| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105499 | A. Building<br>B. Wing | 02/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Promedica Skilled Nursing and Rehabilitation (Lely | 6135 Rattlesnake Hammock Road<br>Naples, FL 34113 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155<br><br>Based on observation, review of facility policy and procedure, record review and staff interviews, the facility failed to treat 1 (Resident #46) of 22 residents observed on the memory care unit with respect and dignity during medication administration.<br><br>The findings included:<br><br>The facility Policy Quality of Life - Dignity documented Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality . Residents shall be treated with dignity and respect at all times . the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth .<br><br>The facility policy IIBI: Administration Procedures For All Medications documented To administer medications in a safe and effective manner . Provide privacy for resident during administration of medications .<br><br>Review of the clinical record revealed Resident #46 had an admitted [DATE] with diagnoses including dementia with behavioral disturbance and seizures.<br><br>Review of the Brief Interview for Mental Status dated 1/31/25 revealed Resident #46<br><br>score of 03 on the evaluation, indicating severe cognitive impairment.<br><br>On 2/3/25 at 12:38 p.m., Registered Nurse (RN) Staff G was observed administering medications to residents in the dining room. Multiple residents were sitting at tables waiting for their lunch meal.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #46 was observed seating at a dining room table with her head down. RN Staff G instructed Resident #46 to lift her head to take her medications. The resident kept her head down. RN Staff G placed two capsules in some pudding. He placed a hand on Resident #46's head and lifted her head. While holding the resident's head, RN Staff G placed one of the capsules in the resident's mouth with some pudding. Resident #46 pushed the capsule out of her mouth onto her lower lip. RN Staff G scraped the capsule and pudding from the resident's mouth with the spoon and placed it back in her mouth. RN Staff G continued to hold Resident #46's head with one hand and placed the second capsule into the resident's mouth with some pudding. Resident #46 spit the capsule out three times. Each time RN Staff G used the spoon to scrape the pudding from the resident's lips and chin and place it back in the resident's mouth with the capsule. Staff G continued to hold the resident's head until she swallowed the medications.<br><br>On 2/3/25 at 12:45 p.m., in an interview RN Staff G verified he held the resident's head, scraped the pudding and medications several times and placed them back into the resident's mouth. RN Staff G replied ok and walked away when asked about the concern of treating Resident #46 with dignity.<br><br>On 2/4/25 at 10:15 a.m., Licensed Practical Nurse (LPN) Staff D was observed administering medications in the dining room of the [NAME] memory care unit during an activity program. Resident #46 was observed sitting at a table.<br><br>On 2/4/25 at 10: 20 a.m., LPN Staff D approached Resident #46 and instructed her to open her mouth to take her medication. LPN Staff D placed the medications in the resident's mouth and told her to swallow them. The instructions were clearly audible to the other resident sitting at the table. |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905<br><br>Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from neglect for 1 (Resident #27) of 2 residents reviewed for incontinent care by failing to provide incontinent care and services to meet the needs resulting in prolong skin exposure to urine resulting in moisture associated skin damage.<br><br>The findings included:<br><br>Review of the facility's Job Description for Certified Nursing Assistants included Safety: the CAN (Certified Nursing Assistant) Reports all accidents and incidents observed on shift.<br><br>Nursing Care and Responsibilities included, Assists residents with bowel and bladder functions; Ensures the resident personal care needs are being met in accordance with residents' wishes.<br><br>The facility policy for Activities of Daily Living (ADL) Supporting page 1 indicated, Appropriate care and services will be provided for residents who are unable to carry out ADLs independently . (including) Elimination (toileting).<br><br>The facility policy for Resident Mistreatment, Neglect, and Abuse Prohibition Guidelines noted, Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress .<br><br>On 2/3/25 at 11:35 a.m., in an interview Resident #27 said, They don't change my (incontinent briefs) and now I have this redness and irritation on my buttocks.<br><br>The resident said she was incontinent of urine and feces and wears an incontinent brief all the time. She said the last time the CNA changed her was approximately 5:00 a.m. The resident said, Before that, I was changed at midnight. The resident said the day shift CNA had not changed her yet. Resident #27 said, I tell them all the time there is moisture under the foam bandage they apply to my buttocks, and it hurts, but they don't do anything.<br><br>The resident said the incontinent brief is not changed very often and they don't check on her throughout the day.<br><br>She said, I stay in bed until 2:00 p.m. They get me up into the chair and then I go back to bed at 8:00 p.m. The resident said sometimes staff change her brief the diaper at 8:00 p.m., and then not again until 5:00 a.m.<br><br>Resident #27 said, I am so glad you are here and began to cry.<br><br>On 2/3/25 at 11:47 a.m., CNA Staff I was observed going into Resident #27's room. She took a mechanical lift from the bathroom, left the room, and walked down the hall. CNA Staff I did not ask Resident #27 if she needed to be changed.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 2/3/25 at approximately 11:50 a.m., in an interview as she walked out of the room, CNA Staff I said she was responsible for taking care of Resident #27 today. CNA Staff I said Resident #27's incontinent brief was last changed on the night shift at approximately 5:00 a.m., more than six hours ago.<br><br>On 2/3/25 at 11:55 a.m., in an interview Registered Nurse (RN) Staff J said she was taking care of Resident #27 today but had not changed the resident's briefs.<br><br>RN Staff J went in the room and checked Resident #27's incontinent brief. The resident was wearing an incontinent brief with an absorbent pad underneath. The pad was yellow and full of urine<br><br>photographic evidence obtained.<br><br>At that time, Staff I entered the room with a box of gloves. In the presence of the nurse, Staff I said she did not change the resident this morning and the last time the resident was changed was the night shift. RN Staff J said that was not acceptable and the CNA should be checking the resident at least every 2 hours and change the incontinent brief when soiled.<br><br>The CNA did not offer any explanation as to why she did not change the resident.<br><br>On 2/4/25 at 4:56 p.m., in an interview RN Staff K said the CNAs should be checking their residents and offering incontinent care according to the residents' needs.<br><br>On 2/5/25 at 10:21 a.m., in an interview Resident #27 said she was incontinent of bowel and bladder. She said urine gets under the bandage on her buttocks and makes the buttocks hurt. The resident said the pain was getting worse.<br><br>On 2/5/25 at 11:22 a.m., observation of wound care to the buttocks for Resident #27 revealed the following:<br><br>RN Staff E removed the resident's incontinent brief. The brief was wet with urine.<br><br>RN Staff E rolled the resident onto the right side to expose a bandage covering both sides of the buttocks.<br><br>As RN Staff E removed the bandage, Resident #27 told the nurse the area was painful and pulling off the dressing increased the pain.<br><br>Observation of the resident's buttocks revealed a wound to the left and right buttocks. Each wound measured approximately 3.0 inches by 3.0 inches with a pinkish-red wound bed.<br><br>The wound care physician entered the room and said Resident #27 probably did not need the bandage. He told the resident the barrier cream alone could treat the wound.<br><br>The resident said the area was painful and did not think the cream alone would protect the skin from the pain.<br><br>RN Staff E placed a clean bandage over the wounds. Staff E did not use barrier cream.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 2/5/25 at 11:30 a.m., in an interview during an interview the wound care physician said prolonged urine exposure was not good for the skin. He said the dressing can hold moisture from urine and perspiration.<br><br>He said residents usually feel the foam bandage will protect the skin.<br><br>The wound care physician said Resident #27 had moisture associated damage (MASD) to the buttocks area.<br><br>Review of the medical record revealed Resident #27 was admitted to the facility on [DATE]. Diagnoses included chronic kidney disease, other abnormalities of gait and mobility, Alzheimer's disease, and overactive bladder (a condition characterized by frequent and sudden urges to urinate, often accompanied by urinary incontinence.)<br><br>Review of the Quarterly Minimum Data Set (MDS) assessment with a target date of 1/19/25 revealed Resident #27's cognition was intact with a Brief Interview for Mental Status score of 15. Resident #27 was occasionally incontinent of urine and always incontinent of bowel.<br><br>There was no documentation in the comprehensive assessment, care plans, or nursing progress notes the resident refused incontinent brief changes.<br><br>Review of the CNA Toileting Record (a documented history of the dates and times a task is completed) revealed Resident #27 received toileting assistance 2-3 times within a 24-hour period on 2/1/25 at 12:22 a.m. and 8:52 p.m.; on 2/2/25 at 11:59 p.m., 9:10 a.m. and 8:45 p.m.; on 2/3/25 at 11:38 p.m., 2:00 p.m., and 8:49 p.m.; on 2/4/25 at 6:59 a.m., 2:59 p.m., and 10:59 p.m.; on 2/5/25 at 12:37 a.m., 2:59 p.m., and 7:54 p.m.<br><br>Review of the wound evaluation and management summary by the physician dated 7/10/24 revealed a stage 2 sacrum pressure wound measuring 6.9 x 7.9 x 0.1 centimeters (cm) with a surface area of 54.51 square centimeters (cm2); open ulceration area measured 16.35 cm2.<br><br>Review of the physician's wound evaluation and management summary dated 2/5/25 revealed moisture associated skin damage of the buttocks non pressure wound, measuring 8.9 x 12.2 x 0.1 cm with a surface area of 108.58 cm2; open ulceration area measured 76.01 cm2.<br><br>Resident #27 was not seen by the wound physician from 7/11/24 through 2/4/25. On 2/5/25, Resident #27's wounds were classified as moisture associated skin damage.<br><br>On 2/6/25 at 1:02 p.m., in an interview RN Staff E said she evaluates the sacrum wound each week. Sometimes it is decreasing and sometimes it gets worse. Staff E said the CNAs should be checking and changing the residents every 2 hours and more frequently if needed to keep the residents comfortable and dry. RN Staff E said prolonged exposure to urine and sweat will contribute to moisture-associated skin damage.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 2/6/25 at 11:43 a.m., in an interview the Director of Nursing (DON) said she did not hear about the incontinent care incident for Resident #27 from the nurse or CNA until the next day. Staff I nor Staff J told her about it. The DON said she expected the staff to report the incident when it occurred. The DON said it was unacceptable to leave the resident in a wet incontinent brief for six hours. The DON said she did not consider this incident resident neglect. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155<br><br>Based on observation, review of the clinical record, review of facility policy and procedures, and staff interviews, the facility failed to develop a care plan that described the resident's medical, physical, mental and psychosocial needs and preferences and how the facility will assist in meeting these needs and preferences for 4 (Resident #46, # 54, #42 and #55) of 4 residents residing on the memory care unit. The failure to complete an individualized care plan has the potential to impact the resident's quality of life and quality of care.<br><br>The findings included:<br><br>The facility policy Baseline Care Plan and Summary documented the facility will develop and implement a care plan for each resident that includes the instructions needed to provide effective and person centered care of the resident.<br><br>1. Review of the clinical record revealed Resident #42 had a readmitted [DATE]. Diagnoses included severe dementia with behavioral disturbance, depression, degenerative disease of the nervous system, and anxiety.<br><br>The clinical record documented a brief interview for mental status (BIMS) could not be conducted as Resident #42's cognition was severely impaired.<br><br>The care plan initiated on 3/5/24 indicated Resident #42 Prefers not to participate in group activities but will sit in on group activities.<br><br>The goal for the resident specified, Will participate in independent leisure activities of choice daily such as walking in the halls and listening to music.<br><br>The interventions included Respect choice in regard to limited/ no activity participation. Responses within recreational programs or activity visits are limited related to physical impairments and impaired cognitive functioning.<br><br>The care plan also identified Resident #42 had behaviors symptoms related to anxiety including, refusing to wear safety helmet for preventing falls related to traumatic brain injury, picking up items from the floor and putting it in her mouth, Resident removes the signs from the walls, wiping/taking out things from the wall, yelling screaming bumping into things below waist.<br><br>Observations on 2/3/25 from 10:00 a.m., to 12:30 p.m., 2/4/25 at 11:32 a.m., 2/3/25 at 2:00 p.m., and 2/5/25 at 9:52 a.m., Resident #42 was observed wandering the hallway of the memory care unit. Resident #42 was observed going in and out of other residents rooms. She was wiping walls and doors with her hands. Staff did not redirect the resident.<br><br>Review of the clinical record revealed Resident #46 had an admitted [DATE] with diagnoses including dementia with behavioral disturbance and seizures.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of a Brief Interview for Mental Status (BIMS) dated 1/31/25 revealed Resident #46 scored 03, indicating severe cognitive impairment.<br><br>The care plan initiated 8/7/23 identified Resident #46 Prefers not to attend group activities/limited group activities. However: Enjoys/Enjoyed activities such as watching television and listening to music.<br><br>The goal for Resident #46 specified, Will participate in independent leisure activities of choice daily.<br><br>The interventions included, Provide supplies/materials for leisure activities as needed/requested.<br><br>On 2/5/25 at 1:12 p.m., in an interview the Activity Director said Resident #46 does not participate and yells out. She had a baby doll that she would carry around but it is lost and a new one was ordered.<br><br>The Activity Director said Resident #46's care plan identified the resident liked to hold a doll. When asked about the care plan goal for the resident was to participate in independent leisure activities of choice daily, when she had a BIMS score of 03, the Activity Director confirmed Resident #46 was not able make that choice. She said, I would never put that on a care plan for her.<br><br>Further review of the care plan failed show documentation Resident #46's had the desire to hold a baby doll.<br><br>3. Review of the clinical record for Resident #54 revealed a readmitted [DATE].<br><br>Diagnoses included Alzheimer's disease, anxiety disorder, adjustment disorder, dementia and major depressive disorder.<br><br>Review of the BIMS dated 1/18/25 showed Resident #54 scored 00, indicating severe cognitive impairment.<br><br>The care plan revised on 7/25/23 documented Resident #54, Prefers not to attend group activities/limited group activities. However: Enjoys/Enjoyed activities such as listening to music, socializing, being outdoors.<br><br>The goal for Resident #54 specified, Will participate in independent leisure activities of choice daily such as socializing<br><br>The interventions included, Familiarize with center environment and activity programs on regular basis. Provide supplies/materials for leisure activities as needed/requested. Responses within recreational programs or activity visits are limited related to physical impairments and impaired cognitive functioning.<br><br>On 2/3/25 at 10:21 a.m., 2/4/25 at 10:13 a.m., 2/5/25 at 9:18 a.m., and 2/5/25 at 9:48 a.m., Resident #54 was observed seating at a table in the dining room with magazines in front of her. Resident #54 kept her head down. Resident #54 was not engaged in any activity and often calling out loudly.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 4. Record review for Resident #55 revealed an admitted [DATE]. Diagnoses included dementia with behavioral disturbance, cognitive communication deficit, sexual dysfunction not due to a substance or known physiological condition, and major depressive disorder.<br><br>Review of the clinical record revealed Resident #55 was Spanish speaking with a BIMS score of 03, indicating severe cognitive impairment.<br><br>The care plan initiated 11/1/23 identified Resident #55 Prefers not to attend group activities/limited group activities. However: Enjoys/Enjoyed activities such as watching action/war movies, socializing, and people watching Spanish television.<br><br>The goal for Resident #55 specified, Will participate in independent leisure activities of choice daily such as watching movies and television.<br><br>The care plan interventions included, Provide supplies/materials for leisure activities as needed/requested.<br><br>On 2/3/25 from 10:00 a.m., until 12:30 p.m., 2/4/25 at 9:52 a.m., 2/4/25 at 12:59 p.m., 2/5/25 at 9:36 a.m., and 2/5/24 at 10:02 a.m., Resident #55 was observed seating at a table in the dining room. The resident was observed continually attempting to stand up from the wheelchair or with his head down and appeared to be sleeping.<br><br>On 2/6/25 at 8:37 a.m., in an interview the Activity Director said the Regional Director of Client Relations and herself identified that there were no activity preference assessments completed for Residents #46, #54, #42 and #55. The Activity Director said the care plans were individualized for each resident on the memory care unit.<br><br>The care plans for Residents #55, #54, #46 and #42 were reviewed with the Activity Director. She confirmed Residents #55, #54, #46 and #42 had severe cognitive impairment and were not able to choose individualized activities.<br><br>She said there were issues with the care plans.<br><br>On 2/6/25 at 8:57 a.m., in an interview Unit Manager Registered Nurse Staff H said she was also the Care Plan Coordinator but did not write the activity care plans. She said the activity department wrote their own care plans.<br><br>Unit Manager Staff H said the care plans should be reviewed and updated with any changes in the residents condition and before scheduled care plan meetings. |

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|---|---|
| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide activities to meet all resident's needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155<br><br>Based on observation, review of the clinical record, review of facility policy and procedures, and staff interviews, the facility failed to ensure they provided an ongoing program to support the residents in their choice of activities which are designed to meet the resident's interests and support the resident's physical, mental, and psychosocial well-being for 5 (Resident #46, #54, #42, #55 and #5) reviewed for involvement in activity programs.<br><br>The findings included:<br><br>Review of the facility policy 2.8 Activity Programs revealed, Activity programs designed to meet the needs of each resident are available on a daily basis . are designed to encourage maximum individual participation and are geared to meet the individual needs .<br><br>Review of the clinical record revealed Resident #42 had a readmitted [DATE]. Diagnoses included severe dementia with behavioral disturbance, depression, degenerative disease of the nervous system, and anxiety.<br><br>The care plan initiated on 3/5/24 indicated Resident #42, Prefers not to participate in group activities but will sit in on group activities. The goal for the resident specified, Will participate in independent leisure activities of choice daily such as walking in the halls and listening to music.<br><br>The interventions included, Respect choice in regard to limited/ no activity participation. Responses within recreational programs or activity visits are limited related to physical impairments and impaired cognitive functioning.<br><br>The care plan noted Resident #42 had behaviors symptoms related to anxiety including refusing to wear safety helmet for preventing falls related to traumatic brain injury, picking up items from the floor and putting it in her mouth, Resident removes the signs from the walls, wiping/taking out things from the wall, yelling screaming bumping into things below waist.<br><br>The clinical record documented a brief interview for mental status (BIMS) could not be conducted as Resident #42 was rarely understood.<br><br>Observations on 2/3/25 from 10:00 a.m., to 12:30 p.m., 2/4/25 at 11:32 a.m., 2/3/25 at 2:00 p.m., and 2/5/25 at 9:52 a.m., Resident #42 was observed wandering the hallway of the memory care unit. Resident #42 was observed going in and out of other residents rooms. She was wiping walls and doors with her hands. Staff did not redirect the resident. No activities were offered to the resident.<br><br>On 2/6/25 at 8:37 a.m., in an interview the Activity Director was asked about individualized activity interventions to decrease Resident #42's wandering behavior. The Activity Director replied Resident #42, will attend activities at times but does not stay because it's her choice to walk, we can't make her sit.<br><br>Review of the clinical record revealed Resident #46's diagnoses included dementia with behavioral disturbance and seizures.<br><br>(continued on next page) |

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|---|---|---|---|
| | 105499 | A. Building<br>B. Wing | 02/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Promedica Skilled Nursing and Rehabilitation (Lely | 6135 Rattlesnake Hammock Road<br>Naples, FL 34113 |

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|---|---|
| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of a Brief Interview for Mental Status (BIMS) dated 1/31/25 revealed Resident #46 scored 03 indicating severe cognitive impairment.<br><br>The care plan initiated on 8/7/23 noted Resident #46, Prefers not to attend group activities/limited group activities. However: Enjoys/Enjoyed activities such as watching television and listening to music.<br><br>The goal for Resident #46 specified, Will participate in independent leisure activities of choice daily.<br><br>The interventions included, Provide supplies/materials for leisure activities as needed/requested.<br><br>The care plan noted Resident #46 had Behavior symptoms as evidenced by resident being tearful and referring her body is covered with wires. The goal was to reduce the behavior.<br><br>On 2/3/25 from 10:00 a.m., to 12:30 p.m., Resident #46 was observed seating at a back table in the corner of the dining room with a coloring book and pencils in front of her. Resident #46 had her head down, appeared to be sleeping. Resident #46 would randomly lift her head and yell out.<br><br>Activity Assistant Staff B was tossing a balloon with six residents in a circle while music was playing. She did not attempt to engage Resident #46 in the activity.<br><br>On 2/4/25 at 10:05 a.m., Activity Assistant Staff B, the Activity Director and the Regional Director of Client Relations had a circle of 10 residents in the center of the dining room. They were tossing a balloon and dancing with the residents. Resident #46 was observed sitting at a table in the back of the dining room. Certified nursing assistant (CNA) staff C was seated next to the Resident. She offered her a snack and soft squeeze balls from a bin. Resident #46 did not respond and was randomly yelling out loudly.<br><br>On 2/5/25 at 9:20 a.m., in an interview Activity Assistant Staff B said at this time she was the only activity assistant for the facility. She said, I do the activities in the building, there is no one else but me. The Activity Director helps out and the CNA's will help when they can, but they have their own work to do. Right now, I go back and forth to all the units for the activities. For residents like Resident #46 I do aroma therapy, sensory stimulation like massage or sensory lap blankets.<br><br>On 2/5/25 at 9:38 a.m., Resident #46 was observed seating at a table in the back of the dining room. A group activity of balloon toss and music with 8 residents in the circle was observed. There was a magazine placed in front of Resident #46, but she did not look at it or touch it. Resident #46 had her head down and eyes closed. Activity Assistant Staff B came to the table, took the magazine and placed a busy book in front of the resident. Staff B instructed the resident to touch the book and walked away. Resident #46 touched the busy book for less than a minute and began to grab the table and rotate it as she loudly yelled out. No staff member intervened to offer redirection or support.<br><br>On 2/5/25 at 9:59 a.m., Resident #46 was observed yelling out as she sat at the table. CNA Staff L offered the resident graham crackers and water.<br><br>(continued on next page) |

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| Promedica Skilled Nursing and Rehabilitation (Lely | 6135 Rattlesnake Hammock Road<br>Naples, FL 34113 |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 2/5/25 at 10:00 a.m., in an interview the regional Director of Client Relations said Resident #46 gets upset after meals and she will start yelling. She is occasionally able to say a few words but mostly she just calls out.<br><br>On 2/5/25 at 10:22 a.m., Resident #46 remained at the table in the back of the dining room frequently yelling out. The resident was not offered staff interventions including aroma therapy, sensory stimulation like massage or sensory lap blankets.<br><br>On 2/5/25 at 1:12 p.m., the Activity Director said, for Resident #46 who does not participate and yells out, she had a baby doll that she would carry around but it is lost and a new one was ordered. The Activity Director said Resident #46's care plan identified the resident liked to hold a doll.<br><br>On 2/5/25 at 1:21 p.m., Resident #46 was observed seating at the back of the dining room at the same table and was frequently yelling out. On 2/5/25 at 1:23 p.m., Activity Assistant Staff B entered the dining room carrying a doll. Staff B approached Resident #46 and said, I have your baby. Staff B tried to place the doll in the resident's arms twice. Resident #46 would not hold the doll. Staff B placed the doll on the table in front of the resident and left the room.<br><br>Review of the clinical record revealed Resident #54 had a readmitted [DATE]. Diagnoses included Alzheimer's disease, anxiety disorder, adjustment disorder, dementia and major depressive disorder.<br><br>Review of a BIMS dated 1/18/25 revealed Resident #54 scored 00 indicating severe cognitive impairment.<br><br>The care plan revised 7/25/23 documented Resident #54 Prefers not to attend group activities/limited group activities. However: Enjoys/Enjoyed activities such as listening to music, socializing, being outdoors.<br><br>The goal for Resident #54 specified, Will participate in independent leisure activities of choice daily such as socializing<br><br>The interventions included, Familiarize with center environment and activity programs on regular basis. Provide supplies/materials for leisure activities as needed/requested. Responses within recreational programs or activity visits are limited related to physical impairments and impaired cognitive functioning.<br><br>On 2/3/25 at 10:21 a.m., Resident #54 was observed seated at a table in the dining room with magazines in front of her. 80's music was playing in the background while Activity Assistant Staff B was tossing a balloon to 6 residents seated in a circle. The resident had her head down and was not participating in the activity.<br><br>On 2/4/25 at 10:13 a.m., Resident #54 was observed seated in a group circle listening to 80's music while the Activity Director, Activity Assistant Staff B and the Regional Director of Client Relations assisted the residents to dance. Resident #54 had her head down and was not engaged in the activity.<br><br>(continued on next page) |

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| Promedica Skilled Nursing and Rehabilitation (Lely | 6135 Rattlesnake Hammock Road<br>Naples, FL 34113 |

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|---|---|
| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 2/5/25 at 9:18 a.m., and 2/5/25 at 9:48 a.m., Resident #54 was observed seated at the table in the dining room. The resident was agitated and yelling out. There was no staff intervention or activity offered to the resident to address the agitation and yelling.<br><br>There was a group circle of eight residents participating in music and balloon toss. Six other residents were observed sitting at tables with magazines, blocks or a sensory book on the tables in front of them, who received no staff intervention.<br><br>Record review for Resident #55 revealed an admitted [DATE]. Diagnoses included dementia with behavioral disturbance, cognitive communication deficit, and major depressive disorder.<br><br>Review of the clinical record revealed Resident #55 was Spanish speaking with a BIMS score of 03, indicating severe cognitive impairment.<br><br>The care plan initiated 11/1/23 identified Resident #55 Prefers not to attend group activities/limited group activities. However: Enjoys/Enjoyed activities such as watching action/war movies, socializing, and people watching Spanish television.<br><br>The goal for Resident #55 specified Will participate in independent leisure activities of choice daily such as watching movies and television.<br><br>The care plan interventions included, Provide supplies/materials for leisure activities as needed/requested.<br><br>On 2/3/25 Resident #55 was observed seated in the dining room at a table from 10:00 a.m., until 12:30 p.m. There were magazines (English language) on the table in front of him, but he showed no interest. He sat with his head down, occasionally attempting to stand from the wheelchair (w/c) and was instructed by staff members to sit down.<br><br>On 2/4/25 at 9:52 a.m., Resident #55 was observed seated at the same table in the dining room with his head down, alternating sleeping, yelling out or attempting to stand. There was a busy book in front of him but he did not touch it. There was a group activity in progress, but staff did not ask him if he wished to participate.<br><br>On 2/4/25 at 12:59 p.m., Resident #55 was observed at the same table in the dining room having just completed the noon meal. He was observed continually standing up from the w/c, and staff call out for him to sit back down. There was no intervention of Spanish television, or war movies offered to him.<br><br>Observations on 2/5/25 at 9:36 a.m., and 10:02 a.m., revealed Resident #55 sitting at the same location at a table in the back of the dining room in a w/c. He had his head down, alternating sleeping, calling out and attempting to stand.<br><br>On 2/5/25 at 10:15 a.m., Resident #55 was observed calling out and attempting to stand from the w/c. A magazine (English language) was on the table in front of him. A Spanish Speaking Staff member approached Resident #55 asked him his name and gave her name. The conversation in the residents language lasted approximately two minutes. Resident #55 remained in the same location but the magazine was removed and he continued to stand and was told to sit back in the w/c.<br><br>(continued on next page) |

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| Promedica Skilled Nursing and Rehabilitation (Lely | 6135 Rattlesnake Hammock Road<br>Naples, FL 34113 |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During observations on 2/5/25 at 1:21 p.m., 2/6/25 at 8:30 a.m., Resident #55 was observed in the same position at the table, calling out and attempting to stand, then sits and repeats the behavior.<br><br>On 2/6/25 at 8:33 a.m., in an interview the Activity Director confirmed Resident #55 was not able to self-initiate activities. She said we will do Spanish Puzzles, and word search for Resident #55 and said the resident will attend group activities when he wants to.<br><br>On 2/6/25 at 8:37 a.m., in an interview the Activity Director said the Regional Director of Client Relations and herself identified that there were no activity preference assessments completed for Residents #46, #54, #42 and #55. The Activity Director said the care plans were individualized for each resident on the memory care unit.<br><br>The care plans for Residents #46, #54, #42 and #55 were reviewed with the Activity Director who confirmed the residents were not able to choose and self-initiate activities.<br><br>Review of the February 2025 [NAME] Memory Care Unit Activity Calendar revealed the following activities were scheduled:<br><br>2/3/25- 9:00 a.m., daily chronicles. 9:30 a.m., Move and Grove, 10:00 Reminiscing, 11:00 a.m., what's that sound, 2:00 p.m., snacks and hydration, 3:00 Touch therapy-textures.<br><br>2/4/25 at 9:00 Daily Chronicles, 9:30 arts and crafts-abstract art, 10:00 Coordination games- catch, 11:00 a.m., move and groove, 2 :00 p.m., snacks and hydration, 3:00 Music Therapy- sing along to the 60's Reminiscing.<br><br>2/5/25 At 9:00 a.m., daily chronicles, 9:30 Move and groove, , 11:00 Aroma Therapy - calming scents, 2:00 p.m., snacks and hydration, 3:00 Reminiscing- Childhood.<br><br>2/6/25 9:00 a.m., Daily Chronicles, 9:30 a.m., Catholic church services, 10:00 matching games-color, 11:00 move and groove, 2:00 p.m., snacks and hydration, 3:00 Dancing in the 70's.<br><br>On 2/5/25 at 1:12 p.m., in an interview the Activity Director said when Activity Assistant Staff B is not on the memory care unit doing activities, she covers for her. She said they do not always follow the activity calendar because it all depends on the residents moods and what they want to do.<br><br>25618<br><br>On 2/3/25, observations of Resident #5 at 9:30 a.m., 10:16 a.m., 11:43 a.m., and 1:35 p.m. revealed the resident was in her room, in bed wearing a hospital gown. During the observations neither the television nor the radio where on, and Resident #5 was not observed in an in-room or an out of room facility activity program during the day.<br><br>On 2/04/25, observations of Resident #5 at 11:00 a.m., 12:03 a.m., and 2:35 p.m. revealed Resident #5 was in a wheelchair next to her bed. During the observations neither the television nor the radio where on, and Resident #5 was not observed in an in-room or an out of room facility activity program during the day.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident #5's medical record revealed she was admitted to the facility on [DATE] with diagnoses of pneumonitis, atrial fibrillation, hypothyroidism, dementia without behavioral disturbance, mood disorder, depression, and anxiety disorder.<br><br>Further review of Resident #5's medical record revealed the Activity Admission Assessment, and an interim activity care plan had not been initiated.<br><br>Review of the Director of Activities (DOA) job description stated they were required to delegate the development and delivery of therapeutic recreational services to promote the residents' opportunities for engaging in normal life enhancement pursuits and to increase and/or maintain functioning levels. They DOA was to encourage resident participation in group and individual activities and ensure each resident's participation in facility and individual daily activity programs were documented in their medical record.<br><br>On 2/05/25 at 1:18 p.m., during an interview with the DOA, she said she had worked at the facility for about 5 years. The DOA said part of her responsibility was to ensure all the residents in the facility received the activity of their choice on a routine basis. The DOA said as part of her job duties she was required to develop completed the Activity Admission Assessment tool within 7 days of the resident admission to the facility. She said the Activity Admission Assessment form was used to develop an individual activity program for each resident to promote opportunities for the resident to engage in activities which would provide normal life enhancement to increase and/or maintain the resident's highest functional levels.<br><br>The DOA reviewed Resident #5's medical record. The DOA confirmed Resident #5 was admitted to the facility on [DATE] with diagnoses of pneumonitis, atrial fibrillation, hypothyroidism, dementia without behavioral disturbance, mood disorder, depression, and anxiety disorder. The DOA said she was unable to find documentation she had completed Resident #5's Activity Admission Assessment and/or documentation Resident #5 had participated in any facility activities and/or activities of Resident #5's choice since her admission to the facility as required. |

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| F 0825<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or get specialized rehabilitative services as required for a resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30599<br><br>Based on record review, resident and staff interviews, the facility failed to provide Physical and Occupational therapy to 1 (Resident #130) of 2 residents reviewed for specialized rehabilitative services.<br><br>The findings included:<br><br>Review of the clinical record for Resident #130 revealed an admitted [DATE]. Diagnoses included Multiple Sclerosis, Urinary Tract Infection, Depression, Anxiety Disorder, and a history of falling.<br><br>Review of the five-day Minimum Data Set, dated dated dated [DATE] revealed Resident #130 scored 10 on the Brief Interview for Mental Status, indicative of moderate cognitive impairment.<br><br>On 2/3/25 at 11:00 a.m., in an interview Resident #130 said she felt like her husband had dumped her at the facility. She stated staff were not doing anything for her since her admission and she had not received any rehabilitative services.<br><br>Review of the physician's order revealed an order dated 1/24/25 to admit Resident #130 to the facility for Rehabilitation services.<br><br>A physician's order dated 1/24/25 read, PT [Physical Therapy] evaluation and treatment as indicated.<br><br>A physician's order dated 1/24/25 read, OT [Occupational Therapy] evaluation and treatment as indicated.<br><br>On 2/6/25 at 9:20 a.m., in an interview Resident #130 said she had not received any therapy. She stated no one was telling her what she was doing here. She said she felt like she had been dumped at the facility.<br><br>On 2/6/25 9:30 a.m., in an interview the Regional Physical Therapy Consultant verified Resident #130 had physician's orders dated 1/24/25 for Physical and Occupational therapy but had not been evaluated by Physical Therapy or Occupational Therapy as ordered. |