

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105965	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER Capri Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1450 East Venice Avenue Venice, FL 34292	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155</p> <p>Based on observation, review of facility policy and procedures and staff interview, the facility failed to provide a clean, safe and sanitary environment for residents in 6 (Rooms 110, 113, 114, 116, 118 and 119) of 17 rooms observed on the Memory Care Unit.</p> <p>The findings included:</p> <p>On 6/24/24 at 9:30 a.m., during an initial tour on the Memory Care Unit the following was observed:</p> <ol style="list-style-type: none"> 1. room [ROOM NUMBER]. In the bathroom there was a bed pan on the floor next to the toilet, a wash basin wedged between the toilet and the wall. There was a container of disinfecting wipes behind the toilet on the floor with a soiled washcloth. <p>Photographic evidence obtained.</p> <ol style="list-style-type: none"> 2. room [ROOM NUMBER]. The bathroom had cracks in the tiles, brown and black grime on the tiles surrounding the base of the toilet. <p>Photographic evidence obtained.</p> <ol style="list-style-type: none"> 3. room [ROOM NUMBER] A. Multiple bottle of lotion, cream and sprays were stored in two wash basins on the nightstand. <p>Photographic evidence obtained.</p> <ol style="list-style-type: none"> 4. room [ROOM NUMBER] B. Bottle of body lotion, shampoo and body wash were stored in a caddy. <p>Photographic evidence obtained.</p> <ol style="list-style-type: none"> 5. room [ROOM NUMBER]. A wash basin was stored on the floor under the sink, and another one was stored on the floor next to the toilet. <p>Photographic evidence obtained.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>6. room [ROOM NUMBER]. A wash basin was stored on the bathroom floor behind the toilet. The tile surrounding the base of the toilet had a black substance on the tiles.</p> <p>Photographic evidence obtained.</p> <p>7. room [ROOM NUMBER]. A wash basin was stored on the floor in the bathroom near the toilet. Two packs of incontinent wipes, a soiled washcloth, a bottle of lotion and a bottle of foaming wash were stored on the toilet tank.</p> <p>Photographic evidence obtained.</p> <p>8. room [ROOM NUMBER] A. A tube of antifungal cream was stored unsecured on the nightstand. A nebulizer (machine used to deliver medication into the lungs) mask was observed uncovered on the machine.</p> <p>Photographic evidence obtained.</p> <p>On 6/24/24 at 11:30 a.m., in an interview the Director of Nursing (DON) was informed of the concerns and findings on the Memory care unit. The DON said he had not toured the unit.</p> <p>On 6/24/24 at 11:40 a.m., Certified Nursing Assistant (CNA) Staff C was observed coming down the Memory Care Unit hallway with bags of wash basins and bed pans. Staff C said the DON had called the unit and said to remove them from the bathroom floors. CNA Staff C said resident personal care items should be stored in the resident's bedside dresser along with the wash basins.</p> <p>On 6/24/24 at 11:49 a.m., Licensed Practical Nurse Staff A verified the items left in the bathroom on the floors and said, I know, the wash basins should not be on the bathroom floor. The personal care items can be left out.</p> <p>On 6/24/24 at 12:30 p.m., in an interview the Regional Nurse Consultant (RNC) verified the residents' personal items were left unsecured in the dementia unit, including bottles of shampoo, lotion, sprays and disinfecting wiped. He said the residents on that unit wander.</p> <p>He said, I can't guarantee that a resident won't eat or drink it but like I said, it is not a psych ward.</p> <p>The RNC said he did not know what the policy was for keeping personal items on the Memory Care Unit.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155</p> <p>Based on observation, review of facility policy and procedures, record review, staff and resident interviews, the facility failed to provide the necessary care and services to meet the needs for 3 (Resident #999, #875 and #900) of 5 residents reviewed for activities of daily living (ADLs).</p> <p>The findings included:</p> <p>The facility policy Standards and Guidelines : ADL Care and Services issued 4/2020 (revised 1/2024) documented :Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition grooming and personal and oral hygiene . Residents will be provided with care treatment and services to ensure that their activities of daily living are met . 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 care and oral care . The resident has the right to refuse any and all ADL care the refusal of care will be documented in the resident's medical record with the appropriate notification including the physician and resident representative.</p> <p>1. Review of the clinical record revealed Resident #999 had an admitted [DATE] with diagnoses including stage 4 pressure ulcer to the sacral region, protein calorie malnutrition and muscle weakness.</p> <p>The Quarterly Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date of 5/9/24 documented the resident was dependent on 1-2 staff for bathing.</p> <p>The MDS noted Resident #999's cognitive skills for daily decision making were moderately impaired.</p> <p>Review of the Certified Nursing Assistant (CNA) documentation for May 2024 revealed the resident refused showers on 5/13/24, 5/20/24, 5/23/24. On 5/30/24 there was no documentation that a shower was provided.</p> <p>The CNA documentation for June showed N/A [not applicable] on 6/3/24 and 6/17/24. There was no documentation in the clinical record the resident had refused care. On 6/6/24 and 6/13/24 the documentation revealed the resident refused showers.</p> <p>There was no documentation in the clinical record indicating the staff attempted to encourage bathing.</p> <p>On 6/24/24 at 10:30 a.m., Resident #999 was observed in bed, her hair was uncombed, and she looked unkempt. In an interview, the resident said she had not received a shower for a while now. She said, I have asked but all I get is a bed bath once a week.</p> <p>2. Review of the clinical record revealed Resident #875 had an admitted [DATE] with diagnoses including muscle weakness, repeated falls, and compression fracture of the first lumbar vertebrae.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Admission Minimum Data Set with an assessment reference date of 6/17/24 documented Resident #875 required substantial to maximum assistance for bathing and partial to moderate assistance for personal hygiene.</p> <p>The MDS noted Resident #875's cognitive skills for daily decision making were moderately impaired.</p> <p>On 6/24/24 at 10:45 a.m., in an interview Resident #875 said staff did not assist her with showers. She said, They give me bed baths. I want a shower, but they said it is easier for them to do a sponge bath, so I just gave up.</p> <p>Resident #875 was observed in her bed. Her hair was greasy and uncombed. She had long fingernails, extending approximately 1/4 inch with a brown substance under several nails.</p> <p>Review of the CNA task list failed to show documentation the resident was scheduled for showers or had received any showers since her admission.</p> <p>On 6/24/24 at 12:00 p.m., in an interview Licensed Practical Nurse (LPN) Staff D said she did not know why the resident did not receive any shower since admission. She said all the residents are scheduled for a shower twice a week. LPN Staff D said, I know the CNA will make three attempts to encourage the resident to shower and then the nurse will try.</p> <p>3. Review of the clinical record revealed Resident #900 had an admitted [DATE] with diagnoses including hemiplegia and hemiparesis affecting the left side, contracture of the left hand and right and left foot drop.</p> <p>The plan of care identified Resident #900 had an ADL self-care deficit and indicated the resident was dependent on 2 staff members for bathing.</p> <p>On 6/24/24 at 2:25 p.m., in an interview Resident #900 said, I don't get showers because they come in all rude and throw the towels on the foot of the bed and say it's time for your shower. I don't know who they are because they have changed staff so much. They don't introduce themselves.</p> <p>Resident #900 said, I do take showers sometimes, if the staff are polite.</p> <p>Resident #900 was in bed during the interview. She appeared unkempt. Her hair was uncombed and severely matted. Her bedding was in disarray and soiled with food crumbs. The resident was completely nude in the bed with a soiled bath towel covering her upper torso. The resident was noted to have contractures of the left shoulder, hand and arm.</p> <p>Review of the care plan initiated 10/30/23 documented Resident #900 is resistive to care/refusing care (heel protectors/boots, showers, medications, treatment, getting out of bed etc.</p> <p>The interventions included:</p> <p>Educate resident/family of the possible outcomes of not complying with treatment of care.</p> <p>Give clear explanation of all care activities as they occur during each contact.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide consistency within care to promote comfort with ADL's.</p> <p>Review of the CNA documentation for May 2024 documented N/A on 5/4/24 and 5/14/24. The resident refused a shower on 5/23/24 and 5/29/24.</p> <p>Review of the CNA documentation for June 2024 revealed the resident refused scheduled showers on 6/1/24, 6/5/24, 6/8/24, 6/22/24.</p> <p>On 6/26/24 at 2:00 p.m., in a telephone interview Resident #900's son said his mother was very lucid and makes decisions for herself. The son said as a family they expressed concerns related to the care of his mother at the quarterly care plan meeting. He said even though his mother was set in her ways, and it is painful for her but they don't even try to get her out of bed. They even hold care plan meetings in her room. The management staff told him it was easier than getting her out of bed. The resident's son said no one from the facility discussed her personal hygiene or refusal of showers with him. He said he thought his mother received a shower at least weekly.</p> <p>On 6/25/24 at 11:40 a.m., in an interview the Director of Nursing (DON) said when a resident refuses a shower, three attempts are made. If the resident still refuses, the CNA alerts the nurse and it is documented. The DON said the nurse is responsible to document the refusal in the electronic record. The DON said the staff will notify the family and ask them to speak with the resident to see if they can encourage the resident. We call the family as well and let them know their loved one has refused bathing or any other care.</p> <p>The DON said Resident #900 was alert and oriented and had the right to refuse care. She said, It is in her care plan as well.</p> <p>On 6/25/24 at 12:53 p.m., in an interview CNA Staff G said, the policy is to try three different times during the shift to offer a shower. If the resident continues to refuse, she notifies the nurse. The nurse will speak with the resident. If the resident continues to refuse the shower, the nurse documents the refusal. CNA Staff G said she will then offer a bed bath to the resident.</p> <p>On 6/25/24 at 2:53 p.m., in an interview Unit Manager Staff H said the CNA is to make three attempts to shower the resident then notify the nurse if the resident still refuses. She or the nurse would then try and encourage the resident to shower. If the resident still refuses, the nurse will document the refusal. The Unit Manager said she did not know until 6/24/24 Resident #900 had been refusing showers multiple times. She said Resident #900 was set in her ways and, if she doesn't want it, she doesn't want it. Staff H said it was the resident's right to refuse to shower but she had not collaborated or discussed with staff the reason for the refusal and how they could encourage the resident to accept her showers.</p> <p>On 6/26/24 at 3:08 p.m., in an interview the Medical Director, he said he was not aware Resident #900 was refusing showers. The Medical Director said, The memory changes and someone can be fully demented and still refuse care. We can't physically drag a patient into the shower and force them to shower.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155</p> <p>Based on review of facility policy and procedures, record review, staff and resident interviews, the facility failed to provide the necessary care and services to ensure each resident who is incontinent of urine is identified, assessed and provided appropriate incontinent care for 2(Resident #999 and #900) of 3 residents reviewed with incontinence.</p> <p>The findings included:</p> <p>The facility policy Standards and Guidelines : ADL Care and Services issued 4/2020 (revised 1/2024) documented :Residents who are unable to carry out activities of daily living (ADLs)independently will receive the services necessary to maintain good nutrition grooming and personal and oral hygiene. Residents will be provided with care treatment and services to ensure that their activities of daily living are met. Appropriate care and services will be provided for residents who are unable to carry out ADL's (activities of daily living) independently, with the consent of the resident and in accordance with the plan of care including appropriate support and assistance with hygiene and elimination(toileting).</p> <p>1. Review of the clinical record revealed Resident #999 had an admitted [DATE] with diagnoses including stage 4 pressure ulcer to the sacral region, protein calorie malnutrition and muscle weakness.</p> <p>The Quarterly Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with a date of 5/9/24 documented the resident was frequently incontinent of bladder and always incontinent of bowel.</p> <p>The MDS noted Resident #999's cognitive skills for daily decision making were moderately impaired.</p> <p>The care plan identified Resident #999 required assistance with ADLs including toileting. The interventions specified The resident is not able to participate in the task at all and will need staff to move, clean, and dress them. This may require the dependent assistance of two people to be done thoroughly and safely.</p> <p>On 6/24/24 at 10:30 a.m., during an interview Resident #999 said I am left in bed and not always assisted out of bed. I use a lift and I can't use the bathroom. When I wet on myself, they don't come or they tell me they will be back with help to change me, but they do not come back. I lay here wet, and I don't like it. The resident said I have a wound on my backside and it is not good for me to be wet.</p> <p>2. Review of the clinical record revealed Resident #900 had an admitted [DATE] with diagnoses including hemiplegia and hemiparesis affecting the left side, contracture of the left hand and right and left foot drop.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The plan of care identified Resident #900 had was at risk for complications related in bowel or bladder incontinence. The care plan interventions specified, Toileting: The resident is not able to participate in the task at all and will need staff to move, clean, and dress them. This may require the dependent assistance of two people to be done thoroughly and safely. Provide incontinence care with each incontinent episode as tolerated.</p> <p>On 6/24/24 at 2:25 p.m., in an interview Resident #900 said the staff say they change us every two hours but it is more like every four hours. I put the light on to be changed and they turn it off and don't return. I have to have two people because I fell out of bed two years ago when one CNA was changing me. They can never seem to find another person to help. Being wet is not pleasant, I want to be changed.</p> <p>On 6/24/24 at 11:40 a.m., Certified Nursing Assistant (CNA) Staff C said we try and toilet the resident whenever they ask. Every couple of hours if they are incontinent, we clean the resident and change them.</p> <p>On 6/25/24 at 12:02 p.m., in an interview Licensed Practical Nurse (LPN) Staff E said I think the CNA's are to toilet/change residents every 2-3 hours and when they request it.</p> <p>On 6/25/24 at 9:30 a.m., in an interview CNA Staff F said in my opinion the emergency light should be answered immediately or within 1 minute. I try to think if it were me that is what I would want. I don't know if the facility has a toileting program and I can only speak for myself, but I try and toilet or change residents every 2 hours. Most of the residents will let you know if they have to use the toilet or they need to be changed.</p> <p>On 6/25/24 at 12:53 p.m., in an interview CNA Staff G said, we toilet the residents every few hours, there isn't a schedule, you just do.</p> <p>6/25/24 at 8:50 a.m., in an interview the Director of Nursing (DON) said the facility did not have a toileting program. When asked what the expectation was for staff providing assistance for continent and incontinent residents, the DON replied the same as it would be at any other place.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155</p> <p>Based on record review, review of facility policy and procedures and resident and staff interviews the facility failed to ensure pain medications were provided in accordance with professional standards of practice and physician orders for 2 (Resident #99 and #399) of 3 residents reviewed for pain management.</p> <p>The findings included:</p> <p>The facility policy Medication Administration issued 10/2020 (revised 1/2024) specified: medications are ordered and administered safely and as prescribed. The director of nursing services directs all personnel who administer medications and or have related functions. Medications are administered in accordance with prescribed orders, including any required time limit. If a drug is withheld, refused, or given at a time other than the schedule time, the individual administering the medication shall document the rationale in the residence medical record and notify the physician and responsible party if indicated.</p> <p>1. Review of the clinical record revealed Resident #99 had an admitted [DATE] with diagnoses including colon cancer, rheumatoid arthritis and major depressive disorder.</p> <p>On 6/25/24 at 8:25 a.m., in an interview Resident #99 said she was not consistently receiving her pain medications and was informed by the nurse that the pharmacy did not send it. The resident said she was to receive scheduled Oxycodone 5 milligrams (mg) at 6:00 a.m., and 12:00 p.m. Resident #99 said, the medication was scheduled and after that I have to ask for it. I can have it every six hours as needed. Every month they run out and no one can tell me why. I have reported it to the nurse, the Social Worker, and the Unit Manager. No one can tell me why they keep running out and there is always a two-to-three-day gap before I get my medication. I usually take a total of three pain pills per day. My pain is in my back, abdomen and left leg as it swells up. Sometimes I cry because it hurts so bad the pain gets to a 10/10. By that time my whole body is hurting.</p> <p>Review of the physician's orders revealed an order dated 4/19/24 to administer Oxycodone 5 mg two times a day, to be given at 6:00 a.m., and 12:00 p.m.</p> <p>The physician's orders dated 4/19/24 included to administer Oxycodone 5 mg every 6 hours as needed for pain after the routine 12:00 p.m. dose.</p> <p>Review of the June 2024 Medication Administration Record (MAR) lacked documentation the routine Oxycodone 5 mg was administered on 6/2/24 (6:00 a.m., and 12:00 p.m.), on 6/3/24 at 6:00 a.m., on 6/17/24 at 12:00 p.m., and on 6/23/24 at 12:00 p.m.</p> <p>On 6/2/24 at 5:16 a.m., the nurse documented on a progress note the Oxycodone was on order.</p> <p>On 6/2/24 at 1:42 p.m., the nurse documented the Oxycodone was not available.</p> <p>On 6/3/24 at 6:09 a.m., the nurse documented awaiting delivery</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/23/24 at 12:13 p.m., the nurse documented the Oxycodone 5 mg was not available.</p> <p>On 6/25/24 at 12:02 p.m., in an interview Licensed Practical Nurse (LPN) Staff E said she has been employed at the facility less than two months. Staff E said sometimes the medications are not available. Staff E said, I don't know why but sometimes the pharmacy does not bring the medications. You need to call the pharmacy and ask them to send the medication.</p> <p>2. Review of the clinical record revealed Resident #399 had an admitted [DATE] with diagnoses including, right hip fracture, end stage renal disease and anxiety.</p> <p>On 6/26/24 at 9:00 a.m., in an interview Resident #399 said she had a fall at another facility and broke her right hip. I am getting my pain medication most of the time. The nurse gives it to me. I can have it so many times a day and then I have to ask for it. Sometimes my hip hurts so bad 10 out of 10. I ask for a pain pill and they don't give it to me.</p> <p>Review of the Physician's order dated 5/21/24 documented to administer Oxycodone HCl oral tablet 5 mg one tablet by mouth three times a day for pain.</p> <p>Review of the MAR for May 2024 failed to reveal documentation the resident received the scheduled dose of Oxycodone on 5/21/24 at 6:00 a.m., 5/26/24 at 6:00 a.m., 5/31/24 at 2:00 p.m., 6/2/24 at 6:00 a.m., 6/4/24 at 10:00 a.m., 6/6/24 at 10:00 a.m., and 2:00 p.m</p> <p>Review of the nursing progress notes failed to show documentation of the reason why the Oxycodone 5 mg was not administered as ordered.</p> <p>On 6/25/24 at 12:30 p.m., in an interview the Director of Nursing (DON) said, if a medication was unavailable the nurse can get it from the Pyxis (emergency medication dispensing machine) and contact the pharmacy for delivery.</p> <p>The DON said, Resident #99 confabulates things and it is in her care plan.</p> <p>On 6/25/24 at 1:05 p.m., in an interview the DON said he checked the Pyxis and on 6/2/24 the last Oxycodone 5 mg was removed. The quantity delivered by the pharmacy was 20 Oxycodone 5 mg tablets in the Pyxis. The same thing occurred on 6/22/24, the last Oxycodone 5 mg tablet was removed so it would be empty on 6/23/24.</p> <p>The DON said, I do know we have been having issues with the pharmacy and the delivery of medications this month, I don't know why. I will contact them and increase the par for the Oxycodone 5 mg in the Pyxis.</p> <p>The DON said he did not know when the pharmacy delivers the medications or restocks the Pyxis. The DON said he was not aware Resident #99 had missed several doses of the scheduled pain medication.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105965	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER Capri Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1450 East Venice Avenue Venice, FL 34292	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/26/24 at 9:45 a.m., in an interview Unit Manager Registered Nurse Staff H said when medications are needed they text the physician. They call the pharmacy when they are running low on medications, and if the medication is not at the facility. Staff H said they also check the computer system to see when the medication was reordered and call the pharmacy. She said she was aware Resident #99 ran out of her pain medication twice but she was not in pain when the medication was not available as documented on the MAR. Staff H said Resident #99 also receives Tylenol, Gabapentin and Ibuprofen for pain.</p> <p>On 6/25/24 at 10:00 a.m., review of the Pyxis medication log with the DON showed one Oxycodone 5 mg remaining with a PAR (Periodic Automatic Replacement) level of 10 tablets of Oxycodone. The DON said, You tell me what to do when the pharmacy is not delivering the medications. What do we do?</p> <p>The DON said he did not have weekly or monthly interdisciplinary team (IDT) meetings with the staff to review residents with repeat issues/concerns/care needs. The DON said they have a monthly staff meeting and there is a care plan meeting.</p> <p>On 6/26/24 at 3:08 p.m., in an interview the Medical Director said he was not notified Resident #99 and #399 had missed doses of scheduled pain medication and said he knew there were issues with the pharmacy, the facility was working on that.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>41155</p> <p>Based on observation, review of facility policy and procedures, review of clinical records and staff and resident interview, the facility failed to secure all medications in a locked storage compartment and failed to ensure 1 medication cart (East wing) of 5 medication carts was secured and locked when out of the direct supervision of the nurse.</p> <p>The findings included:</p> <p>The facility policy Medication Storage and Labeling issued 3/2021 (revised 01/2024) specified The facility stores all drugs and biological's in a safe, secure, and orderly manner. Drugs and biological's used in the facility are stored in locked compartments under proper temperature, light, and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications.</p> <p>1. On 6/24/24 at 2:25 p.m., during an observation on the second floor, the medication cart on the East Wing was observed unlocked, and unattended. Two nurses were observed standing in the East hallway talking. The medication cart was not under direct observation of the nurses. One resident was observed in a wheelchair going past the unsecured medication cart.</p> <p>Photographic evidence obtained.</p> <p>On 6/24/24 at 2:27 p.m., Licensed Practical Nurse (LPN) Staff K quickly came up the hall to the cart and said, I know it was unlocked. I had an emergency. I had to go and I ran and I forgot to lock it.</p> <p>2. On 6/25/24 at 9:40 a.m., a large bottle of antacid was observed on Resident #800's bedside table.</p> <p>Photographic evidence obtained.</p> <p>In an interview during the observation Resident #800 said, I keep them here and take them when I have heartburn. Resident #800 opened the bottle, placed two antacid tablets in his mouth, chewed and swallowed them.</p> <p>On 6/25/24 at approximately 9:45 a.m., LPN Staff E went in the resident's room and confirmed the observation of the bottle of antacid stored on the resident's bedside table. LPN Staff E said she did not know if it was permitted to self-administer and store medications at the bedside.</p> <p>Review of the clinical record for Resident #800 revealed a physician order dated 7/21/23 to give two tablets of (brand name) chewable antacid every six hours as needed for heartburn. The clinical record did not show an assessment verifying Resident #800 was able to safely self-administer the antacid, and was able to safely, and securely store the antacid.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/25/24 at 11:20 a.m., in an interview the Director of Nursing (DON) said he was not aware Resident #800 kept the bottle of antacid at the bedside. He confirmed Resident #800 was not assessed to determine if he was able to safely self-administer the antacid, and his ability to ensure the antacid is stored safely and securely.</p>		