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	07/01/2026

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

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, resident interview and observation, the facility failed to protect the resident's right to be free from neglect by failing to provide antibiotics in a timely manner to 1 (Resident #1) of 4 residents reviewed. The failure to provide the necessary care, antibiotics for a positive wound culture, to avoid physical harm placed the resident at risk for sepsis, a life-threatening response to an infection. The findings included: Review of facility policy titled Abuse, Neglect, Misappropriation of Resident Property, Injury of Unknown Origin, revised 8/2024 which stated, Neglect 1. Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.Review of Resident #1's clinical records documented she is a [AGE] year-old female admitted to the facility on 4/9/ 2026. The primary admitting diagnosis was surgical aftercare following surgery of the digestive system. Secondary diagnosis include diverticulitis of intestine, sepsis, and unspecified open wound of abdominal wall.Resident #1's care plan initiated on 4/9/26 and revised on 4/17/26 documented the resident is at risk for skin breakdown related to new ileostomy, indwelling catheter, impaired mobility. Interventions included to observe for signs and symptoms of infection or delayed healing and report to physician PRN (as needed): Redness / erythema drainage, fever, increased discomfort to wound, bowel odor from wound.Resident #1 Minimum Data Set (MDS) completed on 4/21/26 documented a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident is cognitively intact.Resident #1 abdominal wound culture report documented the specimen was collected on 6/22/26, received in the lab on 6/23/26 and resulted on 6/25/26 at 12:14 p.m. The abdominal wound culture was positive for Escherichia coli bacteria.Resident #1 physician orders documented an order for Midline placement for intravenous (IV) antibiotic via IV access dated 6/28/26. An order for Ertapenem Sodium Injection Solution 1 gram (GM) was placed 6/28/26 with the antibiotic start date of 6/29/26.Nursing progress note dated 6/22/26 at 10:51 a.m. documented by the facility wound care nurse stated, This nurse while performing wound care to patient observed ileostomy site to be soiled, when replacing wafer noted abdominal wound appeared with excessive drainage. Notified MD (Medical Doctor) who then gave orders for wound culture. Culture has been obtained and is in the fridge on north, labeled with requisition PCC order put into pop up on night shift for (lab) to pick up.Nursing progress note dated 6/26/26 at 10:51 p.m. documented, Ileostomy wafer and bag were changed; New dressing was applied. Site looks red and resident complained of pain from the site.Nursing progress note dated 6/27/26 at 10:59 p.m. documented, Resident is alert and oriented called and requested antibiotic. Resident stated antibiotic was prescribed by her surgeon X1 week. She was informed that there was no RX (prescription) for antibiotic noted. Culture results reviewed, waiting to be signed by MD or NP (Nurse Practitioner). She denied any pain at present. Verbal report given to upcoming nurse to message MD in the morning regarding resident concerns. Comfort care maintains.Nursing progress note dated 6/28/26 at 11:45 a.m. documented, Reviewed wound culture results; Escherichia coli detected in abdomen wound; notified NP. She confirmed new orders of starting antibiotic OK ertapenem IG IV daily for 7 days. Called (Intravenous access insertion company) and they will call back facility to confirm ETA (estimated time of arrival).On 7/1/26 at 9:25 a.m., (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observed resident #1 in bed with dressing to right arm. Resident #1 said the wound nurse thought her wound was infected and sent a wound culture on 6/22/26 when she did her dressing. She had an appointment with her surgeon that day too and he said he thought it was infected and was starting antibiotics. The resident said she thought she was getting her antibiotic in the cup of pills they give her daily. I was under the impression I was getting my antibiotics. I asked the nurses and was told that I didn't have any antibiotics ordered. I was told that the culture came back positive and they just put it in the file. Then they did not follow up with the doctor.On 7/1/26 at 10:50 a.m., interviewed the wound care nurse who said she was changing the dressing on the abdominal wound on 6/22/26, It sparked my interest since she complained of pain which she does not usually do. I reached out to the medical director and the NP and they agreed to send a swab. The wound care nurse confirmed the culture was collected 6/22/26, sent to the lab 6/23/26 and resulted on 6/25/26. Saying, The resident, told me verbally the surgeon prescribed antibiotics. I was off Friday 6/26/26 and noted it on 6/29/26 so I assumed she knew what she was talking about. I should have checked for the orders even though she is with it. The wound care nurse said not starting the antibiotics until 6/29/26 was a delay and put the resident at risk for getting sicker.On 7/1/26 at 11:05 a.m., interviewed Licensed Practical Nurse (LPN) Staff A who said about Resident #1, It was this weekend on Sunday, and she asked if she was on antibiotics, and I said no. She said the GI (Gastrointestinal) doctor put her on them. That is when she said she had the wound culture. I saw the results. I notified the primary doctor, and they stated she needed a PICC (Peripherally inserted central catheter) and to start the antibiotics. No one told me about a culture pending.On 7/1/26 at 11:15 a.m., interviewed the Director of Nursing (DON) who confirmed Resident #1 had a wound culture collected 6/22/26, processed 6/23/26 and resulted 6/25/26, a PICC line started on 6/28/26 and antibiotics started on 6/29/26. The DON said that it was Not acceptable about the delay in reporting the positive culture and starting antibiotics.On 7/1/26 at 12:00 p.m., in an interview, the Assistant Director of Nursing (ADON) confirmed that Resident #1's wound culture resulted as positive on 6/25/26 and there were no nursing notes documenting communicating with the MD or the NP prior to 6/28/26. The ADON said the risk of not having interventions or treatment for a positive wound culture would be sepsis and or getting sicker. We should have seen it earlier and followed up the NP/ MD earlier.On 7/1/26 at 12:40 p.m., the facility Administrator said, If the resident stated she was starting antibiotics the staff should have followed up. The results were positive on 6/25/26, They should have called the next day. That's a delay in service. I will need to find out why. The Administrator said the delay in treatment could put the resident at risk for septicemia and this is a compromised population.On 7/1/26 at 1:40 p.m., interviewed facility NP over the phone who said she was first notified of the culture results on 6/28/26. The NP said she should have been notified right away or at least the morning after the culture resulted. I don't know why there was a delay with Resident #1 results. The NP said there was a risk of sepsis, ending up in the hospital. It's not anything to be taken lightly. This is unfortunate and should not have happened.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility policy review, and staff interviews the facility failed to ensure staff notified providers of abnormal lab results in a timely manner for 1 (Resident #1) of 4 residents reviewed.The findings included: Review of facility policy titled Condition Change and Physician Notification Policy and Procedure reviewed January 2024 which stated, Doctor (Designee)/ Family Notification of a resident condition change will occur when a resident experiences a change of condition including but not limited to acute change in condition fever, nausea vomiting diarrhea, behavioral changes, lab work, falls, etc. If unable to reach family all attempts will be documented. If a resident attending physician does not return call timely, the DON and Medical Director must be notified.Review of facility policy titled Episodic and Narrative Documentation and Physician Notification, reviewed 1/2026 which stated, Documentation will occur in the Nurses Progress notes to reflect a change in status, event, or notification of the Responsible Party or Physician . A single narrative entry will occur for the following episodes including but not limited to, the following: change in condition . Physician notification . Document the date and time the Physician and Responsible Party were notified. Document whether physician orders were obtained or not.Review of Resident #1's clinical records documented she is a [AGE] year-old female admitted to the facility on 4/9/ 2026. The primary admitting diagnosis was surgical aftercare following surgery of the digestive system. Secondary diagnoses included diverticulitis of intestine, sepsis, and unspecified open wound of abdominal wall.Resident #1's care plan initiated on 4/9/26 and revised on 4/17/26 documented the resident is at risk for skin breakdown related to new ileostomy, indwelling catheter, impaired mobility. Interventions included to observe for signs and symptoms of infection or delayed healing and report to physician PRN (as needed): Redness / erythema drainage, fever, increased discomfort to wound, bowel odor from wound.Resident #1 Minimum Data Set (MDS) completed on 4/21/26 documented a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident is cognitively intact.Resident #1 abdominal wound culture report documented the specimen was collected on 6/22/26, received in the lab on 6/23/26 and resulted on 6/25/26 at 12:14 p.m. The abdominal wound culture was positive for Escherichia coli bacteria.Resident #1 physician orders documented an order for Midline placement for intravenous (IV) antibiotic via IV access dated 6/28/26. An order for Ertapenem Sodium Injection Solution 1 gram (GM) was placed 6/28/26 with the antibiotic start date of 6/29/26.Nursing progress note dated 6/22/26 at 10:51 a.m. documented by the facility wound care nurse stated, This nurse while performing wound care to patient observed ileostomy site to be soiled, when replacing wafer noted abdominal wound appeared with excessive drainage. Notified MD (Medical Doctor) who then gave orders for wound culture. Culture has been obtained and is in the fridge on north, labeled with requisition PCC order put into pop up on night shift for Ecolab to pick up.Nursing progress note dated 6/26/26 at 10:51 p.m. documented, Ileostomy wafer and bag were changed; New dressing was applied. Site looks red and resident complained of pain from the site.Nursing progress note dated 6/27/26 at 10:59 p.m. documented, Resident is alert and oriented called and requested antibiotic. Resident stated antibiotic was prescribed by her surgeon X1 week. She was informed that there was no RX for antibiotic noted. Culture result reviewed, waiting to be signed by MD or NP (Nurse Practitioner). She denied any pain at present. Verbal report given to upcoming nurse to message MD in the morning regarding resident concerns. Comfort care maintains.Nursing progress note dated 6/28/26 at 11:45 a.m. documented, Reviewed wound culture results; Escherichia coli detected in abdomen wound; notified NP. She confirmed new orders of starting antibiotic OK ertapenem IG IV daily for 7 days. Called IV access and they will call back facility to confirm ETA (estimated time of arrival).On 7/1/26 at 9:25 a.m., observed resident #1 in bed with dressing to right arm. Resident #1 said the wound nurse thought her wound was infected and sent a wound culture on 6/22/26 when she (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did her dressing. She had an appointment with her surgeon that day too and he said he thought it was infected and was starting antibiotics. The resident said she thought she was getting her antibiotic in the cup of pills they give her daily. I was under the impression I was getting my antibiotics. I asked the nurses and was told that I didn't have any antibiotics ordered. I was told that the culture came back positive and they just put it in the file. Then they did not follow up with the doctor.On 7/1/26 at 10:50 a.m., interviewed the wound care nurse who said she was changing the dressing on the abdominal wound on 6/22/26, It sparked my interest since she complained of pain which she does not usually do I reached out to the medical director and the NPC and they agreed to send a swab. The wound care nurse confirmed the culture was collected 6/22/26, sent to the lab 6/23/26 and resulted on 6/25/26. Saying, The resident, told me verbally the surgeon prescribed antibiotics. I was off Friday 6/26/26 and noted it on 6/29/26 so I assumed she knew what she was talking about. I should have checked for the orders even though she is with it. The wound care nurse said not starting the antibiotics until 6/29/26 was a delay and put the resident at risk for getting sicker.On 7/1/26 at 11:05 a.m., interviewed Licensed Practical Nurse (LPN) Staff A who said about Resident #1, It was this weekend on Sunday, and she asked if she was on antibiotics, and I said no. She said the GI (Gastrointestinal) doctor put her on them. That is when she said she had the wound culture. I saw the results. I notified the primary doctor, and they stated she needed a PICC (Peripherally inserted central catheter) and to start the antibiotics. No one told me about a culture pending.On 7/1/26 at 11:15 a.m., interviewed the Director of Nursing (DON) who confirmed Resident #1 had a wound culture collected 6/22/26, processed 6/23/26 and resulted 6/25/26, a PICC line started on 6/28/26 and antibiotics started on 6/29/26. The DON said that it was Not acceptable about the delay in reporting the positive culture and starting antibiotics.On 7/1/26 at 12:00 p.m. the Assistant Director of Nursing (ADON) interviewed who confirmed that Resident #1's wound culture resulted as positive on 6/25/26 and there were no nursing notes documenting communicating with the MD or the NP prior to 6/28/26. The ADON said the risk of not having interventions or treatment for a positive wound culture would be sepsis and or getting sicker. We should have seen it earlier and followed up the NP/ MD earlier.On 7/1/26 at 12:40 p.m., the facility Administrator said, If the resident stated she was starting antibiotics the staff should have followed up. The results were positive on 6/25/26 They should have called the next day. That's a delay in service. I will need to find out why. The Administrator said the delay in treatment could put the resident at risk for septicemia and this is a compromised population.On 7/1/26 at 1:40 p.m. interviewed facility NP over the phone who said she was first notified of the culture results on 6/28/26. The NP said she should have been notified right away or at least the morning after the culture resulted. I don't know why there was a delay with (Resident #1) results. The NP said there was a risk of sepsis ending up in the hospital. It's not anything to be taken lightly. This is unfortunate and should not have happened.On 7/1/26 at 2:45 p.m., interviewed LPN Staff B over the phone who confirmed she cared for Resident #1 over the past weekend. LPN Staff B said she did not know that Resident #1 had a wound culture pending. LPN Staff B said, I probably overlooked it and after the resident asked for her antibiotics I looked then. We usually call the MD with any results like a positive culture. That is the expectation. LPN Staff B said she made sure to tell the nurse starting her shift after her to contact the MD. Asked why she did not notify the MD or NP when she saw the result LPN Staff B replied, I don't know, it was late.