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	03/06/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, review of facility's policies and procedures, residents and staff interviews, the facility failed to implement processes to prevent avoidable accidents by failing to ensure the appropriate storage of ignition devices for four (Residents #37, #67, #118 and #119) of 17 smokers observed with lighters in their rooms. The unsafe practice of allowing four of 17 residents who smoke to store unsecure ignition sources such as lighters in their rooms created a significant fire hazard from accidental ignition. A possible accidental ignition and fire risk created a likelihood of serious injury, impairment or death and resulted in the determination of Immediate Jeopardy.The findings included:Cross reference F835, F926Review of the facility's policy and procedure titled, Resident Smoking supervised and Unsupervised - Use of Electronic Smoking/Vaping Devices issued 2/1/26 revealed, Residents who have independent smoking privileges are NOT permitted to keep cigarettes, e-cigarettes (electronic cigarettes), pipes, tobacco, nicotine, and other smoking/vaping articles in their possession including all forms of lighters, matches, and electronic smoking/vaping device paraphernalia . Residents without independent smoking privileges may not have or keep any smoking/vaping materials, including cigarettes, e-cigarettes, tobacco, nicotine, etc., except when they are under supervision .Resident #37On 3/2/26 at 11:04 a.m., Resident #37 was observed in his room, in bed. In an interview, Resident #37 said that staff usually takes him outside to smoke around 12:30 p.m. He said that he smokes cigarettes and keeps his cigarettes and lighter in his bedside table. Resident #37 was observed removing cigarettes and a lighter from the front pocket of his gown. He flicked the lighter, producing a visible flame. Review of the clinical record for Resident #37 revealed an admission date of 1/29/24. Diagnoses included unspecified Parkinsonism, primary progressive Multiple Sclerosis (progressive degenerative disorder), Generalized muscle weakness, major depressive disorder, anxiety disorder, schizoaffective disorder, bipolar type (chronic mental health condition).Review of the Quarterly MDS (Minimum Data Set) Assessment with an assessment reference date of 11/6/25 revealed Resident #37 scored 12 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment.The most recent completed smoking evaluation for Resident #37 was dated 10/2/25. The evaluation did not indicate if the resident had independent smoking privileges. The smoking evaluation noted that the resident was able to acknowledge understanding of the smoking policy. No was entered for question, Has the policy related to smoking times and storage of smoking materials been reviewed with the resident?The resident's care plan did not address smoking. On 3/3/26 at 3:18 p.m., in an interview the Director of Nursing (DON) said that each resident should have smoking in their care plan if they are a smoker.On 3/3/26 at 3:26 p.m., in an interview the MDS nurse said that smoking was removed from Resident #37's care plan since he quit smoking in 2025. When asked about the observation of Resident #37 smoking in the smoking area and the observation of cigarettes and a lighter in the resident's pocket, the MDS nurse said she would have to speak to the Unit Manager about it. She said she was not aware Resident #37 had started to smoke again. On 3/4/26 at 3:11 p.m., the DON provided an acknowledgement of smoking rules that Resident #37 signed on 12/18/18.On 3/5/26 at 11:04 a.m., in an interview, the DON said she was not employed at the facility when Resident #37 signed the acknowledgement of smoking rules. She said (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the resident has been here so long that they may not have had him sign another acknowledgement of smoking rules since he had already signed one in 2018. Resident #67:On 3/2/26 at 12:01 p.m., Resident #67 was interviewed in his room. The resident said that he goes outside to smoke any time he wants. When asked about storage of smoking materials, Resident #67 said he stored his cigarettes in a box on his bedside table. He said he knew he was not supposed to have a lighter but kept one in his pocket. Cigarettes were observed in a box on the resident's bedside table, and the outline of a lighter was observed in the pocket of the resident's sweatshirt.Review of the clinical record for Resident #67 revealed an admission date of 9/3/25. Diagnoses included opioid dependence, sedative, hypnotic or anxiolytic dependence, anxiety disorder, generalized weakness and repeated falls.The smoking evaluation dated 9/3/25 noted that the resident exhibited signs of confusion.The care plan initiated on 9/3/25 documented that Resident #67 had the potential to display behaviors of entering other residents' rooms without permission and was verbally belligerent. The care plan noted that Resident #67 was not following facility policy, stealing food off other residents' trays.A nursing progress note dated 9/14/25 read, Resident was caught smoking in his room. When confronting resident, he put it out and said, I know that I am not supposed to do it, but I don't care because I can't sleep.The care plan created on 9/15/25 noted, Smoking in room/educated. The interventions included to explain/reinforce why behavior is inappropriate and/or unacceptable to the resident; Intervene as necessary to protect the rights and safety of others; Redirect resident as necessary. The care plan did not include supervision to prevent unsafe smoking practices.On 3/3/26 at 12:12 p.m., in an interview, Licensed Practical Nurse (LPN) Staff I said she has been employed at the facility for 4 months. She said that residents who smoke keep cigarettes and lighters with them. Resident #118On 3/2/26 at 11:14 a.m., an observation of Resident #118's room revealed a white lighter left unattended and unsecured on the resident's bedside table, amidst other items, including a television remote, a tube of pain-relieving gel. Resident #118 was not in the room at the time of the observation.On 3/2/26 at 2:21p.m., observation of Resident #118's room with the DON revealed the white lighter remained on the resident's bedside table. The DON walked in the room and leaned over and took the resident's lighter. Resident #118 was in the room at the time of the observation. He appeared angry and yelled at the DON to get out.Upon leaving the resident's room, the DON said that smokers were not allowed to keep lighters at their bedside, the lighters should be locked in the smoking cart.In an interview the DON said smokers were not allowed to keep lighters at their bedside. The lighters should be locked in the smoking cart.Review of the clinical record for Resident #118 revealed an admission date of 3/15/24. Diagnoses included anxiety disorder, history of other mental and behavioral disorders, chronic respiratory failure with hypoxia and protein-calorie malnutrition.The most recent smoking evaluation was dated 3/25/25.Review of the Annual MDS with an Assessment Reference Date of 9/3/25 revealed No was entered for Current tobacco use.The care plan initiated on 3/19/24 noted that Resident #118 was a safe smoker with supervision. No revision was made to the care plan until 3/2/26.Review of the facility provided list of 9 wanderers and residents at elopement risk revealed 2 of the 9 residents resided in close proximity to Resident #118's room where the lighter was observed unsecured and unattended.Resident #119On 3/3/26 at 9:58 a.m., Resident #119 was interviewed in his room. The resident said he smokes cigarettes and keeps his cigarettes and a lighter with him. Resident #119 said, If you put smoking materials in the lock box, they leave the box open. Cigarettes and a lighter were observed in the pocket of the resident's shirt.Review of the clinical record for Resident #119 revealed an admission date of 9/12/24. Diagnoses included syncope and collapse, alcohol dependence, alcohol abuse with withdrawal, nicotine dependence, cigarettes, chronic obstructive pulmonary disease, generalized muscle weakness, repeated falls.Review of the care plan created on 5/11/23 noted that Resident #119 was a safe smoker.The care plan for Resident #119 included accumulates clutter, refuses to organize room, refuses to allow staff to clean/organize his room. Resident #119 is also noncompliant with policies regarding alcohol in his room. He frequently goes out via his wheelchair and returns ETOH (intoxicated).On 3/3/26 at 10:35 a.m., in an interview, (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the Administrator said he was informed that several Residents had been found with lighters in their possession. He said the facility's policy was to turn the lighters and cigarettes in to the smoking attendant.On 3/5/26 at 11:04 a.m., in an interview, the DON said they tell the residents that any smoking items should be returned to the smoking attendant at the end of the smoking break. The DON said they found out this week that people are not as honest and they may hide paraphernalia. She said they had even caught residents door-dashing smoking supplies before. She said the resident who are doing it have a high BIMS score. They can be a bit manipulative and confabulate. She said they had educated the residents in the past. From time to time, they conduct room sweeps and try to explain the safety concerns to the residents.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, record review, residents and staff interviews, the facility administration failed to provide effective oversight and failed to take appropriate actions to protect residents' safety from foreseeable and avoidable incidents from unsafe smoking practices and unsafe storage of ignition devices. This failure created an environment that placed four (Residents #37, #67, #118 and #119) of 17 resident smokers at a likelihood of serious injury, impairment or death from an accidental fire and resulted in the determination of Immediate Jeopardy. The findings included:Refer to F689, F926Review of the Director of Nursing's job description revealed that the essential duties and responsibilities included: Plan, develop, organize, implement, evaluate, and direct the nursing services department, as well as its programs and activities, in accordance with current rules, regulations, policies/procedures and guidelines that govern the long-term care facilities. Regularly inspect the facility and nursing practices for compliance with federal, state, and local standards and regulations.On 11/3/25, the Director of Nursing (DON) signed that she understood this job description and its requirements.Review of the Administrator's job description revealed that essential duties and responsibilities included: Monitor each department's activities, communicate policies, evaluate performance, provide feedback and assist, observe, coach, and discipline as needed. Consult with department managers concerning the operation of their departments to assist in elimination/correcting problem areas, and/or improvement of services.The Administrator signed the job description on 1/5/26.Review of the facility's Resident Smoking Supervised and Unsupervised - Use of Electronic Smoking/Vaping Devices policy and procedure from the Nursing/Clinical Quality of Care Manual revealed, Standard: The facility shall establish and maintain safe resident smoking practices, and/or use of electronic smoking/vaping devices. Guideline: Safety practices apply to smoking and non-smoking residents in accordance with State and Federal regulations. All smoking/vaping materials shall be kept at the nurse's station or other designated facility location. Smoking/vaping materials will be returned to the nurse's station or other designated facility location following each smoking session . Residents may not maintain cigarettes, e-cigarettes (electronic cigarettes), vaping materials or lighters in their possession .Resident #37Resident #37 was a smoker with an admission date of 1/29/24. Review of the clinical record revealed diagnoses included primary progressive Multiple Sclerosis (progressive degenerative disorder), Generalized muscle weakness, major depressive disorder, anxiety disorder, schizoaffective disorder, bipolar type (chronic mental health condition). Resident #37 smoked cigarettes.The Quarterly MDS (Minimum Data Set) Assessment with an ARD (Assessment Reference Date) of 11/6/25 revealed Resident #37 scored 12 on the Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition.On 3/2/26 at 11:04 a.m., Resident #37 was observed in his room, in bed. In an interview, Resident #37 said that staff usually takes him outside to smoke around 12:30 p.m. He said that he keeps his cigarettes and lighter in his bedside table. Resident #37 was observed removing cigarettes and a lighter from the front pocket of his gown. He flicked the lighter, producing a visible flame. Resident #67Resident #67 was a smoker with an admission date of 9/3/25. Review of the clinical record revealed diagnoses included opioid dependence, sedative, hypnotic or anxiolytic dependence, anxiety disorder, generalized weakness and repeated falls.Review of the nursing progress notes revealed that on 9/14/25, Resident was caught smoking in his room. When confronting resident, he put it out and said, I know that I am not supposed to do it, but I don't care because I can't sleep.The care plan created on 9/15/25 noted, Smoking in room/educated.On 3/2/26 at 12:01 p.m., Resident #67 was interviewed in his room. The resident said that he goes outside to smoke any time he wants. Resident #67 said that he knew he was not supposed to have a lighter but kept one in his pocket and stored his cigarettes in a box on his bedside table. Cigarettes were observed in a box on the resident's bedside table and the outline of a lighter was observed in the pocket of the resident's sweatshirt.Resident #118Resident #118 was a smoker with an admission date of 3/15/24. Review of the clinical record revealed (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	diagnoses included Anxiety Disorder, history of other mental and behavioral disorders, chronic respiratory failure with hypoxia (lack of adequate oxygen level) and protein-calorie malnutrition.The care plan for smoking initiated on 3/19/24 documented that Resident #118 was a safe smoker with supervision. The most recent smoking evaluation was dated 3/25/25.On 3/2/26 at 11:14 a.m., an observation of Resident #118's room revealed a white lighter left unattended and unsecured on the resident's bedside table. Resident #118 was not in the room at the time of the observation.On 3/2/26 at 2:21p.m., observation of Resident #118's room with the DON revealed the white lighter remained on the resident's bedside table.Resident #119Resident #119 was a smoker with an admission date of 9/12/24. Review of the clinical record revealed diagnoses included syncope and collapse, alcohol dependence, alcohol abuse with withdrawal, nicotine dependence, cigarettes, chronic obstructive pulmonary disease, generalized muscle weakness, repeated falls.Review of the care plan with a revision date of 11/10/25 revealed Resident #119 was at risk for substance abuse related to a history of ETOH (alcohol) abuse. The resident was non-compliant with policies regarding alcohol in his room.The care plan noted the resident frequently went out via his wheelchair and returned ETOH (intoxicated).On 3/3/26 at 9:58 a.m., Resident #119 was interviewed in his room. He verified that he smokes cigarettes. In an interview, Resident #119 said that he keeps his cigarettes and a lighter with him. He said, If you put smoking materials in the lock box, they leave the box open. Cigarettes and a lighter were observed in the pocket of the resident's shirt.On 3/5/26 at 11:04 a.m., in an interview, the DON said the facility's policy noted that the smoking evaluation is done on admission, annually and with completion of the MDS with a significant change. She said that a Certified Nursing Assistant (CNA) is assigned to the courtyard for 16 hours a day. They ask that smoking items be returned to them at the end of the smoking break. The DON said they found out this week during the survey that residents are not as honest and may hide paraphernalia. She said the residents doing it had a high BIMS score. The DON said, They can be a bit manipulative and confabulate. She said they were educated in the past. They have even caught residents door-dashing smoking supplies before. The DON said, From time to time we do room sweeps and try to explain the safety concerns. She said if they had a repeat offender, they definitely educated the resident, but with continued noncompliance, they can issue a 30 day discharge notice as we cannot continue to jeopardize the safety of other residents. The DON said on July 7, 2025, they educated residents on the smoking policy.On 3/5/26 at 11:22 a.m., in an interview the Administrator said they had not identified the smoking concerns revealed this week. The facility had a guardian angel program in which the managers are assigned residents' rooms. They have a check list of things to look for, including a section for any hazards. He said the list does not include smoking materials but he would expect his staff to document any unsafe items and bring them to morning meeting to be addressed. He said he started employment at the facility about a month ago and attended a Resident Council meeting to reiterate that they have to follow the smoking policy for safety. He said that if a resident is found with smoking supplies, they are taken from them and placed in the smoking supplies box. The Administrator said that safety trumps rights. They continue to reinforce the policy but the population is so much younger in that facility. They are constantly ordering packages, which they have a right to do, but they can get just about anything delivered. If they have repeat offenders, they need to just keep reiterating the rules. They can also issue a 30-day discharge notice, if they are putting others at risk, they don't need to be here.On 3/6/26 at 10:57 a.m., in an interview, the Administrator said that per policy, smoking privileges can be revoked, but that has not happened since he started employment at the facility.

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F 0926 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Have policies on smoking. Based on observations, record review, review of facility's policies and procedures, residents and staff interviews, the facility failed to implement and enforce the facility's Resident Smoking Supervised and Unsupervised policy to ensure safe smoking practices for 4 (Residents #37, #67, #118 and #119) of 4 sampled residents reviewed for safe smoking out of 17 total smokers in the facility.The facility failure to enforce the smoking policy that clearly addressed the safe storage of ignition devices by allowing residents to keep lighters/ignition devices unsecured in their rooms created an avoidable fire safety risk, placing four of 17 resident smokers at a likelihood for serious harm, injury or death. These concerns resulted in the determination of immediate jeopardy. The findings included:Cross reference F689, F835Review of the facility's policy and procedure titled Resident Smoking Supervised and Unsupervised - Use of Electronic Smoking/Vaping Devices from the Nursing/Clinical Quality of Care Manual revealed, Prior to, and upon admission, residents shall be informed of the facility smoking policy, including use of electronic smoking/vaping devices, designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. Residents and/or resident's representative will be required to review, sign and therefore agree to the terms of the facility Smoking/Vaping Contract as applicable. The resident will be evaluated on admission to determine if he or she is a smoker and/or uses an electronic smoking/vaping device . If a smoker, the evaluation will include . ability to smoke safely with or without supervision. A resident's ability to smoke safely and/or use an electronic smoking/vaping device will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff and shall be noted on the care plan. Residents who have independent smoking privileges are NOT permitted to keep cigarettes, e-cigarettes (electronic cigarettes), pipes, tobacco, nicotine, and other smoking/vaping articles in their possession including all forms of lighters, matches . Residents without independent smoking privileges may not have or keep any smoking/vaping materials, including cigarettes, e-cigarettes . except when they are under supervision.Review of the Smoking/Vaping Contract Acknowledgement form that residents or resident's representative are required to review and sign revealed, Absolutely no tobacco paraphernalia and/or tobacco products are to be kept in resident rooms. If at any time, a resident is found with. smoking materials (including lighters, matches .) in his/her room or is found smoking . in the room or inside the facility, such articles will be removed, smoking/vaping privileges will be revoked and could result in Resident discharge from the facility. If at any time this policy/contract is violated, smoking/vaping and/or tobacco/nicotine usage privileges will be revoked. Procedure: A licensed nurse will evaluate residents who smoke . upon admission or at the start of such activity and as cognitive or physical status changes warrant. Residents will periodically be reviewed to reassess their ability to smoke . safely .Review of the Exhibit C, Smoking Policy revised 10/20/23, included in the admission Packet revealed, To assure maximized safety, all residents who choose to smoke will be supervised smokers. All smoking materials will be kept in a lock box at the adjacent nurse's station. Residents who smoke will turn in all smoking materials and paraphernalia to the staff person in charge when leaving the smoking area. No resident may have or keep any smoking materials or paraphernalia, including cigarettes . lighters, matches etc. in their possession outside the designated smoking area.Review of the undated facility provided list of 17 current residents who smoke tobacco products revealed Residents #37, #67, #118 and #119 were smokers.Resident #37:On 3/2/26 at 11:04 a.m., Resident #37 was observed in his room, in bed. In an interview, Resident #37 said that he keeps his cigarettes and lighter in his bedside table. Resident #37 was observed removing cigarettes and a lighter from the front pocket of his gown. He flicked the lighter, producing a visible flame. Review of the clinical record for Resident #37 revealed an admission date of 9/27/2024.The smoking evaluation was dated 10/2/25. The evaluator entered No for the question, Has the policy related to smoking and storage of smoking materials been reviewed with the resident? and Yes for the question, Is the resident able to acknowledge understanding of smoking policy?The (continued on next page)

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F 0926 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident's care plan did not address smoking and the result of the smoking evaluation.On 3/3/26 at 3:26 p.m., in an interview the MDS (Minimum Data Set) nurse said that smoking was removed from Resident #37's care plan in 2025 as he quit smoking. The observation of the lighter and cigarettes in Resident #37's possession in his room and the observation of the resident smoking cigarettes in the designated smoking area were shared with the MDS nurse. She said she did not know Resident #37 had started to smoke again and would have to speak to the Unit Manager about it.On 3/4/26 at 3:11 p.m., the Director of Nursing (DON) provided an acknowledgement of smoking rules that Resident #37 signed on 12/18/18.Resident #67:On 3/2/26 at 12:01 p.m., Resident #67 was interviewed in his room. The resident said that he knew he was not supposed to have a lighter but kept one in his pocket and stored his cigarettes in a box on his bedside table. Cigarettes were observed in a box on the resident's bedside table and the outline of a lighter was observed in the pocket of the resident's sweatshirt.Review of the clinical record for Resident #67 revealed an admission date of 9/3/25.On 3/4/26 at 2:20 p.m., upon request for the smoking contract for Resident #67, the DON provided the admission agreement Resident #67 signed on 9/9/25 and said the admission agreement included the smoking policy.A nursing progress note dated 9/14/25 noted, Resident was caught smoking in his room. When confronting resident, he put it out and said, I know that I am not supposed to do it, but I don't care because I can't sleep. Will continue to monitor resident for compliance.The care plan created on 9/15/25 and revised on 12/22/25 noted, Smoking in room/educated. The goal was Resident #67, will have a minimized risk of disruptive behaviors and/or harm through next review. The target date was 3/22/26. The care plan interventions did not include how Resident #67 would be monitored for compliance.Resident #118:On 3/2/26 at 11:14 a.m., an observation of Resident #118's room revealed a white lighter left unattended and unsecured on the resident's bedside table. Resident #118 was not in the room at the time of the observation.On 3/2/26 at 2:21p.m., observation of Resident #118's room with the DON revealed the white lighter remained on the resident's bedside table. Resident #118 was visibly upset and told the DON to get out of his room. The DON took the resident's lighter and said that residents were not supposed to have smoking material in their possession.Review of the clinical record for Resident #118 revealed an admission date of 3/15/24.The smoking evaluation was dated 3/25/25.The care plan created on 3/19/24 and revised on 3/3/26 noted that Resident #118 was a safe smoker with supervision.The Annual MDS (Minimum Data Set) Assessment with an Assessment Reference Date of 9/2/25 had No entered for current tobacco use.On 3/4/26 at 2:20 p.m., the DON provided an undated Exhibit C. Smoking Policy form with digital initials on the bottom of the form. The DON said the initials were Resident #118's electronic signature, acknowledging that he had read the policies attached to his contract. On 3/5/26 at 11:04 a.m., in an interview, the DON said smoking evaluations are usually done annually and if something has changed or something significant.Resident #119:On 3/3/26 at 9:58 a.m., Resident #119 was interviewed in his room. Resident #119 said that he smokes cigarettes and keeps his cigarettes and a lighter with him. He said, If you put smoking materials in the lock box, they leave the box open. Cigarettes and a lighter were observed in the pocket of the resident's shirt.Review of the clinical record for Resident #119 revealed an admission date of 9/12/24.Review of the care plan with a revision date of 11/10/25 revealed Resident #119 was at risk for substance abuse related to a history of ETOH (alcohol) abuse. The resident was non-compliant with policies regarding alcohol in his room.The care plan noted the resident frequently went out via his wheelchair and returned ETOH (intoxicated).The care plan created on 3/3/26 noted that Resident #119 must smoke with supervision.On 3/4/26 at 3:08 p.m., when asked about a smoking contract for Resident #119, the DON provided a smoking evaluation dated 12/17/25. The evaluation noted that the policy related to smoking times and storage of smoking materials have been reviewed with and understood by the resident. The DON verified that there was no smoking contract signed by Resident #119.On 3/5/26 at 11:22 a.m., in an interview the Administrator said that the residents are all given the policy on admission and sign a smoking contract that they will adhere to the policy. He said the facility has smoking aides 16 hours a day who sit in the courtyard to monitor the smoking area. He said the smoking material is kept in a locked cart.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to have sufficient staff to provide nursing care and services to maintain safety and the highest level of resident care needed to meet the needs of the residents, # 2, #12, #24 #50, #51, #52, #22, #25,#30, #133, and #140, by failing to ensure enough staff were available to respond to call lights and address resident concerns.The findings included: Review of the Facility Assessment's Staff Assignments plan noted we conduct a comprehensive assessment of each resident's medical, physical, and emotional needs upon admission. The Facility Assessment further states the facility will ensure an equitable distribution of workload among staff to prevent burnout and maintain high-quality care.Resident #50On 3/2/26 at 10:19 a.m., Resident #50 was observed sitting up in bed, removing her blanket, moving to the edge of the bed and pointing at the bathroom. Resident #50's roommate (Resident #22) said she is not able to get up on her own because she will fall.On 3/2/26 at 10:20 a.m., RN (Registered Nurse) Staff A was observed at the Resident #50's room doorway. RN Staff A said they would get help.On 3/2/26 at 10:21 a.m., the call bell was activated.On 3/2/26 at 10:22 a.m. CNA (Certified Nursing Assistant) Staff B was observed entering Resident #50's room. CNA Staff B observed turning off Resident #50's call bell and exiting the room. CNA Staff B did not interact with Resident #50.On 3/2/26 at 10:41 a.m. the call bell was activated and responded to at 10:46 am. By LPN (Licensed Practical Nurse) Staff C.On 3/2/26 at 10:46 a.m. LPN (Licensed Practical Nurse) Staff C was observed entering the room and addressing Resident #50's needs.Record review for Resident #50 showed she was admitted on [DATE] with a diagnosis of a displaced intertrochanteric fracture of left femur, history of falling, muscle weakness, lack of coordination and dementia. Resident #50's brief interview for mental status (a test used to look at cognitive function) on 1/26/26 gave her a score of 3 indicating severe cognitive impairment.Review of Resident #50's care plan (initiated 1/20/26) noted her as a risk for falls with interventions to ensure call light is within reach and encourage use for assistance. Resident #50's care plan also noted Resident #50 has impaired cognitive function/impaired thought processes r/t (related to) decision making problem, dementia, developmentally delayed, head injury, long term memory problem, problem making self-understood, problem understanding others, psychosis (initiated 1/21/26). Resident #50's care plan further noted she needs assist Substantial x1 staff for: showers, bathing, dressing, transfers, toileting, personal hygiene, bed mobility (initiated 1/21/26). Resident #51During an interview on 3/2/26 at 9:32 a.m. Resident #51 said the staff do not come quickly when you press the call light. Resident #51 said on average, he is waiting longer than 30 minutes for staff to answer his call light. He said his colostomy bag needs to be emptied now. Colostomy bag observed full of air. He said he has several CNAs that he asks to do it and never do. Resident #50 said it usually happens on 2nd and 3rd shift. He said his colostomy bag exploded earlier this morning and required him to be cleaned up.Resident #22During an interview on 3/2/26 at 10:16 a.m. Resident #22 said she wishes there were more staff. She said the staff have a lot on their plates, so they forget things and also forget about me. Resident #22 said on average, she is waiting longer than 30 minutes for staff to answer her call light.Resident #25During an interview on 3/2/26 at 11:10 a.m. Resident #25 said nighttime is a problem for staffing. She said they are much slower at night and make excuses for why they don't come.Resident #30During an interview on 3/2/26 at 11:32 a.m. Resident #30 said the staff told her she could not go to the bathroom on her own and to call for assistance. Resident #30 said she will use the call light, and it will take up to 1.5 hours for staff to come and assist her.Resident #133During an interview on 3/3/26 at 8:08 a.m. Resident #133 said it can take a long time for staff to answer the call light. Resident #133 said on average, he is waiting longer than 30 minutes for staff to answer his call light. Resident #140During an interview on 3/3/26 8:12 a.m. Resident #140 said if you got hurt on 3rd shift you would die. Resident #140 said he will call for staff assistance, and it takes up (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to 2 hours for them to help him.Resident #52During an interview on 3/5/26 at 11:06 a.m. Resident #52 said she has to call the front desk to get help because no one will answer her call light. Resident #52 said they will page overhead and still no one will come to assist her. Resident #52 said she has had to wait for 6 hours in urine.During a resident council meeting conducted on 3/3/26 at 2:55 p.m. the residents at the meeting said they have to wait too long to get care and there is a problem with staffing. They said there are usually not enough CNAs. They said they will have to wait an hour or two to have their needs met. They said if a CNA that is not assigned to them answers the call light, they are told they will have to wait until your CNA comes. Residents also reported long wait times for pain medications and assistance with showers.Review of the Resident Council Minutes from November of 2025 noted call light response too slow, at times, mainly at night. Actions taken noted staff in serviced on call light response times. The outcome was noted as Not Resolved - Action needed.Review of the Resident Council Minutes from December call light response too slow, at times, mainly at night. Actions taken noted staff in serviced on call light response times. The outcome was noted as Not Resolved - Action needed.Review of the Resident Council Minutes from January and February 2026 with no outcome of resolved for call light response concern.Resident #8During an interview on 3/5/26 at 8:20 a.m., Resident #8 said she is the Resident Council President. Resident #8 said there have been concerns with staffing and call light response time mentioned during their Resident Council meetings without improvement. Resident #8 said there is not enough staff. Resident #8 said a lot of residents including herself require 2 to 3 staff to assist them with care. Resident #8 said when they are with her, there are no staff to assist the other resident's needs. Resident #8 said they bring it up each month and nothing is being done. Resident #8 said there has been no improvement with staffing.Resident #12Review of the Resident Grievance Log showed Resident #12 had filed a grievance for call light response time on 11/6/25, 11/8/26, 1/12/26 and 2/10/26. Review of the grievance forms for Resident #12 showed the resident was not satisfied with the grievance resolution.During an interview on 3/5/26 at 10:57 a.m. Resident #12 said CNAs are not coming. Resident #12 said on average it takes an hour for staff to respond to her call light. Resident #12 said she has waited up to 3 hours for assistance. Resident #12 said nothing has been resolved and there has been no improvement. Resident #12 said she needs assistance with perineal care and emptying of her urinary catheter. Resident #12 said she put her grievances in and never saw anyone again.Resident #2Further review of the grievance log showed call light grievances for Resident #2 (filed on 1/12/26) and Resident #24 (filed on 1/17/26) with both marked as resolved.During an interview on 3/5/26 at 11:10 a.m. Resident #2 said on an average day it take an hour to get care. He said he needs a lot of assistance due to his amputation. Resident #2 said he still has to wait over an hour to get care. Resident #2 said nothing has changed since he filed his grievance. Resident #2 said he gave up because nothing is going to change.Resident #24During an interview on 3/6/26 at 9:10 a.m. Resident #24 said she filed a grievance due to slow call light response times from staff. Resident #24 said no one ever came back and discussed anything with her after filing her grievance.During an interview on 3/5/26 at 8:25 a.m., CNA Staff D said there are not enough staff to meet the needs of the residents. CNA Staff D said there are usually only 2 to 3 CNAs on duty in her section. CNA Staff D said a resident in their section requires 4 CNAs to take care of her. CNA Staff D said that there is not enough CNAs to take care of that resident. CNA Staff D said when they are in there with her, they can't take care of the other residents.During an interview on 3/5/26 at 8:35 a.m., CNA Staff E said her typical assignment is 14 to 15 residents with most of the residents in her assignment requiring 2 CNAs to care for them. CNA Staff E said if they have only 3 CNAs, it is hard to take care of all of the residents. CNA Staff E said she does the best she can but there are not enough staff to take care of the residents.During an interview on 3/5/26 at 9:33 a.m., CNA Staff F said there are not enough staff to take care of the residents here. CNA Staff F said the usual assignment is 15 to 16 residents and some days she can have up to 19 residents. CNA Staff F said they are responsible for giving showers, serving meals, feeding the residents and doing other all other care. CNA Staff F said if she has to get (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	another CNA to assist with a mechanical lift, there are no CNAs left on the floor. CNA Staff F said, we are trying our best.During an interview on 3/5/26 at 9:40 a.m., CNA Staff G said there is not enough staff to take care of the residents at the facility. CNA Staff G said she has average assignment of between 14 to 16 residents. CNA Staff G said when a resident requires 2 or more assistance there is no one left on the floor to assist the other residents. CNA Staff G said she has 6 residents today who require 2 or more staff members for assistance with care.During an interview on 3/5/26 at 11:35 a.m., the Director of Nursing (DON) said once she receives a grievance, she does the investigation and education of the staff. She said the Social Services Director will follow up with the resident to make them aware of the corrective action and see if they are satisfied. The DON said her expectation is that call lights are to be answered within 5 to 10 minutes. The DON said when staff answer the call bell, it is her expectation that the staff be polite, respectful and the resident's needs are met. The DON said if a resident is cognitively impaired and is a fall risk, the staff need to get there as soon as possible to assist the resident.During an interview on 3/6/26 at 8:02 a.m., the Social Services Director confirmed the Resident Council has concerns with staffing. The Social Services Director confirmed there is no documentation that the call light concerns from resident council were resolved. The Social Services Director confirmed that no one followed up or resolved Resident #12's grievances for call lights according to documentation. When told that Resident #2 and Resident #12 said no one followed up on their grievances for call lights, she said the people who fill out these forms need to understand that these residents can say whether someone is following up. The Social Services Director said we need to make sure we are following up with all grievances.During an interview on 3/6/26 the Nursing Home Administrator said his expectation with resident council and grievances is they need to get back within 5 days with a resolution or plan. When told about the call light observation with Resident #50, the Nursing Home Administrator said she is a fall risk and could have fallen. The Nursing Home Administrator said someone should have assisted her.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure medications were secured, locked and inaccessible to unauthorized staff, residents, and visitors, or under direct observation of authorized staff for 4 (Residents # 67, #16, #118, and #132) of 4 residents observed with medications left at bedside.The findings included: Facility policy titled Medication Administration, revision date 10/2023 indicated Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Compliance guideline #15 indicated: Observe resident consumption of medication. On 3/2/2026 at 9:27 a.m., a red tablet was observed on Resident #67's bedside table. Resident #67 walked to the bedside table, picked up the red circular tablet and set it back on the table. He said it was his iron pill and said sometimes he didn't take it. On 3/2/2026 at 9:45 a.m., an inhaler was observed on the bedside table. Resident #16 said the staff just leave the inhaler on her tray table in the morning and then they come back and pick it up later. On 3/2/2026 at 10:58 a.m., two medications cups were observed on Resident #118's bedside table with one white round tablet in each medicine cup. Resident #118 said the staff just give him the cup of medications. He thought the pills might be melatonin and sometimes he didn't take it. On 3/2/2026 at 2:05 p.m., the Director of Nursing (DON) said no resident should have medications at their bedside. She said if a resident was care planned to administer their own medications, they would be able to have medication at their bedside, however the facility currently had no residents care planned to administer their own medications. Photographic evidence obtained. On 3/2/26 at 10:58 a.m., observation of Resident 132's bedside table revealed a medication cup with 2 round medication tablets inside the medication cup. Resident #132 said he thought it was his TUMS medication (antacid) which the nurse had left for him to take later when he was ready. On 3/2/26 at 11:27 a.m., in an interview with Staff I License Practical Nurse (LPN), she said when she had administered Resident #132's medications to him that morning, he told her he wanted to take the TUMS medication later, so she left the medication for him to take later when he was ready, She said she doesn't leave medication for residents to take later but he had told her he would take the medication later when he was ready. On 3/4/26 at 3:19 p.m., in an interview with the Director of Nursing (DON), she said a nurse should not leave medication(s) in a resident's room unattended as per their facility policy and procedure. She said she had started reeducation with the nursing staff to remind them they cannot leave Resident's medication(s) at their bedside unattended and were required to ensure all residents' medication were administered as per physician orders.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interviews and record review the facility failed to respond and follow up with grievances and concerns brought forward by the resident council for 2 of 4 Resident Council meetings minutes reviewed (November and December 2025).The findings included: Review of the facility Resident Right-Grievances policy (last revised 2/1/26) states the resident has right to and the facility will make prompt efforts by the facility to resolve grievances the resident may have. The policy further states 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 pertinent findings or conclusions the regarding resident's concerns, 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.During a resident council meeting conducted on 3/3/26 at 2:55 p.m., the residents at the meeting said they have to wait too long to get care and there is a problem with staffing. They said there are usually not enough Certified Nursing Assistants (CNAs). They said they will have to wait an hour or two to have their needs met. They said if a CNA that is not assigned to them answers the call light, they are told they will have to wait until your CNA comes. Residents also reported long wait times for pain medications and assistance with showers.Review of the Resident Council Minutes from November of 2025 noted call light response too slow, at times, mainly at night. Actions taken noted staff in serviced on call light response times. The outcome was noted as Not Resolved - Action needed.Review of the Resident Council Minutes from December call light response too slow, at times, mainly at night. Actions taken noted staff in serviced on call light response times. The outcome was noted as Not Resolved - Action needed.Review of the Resident Council Minutes from January and February 2026 with no outcome of resolved for call light response concern.During an interview on 3/5/26 at 8:20 a.m., Resident #8 said she is the Resident Council President. Resident #8 said there have been concerns with staffing and call light response time mentioned during their Resident Council meetings without improvement. Resident #8 said there is not enough staff. Resident #8 said a lot of residents including herself require 2 to 3 staff to assist them with care. Resident #8 said when they are with her, there are no staff to assist the other resident's needs. Resident #8 said they bring it up each month and nothing is being done. Resident #8 said there has been no improvement with staffing.During an interview on 3/6/26 at 8:02 a.m., the Social Services Director confirmed the resident council president have brought forward concerns with staffing. The Social Services Director confirmed that Resident Council have concerns with staffing. The Social Services Director confirmed there is no documentation that the call light concerns from resident council were resolved.During an interview on 3/6/26 the Nursing Home Administrator said his expectation with resident council and grievances is they need to get back within 5 days with a resolution or plan.

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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. Based on record review, review of facility policy and procedure, residents and staff interviews, the facility failed to ensure prompt resolution and follow-up for grievances for 3 (Resident #12 Resident #2 and Resident #24) of 3 residents reviewed for grievances.The findings included: Review of the facility Resident Right- Grievances policy (last revised 2/1/26) states the resident has right to and the facility will make prompt efforts by the facility to resolve grievances the resident may have. The policy further states 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 pertinent findings or conclusions the regarding resident's concerns, 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.Review of the Resident Grievance Log showed Resident #12 had filed a grievance for call light response time on 11/6/25, 11/8/26, 1/12/26 and 2/10/26. Review of the grievance forms for Resident #12 showed the resident was not satisfied with the grievance resolution.During an interview on 3/5/26 at 10:57 a.m., Resident #12 said CNAs are not coming. Resident #12 said on average it takes an hour for staff to respond to her call light. Resident #12 said she has waited up to 3 hours for assistance. Resident #12 said nothing has been resolved and there has been no improvement. Resident #12 said she needs assistance with perineal care and emptying of her urinary catheter. Resident #12 said she put her grievances in and never saw anyone again.Review of Resident #12 clinical records documented a Brief Interview of Mental Status (BIMS) completed 1/2/26 score of 15 indicating Resident #12 is cognitively intact.Further review of the grievance log showed call light grievances for Resident #2 (filed on 1/12/26) and Resident #24 (filed on 1/17/26) with both marked as resolved.During an interview on 3/5/26 at 11:10 a.m., Resident #2 said on an average day it take an hour to get care. He said he needs a lot of assistance due to his amputation. Resident #2 said he still has to wait over an hour to get care. Resident #2 said nothing has changed since he filed his grievance. Resident #2 said he gave up because nothing is going to change.Review of Resident #2 clinical records documented a BIMs completed 12/26/25 score of 14 indicating Resident #2 is cognitively intact.During an interview on 3/6/26 at 9:10 a.m., Resident #24 said she filed a grievance due to slow call light response times from staff. Resident #24 said no one ever came back and discussed anything with her after filing her grievance.Review of Resident #24 clinical records documented a BIMs completed 2/6/26 score of 15 indicating Resident #2 is cognitively intact.During an interview on 3/5/26 at 11:35 a.m., the Director of Nursing (DON) said once she receives a grievance, she does the investigation and education of the staff. She said the Social Services Director will follow up with the resident to make them aware of the corrective action and see if they are satisfied.During an interview on 3/6/26 at 8:02 a.m., the Social Services Director confirmed the Resident Council and Resident Council President have concerns with staffing. The Social Services Director confirmed there is no documentation that the call light concerns from resident council were resolved. The Social Services Director confirmed there that no one followed up or resolved Resident #12's grievances for call lights according to documentation. When told that Resident #2 and Resident #12 said no one followed up on their grievances for call lights, she said the people who fill out these forms need to understand that these residents can say whether someone is following up. The Social Services Director said we need to make sure we are following up with all grievances.During an interview on 3/6/26 at 9:25 a.m., the Nursing Home Administrator said his expectation with resident council and grievances is they need to get back within 5 days with a resolution or plan.

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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** Based on interview and record review the facility failed to ensure Level 1 PASRR (Preadmission Screening and Resident Review Process- a federal requirement for nursing facilities to screen individuals for mental illness (MI), intellectual / developmental disabilities (ID/DD) to ensure appropriate placement and access to specialized services preventing unnecessary institutionalization and supporting community living) assessments were completed accurately and Level 2 pre-admission screening and resident review (PASRR) screenings were completed as required for 2 (Residents #8 and #50) of 3 residents reviewed.The findings included: Facility policy Coordination-PreFacility policy Coordination - Pre-admission Screening and Resident Review (PASRR) Program. Policy: It is the policy of the facility to assure that all residents admitted to the facility receive a Pre-admission Screening and Resident Review, in accordance with State and Federal Regulations. Procedure: 1. The facility will coordinate assessments with the pre-admission screening and resident review (PASRR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. 2. Coordination includes: a. Incorporating the recommendations from the PASRR level II determination and the PASRR evaluation report into a resident's assessment, care planning, and transitions of care. b. Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.Review of clinical admission records for Resident #50 documented that she was [AGE] year-old and diagnosed with major depressive disorder and a severe cognitive impairment prior to admission on set date 1/20/26. The PASRR completed 1/20/26 for Resident #50 failed to document the resident had major depressive disorder and had a disorder resulting in functional limitations in major life activities that would otherwise be appropriate for her developmental stage. A Level 2 PASRR was not completed.Review of clinical admission records for Resident #8 documented that she was a [AGE] year-old diagnosed with bipolar disorder onset 8/29/22 and was cognitively intact. The PASRR completed on 8/10/25 for resident #8 failed to document the resident had bipolar disorder and had a disorder resulting in functional limitations in major life activities that would otherwise be appropriate for her developmental stage. A Level 2 PASRR was not completed.On 3/4/2026 at 9:18 a.m., in an interview the Director of Admissions said the Unit Manager and Director of Nursing (DON) review admission packets for PASRR/Clinical Documentation. She said she has noticed PASRRs seemed to be incorrect. The diagnoses aren't listed correctly. She said nurses call her all the time saying, ?this is not right.' She said according to facility policy the facility should ensure PASRRs are completed in accordance with State and Federal Regulations. The Director of Admissions said not only should they be completed, but they should also be correct.On 3/4/26 at 10:12 a.m., in an interview, Staff H Registered Nurse (RN) Unit Manager said she reviews the PASRR for all new admissions to be sure it's completed correctly and that there is nothing missing. Staff H RN Unit Manager said if there are items missing, staff notify admissions to request information or correction from the hospital.On 3/4/26 at 12:35 p.m., in an interview, the DON said she reviews the PASRR for new admissions. She said their policy is to ensure the PASRR is completed correctly, not just that it is done. The DON reviewed the clinical records for Residents #8 and #50 saying Resident #8 has a diagnosis of major depressive disorder that is not documented on the PASRR, which is an error. She said the resident has a disorder which results in functional limitations in major life activities that would otherwise be appropriate for her developmental age. She said this resident should have had a Level II PASRR. The DON said Resident #50 has a diagnosis of bipolar disorder that is not documented on the PASRR also in error. She said the resident has a disorder which results in functional limitations in major life activities that would otherwise be appropriate for her developmental age. The DON said this resident should have had a Level II PASRR. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/26 at 1:00 p.m., in an interview the Director of Social Services said she normally reviews PASRR, though she has not done so at this facility yet because she has only worked there for 2 weeks. She reviewed the clinical record for Resident #8. She said the resident has a diagnosis of major depressive disorder that is not documented on the Level I PASRR. She said that it's possible a Level II PASRR should have been completed. She reviewed the clinical record for Resident #50 and said that the resident has bipolar disorder and is on medication for depression. She said the resident should have had a Level 2 PASRR.

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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** Based on observation, record review, staff and resident review, the facility failed to provide the necessary services to maintain personal grooming and hygiene for 1 (Resident #132) of 3 residents requiring assistance with activities of daily living. This had the potential to cause psychological harm to the resident.The findings included: On 3/2/26 at 11:02 a.m., Resident #132 was observed laying in his bed wearing a hospital gown, his fingernails on both hands were observed to be uneven and extending approximately 3/4 of an inch long with dark brown substance noted under each nail. Resident #132's hair and beard were uncombed and long. Resident #132 said his fingernails had not been trimmed in a long time and he had asked the staff to trim his fingernails several times over the past few months.Review of Resident #132's medical record revealed he was admitted to the facility on [DATE]. Review of Resident #132's Minimum Data Set (MDS) quarterly assessment on 2/19/26 noted a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. A BIMS score is a screening tool that aids in detecting cognitive impairment.Review of the Activities of Daily Living (ADL) form to be completed each shift by Resident #132's Certified Nursing Assistant (CNA) stated ADL - personal hygiene resident prefers longer nails, please encourage this resident to have his nails cut. Review of January, February and March 2026, ADL documentation, noted the CNA had not documented Resident #132 had refused getting his fingernails cut as of 3/2/26.On 3/3/26 at 3:00 p.m., in an interview with Staff H Registered Nurse (RN) Unit Manager (UM), she said the nursing staff were required to complete daily ADL care for all residents to include trimming a resident's nails, unless they were diabetic. She said if a resident refused ADL care to include the trimming of their fingernails, the CNAs were required to try again later and if the resident continues to refuse ADL care they should inform the resident's nurse.She said after reviewing Resident #132's medical record, she confirmed Resident #132 was care planned for liking his nails long, but staff were required to encourage Resident #132 to have his nails trimmed. She said she was unable to find documentation Resident #132's CNAs had documented that Resident #132 was refusing to have his fingernails trimmed during ADL care.On 3/3/26 at 3:15 p.m., an observation of Resident #132 with Staff A UM and Resident #132's Power of Attorney (POA) confirmed Resident #132's fingernails on both hands were uneven and extending approximately 3/4 of an inch long with dark brown substance noted underneath each nail. Staff A UM said due to Resident's #132's long fingernails she was unable to determine when the last time they were trimmed.On 3/3/26 at 3:17 p.m. in an interview with Resident #132's POA, she said she had asked the nursing staff to trim Resident #132's fingernails and beard since December 2025 and on January 19, 2026, his birthday, but as of this time the nursing staff had not honored her request. She said staff had not informed her Resident #132 was refusing to have his fingernails cut and/or have his beard trimmed. She said if they had, she would have come to the facility and encourage him to have his fingernails and beard trimmed. She and Resident #132 said it was okay to take a picture of his fingernails on both hands.On 3/4/25 at 3:19 p.m., in an interview with the Director of Nursing (DON) she said the nursing staff were required to complete a resident's ADL care daily. She said if they were unable to complete a resident's daily ADL care to include trimming a resident's fingernails, the nursing staff should document their attempts to complete the ADL care, the resident refusal and any action taken to complete the required ADL care.The DON said she had reviewed Resident #132's medical record and confirmed his ADL plan of care stated Resident #132 likes to have his fingernails long, but staff are required to encourage him to have his nails cut. I showed the DON the picture of Resident #132's fingernails on both hands and she confirmed Resident #132's fingernails were uneven and extending approximately 3/4 of an inch long with dark brown substance noted under each nail. The DON said the nursing staff should attempt to trim Resident #132's fingernails, and if Resident #132 refuses his fingernail care the staff were required to encourage him to have his fingernails trimmed. She said the nursing staff did not document Resident (continued on next page)

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	03/06/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#132's refusal to have his fingernails trimmed except on 2/2/26 as required nor the interventions to encourage Resident #132 to have his fingernails trimmed on a routine basis.