STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105723	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedarbrook Health and Rehabilitation Center	1600 Matthew Drive Fort Myers, FL 33907

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, record review and staff interviews, the facility failed to ensure a safe, clean, comfortable and sanitary environment for residents and failed to provide the necessary linens required for resident care. The findings included: 1. On 11/12/24 at 9:09 a.m., upon entrance to the facility a strong odor of urine was noted. A large brown crawling insect was observed on its back in the small dining room. On 11/12/24 at 11:41 a.m., Maintenance Assistant Staff C verified the observation of the brown crawling insect in the small dining room. Staff C picked up the insect from the floor. The insect was alive and crawled up the staff's arm. 2. On 11/12/24 at 9:30 a.m., the following observations were made during an initial tour of the 400 unit: Resident #25's indwelling catheter drainage bag was on the floor. Registered Nurse Staff A was present during the observation and verified the resident's indwelling catheter drainage bag was on the floor. Photographic evidence obtained. 2. room [ROOM NUMBER]: The wall behind the head of the bed had multiple repairs areas patched with a white material and left unpainted. 3. room [ROOM NUMBER]: A toilet plunger was stored in a wash basin on the floor, urine was observed in the toilet. The grout around the toilet was black. The tile behind the toilet was peeling up. The room had a very strong odor of urine. In an interview during the observation, Resident #8's spouse said the bathroom toilet is often clogged and she had reported it several times to the nurse. She said the bedroom often smells of urine. Photographic evidence obtained. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105723	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident #213's room had a very strong odor of urine. The resident's urinal was on the bedside table in front of him. 5. On 11/12/24 at 11:11 a.m., in an interview Resident #15 said the floors in her room are always sticky with crumbs all over. 6. On 11/12/24 at 11:18 a.m., Resident #39 stated there was feces on the floor in the bathroom. The bathroom sink was clogged. The resident said it was reported to the staff four days ago. Photographic evidence obtained. 7. On 11/12/24 at 12:25 p.m., during an observation in Resident #95's bathroom it was noted to be dirty with buildup around the toilet and behind the seat of the toilet. The resident said it had been like that since he was admitted to the facility on [DATE]. 8. On 11/13/24 at 9:35 a.m., Resident #83's bathroom was observed with an area of laminate missing from the bathroom sink. There were brown particles behind the toilet seat between the seat and the tank. 9. On 11/15/24 at 10:01 a.m., in an interview the Maintenance Director said the pest control company comes weekly. He said the process for the pest control was he would check all the rooms weekly and the units and if staff have any issues they let me know. The technician from the pest control company comes right to him when he comes in. He lets him know of any issues anywhere in the facility that need to be addressed. The Maintenance Director said some residents' walls have patches on them from the wheelchairs and beds hitting the walls. He said he was planning to get paint to paint the walls next week. He said he was not aware of the condition of room [ROOM NUMBER]'s wall but would take care of it. The Maintenance Director said he had no maintenance books where staff could report issues and relied on maintenance rounds. 10. On 11/12/24 at 11:08 a.m., uncovered clean linen was observed stacked on the dresser in Resident #25's room. In an interview during the observation, Resident #25 said he had to store clean linen on his dresser or he would not have any linen to change his bed when the staff assisted him with care. 11. On 11/13/24 at 9:02 a.m., in an interview Resident #18 said the facility never has enough clean linen, including towels to get washed or sheets to change her bed. The resident said the facility has not had enough linen for several months. She had reported it to the nurse and the manager. Nothing has been done. 12. On 11/13/24 at 9:04 a.m., Certified Nursing Assistant (CNA) Staff J said she has been employed at the facility for only a few weeks. She said there was not enough clean linen to provide the necessary resident care. 13. On 11/13/24 at 9:21 a.m., initial tour of the laundry room showed the facility had two clothes dryers, and two washers. One of the dryers had a note on the door indicating it was broken. One washers had a note dated August 30, 2024 on the door indicating the machine was broken. The functional washer and dryer were in use. A bin of wet linen was observed waiting to be dried. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	14. On 11/13/24 at 9:36 a.m., in an interview Laundry Aide Staff B said I have worked here over [AGE] years and I have never seen it so bad. We have no linen. Staff B said the air-conditioner in the laundry room had been broken for months and it gets so hot in here. The machines have been broken for months. I have told the Director of Nursing, the Administrator and the Housekeeping Supervisor. Nothing gets done. Staff B said she had just collected and placed the soiled linen from all six units in a barrel. The barrel was only half full. She said that was all she had for the day so far. Staff B said she took a cart of clean linen to the North Unit at 7:30 a.m., but it was just a few towels and sheets. Staff B pointed to the folding table with some towels and some sheets she said will go to the South Unit. She said she had not taken any clean linen to the South Unit because she did not have enough. She said residents and staff come and ask for clean linen but she has to tell them she does not have any. 15. On 11/13/24 at 1:26 p.m., in an interview the Housekeeping Supervisor said there was no PAR (Periodic Automatic Replenishment) for the linen on each unit. He said, We see who needs linen first and we take it to that unit. We look to see who is running out and then we split the rest. I have a supply of new linen in the laundry room. Observation of locked storage cabinet where the Housekeeping Supervisor said he kept a supply of new linen showed a few pillows, thermal blankets, a small stack of fitted and flat sheets and a small pack of about 12 towels wrapped in plastic. He said he and the Maintenance Director were the only two with keys to the new linen storage closet. He said if the residents complain in Resident Council meetings that they need towels, then he puts them out. He said he did not have a PAR system and took linen to the units where it is needed first. The Supervisor provided the sales agreement for the washing machine part ordered 9/30/24. He said the part should be in next week and he will have them fix the dryer at that time. On 11/13/24 at 2:48 p.m., observation of the south unit linen closet showed three blankets and six hospital gowns. 16. Review of the Resident Council Minutes dated 6/5/24 documented Old Business- Towels and washcloths needed. Bed sheets and pillow cases needed. Bed sheets do not fit. Review of the Resident Council Minutes for 7/10/24 checked marked all issues have been resolved. 17. On 11/15/24 at 9:33 a.m., in an interview the Housekeeping Supervisor said when the residents reported a lack of linen in the Resident Council meeting, he put more linen out right away. 18. On 11/15/24 at 11:33 a.m., in an interview the Administrator said the facility did not have a policy for laundry services. 19. On 11/15/24 at 1:07 p.m., the housekeeping supervisor provided the following linen purchase orders: 11/1/24: Three dozen of flats sheets. 9/10/24: Eight dozen of bath towels. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/1/24: 25 dozen of washcloths. 8/8/24: Eight dozen of bath towels. 20. On 11/15/24 at 12:26 p.m., the Administrator provided the facility PAR for Linen that read: Six carts per pod (20 rooms): 40 towels, 30 blankets, 30 sheets, 40 washcloths. Two clean linen rooms, one per unit. Stocked once per shift.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, review of the clinical record, review of facility policy and procedure, residents, residents' family and staff interviews, the facility failed to provide the necessary care and services to maintain personal hygiene for 5 (Residents #8, #51, #89, #95 and #317) of 10 residents reviewed for activities of daily living (ADL's). The findings included: The facility policy ADL Care and Services revised 01/2024 documented, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADL's . 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 appropriate support and assistance with: Hygiene (bathing, dressing, grooming, nail and oral care.) 1. Review of the clinical record revealed Resident #8 had an admitted [DATE] with diagnoses including dementia with mood disturbance, muscle weakness and anxiety. The 5-day scheduled Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date of 10/31/24 documented Resident #8 required supervision for showers and was independent for personal hygiene. The MDS noted Resident #8's cognitive skills for daily decision making were moderately impaired with a Brief Interview for Mental Status score of 09. The care plan initiated 6/11/24 (revised 9/23/24) for Resident #8 identified an ADL selfcare performance deficit related to dementia. ADL needs and participation may vary at times due to weakness, fatigue, cognition., The goal specified the resident will not have a decline in ADL functioning through next review date. The interventions for the resident included: Assistive devices as ordered/indicated. Encourage and assist with all ADL tasks as indicated, as tolerated by resident, including locomotion/ambulation, bathing, bed mobility, transfers, toileting tasks, meals, personal/oral hygiene, etc. On 11/12/24 at 9:39 a.m., Resident #8 was observed sitting in the center area of the Pod (sitting area on each hallway) at a table. He was dressed in his own clothing. He had a strong body odor of urine. Resident #8 was not able to say if he received his showers. On 11/12/24 at 1:03 p.m., in an interview Resident #8's wife said, I must come in and shave him. When she asked the nurses who was responsible for shaving him they replied, that is a good question. The wife said she visits her husband for two hours every day. He is not always clean and most of the time he smells like urine. She said, There is no supervision here, no one knows anything when you ask. I put the light on for help because he can't remember, and no one comes. Sometimes it takes over 30 minutes, on the weekend it is worse. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/14/24 at 12:31 p.m., Resident #8 was observed with approximately three days of facial hair growth. In an interview during the observation, Resident #8's wife said, look he has not been shaved since I did it three days ago, I will have to do it tomorrow. No one here checks, they look at him, but they don't see it. I have told the nurse, but it does not get done unless I do it. Review of the Certified Nursing Assistant (CNA) documentation for October 2024 revealed the resident was scheduled for showers on Wednesdays and Saturdays on the 3:00 p.m., to 11:00 p.m., shift. There was no documentation Resident #8 received his scheduled shower on 10/9/24 and 10/23/24. On 10/16/24 and 10/19/24 N/A (not applicable) was documented. The CNA documentation personal hygiene including shaving was provided to the resident on the 7:00 a.m., to 3:00 p.m., shift on 10/7/24, 10/8/24, 10/9/24, 10/10/24, 10/11/24, 10/12/24, 10/13/24, 10/15/24, 10/16/24, 10/22/24, 10/24/24, 10/28/24, 10/29/24, 10/20/24, 10/31/24, 11/4/24, 11/5/24 and 11/6/24. N/A was entered on 11/2/24. There was no documentation of care provided to the resident during the 3:00 p.m., to 11:00 p.m., shift on 10/7/24, 10/8/24, 10/9/24, 10/10/24, 10/11/24, 10/17/24, 10/20/24, 10/22/24, 10/23/24, 10/28/24, 11/7/24, 11/8/24 and 11/11/24. 2. Review of the clinical record revealed Resident #51 had an admitted [DATE] with readmission on 10/1/24. Diagnoses included heart failure, dementia, anxiety, muscle weakness and need for assistance with personal care. The Quarterly MDS dated [DATE] documented Resident #51 required substantial/maximum assistance with showers. The MDS noted Resident #51's cognitive skills for daily decision making were intact. The care plan initiated 7/26/24 (revised 10/2/24) documented Resident has an ADL self-care deficit related to cerebral vascular accident, left above the knee amputation, altered cardiorespiratory status, and dementia. ADL needs and participation may vary at times due to weakness, fatigue, cognition, etc. The goal for the Resident specified will maintain and/or improve ADL functioning through next review date. Interventions specified Encourage and assist with all ADL tasks as indicated, as tolerated by resident, including locomotion/ambulation, bathing, bed mobility, transfers, toileting tasks, meals, personal/oral hygiene, etc. Bathing extensive assistance. On 11/12/24 at 11:16 a.m., in an interview Resident #51 said he showered daily at home and here they only showered him two times a week. He said I finally got them to increase my showers to four times a week which is great if I can ever get them. No one comes to give the showers. My showers are on the day shift and night shift. I can't remember when I got my last one. I'm lucky to get one shower a week or every two weeks. I have spoken to the nurse, the Director of Nursing and the Administrator about not receiving my showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/13/24 at 9:51 a.m., Resident # 51 was observed in bed. He said, I still have not received a shower this week. Review of the CNA documentation for October 2024, and November 2024 revealed Resident #51 was scheduled for showers on the 7:00 a.m., to 3:00 p.m., shift on Wednesdays and Saturdays. On 10/2/24, 10/12/24, 10/16/24 and 10/30/24 N/A was entered for the showers. There was no documentation the resident received the scheduled showers on 10/9/24 and 10/23/24. Resident #51 was scheduled to receive a shower during the 3:00 p.m. to 11:00 p.m. shift on Tuesdays and Fridays. There was no documentation the resident received the scheduled showers on 10/1/24, 10/4/24, 10/8/24, 10/15/24, 10/22/24, and 10/29/24. On 10/18/24, N/A was entered. On 10/25/24 the documentation showed the resident refused his scheduled shower. Review of the November 2024 CNA documentation on the 7:00 a.m., to 3:00 p.m., shift revealed no documentation on 11/2/24 and on 11/6/24 the resident received the scheduled showers. On 11/9/24 N/A was entered. 3. Review of the clinical record revealed Resident #89 had a readmitted [DATE] with diagnoses including venous insufficiency, tacky-cardiac, severe morbid obesity, chronic diastolic congestive heart failure, and open wound lower leg. The Quarterly MDS dated [DATE] documented Resident #51 was dependent for showers, and required partial/moderate assistance for personal hygiene. The Care Plan initiated 10/27/24 (revised 3/4/24) identified Resident #89 had an ADL self-care deficit related to impaired respiratory and cardiovascular status and other chronic medical conditions. ADL needs and participation may vary at times due to weakness, fatigue, cognition, etc. The care plan interventions specified Encourage and assist with all ADL tasks as indicated, as tolerated by resident, including locomotion/ambulation, bathing, bed mobility, transfers, toileting tasks, meals, personal/oral hygiene, etc. On 11/12/24 at 10:03 a.m., during observation and interview Resident #89's call light was observed on. After 10 minutes of continuous observation, Registered Nurse (RN) Staff A entered the room and asked the resident what he needed. The resident requested assistance to get out of bed. The nurse said she would let someone know and turned the call light off. During the 10 minutes spent interviewing the resident no other staff member entered the room. Resident #89 was observed unshaven approximately 3 to 4 days growth and his fingernails extended approximately 1/2 inch in length. His urinal which contained a small amount of urine, was on the bedside table in front of him. He said he does not receive the help he needs and if he puts the call light on, he waits a long time, over 30 minutes at times. There was a strong odor of urine in the room. The resident's bed sheets were soiled. Photographic evidence obtained. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	His uncovered feet had a thick yellow, black, peeling crust from his lower legs and feet. On 11/14/24 at 12:48 p.m., and 11/14/25 at 12:35 p.m., Resident #89 was observed in his room in bed. He remaining unshaven. He said no one had offered to shave him or cut his nails. He said he has not refused to be shaved or to have nail care. He said he did not care for facial hair or long nails. Review of the CNA documentation for October 2024 personal hygiene on the day shift was not documented as completed on 10/7/24, 10/8/24, 10/9/24, 10/10/24, 10/11/24, 10/12/24, 10/13/24, 10/15/24, 10/16/24, 10/20/24, 10/29/24 and 10/30/24. The 3-11 shift documented no personal hygiene care on 10/7/24, 10/8/24, 10/9/24, 10/10/24, 10/11/24, 10/17/24, 10/20/24, 10/22/24 and 10/28/24. The 11-7 shift documented no personal hygiene assistance was provided on 10/3/24, 10/8/24, 10/9/24, 10/10/2410/11/24, 10/14/24, 10/18/24, 10/24/24 and 10/28/24. Bathing was scheduled on the day shift on Monday and Thursday's documented on 10/3/24 resident refused, 10/7/24 and 10/10/24 no documentation. On 10/28/24 documented N/A. The CNA documentation for November 2024 personal hygiene on the day shift showed no documentation of care on 11/5/24 , 11/6/24 and 11/9/24. On the 3-11 shift no documentation of personal hygiene provided on 11/2/24, 11/7/24, 11/8/24 and 11/11/24. On the 11-7 shift on 11/1/24, 11/4/24, and 11/10/24 there was no documentation of care. On 11/6 and 11/7/24 documented N/A. On 11/14/24 at 2:00 p.m., in an interview Certified Nursing Assistant (CNA) Staff G said there was a shower sheet at the desk and on each unit and the schedule is also in the electronic record. Staff G said residents were shaved daily or every other day. If they refuse, we tell the nurse. Staff G said CNA's can cut fingernails and sometimes the activities staff will do it. On 11/14/24 at 2:17 p.m., in an interview CNA Staff H said there was a shower sheet on each unit and at the nurses station. There are steps we have to follow here if a resident refuses care like showers. We ask the resident at least twice and if they refuse, then we let the nurse know and she has to ask the resident and if they still refuse the nurse has to document it. Staff H said shaving is done with showers or if they ask, and we can do nail care as long as the resident is not a diabetic, then the nurse has to do it. The Activities staff will cut and clean fingernails at times. On 11/14/24 at 2:27 p.m., in an interview CNA Staff I said they followed the shower sheet on the Pod and at the nurse's station. If the resident refuses and they have tried several times, then they tell the nurse. It is a process that the nurse tries and documents if they refuse. Staff I said CNAs can trim nails. They shave men daily or every other day, depending on the resident's preference. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/15/24 at 8:45 a.m., in an interview the Director of Nursing (DON) said the expectation for showers was the CNA to follow the shower schedule. The DON said residents refuse, not everyone wants a shower, and it should be documented. The DON said she has been employed at the facility for one month. She had identified residents not receiving showers as a problem and was in the process of correcting the concern. On 11/15/24 at 9:52 a.m., in an interview Unit Manager RN Staff D said the CNA's were responsible to give the scheduled showers. Staff D said if a resident refuses and they have a right and they will try and offer it on a different day or time. Staff D said the nurses are responsible for ensuring the staff are providing showers. Shaving and nail care are to be done with the shower or when needed. Staff D said Resident #89 refuses to be shaved or have his nails cut and it is in the care plan. Staff D said Resident #89 was able to shave himself with an electric razor. This writer informed her Resident #89's MDS and care plan documented he requires assistance with bathing and personal hygiene and requested documentation the resident had refused the offered assistance. No documentation of refusal of care for Resident #89 was provided at the end of the survey. 30599 4. Clinical record review showed Resident #317 was admitted to the facility on [DATE]. On 11/13/24 at 9:16 a.m., in an interview Resident #317 said he had not had a shower or brushed his teeth since he was admitted to the facility. He said he did not have a toothbrush. The resident's hair looked greasy and lacked [NAME]. is observed to be lack of [NAME]. He was unshaven. The resident's teeth looked covered with plaque and discolored. Resident #317 said he wanted to be shaved but no one has shaved him. Resident #317's Visual/Bedside Kardex Report showed no shower schedule documented. The shower schedule documentation in the electronic record showed the last time Resident #317 received a bath or shower was on 11/1/24. On 11/15/24 at 11:51 a.m., in an interview the Director of Nursing (DON) verified there was no documentation Resident #317 received his scheduled showers twice a week. The DON said she had already identified the issue related to the showers and started a Performance Improvement Plan to correct the issue. On 11/15/24 at 12:45 p.m., Resident #317 was observed in the living area of the 600 unit. He remained unshaved. His hair remained greasy and dull. On 11/15/24 at 2:03 p.m., Certified Nursing Assistant (CNA), Staff N was observed searching Resident #317's room for a toothbrush. Staff N checked all the drawers and the bathroom and verified Resident #317 did not have a toothbrush available. On 11/15/24 at 2:06 p.m., CNA Staff J verified she was assigned to Resident #317 and had not brushed his teeth when she provided morning care. 5. Review of the clinical record revealed Resident #95 was admitted to the facility on [DATE]. Diagnoses included Parkinson's disease, Dementia, and Depression. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #95's significant other was responsible for healthcare decisions. The Admission Minimum Data Set (MDS) assessment with a target date of 10/15/24 noted the resident's cognition was severely impaired with a Brief Interview for Mental Status score of 03. On 11/12/24 at 12:10 p.m., in an interview Resident #95's significant other/responsible party said he was supposed to receive a shower Mondays and Thursdays. She said she did not think he was being showered. When she asks staff about his showers, they tell her they don't know if he's received a shower and don't know how to find out. Review of the Visual/Bedside Kardex Report showed Resident #95 required extensive Assistance with showering. The resident's showers were scheduled on Tuesdays and Thursdays during the 7:00 a.m. to 3:00 p.m. shift. On 11/15/24 the DON provided the bathing/showering documentation which showed before 11/15/24 the last documented shower was on 10/31/24. On 11/15/24 at 11:53 a.m., in an interview the DON verified the lack of documentation Resident #95 received his scheduled showers weekly. She said she identified the issue with the lack of shower documentation prior to to the survey and started a Performance Improvement Plan (PIP).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105723	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER: Cedarbrook Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1600 Matthew Drive Fort Myers, FL 33907	

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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 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** 30599 Based on observations, Interviews, and record reviews the facility failed to provide sufficient staff to ensure call lights were answered in a timely manner for nine of nine residents surveyed (Resident #89, #213, #23, #13, #95, #8, #51, #317, and #18) and failed to provide showers, activities of daily living care, oral and nail care in a timely manner. Findings included: 1. On 11/12/24 at 10:03 a.m. Resident #89 was observed in the bed, he was unshaven, and his fingernails were approximately 1/2 inch in length. His feet were uncovered, and he had a thick peeling crust that was visible on the soiled sheets. His urinal was on the bedside table. He said he does not receive the help he needs and if he puts the call light on, he waits a long time over 30 minutes. There was a strong odor of urine in the room. On 11/14/24 at 12:48 p.m., and 11/14/25 at 12:35 p.m., Resident #89 was observed in his room in bed remaining unshaven. He said no one had offered to shave him or cut his nails. He said he has not refused to be shaved or to have nail care. He said he did not care for facial hair or long nails. 2. On 11/12/24 at 10:33 a.m. Resident #213 said when he puts his call light on to be changed staff do not respond for 30 minutes or more. Resident #213 said the response time was worse on the 3-11 and 11-7 shift. Resident #213 said he could see staff sitting in the center area of the unit watching Television. Resident #213 said sometimes staff would come in his room, turn off the call light. He said staff will say they are coming back but they don't return to assist him. 3. On 11/12/24 at 11:05 a.m. Resident #23 said she has been living at the facility for 2 years. She said the staff on the 3rd shift are slow to answer her call light at times. She said sometimes it takes the aides on the 3rd shift one or two hours before they will answer her call light. 4. On 11/12/24 at 11:08 a.m. Resident #13's daughter said there was not enough staff on the memory care unit. She said there was usually only two aides for the residents. She said she had spoken with administration and there answer is we meet the state requirements with two aides. Resident #13's daughter said she knows of a resident who recently fell on her face. She said another resident had a bowel movement in her mother's room. She said residents wander in her mothers room and take things. She said there is not enough staff to monitor all the residents all the time. The resident daughter said she was almost hit by a resident yesterday. They need more than two aides on the memory care unit. 5. 11/12/24 at 11:19 a.m., in an interview Resident #51 said no one answers the call light at night. The resident said, I have waited 45 minutes to an hour at night and I can see them sitting in the center lounge area watching TV. If they do answer the light, they come in ask what I want turn it off and say they will be back but they never come back. On 11/13/24 at 9:51 a.m., Resident #51 was observed in bed. He said, I still have not received a shower this week. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Cedarbrook Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 Matthew Drive Fort Myers, FL 33907	

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the CNA documentation for October 2024 revealed Resident #51 was scheduled for showers on the 7 a.m., to 3 p.m., shift on Wednesdays and Saturdays. The documentation on 10/2/24, 10/12/24, 10/16/24 and 10/30/24 was N/A (not applicable). There was no documentation of showers on 10/9/24 and 10/23/24. On the 3 p.m., to 11 p.m., shift the resident was scheduled for showers on Tuesdays and Fridays. On 10/1/24, 10/4/24, 10/8/24, 10/15/24, 10/22/24, and 10/29/24 there was no documentation of a shower provided. On 10/18/24 the documentation showed N/A and on 10/25/24 the resident refused his scheduled shower. Review of the November 2024 CNA documentation on the 7 a.m., to 3 p.m., shift revealed no documentation on 11/2/24 and on 11/6/24 and 11/9/24 documented N/A. 6. On 11/12/24 at 12:21 p.m. Resident #95's significant other/responsible party said Resident #95 does not get showers when he needs them. She said on 11/11/24 she observed Resident #95 with his pants soaked through with urine. She said staffing response time is worse on the evening shift. Review of the electronic record for shower documentation provided by the facility shows he had not received a shower from 11/1/24 to 11/15/24. 7. On 11/12/24 at 1:03 p.m. Resident #8's wife said, I have to come in and shave him. I asked who was responsible to shave him and they replied that is a good question. I come in for 2 hours every day. He is not always clean and he smells like urine most of the time. Resident # 8 was observed still sitting at the same table with no activity and not moved for care. There is no supervision here, no one knows anything when you ask. I put the light on for help because he can't remember and no one comes, sometimes it takes over 30 minutes. She said on the weekend it is worse. Review of the clinical record revealed Resident #8 had an admitted [DATE] with diagnoses including dementia with mood disturbance, muscle weakness and anxiety. The Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date of 10/31/24 documented Resident #8 required supervision for showers and was independent for personal hygiene. The MDS noted Resident #8's cognitive skills for daily decision making were moderately impaired. On 11/12/24 at 9:39 a.m., Resident #8 was observed sitting in the center area of the Pod (sitting area on each hallway) at a table. He was dressed in his own clothing. He had a strong body odor of urine. Resident #8 was not able to say if he had received his showers. On 11/14/24 at 12:31 p.m., in an interview Resident #8's wife said, look he has not been shaved since I did it 3 days ago, I will have to do it tomorrow. No one here checks, they look at him, but they don't see it. I have told the nurse, but it does not get done unless I do it. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the certified nursing assistant (CNA) documentation for October 2024 revealed the resident was scheduled for showers on Wednesday and Saturday on the 3 p.m., to 11 p.m., shift. On 10/9/24, 10/23/24 there was no documentation of a shower being provided. On 10/16/24 and 10/19/24 documented not applicable (N/A). The CNA documentation for personal hygiene including shaving documented no care provided on the 7 a.m., to 3 p.m., shift on 10/7/24, 10/8/24, 10/9/24, 10/10/24, 10/11/24, 10/12/24, 10/13/24, 10/15/24, 10/16/24, 10/22/24, 10/24/24, 10/28/24, 10/29/24, 10/20/24 and 10/31/24. On the 3 p.m., to 11p.m., shift there was no documentation of care on 10/7/24, 10/8/24, 10/9/24, 10/10/24, 10/11/24, 10/17/24, 10/20/24, 10/22/24, 10/23/24 and 10/28/24. The CNA documentation for November 2024 personal hygiene on the 7 a.m., to 3 p.m., shift showed no documentation of care provided on 11/4/24, 11/5/24, 11/6/24 and N/A on 11/2/24. On the 3 p.m., to 11 p.m., shift there was no documentation of care on 11/7/24, 11/8/24 and 11/11/24. 8. On 11/13/24 at 9:06 a.m. Resident #18 said the staff in the evening and night shift are terrible, they do not answer the call light. I put it on and sometimes I wait for help for over an hour, or they come in and just turn it off, so it doesn't ring. 9. On 11/13/24 at 9:15 a.m. Resident #317 said he has not been showered since he arrived at the facility. States he has not been shaven, and he has not brushed his teeth. The resident was observed with unwashed hair and unbrushed teeth. On 11/13/24 at 10:07 a.m. The surveyor observation of the 300, 400 and 500 pods from nursing desk, call lights were on for over 15 minutes before being turned off. Emergency bathroom call lights were on for over 15 minutes. Within 5 additional minutes some of the lights were turned on again. Review of the facility shower documentation for Resident #317 shows he had not had a documented shower/bath since 11/1/24. On 11/15/24 at 12:45 p.m. Resident #317 was observed in the living area of the 600 unit he remained still unshaved with hair no [NAME] and greasy. On 11/15/24 at 2:03 p.m. Certified Nursing Assistant (CNA), Staff N was observed searching Resident #317's room for a toothbrush. Staff N checked all the drawers and the bathroom and verified Resident #317 did not have a toothbrush available. On 11/15/24 at 2:06 p.m. CNA, Staff J verified at that time she did not brushed Resident #317's that morning.