STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105439	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Naples Health and Rehabilitation Center	2900 12th Street N Naples, FL 34103

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 and interview, the facility failed to demonstrate prompt efforts to address grievances, including steps taken to investigate the grievance and failed to maintain evidence of the result of the grievance voiced by the family member of 1 (Resident #1) of 3 residents reviewed for grievances. The findings included: Review of the facility policy titled Resident Right - Grievances, issued 11/7/2024 revealed, It is the policy of the facility to allow the resident and or legal representative to voice a grievance in such a manner to acknowledge and respect resident rights . The resident has the right to and the facility will make prompt efforts by the facility to resolve grievances the resident may have . All residents, staff, and visitors will have access to the professional designated to manage the Grievance Program, Grievance Officer. The grievance policy must include . Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the residents concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued. On 5/29/25 at 10:07 a.m., in a telephone interview Resident #1's niece in-law said Resident #1 passed away at the facility on 3/11/25. She said she lives out of state. She spoke with several people at the facility and asked them to box and store Resident #1's belongings until she could pick them up in a few weeks. When she arrived on 3/27/25 to pick up the resident's ashes and belongings, the Social Worker (SW) handed her a small plastic bin. Many of Resident #1's belongings were missing. The SW took her to various closets, including Resident #1's former room to search for the missing items but nothing was found. She said the next day she called and spoke with the former interim Administrator who said he would look for the missing items and call her back. Resident #1's niece said the Administrator never called her back even after she left several phone messages. The niece said she did not have an inventory of Resident #1's belongings but really wanted his address book to contact his friends and a book he wrote his memories in. Review of Resident #1's clinical record failed to reveal an inventory list. There was no documentation in the clinical record of communication with Resident #1's family about the disposition of the resident's possessions. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/29/25 at 11:24 a.m., in an interview the Administrator said an inventory list is completed on admission. When new items come, the inventory list should be updated. She said sometimes family members bring in different items and they do not inform the facility. If a resident passes away, the belongings are kept for 30 days. The family is contacted to pick up the resident's possessions or let them know what to do with them. She said typically the Social worker is the Grievance Officer but the facility currently did not have a Social Worker (SW). On 5/29/25 at 2:15 p.m., in an interview the Corporate Traveling Director of Nursing (DON) said Resident #1's was admitted in 2019. They did not have an inventory list as they didn't own the company at that time. On 5/29/25 at 2:30 p.m., in an interview Licensed Practical Nurse (LPN) Staff A said she frequently worked with Resident #1. He had a lot of paperwork like journals. He had some bagged items, but she didn't know what they were. She said usually the Social Worker would gather the resident's belongings but she wasn't there when Resident #1 passed away. On 5/29/25 at 2:43 p.m., in an interview LPN Staff B said she frequently worked with Resident #1. He had a lot of papers in his room, and a tumbler cup he liked. There were some boxes in the closet, but she didn't know what was in them. She said she was not taking care of Resident #1 when he passed away but believed the SW packed up his belongings and called the family. On 5/29/25 at 2:55 p.m., in a telephone interview the former Social Worker (SW) said when he came back from vacation, he had a message from Resident #1's niece asking about his belongings. The SW said the nurses had packed the resident's belongings in a clear plastic tote and placed the tote in a closet used to store residents' belonging. He said he gave the clear plastic tote to Resident #1's niece when she came to collect the resident's belongings. The niece said some of Resident #1's possessions were missing. He notified the Interim Administrator. The niece also called and spoke with the Interim Administrator but he didn't know what happened from there. He said Resident #1 had a lot of stuff in his room, like a hoarder but he only had one clear tote to give to the niece. On 5/29/5 at 3:01 p.m., in a telephone interview the former interim Administrator said he believed Resident #1 passed before he started working at the facility. He said residents' belongings get bagged and stored in a designated area at the facility. He verified Resident #1's niece called and said some of his possessions were missing. He was not sure if anyone wrote a grievance but he told her to follow up with the Social Worker. He said he did not know what was given to the niece but staff told him all of Resident #1's belongings had been packed in bags. On 5/29/25, review of the facility's grievance log failed to reveal documentation of the grievance voiced by Resident #1's niece or steps taken to resolve it.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on observation, interviews, and records review, the facility failed to identify, investigate and prevent misappropriation of physician prescribed medication for 1 (Resident #4) of 3 residents reviewed. The findings included: Review of the facility policy titled, Abuse, Neglect, and Exploitation with a date reviewed/revised of 11/16/23 revealed, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit . exploitation and misappropriation of resident property. Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent. Review of the facility policy titled, Pharmacy Services with a date reviewed/revised of 4/17/23 revealed, The facility will provide pharmaceutical services to include procedures that assure the accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs . to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice . Review of the clinical record revealed Resident #4 had an admitted [DATE]. Review of the physician's orders revealed an order dated 2/28/25 for Fioricet capsule 50-300-40 mg (Butalbital-Acetaminophen-Caffeine), 1 capsule by mouth every 8 hours as needed for headache/Migraine. On 5/29/25 at 2:51 p.m., in an interview Resident #4 said on 5/24/25 during the night, the nurse gave him a Fioricet and said there was no Fioricet left, he'd have to reorder from the pharmacy. Resident #4 said when he asked for a Fioricet on 5/25/25, the nurse told him the Fioricet had not been delivered yet. Resident #4 said he did not receive the Fioricet until 5/26/25 in the evening. Resident #4 said he was in so much pain he felt as though his head would explode. He said it was unacceptable, the facility knows he requires the medication for migraine headaches, and he did not like that someone was messing with his medication. Review of the grievance log revealed on 5/27/25 Resident #4 filed a Medication concern. The log noted, Medication ordered on 5/24 and received on 5/25 and medication is PRN (as needed). Review of the grievance report dated 5/27/25 revealed Resident #4 complained about not having his migraine medication for one day. The documentation of investigation and facility follow up noted the PRN migraine medication was ordered on 5/25 and received the same day. Review of the pharmacy Packing Slips revealed the pharmacy delivered 30 capsules of Fioricet on 5/14/25 for Resident #4. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/29/25 at 2:26 p.m., during a telephone interview, the pharmacy representative verified 30 capsules of Fioricet were delivered for Resident #4 on 5/14/25. Review of the Medication Administration Record (MAR) for May 2025 showed Resident #4 was administered a total of 11 capsules of Fioricet from 5/14/25 through 5/24/25, leaving 19 capsules of Fioricet unaccounted for. Resident #4 received one Fioricet on 5/24/25 at 2:26 a.m. The next dose was administered two days later, on 5/26/25 at 7:42 p.m. The pharmacy packing slips revealed on 5/26/25 at 5:50 p.m., the pharmacy delivered an additional 30 capsules of Fioricet. The MAR for May 2025 revealed Resident #4 received a total of 7 doses of Fioricet from 5/26/25 at 5:50 p.m. , through 5/29/25 at 1:57 p.m. On 5/29/25 at 3:00 p.m., observation of the pharmacy package of Fioricet revealed 8 capsules of Fioricet had been removed from the package, leaving one capsule of Fioricet unaccounted for. On 5/29/25 at 3:07 p.m., in an interview Licensed Practical Nurse (LPN) Staff I said they were trying to get the Fioricet to be placed in the double locked drawer. On 5/29/25 at 3:37 p.m., an observation of the medication cart was done with the Director of Nursing (DON) and LPN Staff I. The DON verified no additional package of Fioricet was found in the medication cart for Resident #4. On 5/30/25 at 9:52 a.m., during a telephone interview the pharmacy consultant said Fioricet was not a controlled substance therefore not required to be double locked. She said she audits medications by pulling cards and checking expiration dates. She said she does not recall spot checking Resident #4's Fioricet medication. She said she did not know there was a problem until 5/29/25. She said one ingredient in Fioricet is Butalbital which is a barbiturate. On 5/30/25 at 1:26 p.m., in an interview the Corporate Traveling DON said she did not think anyone could truly determine what occurred with Resident #4's medication. She said it looked like a documentation error, and the nurses did not sign out the medication approximately 20 times.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 clinical record review, residents and staff interviews, the facility failed to ensure 3 (Residents #7, #8, and #3) of 3 dependent residents reviewed received their scheduled showers. The findings included: 1. On 5/29/25 at 9:30 a.m., in an interview Resident #7 said she asks staff regularly for a shower but has only received one shower since her admission to the facility. She said once she refused a shower as she was already in bed for the night. Review of the clinical record revealed Resident #7 was admitted on [DATE]. The 5-Day Minimum Data Set (MDS) assessment with a target date of 5/21/25 revealed Resident #7 scored 12 on the Brief Interview for mental status (BIMS), indicative of moderate cognitive impairment. Diagnoses included weakness and history of falling. The MDS assessment revealed Resident #7 required partial assistance with bathing and showers and did not reject care. Review of the shower schedule revealed Resident #7 was scheduled for a shower on the evening shift on Monday and Thursday. Review of the Certified Nursing Assistant (CNA) bathing task documentation for Resident #7 revealed: On 5/15/25 at 9:59 p.m., 5/19/25 at 11:41 a.m., and 5/22/25 at 9:59 p.m., Not Applicable was documented for the scheduled shower. On 5/19/25 at 6:27 p.m., and 5/29/25 at 1:20 p.m., a bed bath was documented. On 5/26/25 at 9:59 p.m., Resident refused was checked off. On 5/30/25 at 10:54 a.m. CNA Staff E said Resident #7 refuses showers when she offers them. The progress notes revealed no documentation that Resident #7 refused a shower. 2. Review of the clinical record revealed Resident #8 was admitted on [DATE]. Review of the physician note dated 4/25/25 at 5:23 p.m., revealed Resident #8 had a wound vac in place (a medical device that uses negative pressure wound therapy to help heal difficult or slow-healing wounds.) Review of the 5-day MDS assessment dated ,d+[DATE] 25 revealed diagnoses of digestive system surgery, perforation of the intestine, and need for assistance with personal care. The MDS revealed Resident #8 required maximum assistance with bathing and showers and did not reject care. Review of the shower schedule revealed Resident #8's showers were on Tuesdays and Fridays. Review of the ADL care plan dated 5/8/25 revealed Resident #8 preferred a bed bath twice a week. The CNA Kardex (provides instructions for safe care) documented to give a bed bath twice a week. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the CNA Task documentation from 4/30/25 through 5/29/25 revealed Resident #8 received bed baths. On 5/29/25 at 5:32 p.m., in an interview Resident #8 said he took showers his whole life and wondered why no one offered him a shower. He said he did not tell the nurse he preferred bed baths. On 5/29/25 at 5:35 p.m., in an interview the MDS Coordinator RN Staff C said she documented in the ADL care plan that Resident #8 preferred bed baths. She said she obtained the information from the nursing admission assessment. She did not ask Resident #8 if he wanted a shower. On 5/29/25 at 6:10 p.m., in an interview Licensed Practical Nurse (LPN) Staff D said she documented in the admission assessment for Resident #8 to receive bed baths because of the abdominal surgery and the wound vac. She said she did not ask the resident if he wanted a shower. On 5/29/25 at 6:17 p.m., in an interview the Director of Nursing said the wound vac was discontinued on 5/14/25 and the resident's abdominal wound was healed on 5/18/25. The DON said the resident could have started receiving showers after 5/18/25 if the resident wanted one. The DON said he did not know the resident did not receive a shower. On 5/30/25 at 11:38 a.m., in an interview the Regional Director of Nursing said Resident #8 had an open wound and a wound vac that prohibited a shower. He said, There are no odors here and the residents are being taken care of. 3. Review of the clinical record for Resident #3 revealed an admitted [DATE]. The Nursing Admission Evaluation dated 5/23/25 noted: Bath was documented for preference and choices for question, What type of bathing would you prefer? (Example- shower, bed bath, etc.), and Twice a week was documented for question, How often do you want to have your shower/ bath/ etc during your stay. The Admission MDS assessment with a target date of 5/28/25 revealed Resident #3 scored 15 on the Brief Interview for Mental Status, indicating intact cognition. Diagnoses included fusion of cervical spine, opioid dependence, and diabetes. The MDS noted Resident #3 required substantial/maximal assistance with shower/bathing. The resident's interview for daily preferences revealed it was very important for the resident to choose between a tub bath, shower, bed bath or sponge bath. On 5/29/25 at 12:13 p.m., in an interview Resident #3 said he has not received a shower since his admission. He said he usually showers every day. He begged for a shower, his hair has not been washed in 2 weeks. Review of the shower schedule revealed Resident #3's showers were scheduled for Tuesdays and Fridays. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the CNA documentation from 5/24/25 through 5/29/25 revealed Resident #3 received a bed bath on 5/24/25, 5/25/25, 5/26/25, 5/27/25 and 5/29/25. There was no documentation the resident received or refused the scheduled showers. On 5/30/25 at 10:54 a.m., in an interview Certified Nursing Assistant (CNA) Staff E said when a resident refuses a shower you document it in the CNA tasks and report to the nurse. On 5/30/25 at 11:11 a.m., in an interview CNA Staff F said if a resident refuses a shower, you report it to the nurse and document it in the CNA tasks. On 5/30/25 at 11:14 a.m., in an interview CNA Staff G said when a resident refuses a shower you report to the nurse and document in the record. On 5/30/25 at 11:18 a.m., in an interview CNA Staff H said you tell the nurse and document in the record whenever a resident refuses a shower.