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Form Approved OMB
No. 0938-0391

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 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capri Health and Rehabilitation Center	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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37256 Based on observation and interview, the facility failed to ensure housekeeping and maintenance services to maintain a safe, functional, sanitary and comfortable environment for residents, staff and the public on the first and second floor of the facility. The findings included: During a tour of the facility on 9/24/24 at 5:00 p.m., the following environmental observations were made: A black substance was observed on the ceiling vents and surrounding ceiling tiles of the Capri reading room, the first floor hallway near the elevator, and the Social Service Office on the second floor 2nd floor. Photographic evidence obtained. The floor and cove base of the first floor hallway near the nourishment room, the first floor hallway near the central bath, the memory care near the speech therapy room, and near room [ROOM NUMBER] were in poor repair, cracked and separating. Photographic evidence obtained. The wallpaper was peeling from wall with orange discoloration coming through the paper in the memory care near the speech therapy room and the second floor hallway near the elevators Photographic evidence obtained. Black biogrowth was observed on the walls and/or ceiling of the second floor wall across from the elevator and the ceiling tiles of the second floor storage room. Photographic evidence obtained. (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/25/24 at 9:13 a.m., in an interview the Administrator said they had received quotes for roof replacement which had been sent to corporate for review. The Administrator agreed areas of the building were getting old and could use some attention. She said they had begun working on the walls and wallpaper, but due to the impending hurricane staff had been sent to sister facilities. She said at this time there was no definitive end date for the repairs but was working on getting a plan in place.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on observation, interview, and record review, the facility failed to develop a resident centered care plan to meet the needs of 1 (Resident #45) of 3 residents reviewed with impaired hearing. The findings included: Review of the medical record revealed Resident #45 was admitted to the facility on [DATE]. Diagnoses included mixed conductive and sensorineural hearing loss, and cochlear implant (Surgically implanted device that helps people with severe to profound hearing loss perceive sound) status. Review of the Significant Change in Status Assessment with a target date of 8/26/24 revealed Resident #45's hearing was highly impaired with absence of useful hearing. Resident #45's cognition was moderately impaired with a Brief Interview for Mental Status score of 09. The care plan initiated on 10/16/23 and revised on 10/26/23 noted Resident #45 had a communication problem related to hearing deficit. Per the resident's family, the cochlear implant has stopped working. The care plan initiated on 10/9/23 noted Resident #45 was able to make leisure needs and preferences known. The resident preferred a balance of social and independent leisure activities. The goal was for the resident to express satisfaction with leisure routine. The interventions included to encourage in-room leisure time such as television. On 9/23/24 at 5:27 a.m., Resident #45 was observed in the bedroom with eyes closed. The resident did not respond to interview questions. On 9/23/24 at 11:50 a.m., in an interview the resident's spouse said Resident #45 was 100% deaf. She told staff numerous times it was important for them to turn on the closed captioning (text that reflects an audio track and can be read while watching visual content) when he watched television since he could not hear. She said Resident #45 was not able to turn on the closed captioning himself. Resident #45's spouse said it should be a simple thing to do but the staff don't turn it on. She said every time she visits, she has to turn it on herself, including when she arrived today. On 9/24/24 at 9:51 a.m., Resident #45 was observed in a wheelchair facing the television set. The closed captioning was not turned on. No text was displayed on the television screen. The television remote control was observed on the nightstand on the opposite side of the bed and was not within reach of the resident. On 9/25/24 at 9:18 a.m., Resident #45 was observed in his room. The television was on but the closed captioning was not turned on. No text was displayed on the television screen. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Practical Nurse (LPN) Staff Y verified the closed caption function was not turned on. In an interview LPN Staff Y said she knew Resident #45's hearing was impaired. She acknowledged there was no care plan interventions to remind staff to turn on the closed caption when Resident #45 was watching television. On 9/25/24 at 9:26 a.m., the Minimum Data Set (MDS) coordinator said she was responsible to ensure care plan interventions were individualized to meet the needs of each resident. The MDS coordinator verified Resident #45's care plan included to encourage in-room leisure time such as television but did not direct staff to turn on the closed caption since the resident's hearing was highly impaired.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, review of the clinical record, review of facility policy, resident and staff interviews, the facility failed to consistently apply a physician ordered orthotic device to prevent the decline in range of motion for 1 (Resident #32) of 1 resident reviewed with contractures (rigidity of joint). The findings included: The facility policy Standards and Guidelines : Physician Orders documented Physician orders should be followed as prescribed, and if not followed, this should be recorded in the resident's medical record during that shift. Physician should be notified and the responsible party if indicated. Review of the clinical record revealed Resident #32 had an admitted [DATE] with diagnoses including Parkinson's disease, anxiety and muscle weakness. The Quarterly Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date of 9/7/24 documented Resident #32 was dependent on staff for activities of daily living. The MDS noted Resident #32's cognitive skills for daily decision making were moderately impaired. The Physician orders dated 6/28/24 included for the resident to use bilateral palm guards during the day shift. Remove as needed during hygiene care and during meals. Review of the Certified Nursing Assistant (CNA) care Kardex (provides instruction for resident care) instructed to use bilateral hand palm guards during the day shift. Remove as needed during hygiene care and during meals. Check skin integrity. On 9/23/24 at 5:47 a.m., and at 3:45 p.m., Resident # 32 was observed in his bed. The resident's hands were contracted. Resident #32 was not wearing the splinting device as ordered. Two hand splints were observed on the nightstand. On 9/24/24 at 10:23 a.m., Resident #32 was observed in bed without the physician's ordered splints to his hands. The splints were observed on the nightstand. On 9/24/24 at 10:30 a.m., CNA Staff A said she was not aware the resident had hands splints. Staff A said she had not observed the resident using the hand splints in a while. On 9/24/24 at 2:53 p.m., Resident #32 was observed in his room in bed without the splints to his hands. In an interview Resident #32 said he did not know why he did not have the hand splints on, and he did not refuse to wear them. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/24/24 at 3:00 p.m., during a joint observation with Licensed Practical Nurse Staff D confirmed Resident #32 was not wearing the palm protectors (splints) to his hands as ordered. Resident #32 told the nurse he did not know where his palm protectors were and said no one applied the splints for him. On 9/24/24 at 3:37 p.m., in an interview Occupational Therapist Staff E said Resident #32 was to wear the palm guards daily.