

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 83602	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/12/2025
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NAME OF PROVIDER OR SUPPLIER REHAB & HEALTHCARE CENTER OF CAPE CORAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2629 DEL PRADO BLVD CAPE CORAL, FL 33904
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N 000	<p>INITIAL COMMENTS</p> <p>An unannounced off-hour relicensure survey with complaints #2024016400, #2025001412, #2025001390, #2023015487, #2024007902, #2024013759, #2024014571, #2023016864, 2025000472 and #2024008366 was conducted on _____ through _____ at Rehab & Healthcare Center of Cape Coral, a skilled nursing facility in Cape Coral, Florida.</p> <p>Complaint #2024016400 was unsubstantiated. Complaint #2025001412 was substantiated with citation at N201. Complaint #2025001390 was substantiated with citation at N201. Complaint #2023015487 was unsubstantiated. Complaint #2024007902 was unsubstantiated. Complaint #2024013759 was substantiated without citation. Complaint #2024014571 was unsubstantiated. Complaint #2023016864 was unsubstantiated. Complaint #2025000472 was unsubstantiated. Complaint #2024008366 was substantiated without citation.</p> <p>The following is the description of the deficiencies.</p>	N 000		
N 054 SS=D	<p>59A-4.107(5), FAC Follow Physician Orders</p> <p>All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident's medical record during that shift.</p> <p>This Statute or Rule is not met as evidenced by: Based on observation, review of facility policy and procedure, record review and staff interview the facility failed to follow physician's orders for 5 (Residents #26, #23, #271, #470, and #60) 26</p>	N 054	1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X8) DATE

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N 054	<p>Continued From page 1</p> <p>sampled residents.</p> <p>The findings included:</p> <p>The facility policy "Medication Administration General Guidelines" documented "The individual who administers the medication, records the administration on the resident's MAR immediately following the medication being given. . . If a scheduled medication is withheld, refused, the space provided on the front of the MAR/TAR (treatment administration record) for that dosage administration is initialed and circled. An explanatory note is entered. . ."</p> <p>Review of the clinical record revealed Resident #26 had a readmission date of with diagnoses including , , , need for assistance with personal care, , and .</p> <p>A nursing progress note with a date of documented SOC (standards of care) meeting today. Resident readmitted to facility 2 days ago after hospitalization. Resident previously pulled her out and was reinserted during hospitalization. binder in place for protection to be removed for skin integrity checks and care every shift. Will continue to monitor.</p> <p>A physician order dated instructed "Maintain binder in place. Remove for care and to monitor skin integrity, every shift for monitoring skin integrity."</p> <p>On at 12:07 p.m., during an observation Resident #26 was in bed wearing a hospital gown she had pulled up, exposing the .</p> <p>The insertion site was leaking on</p>	N 054	<p>A. RN staff R and RN staff K was educated on medication administration. B. Residents #26, #23, #271, #470 and #60 no negative outcome was noted.</p> <p>2: How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>A. Audit was completed to ensure residents was receiving correct medications and abnormal finding was corrected.</p> <p>3: What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;</p> <p>A. License Nurses was educated on F759 documentation and medication administration this education will be provided annually and upon new hire orientation. B. Nursing Mangers will audit medication administration for any documentation of such as but not limited to not available, holes/blanks in the MAR and ensure that appropriate follow up was completed. C. Medication competency was completed for current license nurses and any new license nurse hired.</p> <p>4: How the corrective action(s) will be monitored to ensure the deficient practice</p>	

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N 054	<p>Continued From page 2</p> <p>resident's gown. There was no binder covering the _____</p> <p>On _____ at 1:20 p.m., during an observation of the _____ with Registered Nurse (RN) Staff K said the resident was to have an binder on because she will pull the _____ out, but they could not find it. She had the _____ covered with a towel and the towel had a large stain form the _____ RN Staff K said the resident had recently pulled the _____ out twice.</p> <p>A review of the TAR revealed RN Staff K had signed the TAR for the day and evening shifts indicating the _____ binder was in place.</p> <p>On _____ at 3:23 p.m., Resident #26 was in bed, the room door was open. The resident had the covers down and her shirt up. She had the _____ in her _____ pulling on the tube.</p> <p>A review of the TAR revealed the binder was signed on the TAR as applied by the nurse for the day and evening shift on _____</p> <p>On _____ at 3:44 p.m., an observation with RN Unit Manager Staff E verified the binder had not been applied for resident #26 as ordered by the physician. She said it was sent to the laundry to be washed. RN Staff E confirmed if the _____ binder was not available, the nurse should not have documented it was applied.</p> <p>On _____ at 10:00 a.m., RN Staff K said she did not sign the TAR to indicate the _____ binder was in place on _____ RN Staff K said it was in the laundry and so we used a sheet and wrapped it around her abdomen because she has pulled the _____ out twice now. RN Staff K confirmed she had signed the TAR indicating she _____</p>	N 054	<p>will not recur, i.e., what quality assurance program will be put into place.</p> <p>The Director of Nursing/Designee will do random audits of license nurses during medication administration to ensure proper procedure/techniques is being utilized weekly for four weeks then monthly for one quarter. The Director of Nursing/Designee will submit a report of findings to the Quality Assessment, Assurance and Compliance Committee monthly for one quarter.</p> <p>1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>A. Resident #26 _____ binder use was corrected.</p> <p>B. RN staff K educated on documentation.</p> <p>2: How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>A. Complete audit of resident _____ and any specialty device used for their tube was completed and any abnormal findings were corrected.</p> <p>3: What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;</p>		

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N 054	<p>Continued From page 3</p> <p>had applied and checked the placement of the binder</p> <p>On at 9:15 a.m., Registered Nurse (RN) Staff R was observed administering 11 different medications to Resident #470, including: Patch 5% (,), one patch to the resident's left and one patch to the resident's left () 10 milligrams (mg), one tablet by 75 mg (,), one tablet by</p> <p>Reconciliation of the medication administration observation with the physician's orders revealed the current physician's orders included: external patch 4%, apply to left /left , one time a day for () 75 mg, give one tablet by one time a day related to Major , administer with 37.5 mg total to be administered is 112.5 mg. The physician's orders included to administer 10 mg, one tablet one time a day for . The medication was scheduled to be administered daily at 9:00 a.m. RN Staff R was not observed administering the as ordered.</p> <p>Complete review of the clinical record failed to reveal a physician's order for 10 mg</p>	N 054	<p>A. License Nurses was educated on documentation with emphasis on services not provided/ physician orders not carried out and the process of documentation. B. Nurse Manager to review 24 hour report and order detail summary the following business day for any refusal or care, supplies not available and any new order for specialty equipment and follow up to ensure appropriate interventions were implemented. C. Staff was educated on the compenence of F693 and this education will be provided upon new hire orientation and annually.</p> <p>4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>The Director of Nursing/Designee will do random audits of resident , and any speciality equipment used on their , is being utilized weekly for four weeks then monthly for one quarter. The Director of Nursing/Designee will submit a report of findings to the Quality Assessment, Assurance and Compliance Committee monthly for one quarter.</p> <p>1: What corrective action(s) will be accomplished for those residents who have been affected by the deficient practice;</p> <p>A. Resident #271 and #23 was changed.</p>	

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N 054	<p>Continued From page 4</p> <p>administered to the resident. On at 3:22 p.m., in an interview RN Staff R verified she did not administer 37.5 mg with the 75 mg per the physician's order. She verified there was no physician's order for the 10 mg she administered to Resident #470. RN Staff R said she administered 10 mg instead of 10 mg to the resident. She said, "That's an _____ pill, that's what we give." RN Staff R asked if the _____ and _____ were not "the same thing." She said she did not realize the strength of the patches she applied to the resident's left _____ and left _____ were 5%. She did not realize the physician's order was for patch 4%.</p> <p>On 10:11 a.m., RN Staff K was observed administering four medications to Resident #60, including one tablet of Torsemide 10 mg. Review of the physician's orders for Resident #60 revealed to administer Torsemide 5 mg, one tablet by _____ one time a day for _____ / _____ (_____ caused collection of fluid in the tissues).</p> <p>On at 3:37 p.m., in an interview RN Staff K verified the physician's order was to administer Torsemide 5 mg one time a day to the resident. She acknowledged the medication error and said she administered Torsemide 10 mg to Resident #60, which was twice the amount of Torsemide ordered.</p> <p>Review of the policy for _____ Access Devices and _____ Procedures Change for _____ Access Devices dated _____ _____ the purpose is to prevent local and</p>	N 054	<p>B. LPN staff V was educated on _____ change.</p> <p>2: How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>A. Complete Audit of resident with lines and any abnormal findings were corrected.</p> <p>3: What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;</p> <p>A. License Nurses was educated on _____ changes. B. Nursing Management will review 24-hour report and order listing report for any new placement and any refusal of care related to _____ change and follow up to ensure appropriate interventions are being followed. C. License nurses was educated on F694, documentation of care and services provided and refusal of care and services, this education will also be provided during new hire orientation and annually.</p> <p>4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>The Director of Nursing/Designee will do audits of resident receiving _____ s has received their _____ change weekly for</p>		

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N 054	<p>Continued From page 5</p> <p>systemic related to the . A sterile is maintained on all , and central access devices to protect the site, provide microbial barrier, and to provide access device securement. Short are changed every 7 days or when the integrity of the is compromised.</p> <p>On at 10:16 a.m., Resident #271 was observed in bed with () infusing through an line inserted in the resident's right upper arm. The insertion site was dated . "Photographic evidence obtained."</p> <p>On at 10:40 a.m., Licensed Practical Nurse (LPN) Supervisor Staff V entered the bedroom and observed the . In an interview LPN Staff V stated, "The cover is outdated and should be changed every 7 days."</p> <p>Review of Resident 271's Medication Administration Record (MAR) for revealed a physician's order written on at 1:50 p.m. to change the cover every 7 days and as needed for soiling or dislodgement. The MAR contained documentation that the nurse signed off the was changed on .</p> <p>Review of Resident #271's care plans revealed a care plan initiated on for medications with instructions to check the site daily and change the per physician's orders and facility policy. Review of the progress notes from through revealed no documentation Resident #271 refused to have the cover changed.</p>	N 054	<p>four weeks then monthly for one quarter. The Director of Nursing/Designee will submit a report of findings to the Quality Assessment, Assurance and Compliance Committee monthly for one quarter.</p>	

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N 054	<p>Continued From page 6</p> <p>On at 10:54 a.m., Resident #23 was observed with an insertion site to the left upper arm. The was dated . The was eight days old. "Photographic evidence obtained."</p> <p>Review of Resident #23's MAR for revealed a physician's order dated at 4:56 p.m. to change the cover every 7 days and as needed for soiling or dislodgement. The MAR contained documentation that the nurse signed off the was changed on and .</p> <p>Review of Resident #23's care plans revealed a history of refusing care including medications and activities of daily living care dated . The care plan did not include information Resident #23 refused change.</p> <p>Review of the nursing progress notes from through revealed no documentation that Resident #23 refused to have the cover changed.</p> <p>On at 9:06 a.m., in an interview the Director of Nursing (DON) said the are changed every seven days to prevent . The DON said the nurses did not follow physician's orders to change the for Resident #271 and #23. The DON said the expectation is the nurse signs off when a task is completed and not prior to completing the task, in case the nurse does not get to the task because of being side-tracked or forgetting to do it. She said the MARS for for both Residents #271 and #23 were incorrect. She said the nurses documented completion of changes that were not done.</p> <p>Class III</p>	N 054		

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N 072 SS=D	<p>59A-4.109(2), FAC; Comprehensive Care Plans</p> <p>59A-4.109 FAC</p> <p>(2) The nursing home licensee develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and . . . needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and social well-being. The care plan must be completed within 7 days after completion of the resident assessment.</p> <p>This Statute or Rule is not met as evidenced by: Based on observation, review of the clinical record, and resident and staff interviews, the facility failed to develop a care plan that described the resident's medical, physical, mental and . . . needs and preferences and how the facility will assist in meeting these needs and preferences for 1 (Resident #83) of 28 care plans reviewed. The failure to complete an accurate and individualized care plan has the potential to impact the resident's quality of life and quality of care.</p> <p>The findings included:</p> <p>Review of the clinical record revealed Resident #83 was a . . . male with a readmission date of . . . Diagnoses for the resident included . . . (. . . of one side of the body) and . . . (. . . of one side of the body) following . . . , and . . . major . . . , and . . . wasting.</p> <p>The record indicated Resident #83 was on</p>	N 072	<p>1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>A. #83 care plan was updated to reflect resident current status. B. Education for F656 provided to RN staff B, care plan coordinator Staff L and Care plan coordinator RN staff H. C. Director of Rehab is no longer at the facility.</p> <p>2: How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>A. Complete Audit of resident with contractors and limited ROM was conducted and any abnormal findings were corrected.</p>	

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N 072	<p>Continued From page 8</p> <p>hospice services beginning</p> <p>A significant change Minimum Data Set (MDS) assessment dated _____ documented the resident had a limitation in range of motion (ROM) on both sides of the lower extremities and one side of the upper extremity. The MDS noted Resident #83's _____ skills for daily decision making were intact.</p> <p>The care plan initiated on _____ identified Resident #83 was dependent on staff for activities of daily living (ADLs).</p> <p>On _____ at 11:55 a.m., Resident #83 was observed in bed in a _____ position on his left side. He was noted to hold his left _____ in a tight fist and his _____ were bent with his heels toward his _____. There were no _____ devices or pillows in place to assist the resident with positioning. The resident said he was not able to move his left _____ or straighten his _____.</p> <p>During observations on _____ at 10:01 a.m., and _____ at 2:14 p.m., Resident #83 was in bed with his left _____ in a fist position and his _____ and _____ drawn up toward his _____ and his heels toward his _____. He had no _____ or positioning devices in place including pillows. Resident #83 said he could move his right _____ but when encouraged he was not able to move his _____.</p> <p>On _____ at 4:35 p.m., in an interview the Director of Rehab said Resident #83 was now on hospice services but had been on case load on and off through the years. The Director of Rehab said _____ had tried all different types of _____ and positioning devices for his _____. The resident said would say he was going to wear it and then</p>	N 072	<p>3: What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;</p> <p>A. License staff was educated on the components of F656.</p> <p>B. Nursing management will review 24 hour report and follow up on any new limited ROM or contractors and update care plan as needed.</p> <p>C. All New residents will be reviewed and reassessed if needed and review by the IDT team the following business day for any limited ROM or contractors to ensure appropriate interventions are in place.</p> <p>D. Education on F656 will be provided annually and upon new hire orientation.</p> <p>4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>The Director of Care Plans /Designee will audit new residents _____ chart and any change of condition charts to ensure that care plans are appropriate to reflect the status of the resident with emphasis on contractor or limited ROM weekly for four weeks then monthly for one quarter. The Director of Care Plans/Designee will submit a report of findings to the Quality Assessment, Assurance and Compliance Committee monthly for one quarter.</p>	

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N 072	<p>Continued From page 9</p> <p>would refuse.</p> <p>On at 4:45 p.m., in an interview Registered Nurse (RN) Staff B said she looked in the residents record and found no information regarding the use of , pillows etc., for Resident #83's . RN Staff B said, "I have not been able to find anything that he refused care or . He does refuse care all the time. But I did not find any documentation. I know, if it wasn't documented it wasn't done."</p> <p>On at 9:08 a.m., in an interview the Director of Nursing (DON) said she was unaware of the resident's , and the lack of documentation or services for the management of resident #83's .</p> <p>On at 9:25 a.m., in an interview Care Plan Coordinator Staff I confirmed there was no care plan to address the lower for Resident #83. The Care Plan Coordinator said the loss of ROM in the left was addressed but confirmed there were no interventions for the left including ROM, , pillows. Staff I said the Resident #83 was on hospice services and did not receive . Staff I said, "We have interdisciplinary team meetings weekly and there was no mention regarding the presence or care of the lower ."</p> <p>On at 10:08 a.m., in an interview Care Plan Coordinator Staff I said Resident #83 received , on after a return from the hospital and he was refusing it. She confirmed the was dated for one day only and was actually an evaluation the resident refused. She confirmed there was no additional documentation of , for Resident #83.</p>	N 072		

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N 072	<p>Continued From page 10</p> <p>On at 10:15 a.m., in an interview RN Care Plan Coordinator Staff H said she completed the Significant change MDS dated . She said Resident #83 was not like that when she saw him for the significant change MDS. She said a limitation in ROM does not mean a . She observed the resident and he is now. She confirmed the limited ROM or was not identified in the care plan.</p> <p>On at 10:43 a.m., in an interview the DON said the facility did not have a restorative program and there was no documentation the direct care staff was educated to provide ROM, or to address the resident's</p> <p>Class III</p>	N 072		
N 110 SS=E	<p>400.141(1)(h) FS; 59A-4.122(1) FAC Physical Environment - Safe, Clean, Homelike</p> <p>400.141(1)(h) FS Maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner.</p> <p>59A-4.122(1) FAC The licensee must provide a safe, clean, comfortable, and homelike environment, which allows the resident to use his or her personal belongings to the extent possible</p> <p>This Statute or Rule is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to provide a safe, sanitary, and homelike environment as evidenced</p>	N 110	1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	

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N 110	<p>Continued From page 11</p> <p>by dry wall damage in resident's rooms. Failure to identify and complete needed repairs could cause safety and sanitary hazards to residents on Unit 1, which had damage in 8 of 31 rooms.</p> <p>The findings included:</p> <p>On during the initial tour of Unit 1's resident rooms: observation revealed the drywall and chair-rails behind resident's beds in , 18, 21, 35, 37 and 39 were damaged and chair-rails were on the floor. Holes were observed in the dry walls next to the bathroom door in , 21, and 39.</p> <p>On at 10:23 a.m., in an interview with Resident #55, he said the chair rail molding behind bed A and B had been damaged and broken for the past several months. He said he told the staff about the drywall damage in the room, but nothing had been done to repair the drywall damage and the missing chair rails behind the beds in months.</p> <p>The review of the Maintenance Director's Job Description stated they were responsible for the overall maintenance of the facility and provided directions for all activities related to plan operations. Job duties and responsibilities include but were not limited to minor repairs and supervision of the day-to-day repair, improvement and preventive maintenance of the facility to ensure that machines continued to run smoothly, building systems operated effectively, or the physical condition of the facility did not deteriorate.</p> <p>Review of the "Physical Environment" policy and procedure, effective , stated a safe, clean, comfortable, and home-life environment</p>	N 110	<p>practice;</p> <p>A. # ,18,21,35,37,39 findings were fixed and addressed.</p> <p>2: How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>A. A Complete audit of all room was conducted, and findings were noted and put on a schedule to be completed.</p> <p>3: What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;</p> <p>A. Staff was educated on the TELS system. B. Facility Maintenance department and the staff was educated on the components of F584. C. The Maintenance director will check the TELS system daily. D. During morning meeting any environmental concerns will be relayed. Department heads concierge rounds were added to report any environmental concerns. E. Education on the components of F584 will be provided annually and upon new hires.</p> <p>4: How the corrective action(s) will be monitored to ensure the deficient practice</p>	

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N 110	<p>Continued From page 12</p> <p>would be provided for each resident.</p> <p>Review of the facility policy and procedure titled, "Work Orders", with an effective date of , the policy noted "work orders outside of the service reports and equipment records are a mandatory means of maintenance communication. ... Work orders should be used and completed with priority classification noted by the department or the Administrator."</p> <p>On at 11:44 a.m., in an interview with the Maintenance Director, he said he was hired as the Maintenance Director 6 days ago. He was told the facility did not have a Maintenance Director for the past several months. He said he was told the Regional Maintenance Director had overseen the continuous maintenance of the facility during the time the facility did not have a full time Maintenance Director.</p> <p>On at 12:00 p.m., during the tour of residents' rooms on Unit 1, the Maintenance Director confirmed the drywall and chair rails behind resident's beds in , 18, 21, 35, 37 and 39 were damaged and chair-rails were on the floor. He also confirmed there was dry wall damage and holes in the drywall next to the bathroom door in , 21, and 39.</p> <p>The Maintenance Director said after reviewing the Work Orders in their maintenance computer program, the damage he observed in , 18, 21, 35, 37 and 39 were not documented on a Work Order in their computer system as required. He said he was not told of the resident room damage identified during the tour.</p> <p>On at 12:30 p.m., during an interview with the Administrator, he confirmed the facility did not</p>	N 110	<p>will not recur, i.e., what quality assurance program will be put into place.</p> <p>The Nursing Home Administrator/Designee will audit the Tels system for timely resolution of work orders along with random room rounds to ensure adequate safe environment is maintained weekly for four weeks then monthly for one quarter. The Nursing Home Administrator/Designee will submit a report of findings to the Quality Assessment, Assurance and Compliance Committee monthly for one quarter.</p>	
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N 110	Continued From page 13 have a full-time Maintenance Director for several months. He confirmed the facility had hired a new Maintenance Director several days ago. He confirmed part of the Maintenance Director responsibilities was to ensure minor repairs and the supervision of the day-to-day maintenance so the building could continue to run smoothly, building systems would operate efficiently, and the physical condition of the facility did not deteriorate as noted by the drywall damage in _____, 18, 21, 35, 37 and 39. Class III	N 110		
N 201 SS=E	400.022(1)(f), FS Right to Adequate and Appropriate Health Care (f) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on record review, and staff interviews, the facility failed to have documentation nursing staff addressed a reported change of condition for 2 (Residents #46 and #66) of 3 residents reviewed for changes that may indicate a change in health status and need to revise the plan of care. The facility failed to provide the necessary care and services to maintain personal hygiene for 5 (Resident #24, #69, #72, #83 and #271) of 6 residents reviewed for activities of daily living (ADL's).	N 201	1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A. #24, grooming was completed, #69, nails were cut, #271, was shaved and showered, #72, was shaved and _____ cut and clean, #83 was shaved, and _____ were cut and cleaned. B. Rn staff J, CNA staff G, Unit Manager	

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N 201	<p>Continued From page 14</p> <p>The findings included:</p> <p>Review of the facility's policy and procedure titled, "Notification of Resident/Patient Change in Condition" effective _____ revealed, "Notify the Physician . . . if there is a significant change in condition, regardless of the time of day . . ."</p> <p>Review of the facility's "Stop and Watch Early Warning Tool" noted, "If you have identified a change while caring for or observing a resident, please circle the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can."</p> <p>The symptoms to report included but were not limited to: Overall needs more help, ate less, tired, weak, _____, or drowsy, help with walking, transferring, toileting more than usual.</p> <p>Review of the clinical record revealed Resident #46 was admitted to the facility on _____ Diagnoses included but were not limited to _____ and _____ _____ of _____, and history of _____</p> <p>Review of the Admission Minimum Data Set (MDS) Assessment with a target date of _____ revealed Resident #46 scored "15" on the _____ (_____), indicating intact cognition. Diagnoses included but were not limited to _____ failure, _____, and _____ (_____ flow blockage).</p> <p>The care plan initiated on _____ noted Resident</p>	N 201	<p>staff E, CNA staff C, CAN staff A, ADON, LPN staff W, Unit manager LPN staff M CNA staff Q and CNA staff O were all educated on F677</p> <p>2: How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>A. A Complete audit were done on all resident for proper grooming and adl care and any abnormal findings were corrected.</p> <p>3: What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;</p> <p>A. License staff was educated on the components of F677. B. Nursing managers will review POC documentation the following business day for any refusal and completion of ADL care and follow up as needed. C. Nursing managers will review 24-hour report for any refusal or care and follow up as needed. D. License staff was educated on documentation of care provided and refusal of care. E. Concierge rounds will include resident appearance, and any abnormal findings will be brought to morning stand up for further follow up. F. Education on F677 will be provided annually and upon new hire orientation.</p>	
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N	<p>Continued From page 15</p> <p>#46 used an _____ (_____) inserted in the _____ to drain _____ with risk for _____ and/or complications: _____</p> <p>The interventions included to observe, document, report to the physician signs and symptoms of _____ which included but were not limited to _____, change in behavior, change in eating patterns.</p> <p>Review of the progress notes revealed: 1. On _____ at 12:23 p.m., _____ Assistant (PTA) Staff S documented, "PTA facilitated functional transfer from bed to w/c (wheelchair) with max (maximum) assist. Patient reported not feeling well and hot. Checked room air and conditioner not working today. Nurse reports putting info in TELS (Electronic building management platform) . . . PTA instructed patient with BLE (_____ Lower Extremities) exercises with patient unable to follow commands. Returned to nursing and patient placed in bed. Nursing notified . . ."</p> <p>On _____ at 3:20 p.m., in an interview PTA Staff S said on _____ when she saw Resident #46, "Something with his transfers was more difficult. We got him sitting on the side of the bed, asked him to reach for the arm rest. He went from a moderate to _____ with transfers." She said, "The _____ don't know if there is anything going on medically with the resident, that's why they report their observation to nursing". The clinical record lacked documentation of a nursing evaluation.</p> <p>Review of the TELS log for _____ and _____ showed no documentation of request for repair (work order) for the air-conditioning unit in Resident #46's room. The log noted, "There are</p>	N 201	<p>4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>The Director of nursing/Designee will audit the resident appearance and random audits of the 24-hour report and POC for documentation weekly for four weeks then monthly for one quarter. The director of Nursing/Designee will submit a report of findings to the Quality Assessment, Assurance and Compliance Committee monthly for one quarter.</p> <p>1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>A. Resident #66 and resident #46 are no longer in the facility. B. PTA staff F, COTA staff Y, LPN staff W, _____ staff AA, CNA staff N, RN staff R, PTA staff Z, Evening supervisor RN staff B, RN staff X, LPN staff M was educated on F684.</p> <p>2: How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>A. _____ complete audit of resident with a change of condition and resident requesting to go to the hospital was completed and any abnormal findings were corrected.</p> <p>3: What measures will be put into place or</p>		

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N 201	Continued From page 17 (). Further , withheld. Nursing conferred on patient status and notified." On at 3:00 p.m., in an interview Certified Nursing Assistant Staff N said she remembered Resident #46. She said she reported to the nurse on that he was not acting right, he was not talking as much and did not eat as much. On at 11:43 a.m., in an interview the DON said she could not find documentation nursing obtained vital signs or assessed Resident #46 on when Staff AA reported to nursing that , was withheld due to patient status, at rest and unable to get clear readings on vitals. She said 911 should have probably been called then. The DON said, "When you have hounding you and telling you someone is not feeling well, you should assess the resident and call the doctor." On at 4:45 p.m., in an interview Occupational Staff AA said on when she went to see Resident #46 with the Physical , he looked pretty sick. Staff AA said, "I hope he's alright." She said she tried to get vital signs on different machines but could not get a reading, including the resident's saturation. They reported it to RN Staff R. 4. On at 5:17 p.m., PTA Staff Z documented in a progress note, "... Patient is observed to be () and isn't as mobile. , after multiple failed attempts to get (), HR (rate), () reported patient current condition to nursing and left patient in nursing care ..." On at approximately 2:00 p.m., in an interview the Administrator said he reviewed the	N 201	annually and upon new hire orientation. 4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The Director of Nursing /Designee will audit the follow up for any change of condition or request to go to the hospital to ensure timely assessment, documentation and notification is obtained and audit , communication for change in condition weekly for four weeks then monthly for one quarter. The Director of Nursing/Designee will submit a report of findings to the Quality Assessment, Assurance and Compliance Committee monthly for one quarter.	

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N 201	<p>Continued From page 18</p> <p>facility's surveillance video for _____ and it showed PTA Staff Z saw resident #46 at approximately 1:48 p.m.</p> <p>The clinical record lacked documentation of nursing evaluation _____ the concerns by PTA Staff Z .</p> <p>5. On _____ at 5:35 p.m., the Advanced Practice Registered Nurse (APRN) documented in a progress note Resident #46 was seen and evaluated today for ataxic gait and general management of his medical _____. The assessment and plan was to continue with physical/ _____, _____ for the ataxic gait; _____ and continue supportive care; _____, _____, continue to monitor _____ rate, _____, proton pump inhibitor and continue supportive care.</p> <p>On _____ at 12:10 p.m., in an interview the APRN said on _____ she saw Resident #46 before lunch. It was between 10:00 a.m., and 11:00 a.m., but wrote the progress note on at 5:30 p.m. She said the Certified Nursing Assistant was in the room providing care. Resident #46 was ok and talking with her. She did not notice any signs of distress. She did not look at the resident's _____ in the _____ as it was covered and the aide was providing care. She said the resident was alert and oriented and able to say if he wasn't feeling well. She said when she saw him that morning, he did not voice any concerns. He was his normal self.</p> <p>On _____ at approximately 2:00 p.m., in an interview the Administrator said he reviewed the facility's surveillance video for _____ and it showed the APRN saw resident #46 at _____</p>	N 201		

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N 201	<p>Continued From page 19</p> <p>approximately 11:45 a.m.</p> <p>6. On _____ at 6:45 p.m., Registered Nurse (RN) Staff B, Evening Supervisor documented in a progress note the resident noted to have increased _____ and _____ at _____ saturation was 88 and put onto _____ at 3 liters. _____ low and call to physician with new orders noted for updraft treatment (_____) to deliver medication to the (_____) and give one dose of (_____) (_____). Updraft treatment and _____ given per order.</p> <p>The note did not specify a _____ reading.</p> <p>On _____ at 10:10 a.m., in an interview Evening Supervisor RN Staff B said on _____ RN Staff R called her to come and evaluate Resident #46. It was around 6:30 p.m. His _____ saturation was 70%. She put him on _____ and called the Practitioner on call. The APRN gave an order for the _____ and _____. She said to monitor him and if not better in an hour to send him to the hospital. She said she retrieved the _____ from the emergency drug kit and they administered it to the resident right away. A while later the nurse called again and said Resident #46 got better but then got worse. She went and assessed the resident. His nailbeds were blue. They called 911. RN Staff B said she could not find her handwritten notes with a timeline of the event.</p> <p>A review of the transaction print out of the emergency drug kit revealed the _____ was removed from the machine on _____ at 6:27 p.m.</p> <p>7. On _____ at 8:05 p.m., Evening Supervisor RN Staff B documented in a progress note the resident was noted with some improvement</p>	N 201		

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N 201	<p>Continued From page 20</p> <p>earlier after updraft treatment and injection. She went to see the resident again and he had declined again with lower <u> </u> level. Vital signs were unstable and <u> </u> level decreased and the resident was on a non-rebreather (<u> </u> mask) at this time. The resident was sent to the Emergency Room via 911.</p> <p>On <u> </u> at 5:00 p.m., in an interview RN Staff R said on <u> </u> she was assigned to Resident #46 when he was sent to the hospital. She said she spent a lot of time with the resident that day, checked his <u> </u> saturation but did not document her assessments. She said, "I am sorry. I am still new here." RN Staff R said she thought RN Staff B the Evening Supervisor would document everything.</p> <p>Review of the hospital record for <u> </u> revealed Resident #46 presented to the emergency department via ambulance due to concerns of <u> </u>, distress. Emergency Medical Services report the patient was <u> </u> (low <u> </u>) on scene. They felt as though he was <u> </u>. They gave him fluids and transported him to the hospital. The patient is unresponsive and in <u> </u>, distress. Patient with agonal <u> </u> on arrival (gasping, labored breathing). Resident #46 was intubated and transferred to the <u> </u> for further management.</p> <p>The admitting diagnosis was <u> </u>, (life threatening complication of an <u> </u>).</p>	N 201		
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N 201	<p>Continued From page 21</p> <p>8. Review of the clinical record for Resident #66 revealed an admission date of _____ Diagnoses included rapid wasting, _____ and _____ failure.</p> <p>Review of the admission and discharge log revealed: On _____, Resident #66 was transferred to the hospital. Diagnoses listed on the hospital 3008 form included _____ and _____ On _____, Resident #66 was transferred to the hospital. Diagnoses upon return included _____ (_____ of the _____) and rapid _____.</p> <p>Review of the _____ rate log revealed: On _____ at 2:55 p.m., the resident's _____</p> <p>On _____ at 11:51 a.m., the resident's _____, new onset and irregular.</p> <p>Review of the nursing progress note revealed on _____ at 6:50 a.m., Registered Nurse (RN) Staff X documented, "Resident called nurse for _____, medication, and nurse gave her the _____ relief medication. The resident asked for ice water, which the nurse gave to her as well. However, the resident kept pouring the water in her basin and said that she needed more water. I gave her ice chips instead because she kept pouring the water in her basin. For that reason, she said that she wanted to go to the hospital because they would treat her better there, and she asked the nurse to have the supervisor to come into the room. The nurse went and told the supervisor about the _____</p>	N 201		

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N 201	<p>Continued From page 22</p> <p>resident's request."</p> <p>Review of the nursing progress notes and assessments from _____ at 11:00 p.m. through _____ at 6:50 a.m., failed to reveal documentation RN Staff X assessed Resident #66 when she requested to go to the hospital.</p> <p>On _____ at 11:48 a.m., a nursing progress note revealed the practitioner was at the facility, saw Resident #66 and issued an order for the resident to be transferred to the hospital.</p> <p>Review of the practitioner's late entry progress note dated _____ revealed "Attempt at obtaining an (_____) line were unsuccessful due to _____ and _____ due to multiple _____ episodes. Resident is not medically stable and requires hospitalization."</p> <p>On _____ at 11:44 a.m., in an interview Resident #66 said the incident on _____ really bothered her. She said on _____ she had been sick all day with _____ and _____.</p> <p>On _____ at 2:30 a.m., after _____ all day and _____ several cups of water, she told Registered Nurse (RN) Staff X she wanted to go to the hospital.</p> <p>Resident #66 said RN Staff X said he could not call the doctor at 2:30 in the morning. She asked to see the supervisor but the supervisor never came.</p> <p>Later on the morning of _____, she told Unit Manager LPN Staff M she wanted to go to the hospital. Staff M told her the practitioner would be at the facility in 30 minutes to see her. She said LPN Staff M took her _____ and it was _____.</p> <p>On _____ at 1:43 p.m., in an interview the Risk</p>	N 201		
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N 201	<p>Continued From page 23</p> <p>Manager said she was not aware of the incident involving Resident #66 on _____ and _____ until today.</p> <p>She interviewed the resident and RN Staff X. Staff X told her Resident #66 requested to go to the hospital, but he did not contact the provider and did not transfer the resident to the hospital. The risk manager said RN Staff X was suspended pending the outcome of the investigation.</p> <p>The risk manager said RN Staff X that could have initiated the hospital transfer without a doctor's order. It is similar to a resident calling 911 for themselves if they were at home.</p> <p>Review of the facility's investigation initiated on _____ revealed Resident #66 signed a statement noting, "On the day I went to the hospital, around 2:30 a.m., I told (Staff X) I had _____ and wanted to go to the hospital. He gave me a _____ pill and it didn't stay down. I was told the doctor said stay and will see me in the morning. Around 10:30 - 11:00 a.m., a provider came to see me. She said if they couldn't start an _____ line () they would send me to the hospital. They couldn't get the _____ in, so I went to the hospital. In the ambulance they couldn't start an _____. I went to (Hospital name). I didn't tell anyone except my husband, and he was going to call the state."</p> <p>Review of RN Staff X's _____-written witness statement dated _____ revealed, "Resident was asking for water. I gave the resident a cup of water. After a couple minutes, a CNA was passing by the resident's room, and I heard the resident ask the CNA for water. I went into the resident's room and told her that I just gave her water. However, the resident said she threw it up and wanted another cup. I went and got her</p>	N 201			

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N 201	<p>Continued From page 24</p> <p>another cup of water, but that time I did not leave the room fully. I was hiding myself behind the curtain to see what the resident was doing and I saw the resident poured the cup of water in her basin. I told her, "Okay, I see what's going on with the water. I will give you ice chips instead." I went and gave her a cup of ice chips. The resident kept saying that she wanted to go to the hospital. When I asked her to give me a reason or something to say to the provider, she said that they will treat her better at the hospital because they will give her water there."</p> <p>On _____ at 4:24 p.m., in an interview Unit Manager Staff M said on _____ in the morning, Resident #66 refused _____. She went to see the resident in her room. Resident #66 was pale, sweating, and had an abnormally fast heartbeat at _____. (normal _____ rate is between 60 and _____). She said she recognized it as an emergency and called the doctor. The doctor ordered _____ (used for _____ and _____). Resident #66 refused the _____. She wanted to go to the hospital. The provider came to the facility and gave the order to send Resident #66 to the hospital.</p> <p>On _____ at 4:56 p.m., Resident #66 said RN Staff X the night shift nurse told her she would be kicked off the physician's service for going to the hospital too many times. She said it was scary at the facility, and she wanted to go home.</p> <p>On _____ at 1:24 p.m., in an interview Licensed Practical Nurse (LPN) Staff M said she inaccurately documented the vital signs and transfer date on the _____ hospital transfer form. She obtained the vital signs from _____, and those vital signs did not portray an accurate description of the resident at the transfer time.</p>	N 201		

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N 201	<p>Continued From page 25</p> <p>Staff M said there was no nursing assessment for the night shift when the resident initially requested hospital transfer. She said if the nurse was not going to call the doctor, he should have assessed the resident and/or sent the resident to the hospital.</p> <p>On at 3:49 p.m., the Director of Nursing (DON) said she would expect RN Staff X to document a nursing assessment during the night shift when the resident requested transfer to the hospital, but there was nothing in the progress notes, vital signs log or evaluations. The DON said if Staff X was unwilling to contact the physician and the nurse did not transfer the resident, the nurse should have documented that everything was okay. The DON said Staff X was suspended pending the investigation outcome.</p> <p>Review of the Hospital Progress note dated at 6:40 a.m., noted Resident #66 presented to the hospital with and going on for two days. The resident was admitted for further evaluation. A panel was positive for (). Her went out and was unable to find an per Emergency Medical Personnel... Central line was placed on . Was continued on for rate control, continued hydration. Patient still with reasonable and . . . Central line was placed yesterday due to lack of access.</p> <p>Review of the progress note Revealed Resident #66 returned to the facility on , 10 days after she was transferred to the hospital.</p> <p>9. On at 10:16 a.m., in an interview</p>	N 201		
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N 201	<p>Continued From page 26</p> <p>Resident #271 said he was not a complainer, but he had not had a shower since he was admitted and would love to feel warm water on his skin. He said he would appreciate a beard trim and have his shaved. He said no one has offered a shower or a shave. He said he has a hard time standing but can sit up in the wheelchair.</p> <p>On at 3:50 p.m., in an interview Resident #271 said he still has not been showered or shaved. The beard was long and covered most of his .</p> <p>On at 4:12 p.m., in an interview LPN Staff W said the rule was showers twice a week by the CNA. She said if the resident refuses, the CNA should report to the nurse, and she will check with the patient and document in the progress notes the refusal. She said she is taking care of Resident #271 and was not aware of any recent refusals.</p> <p>On at 4:17 p.m., in an interview Unit Manager LPN Staff M said Resident #271's showers were scheduled on Wednesdays and Saturdays on the evening shift. The residents get their beards shaved or trimmed on shower days and by special request.</p> <p>On at 4:37 p.m., in an interview the Minimum Data Set (MDS) Coordinator said Resident #271 was alert and oriented. She could not recall the resident refusing showers. She said he got a partial bed bath on , partial bed bath on , and a bed bath on . She said there were no behaviors listed for Resident 271.</p> <p>On at 4:48 p.m., CNA Staff Q said she</p>	N 201		
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N 201	<p>Continued From page 27</p> <p>takes care of the resident on the evening shift, but showers don't on her shift. She said Resident #271 never refuses care but she's never shaved him.</p> <p>On at 5:32 p.m., Staff Q said she shaved the resident but did not ask him if he wanted a shower.</p> <p>On at 10:58 a.m., in an interview CNA Staff O said she took care of Resident #271 during day shift and gave him a good bed bath. She said he has all those tubes and things in the abdomen, and she did not think it was a good idea to give a shower. She said no one ever told her the resident could not get a shower; she just figured it was not a good idea. She said she did not shave or shower him.</p> <p>Review of the care plans for ADLs included instructions for "Shower Device: Shower Bed; shower per schedule and as needed; see shower schedule for details, initiated on ."</p> <p>Resident 271's care plan did not include refusals of care, including showers.</p> <p>Review of the progress notes failed to show documentation Resident 271 refused showers or care.</p> <p>Review of the CNAs ADL documentation record for and revealed Resident #271's showers were scheduled on Wednesdays and Saturdays on the 3:00 p.m., to 11:00 p.m. shift. On the resident received a partial bath at 10:55 p.m. On the resident was given a bed bath at 10:57 p.m. There were no additional entries on the</p>	N 201		
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N 201	<p>Continued From page 29</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 documented Resident #24 required substantial to _____ with showers, partial to _____ with toileting and _____ supervision with personal hygiene. The MDS noted Resident #24's _____ skills for daily decision making were intact.</p> <p>The care plan initiated _____ identified Resident #24 had an ADL Self Care Performance and was _____ of _____ and _____. The goal specified "Will have ADL needs _____ and met by staff." The interventions included Shower per schedule & as needed; see shower schedule for details.</p> <p>On _____ at 9:28 a.m., Resident #24 was observed in her bed. Her hair was greasy and matted, her _____ extended approximately _____ inch in length with a brown and black substance under the nails. The resident had a pungent body odor.</p> <p>On _____ at 9:51 a.m., Resident #24 was observed in bed, her hair was greasy, her _____ remained long with a brown and black substance under the nails. Resident #24 was lying on her right side in a _____ position. The resident was wearing a shirt and an adult brief. The resident kept repeating, "I need a diaper change."</p> <p>On _____ at 9:59 a.m., Registered Nurse (RN) Staff J said "Ok thank you." when informed of the resident's request for an _____ brief change.</p>	N 201		
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N 201	<p>Continued From page 30</p> <p>On at 10:17 a.m., at 10:41 a.m., Resident #24 was observed in bed in the same position. The call light was on the floor. Resident #24 kept asking for an brief change.</p> <p>11. Review of the clinical record revealed Resident #69 had a readmission date of with diagnoses including need for assistance with personal care, and</p> <p>The Quarterly MDS dated documented Resident #69 had limitations in range of motion on both sides of the upper and lower extremities. The MDS documented the resident was dependent on staff for showers and required supervision for personal hygiene. The MDS noted Resident #24's skills for daily decision making were intact.</p> <p>The care plan revised indicated the Resident has an ADL Self Care Performance related to</p> <p>The goal for Resident #69 specified "Will minimize risk of decline in ADL self performance."</p> <p>On at 12:11 p.m., Resident #69 was observed in bed. the left extended approximately 1/2 in length with brown substances under the nails. In an interview during the observation, the resident said he couldn't cut his own nails, and no one had done it for him.</p> <p>On at 11:06 a.m., and at 10:44 a.m., Resident #69 was observed in bed. His remained approximately in in length with a brown substance under the nails.</p> <p>On at 10:45 a.m., in an interview</p>	N 201		
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N 201	<p>Continued From page 31</p> <p>Resident #69 said, "Yes the nails are long but they are not cutting into the skin yet. I will have someone cut them because I can't do it myself."</p> <p>On _____ at 12:20 p.m., in an interview the Assisted Director of Nursing (ADON) said the expectation if a resident refused care, the CNA was to notify the nurse. The nurse will speak with the resident and document the reason of the refusal of care.</p> <p>12. Review of the clinical record revealed Resident #72 had a readmission date of _____ with diagnoses including _____, _____, and _____, _____, and _____.</p> <p>The Quarterly MDS dated _____ documented Resident #72 required substantial to _____ with showers/bathing and _____ partial/_____ with personal hygiene.</p> <p>The MDS noted Resident #72's _____ skills for daily decision making were severely _____.</p> <p>The care plan initiated on _____ documented "The Resident has an ADL Self Care Performance _____ Resident re-admitted under hospice services for end of life."</p> <p>The goal for Resident #72 specified "Will have ADL Needs _____ and met by staff through next review Date Initiated: _____ Revision on: _____</p> <p>The interventions included the resident was totally dependent on staff for ADL's.</p> <p>On _____ at 9:41 a.m., Resident #72 was observed in bed. The resident looked unkempt with approximately seven days of _____ hair growth. His _____ extended approximately _____ of an inch with a brown substance under the</p>	N 201		

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N 201	<p>Continued From page 32</p> <p>nails.</p> <p>On at 2:09 p.m., in an interview CNA Staff F said Resident #72 required total care and assistance of two for transfers. CNA Staff F said the resident was and not able to do anything for himself.</p> <p>On at 10:04 a.m., Resident #72 was observed in bed. He had approximately eight days of hair growth. His remained with a brown substance under the nails.</p> <p>Review of the CNA documentation for revealed Resident #72 was scheduled for showers on Tuesdays and Fridays on the 7:00 a.m. to 3:00 p.m. shift. There was no documentation the scheduled showers were provided on . On Resident #72 refused his shower. On and 21/31/25 there was no documentation the resident refused a shower, he received a bed bath.</p> <p>Review of the CNA documentation showed on and the resident refused bathing.</p> <p>13. Review of the clinical record revealed Resident #83 was a male with a readmission date of . Diagnoses included and following major wasting, and .</p> <p>Resident #83 received hospice services.</p> <p>Review of the significant change MDS dated revealed Resident #83 had a limitation in range of motion (ROM) on both sides of the lower</p>	N 201		

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N 201	<p>Continued From page 33</p> <p>extremities and one side of the upper extremities. The MDS noted Resident #83's skills for daily decision making were intact.</p> <p>The care plan initiated on identified Resident #83 was dependent on staff for ADL's.</p> <p>On at 11:55 a.m., Resident #83 was observed in bed wearing an adult brief and a hospital gown. His hair was matted, greasy and extended to his . The resident's extended approximately 1/2 inch in length with a brown substance under the nails.</p> <p>On at 1:02 p.m., in an interview CNA staff F said "the resident will feed himself but that is all he can do." She said the resident was dependent for his care and he receives a shave when needed.</p> <p>On at 9:52 a.m., Resident #83's call light was on. In an interview, the resident said he needed water because he had a pill stuck in his . He said he was wet and needed to be changed. RN Staff J was informed Resident #83 said he needed water because he had a pill stuck in his and also needed to be changed. RN Staff J replied, "Ok, thank you".</p> <p>On at 10:08 a.m., Resident #83's call light was on. Resident #83 asked for water and said he wet and needed to be changed. He was unkempt with long greasy, matted hair, approximately one inch of hair growth. His had a brown substance under the nails.</p> <p>On at 3:05 p.m., in an interview CNA Staff G said Resident #83 refuses showers. He will resist you and says to leave him alone.</p>	N 201		
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N 201	<p>Continued From page 34</p> <p>When he refuses she tells the nurse.</p> <p>On _____ at 3:00 p.m., in an interview the Administrator said the expectation is for the staff to check oral care, shaving and nail care daily and provide it if needed. For _____ care they check the residents every two hours and as needed. The Administrator said staff shower residents according to the shower list and if they refuse, the staff are to notify the nurse.</p> <p>On _____ at 3:16 p.m., in an interview Unit Manager RN Staff E said Resident #83 was a hospice patient and refuses care. RN Staff E said the expectation is for the residents to be cleaned daily. She said she made an _____ with the beautician for Resident #83 for a hair cut and a shave this week. RN Staff E said "if a resident is refusing care it should be documented in the progress note, that is, if the CNA lets you know."</p> <p>On _____ at 8:55 a.m., in an interview CNA Staff C said "The shower schedule was at the desk, and we follow it. We shave and cut or clean nails when the resident needs it. If a resident refuses we notify the nurse.</p> <p>On _____ at 9:21 a.m., in an interview CNA Staff A said, shaving for males is done weekly at the beauty shop and nail care is done by the nurse, we are not allowed to cut _____. For showers, there is a list and we follow the shower schedule. CNA Staff A said if a resident refuses care then we let the nurse know.</p> <p>Review of the CNA documentation for _____ documented showers were scheduled every Tuesday and Friday on the _____ shift. The documentation showed on _____ and _____ Resident _____</p>	N 201		
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N	Continued From page 35 #83 received bed baths only. There was no documentation the resident refused care and showers. Class III	N 201		
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F 000	<p>INITIAL COMMENTS</p> <p>An unannounced off hour recertification survey with complaints #2024016400, #2025001412, #2025001390, #2023015487, #2024007902, #2024013759, #2024014571, #2023016864, 2025000472 and #2024008366 was conducted on _____ through _____ at Rehab & Healthcare Center of Cape Coral, a skilled nursing facility in Cape Coral, Florida.</p> <p>Complaint #2024016400 was unsubstantiated. Complaint #2025001412 was substantiated with citation at F684. Complaint #2025001390 was substantiated with citation at F684. Complaint #2023015487 was unsubstantiated. Complaint #2024007902 was unsubstantiated. Complaint #2024013759 was substantiated without citation. Complaint #2024014571 was unsubstantiated. Complaint #2023016864 was unsubstantiated. Complaint #2025000472 was unsubstantiated. Complaint #2024008366 was substantiated without citation.</p> <p>Rehab & Healthcare Center of Cape Coral is not in compliance with the Code of Federal Regulations (CFR) 42, Part 483, Subparts B-F, Requirements for Long-Term Care Facilities.</p> <p>The following is description of the noncompliance.</p>	F 000			
F 558 SS=D	<p>Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)</p> <p>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would</p>	F 558			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

/2025

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.

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F 558	<p>Continued From page 1</p> <p>endanger the health or safety of the resident or other residents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to accommodate smoking needs and preferences for 1 (Resident #470) of 2 reviewed for smoking, who required a specialized chair for transport to the smoking area, which was not available, that prevented the resident from smoking. This failure caused unnecessary _____, to the resident, who was a long-term smoker, who required assistance from the facility staff and specialized equipment to get to the designated smoking area.</p> <p>The findings included:</p> <p>Review of the facility policy for Resident Rights Effective _____ noted the facility strives to assure that each resident has a dignified existence and self-determination (Self-determination is a set of concepts and values that people with _____ should have the freedom and support to decide how they live and participate in the community)</p> <p>Review of the facility policy for Smoking/Tobacco Use Effective _____, the facility permits smoking and use of tobacco products in accordance with state-specific regulations . . . The objective of this policy and procedure is not to discourage or restrict one's smoking privileges, but to promote safety for residents, visitors, and employees. Page 2 - The Nursing Home Administrator (NHA) and facility Interdisciplinary Team (IDT) will determine the needs of the residents and establish smoking times . . . Page 3 - Provide the smoker with assistance and safety</p>	F 558	<p>1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>A. Resident #470 was assessed, and appropriate chair was provided, smoking assessment completed, B. Education was given to CNA O, SSD, LPN W, Admission Director, Unit manager LPN M. C. Director of Rehab is no longer at the facility.</p> <p>2: How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>A. Audit of all current resident who wants to smoke and who currently smokes was completed to ensure they are able to smoke and abnormal findings were corrected.</p> <p>3: What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;</p> <p>A. Education to staff regarding the components of F558. B. Nursing management is to review new admission the following business day</p>		

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F 558	<p>Continued From page 2</p> <p>devices indicated. Page 4 - Stop Smoking Assistance: Obtain an order from the physician for the use of specific stop smoking assistance techniques and self-help programs (i.e., dermal patches, and oral medications).</p> <p>Review of the Resident Handbook, page 20: Smoking is not permitted inside the facility. Smoking is permitted in the facility's designated smoking areas but only at posted times and under staff supervision.</p> <p>The Admission Data Collection and Baseline Care Plan revealed Resident #470 was transferred from another skilled nursing facility and arrived at the facility on _____ at 5:25 p.m. Diagnoses included right _____ () with left side affected _____, and _____.</p> <p>Resident 470 was oriented to person, place, time and current year and was at the facility for long term care. The Data Collection and Baseline Care Plan revealed Resident #470 smoked and used cigarettes. Resident #470 was not interested in a smoking cessation program.</p> <p>Resident #470's care plan initiated _____ revealed the resident was a current smoker. Interventions included informing the resident of the smoking policy, informing of designated smoking areas and time, and smoking materials kept by facility staff.</p> <p>Resident #470's smoking evaluation not completed until _____, six days after admission.</p> <p>On _____ 11:03 a.m., observation of Resident #470 in the bed in the resident's room revealed left sided tightness of the left _____ and _____.</p>	F 558	<p>to ensure resident who wants to smoke has accommodation to do so.</p> <p>C. Nursing managers will review 24 hour report for any documentation or changes to resident smoking preferences.</p> <p>D. Education for smoking accommodation and F558 will be provided annually and upon new hire orientation.</p> <p>4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>The Director of nursing/Designee will audit the 24 hour report and review new smoking residents for accommodation and assessment weekly for four weeks then monthly for one quarter. The Nursing Home Administrator/Director of nursing /Designee will submit a report of findings to the Quality Assessment, Assurance and Compliance Committee monthly for one quarter.</p>		

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F 558	<p>Continued From page 3</p> <p>The left was bent, and the left was drawn to the resident's and tightly closed. The resident's left was bent and drawn up to the area. The resident said she was admitted on and her power scooter did not arrive with her. The resident said because of her (a condition of shortening and hardening of , or other tissue, often leading to deformity and rigidity of joints,) she requires a specialized chair to be transported to the smoking area. She said she told the nurse and several other staff. They told her the chair was coming. She said the chair has not arrived and she has not been able to leave the bedroom. The resident said someone came in to complete the smoking evaluation, but they left and did not come . Resident #470 said she was going through withdrawal, was miserable. The resident began to cry.</p> <p>On at 11:15 a.m., in an interview Certified Nursing Assistant (CNA) Staff O said the resident requires a "high chair or something." She said she thinks they are aware of the smoking situation.</p> <p>On at 11:20 a.m., in an interview the Social Services Director (SSD) said she met with Resident #470 and was not aware of any special issues with the resident. She checked on the resident when she arrived at the facility. She asked the resident if she needed anything, and the resident told her no.</p> <p>On at 12:41 p.m., in an interview the SSD said she spoke to the resident and went over her goals and the reason she was here at the facility. She said she did not hear of any problems the resident was having.</p>	F 558			

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F 558	<p>Continued From page 4</p> <p>On at 4:10 p.m., in an interview Licensed Practical Nurse (LPN) Staff W said Resident #470 needed a power chair but it was left at the other facility. Staff W said the resident was unable to smoke and was just lying in bed because the facility did not have a chair for her. She said Resident #470 needed a special high- chair or "Broda" chair but the facility only had one and it was currently being used by another resident.</p> <p>On at 5:06 p.m., in an interview the Rehabilitation Director said they were performing , sessions in Resident #470's bedroom because the facility did not have the necessary equipment to transport her out of the bedroom. The , Director said the resident's have been there for years and she needed a special chair to accommodate her transport out of the bedroom. She said Unit Manager LPN Staff M was aware of it.</p> <p>On at 5:35 p.m., in an interview Unit Manager Staff M said they were trying to find an appropriate wheelchair for Resident #470 so she could get out of bed. She said she met with the resident on . The resident told her she wanted to smoke. Staff M said they did not complete a smoking evaluation since the resident could not leave her room to go smoke. She said the admissions coordinator called the previous facility to arrange for pickup or delivery of the resident's specialized scooter. She said the provider offered the patch, but the resident declined. Staff M said she did not know the provider's name.</p> <p>On at 5:57 p.m., in an interview the NHA</p>	F 558		

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F 558	Continued From page 5 said he was not aware Resident #470 needed a specialized chair to get out of bed. He said he would obtain a chair from another facility. On _____ at 9:11 a.m., in an interview the Admissions Director said she reviews the medical record before admission and meets the resident if possible. She said she was not aware the resident required a specialized chair. She said she accepted the resident for admission because she thought they had everything in place to accommodate her needs, but they did not. On _____ at 12:01 p.m., in an interview Resident 470 said she was not offered the _____ patch in the beginning when it was determined there was no chair for her to be transported outside to smoke. She said at that time she was very upset and _____ and probably would have accepted the _____ patch. She was not aware that it would take as long as it did (6 days) to acquire a special chair for her to use.	F 558		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safety. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can	F 584		

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F 584	Continued From page 6 receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after , must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to provide a safe, sanitary, and homelike environment as evidenced by dry wall damage in resident's rooms. Failure to identify and complete needed repairs could cause safety and sanitary hazards to residents on Unit 1, which had damage in 8 of 31 rooms. The findings included:	F 584	1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A. # , 18,21,35,37,39 findings were fixed and addressed. 2: How you will identify other residents		

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F 584	<p>Continued From page 7</p> <p>On during the initial tour of Unit 1's resident rooms: observation revealed the drywall and chair-rails behind resident's beds in , 18, 21, 35, 37 and 39 were damaged and chair-rails were on the floor. Holes were observed in the dry walls next to the bathroom door in , 21, and 39.</p> <p>On at 10:23 a.m., in an interview with Resident #55, he said the chair rail molding behind bed A and B had been damaged and broken for the past several months. He said he told the staff about the drywall damage in the room, but nothing had been done to repair the drywall damage and the missing chair rails behind the beds in months.</p> <p>The review of the Maintenance Director's Job Description stated they were responsible for the overall maintenance of the facility and provided directions for all activities related to plan operations. Job duties and responsibilities include but were not limited to minor repairs and supervision of the day-to-day repair, improvement and preventive maintenance of the facility to ensure that machines continued to run smoothly, building systems operated effectively, or the physical condition of the facility did not deteriorate.</p> <p>Review of the "Physical Environment" policy and procedure, effective , stated a safe, clean, comfortable, and home-life environment would be provided for each resident.</p> <p>Review of the facility policy and procedure titled, "Work Orders", with an effective date of , the policy noted "work orders outside of the service reports and equipment records are a</p>	F 584	<p>having potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>A. A Complete audit of all room was conducted, and findings were noted and put on a schedule to be completed.</p> <p>3: What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;</p> <p>A. Staff was educated on the TELS system. B. Facility Maintenance department and the staff was educated on the components of F584. C. The Maintenance director will check the TELS system daily. D. During morning meeting any environmental concerns will be relayed. Department heads concierge rounds were added to report any environmental concerns. E. Education on the components of F584 will be provided annually and upon new hires.</p> <p>4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>The Nursing Home Administrator/Designee will audit the Tels system for timely resolution of work orders</p>	

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F 584	<p>Continued From page 8</p> <p>mandatory means of maintenance communication. ... Work orders should be used and completed with priority classification noted by the department or the Administrator."</p> <p>On at 11:44 a.m., in an interview with the Maintenance Director, he said he was hired as the Maintenance Director 6 days ago. He was told the facility did not have a Maintenance Director for the past several months. He said he was told the Regional Maintenance Director had overseen the continuous maintenance of the facility during the time the facility did not have a full time Maintenance Director.</p> <p>On at 12:00 p.m., during the tour of residents' rooms on Unit 1, the Maintenance Director confirmed the drywall and chair rails behind resident's beds in , 18, 21, 35, 37 and 39 were damaged and chair-rails were on the floor. He also confirmed there was dry wall damage and holes in the drywall next to the bathroom door in , 21, and 39.</p> <p>The Maintenance Director said after reviewing the Work Orders in their maintenance computer program, the damage he observed in , 18, 21, 35, 37 and 39 were not documented on a Work Order in their computer system as required. He said he was not told of the resident room damage identified during the tour.</p> <p>On at 12:30 p.m., during an interview with the Administrator, he confirmed the facility did not have a full-time Maintenance Director for several months. He confirmed the facility had hired a new Maintenance Director several days ago. He confirmed part of the Maintenance Director responsibilities was to ensure minor repairs and</p>	F 584	<p>along with random room rounds to ensure adequate safe environment is maintained weekly for four weeks then monthly for one quarter. The Nursing Home Administrator/Designee will submit a report of findings to the Quality Assessment, Assurance and Compliance Committee monthly for one quarter.</p>	

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F 584	Continued From page 9 the supervision of the day-to-day maintenance so the building could continue to run smoothly, building systems would operate efficiently, and the physical condition of the facility did not deteriorate as noted by the drywall damage in , 18, 21, 35, 37 and 39.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and , needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and , well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. () In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		

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F 656	<p>Continued From page 10</p> <p>desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and -informed. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, review of the clinical record, and resident and staff interviews, the facility failed to develop a care plan that described the resident's medical, physical, mental and . . . needs and preferences and how the facility will assist in meeting these needs and preferences for 1 (Resident #83) of 28 care plans reviewed. The failure to complete an accurate and individualized care plan has the potential to impact the resident's quality of life and quality of care.</p> <p>The findings included:</p> <p>Review of the clinical record revealed Resident #83 was a . . . male with a readmission date of . . . Diagnoses for the resident included . . . (. . . of one side of the body) and . . . (. . . of one side of the body) following . . . , and . . . , major . . . , and . . . wasting.</p>	F 656	<p>1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>A. #83 care plan was updated to reflect resident current status.</p> <p>B. Education for F656 provided to RN staff B, care plan coordinator Staff L and Care plan coordinator RN staff H.</p> <p>C. Director of Rehab is no longer at the facility.</p> <p>2: How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>A. Complete Audit of resident with contractors and limited ROM was conducted and any abnormal findings</p>		

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F 656	<p>Continued From page 11</p> <p>The record indicated Resident #83 was on hospice services beginning .</p> <p>A significant change Minimum Data Set (MDS) assessment dated _____ documented the resident had a limitation in range of motion (ROM) on both sides of the lower extremities and one side of the upper extremity. The MDS noted Resident #83's _____ skills for daily decision making were intact.</p> <p>The care plan initiated on _____ identified Resident #83 was dependent on staff for activities of daily living (ADLs).</p> <p>On _____ at 11:55 a.m., Resident #83 was observed in bed in a _____ position on his left side. He was noted to hold his left _____ in a tight fist and his _____ were bent with his heels toward his _____. There were no _____ devices or pillows in place to assist the resident with positioning. The resident said he was not able to move his left _____ or straighten his _____.</p> <p>During observations on _____ at 10:01 a.m., and _____ at 2:14 p.m., Resident #83 was in bed with his left _____ in a fist position and his _____ and _____ drawn up toward his _____ and his heels toward his _____. He had no _____ or positioning devices in place including pillows. Resident #83 said he could move his right _____ when encouraged he was not able to move his _____.</p> <p>On _____ at 4:35 p.m., in an interview the Director of Rehab said Resident #83 was now on hospice services but had been on case load on and off through the years. The Director of Rehab said _____ had tried all different types of _____.</p>	F 656	<p>were corrected.</p> <p>3: What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;</p> <p>A. License staff was educated on the components of F656. B. Nursing management will review 24 hour report and follow up on any new limited ROM or contractors and update care plan as needed. C. All New residents will be reviewed and reassessed if needed and review by the IDT team the following business day for any limited ROM or contractors to ensure appropriate interventions are in place. D. Education on F656 will be provided annually and upon new hire orientation.</p> <p>4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>The Director of Care Plans /Designee will audit new residents' _____ chart and any change of condition charts to ensure that care plans are appropriate to reflect the status of the resident with emphasis on contractor or limited ROM weekly for four weeks then monthly for one quarter. The Director of Care Plans/Designee will submit a report of findings to the Quality Assessment, Assurance and Compliance Committee monthly for one quarter.</p>		

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F 656	<p>Continued From page 12</p> <p>and positioning devices for his . . . The resident said would say he was going to wear it and then would refuse.</p> <p>On . . . at 4:45 p.m., in an interview Registered Nurse (RN) Staff B said she looked in the residents record and found no information regarding the use of . . . pillows etc., for Resident #83's . . . RN Staff B said, "I have not been able to find anything that he refused care or . . . He does refuse care all the time. But I did not find any documentation. I know, if it wasn't documented it wasn't done."</p> <p>On . . . at 9:08 a.m., in an interview the Director of Nursing (DON) said she was unaware of the resident's . . . and the lack of documentation or services for the management of resident #83's</p> <p>On . . . at 9:25 a.m., in an interview Care Plan Coordinator Staff I confirmed there was no care plan to address the lower . . . for Resident #83. The Care Plan Coordinator said the loss of ROM in the left . . . was addressed but confirmed there were no interventions for the left . . . including ROM, . . . pillows. Staff I said the Resident #83 was on hospice services and did not receive . . . Staff I said, "We have Interdisciplinary team meetings weekly and there was no mention regarding the presence or care of the lower . . ."</p> <p>On . . . at 10:08 a.m., in an interview Care Plan Coordinator Staff I said Resident #83 received . . . on . . . after a return from the hospital and he was refusing it. She confirmed the . . . was dated for one day only and was actually an evaluation the resident</p>	F 656			

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F 656	Continued From page 13 refused. She confirmed there was no additional documentation of , , for Resident #83. On at 10:15 a.m., in an interview RN Care Plan Coordinator Staff H said she completed the Significant change MDS dated . . She said Resident #83 was not like that when she saw him for the significant change MDS. She said a limitation in ROM does not mean a . She observed the resident and he is . now. She confirmed the limited ROM or was not identified in the care plan. On at 10:43 a.m., in an interview the DON said the facility did not have a restorative program and there was no documentation the direct care staff was educated to provide ROM, or to address the resident's	F 656		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, review of job description, clinical record review, staff and resident interviews, the facility failed to provide the necessary care and services to maintain personal hygiene for 5 (Resident #24, #69, #72, #83 and #271) of 6 residents reviewed for activities of daily living (ADL's). The findings included:	F 677	1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A. #24, grooming was completed, #69, nails were cut, #271, was shaved and showered, #72, was shaved and cut and clean, #83 was shaved, and were cut and	

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F 677	<p>Continued From page 14</p> <p>The facility "Job Description, Position: CNA's" documented "The CNA is responsible for assisting with direct residents/patients care. . . Ensures that each resident's personal care needs are being met in accordance with the resident's/patient' wishes. . .Bathes residents (recognizing that some residents may physically resist bathing). . . Gives oral hygiene. . . Shaves patients. . . Provides nail and hair care. . ."</p> <p>1. Review of the clinical record revealed Resident #24 had a readmission date of _____ with diagnoses including _____, _____, and _____.</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 _____ documented Resident #24 required substantial to _____ with showers, partial to _____ with toileting and supervision with personal hygiene.</p> <p>The MDS noted Resident #24's _____ skills for daily decision making were intact.</p> <p>The care plan initiated _____ identified Resident #24 had an ADL Self Care Performance _____ and was _____ of _____ and _____. The goal specified "Will have ADL needs _____ and met by staff." The interventions included Shower per schedule & as needed; see shower schedule for details.</p> <p>On _____ at 9:28 a.m., Resident #24 was observed in her bed. Her hair was greasy and matted, her _____ extended approximately _____ inch in length with a brown and black substance under the nails. The resident had a</p>	F 677	<p>cleaned.</p> <p>B. Rn staff J, CNA staff G, Unit Manager staff E, CNA staff C, CAN staff A, ADON, LPN staff W, Unit manager LPN staff M CNA staff Q and CNA staff O were all educated on F677</p> <p>2: How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>A. A Complete audit were done on all resident for proper grooming and adt care and any abnormal findings were corrected.</p> <p>3: What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;</p> <p>A. License staff was educated on the components of F677.</p> <p>B. Nursing managers will review POC documentation the following business day for any refusal and completion of ADL care and follow up as needed.</p> <p>C. Nursing managers will review 24-hour report for any refusal or care and follow up as needed.</p> <p>D. License staff was educated on documentation of care provided and refusal of care.</p> <p>E. Concierge rounds will include resident appearance, and any abnormal findings will be brought to morning stand up for further follow up.</p>		

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F 677	<p>Continued From page 15 pungent body odor.</p> <p>On at 9:51 a.m., Resident #24 was observed in bed, her hair was greasy, her remained long with a brown and black substance under the nails. Resident #24 was lying on her right side in a position. The resident was wearing a shirt and an adult brief. The resident kept repeating, "I need a diaper change."</p> <p>On at 9:59 a.m., Registered Nurse (RN) Staff J said "Ok thank you." when informed of the resident's request for an brief change.</p> <p>On at 10:17 a.m., at 10:41 a.m., Resident #24 was observed in bed in the same position. The call light was on the floor. Resident #24 kept asking for an brief change.</p> <p>2. Review of the clinical record revealed Resident #69 had a readmission date of with diagnoses including , , , need for assistance with personal care, and .</p> <p>The Quarterly MDS dated documented Resident #69 had limitations in range of motion on both sides of the upper and lower extremities. The MDS documented the resident was dependent on staff for showers and required supervision for personal hygiene. The MDS noted Resident #24's skills for daily decision making were intact.</p> <p>The care plan revised indicated the Resident has an ADL Self Care Performance related to .</p>	F 677	<p>F. Education on F677 will be provided annually and upon new hire orientation.</p> <p>4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>The Director of nursing/Designee will audit the resident appearance and random audits of the 24-hour report and POC for documentation weekly for four weeks then monthly for one quarter. The director of Nursing/Designee will submit a report of findings to the Quality Assessment, Assurance and Compliance Committee monthly for one quarter.</p>	

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F 677	<p>Continued From page 16</p> <p>The goal for Resident #69 specified "Will minimize risk of decline in ADL self performance."</p> <p>On at 12:11 p.m., Resident #69 was observed in bed. the left extended approximately 1/2 in length with brown substances under the nails. In an interview during the observation, the resident said he couldn't cut his own nails, and no one had done it for him.</p> <p>On at 11:06 a.m., and at 10:44 a.m., Resident #69 was observed in bed. His remained approximately in length with a brown substance under the nails.</p> <p>On at 10:45 a.m., in an interview Resident #69 said, "Yes the nails are long but they are not cutting into the skin yet. I will have someone cut them because I can't do it myself."</p> <p>On at 12:20 p.m., in an interview the Assisted Director of Nursing (ADON) said the expectation if a resident refused care, the CNA was to notify the nurse. The nurse will speak with the resident and document the reason of the refusal of care.</p> <p>3. Review of the clinical record revealed Resident #72 had a readmission date of with diagnoses including , , and , and</p> <p>The Quarterly MDS dated documented Resident #72 required substantial to with showers/bathing and partial/ with personal hygiene.</p> <p>The MDS noted Resident #72's skills for daily decision making were severely</p>	F 677		

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F 677	<p>Continued From page 17</p> <p>The care plan initiated on _____ documented "The Resident has an ADL Self Care Performance _____. Resident re-admitted under hospice services for end of life." The goal for Resident #72 specified "Will have ADL Needs _____ and met by staff through next review Date Initiated: _____. Revision on: _____." The interventions included the resident was totally dependent on staff for ADL's.</p> <p>On _____ at 9:41 a.m., Resident #72 was observed in bed. The resident looked unkempt with approximately seven days of _____ hair growth. His _____ extended approximately _____ of an inch with a brown substance under the nails.</p> <p>On _____ at 2:09 p.m., in an interview CNA Staff F said Resident #72 required total care and assistance of two for transfers. CNA Staff F said the resident was _____ and not able to do anything for himself.</p> <p>On _____ at 10:04 a.m., Resident #72 was observed in bed. He had approximately eight days of _____ hair growth. His _____ remained with a brown substance under the nails.</p> <p>Review of the CNA documentation for _____ revealed Resident #72 was scheduled for showers on Tuesdays and Fridays on the 7:00 a.m. to 3:00 p.m. shift. There was no documentation the scheduled showers were provided on _____. On _____ Resident #72 refused his shower. On _____ and 2/13/25 there was no documentation the resident refused</p>	F 677			

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F 677	<p>Continued From page 19</p> <p>was on. In an interview, the resident said he needed water because he had a pill stuck in his . He said he was wet and needed to be changed. RN Staff J was informed Resident #83 said he needed water because he had a pill stuck in his and also needed to be changed. RN Staff J replied, "Ok, thank you".</p> <p>On at 10:08 a.m., Resident #83's call light was on. Resident #83 asked for water and said he wet and needed to be changed. He was unkempt with long greasy, matted hair, approximately one inch of hair growth. His had a brown substance under the nails.</p> <p>On at 3:05 p.m., in an interview CNA Staff G said Resident #83 refuses showers. He will resist you and says to leave him alone. When he refuses she tells the nurse.</p> <p>On at 3:00 p.m., in an interview the Administrator said the expectation is for the staff to check oral care, shaving and nail care daily and provide it if needed. For care they check the residents every two hours and as needed. The Administrator said staff shower residents according to the shower list and if they refuse, the staff are to notify the nurse.</p> <p>On at 3:16 p.m., in an interview Unit Manager RN Staff E said Resident #83 was a hospice patient and refuses care. RN Staff E said the expectation is for the residents to be cleaned daily. She said she made an with the beautician for Resident #83 for a hair cut and a shave this week. RN Staff E said "if a resident is refusing care it should be documented in the progress note, that is, if the CNA lets you know."</p>	F 677			

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F 677	<p>Continued From page 20</p> <p>On at 8:55 a.m., in an interview CNA Staff C said "The shower schedule was at the desk, and we follow it. We shave and cut or clean nails when the resident needs it. If a resident refuses we notify the nurse.</p> <p>On at 9:21 a.m., in an interview CNA Staff A said, shaving for males is done weekly at the beauty shop and nail care is done by the nurse, we are not allowed to cut . For showers, there is a list and we follow the shower schedule. CNA Staff A said if a resident refuses care then we let the nurse know.</p> <p>Review of the CNA documentation for documented showers were scheduled every Tuesday and Friday on the shift. The documentation showed on and Resident #83 received bed baths only. There was no documentation the resident refused care and showers.</p> <p>5. On at 10:16 a.m., in an interview Resident #271 said he was not a complainer, but he had not had a shower since he was admitted and would love to feel warm water on his skin. He said he would appreciate a beard trim and have his shaved. He said no one has offered a shower or a shave. He said he has a hard time standing but can sit up in the wheelchair.</p>	F 677			

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F 677	<p>Continued From page 21</p> <p>On _____ at 3:50 p.m., in an interview Resident #271 said he still has not been showered or shaved. The beard was long and covered most of his _____.</p> <p>On _____ at 4:12 p.m., in an interview LPN Staff W said the rule was showers twice a week by the CNA. She said if the resident refuses, the CNA should report to the nurse, and she will check with the patient and document in the progress notes the refusal. She said she is taking care of Resident #271 and was not aware of any recent refusals.</p> <p>On _____ at 4:17 p.m., in an interview Unit Manager LPN Staff M said Resident #271's showers were scheduled on Wednesdays and Saturdays on the evening shift. The residents get their beards shaved or trimmed on shower days and by special request.</p> <p>On _____ at 4:37 p.m., in an interview the Minimum Data Set (MDS) Coordinator said Resident #271 was alert and oriented. She could not recall the resident refusing showers. She said he got a partial bed bath on _____, partial bed bath on _____, and a bed bath on _____. She said there were no behaviors listed for Resident 271.</p> <p>On _____ at 4:48 p.m., CNA Staff Q said she takes care of the resident on the evening shift, but showers don't _____ on her shift. She said Resident #271 never refuses care but she's never shaved him.</p> <p>On _____ at 5:32 p.m., Staff Q said she shaved the resident but did not ask him if he wanted a</p>	F 677			

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F 677	Continued From page 22 shower. On _____ at 10:58 a.m., in an interview CNA Staff O said she took care of Resident #271 during day shift and gave him a good bed bath. She said he has all those tubes and things in the abdomen, and she did not think it was a good idea to give a shower. She said no one ever told her the resident could not get a shower; she just figured it was not a good idea. She said she did not shave or shower him. Review of the care plans for ADLs included instructions for "Shower Device: Shower Bed; shower per schedule and as needed; see shower schedule for details, initiated on _____." Resident 271's care plan did not include refusals of care, including showers. Review of the progress notes failed to show documentation Resident 271 refused showers or care. Review of the CNAs ADL documentation record for _____ and _____ revealed Resident #271's showers were scheduled on Wednesdays and Saturdays on the 3:00 p.m., to 11:00 p.m. shift. On _____ the resident received a partial bath at 10:55 p.m. On _____ the resident was given a bed bath at 10:57 p.m. There were no additional entries on the ADL sheet from _____ through _____.	F 677			
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684			

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F 684	<p>Continued From page 23</p> <p>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, and staff interviews, the facility failed to have documentation nursing staff addressed a reported change of condition for 2 (Residents #46 and #66) of 3 residents reviewed for changes that may indicate a change in health status and need to revise the plan of care.</p> <p>The findings included:</p> <p>Review of the facility's policy and procedure titled, "Notification of Resident/Patient Change in Condition" effective _____ revealed, "Notify the Physician . . . if there is a significant change in condition, regardless of the time of day . . ."</p> <p>Review of the facility's "Stop and Watch Early Warning Tool" noted, "If you have identified a change while caring for or observing a resident, please circle the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can." The symptoms to report included but were not limited to: Overall needs more help, ate less, tired, weak, _____, or drowsy, help with walking, transferring, toileting more than usual.</p> <p>Review of the clinical record revealed Resident</p>	F 684	<p>1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>A. Resident #66 and resident #46 are no longer in the facility. B. PTA staff F, COTA staff Y, LPN staff W, staff AA, CNA staff N, RN staff R, PTA staff Z, Evening supervisor RN staff B, RN staff X, LPN staff M was educated on F684.</p> <p>2: How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>A. complete audit of resident with a change of condition and resident requesting to go to the hospital was completed and any abnormal findings were corrected.</p> <p>3: What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;</p>	

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F 684	<p>Continued From page 24</p> <p>#46 was admitted to the facility on Diagnoses included but were not limited to and of , and history of</p> <p>Review of the Admission Minimum Data Set (MDS) Assessment with a target date of revealed Resident #46 scored "15" on the (), indicating intact cognition. Diagnoses included but were not limited to failure, , and (flow blockage).</p> <p>The care plan initiated on noted Resident #46 used an (inserted in the to drain) with risk for and/or complications:</p> <p>The interventions included to observe, document, report to the physician signs and symptoms of which included but were not limited to , change in behavior, change in eating patterns.</p> <p>Review of the progress notes revealed: 1. On at 12:23 p.m., Assistant (PTA) Staff S documented, "PTA facilitated functional transfer from bed to w/c (wheelchair) with max (maximum) assist. Patient reported not feeling well and hot. Checked room air and conditioner not working today. Nurse reports putting info in TELS (Electronic building management platform) . . . PTA instructed patient with BLE (Lower Extremities) exercises with patient unable to follow commands. Returned to nursing and patient placed in bed. Nursing notified . . ."</p>	F	<p>A. License nurses was educated on resident request to be sent to the hospital and documentation of change in condition.</p> <p>B. Nursing managers will review 24 hour report the following morning for any documentation of change in condition to ensure appropriate interventions were taken including but not limited to sending the resident out to the hospital.</p> <p>C. . . . is to bring all concerns of change in condition to the morning meeting for re follow up by the nurse management team.</p> <p>D. License nurses will document and assess any concerns brought to them by any staff members regarding a change in condition and they must notify physician in a timely manner to obtain further interventions and if nurses are unable to get ahold of the physician they can contact the medical director. If in an emergent case such as , or license nurses will call 911 and have resident sent to the hospital and then document entirely on the findings and interventions.</p> <p>E. Staff will use the interact stop and watch program/ form to relay any change in condition noted by any resident at the facility. A copy of the stop and watch form will also be brought to morning clinical meeting to be reviewed by nurse mangers/IDT to ensure appropriate measures were taken and followed.</p> <p>F. Staff education on the components of F684 this education will be provided annually and upon new hire orientation.</p>		

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F 684	<p>Continued From page 25</p> <p>On _____ at 3:20 p.m., in an interview PTA Staff S said on _____ when she saw Resident #46, "Something with his transfers was more difficult. We got him sitting on the side of the bed, asked him to reach for the arm rest. He went from a moderate to _____ with transfers." She said, "The _____ don't know if there is anything going on medically with the resident, that's why they report their observation to nursing". The clinical record lacked documentation of a nursing evaluation.</p> <p>Review of the TELS log for _____ and _____ showed no documentation of request for repair (work order) for the air-conditioning unit in Resident #46's room. The log noted, "There are no completed work orders matching your filters."</p> <p>On _____ at 11:43 a.m., in an interview the Director of Nursing (DON) said she reviewed Resident #46's clinical record and could not find documentation nursing addressed the concern PTA Staff S reported. She said, "If someone brings a resident _____ and the resident says they're not feeling well, they should document an assessment."</p> <p>2. On _____ at 2:14 p.m., Certified Occupational Assistant (COTA) Staff Y documented in a progress note she reported to the nurse Resident #46 stated he wasn't feeling well. The nurse took the resident's temperature which was 97.1. The clinical record lacked documentation of a nursing evaluation.</p> <p>On _____ at 4:51 p.m., Licensed Practical Nurse (LPN) Staff W documented a _____ a _____</p>	F 684	<p>4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>The Director of Nursing /Designee will audit the follow up for any change of condition or request to go to the hospital to ensure timely assessment, documentation and notification is obtained and audit _____ communication for change in condition weekly for four weeks then monthly for one quarter. The Director of Nursing/Designee will submit a report of findings to the Quality Assessment, Assurance and Compliance Committee monthly for one quarter.</p>		

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F 684	<p>Continued From page 26 of</p> <p>On at 11:43 a.m., in an interview the Director of Nursing (DON) said when COTA Staff Y reported Resident #46 was not feeling well, the nurse took the resident's temperature but there was no documentation the nurse evaluated the resident. The DON said the nurse should have assessed the resident and should have documented her assessment.</p> <p>3. On at 4:10 p.m., Occupational () Staff AA documented a missed session in a progress note. The documented the session was withheld due to the resident's status. Resident #46 appeared to be, "not at normal baseline with at rest. Unable to get clear reading on vitals (,). Further, withheld. Nursing conferred on patient status and notified."</p> <p>On at 3:00 p.m., in an interview Certified Nursing Assistant Staff N said she remembered Resident #46. She said she reported to the nurse on that he was not acting right, he was not talking as much and did not eat as much.</p> <p>On at 11:43 a.m., in an interview the DON said she could not find documentation nursing obtained vital signs or assessed Resident #46 on when Staff AA reported to nursing that, was withheld due to patient status,, at rest and unable to get clear readings on vitals. She said 911 should have probably been called then. The DON said, "When you have hounding you and telling you someone is not feeling well, you should assess the resident and call the doctor."</p>	F 684		

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F 684	<p>Continued From page 27</p> <p>On at 4:45 p.m., in an interview Occupational Staff AA said on when she went to see Resident #46 with the Physical he looked pretty sick. Staff AA said, "I hope he's alright." She said she tried to get vital signs on different machines but could not get a reading, including the resident's saturation. They reported it to RN Staff R.</p> <p>4. On at 5:17 p.m., PTA Staff Z documented in a progress note, "... Patient is observed to be () and isn't as mobile. , after multiple failed attempts to get (), HR (rate), () reported patient current condition to nursing and left patient in nursing care..."</p> <p>On at approximately 2:00 p.m., in an interview the Administrator said he reviewed the facility's surveillance video for and it showed PTA Staff Z saw resident #46 at approximately 1:48 p.m.</p> <p>The clinical record lacked documentation of nursing evaluation the concerns by PTA Staff Z.</p> <p>5. On at 5:35 p.m., the Advanced Practice Registered Nurse (APRN) documented in a progress note Resident #46 was seen and evaluated today for ataxic gait and general management of his medical . The assessment and plan was to continue with physical/ for the ataxic gait; and continue supportive care; , continue to monitor rate, proton pump inhibitor and continue supportive care.</p>	F 684		

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F 684	<p>Continued From page 28</p> <p>On _____ at 12:10 p.m., in an interview the APRN said on _____ she saw Resident #46 before lunch. It was between 10:00 a.m., and 11:00 a.m., but wrote the progress note on at 5:30 p.m. She said the Certified Nursing Assistant was in the room providing care. Resident #46 was ok and talking with her. She did not notice any signs of distress. She did not look at the resident's _____ in the _____ as it was covered and the aide was providing care. She said the resident was alert and oriented and able to say if he wasn't feeling well. She said when she saw him that morning, he did not voice any concerns. He was his normal self.</p> <p>On _____ at approximately 2:00 p.m., in an interview the Administrator said he reviewed the facility's surveillance video for _____ and it showed the APRN saw resident #46 at approximately 11:45 a.m.</p> <p>6. On _____ at 6:45 p.m., Registered Nurse (RN) Staff B, Evening Supervisor documented in a progress note the resident noted to have increased _____ and _____ saturation was 88 and put onto _____ at 3 liters. _____ low and call to physician with new orders noted for updraft treatment (_____, _____, _____, _____) to deliver medication to the (_____) and give one dose of _____ (_____) _____ (_____). Updraft treatment and _____ given per order.</p> <p>The note did not specify a _____ reading.</p> <p>On _____ at 10:10 a.m., in an interview Evening Supervisor RN Staff B said on _____ RN Staff R called her to come and evaluate Resident #46. It</p>	F 684		

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F 684	<p>Continued From page 29</p> <p>was around 6:30 p.m. His <input type="text"/> saturation was 70%. She put him on <input type="text"/> and called the Practitioner on call. The APRN gave an order for the <input type="text"/> and <input type="text"/>. She said to monitor him and if not better in an hour to send him to the hospital. She said she retrieved the <input type="text"/> from the emergency drug kit and they administered it to the resident right away. A while later the nurse called again and said Resident #46 got better but then got worse. She went and assessed the resident. His nailbeds were blue. They called 911. RN Staff B said she could not find her handwritten notes with a timeline of the event.</p> <p>A review of the transaction print out of the emergency drug kit revealed the <input type="text"/> was removed from the machine on <input type="text"/> at 6:27 p.m.</p> <p>7. On <input type="text"/> at 8:05 p.m., Evening Supervisor RN Staff B documented in a progress note the resident was noted with some improvement earlier after updraft treatment and injection. She went to see the resident again and he had declined again with lower <input type="text"/> level. Vital signs were unstable and <input type="text"/> level decreased and the resident was on a non-rebreather (<input type="text"/> mask) at this time. The resident was sent to the Emergency Room via 911.</p> <p>On <input type="text"/> at 5:00 p.m., in an interview RN Staff R said on <input type="text"/> she was assigned to Resident #46 when he was sent to the hospital. She said she spent a lot of time with the resident that day, checked his <input type="text"/> saturation but did not document her assessments. She said, "I am sorry. I am still new here." RN Staff R said she thought RN Staff B the Evening Supervisor would document everything.</p>	F 684			

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F 684	Continued From page 30 Review of the hospital record for revealed Resident #46 presented to the emergency department via ambulance due to concerns of , distress. Emergency Medical Services report the patient was , (low) on scene. They felt as though he was . They gave him fluids and transported him to the hospital. The patient is unresponsive and in , distress. Patient with agonal on arrival (gasping, labored breathing). Resident #46 was intubated and transferred to the for further management. The admitting diagnosis was (life threatening complication of an). Review of the clinical record for Resident #66 revealed an admission date of . Diagnoses included rapid , , and , failure. Review of the admission and discharge log revealed: On , Resident #66 was transferred to the hospital. Diagnoses listed on the hospital 3008 form included and . On , Resident #66 was transferred to the	F 684			

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F 684	<p>Continued From page 31</p> <p>hospital. Diagnoses upon return included () of the) and rapid .</p> <p>Review of the rate log revealed: On at 2:55 p.m., the resident's</p> <p>On at 11:51 a.m., the resident's , new onset and irregular.</p> <p>Review of the nursing progress note revealed on at 6:50 a.m., Registered Nurse (RN) Staff X documented, "Resident called nurse for , medication, and nurse gave her the , relief medication. The resident asked for ice water, which the nurse gave to her as well. However, the resident kept pouring the water in her basin and said that she needed more water. I gave her ice chips instead because she kept pouring the water in her basin. For that reason, she said that she wanted to go to the hospital because they would treat her better there, and she asked the nurse to have the supervisor to come into the room. The nurse went and told the supervisor about the resident's request."</p> <p>Review of the nursing progress notes and assessments from at 11:00 p.m. through at 6:50 a.m., failed to reveal documentation RN Staff X assessed Resident #66 when she requested to go to the hospital.</p> <p>On at 11:48 a.m., a nursing progress note revealed the practitioner was at the facility, saw Resident #66 and issued an order for the resident to be transferred to the hospital.</p> <p>Review of the practitioner's late entry progress</p>	F 684			

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F 684	<p>Continued From page 32</p> <p>note dated revealed "Attempt at obtaining an () line were unsuccessful due to and due to multiple episodes. Resident is not medically stable and requires hospitalization."</p> <p>On at 11:44 a.m., in an interview Resident #66 said the incident on really bothered her. She said on she had been sick all day with and .</p> <p>On at 2:30 a.m., after all day and several cups of water, she told Registered Nurse (RN) Staff X she wanted to go to the hospital.</p> <p>Resident #66 said RN Staff X said he could not call the doctor at 2:30 in the morning. She asked to see the supervisor but the supervisor never came.</p> <p>Later on the morning of , she told Unit Manager LPN Staff M she wanted to go to the hospital. Staff M told her the practitioner would be at the facility in 30 minutes to see her. She said LPN Staff M took her and it was .</p> <p>On at 1:43 p.m., in an interview the Risk Manager said she was not aware of the incident involving Resident #66 on and until today.</p> <p>She interviewed the resident and RN Staff X. Staff X told her Resident #66 requested to go to the hospital, but he did not contact the provider and did not transfer the resident to the hospital. The risk manager said RN Staff X was suspended pending the outcome of the investigation.</p> <p>The risk manager said RN Staff X that could have initiated the hospital transfer without a doctor's order. It is similar to a resident calling 911 for</p>	F 684			

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F 684	<p>Continued From page 33</p> <p>themselves if they were at home.</p> <p>Review of the facility's investigation initiated on revealed Resident #66 signed a statement noting, "On the day I went to the hospital, around 2:30 a.m., I told (Staff X) I had . . . and wanted to go to the hospital. He gave me a . . . pill and it didn't stay down. I was told the doctor said stay and will see me in the morning. Around 10:30 - 11:00 a.m., a provider came to see me. She said if they couldn't start an . . . line () they would send me to the hospital. They couldn't get the . . . in, so I went to the hospital. In the ambulance they couldn't start an . . . I went to (Hospital name). I didn't tell anyone except my husband, and he was going to call the state."</p> <p>Review of RN Staff X's -written witness statement dated . . . revealed, "Resident was asking for water. I gave the resident a cup of water. After a couple minutes, a CNA was passing by the resident's room, and I heard the resident ask the CNA for water. I went into the resident's room and told her that I just gave her water. However, the resident said she threw it up and wanted another cup. I went and got her another cup of water, but that time I did not leave the room fully. I was hiding myself behind the curtain to see what the resident was doing and I saw the resident poured the cup of water in her basin. I told her, "Okay, I see what's going on with the water. I will give you ice chips instead." I went and gave her a cup of ice chips. The resident kept saying that she wanted to go to the hospital. When I asked her to give me a reason or something to say to the provider, she said that they will treat her better at the hospital because they will give her water there."</p>	F 684			

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F 684	<p>Continued From page 34</p> <p>On _____ at 4:24 p.m., in an interview Unit Manager Staff M said on _____ in the morning, Resident #66 refused _____. She went to see the resident in her room. Resident #66 was pale, sweating, and had an abnormally fast heartbeat at _____ (normal _____ rate is between 60 and _____). She said she recognized it as an emergency and called the doctor. The doctor ordered _____ (used for _____ and _____). Resident #66 refused the _____. She wanted to go to the hospital. The provider came to the facility and gave the order to send Resident #66 to the hospital.</p> <p>On _____ at 4:56 p.m., Resident #66 said RN Staff X the night shift nurse told her she would be kicked off the physician's service for going to the hospital too many times. She said it was scary at the facility, and she wanted to go home.</p> <p>On _____ at 1:24 p.m., in an interview Licensed Practical Nurse (LPN) Staff M said she inaccurately documented the vital signs and transfer date on the _____ hospital transfer form. She obtained the vital signs from _____ and those vital signs did not portray an accurate description of the resident at the transfer time. Staff M said there was no nursing assessment for the night shift when the resident initially requested hospital transfer. She said if the nurse was not going to call the doctor, he should have assessed the resident and/or sent the resident to the hospital.</p> <p>On _____ at 3:49 p.m., the Director of Nursing (DON) said she would expect RN Staff X to document a nursing assessment during the night shift when the resident requested transfer to the</p>	F 684			

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F 684	Continued From page 35 hospital, but there was nothing in the progress notes, vital signs log or evaluations. The DON said if Staff X was unwilling to contact the physician and the nurse did not transfer the resident, the nurse should have documented that everything was okay. The DON said Staff X was suspended pending the investigation outcome. Review of the Hospital Progress note dated at 6:40 a.m., noted Resident #66 presented to the hospital with _____ and _____ going on for two days. The resident was admitted for further evaluation. A _____ panel was positive for _____ (_____. Her _____ went out and was unable to find an _____ per Emergency Medical Personnel... Central line was placed on _____. Was continued on _____ for rate control, continued hydration. Patient still with reasonable _____ and _____. Central line was placed yesterday due to lack of access. Review of the progress note Revealed Resident #66 returned to the facility on _____, 10 days after she was transferred to the hospital.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and	F 688		

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F 688	<p>Continued From page 36</p> <p>services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, clinical record review, staff and resident interviews, and review of facility policy and procedure, the facility failed to identify and provide the appropriate services and interventions for the management of and limitations in range of motion (ROM) for 1(resident #83) of 3 residents reviewed for limitations in ROM. The failure to provide the necessary services and interventions has the potential to cause, and worsening of the and loss of ROM.</p> <p>The findings included:</p> <p>The facility policy "Restorative Nursing Programs and Guidelines" (revised) documented "The facility provides Restorative Nursing Programs that involve interventions to improve or maintain the optimal physical functioning. . . management and prevention. . . includes the provision of active and or passive ROM exercises/movements to maintain or improve, flexibility as well as strength. . ."</p> <p>Review of the clinical record revealed Resident #83 was a male with a readmission date of . Diagnoses for the resident included and following included, and, major</p>	F 688	<p>1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>A. #83 was assessed, and care plan was updated. B. RN unit manager E, Hospice CNA, RN staff B, CNA staff C, care plan coordinator Staff I, CNA staff A, RN care plan coordinator staff H was educated.</p> <p>2: How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>A. Complete audit of resident with Limited ROM and was completed any abnormal findings was corrected.</p> <p>3: What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;</p>	

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F 688	<p>Continued From page 37</p> <p>and wasting.</p> <p>The record indicated Resident #83 was on hospice services beginning .</p> <p>The facility identified Resident #83 had a change in his condition and a significant change MDS standardized assessment tool that measures health status in nursing home residents) dated documented the resident had a limitation in range of motion (ROM) on both sides of the lower extremities and one side of the upper extremity.</p> <p>The MDS noted Resident #83's skills for daily decision making were intact.</p> <p>The care plan initiated on identified Resident #83 was dependent on staff for activities of daily living (ADL's).</p> <p>Review of the () discharge summary dated documented "LLE (left lower extremity) for increased extension/ROM of LLE. . . PROM/AAROM (passive/active range of motion) of LUE (left upper extremity). . . Patient denies wear tolerance, behavioral outbursts when attempted on LLE increasing caregiver burden and increased risk of and stiffness . . ."</p> <p>The discharge summary for services from to documented, " provided patient with gentle/prolonged stretch of LLE and in preparation for LUE tolerance and increased ROM, decreased stiffness needed. . . engaged patient in donning LUE . . . Patient requires assistance with donning and doffing of . . ."</p>	F 688	<p>A. License staff was educated on the documentation of refusal of care, limited ROM and</p> <p>B. Nursing management will review 24-hour report for any refusal of care documentation and ensure and or contractor management are being followed and follow up with any concerns noted.</p> <p>C. Nurse managers will review POC (point of Care) documentation for any refusal or blanks and follow up as needed.</p> <p>D. Nurse Managers will review new admitted residents the following day for any limited ROM and or contractors and ensure appropriate interventions are in place.</p> <p>E. Education for F688 will be provided annually and upon new hire orientation.</p> <p>F. Resident will be screen upon admission and then quarterly by for any decrease in ROM or contractors and appropriate interventions and care plans will be put in place for those residents identified.</p> <p>4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>The Director of Nursing/Designee will audit identified residents with limited ROM or contractors to ensure adequate interventions are followed weekly for four weeks then monthly for one quarter. The Director of Nursing/Designee will submit a</p>		

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F 688	<p>Continued From page 38</p> <p>On Resident #83 was referred to after an inpatient hospital stay but the resident refused the evaluation.</p> <p>Review of Physical () progress and discharge summary from to documented, "the patient presents with right flexion . . . the goal indicated The patient will demonstrate decreased right . . ." The goal was not met due to patient not very with and inconsistent participation.</p> <p>On Resident #83 had a evaluation and refused services.</p> <p>On at 11:55 a.m., Resident #83 was observed in bed in a position on his left side. He was noted to hold his left in a tight fist and his were bent with his heels toward his . There were no , devices or pillows in place to assist the resident with positioning. The resident said he was not able to move his left or straighten his .</p> <p>During random observation on at 10:01 a.m., and at 2:14 p.m., Resident #83 was in bed with his left in a fist position and his and drawn up toward his and his heels toward his . He has no or positioning devices in place including pillows. Resident #83 said he could move his right but when encouraged he was not able to move his .</p> <p>On at 3:16 p.m., in an interview with Registered Nurse Unit Manager Staff E said Resident #83 refuses and does not tolerate</p>	F 688	<p>report of findings to the Quality Assessment, Assurance and Compliance Committee monthly for one quarter.</p>		

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F 688	<p>Continued From page 39</p> <p>anything for positioning not even pillows.</p> <p>On at 4:35 p.m., in an interview with the Director of Rehab said Resident #83 is now on hospice services but was on case load on and off through the years. The Director of Rehab said had tried all different types of and positioning devices for his and he would say he was going to wear it and then would refuse.</p> <p>On at 11:20 a.m., in an interview the hospice certified nursing assistant (CNA) said she visits twice a week to provide showers/bed bath for the resident. She said, "Resident #83 has never been physically aggressive to her but he was very verbally combative, he will curse and yell and say don't touch me, get out." Resident #83 was observed in bed and he was using the bed controls to put the of the bed up and down repeatedly. He was noted in the same position as previous observations with no positioning devices. The CNA said I wash him, and I put a pillow between his because of the pressure. I don't know if he keeps it on or not because I leave after I am done. I was not informed by the facility staff of any or anything for him.</p> <p>On at 11:43 a.m., in an interview the Director of Rehab said Resident #83 was on hospice services and is not followed by unless there was a problem that needed to be addressed.</p> <p>On at 4:45 p.m., in an interview RN Staff B said she looked in the residents record and found no information regarding the use of , pillows etc., for Resident #83's . RN Staff B said I have not been able to find</p>	F 688			

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F 688	<p>Continued From page 40</p> <p>anything that he refused care or , . "He does refuse care all the time. But I did not find any documentation, I know, if it wasn't documented it wasn't done."</p> <p>On at 8:56 a.m., in an interview CNA Staff C said if a resident had a problem with ROM we tell the nurse and the nurse lets , , know. If they have a , the directions would be on the inside of the closet door.</p> <p>On at 9:08 a.m., in an interview the Director of Nursing (DON) said she was unaware of the resident's , and the lack of documentation or services for the management of Resident #83's .</p> <p>On at 9:25 a.m., Care Plan Coordinator Staff I confirmed there was no care plan to address the lower , for Resident #83. The Care Plan Coordinator said the loss of ROM in the left was addressed but confirmed there were no interventions for the left including ROM, , pillows. Staff I said the Resident #83 was on hospice services and did not receive , . Staff I said we have interdisciplinary team meetings weekly and there was no mention regarding the presence or care of the lower .</p> <p>On at 9:41 a.m., in an interview CNA Staff A said she has worked at the facility for three years and Resident #83 has had the left and both since she started working at the facility. "He has not had any that I'm aware of." There were two positioning wedges located on top of the closet and the CNA said we do use them when we position him.</p>	F 688			

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F 688	Continued From page 41 On at 10:08 a.m., in an interview Care Plan Coordinator Staff I said Resident #83 received , on after a return from the hospital and he was refusing it. She confirmed the , was dated for 1 day only and was actually an evaluation the resident refused. She confirmed there was no additional documentation of , for Resident #83. On at 10:15 a.m., in an interview RN Care Plan Coordinator Staff H said she completed the significant change MDS dated . She said she observed the resident and "Resident #83 was not like that when I saw him for the significant change MDS. She said a limitation in ROM does not mean a but he is now." She confirmed the limited ROM or was not identified in the care plan. On at 10:43 a.m., the DON confirmed the facility did not have a restorative program and there was no documentation of education provided for the staff on ROM, or	F 688		
F 690 SS=D	CFR(s): 483.25(e)(1)-(3) §483.25(e) §483.25(e)(1) The facility must ensure that resident who is of and on admission receives services and assistance to maintain unless his or her clinical condition is or becomes such that is not possible to maintain. §483.25(e)(2) For a resident with	F 690		

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F 690	<p>Continued From page 42</p> <p>, based on the resident's comprehensive assessment, the facility must ensure that-</p> <p>(i) A resident who enters the facility without an _____ is not _____ unless the resident's clinical condition demonstrates that _____ was necessary;</p> <p>(ii) A resident who enters the facility with an _____ or subsequently receives one _____ is assessed for removal of the _____ as soon as possible unless the resident's clinical condition demonstrates that _____ is necessary; and</p> <p>(iii) A resident who is _____ of _____ receives appropriate treatment and services to prevent _____ and to restore _____ to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal _____, based on the resident's comprehensive assessment, the facility must ensure that a resident who is _____ of _____ receives appropriate treatment and services to restore as much normal _____ function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review, and staff interviews, the facility failed to provide appropriate care and services to prevent _____ for 1 (Resident #107) of 2 residents reviewed with _____.</p> <p>The findings included:</p> <p>Clinical record review revealed Resident #107 was admitted to the facility on _____ and had a re-admission date of _____.</p> <p>The Admission Minimum Data Set (MDS)</p>	F 690	<p>1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>A. Resident #107 has no complication with her _____.</p> <p>B. CNA staff BB and CNA staff CC was reeducated on F590 and _____ care.</p> <p>2: How you will identify other residents having potential to be affected by the</p>		

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F 690	<p>Continued From page 43</p> <p>assessment with a target date of _____ noted the resident was rarely/never understood. Diagnoses included _____ of the _____, (flow of _____ is blocked in the _____ tract). Resident #107 had an _____ inserted into the _____ to drain _____.</p> <p>The care plan initiated on _____ noted Resident #107 used a _____ with risk for _____ and/or complications related to retention. The goal was for early identification and treatment of _____. The interventions included but were not limited to: Provide _____ care daily and as needed.</p> <p>Review of the Interdisciplinary Team progress note dated _____ revealed Resident #107 was recently started on _____ related to a complicated _____ with the addition of _____ due to history of recurrent _____.</p> <p>On _____ at 4:59 p.m., Certified Nursing Assistant (CNA) Staff BB and CNA Staff CC were observed providing _____ care and care to Resident #107. The Director of Nursing (DON) was in the room observing. A wash basin with soapy water was observed on the resident's over the bed table. When asked about the soap used for care, the DON said CNA Staff BB used the soap from the _____ soap dispenser in the bathroom. CNA Staff BB donned gloves and used a washcloth with the soapy water. She wiped between the resident's right and left thighs and outer _____ from front to _____.</p>	F 690	<p>same deficient practice and what corrective action will be taken;</p> <p>A. Complete Audit of resident with _____ to ensure appropriate interventions are in place and any abnormal findings were corrected. B. Audit of CNA competency for care completed and any abnormal findings was corrected</p> <p>3: What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;</p> <p>A. License staff was educated on _____ care. B. Competency for _____ care was completed for current CNAs and will be obtain for any new hires. C. Education on F690 will be completed for staff, upon new hire orientation and annually.</p> <p>4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>The Director of Nursing/Designee will do random audits of _____ care to ensure proper procedure/techniques is being utilized weekly for four weeks then monthly for one quarter. The Director of Nursing/Designee will submit a report of findings to the Quality Assessment,</p>	

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F 690	<p>Continued From page 44</p> <p>CNA Staff BB used another washcloth with soapy water and wiped the resident's inner thighs. She used another soapy washcloth and wiped the resident from to front (area to insertion site).</p> <p>CNA Staff CC stopped her and instructed her to wash from front to .</p> <p>CNA Staff BB did not reply and turned the resident to her side. She said she was done with the care.</p> <p>On at 5:10 p.m., in an interview the DON said CNA Staff BB did a great job with the care and care.</p> <p>Review of the facility's competency for Care/ care revealed: Female residents: 1. Applies a small amount of liquid soap to each wash cloth as it is being used. 2. Cleans in a downward motion from front to 3. Properly separates for procedure. 4. Changes water and repeats procedure to remove soap, changes gloves, washes and re-gloves. 5. Dries entire area, using a blotting motion from front to care Male and Female</p> <p>For those residents with : PCAs (Patient Care Assistants) may need additional wash cloths.</p> <ol style="list-style-type: none"> uses a wash cloth for the cleaning with soap and rinsing with changed water. is held with thumb and index where it exits the is cleansed downward from the exit four inches. 	F 690	Assurance and Compliance Committee monthly for one quarter.	

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F 690	Continued From page 45 On at 5:15 p.m., the facility's , care, care step by step list was reviewed with the DON. The DON said the CNAs did not provide , care or care correctly which placed the resident at risk for . She verified CNA Staff BB did not follow the steps in the list for the care and , care. Review of CNA Staff BB's competency review revealed on CNA Staff BB completed a competency related to performing female , care, and care. CNA Staff BB also attended an in-service on , on , care and , care, using the step by step list.	F 690		
F 693 SS=D	<p> Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) </p> <p> §483.25(g)(4)-(5) Nutrition (Includes naso- and , tubes, both , , and endoscopic , , and fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- </p> <p> §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by methods unless the resident's clinical condition demonstrates that feeding was clinically indicated and consented to by the resident; and </p> <p> §483.25(g)(5) A resident who is fed by means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of feeding </p>	F 693		

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F 693	<p>Continued From page 46 including but not limited to abnormalities, and This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, review of facility policy and procedure, record review and staff interview the facility failed to follow physician's orders for an binder over a for 1 (Resident #26) of 1 resident reviewed, to prevent pulling and accidental removal of the tube.</p> <p>The findings included:</p> <p>The facility policy "Medication Administration General Guidelines" documented "The individual who administers the medication, records the administration on the resident's MAR immediately following the medication being given. . . . If a scheduled medication is withheld, refused, the space provided on the front of the MAR/TAR (treatment administration record) for that dosage administration is initialed and circled. An explanatory note is entered. . . ."</p> <p>Review of the clinical record revealed Resident #26 had a readmission date of with diagnoses including need for assistance with personal care, , and The record indicated the resident was Spanish speaking only.</p> <p>A nursing progress note with a date of documented SOC (standards of care) meeting today. Resident readmitted to facility 2 days ago after hospitalization. Resident previously pulled her out and was reinserted during hospitalization. binder in place for protection to be removed for skin integrity checks</p>	F 693	<p>1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>A. Resident #26 binder use was corrected. B. RN staff K educated on documentation.</p> <p>2: How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>A. Complete audit of resident and any specialty device used for their tube was completed and any abnormal findings were corrected.</p> <p>3: What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;</p> <p>A. License Nurses was educated on documentation with emphasis on services not provided/ physician orders not carried out and the process of documentation. B. Nurse Manager to review 24 hour report and order detail summary the following business day for any refusal or care, supplies not available and any new</p>		

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F 693	<p>Continued From page 47</p> <p>and _____ care every shift. Will continue to monitor.</p> <p>A physician order dated _____ instructed "Maintain _____ binder in place. Remove for _____ care and to monitor skin integrity, every shift for monitoring skin integrity."</p> <p>On _____ at 12:07 p.m., during an observation Resident #26 was in bed wearing a hospital gown she had pulled up, exposing the _____ The _____ insertion site was leaking on resident's gown. There was no _____ binder covering the _____</p> <p>On _____ at 1:20 p.m., during an observation of the _____ with Registered Nurse (RN) Staff K said the resident was to have an binder on because she will pull the _____ out, but they could not find it. She had the _____ covered with a towel and the towel had a large stain form the _____ RN Staff K said the resident had recently pulled the _____ out twice.</p> <p>A review of the Treatment Administration Record (TAR) revealed RN Staff K had signed the TAR for the day and evening shifts indicating the binder was in place.</p> <p>On _____ at 3:23 p.m., Resident #26 was in bed, the room door was open. The resident had the covers down and her shirt up. She had the _____ in her _____ pulling on the tube.</p> <p>A review of the TAR revealed the _____ binder was signed on the TAR as applied by the nurse for the day and evening shift on _____</p> <p>On _____ at 3:44 p.m., an observation with RN</p>	F 693	<p>order for specialty equipment and follow up to ensure appropriate interventions were implemented.</p> <p>C. Staff was educated on the compomence of F693 and this education will be provided upon new hire orientation and annually.</p> <p>4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>The Director of Nursing/Designee will do random audits of resident _____ and any specialty equipment used on their _____ is being utilized weekly for four weeks then monthly for one quarter. The Director of Nursing/Designee will submit a report of findings to the Quality Assessment, Assurance and Compliance Committee monthly for one quarter.</p>	

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F 693	Continued From page 48 Unit Manager Staff E verified the binder had not been applied for resident #26 as ordered by the physician. She said it was sent to the laundry to be washed. RN Staff E confirmed if the binder was not available, the nurse should not have documented it was applied. On at 10:00 a.m., RN Staff K said she did not sign the TAR to indicate the binder was in place on . RN Staff K said it was in the laundry and so we used a sheet and wrapped it around her abdomen because she has pulled the out twice now. RN Staff K confirmed she had signed the TAR indicating she had applied and checked the placement of the binder	F 693			
F 694 SS=D	CFR(s): 483.25(h) § 483.25(h) Fluids. fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure short (a thin, flexible tube is inserted into a , usually in the of the , the lower part of the arm) cover was changed every 7 days to prevent local and systemic related to the () for 2 residents (271 and 23) of 3 reviewed for The findings included:	F 694	1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A. Resident #271 and #23 was changed. B. LPN staff V was educated on change. 2: How you will identify other residents		

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F 694	<p>Continued From page 49</p> <p>Review of the policy for Access Devices and Procedures. Change for Access Devices dated , the purpose is to prevent local and systemic related to the . A sterile is maintained on all , and central access devices to protect the site, provide microbial barrier, and to provide access device securement. Short are changed every 7 days or when the integrity of the is compromised.</p> <p>On at 10:16 a.m., Resident #271 was observed in bed with () infusing through an line inserted in the resident's right upper arm. The insertion site was dated "Photographic evidence obtained."</p> <p>On at 10:40 a.m., Licensed Practical Nurse (LPN) Supervisor Staff V entered the bedroom and observed the . In an interview LPN Staff V stated, "The cover is outdated and should be changed every 7 days."</p> <p>Review of Resident 271's Medication Administration Record (MAR) for revealed a physician's order written on at 1:50 p.m. to change the cover every 7 days and as needed for soiling or dislodgement. The MAR contained documentation that the nurse signed off the was changed on .</p> <p>Review of Resident #271's care plans revealed a care plan initiated on for medications with instructions to check the site daily</p>	F 694	<p>having potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>A. Complete Audit of resident with lines and any abnormal findings were corrected.</p> <p>3: What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;</p> <p>A. License Nurses was educated on changes.</p> <p>B. Nursing Management will review 24-hour report and order listing report for any new placement and any refusal of care related to change and follow up to ensure appropriate interventions are being followed.</p> <p>C. License nurses was educated on F694, documentation of care and services provided and refusal of care and services, this education will also be provided during new hire orientation and annually.</p> <p>4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>The Director of Nursing/Designee will do audits of resident receiving 's has received their change weekly for four weeks then monthly for one quarter. The Director of Nursing/Designee will submit a report of findings to the Quality</p>		

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F 694	<p>Continued From page 50</p> <p>and change the _____ per physician's orders and facility policy. Review of the progress notes from _____ through _____ revealed no documentation Resident #271 refused to have the _____ cover _____ changed.</p> <p>On _____ at 10:54 a.m., Resident #23 was observed with an _____ insertion site to the left upper arm. The _____ was dated _____. The _____ was eight days old. "Photographic evidence obtained."</p> <p>Review of Resident #23's MAR for _____ revealed a physician's order dated _____ at 4:56 p.m. to change the _____ cover _____ every 7 days and as needed for soiling or dislodgement. The MAR contained documentation that the nurse signed off the _____ was changed on _____ and _____.</p> <p>Review of Resident #23's care plans revealed a history of refusing care including medications and activities of daily living care dated _____. The care plan did not include information Resident #23 refused _____ change.</p> <p>Review of the nursing progress notes from _____ through _____ revealed no documentation that Resident #23 refused to have the _____ cover _____ changed.</p> <p>On _____ at 9:06 a.m., in an interview the Director of Nursing (DON) said the _____ are changed every seven days to prevent _____. The DON said the nurses did not follow physician's orders to change the _____ for Resident #271 and #23. The DON said the expectation is the nurse signs off when a task is completed and not prior to completing the task, in case the nurse does not get to the task because _____.</p>	F 694	<p>Assessment, Assurance and Compliance Committee monthly for one quarter.</p>		

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F 694	Continued From page 51 of being side-tracked or forgetting to do it. She said the MARS for for both Residents #271 and #23 were incorrect. She said the nurses documented completion of changes that were not done.	F 694			
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interviews the facility failed to ensure a medication error rate less than 5 percent. 29 opportunities, 5 residents and four different nurses were observed. Four medication errors were identified resulting in a medication error rate of 13.79%. The findings included: On at 9:15 a.m., Registered Nurse (RN) Staff R was observed administering 11 different medications to Resident #470, including: Patch 5% (,) one patch to the resident's left and one patch to the resident's left () 10 milligrams (mg), one tablet by 75 mg (,) one tablet by Reconciliation of the medication administration observation with the physician's orders revealed the current physician's orders included:	F 759	1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A. RN staff R and RN staff K was educated on medication administration. 2: How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken; A. Audit was completed to ensure residents was receiving correct medications and abnormal finding was corrected. 3: What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not		

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F 759	<p>Continued From page 52</p> <p>external patch 4%, apply to left /left _____ one time a day for _____ (_____) 75 mg, give one tablet by _____ one time a day related to Major _____, administer with 37.5 mg total to be administered is 112.5 mg. The physician's orders included to administer 10 mg, one tablet one time a day for _____. The medication was scheduled to be administered daily at 9:00 a.m. RN Staff R was not observed administering the _____ as ordered.</p> <p>Complete review of the clinical record failed to reveal a physician's order for _____ 10 mg administered to the resident. On _____ at 3:22 p.m., in an interview RN Staff R verified she did not administer _____ 37.5 mg with the _____ 75 mg per the physician's order. She verified there was no physician's order for the _____ 10 mg she administered to Resident #470. RN Staff R said she administered _____ 10 mg instead of _____ 10 mg to the resident. She said, "That's an _____ pill, that's what we give." RN Staff R asked if the _____ and _____ were not "the same thing." She said she did not realize the strength of the patches she applied to the resident's left _____ and left _____ were 5%. She did not realize the physician's order was for patch 4%.</p> <p>On _____ 10:11 a.m., RN Staff K was observed administering four medications to Resident #60, including one tablet of Torsemide 10 mg. Review of the physician's orders for Resident #60</p>	F 759	<p>recur;</p> <p>A. License Nurses was educated on F759 documentation and medication administration this education will be provided annually and upon new hire orientation.</p> <p>B. Nursing Mangers will audit medication administration for any documentation of such as but not limited to not available, holes/blanks in the MAR and ensure that appropriate follow up was completed.</p> <p>C. Medication competency was completed for current license nurses and any new license nurse hired.</p> <p>4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>The Director of Nursing/Designee will do random audits of license nurses during medication administration to ensure proper procedure/techniques is being utilized weekly for four weeks then monthly for one quarter. The Director of Nursing/Designee will submit a report of findings to the Quality Assessment, Assurance and Compliance Committee monthly for one quarter.</p>	

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F 759	Continued From page 53 revealed to administer Torsemide 5 mg, one tablet by _____ one time a day for _____. _____ caused collection of fluid in the tissues). On _____ at 3:37 p.m., in an interview RN Staff K verified the physician's order was to administer Torsemide 5 mg one time a day to the resident. She acknowledged the medication error and said she administered Torsemide 10 mg to Resident #60, which was twice the amount of Torsemide ordered.	F 759		
F 880 SS=D	Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Control The facility must establish and maintain an prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable and _____. §483.80(a) _____ prevention and control program. The facility must establish an _____ prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling and communicable _____ for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F 880		

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/12/2025
NAME OF PROVIDER OR SUPPLIER REHAB & HEALTHCARE CENTER OF CAPE CORAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2629 DEL PRADO BLVD CAPE CORAL, FL 33904	
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F 880	<p>Continued From page 54</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable or before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable or should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of () When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable or skin from direct contact with residents or their food, if direct contact will transmit the ; and</p> <p>(vi) The hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of .</p> <p>§483.80(f) Annual review.</p>	F 880		

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F 880	<p>Continued From page 55</p> <p>The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview and facility policy review the facility failed to provide appropriate control practices during care for 2 (Residents #53 and #107) of 3 residents reviewed for control/Enhanced Barrier Precautions.</p> <p>The findings included:</p> <p>Review of the clinical record revealed Resident #53 was admitted to the facility on . Her medical history included Loss, and . She had Physician orders for daily care. She also had Physician orders for Enhanced Barrier Precautions. There was PPE (Personal Protective Equipment) and a sign on her room door along with a sign over her bed that said EBP (Enhanced Barrier Precautions); Gown and gloves required.</p> <p>The Policy and Procedure provided by the facility for Barrier Precautions with an effective date of stated "Enhanced Barrier Precautions (EBP) refers to a control intervention designed to reduce transmission or multi-drug-resistant organisms that employ targeted gown and glove use during high contact resident activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDROs (Multi Drug Resistant Organization) to staff and clothing. EBP is indicated for residents with</p>	F 880	<p>1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>A. Resident #53 and Resident #107 had no negative outcome. B. LPN staff M, RN staff L, RN staff K and evening supervisor staff B was educated on control and proper change procedure.</p> <p>2: How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>A. Complete Audit of resident with care to ensure appropriate orders and interventions are in place and any abnormal findings was corrected.</p> <p>3: What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;</p> <p>A. License nurses was educated on proper change procedure/technique. B. Competency for change completed on current license nurses and will be completed on any new License nurse hire.</p>	

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F 880	<p>Continued From page 56</p> <p>any of the following:</p> <ol style="list-style-type: none"> or colonization with a CDC (Center for Control)-targeted multi-drug-resistant organism when Contact Precautions do not otherwise apply or, and/or medical devices even if the resident is not known to be or colonized with a multi-drug resistant organism. <p>On at 11:00 a.m., Licensed Practical Nurse (LPN) Staff M, and Registered Nurse (RN) Staff L were observed providing care for Resident #53. Staff M, LPN and Staff L, RN only utilized gloves during care. After care was completed for Resident #53, they were asked if Resident #53 was on EBP precautions. They both answered yes. They were then asked if gowns should have been worn during care? They both answered yes.</p> <p>On at 11:30 a.m., in an interview the Director of Nursing (DON) and the Regional DON were asked if Enhanced Barrier Precautions Policy required staff to wear a gown and gloves during change for care. Both answered yes.</p> <p>Review of the clinical record for Resident #107 revealed an admission date of and re-admission date of . Diagnoses included (,) and (,). Resident #107 was bedbound and dependent on staff for all activities of daily living. Review of the progress note dated revealed Resident #107 was readmitted with a surgical to the area with staples and , and a pressure injury to the left</p>	F 880	<p>C. Nursing managers to do weekly rounds to ensure appropriate treatment and healing of is followed.</p> <p>D. Education of staff on the components of F880 this will be provided annually and upon new hire orientation.</p> <p>4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>The Director of Nursing/Designee will do random audits of care to ensure proper procedure/techniques is being utilized weekly for four weeks then monthly for one quarter. The Director of Nursing/Designee will submit a report of findings to the Quality Assessment, Assurance and Compliance Committee monthly for one quarter.</p>	

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F 880	<p>Continued From page 57</p> <p>On at 2:00 p.m., Registered Nurse (RN) Staff K was observed changing the to the resident's and the to the resident's left Evening Supervisor RN Staff B was assisting with the care.</p> <p>RN Staff K donned gloves placed a barrier field on the resident's over the bed table. She placed her supplies, including 2% (), 0.1% () squeezed into individual medicine cups, and opened packs of gauze which she placed into plastic cups.</p> <p>RN Staff K removed the gloves.</p> <p>RN Staff K picked up a bottle of cleanser from the treatment cart and dropped it on the floor in the resident's room.</p> <p>She donned gloves, picked up the bottle of cleanser and placed it on the barrier field with the rest of the clean and sterile care supplies.</p> <p>RN Staff B Evening Supervisor turned Resident #107 to the left.</p> <p>RN Staff K removed the soiled to the resident's right</p> <p>She removed her gloves, performed hygiene and donned a clean pair of gloves. RN Staff K took her glasses from the top of her and placed them on her</p> <p>She did not change gloves or perform hygiene.</p> <p>She used the bottle of cleanser she picked up from the floor and sprayed cleanser on 4 by 4 gauze.</p> <p>She wiped the resident's multiple times, going from the to the surrounding area, wiped between the resident's and wiped into the</p>	F 880			

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F 880	<p>Continued From page 58</p> <p>RN Staff K did not remove her gloves or performed hygiene.</p> <p>She used her gloved _____ to apply the _____ and the _____ in and around the _____. She spread the _____ in the resident's _____, the surrounding skin, between the resident's and _____ to the _____ bed.</p> <p>She applied a _____ to the _____.</p> <p>RN Staff K performed _____ hygiene and donned gloves.</p> <p>She removed the _____ to the resident's left _____.</p> <p>She sprayed _____ cleanser onto 4 by 4 gauze. She removed her gloves and donned a new pair of gloves.</p> <p>She wiped the _____ to the left _____ multiple times in an up and down motion.</p> <p>She applied a _____ to the left _____ and secured the _____ with rolled gauze she wrapped around the resident's _____.</p> <p>She removed her gloves, did not wash her _____.</p> <p>She went to the treatment cart, retrieved scissors which she placed on the resident's nightstand. RN Staff K did not clean or sanitize the scissors. She used it to cut the rolled gauze and tape to secure the _____ to the left _____.</p> <p>She then unwrapped the resident's left and right heel without performing _____ hygiene or changing her gloves.</p> <p>She applied skin prep (skin protective film) to the resident's heels.</p> <p>On _____ at 5:30 p.m., in an interview, RN Staff K said she realized she failed to follow _____ prevention technique during the _____ care which placed Resident #107 at risk for _____.</p> <p>_____ RN Staff K said, "Thank you for telling me."</p> <p>On _____ at approximately 12:15 p.m., in an</p>	F 880			

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F 880	Continued From page 59 interview the Assistant Director of Nursing said it was not acceptable for the nurse to pick up the bottle of _____ cleanser from the floor and use it. Review of the facility's _____ change skills checklist revealed to apply gloves, remove the soiled _____, remove gloves, wash _____, cleanse the _____ with Normal _____ (Clean to dirty) or other physician ordered cleansing agent. Then, remove gloves and wash _____. Apply gloves perform the _____ treatment according to the physician's order.	F 880			