STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105995	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adviniacare at Naples	7801 Airport Pulling Road N Naples, FL 34109

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, review of facility's policies and procedure, resident and staff interviews, and record review the facility failed to provide appropriate care and services to 2 (Residents #47 and #48) of 2 residents receiving intravenous antibiotics through peripherally inserted central catheters (PICCs).The findings included:Review of the facility provided policy for PICC Line Dressing Changes last revised on 2/2026 revealed on page 1, #4. When a transparent dressing is applied over a gauze dressing it is considered a gauze dressing and is changed every 48 hours or sooner.Review of the clinical record for Resident #48 revealed an admission date of 5/19/26. Admitting diagnoses included infection following a procedure. On 5/19/26 at 7:47 p.m., Registered Nurse (RN) Staff A documented in a nursing progress note that Resident #48 was admitted to the facility with orders to continue antibiotics until 5/27/26. The note documented that Resident #48 had an existing intravenous site (IV) line that was intact without redness, swelling, drainage or kinking. Review of the physician's order summary revealed an order dated 5/20/26 to change the IV transparent cover dressing on admission, weekly, and PRN (as needed).The Medication Administration Record (MAR) for May 2026 did not include the physician's order dated 5/20/26 to change the transparent dressing on admission, weekly and PRN. On 5/26/26 at 9:44 a.m., Resident #48 was observed with a PICC line to the left upper arm. The dressing to the PICC line insertion site was dated 5/19/26. In an interview, Resident #48 said that the PICC line was inserted at the hospital prior to his admission to the facility. The Resident said that the PICC line dressing has not been changed since his admission on [DATE]. Photographic evidence obtainedOn 5/27/26 at 3:57 p.m., in a follow up interview, Resident #48 said that the PICC line dressing has not been changed.On 5/27/26 at 4:00 p.m., Resident #48's PICC line dressing was observed with the Director of Nursing (DON). The DON verified that the PICC line dressing was dated 5/19/26 and had not been changed since the resident's admission to the facility on 5/19/26. The DON Said that the PICC line dressing should have been changed as ordered by the physician. The DON verified that the physician's orders for the PICC line dressing changes were not transcribed on the MAR. She said that RN Staff A did not activate the physician's order, therefore the order did not transfer onto the MAR.On 5/28/26 at 8:30 a.m., in an interview, RN Staff A confirmed that he did not change Resident #48's PICC line dressing as ordered by the physician. Review of the clinical record for Resident #47 revealed an admission date of 5/22/26 (Friday). Admitting diagnoses included discitis (infection of the disk space in the spine), and osteomyelitis (bone infection) of the lumbar region.The physician's orders included:Daptomycin 745 milligrams intravenous once a day for Osteomyelitis until 6/21/26. Ertapenem Sodium 1 Gram intravenous at bedtime for Osteomyelitis until 6/21/26.On 5/26/26 at 9:51 a.m., Resident #47 was observed with a PICC line to the right upper arm with an undated gauze dressing to the PICC line insertion site. Photographic evidence obtainedReview of the Treatment Administration Record (TAR) revealed a physician's order dated 5/22/26 at 3:37 p.m., to change the IV PICC transparent dressing every night shift every Friday.On 5/22/26, RN Staff E entered 8 (other) for the PICC dressing change and documented in a progress note dated 5/23/26 at 12:15 a.m., Dressing changed one day ago. On 5/27/26 at 4:10 p.m., in an interview, the DON verified that the dressing to Resident #47's PICC line (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had not been changed at the facility. She said that 8 entered on the TAR meant that the physician's order was not carried and the explanation would be in a progress note. The DON said that when a resident is admitted with a PICC line, the nurse is supposed to change the dressing and apply a transparent dressing. Then, the PICC line dressing is changed every 7 days. The DON said that the nurse should have changed the dressing on 5/22/26.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation and interview, the facility failed to post the nurse staffing data at the beginning of each shift for 3 consecutive days on 5/23/26, 5/24/26, and 5/25/26.The findings included: On Tuesday 5/26/26 at 9:00 a.m., the nurse staffing data was observed displayed behind a plastic stand at the nurse's station. The nurse staffing data was dated 5/22/26 (Friday).Photographic evidence obtainedOn 5/28/26 at 8:51 a.m., in an interview, Registered Nurse (RN) Staff B said the night shift nurse should have changed the nurse staffing data over the weekend and on Monday. She said she worked the day shift over the weekend and did not notice the nurse staffing data was not changed on 5/23/26 (Saturday), 5/24/26 (Sunday), or 5/25/26.On 5/28/26 at 8:54 a.m., in an interview, Medical Records Staff F said she was responsible to post the nurse staffing data Monday through Friday but did not work on Monday or Tuesday. She said that in her absence, the Director of Nursing (DON) completed the nurse staffing data sheets and would have arranged to have it posted.On 5/28/26 at 9:00 a.m., in an interview, the DON verified that she failed to ensure the nursing data was posted on 5/23/26, 5/24/26, and 5/25/26.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on record review, facility policy review, resident, family member and staff interviews, the facility failed to ensure dental services were appropriately coordinated for 1 (Resident #39) of 2 residents reviewed for dental services. The facility failed to maintain documentation of dental consultations in the medical record, failed to follow up on recommendations made during a dental consultation and failed to ensure the Resident was informed of financial responsibility and payment options for recommended dental services. These failures have delayed necessary dental care and impeded the Residents ability to make informed decisions regarding treatment and associated costs.The findings included:Review of the facility Dental Services policy (last revised October 2022) noted routine and emergency dental care services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care . Routine and 24-hour emergency dental services are provided to our residents through: a contract agreement with a licensed dentist that comes to our facility monthly, referral to the resident's personal dentist, referral to community dentists, or referral to other health care organizations that provide dental services . Identified individuals will assist residents with appointments, transportation arrangements, and for reimbursement of dental services under the state plan, if eligible.all dental services provided are recorded in the resident's medical record. On 5/27/26 at 2:32 p.m., in an interview, Resident #39 said that he did not have dentures when he arrived at the facility. He said that when he first arrived here a dentist that came to the facility saw him and took molds of his mouth. He said he had mentioned to the dentist that he didn't know how he would pay for new dentures because his insurance did not cover it. He said then he stopped treatment because he wanted more information on how he was going to pay. He said that the dentist then kind of stepped back. Resident #39 said that he has adapted to not having teeth and tries to get soft foods. He said he would really like to have a new set of dentures as well as information on how to pay for them.On 5/28/26 at 10:02 a.m., in an interview, Resident #39's daughter stated that her father has been without teeth for over 2 years and it has been an ongoing issue with her father trying to get teeth. She said, I feel so bad for him. She said he did see the dental service that the facility provided but when it came time to make the dentures, they wanted her to pay them from the responsibility that she owes to the facility. She said she felt like that was a ?scam'. She said that she has made multiple calls to the facility without any answers. No one at the facility was able to answer how the payment for the dentures was to ensue.Review of the clinical record for Resident #39 revealed an admission date of 11/22/24. Diagnoses included Gasto-esophageal reflux and pneumonia (infection of the lungs).Review of the Brief Interview for Mental Status dated 3/20/26 revealed Resident #39 scored 15, indicating intact cognition.Resident #39's care plan last revised 4/7/26 noted that the resident has a nutritional problem related to . decreased dentition.On 5/27/26 at 3:16 p.m. In an interview with the Minimum Data Set Coordinator, she verified that Resident #39 was documented as having no natural teeth. She said that during the facility's clinical meeting they will discuss each Resident that had a recent quarterly review to discuss any referrals that need to be made for the Resident. She said she could not find any documentation or notes stating that Resident #39 had seen a dentist since he came to reside here or any referrals made. On 5/27/26 at 3:46 p.m., in an interview with the Social Services Director (SSD), she said she was unable to find any electronic documentation regarding any dental consultation for Resident #39. She said normally if a resident is seen by dental the paperwork would be uploaded into the electronic record.On 5/27/26 at 4:11 p.m., the Social Services Director said she contacted the dental service provider today and had them fax the records to the facility. The SSD provided a dental consult dated 7/1/25 for Resident #39. Review of the dental consult revealed that Resident #39 was interested in upper partial and lower denture. Per the Social Worker, the dentures have been approved. Resident #39 agreed to the treatment. Upper and lower initial impressions were taken. Final impressions using upper and lower custom trays would be done at the next visit.The dental Patient (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress Report dated 7/29/25 noted that Resident #39 presented for final upper and lower impressions using custom trays. Resident #39 agreed to treatment. The next visit would be for bite registration using upper and lower wax rims.The dental Patient Progress Report dated 7/31/25 noted that Resident #39 was scheduled for a denture consult. The dentist office confirmed with the patient's POA (Power of Attorney) and family that the patient was not interested in receiving treatment or moving forward with a denture fabrication. No further follow up was needed.On 5/28/26 at 9:35 a.m., in an interview, the SSD said there was no follow up from the facility related to Resident #39's dental consultation, because no one ensured the dental documentation was in the Residents medical record. She said there was no documentation that Resident #39 may have needed additional support from the facility to continue with dental services and payment assistance after his dental consultation.On 5/27/26 at 4:00 p.m., an interview was held with the Admissions Director and the Administrator.The Admissions Director stated that he did not know if Resident #39 or his family was aware of options related to dental and Medicaid payment.The Administrator said she could not answer as to why the dental exam from July 2025 was not scanned into the electronic medical record and why the documents were just received today. She stated that Resident #39 was a Medicaid recipient therefore dentures would be covered under Medicaid payment. When asked if Resident #39 or his representative were aware of the process of payment using his prescribed insurance, she said she did not know.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on record review and interview, the facility failed to have a binding arbitration agreement for 3 (Residents #1, #20 and #28) of 3 residents reviewed that explicitly states that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. This has the potential to affect all residents residing in the facility.Review of the facility's binding arbitration agreement (not dated) revealed that it did not state that signing this agreement is not a requirement for admission. The signature page of the document states the undersigned acknowledge that each of them has read all six (6) pages of this agreement . that by signing this agreement each has waived his/her rights to a trial, before a judge and/or jury, and that each of them voluntarily consents to all terms of this agreement. Residents #1, #20 and #28 were sampled from the facility provided list of admissions who had signed the arbitration agreement.On 5/27/26 at 1:20 p.m., in an interview, Resident #28 said that she has resided in the facility for over 2 years. She said she cannot recall ever being educated on a binding arbitration, but she had to sign so many papers it would be hard to remember. She said she was not aware she was in any kind of legal arbitration with the facility. She said no one has ever said that she had to sign anything legal to reside here.On 5/27/26 at 1:26 p.m., in an interview, Resident #20 stated that he cannot remember if anyone explained what a binding arbitration is. He said no one said whether he had to sign it or not to stay here. He said it was so long ago he does not know if he received a copy of the agreement. On 5/27/26 at 1:41 p.m., in an interview, Resident #1 said that she has not any idea of what a binding arbitration is, or if anyone had told her she had to sign it to stay here. She said she cannot remember if she received a copy of the agreement.On 5/27/26 at 2:04 p.m., in an interview, the Admissions Director stated that he goes over the binding arbitration agreement with the Resident during the admission process. The Admissions Director verified that the document did not contain any statement, making the Resident or Resident representative aware that they do not have to enter a binding arbitration to reside in the facility. He said that it did not state that in the document.On 5/28/26 at 11:34 a.m., in an interview, the Director of Nursing confirmed that they provide Residents with a binding arbitration agreement upon admission. She verified that the binding arbitration agreement provided to the residents does not contain any statement to ensure each Resident or Resident representative is aware that they do not have to enter a binding arbitration with the facility for admission or to receive care.