STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105524	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Port Charlotte Rehabilitation Center	25325 Rampart Blvd Port Charlotte, FL 33948

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 44824 Based on observation, record review, review of facility's policy and procedure, resident and staff interview, the facility failed to accommodate the needs of 1 (Resident #59) of 4 dependent residents reviewed by failing to place the call system within reach of the resident. The findings included: The Facility policy Universal Fall Precautions purpose said Universal fall precautions revolve around keeping the patient's environment safe and comfortable. This included maintain call light within reach. Review of the Quarterly Minimum Data Set (MDS) assessment with a target date of 11/25/24 revealed Resident #59's cognition was intact with a Brief Interview for Mental Status score of 13. The assessment noted the resident was dependent for wheelchair mobility. On 12/16/24 at 1:30 p.m., Resident #59 was observed sitting in a wheelchair in her room. The call light was wrapped around the side rail of the bed behind the wheelchair, and not within the resident's reach. Photographic evidence obtained. In an interview during the observation, Resident #59 said she was not allowed to get up and could not reach the calllight. On 12/16/2024 at 3:45 p.m., Resident #59 was observed sitting in a wheelchair in her room watching television. The calllight remained wrapped around the side rail at the top of the bed behind the wheelchair and not within reach of the resident. On 12/18/2024 at 11:55 a.m., Resident #59 was observed sitting in a wheelchair in her room watching television. The call light was tied to the head of the bed and was not within reach of the resident. Photographic evidence obtained. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview during the observation, Resident #59 said she was able to use the call light but could not reach it to request assistance, she would have to call out for help. The resident said , it happens often. On 12/18/24 at approximately 12:00 p.m., Certified Nursing Assistant (CNA) Staff I walked into the room and verified the calllight was not within reach of the resident. She said she must have forgotten to put the calllight on the resident's lap but it had only been a few minutes. She said she was assigned to Resident #59 on 12/16/24 but could not remember leaving the calllight out of the resident's reach. On 12/19/24 at 12:15 p.m., the observations of the calllight not within Resident #59's reach were shared with the Administrator and Regional Nurse Manager. They said the resident's ability to use the calllight fluctuates but the calllight should be within the resident's reach unless they're not able to use it. On 12/19/2024 at 2:00 p.m., in an interview Licensed Practical Nurse Staff L said Resident #59 rarely used the calllight. During the interview, upon request Resident #59 picked up and activated the calllight twice.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on observation, interview and record review, the facility failed to revise the comprehensive care plans with resident centered interventions to ensure 1 (Resident #85) of 3 sampled residents reviewed achieved their highest practicable physical, mental and psychosocial wellbeing. The findings included: Review of the medical record for Resident #85 revealed an original admitted [DATE] and readmissions on 10/16/24 and 11/13/24. Diagnoses included atrial fibrillation and chronic heart failure. Review of the hospital record for 10/11/24, Resident #85 had a cardiac pacemaker. Review of the admission nursing evaluations dated 10/16/24 and 11/13/24 revealed documentation Resident #85 had a cardiac pacemaker. Review of Resident #85's care plans revealed there no care plan addressing the cardiac pacemaker. On 12/18/24 at 9:10 a.m., Resident #85 was observed in his room with family members visiting. In an interview the resident's daughter said her father had not seen the cardiologist for the past two years for a pacemaker check. She said she visits her father every day and no one has asked her about her father's pacemaker or explained the plan for pacemaker check. On 12/18/24 at 10:43 a.m., in an interview the Minimum Data Set Coordinator Staff R verified there was no cardiac pacemaker care plan in the record for Resident #85, and no physician's order for cardiology consult. She said there should be a care plan for care and monitoring. On 12/18/24 at 3:56 p.m., in an interview the Director of Nursing said there should be a care plan for Resident #85's pacemaker.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 41155 Based on record review, staff, resident and family interviews and review of facility policy and procedures the facility failed to provide the necessary care and services to maintain personal hygiene for 2 (Resident #5, and #24) of 3 residents reviewed for activities of daily living (ADL's). The findings included: The facility policy Activities of Daily Living, Supporting documented Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including hygiene (bathing, dressing, grooming and oral care. 1. Review of the clinical record revealed Resident #5 was [AGE] years old with an admitted [DATE] and diagnoses including fracture of lower end of right femur, muscle weakness, and need for assistance with personal care. The Admission Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date (ARD) of 10/21/24 documented Resident #5 required substantial to maximum assistance with bathing. The MDS noted Resident #5's cognitive skills for daily decision making were intact. Review of the care plan initiated 10/21/24 identified Resident #5 had an ADL self-care performance deficit related to impaired balance, surgery of the right femur fracture. The interventions included: Encourage the resident to use bell to call for assistance. Provide only the amount of assistance/supervision that is needed. Report changes in ADL self-performance to the nurse. On 12/16/24 at 10:52 a.m., in an interview Resident #5 and her daughter reported she had not had a shower since her admission to the facility in October. The resident's daughter said her mother required a mechanical lift and two certified nursing assistants (CNA's) to transfer because she was not able to bear weight on the right leg. She said the staff had told her they had no way to take her mother into the shower because of the lift. The resident and her daughter said the physician, and/or the facility never said she was not allowed to take showers because of fear of her leg (right surgical) getting wet. They said they were not able to get her into the shower, so they have been giving her bed baths, but they don't wash her hair, it is usually just the buttocks area that gets cleaned because she is incontinent. Review of the resident's bathroom revealed a large walk in shower. Review of the unit Shower Schedule documented the residents shower days were Wednesday and Saturdays on the evening shift. The shower schedule documented Shower days may differ in PCC(Point Click Care electronic record) depending on Resident preference. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/17/24 at 11:38 a.m., Resident #5 was observed in her room in her bed. She said she was happy because she finally received a shower today. She said it felt wonderful, I had my hair washed. I feel so much better now. I did not have a shower since I arrived here, but I got one today. The girl came in and asked me if I would like one and I said yes. She said she did not care when her showers were scheduled, she was just happy to have one. Review of the CNA documentation for November 2024 documented Resident #5's showers were scheduled Tuesdays and Fridays on the 7-3 shift. The documentation revealed no scheduled showers were provided on 11/1/24, 11/5/24, 11/8/24, 11/12/24, 11/15/24, 11/19/24, 11/22/24, 11/26/24, 11/29/24. Review of the CNA shower sheets provided by the Director of Nursing, documented a bed bath was provided on 11/5/24, 11/9/24, 11/23/24, 11/23/24 and 11/30/24. There was no documentation the resident refused her scheduled showers. Review of the CNA documentation for December 2024 documented that no scheduled showers were provided on 12/1/24, 12/5/24, 12/8/24, 12/12/24, 12/15/24. Review of the CNA shower sheets documented a bed bath was provided on 12/4/24, 12/7/24 and 12/14/24. On 12/17/24 it was documented a shower was provided by therapy. 2. Review of the clinical record revealed Resident #24 was [AGE] years old and admitted on [DATE] with diagnoses including history of falling, displaced intertrochanter fracture of the right femur and need for assistance with personal care. The Admission MDS with an ARD of 11/29/24 documented Resident #24 required substantial to maximum assistance with showers. The MDS noted the Resident #5's cognitive skills for daily decision making were intact. Review of the care plan initiated 11/26/27 identified the resident had an ADL self-care performance deficit related to a right femur fracture. The interventions included: Encourage the resident to participate to the fullest extent possible with each interaction. Provide only the amount of assistance/supervision that is needed. Report changes in ADL self-performance to nurse. On 12/16/24 at 10:31 a.m., Resident #24 was in her room in bed. The resident said she had not received a shower since she arrived at the facility. She said she was admitted in November but unsure of the exact date. She said she did not know why she did not receive a shower; I asked the CNA and she said she could not shower me. The resident said she had not refused to be showered. They wash you in the bed, that is all. Review of the Shower Schedule documented the resident was scheduled for showers on the day shift on Wednesdays and Saturdays. Review of the November CNA documentation revealed no scheduled shower was documented on 11/27/24 or 11/30/24. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the December CNA documentation showed no scheduled showers were provided on 12/4/24, 12/6/24, 12/11/24, 12/13/24 and 12/18/24. Review of the CNA shower sheets documented a bed bath was provided on 11/30/24, 12/4/24, 12/7/24, 12/14/24,12/15/24, 12/16/24 and 12/17/24. On 12/19/24 at 9:16 a.m., in an interview Licensed Practical Nurse Staff J said the CNAs follow the shower schedule but said some residents may want to schedule a shower at a different time and the aids put it in the electronic record. If the resident wants a shower at any time, we just give it. On 12/19/24 at 9:29 a.m., in an interview CNA Staff K said each unit has a shower list and it is also in the electronic record. If a resident refused a shower, I would go back two or three times and ask them and see if I can get them to accept it. I let the nurse know if they continue to refuse and they can make changes to the schedule.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on record review, staff, resident and family interviews and review of facility policy and procedures the facility failed to provide the necessary care and services to maintain continence for 1(Resident #5) and failed to maintain indwelling urinary catheters in a safe and sanitary manner for 2 (Resident #134 and #85) of 3 residents reviewed for bowel and bladder incontinence and urinary catheters. The findings included: The facility policy Activities of Daily Living, Supporting documented Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including elimination (toileting). 1. Review of the clinical record revealed Resident #5 was [AGE] years old with an admitted [DATE] and diagnoses including fracture of lower end of right femur, muscle weakness, and need for assistance with personal care. The Admission Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date of 10/21/24 documented Resident #5 required substantial to maximum assistance with toileting. The MDS specified the resident was always incontinent of bowel and bladder and was not on a toileting program to assist with managing the residents incontinence. The MDS noted Resident #5's cognitive skills for daily decision making were intact. Review of the care plan initiated 10/28/24 identified Resident #5 had bladder incontinence related to impaired mobility. The interventions included check resident frequently during each shift and assist with toileting as needed. Provide a bedpan or bedside commode. On 12/16/24 at 10:55 a.m., a joint interview was conducted with Resident #5 and her daughter. The daughter said her mother was incontinent and frequently did not get changed when she has a bowel movement. She will sit in her bowel movement, and she does not remember to use the call light. She is not checked on frequently enough. She was walking at the assisted living facility before the hurricane when she fractured her leg. She used the toilet but still used briefs because she was incontinent at times. I think since she has been here it has become easier for her to go in the brief then to get out of bed. Resident # 5 said she did not like to use the call light because she did not like to be a bother to the staff. She said sometimes she waits a long time for someone to come and change her when she does use the call light. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the CNA documentation showed Bladder Incontinence documented on the 7-3 shift for November 2024 documented bladder continence Toilet Use on the day shift on 11/1/24, 11/6/24, 11/11/24, 11/14/24, 11/17/24, 11/20, 24, 11/22/24 and 11/23/24 documented 97 (not applicable). On the evening shift on 11/22/24, 11/23/24, 11/28/24, and 11/29/24 documented N/A. On night shift on 11/11/24, 11/23/24, 11/24/24, 11/29/24 and 11/30/24 documented N/A. The remainder of the month was blank for all three shift and not completed by the CNA's. Review of the CNA documentation for the month of December 2024 from 12/1/24 through 12/16/24 documented Toilet Use on the day shift was provided on 12/1/24, 12/3/24, 12/8/24, 12/8/24, 12/9/24, 12/10/24 and 12/11/24. On the evening shift on 12/3/24, and 12/5/24 documented N/A. On the 11-7 shift N/A was documented on 12/1/24, 12/5/24, 12/7/24, 12/8/24, 12/9/24 and 12/13/24. The remaining days for the three shifts were blank. On 12/19/24 at 11:30 a.m., in an interview Licensed Practical Nurse Staff O said the CNA's should toilet incontinent residents every 2-3 hours. On 12/19/24 at 11:35 a.m., in an interview CNA Staff K said she tries to toilet her residents every 2 hours. If they put the light on I will toilet them and I will try and check them every hour to see if they need anything. On 12/19/24 at 12:37 p.m., in an interview CNA Staff M said residents are assisted with toileting every 2-3 hours or when they put the call light on. Review of the facility policy Foley Catheter Use documented Catheter care will be performed every shift and as needed. Catheter tubing will be secured to residents leg. Catheters will be monitored for any kinking, blockage or pulling. 2. Review of the clinical record revealed Resident #134 had an readmitted [DATE] and diagnoses including fracture of the right wrist and hand, muscle weakness, and need for assistance with personal care. The 5-day MDS with an ARD of 11/15/24 documented Resident #134 required substantial to maximum assistance with toileting. The MDS noted Resident #134's cognitive skills for daily decision making were intact. Review of the care plan initiated 10/20/24 identified Resident #134 had an indwelling urinary catheter due to urinary retention and was at risk for urinary tract infections. The goal for the resident was for the resident to remain free from catheter related trauma and show no signs or symptoms of a urinary infection. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The interventions included: Position catheter bag and catheter tubing below the level of the bladder. Observe Foley catheter tubing for kinks and adjust as needed. Provide catheter care. Observe for abnormalities and report to the nurse as needed. On 12/16/24 at 1:32 p.m., in an observation and interview Resident #134 was observed in her room in a wheelchair (w/c) with an indwelling urinary catheter. The resident said she can't void without the catheter. The catheter drainage bag was attached under the w/c seat and the drainage bag was in contact with the front wheel, the tubing was on the floor. Photographic evidence obtained. On 12/16/24 at 3:29 p.m., Resident #134 was observed wheeling herself around the facility in the w/c. The catheter tubing was dragging on the floor and had the potential to cause injury and infection. The drainage bag was attached to the w/c arm rest providing no privacy for the resident. Photographic evidence obtained. On 12/17/24 at 1:03 p.m., Resident #134 was observed in her room sitting in the w/c. The catheter drainage bag was in a pillowcase tied under the w/c seat and was dragging on the ground. The tubing was on the floor. Photographic evidence obtained. On 12/18/24 at 3:17 p.m., in an interview CNA Staff I said if a resident had a catheter the drainage bag is put into a catheter bag and is placed under the w/c and if the resident is in bed we hang it from the bedframe. It should never be on the floor. On 12/19/24 at 11:40 a.m., in an interview CNA Staff K said catheter drainage bags are placed in a catheter bag or in a basin in a bag. She said when in the w/c you put the drainage bag in a catheter drainage bag so no one can see it. If the resident is in bed and the bed is in a low position, you put it in a bag and then put the bag in a clean wash basin to keep it off of the floor. 41905 Review of the clinical record for Resident #85's revealed the resident had an indwelling urinary catheter. Resident #85 required partial to moderate assistance for transfers. On 12/16/24 at 12:27 p.m., observed Resident #85 in the bedroom sitting in a recliner chair. The resident was alert and oriented to person, place and time. The urinary catheter drainage bag was hooked onto the resident's trash can with the bottom of the bag resting on the floor. The resident said the certified nursing assistant (CNA) hooked the drainage bag to the trash can. The resident's door was open and the trash can with the urinary drainage bag on the floor was visible from the hallway. On 12/17/24 at 12:30 p.m., 3:30 p.m., and 4:30 p.m., observed Resident #85 in the recliner chair. The urinary drainage bag remained hooked to the trash can and resting on the floor. The resident's door was open, and the urinary drainage bag was visible from the hallway. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/17/24 at 5:03 p.m., the Unit Manager Staff O verified the urinary drainage bag was hooked to the trash can and resting on the floor. Staff O said the bag should not be on the floor. 12/18/24 at 3:56 p.m., in an interview the Director of Nursing (DON) said the catheter drainage bag should not be on the floor. The DON said in keeping consistent with infection control standards, you don't want the drainage bag on the dirty floor or hooked to the trash can. On 12/19/24 at 11:17 a.m,. during a telephone CNA Staff M said on 12/17/24 she saw Resident #85's urinary drainage bag hooked on the trash can and resting on the floor when she got to work. She said she was going to move it, but she was late for work and just started taking vital signs. She said she should have moved the bag.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, and resident and staff interview, the facility failed to store CPAP (continuous positive airway pressure) equipment in a sanitary manner for 3 (Resident #10, #70 and #14) of 3 resident's reviewed for respiratory care and sleep apnea. This had the potential to cause respiratory infections in compromised residents. The findings included: 1. During observations on 12/16/24 at 1:16 p.m., and 12/17/24 at 4:41 p.m., Resident #10 was noted with a CPAP machine and the mask that was uncovered and lying on top of the nightstand. Photographic evidence obtained. Review of Resident #10's clinical record revealed there was no physician order and no care instructions for the use of the CPAP machine. 2. On 12/16/24 at 1:10 p.m., Resident #70 was observed with a CPAP machine in her room on the bedside table. The mask was uncovered and lying on the table next a cup of liquid and the machine had food and personal items stored next to it. The resident said the staff take care of the CPAP machine for her. Photographic evidence obtained. Review of Resident #70's clinical record revealed the resident was admitted on [DATE] and had no physician order for the use of the CPAP machine and no instructions for the care of the machine. 3. On 12/16/24 at 1:13 p.m., Resident #14 was in her room and a CPAP machine was observed on the nightstand with the mask and tubing uncovered and lying on top of the nightstand. Resident #14 said she used the machine at night and the staff assist her to care for the machine. Photographic evidence obtained. On 12/16/24 at 4:00 p.m., a review of Resident #14's clinical record revealed she was admitted on [DATE] with diagnoses including acute respiratory failure with hypoxia(low level of oxygen in the body), and asthma. The record showed no physician order for the use of the CPAP machine and no instructions for the care of the machine. On 12/18/24 at 2:26 p.m., in an interview the Director of Nursing (DON) said when CPAP/BiPAP machines are not in use the masks and tubing are to be stored in a plastic bag. On 12/18/24 at 5:06 p.m., in an interview the DON she said she did not know why Residents #10, #70 and #14 did not have physician orders or directions for the use of the CPAP machines. She said, I can't answer that.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44824 Based on observation, record review and staff interviews, the facility failed to ensure 1 (Dietary aide Staff N) of 1 staff observed operating the dishwasher was trained, and competent to test the sanitizing solution of the low temp dishwasher to ensure dishes were properly sanitized to prevent foodborne illnesses of residents consuming an oral diet. The findings included: The facility Dish Machine Overview purpose states to maintain proper use and function of dish machine. Number 6 states Perform chemical test strip procedure following the last cycle. Confirm the test strip color matches the manufacturers' recommendation of PPM (parts per million). If not, run dishes through machine again ensuring proper PPM met. On 12/16/24 at 9:15 a.m., the Initial kitchen tour was conducted with the Kitchen Manager. Dietary Aide Staff N was observed operating the dishwasher. The Kitchen Manager said the dishwasher was a low temp machine and required the use of a sanitizing agent. Staff N was unable to use a test strip to measure the concentration of the sanitizer. Using a translator, Staff N said he had never used the test strips and had never been trained to use them or told what they were for. The Kitchen Manager said he did not know if Staff N had received training on using the dishwasher and testing the sanitizer. Review of the dishwasher's log for 12/2024 showed on 12 different days Staff N placed his initials on the log verifying he tested the sanitizer. Staff N verified he placed his initials on the log documenting the water temperature for the wash and rinse cycle of the machine and testing the sanitizer but was not able to explain what was documented on the log. On 12/16/2024, the kitchen Manager provided the survey team with an employee coaching report for Staff N, Dietary Aide for lack of knowledge about sanitizer strip read temps for machine and take sanitizer strip color matches PPM solutions.