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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30599 Based on record review, and interview the facility failed to notify the resident's representative of a dose reduction and discontinuation of antipsychotic medication for 1 (Resident #95) of 5 residents sampled for medication regimen review. The findings included: Record review revealed Resident #95 was an [AGE] year-old male admitted from an acute care hospital on 10/12/24. Diagnoses included Parkinson's disease, Dementia, and Depression. The Admission Minimum Data Set (MDS) assessment with a target date of 10/15/24 showed the resident's cognition was severely impaired with a Brief Interview for Mental Status score of 03. The admission record noted Resident #95's significant other was responsible for making his healthcare decisions. The discharging hospital medication history documented Resident #95 a physician's order for Seroquel (antipsychotic) 50 milligrams (mg) one tablet by mouth two times a day. Review of the physician's orders revealed an order dated 10/13/24 for Seroquel 50 mg one tablet by mouth two times a day for psychotic disturbance. On 10/13/24 a physician's order shows resident #95 was ordered Seroquel 50 mg twice daily. On 10/15/24 the physician issued an order to reduce the Seroquel to 50 mg one time a day. On 10/21/24 the physician issued an order to discontinue the Seroquel. Review of the clinical record, including progress notes showed no documentation Resident #95's representative was informed of the dose reduction of the Seroquel on 10/15/24 or the discontinuation of the Seroquel on 10/21/24. (continued on next page)

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 2:22 p.m., in an interview Resident #95's significant other said the resident had been taking Seroquel for nine years. On 11/1/24 Resident #95 started to become grabby and he was not listening to the staff. She said, He was difficult with me. She asked the nurse to give him his Seroquel. That's when she was told the Seroquel was discontinued. Resident #95's significant other said she was never told he was taken off the medication. On 11/14/24 at 11:47 a.m., in an interview the Director of Nursing said when psychotropic medications are discontinued, the resident's family should be informed and it should be documented in the progress notes in the resident's clinical record. On 11/14/24 at 12:10 p.m., in an interview MDS Coordinator Staff O verified the lack of documentation in the clinical record Resident #95's representative was notified of the dose reduction and subsequent discontinuation of the Seroquel. She said on 10/24/24 she talked about it with the spouse during a care plan meeting but did not document the discussion.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30599 Based on interview and record review the facility failed to ensure the comprehensive assessment was accurate and reflected residents' activity preference for 2 (Residents #83 and #95) of 4 residents surveyed for activities. The findings included: 1. Review of the clinical record for Resident #83 revealed an admitted to the facility of 8/24/24. Diagnoses included Cerebral Vascular Accident (CVA), Dementia, and Parkinson's Disease. The clinical record noted the resident's spouse was the Health Care Surrogate. The Admission Minimum Data Set (MDS) Assessment with a target date of 8/27/24 showed the resident's cognition was severely impaired with a Brief Interview for Mental Status score of 00 (lack of ability to answer basic orientation and memory questions correctly). The MDS noted Resident #83 was interviewed for preferences for Customary Routine and Activities. The assessment showed 1 (very important) was entered for all eight questions for interview for daily preferences, and for all eight questions related to activity preferences. 2. Review of the clinical record for Resident #95 revealed an admitted [DATE]. Diagnoses included Parkinson's disease, Dementia, and Depression. The clinical record noted the resident's significant other was the responsible party for health care decisions. The Admission 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. Resident #95 was able to complete the interview but was not able to report the correct year, the correct month, the correct day. He was not able to recall the words sock, blue or bed. The MDS showed Resident #95 was interviewed for preferences for Customary Routine and Activities and noted 1 (very important) was entered for all eight questions for daily preferences and all eight questions for activity preferences. 3. On 11/15/24 at 11:03 a.m., in an interview the Administrator said the facility had identified the previous Activity Director related completing and appropriately documenting the activity assessments. She said for that reason the Activity Director was no longer employed at the facility. On 11/15/24 at 2:49 p.m., the Administrator verified no Performance Review Plan was initiated for the inaccurate MDS activity assessments.

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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).

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, clinical record review, resident representative and staff interviews, the facility failed to provide an ongoing, meaningful, resident centered activity program to support the interest and meet the physical, mental, and psychological well-being of 2 (Residents #95 and #8) of 7 residents reviewed for involvement in activities. The findings included: 1. Review of the clinical record revealed Resident #8 had an admitted [DATE] with diagnoses including dementia with mood disturbance and anxiety. The 5-day scheduled Minimum Data Set (MDS) assessment with a target date of 10/31/24 noted the resident's cognition was moderately impaired with a Brief Interview for Mental Status (BIMS) score of 09. Review of the Lifestyle and Activity Preferences Evaluation dated 10/29/24 documented activities were very important to the Resident. Questions #2 to 13 were not completed for background information. Functional status questions #1 to 11 were not completed. Leisure Preferences, questions #1 to 12 were not completed. Review of the Care Plan initiated 4/5/24 (Revised 9/17/24) for Resident #8 documented, The resident is able to make leisure needs and preferences known and participates in facility activities as desired. Prefers a balance of social and independent leisure activities. The goal specified the resident will remain engaged in independent leisure activities and participate in facility activity programming as desired, and will express satisfaction with leisure routine through next review. The Care Plan interventions included: Assist resident to/from activities as needed. Encourage in-room leisure time such as TV, phone/video communication with family/friends, reading books/magazines, etc., and allow for resident feedback and suggestions on leisure time activities. Encourage ongoing family involvement. Invite the resident's family to attend special events, activities, meals. Encourage participation in activities of interest. Honor resident's choice to choose own activities, provide reminders/cues for participation as needed. Provide reading materials, stationary, radio, or other materials as requested for independent use by resident. Provide resident with activities calendar. Staff visits with resident as resident agrees/desires to promote independent leisure/socialization. On 11/12/24 at 9:00 a.m., and 1:15 p.m., Resident #8 was observed seated in his wheelchair (w/c) at a table in the lounge area in the center of the Pod (individual sitting areas on each hallway). The television (TV) was on. No individualized activities were observed in progress during observations throughout the day. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 1:20 p.m., in an interview Resident #8's wife said she visited her spouse for two hours every day and did not see any activities, except the television. She said the same residents sat there every day. Review of the facility activity calendar for November 2024 documented 9:30 a.m., morning social, at 10:30 sit and stretch, at 11:00 chicken soup stories, at 1:30 table games, at 2:45 coloring corner. On 11/13/24 at 10:51 a.m., and 2:00 p.m., Resident #8 was observed sitting at a table in the center area in front of the television. No activity was in progress on the unit and no activity materials were placed in front of him on the table. Review of the activity calendar for the day documented 8:30 daily chronicle, 8:30 morning social, 10:30 Uno, 1:00 resident /food council, 2:00 BINGO, 2:30 BINGO store. On 11/13/24 at 3:35 p.m., in an interview, the Activity Director said she started employment at the facility six days ago. She had one assistant who was a certified nursing assistant. The Activity Director said the process for identifying the individualized activity needs of the resident is upon admission to complete the activity preference forms and then she conducts interviews and tries to get to know the resident better. She said she speaks to the family to see if there is anything the resident had liked to do previously. She said she did not make the activity calendar for this month because she just accepted the position. The Activity Director confirmed there were no activities on the individual units, and said, it just would not be possible or fair to all the residents. The activities are done in the main dining room. We are making one-to-one visits I try to see a few residents a day and offer the daily chronicle or a word search. I can't do 1-1 for the whole building in a day so I will try and see about 6 residents a day because I'm still trying to get to know them. I plan to hire another assistant who will work only on the memory care unit. The lack of activities observed for Resident #8 was shared with the Activities Director, and the concerns expressed by the resident's spouse. The Activity Director confirmed she did not leave individualized activity items on the Pods (units) and said she had no plans to do activities on each of the unit Pods. She said it would be impossible. On 11/14/24 at 9:29 a.m., Resident #8 was observed in the center of the unit in his w/c. The television was on but he was not engaged. The resident was restless, attempting to wander in the w/c. Resident #8 was yelling loudly and cursing. Staff was not observed redirecting the resident or offer an activity. Several other residents were observed in the lounge area. There were no activities in progress for the residents. On 11/14/24 at 9:44 a.m., in an interview Activity Assistant Staff E said she has been the activity assistant for two weeks. She comes in daily and passes a copy of the facility daily chronicle to the residents. She encourages them to come to activity programs. Staff E confirmed she did not conduct any group or individual activities on the six unit Pods. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/24 at 11:32 p.m., in an interview Resident #8's spouse, said the facility rarely ever takes her husband to an activity. She said her husband was a military veteran and enjoyed talking to other men about his service who had some of the same experiences. The spouse said I had a meeting here for the care plan and I told them that. I told them I leave at 2:00 p.m., every day and he sits here. I have asked them to take him to the activity but I don't think they do that. I wonder when I leave here if he is still just sitting here. 11/14/24 at 1:55 p.m., Resident #8 was seated at the table in the center of the Pod. On 11/14/24 art 3:20 p.m., Resident #8 was observed seated at the table on the Pod. No activity was in progress. The Activity Aid and the Activity Director were observed to assist other residents from the Pod to the dining room for an activity but did not offer to assist Resident #8 to the activity. The activity calendar specified 8:30 a.m., Daily Chronicle, 9:30 sit and stretch, 10:30 room visits, 2:00 M&M's entertainment, 3:00 puzzle time. On 11/14/24 at 4:00 p.m., the Administrator said there was no policy for the facility activities program. On 11/15/24 at 9:50 a.m., and 2:10 p.m., Resident #8 remained in the center of the Pod at a table with no individualized activity offered to him. The activities 8:30 daily Chronicle, 9:30 Morning Social, 10:30 Dominos, 11:00 Friendly Visit, 1:30 BINGO, 3:00 Nail Spa. 30599 2. Review of the clinical record for Resident #95 revealed an admitted [DATE]. Diagnoses included Parkinson's disease, Dementia, and Depression. The Brief Interview for Mental Status (BIMS) documented on the Admission Minimum Data Set (MDS) shows Resident #95 scored 03. This score shows a severe cognitive deficit. Resident #95's significant other is responsible for making his healthcare decisions. Section F of the MDS shows Resident #95 answered all the questions on his activities assessment with the same answer very important. On 11/12/24 at 12:14 p.m. Resident #95's significant other/responsible party said she did not see staff assist the resident to activities very often. On 11/13/24 at 9:00 a.m. Resident #95 was observed sitting in his wheelchair in the living room area of the 600 unit in front of the TV by himself. On 11/14/24 9:10 a.m. Resident #95 was observed in the living room of the 600 unit at a table with a magazine in front of him. He was eating a snack at the time. On 11/14/24 10:58 a.m. Resident #95 observed in the same area previously seen sleeping in his wheelchair. On 11/14/24 at 12:00 p.m. Resident #95 was observed sitting in his wheelchair in the same area of the living room area of the 600 unit. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the activities calendar in Resident #95's room showed no activities listed past 3:30 p.m. Review of the electronic record under activities shows in the last 30-day Resident #95 had attended activities 3 to 6 times. On 11/15/24 at 11:03 a.m., in an interview the Administrator said they had identified there was issue with the Activities Director not completing assessments and documenting and that is why he no longer employed at the facility. The Administrator said the two activity staff members were new. The Administrator said Resident #95 was taken to Trivia in the afternoon on 11/14/24. When asked about Resident #95's cognitive issues, and the activities calendar not addressing residents on the 600 unit with cognitive deficits, The Administrator said Memory Care has a separate activity schedule specific to cognitively impaired residents. The Administrator said staff do sometimes take cognitively impaired residents to the memory care unit for activities. The Administrator said she could not provide any documentation of Resident #95 attending activities on the memory care unit.

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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 observation, review of facility policy and procedures, record review and staff interviews, the facility failed to maintain urinary catheters in a safe and sanitary manner for 1(Resident #25) of 1 resident reviewed with an indwelling urinary catheter. The findings included: The facility policy Catheter Care issued 10/20 (revised 1/24) documented The facility will maintain infection control guidelines related to catheter use and catheter care to minimize catheter associated infections. Ensure the drainage spigot is not touching the floor, the tubing is free of kinks, the catheter is kept at an appropriate level to promote urine flow, and dignity is maintained. Review of the clinical record revealed Resident #25 was admitted on [DATE] with diagnoses including benign prostatic hypertrophy (enlarged prostate), Parkinson's disease, and neuromuscular dysfunction of the bladder requiring an indwelling urinary catheter. The record showed Resident #25 had a hospital admission on 8/24/24 with diagnosis of a urinary tract infection and returned to the facility on [DATE]. On 11/12/24 at 9:55 a.m., during an observation Resident #25 was in bed and his urinary catheter drainage bag was on the floor. Resident #25 said he did not know how the drainage bag got onto the floor. Photographic evidence obtained. On 11/12/24 at 10:00 a.m., Registered Nurse (RN) Staff A confirmed the catheter drainage bag was on the floor and said it should never be on the floor. On 11/13/24 at 10:34 a.m., Resident #25's catheter drainage bag was observed laying flat on the floor next to the trash can. Photographic evidence obtained. On 11/13/24 at 10:37 a.m., in an interview RN staff A confirmed the catheter drainage bag was on the floor and said, they put a clip here yesterday to keep it off the floor, let me find it. Staff A said here it is and showed this writer a large paper clip that was shaped into a hook attached to the bed. She confirmed a paper clip was being used in place of a drainage bag securement hook and said we don't have a lot of supplies. Photographic evidence obtained. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 2:30 p.m., in an interview Certified Nursing Assistant (CNA) Staff J said when caring for catheter drainage bags you hang them from the wheelchair or the bed frame. The bag is usually hung from the foot of the bed and you make sure it isn't tangled or touching anything. It is emptied at the end of the shift. On 11/13/24 at 2:35 p.m., in an interview CNA Staff I said catheters drainage bags are to be placed in a drainage bag holder and attached to the wheelchair or the bed. Staff I demonstrated how a drainage bag holder was attached to the wheelchair and said the catheter drainage bag goes in there and we also have a bag attached to the bed so when they are in bed, you place the catheter drainage bag in the drainage bag holder and it stays off the floor.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, review of facility policy and procedures, review of the clinical record and resident and staff interview the facility failed to ensure 2 (Residents #67 and #89) of 2 residents receiving intravenous solution received appropriate care of the intravenous insertion site, including dressing changes and flushing the line. The findings included: The facility policy Central Lines documented, Flush catheters at regular intervals to maintain patency and before and after the following: a. administration of intermittent solutions. b.administration of medication. c. obtaining blood samples d. converting from continuous to intermittent therapies. In addition to adhering to professional standards of practice, facilities are responsible for administering IV therapy according to the physician's orders, the residents goals, preferences and advanced directives as applicable and according to State law. 1. Review of the clinical record revealed Resident #67 had an admitted [DATE] with diagnoses including Alzheimer's disease, dementia, bi-polar disorder, adult failure to thrive. The clinical record documented the resident was admitted to hospice services on 11/11/24 and was unresponsive. On 11/12/24 at 10:18 a.m., Resident #67 was observed in bed sleeping. She was noted to have a PICC (peripherally inserted central catheter) in the left forearm area with an undated dressing covering the insertion site. There was an unlabeled and undated bag of intravenous solution 5% dextrose/0.9% sodium infusing. Photographic evidence obtained. Review of the physician order documented Dextrose-NaCl Solution 5-0.45 % (Dextrose-Sodium Chloride) Use 50 ml/hr intravenously every shift for hydration for 7 Days -Start Date 11/07/2024. There were no orders located in the electronic record to the paper chart for the care of the catheter including when to change the dressing and when to flush the catheter. 2. 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. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 10:03 a.m., Resident #89 was observed in bed and noted to have an IV (Intravenous) catheter inserted in his left forearm. Resident #89 said he had the IV since he was readmitted to the facility last week from the hospital. He said he was not receiving any medication through it and did not know why it was not removed. Resident # 89 said they don't do anything with it so why keep it in? The catheter was covered with a transparent border edge dressing without a date. Resident #89 said the hospital had put the catheter in and he has asked the nurse every day to take it out but they did not do it. On 11/12/24 at 10:30 a., in an interview Registered Nurse (RN) Staff A said Resident #89 had a urinary tract infection and that is why he had the catheter. Staff A said she did not know what the order for the care and flush of IV was but would check the residents' record. Staff A checked the record and said she did not see any orders for the care of the IV. Review of the medication administration record (MAR) revealed a physician order dated 11/5/24 for INVanz (an antibiotic) Injection Solution Reconstituted 1 gram (Ertapenem Sodium) use 50 milliliters intravenously one time a day for urinary tract infection for 1 day. The MAR documented the medication had been administered. On 11/12/24 at 1:01 p.m., in an interview, Unit Manager Registered Nurse Staff D said Resident #89 completed antibiotic therapy through the IV on 11/11/24. Staff D said the reason the resident still had the IV was to administer the antibiotic and the last dose was administered yesterday. This writer informed Staff D the medication was ordered for 1 dose only and was administered on 11/5/24. Staff D was informed there was no date on the IV dressing and the resident said it was there since his hospital admission on 11/2/24. Staff D said she would have to check the physician orders and went back to the nurse's desk. Review of the Physician orders showed no order for the care of the catheter and no additional antibiotics ordered after 11/5/24. On 11/12/24 at 2:29 p.m., in an interview Staff D said the antibiotic for Resident #89 ended the day before so she wrote an order to discontinue the IV. Staff D said the nurses assigned to the resident were responsible for the care of the IV. On 11/13/24 at 9:07 a.m., in an interview Staff D confirmed the medication for the use of the IV had been administered on 11/5/24 and there was no order for the care and flush of the IV catheter. Staff D said the IV catheter was removed on 11/12/24. On 11/15/24 at 8:45 a.m., in an interview the Director of Nursing (DON) said she was aware Resident #89 did not have orders for the care including the flushing of the IV. She said going forward the admission nurse will put in the orders and then the Unit Manager will check for an order in the morning and the nurse assigned to the resident will check to ensure there are orders for the care of the IV. The DON said she was not aware Resident #67 did not have orders for the care or flush of the IV.

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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. 41155 Based on observation, review of facility policy and procedure, and staff interviews, the facility failed to maintain resident nebulizer machines (turns liquid medication into a mist that can be inhaled) in a sanitary manner for 2 (Resident #6 and #18) of 2 residents reviewed with a nebulizer. The findings included: The facility policy Nebulizer (revised 12/2023) documented General Guidelines #4, Store nebulizer and tubing in a hygienic manner when not in use (ie., labeling bag with a date tubing was changed. On 11/12/24 at 10:20 a.m., in during an observation in Resident #6's room there was a nebulizer and the mask was on top of the night stand uncovered, and undated. Photographic evidence obtained. On 11/12/24 at 10:44 a.m., Resident #18 was observed in her room. There was a nebulizer in on the nightstand with the mask hanging down the side of the nightstand. On 11/15/24 at 9:52 a.m., in an interview Unit Manager Registered Nurse Staff D said nebulizer masks were to be covered in a plastic bag when not in use and dated. She said the residents will take them out of the bags and just put them down but they should not be on the floor. The RN said the nurse on the unit was responsible for the care of the nebulizer since they administer it.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 30599 Based on interview, and record review the facility failed to obtain physician ordered medication and ensure timely administration of pain medications for 1 (Resident #318) of 5 residents sampled for medication regimen review, causing ongoing severe pain to the resident. The findings included: Review of the clinical record for Resident #318 revealed a date of admission of 11/11/24. Diagnoses included chronic back pain due to spinal stenosis. On 11/13/24 at 10:47 a.m., in an interview Resident #318 said, I waited 20 hours to get a pain pill when I was admitted to the facility. I was miserable, in pain, and crying. The resident said she kept telling the nurse on duty to call the physician. Resident #318 said the nursing staff kept telling her the delivery would be here shortly. The resident said, I waited until 2:00 a.m. and the medication didn't come. Then I waited till 5:00 a.m. and the medication didn't come. Resident #318 said her roommate witnessed her crying at breakfast time. She said at 9:00 a.m. that morning she called her daughter and told her she was going to call 911 if they did not get her something for her pain. Resident #318 said she complained to anyone who walked in the room about her pain. She said the marketer who arranged for her admission told her she would have her medication at the facility when she got there. She said she texted the marketer and she never responded. Resident #318 said she came to the facility for therapy. She could not start therapy due to the pain. Resident #318 said she would not want anyone else to have to go through what she had endured. Review of the physician's orders revealed an order dated 11/11/24 at 11:56 a.m., for Morphine Sulfate Oral Tablet 30 MG (Morphine Sulfate) Give 1 tablet by mouth every 8 hours for Chronic pain and Roxicodone Oral Tablet 15 MG (Oxycodone HCl) Give 1 tablet by mouth every 4 hours as needed for Chronic pain. Review of the November 2024 Medication Administration Record (MAR) showed Resident #318 received the first dose of Roxicodone 15 mg for a pain level of 4 on 11/12/24. The start date for the medication listed on the MAR was 11/11/24 at 11:00 p.m. The order for Morphine Sulfate 30 mg to be given every 8 hours was listed on the MAR on 11/11/24 at 11:00 p.m. The first dose of Morphine was not administered until 11/12/24 at 10:00 p.m. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 11/14/24 at 9:37 a.m., in an interview Resident #318 said she arrived at the facility on 11/11/24 at about 2:30 p.m. and started asking for her pain medication right away. The nurse told her the pain medication was not here yet. She told the nurse on duty she should have a backup pharmacy, or call the physician to get an order for the medication they did have in stock. She said she was rating her pain at that time at a 7 out of 10. She said she would never have said her pain level was a 4. She said her goal with her medication was to get to a 5 in pain. She never got below a 7 level of pain the first night she was here. She said on 11/12/24 at 8:00 a.m. when the breakfast tray came she was crying. Resident #318 said she felt it was cruel to make her wait that long for her medications. Staff could have acted to get her medication sooner and they did not seem to know what to do to obtain her medications. On 11/14/24 at 3:25 p.m., in an interview Registered Nurse, Staff P verified she had worked a double shift on 11/11/24 from 7a.m. to 11p.m. When asked about the delay in obtaining Resident #318's pain medications ordered on 11/11/24 at 11:56 a.m., she said she found the prescription for the Morphine later on that day and faxed it to the pharmacy and documented the prescription on the MAR. Staff P said they did not have the ordered dosage of the pain medication in stock on 11/11/24. Staff P verified Resident #318 told her she was in a lot of pain. She told Resident #318 the prescription was sent to the pharmacy but the medication was not available at the facility. Staff P said she asked the resident if she wanted Tylenol and she said yes. On 11/14/24 at 3:45 p.m., in an interview the Director of Admissions said on 11/11/24 in the afternoon she received a message from the External Marketer for Admissions. She said the text read Resident #318 was requesting her medications. The Director of Admissions said she went to the Director of Nursing (DON) on 11/11/24 around 3:00 p.m., and notified her of Resident #318 needing her pain medications. The DON told her she would make sure the resident received her pain medications. The Director of Admissions said the DON told her they had notified the resident's physician. On 11/14/24 at 3:55 p.m., in an interview the DON said no one spoke to her on 11/11/24 but she had heard about Resident #318 not receiving her pain medications. The DON said she thought the reason staff did not have the medications was because they did not have a prescription. She said if staff could not get a hold of the resident's primary physician they could call the Medical Director. The DON said she started educating staff on the issue on 11/13/24 and is continuing education today. The DON said she would change the education at this time because she not aware staff had a prescription for Resident #318's pain medication on 11/11/24.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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)

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

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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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedarbrook Health and Rehabilitation Center	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 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.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30599 Based on observations, record review and interviews, the facility failed to provide a diet to accommodate the documented gluten and lactose dietary restriction for 1 (Resident #13) of 2 residents reviewed for nutrition. The findings Included: Review of the clinical record revealed Resident #13 was admitted to the facility on [DATE]. Diagnoses included Type II Diabetes, Celiac Disease (immune reaction to eating gluten), and malnutrition. On 11/13/24 at 10:35 a.m., in an interview Resident #13 said she had Celiac Disease, and she is always being served oatmeal and grits. Resident #13 said she has told dietary staff she cannot eat oatmeal and grits. On 11/15/24 at 8:20 a.m., Resident #13's breakfast was observed. The resident's meal ticket said she was allergic to Gluten and Lactose. The meal ticket listed her dislikes as bread and Fish/Seafood. The resident was observed to have a carton of 2% milk, a container of cereal and scrambled eggs. On 11/15/24 at 12:35 p.m., Resident #13 was observed eating lunch in the living room area of the 600 unit. The resident had been served a slice of bread with her meal. On 11/15/24 12:51 p.m., the observations of Resident #13's breakfast and lunch meal were discussed with the Dietary Manager. The Dietary Manager verified Resident #13 was not supposed to have cereal or 2% milk with breakfast. The Dietary Manager verified the bread the resident was being served at lunch was not gluten free.