident #3 revealed an admitted [DATE] following a hospitalization for a liver workup and was on the waitlist for a liver transplant. The hospital discharge instructions included an order for: Lactulose 20 gram/30mL solution, Take 20g total (30mls) by mouth 4 (four) times daily. (Lactulose is used to reduce the amount of ammonia in the blood of patients with liver disease). Review of the Medication Administration Record (MAR) for May 2024 and June 2024 showed a start date of 6/1/24. The Lactulose was scheduled to be administered at 0000 (12:00 a.m.), 0600 (6:00 a.m.), 1200 (12:00 p.m.) and 1800 (6:00 p.m.). Review of Medication Administration Record (MAR) for May 2024 indicated the resident did not receive any medications at the facility on 5/31/2024. Review of the MAR for June 2024 revealed the 12:00 a.m., and 6:00 a.m., doses of Lactulose were not administered. On 6/1/24 at 7:01 a.m., the Licensed Nurse documented in a progress noteand documented in a progress note, New patient. Medication is being ordered and On order. The first dose of Lactulose was documented as given on 6/1/24 at 12:00 p.m. The MAR noted the Lactulose was discontinued on 6/1/24 at 12:53 p.m. Review of the orders and progress notes showed no documentation the physician had ordered the Lactulose to be discontinued on 6/1/24. Review of the progress note for 6/2/24 at 13:21 indicated the family was questioning the dosing of Lactulose and a call was made to the doctor. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Progress note for 6/2/24 at 14:19 indicated the physician returned call and issued a new order to begin Lactulose 30 mg four times daily related to ammonia levels. Further Review of the MAR for June 2024 revealed on 6/2/24 the order to administer 30 mls of Laculose four time a day (12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m.) was entered with a start date of 6/2/24 at 6:00 p.m. The MAR showed that between 6/1/24 and 6/2/24 Resident #3 had missed six out of eight doses of Lactulose. Review of progress notes for 6/3/24 at 9:30 a,m., indicated Resident #3 was lethargic and difficult to arouse. The physician was called and ordered a chest x-ray stat and labs, including an ammonia level. Results of the ammonia level drawn on 6/3/24 came back high at 134 with a reference range of 11 to 35. A nursing progress note dated 6/3/24 at 11:51 a.m., indicated the family was requesting for patient to leave and be transported to a [NAME] hospital. The facility suggested transport to a local hospital. The family declined feeling [NAME] hospitals knew the resident's situation best. The family took the resident out of facility against medical advice. On 7/10/24 at 4:06 p.m., in an interview the Administrator said they found out about the family's concerns when they found a negative online review. The Administrator said their investigation showed a few nurses worked with the resident during his short stay at the facility. Two nurses who are no longer employed at the facility were working to get clarification from the physician as they questioned the Lactulose order. The Administrator said ultimately they found the Lactulose order was correct at 20gm/30mL. The Administrator said the family had been asking for a larger dose. There was no order to change or stop the Lactulose and when clarified, the order was found to be correct. The Administrator said in her investigation she had not discovered the Lactulose had been discontinued and the resident had missed six out of of eight doses. On 7/10/24 at 4:17 p.m., in an interview the Director of Nursing (DON) said she had not been aware Resident #3 missed so many doses of the Lactulose while he was there. She said Lactulose is available in the PYXIS (electronic pharmacy system) and she had gotten it out before. She also said staff can call the pharmacy for an emergency order and she had done it before and had meds delivered at 2:00 a.m. The DON said nurses are not allowed to discontinue medications without a doctors' order and she was not aware a nurse had discontinued the Lactulose order. She said they can't just discontinue orders without a doctors' order. She said with newly admitted residents from the hospital they should always go by the discharge medication list. On 7/10/24 at 4:30 p.m., in a telephone interview the physician said he did not issue an order to discontinue the Laculose order for Resident #3. The Administrator and the Director of Nursing were present during the interview. The physician said he was not aware of the missed doses of Lactulose until the nurse called him to restart the medication. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The physician said he did not know how high the resident's ammonia level was prior to the one obtained on 6/3/24. The physician said Resident #3 was also receiving XiXifan which helped with the ammonia level but the Lactulose probably would have helped decrease the ammonia to a normal level.