STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105427	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Myers Rehabilitation and Nursing Center	7173 Cypress Drive SW Fort Myers, FL 33907

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 51818 Based on observation, record review, and interview, the facility failed to ensure a clean, comfortable, homelike environment that allows the resident to use the physical layout to maximize independence and does not pose a safety risk for 4 (#52, #57, #273, #274) of 5 residents reviewed. The findings included: Review of an admissions agreement (no date) revealed, The facility will provide resident with room and board, nursing service, and laundering of linens. 1. Record review of Resident #52 was admitted on [DATE] a Brief Interview for Metal Status (BIMS), with a score of 10 on 3/5/25, indicating that he has moderately impaired cognition. Resident #52's diagnoses included Schizophrenia and Schizoaffective disorder. On 3/31/25 at 9:25 a.m., Resident #52 was observed sitting on the side of his bed dressed in personal clothing. A blue incontinent brief soiled with feces like substance was observed on the bathroom floor. On 3/31/25 at 9:25 a.m., during an interview and continuous observation Resident #52 gestured to his wheelchair, side table and dresser and stated, It's too tight, there's not enough room, some of this clutter in the drawer, these wipes, it's not my stuff, it's their stuff. I don't use any of what's in the drawer, so my stuff has to go on top of the drawer, and they (facility staff) said I have to keep the wheelchair here between the bed and the bathroom door, but it is hard for me to get in. When asked how he gets to the bathroom, Resident #52 said, I have to get up and walk past the wheelchair and squeeze into the bathroom. Resident #52 stated, I had to change myself (gestured to the soiled brief). I was dirty, I did the best I could while standing up but it was hard and I left the diaper on the floor because where else would it go, there was no trashcan. Resident #52 said that he has requested to have the wheelchair or the bed moved, but he was told the wheelchair must be next to the bed, and the bed can't be moved. On 3/31/25 at 9:35 a.m., during an observation, the Assistant Director of Nursing (ADON) came to the room of Resident #52 and was unable to walk directly into the bathroom. The ADON turned and side stepped into the bathroom through the narrow opening of the bathroom doorway created by the obstruction and then addressed the soiled brief that was sitting on the floor. He did not make any attempts to move the wheelchair or the bed. (continued on next page)

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 - Few	2. Record review of Resident #57 showed an admitted [DATE]. Diagnoses icluded fracture of the left clavicle, pain in left hip and right hip, protein-calorie malnutrition, cutaneous abscess of the chest wall, history of bacterial infection, heart failure, and chronic obstructive pulmonary disease. Review of the Quarterly Minimum Data Set (MDS) assessment with a target date of 3/7/25 revealed the resident's cognition was intact with a BIMS score of 13. Review of the care plan initiated on 11/28/24 and revised on 12/3/24 noted the resident was dependent on 1-2 staff assistance for bed mobility and transfer. On 3/31/25 at 9:45 a.m., an observation of Resident #57's room showed there were multiple personal possessions on the floor out of reach of the resident. A duffel bag was sitting on the floor, tucked behind an oxygen concentrator in the back corner of the room. There was a dresser to the left of the resident, which was filled with incontinence care items. In an interview Resident #57 said, They put their stuff in here, so there's no room for my stuff. On the floor at the end of the bed, there was a cardboard box sitting on the floor with miscellaneous possessions which were also out of reach of the resident. Next to the box was a tall closet that contained very few personal possessions. When asked if he preferred having his possessions out in the open, Resident #57 said, Nobody would help me put my things away, nobody has time, or they have no idea what I'm talking about. On 4/1/25 at 11:00 a.m., in an interview, Certified Nursing Assistant (CNA) Staff LL said that he checks on Resident #57 like he is supposed to, but since he can speak for himself, all he has to do is ask if he needs help. 3. Review of the clinical record for Resident #273 revealed an admitted [DATE]. Diagnoses included squamous cell carcinoma of skin, protein-calorie nutrition, weakness, muscle wasting, and gastrointestinal hemorrhage. Resident #273 requires assistance with Activities of Daily Living (ADL's) and requires a mechanical lift to be transferred to a wheelchair. On 3/31/25 at 10:00 a.m., during an observation of Resident #273, there was moderate sized mucous like stain on the pillowcase behind his head, that was brown, yellow and slightly green. The fitted sheet had come off one corner of the mattress, and Resident #273's bare legs were touching the mattress. A portion of the fitted sheet was bunched under his body. In an interview, Resident #273 stated that the bed was hurting him which was surprising to him because he was supposed to be on an air mattress. He described his room accommodations as, It's not home. Registered Nurse (RN) Staff E was at the resident's bedside during the observation. In an interview on 3/31/25 at 10:00 a.m., RN Staff E said that bedding should be changed every day. He said the resident's bedding had likely been changed already. On 3/31/25 at 10:05 a.m., in an interview CNA Staff FF assigned to Resident #273 stated, I am not changing that resident's bedding today, I will change bedding of residents who go to Dialysis and Therapy today. On 3/31/25 at 11:00 a.m., in an interview Resident #273's spouse said she did not feel the staff understood what he was asking for. She said Resident #273 felt that staff did not understand him. She said, He has also been saying all weekend that the bed is hurting him. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Review of the clinical record for Resident #274 revealed an admitted [DATE]. Diagnoses included muscle wasting and atrophy, pressure ulcer of sacral region, dysphagia, urinary retention, protein-calorie malnutrition, and cardiomyopathy. Review of the nursing assessment dated [DATE] revealed Resident #274 was alert and oriented with periods of confusion. On 3/31/25 at 9:50 a.m., observed Resident #274 lying in bed watching television. In an interview Resident #274 said he wished the staff would move his bed so he could reach his own phone charger rather than having to rely on them because, I can't reach it over there, and when they plug it in, I can't get to it. He also said he couldn't reach the room phone. On 3/31/25 at 9:50, Resident #274 was observed asking RN Staff G to help him to charge his phone. The resident asked, Can you please move my bed because I can't reach my phone charger. RN Staff G said, The charger won't reach, you will have to call us and ask us to plug in your phone for you. RN Staff G did not attempt to reposition the bed or find an alternative option for charging the phone. On 3/31/25 at 3:00 p.m., in an interview Resident #274 said, No, they didn't move anything for me. On 3/31/25 at 11:26 a.m., a clear plastic bag containing a bedpan and several pieces of paper towel was observed tied to the siderail across from the toilet in Resident #274's shared bathroom. Resident #274 said he wasn't sure who the bedpan belonged to. On 3/31/25 at 11:39 a.m., in an interview CNA Staff H said the bedpan in the plastic bag was, garbage and it has not been there very long, I just came back from my break. Photographic Evidence Obtained

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37256 Based on record review and interview, the facility failed to ensure 1 (Resident #96) of 3 residents with newly evident or possible serious mental disorder, or related condition was referred to the appropriate state-designated mental health or intellectual disability authority for review for a Level II screening. The findings included: Resident # 96 was admitted to the facility on [DATE] with a Level I Preadmission Screening and Resident Review (PASRR) with a diagnosis of Anxiety but did not indicate a need for further review. On 7/29/24 a new Level 1 PASRR was completed with mental illness or suspected mental illness including mental disorder, psychosis, and adjustment disorder with anxiety added and indications of lack of focus and adapting to typical change. The new Level 1 PASRR from 7/29/24 was sent for a second level review, with a response on 8/5/25 that Resident #96 was not considered to have a serious mental illness. A review of Resident #96 record revealed the Medication Administration Record contained an order dated 1/14/25 for Seroquel two times a day for schizophrenia. (Seroquel is an antipsychotic medication used to treat schizophrenia). Further review of Resident #96's record revealed a progress notes from the psychiatric provider on 1/14/25 and 4/2/25 in which both notes the medical decision making said dementia with behavioral delusional ro (rule out) schizophrenia and Seroquel for diagnosis of schizophrenia. Record review of Resident #96's chart on revealed the PASRR had never been updated and sent for review for the newly diagnosed /suspected condition of schizophrenia. On 4/3/25 at 9:33 a.m., in an interview the Social Services Director said they had sent a Level II for him in the past, but this time missed the new diagnosis. She said she would follow through and get a new one.

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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** 41905 Based on observation, interview, and record review, the facility failed to provide care and services to meet the needs for personal hygiene, nail care, assistance with dressing, and toileting for 1 (Residents #28) of 5 dependent residents reviewed. The findings included: On 3/31/25 at 4:22 p.m., Resident #28 was observed lying in bed. The nails of the resident's right and left hand extended approximately 3/4 inch from the fingertips. The fingers of the left hand were curled with the nails pressing into the resident's palm. On 4/1/25 at 12:31 p.m., observation of Resident #28's fingernails revealed they remained untrimmed and extended approximately 3/4 inch from the fingertips. In an interview Resident #28 said he guesses staff would trim his nails if he asked. On 4/1/25 at 5:16 p.m., in an interview Resident #28 said staff asked maybe once or twice if they could trim the fingernails. He said he was not able to trim his own nails due to reduced dexterity and limited range of motion to the left hand. On 4/2/25 at 10:32 a.m., Resident #28 was observed in bed. His fingernails nails remained long, untrimmed and extended approximately 3/4 inch from the fingertips. The left-hand fingernails were pressing into the palm. Review of the clinical record for Resident #28 revealed an admitted [DATE]. Diagnoses included cerebral infarction, dementia, amputation of right leg above the knee, and legal blindness. Review of the Quarterly Minimum Data Set (MDS) assessment with a target date of 2/21/25 revealed Resident #28 had functional limitations in range of motion on one side of the lower extremities. The resident was dependent on staff for bathing and personal hygiene. Resident #28's cognition was moderately impaired with a Brief Interview for Mental Status score of 09. The MDS noted the resident refused care. The behavior occurred 1 to 3 days. Resident #28 was transferred to an acute care hospital on 2/10/25 and returned to the facility on [DATE]. Review of the care plan initiated on 9/28/21 and revised on 9/5/24 revealed to check nail length, trim and clean on bath day and as necessary. The care plan noted the resident required assistance from 1-2 staff for personal hygiene. The care plan initiated on 10/4/21 revealed Resident #28 had behaviors of refusing care including labs (laboratory) and therapy. The care plan did not include refusal of nail care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Certified Nursing Assistant (CNAs) documentation (Documentation Survey Report V2) for January 2025, February 2025 and March 2025 revealed Resident #28 refused personal hygiene on 1/27/25 (Day shift), on 2/13/25 (evening shift), and on 3/20/25 (day shift). No other refusal of care was documented for January 2025, February 2025 and March 2025. On 4/3/25 at 10:19 a.m., in an interview Activity Assistant Staff CNA Staff X said Resident #28's left hand has been that way since he came to the facility. Staff X said he refuses to get out of bed and refuses to get a shower. CNA Staff X said Resident #28 does not want to do anything. On 4/3/25 at 11:00 a.m., in an interview Licensed Practical Nurse (LPN) Staff Y said Resident #28 can be resistant to care and was care planned for refusing care. She said Resident #28 was not as bad now with refusing. She said when she checked the resident this week she did not see his nails, they were covered by the blanket. She said if the resident refuses care, the CNA documents on the Documentation Survey Report V2 and tells the nurse. She said the resident tended to cooperate with his current nurse. On 4/3/25 11:09 a.m., LPN Staff Y went to the resident's room and observed Resident #28's fingernails. In an interview LPN Staff Y confirmed the resident's fingernails were long and needed to be trimmed. Resident #28 told LPN Staff Y the CNA did not offer to trim his nails and he has not refused to have his nails trimmed.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, review of the clinical record, review of the facility job description of the Activity Director and staff interviews, the facility failed to ensure they provided an ongoing program to support the residents in their choice of activities which are designed to meet the resident's interests and support the resident's physical, mental, and psychosocial well-being for 2 (Resident #3 and #91) of 3 residents reviewed for involvement in the activity programs. The lack of an ongoing activity program could lead to a decline in the residents' self-esteem, physical, mental, and psychosocial well-being. The findings included: The facility Job Description and Performance Evaluation for the Activity Director documented Responsible for the planning, developing, organizing, implementing, evaluating and directing of activity programs in accordance with current exiting federal, state and local standards. Plan develop, organize, evaluate and direct activity programs to ensure all patients/residents assessed needs are met. Record and maintain activity progress notes as well as a record of resident activities. 1. Review of the clinical record revealed Resident #3 had an admitted [DATE] with diagnoses including dementia with restlessness, anxiety disorder, delusional and adjustment disorder. The Annual Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) dated 5/19/24 documented Resident #3's preference for routine and activities specified it was very important for Resident #3 to have books, newspapers, and magazines to read, to listen to music she likes, and to keep up with the news. It was somewhat important for Resident #3 to be around animals such as pets, and to do her favorite activities. The MDS noted Resident #3's cognitive skills for daily decision making were moderately impaired. Review of the care plan initiated 10/8/20 documented The Resident needs encouragement and assistance in pursuing activities. The care plan interventions included, Invite and assist resident to music related activities. Offer foods that comply with the residents' ordered diet. Offer pet therapy to resident. On 3/31/25 during random observations at 10:24 a.m., 11:32 a.m., 1:20 p.m., and 3:25 p.m., Resident # 3 was observed in her room with the door open. She was in a wheelchair (w/c) facing the side of the closet. She had a tray table in front of her, that was pushed up against the side of the closet. There was nothing on the table for the resident to eat, drink or to occupy her time. She was not meaningfully engaged and had no radio or television on. Review of the March 2025 Activity Calendar specified the activities on 3/31/25:9:00 a.m., Rise and Shine, 10:00 a.m., What's cooking, 1:00 p.m., Arts and Crafts, 2:00 p.m., Room Visits, 3:00 p.m., Gulf Coast Baptist. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/1/25 at 10:00 a.m., Resident # 3 was in her room, in w/c facing the side of the closet with the tray table in front of her and pushed against the closet. She has no liquids, food or items on the table. There was no music and no television on. Review of the April 2025 Activity Calendar specified the activities on 4/1/25: 9:00 a.m., Rise and Shine, 10:00 a.m., Pokeno, 11:00 a.m., Trivia, 1:00 p.m., Movie and Popcorn, 1:45 p.m., room visits. On 4/2/25 at 1:31 p.m., a review of the electronic record for the previous 30 days revealed documentation Resident #3 attended one activity on 3/25/25 at 2:24 p.m., and 3/27/25 at 2:49 p.m. 2. Review of the clinical record revealed Resident #91 was [AGE] years old with diagnoses including senile degeneration of the brain, adjustment disorder, delusional disorder, severe protein calorie malnutrition, dementia, anxiety disorder, restlessness and agitation. The Annual MDS dated [DATE] documented Resident #91's preference for routine and activities specified it was very important to have books, newspapers, and magazines to read, to participate in religious services or practices and do her favorite activities. It was somewhat important for Resident #91 to listen to music she likes and to keep up with the news. The MDS noted Resident #93's cognitive skills for daily decision making were severely impaired. The care plan initiated 1/5/24 identified The Resident requires staff assistance with involvement of activities related to dementia and/or impaired thought process. The interventions for the resident included, invite and assist the resident to group activities, religious services and music related activities and offer the resident pet therapy. During random observations on 3/31/25 at 12:07 p.m., and 3:24 p.m., Resident #91 was observed in her room in her w/c. The bedside table was in front of her and it was push up against a blank wall. No activity items, water or snacks were available on the table for her. She said she was waiting to go to school and looking for her teacher. Observations on 4/1/25 at 9:56 a.m., Resident #91 was in her w/c with a tray table over her and it was pushed up against the blank wall. There were no liquids or food or activity items on the table for the resident. She was anxious repeating, I'm cold and I don't know what I'm doing. At 12:11 p.m., Resident #91 was observed in the w/c in her room with a tray table in front of her that was pushed up against the blank wall. There was a Styrofoam cup of ice water on the table. Continued observations on 4/1/25 at 1:13 p.m., 1:34 p.m., and 3:41 p.m., Resident # 91 was observed in her room in the same position facing a blank wall and yelling out Help me, I want to go to bed. Help me. On 4/2/25 at 9:58 a.m., a review of the electronic record documented in the previous 30 days Resident #91 participated in no activity programs. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/2/25 at 9:06 a.m., in an interview Activity Assistant Staff C said she did not have a certification and no training for the position of activity aid. She said she follows the activity calendar on the wall. For residents who don't come out of the room or to activities, I do room visits every day but I can't see everyone in one day. I talk to them, if they need anything I make up packets with word search, coloring and puzzles. I do nail care and hand massage. I can't get to many of the residents, and I spend about 10 minutes with each resident. On 4/2/25 at 9:42 a.m., in an interview Activity Director Staff A said she was the Activity Director here for 4 years. Staff A said we take the residents to the activity room or the day room on the [NAME] Unit. The day room is for the lower functioning residents. We did have activities here on 3/31/25 and 4/1/25 in the [NAME] day room. This writer mentioned that no one was observed in the day room on 3/31/25 and 4/1/25. Staff A replied it is because only 1 resident showed up and we did not do the activity for just one person. For the residents who do not get out of bed or don't come to activities, I do room visits. We are here 9-5 Monday to Sunday. There are 3 of us, but right now one is out sick. The main activity room is for higher functioning residents. Staff A said she documents participation in the activity program in the electronic record for each resident and she maintained no paper documentation. Staff A said Resident #3 is in the main activity room daily and Resident #91 is in the [NAME] Unit Day room daily for activities. The Activity Director said there was documentation in the electronic record Residents #3 and #91 attend all day activities. This writer showed the Activity Director the previous 30 day documentation for both residents and she confirmed Resident #3 attended 2 activities and Resident #91 attended no activity programs. The Activity Director said I don't know why there is no documentation.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. 41155 Based on review of the facility job description for the Activity Director and staff interviews, the facility failed to ensure the activities program was directed by a qualified professional who is a qualified therapeutic recreation specialist or an activity professional. This has the potential to affect all 131 current residents residing in the facility. The findings included: The facility Job Description and Performance Evaluation documented Responsible for the planning, developing, organizing, implementing, evaluating and directing of activity programs in accordance with current exiting federal, state and local standards. Plan develop, organize, evaluate and direct activity programs to ensure all patients/residents assessed needs are met. Record and maintain activity progress notes as well as a record of resident activities. Qualifications Education College specialization, certification preferred. On 4/2/25 at 9:06 a.m., in an interview Activity Assistant Staff C said she did not have a certification for the position of the Activity Director and no training for the position. She said she had no qualifications for the position of Activity Director, and said I am her assistant. On 4/2/25 at 9:37 a.m., a request was made to Director of Nursing for documentation of the qualifications of the Activity Director. On 4/2/25 at 9:42 a.m., in an interview Certified Nursing Assistant Staff A said she has been the Activity Director for the facility for four years. She said she had not completed training and did not have a certificate for the position of Activity Director. On 4/2/25 at 1:16 p.m., in an interview, the Administrator confirmed Activity Director Staff A did not have the required qualifications for the position of Activity Director.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41155 Based on observation, review of facility policy and procedures, record review and staff and resident interviews, the facility failed to ensure urinary catheters were secured to prevent pulling and injury and failed to maintain the catheters in sanitary manner for 3 (Resident #50, #423, and #274) of 3 residents reviewed with an indwelling urinary catheter. The findings included: The facility policy Catheter-Foley documented Completing the procedure, Secure the catheter to the residents thigh (i.e , Stat Lock or Catheter Strap) to prevent movement, irritation and decrease risk of infection. Never leave the catheter hanging to be pulled by the weight of the bag. Place catheter bag in a dignity bag. 1. Review of the clinical record revealed Resident #50 had a readmitted [DATE] with diagnoses including morbid obesity, paraplegia, type 2 diabetes, chronic kidney disease, urinary retention, dementia, anxiety and delusional disorder. The Annual Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) dated 3/15/25 documented Resident #50 was dependent for personal hygiene and toileting. The MDS noted Resident #65's cognitive skills for daily decision making were moderately impaired. The care plan initiated 7/21/21 specified the resident wanted to have toileting needs met with dignity and promptly. On 3/31/25 at 11:00 a.m., Resident #50 was observed in bed. She was noted to have an indwelling urinary catheter, that was not secured to her leg. The catheter tubing was noted to be taunt and pulling, the drainage bag was attached to the bed frame and was not in a privacy bag. Resident #50 said sometimes the catheter pulls and she has to hold the tube when the staff are caring for her. On 4/1/25 at 11:47 a.m., Resident #50 was observed in bed and she removed the bed covers to show she did not have a securement device for the catheter. The drainage bag was attached to the bed frame and the tubing was noted to be taunt and stretched. On 4/2/25 at 9:22 a.m., Resident #50 was observed in bed and said she did not want anyone to touch her catheter. She said the staff pour water on it and wash it every day. Resident #50 said she did not have anything on her leg to secure the catheter and said it just hangs there and it hurts. She pulled back the covers to show this writer the catheter was not secured. Resident #50 said I usually hold it when they provide care and if I hold it, then it doesn't hurt when they do the care. 2. Review of the clinical record revealed Resident #423 was admitted [DATE] with a readmission on 3/27/25. Resident #423 had diagnoses including urinary retention, senile degeneration of the brain and acute cystitis with hematuria (inflammation of the bladder with blood in the urine). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Myers Rehabilitation and Nursing Center	7173 Cypress Drive SW Fort Myers, FL 33907

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician orders specified to secure catheter tubing to thigh with catheter secure or leg strap. On 3/31/25 at 12:00 p.m., Resident #423 was observed in his bed with a indwelling catheter and the tubing was noted to be pulling taut and was and not secured to his leg to prevent the pulling. The urinary drainage bag was secured to the bed frame and the catheter bag had no privacy cover. On 4/1/25 at 10:07 a.m., Resident #423 was observed in bed with the catheter securement device on the catheter, but it was not secured to his leg. The drainage bag was pulling, and the tubing was stretched tightly. On 4/3/25 at 9:48 a.m., Resident #423 was observed in bed and he did not have a catheter securement device in place. The catheter tubing was pulled tightly and wrapped around the leg of the bedside table. Photographic evidence obtained. On 4/3/25 at 9:49 a.m., Licensed Practical Nurse Staff D observed the resident's catheter and verified in an interview Resident #423's catheter tubing was unsecured and wrapped around the bedside table. On 4/3/25 at 9:55 a.m., in an interview Certified Nursing Assistant (CNA) Staff B said when cleaning the catheter you wipe from front to back and you place the catheter bag in a privacy bag attached to the bed frame. She said she never applies a leg strap; the nurse does that. 51818 3. Resident #274 was admitted to the facility on [DATE] with a diagnosis of muscle wasting and atrophy, pressure ulcer of sacral region, dysphagia, urinary retention, protein-calorie malnutrition, and cardiomyopathy. The resident was last assessed by a nursing assessment as alert and oriented with periods of confusion on 3/27/25. On 3/31/25 at 10:05 a.m., in an interview Resident #274 stated, I have a Foley connected to the end of the bed. Observation of Urinary Catheter bag connected to the bedframe, where the drainage bag, tubing, and valve stem were laying on the floor. On 3/31/25 at 10:10 a.m., an observation was made of a conversation between Registered Nurse (RN) Staff G and Resident #274. Resident #274 asked Staff G, for a dignity bag for his Foley catheter so he can get out of bed. Resident #274 told RN Staff G, You know, if I had a special bag, I could get up and walk around. Can you get me out of bed? Staff G said that he knew the Urinary Catheter should not be touching in the floor, It belongs in a dignity bag. On 4/2/25 at 2:00 p.m., in an interview the Infection Preventionist and Staff Development Coordinator said that maintaining the urinary catheter off the floor is included in staff training for Foley Care.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51818 Based on record review, interview and observation, the facility failed to maintain ongoing communication, coordination and collaboration between the nursing home and the dialysis staff for 1 (Resident #87) of 1 sampled resident receiving dialysis services reviewed. The findings included: Record review of Resident #87 revealed an admitted [DATE]. Diagnoses included End Stage Renal Disease. Review of the Admission Minimum Data Set (MDS) assessment with a target date of [DATE] revealed Resident #87's cognition was mildly impaired with a Brief Interview for Mental Status score of 12. 1. Review of the physician's orders in the Electronic Medical Record (EMR) revealed Resident #87 dialysis days were scheduled for Monday, Wednesday and Friday. The physician order dated [DATE] noted the resident's code status was Do not resuscitate (DNR) meaning not to initiate Cardiopulmonary resuscitation (CPR) in the event of cardiac or respiratory arrest. Review of a Circle of Care meeting dated [DATE] revealed documentation, A circle of care meeting was held today with team: DON opened . Resident at dialysis, his son (name) in attendance. Collaboration with dialysis center. Recommendations noted. On [DATE] at 11:28 a.m., Resident #87's dialysis communication binder (used to exchange information between the dialysis center and the facility) was reviewed. It did not include the resident's current DNR code status. A green sheet of paper in the binder read, FULL CODE (administer cardiopulmonary resuscitation in the event of cardiac or respiratory arrest). The binder contained Physician's Orders and a Medication List that was printed on [DATE]. On [DATE] at 11:35 a.m., in an interview, Licensed Practicing Nurse (LPN) Staff I stated that the Dialysis Communication Binder travels with Resident #87 three times a week to the dialysis center. LPN Staff I stated, It's the nurse's responsibility to make sure the communication binder is updated. If there are new orders and I am working, then I put them in the binder. I don't know what happens to the binder when I am not here, and I don't go to care rounds. I am the desk nurse and the admissions nurse. This is the only way that the nursing staff communicates with the dialysis staff is through the binder. LPN Staff I reviewed the electronic and physical clinical record. She verified that Resident #87 has an active advanced directive for Do Not Resuscitate order dated [DATE]. LPN Staff I also verified that that the Physician Orders and Medication List in the communication binder were out of date. She stated, These are his admission meds (medications) and orders. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 3:00 p.m., during a concurrent interview the Director of Nursing (DON) and Regional Nurse were asked whether it was concerning to them that the Dialysis Communication Binder was not up to date for advanced directives and orders. The DON said, It would be up to the dialysis center to do their own thing for advanced directives, we can tell you that for sure, our record wouldn't matter. The Regional Nurse agreed with the statement. On [DATE] at 7:45 a.m., in a telephone interview a dialysis nurse working at the Dialysis Center for Resident #87 stated, The dialysis communication binder is how we communicate with the facility, I can show no record of a meeting held on [DATE] with the facility in his chart here. If our Social Worker were part of the meeting they would have their notes, but the nurses look in the communication binder and, in our chart, which has no record of advanced directives planning. 2. Review of the progress notes for Resident #87 revealed a psychiatry note dated [DATE] which noted Resident #87 was unaware of his medical condition and has breaks with reality and confusion at dialysis. On [DATE] at 9:30 a.m., Resident #87 was observed freely propelling himself throughout the facility. Resident #87 appeared calm. He was not answering to questions appropriately. The resident was using inappropriate words to respond to questions. On [DATE] at 11:00 a.m., Record Review of the Dialysis Communication Binder for Resident #87 showed an information with letters written in bold stating Sevelamer (medication) sent to dialysis with resident on T-TH-S (Tuesday-Thursday-Saturday) for self-administration x 1 dose. Record review of Resident #87's assessment for self-administration of medications dated [DATE] showed that the resident may not self-administer medications. Review of the Medication Administration Record (MAR) for [DATE] revealed an order dated [DATE] to send Sevelamer to dialysis with resident one time a day every Monday, Wednesday, Friday for ESRD (End Stage Renal Disease). On Wednesday [DATE] the nurse entered 13 (At dialysis with meds) for the 12:00 p.m. dose of Sevelamer. On [DATE] at 11:10 a.m., an observation of Resident #87 dressed in personal clothing with a bagged lunch packed hanging from his wheelchair. On [DATE] at 12:00 p.m., an interview with staff J LPN, said that she only prepped him for dialysis because she doesn't know him that well, not because the paper in the binder said he goes on Tuesday-Thursday-Friday.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 52199 Based on observation and staff interviews, the facility failed to follow proper sanitation procedures for the 3-compartment sink, increasing the risk of cross-contamination and foodborne illness with the potential to impact residents receiving cooked food out of the dietary department. The findings included: The policy for the 3-compartment sink provided by the facility, with no effective date, stated, Sink 1= Wash, sink 2= Rinse, sink 3= Sanitize. Three-compartment sink steps: 1. Preparation: Fill sink (1) with warm Pot and Pan Detergent Solution. Fill Rinse sink (#2) with warm water. Fill the Sanitize sink (#3) with warm sanitizer solution to 200 PPM. 2. Pre-wash: Pre-scrape and rinse all items prior to washing in sink #1. 3. Wash: Scrub all surfaces (including handles). 4. Rinse: Submerge item in rinse water. Let rinse water run back into rinse sink. 5. Sanitize: Submerge item in sanitizer sink for a minimum of 60 seconds. Remove item from sink and let air dry. Do not wipe dry. On 4/2/25 from 11:15-11:25 a.m., during a 3-compartment sink observation, Staff O, a full-time Dietary Aide, was observed submerging dishes into the third compartment (containing the sanitizing solution) of the sink for 1-2 seconds. The employee then shook off the excess water and placed the dishes to the side of the sink on a rubber dry mat to dry. On 4/2/25 at 11:28 a.m., during an interview with Staff O, she was unable to speak to the process for washing, rinsing and sanitizing dishes using the 3-compartment sink. She read aloud the instructions posted on the wall that said, the dishes should be soaked for 60 seconds. **Photographic evidence obtained** On 4/2/25 at 4:50 p.m., during an interview with the Assistant Certified Dietary Manager (ACDM) she said, the procedure for the 3-compartment sink was the first sink was to scrub, the second was to rinse, and the third one was to sanitize. Then they are placed on the metal rack above the sink to air dry. When asked how long the dishes should soak in the third compartment, she said 5-15 minutes. The Certified Dietary Manager then read through the posted instructions on the wall above the sink. She read out loud, The dishes should be submerged for 60 seconds. On 4/3/25 at 8:36 a.m., the ACDM said during an interview that Dietary Aide, Staff O incorrectly sanitized the dishes. They should not be submerged for less than 60 seconds.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, review of the clinical record, review of the facility job description of the Activity Director and staff interviews, the facility failed to ensure resident records were maintained in accordance with accepted professional standards and practices, that are complete, and accurately documented for 2 (Residents #3, and #91) of 28 residents records reviewed. The findings included: The facility Job Description and Performance Evaluation for the Activity Director documented Responsible to Record and maintain activity progress notes as well as a record of resident activities. 1. Review of the clinical record revealed Resident #3 had an admitted [DATE] with diagnoses including dementia with restlessness, anxiety disorder, delusional and adjustment disorder. The Annual Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) dated 5/19/24 documented Resident #3's preference for routine and activities specified it was very important for Resident #3 to have books, newspapers, and magazines to read, to listen to music she likes, and to keep up with the news. It was somewhat important for Resident #3 to be around animals such as pets, and to do her favorite activities. The MDS noted Resident #3's cognitive skills for daily decision making were moderately impaired. Review of the care plan initiated 10/8/20 documented The Resident needs encouragement and assistance in pursuing activities. The care plan interventions included, Invite and assist resident to music related activities. Offer foods that comply with the residents' ordered diet. Offer pet therapy to resident. On 3/31/25 during observations at 10:24 a.m., 11:32 a.m., 1:20 p.m., and 3:25 p.m., Resident # 3 was observed in her room with the door open. She was in a wheelchair (w/c) facing the side of the closet. She had a tray table in front of her, that was pushed up against the side of the closet. There was nothing on the table for the resident to eat, drink or to occupy her time. She was not meaningfully engaged and had no radio or television on. Review of the March 2025 Activity Calendar specified the activities on 3/31/25: 9:00 a.m., Rise and Shine, 10:00 a.m., What's cooking, 1:00 p.m., Arts and Crafts, 2:00 p.m., Room Visits, 3:00 p.m., Gulf Coast Baptist. On 4/1/25 at 10:00 a.m., Resident #3 was in her room, in w/c facing the side of the closet with the tray table in front of her and pushed against the closet. She has no liquids, food or items on the table. There was no music and no television on. Review of the April 2025 Activity Calendar specified the activities on 4/1/25: 9:00 a.m., Rise and Shine, 10:00 a.m., Pokeno, 11:00 a.m., Trivia, 1:00 p.m., Movie and Popcorn, 1:45 p.m., room visits. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/2/25 at 1:31 p.m., a review of the electronic record for the previous 30 days revealed documentation Resident #3 attended one activity on 3/25/25 at 2:24 p.m., and 3/27/25 at 2:49 p.m. 2. Review of the clinical record revealed Resident #91 was [AGE] years old with diagnoses including senile degeneration of the brain, adjustment disorder, delusional disorder, severe protein calorie malnutrition, dementia, anxiety disorder, restlessness and agitation. The Annual MDS dated [DATE] documented Resident #91's preference for routine and activities specified it was very important to have books, newspapers, and magazines to read, to participate in religious services or practices and do her favorite activities. It was somewhat important for Resident #91 to listen to music she likes and to keep up with the news. The MDS noted Resident #93's cognitive skills for daily decision making were severely impaired. The care plan initiated 1/5/24 identified The Resident requires staff assistance with involvement of activities related to dementia and/or impaired thought process. The interventions for the resident included, invite and assist the resident to group activities, religious services and music related activities and offer the resident pet therapy. During random observations on 3/31/25 at 12:07 p.m., and 3:24 p.m., Resident #91 was observed in her room in her w/c with the bedside table in front of her that was pushed up against a blank wall. No activity items, water or snacks were available on the table for her. She said she was waiting to go to school and looking for her teacher. Observations on 4/1/25 at 9:56 a.m., Resident #91 was in her w/c with a tray table over her and it was pushed up against the blank wall. There were no liquids or food or activity items on the table for the resident. She was anxious repeating, I'm cold and I don't know what I'm doing. At 12:11 p.m., Resident #91 was observed in the w/c in her room with a tray table in front of her that was pushed up against the blank wall. There was a Styrofoam cup of ice water on the table. Continued observations on 4/1/25 at 1:13 p.m., 1:34 p.m., and 3:41 p.m., Resident # 91 was observed in her room in the same position facing a blank wall and yelling out Help me, I want to go to bed. Help me. On 4/2/25 at 9:58 a.m., a review of the electronic record documented in the previous 30 days Resident #91 participated in no activity programs. On 4/2/25 at 9:06 a.m., in an interview Activity Assistant Staff C said she did not have a certification and no training for the position of activity aid. She said she follows the activity calendar on the wall. For residents who don't come out of the room or to activities, I do room visits every day but I can't see everyone in one day. I talk to them, if they need anything I make up packets with word search, coloring and puzzles. I do nail care and hand massage. I can't get to many of the residents, and I spend about 10 minutes with each resident. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/2/25 at 9:42 a.m., in an interview Activity Director Staff A said she was the Activity Director here for 4 years. Staff A said we take the residents to the activity room or the day room on the [NAME] Unit. The day room is for the lower functioning residents. We did have activities here on 3/31/25 and 4/1/25 in the [NAME] day room. This writer mentioned that no one was observed in the day room on 3/31/25 and 4/1/25. Staff A replied it is because only 1 resident showed up and we did not do the activity for just one person. For the residents who do not get out of bed or don't come to activities I do room visits. We are here 9-5 Monday to Sunday. There are 3 of us, but right now one is out sick. The main activity room is for higher functioning residents. Staff A said she documents participation in the activity program in the electronic record for each resident and she maintains no paper documentation. Staff A said Resident #3 is in the main activity room daily and Resident #91 is in the [NAME] Unit Day room daily for activities. The Activity Director said there was documentation in the electronic record Residents #3 and #91 attend all day activities. The Activity Director reviewed the previous 30 day documentation for Residents #3 and #91. She confirmed Resident #3 attended 2 activities and Resident #91 attended no activity programs. The Activity Director said, I don't know why there is no documentation. A second review of the documentation for participation in the activity programs for the previous 30 days, showed the documentation was updated and showing that Resident #3 and #91 had participated in one or two activities daily. On 4/2/25 at 1:40 p.m., in an interview the Activity Director confirmed the activity records at this time, for participation in activities documented Resident #3 and #91 attended daily programs in the previous 30 days. When asked why there was now documentation for Resident #3 and #91 participating in daily activity programs, she replied, Late Entries. When asked how Resident #91 was in activity programs on 3/31/25 and 4/1/25 when this writer was monitoring her, she replied I had Resident #91 in the activity room on the [NAME] Unit all day, she was in activities. When asked how the resident could be in the activity programs when she was observed in her room the Activity Director replied, I don't know. On 4/2/25 at 2:39 p.m., Review of the activity participation record documented Resident #3 participated in daily activity programs for the previous 30 days that were not documented when reviewed that morning. The documentation revealed Resident #3 was attending activities daily including Monday 3/31/25 when Resident #3 was monitored and observed in her room all day.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52199 Based on observations and staff interviews, the facility failed to establish and maintain an effective infection prevention and control program, which increased the risk of communicable diseases and infections for 3 (Residents #23, #274 and #278) of 3 residents reviewed for catheter care and enhanced barrier precautions. The findings included: 1. The policy for Catheter-Foley Care provided by the facility, last revised on 4/25/22, stated, Keep the bag below the level of the bladder at all times to prevent the backflow of urine and decrease the risk for infection. Never leave the catheter hanging to be pulled by the weight of the bag. Do not leave the catheter bag/tubing laying on the floor. Place the catheter bag in a dignity bag. To avoid this issue and avoid infection control issues, the catheter bag/dignity bag may also be placed in a wash basin to avoid direct contact with the floor. Clinical record review revealed Resident #23 was admitted to the facility on [DATE]. Diagnoses included a past medical history of bacterial infection and urinary tract infection. Resident #23 required a Foley catheter. Physician orders dated 2/15/25 stated, Foley catheter care every shift, and as needed every day and night shift and Secure catheter tubing to thigh with cath secure or leg strap at all times every day and night shift for Foley care. He was also under Enhanced Barrier Precautions every day and night shift ordered on 3/17/25, and there was a sign posted on his room door. On 3/31/25 at 3:47 p.m., observation revealed Resident #23 lying in his bed, awake, alert, and oriented. His urinary catheter drainage bag was observed on the floor under his bed, outside of a dignity bag. Photographic evidence obtained On 4/1/25 at 9:15 a.m., Resident #23 was observed sitting in his wheelchair; his urinary catheter was observed unsecured and lying on the floor beneath the wheelchair Photographic evidence obtained On 4/1/25 at 9:19 a.m., in an interview, Registered Nurse Staff G said he had worked at the facility for [AGE] years. Staff G said the urinary catheter requires keeping the catheter clean, placed in a dignity bag, and off the floor. Resident #23 was observed in his room. Staff G verified that the Foley catheter bag was lying on the floor, not in a dignity bag. Staff G said, It shouldn't be on the floor. 51818 2. Resident #274 was admitted to the facility on [DATE]. He has a diagnosis of muscle wasting and atrophy, pressure ulcer of sacral region, dysphagia, urinary retention, protein-calorie malnutrition, and cardiomyopathy. He was last assessed by a nursing assessment as alert and oriented with periods of confusion on 3/27/25. (continued on next page)

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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 - Few	On 3/31/25 at 9:25 a.m., during an interview, Resident #274 said, I have a Foley connected to the end of the bed. Observation of Urinary Catheter bag connected to the bedframe, where the drainage bag, tubing, and valve stem were laying on the floor. On 3/31/25 at 9:30 a.m., during an interview Registered Nurse (RN) Staff G said that he knew the Urinary Catheter should not be touching in the floor, It belongs in a dignity bag (bag for privacy and cleanliness). 3. On 4/1/25 at 10:30 a.m., an observation of wound care was conducted for Resident #278. The Resident's door has a sign posted that read, STOP Enhanced Barrier Precautions. Licensed Practical Nurse (LPN), Staff A, Certified Nursing Assistant (CNA) Staff N, and CNA Staff O entered the room. Hand Hygiene was performed and gloves worn, no gowns were worn by any staff. CNA Staff N and CNA Staff O assisted the resident to turn to his side and removed Resident #278's brief while LPN Staff A used Normal Saline and Gauze to clean the resident's wound. LPN Staff A removed her gloves, performed hand hygiene and donned new gloves. LPN Staff A who then opened clean dressing onto clean surface. LPN Staff A applied clean Xeroform gauze and sacral dressing to the resident's wound. CNAs Staff N and Staff O were observed leaning over the bed to assist repositioning the resident. Their scrubs were touching the bed at the hip level. LPN Staff A changed her gloves and applied barrier cream to the resident's groin. On 4/1/25 at 10:45 a.m., in an interview LPN Staff A said she was not sure which resident in the room was on Enhanced Barrier Precautions, or why, and that she didn't need to use a gown to provide wound care. On 4/1/25 at 10:47 a.m., in an interview the Assistant Director of Nursing (ADON) who is also the Infection Preventionist, walked towards the wound care cart and explained that any resident receiving contact care activity, including wound care, would require Enhanced Barrier Precautions, including anyone in the room who is observing, even if they are not touching anything. On 4/1/25 at 10:48 a.m., the Director of Nursing (DON) informed the ADON and Staff A that the only person who is required to wear a gown during wound care is the person who is performing the wound care, because wound care is a high-contact resident care activity. On 4/1/25 at 11:00 a.m., the Personal Protective Equipment (PPE) drawer closest to the room of Resident #278 was observed to be empty. On 4/1/25 at 11:15 a.m., during a follow up interview LPN staff A stated, I know better, it's just only me that needs to wear the gown and I do. I was just nervous, it's not that there wasn't PPE available, I should have gotten some.