Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	83602	A. BUILDING: _____ B. WING _____	R-C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB & HEALTHCARE CENTER OF CAPE CORAL	2629 DEL PRADO BLVD CAPE CORAL, FL 33904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	INITIAL COMMENTS An unannounced revisit survey was conducted on at Rehab & Healthcare Center Of Cape Coral, a skilled nursing facility in Cape Coral, Florida. This was a follow-up to the relicensure survey completed on . The following deficiency was recited at N054.	{N 000}		
{N 054} SS=D	59A-4.107(5), FAC Follow Physician Orders 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. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure physician orders were followed for 1 (Resident #6) of 1 resident reviewed for nutrition and follow up care with a , . Resident #6 was admitted to the facility on . Resident #6's diagnoses included , , , (a tube inserted through the abdomen directly into the used for feeding, hydration and medications) and protein calorie . Resident #6 had a , tube ( ) for all nutrition. Clinical record review noted physician order dated which specified " follow up appoint for 1 week d/t new placement. Dr. [, named, location and telephone number included]. The order was entered into the electronic health record by Staff D, Licensed Practical Nurse (LPN).	{N 054}	1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A. Resident #2, 3, 4, 5, 6 were assessed with no negative outcomes noted B. Resident # 6 , , was scheduled for @ 2:10pm C. Staff A LPN no longer works at the facility 2: How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; A. On , a complete audit of current residents with feedings and the Medication Administration Record was done for the prior day, any abnormal findings were corrected such as notification for physician and any new	

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/25

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{N 054}	Continued From page 1 Physician order dated was to Provide Feed Jevity 1.5 cal continuous via (a specific type of placed using an Endoscopic procedure for feeding). tube to infuse at a rate of 70 ml/hr. daily to begin at 2:00 p.m. 1. On at 2:00 p.m., Staff B Registered Nurse (RN) was observed preparing to administer a feeding via , for Resident #6. The nurse was observed in the hallway with her medication cart in front of # . She approached the medication cart carrying a container of and new tubing. Staff B RN # pushed the cart to the doorway of Resident #6's room, . She put gloves on, labeled the bottle with a blue sharpie marker while wearing the same gloves. She put on a yellow gown, then proceeded to Resident #6's bedside where she was observed to throw out a partially used container of and used tubing. Staff B RN inserted the tubing into the new container of . She connected the tubing to the controlled flow pump and then inserted the end of the tubing into Resident #6's , . She did not check tube placement, check for residual or flush the tube prior to starting the . On at 2:20 p.m., upon exiting the room, Staff B RN said she did not need to flush the tube prior to starting the , because she had passed medications at noon time and flushed the tube before and after the medications were administered. On at 3:25 p.m., during an interview with Staff D, LPN and the Director of Nursing (DON) both staff verified the nurse should have checked placement of the tube prior to starting the , by flushing the tube before using it for	{N 054}	orders were obtain and the Medications Administration Record was updated. 3: What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; A. Licensed Staff were educated on checking placement prior to administering feeding or medications via the . B. License nurses were educated on medication administration, obtaining and documenting the , scale. C. Nursing Mangers will audit the medication administration record for any documentation omissions such as but not limited to not available, holes/blanks in the Medication Administration Record and ensure that appropriate follow up was completed and documenting follow up. D. Medication competencies were completed for current license nurses and any new license nurse hired. E. Feeding competencies were completed for current license nurses and any new license nurse hired. F. License nurses will document the medication administration on the Medication Administration Record post administration. On coming nurses will verify off going nurses Medication Administration Record report prior to taking report. If any discrepancy is noted the Director of Nursing will be made aware immediately. G. Staff education on the components of F684 this education will be provided annually and upon new hire orientation.	

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{N 054}	Continued From page 2 feeding at 2:00 p.m. "its nursing 101 to check the tube placement and flush prior to use" said Staff D, LPN. On at 4:08 p.m., during an interview Staff F. LPN verified standard nursing practice is to always flush the tube just prior to, and after use for any food, meds etc. at 5:07 p.m., the Director of Nursing brought Staff B RN to the conference room and said the nurse was nervous and had a language barrier. The DON said she went to educate the nurse who told her she flushed the prior to starting the . The DON said the night shift puts a new syringe in each room on the night shift for use on the next day. On at 5:13 p.m., Photographic evidence was obtained of a syringe sitting in a dry Styrofoam cup, next to used socks on the nightstand. Both the syringe and the cup were dry. There was no residual water or dampness in the cup or syringe to verify it had recently been used. 2. On at 3:51 p. m., during an interview, Staff E, RN said the medical records clerk schedules all outside , , . Staff E RN checked the medical records book where all , , are recorded. Staff E RN verified there were no , , scheduled for Resident #6. She said the medical records person is informed of the , , needed when we put the orders in. She said the process was to review the charts the next morning. We make sure the medical records person is aware she needs to schedule an , , . On at 4:06 p.m., during an interview, Staff D, LPN reviewed Resident #6's paper chart. She	{N 054}	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. A. The Director of Nursing/Designee will audit daily the Medication Administration Record to ensure no medications were missed the day prior and if any were missed that appropriate interventions were done. This audit will continue weekly for four weeks then monthly for one quarter. B. The Director of Nursing/Designee will do random audits of license nurses and feeding residents to ensure tube placement is checked prior to administration of the . This audit will continue weekly for four weeks then monthly for one quarter. C. The Director of Nursing/Designee will do random audits of license nurses during medication administration to residents to ensure an accurate , scale is obtained and documented. This audit will continue weekly for four weeks then monthly for one quarter D. The Director of Nursing/Designee will submit a report of the findings to the Quality Assessment, Assurance and Compliance Committee monthly for one quarter.	

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{N 054}	Continued From page 3 verified there was an order for Resident #6 to see a ( ) because he had a new . The order read to "see s/p new placed just prior to arrival at the facility". Staff D, LPN confirmed there was no documentation of Resident #6 being seen by the in either the EHR or paper chart. Staff D, LPN said she would call office to determine if resident has an to be seen. On at 4:33 p.m., during a follow up interview Staff D LPN said I just called [name of] doctor. She said she was told they need a referral, which I will get. I will take care of that and get him scheduled. They said they would see the resident within 2 weeks. .	{N 054}		

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{F 000}	INITIAL COMMENTS An unannounced revisit survey was conducted on at Rehab & Healthcare Center Of Cape Coral, a skilled nursing facility in Fort Myers, Florida. This was a follow-up to the recertification survey completed on . The following deficiences were recited at F684, F759, and F880. 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. The following is the description of the noncompliance.	{F 000}		
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care 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: Based on observation, interview and record review the facility failed to ensure physician orders were followed for 1 (Resident #6) of 1 resident reviewed for nutrition and follow up care with a , . Additionally, the facility failed to accurately document administration of physician ordered medications for 2 residents(#2,	{F 684}	1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A. Resident #2, 3, 4, 5, 6 were assessed with no negative outcomes noted	

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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 684}	Continued From page 1 #3) of 2 residents reviewed for medication administration. The facility failed to accurately record the , , scale for 2 residents (#4 and #5) of 4 residents reviewed. Resident #6 was admitted to the facility on . Resident #6's diagnoses included , , , (a tube inserted through the abdomen directly into the used for feeding, hydration and medications) and protein calorie . Resident #6 had a , tube ( ) for all nutrition. Clinical record review noted physician order dated which specified " follow up appoint for 1 week d/t new placement. Dr. [, named, location and telephone number included]. The order was entered into the electronic health record by Staff D, Licensed Practical Nurse (LPN). Physician order dated was to Provide Feed Jevity 1.5 cal continuous via (a specific type of placed using an endoscopic procedure for feeding). tube to infuse at a rate of 70 ml/hr. daily to begin at 2:00 p.m. 1. On at 2:00 p.m., Staff B Registered Nurse (RN) was observed preparing to administer a feeding via , for Resident #6. The nurse was observed in the hallway with her medication cart in front of # . She approached the medication cart carrying a container of and new tubing. Staff B RN # pushed the cart to the doorway of Resident #6's room, . She put gloves on, labeled the bottle with a blue sharpie marker while wearing the same gloves. She put on a yellow	{F 684}	B. Resident # 6 , , was scheduled for @ 2:10pm C. Staff A LPN no longer works at the facility 2: How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; A. On a complete audit of current residents with feedings and the Medication Administration Record was done for the prior day, any abnormal findings were corrected such as notification for physician and any new orders were obtain and the Medications Administration Record was updated. 3: What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; A. Licensed Staff were educated on checking placement prior to administering feeding or medications via the B. License nurses were educated on medication administration, obtaining and documenting the , scale. C. Nursing Mangers will audit the medication administration record for any documentation omissions such as but not limited to not available, holes/blanks in the Medication Administration Record and ensure that appropriate follow up was completed and documenting follow up. D. Medication competencies were	

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{F 684}	Continued From page 2 gown, then proceeded to Resident #7's bedside where she was observed to throw out a partially used container of ␣ and used tubing. Staff B RN inserted the tubing into the new container of ␣. She connected the tubing to the controlled flow pump and then inserted the end of the tubing into Resident #6's , ␣ . She did not check tube placement, check for residual or flush the tube prior to starting the ␣. On at 2:20 p.m., upon exiting the room, Staff B RN said she did not need to flush the tube prior to starting the , ␣ ␣ because she had passed medications at noon time and flushed the tube before and after the medications were administered. On at 3:25 p.m., during an interview with Staff D, LPN, and the Director of Nursing (DON) both staff verified the nurse should have checked placement of the tube prior to starting the ␣ by flushing the tube before using it for feeding at 2:00 p.m. "its nursing 101 to check the tube placement and flush prior to use" said Staff D, LPN. On at 4:08 p.m., during an interview Staff F. LPN verified standard nursing practice is to always flush the tube just prior to, and after use for any food, meds etc. at 5:07 p.m., the Director of Nursing brought Staff B RN to the conference room and said the nurse was nervous and had a language barrier. The DON said she went to educate the nurse who told her she flushed the prior to starting the ␣.	{F 684}	completed for current license nurses and any new license nurse hired. E. Feeding competencies were completed for current license nurses and any new license nurse hired. F. License nurses will document the medication administration on the Medication Administration Record post administration. On coming nurses will verify off going nurses Medication Administration Record report prior to taking report. If any discrepancy is noted the Director of Nursing will be made aware immediately. G. Staff education on the components of F684 this education will be provided 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. A. The Director of Nursing/Designee will audit daily the Medication Administration Record to ensure no medications were missed the day prior and if any were missed that appropriate interventions were done. This audit will continue weekly for four weeks then monthly for one quarter. B. The Director of Nursing/Designee will do random audits of license nurses and feeding residents to ensure tube placement is checked prior to administration of the ␣. This audit will continue weekly for four weeks then monthly for one quarter. C. The Director of Nursing/Designee will	

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{F 684}	Continued From page 3 On at 5:13 p.m., Photographic evidence was obtained of a syringe sitting in a dry Styrofoam cup, next to used socks on the nightstand. Both the syringe and the cup were dry. There was no residual water or dampness in the cup or syringe to verify it had recently been used. 2. On at 3:51p.m., during an interview, Staff E, RN said the medical records clerk schedules all outside , , . Staff E RN checked the medical records book where all , , are recorded. Staff E RN verified there were no , , scheduled for Resident #6 to see the , . She said the medical records person is informed of the , , needed when we put the orders in. She said the process was to review the charts the next morning. We make sure the medical records person is aware she needs to schedule an , , . On at 4:06 p.m., during an interview, Staff D, LPN reviewed Resident #6's paper chart. She verified there was an order for Resident #6 to see a ( ) because he had a new , . The order read to "see s/p, new , placed just prior to arrival at the facility". Staff D, LPN confirmed there was no documentation of Resident #6 being seen by the , in either the EHR or paper chart. Staff D, LPN said she would call office to determine if resident has an , , to be seen. On at 4:33 p.m., during a follow up interview Staff D LPN said, I just called [name of] doctor. She said she was told Resident #6 would need a referral, which I will get. I will take	{F 684}	do random audits of license nurses during medication administration to residents to ensure an accurate , scale is obtained and documented. This audit will continue weekly for four weeks then monthly for one quarter D. The Director of Nursing/Designee will submit a report of the findings to the Quality Assessment, Assurance and Compliance Committee monthly for one quarter.	

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{F 684}	Continued From page 4	{F 684}		

care of that and get him scheduled. They said they would see the resident within 2 weeks.

A policy titled Medication Administration dated which stated that "an individual who administers the medication dose, records the administration on the resident's medication administration record (MAR) immediately following the medication being given. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications." "When as needed (PRN) medications are administered, complaints or symptoms are documented as the reason for which the medication is given."

Record review of the plan of correction by the facility included "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."

1. Resident #2 was admitted to the facility on . He was diagnosed with systemic , failure, wasting, , and .

Record review of Resident #2's MAR, showed there was no documentation showing doses of the flowing medications on : Rosuvastatin 20MG scheduled for 9:00 p.m., , Oral Capsule 250 MG scheduled for 9:00 p.m., and , 25 MG, which were ordered to be given for 9:00 p.m.

On at 11:00 a.m., during an interview with

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{F 684}	Continued From page 5	{F 684}		

the Director of Nursing (DON) and the Unit Manager who stated that MAR audits are self-explanatory, (we are) going through 24-hour reports. We follow up with physician and education is provided to the nurse regarding the process (of documenting the medications) and not just documenting medication not available also we ensure that someone let physician and let responsible party knows. The DON stated that she was aware of omitted doses on the MAR for Resident #2 but said she had verified with the charge nurse that those medications had been given by the nurse. The DON said that "the facility expectation for omitted doses is that the nurse would document the omitted holes/blanks on the MAR on the next working shift."

On at 11:05 a.m., The DON verified that she had not followed up as to whether the nurse had completed the documentation on her next shift. She sated "I would have to check to see if she has been to work since then, I don't know if she has."

Record review of the staff schedule showed that the nurse had worked the previous night, and did not update the clinical record for Resident #2.

On at 2:00 p.m., during an interview with Staff A, LPN, who stated that "they just told me that they wanted me to document the medications 2 hours ago, I also worked last night, had I known it was an issue I would have corrected it on my shift." Staff A also stated that "sometimes we don't get around to documenting the meds we give, because there are a lot of , and my assignment was split on 2 hallways. If you look at other residents you will see that there others with missing documentation."

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{F 684}	Continued From page 6 Resident #3 was admitted to the facility on with , , , , wasting, and . Resident #3's MAR for showed that there was no documentation for the following ordered doses of medications: 10 mg scheduled for 9:00 p.m., 20 mg scheduled for 9:00 p.m., 2.5 mg scheduled for 9:00 p.m., 100 mg scheduled for 9:00 p.m., 25 MG scheduled for 9:00 p.m. and 6:00 a.m. On at 12:00 p.m., during an interview with the DON and the Unit Manager, the Unit Manager stated that "it appears that the same nurse omitted documentation for multiple residents." The DON then stated that she is unable to verify that her charge nurse contacted Staff A to document on her next shift. On at 2:00 p.m., interview with staff A confirmed that she gave all the residents their scheduled medications that evening, she just did not document them because "sometimes we have a lot of ." Staff #A LPN confirmed that she "passed the med pass competency." Record review of the Medication Pass Observation competency included "medications immediately documented following administration." 2. A medication pass was observed on at 9:45 a.m., with Staff B for Resident #4 and #5.	{F 684}		

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{F 684}	Continued From page 7 Resident #4 was asked by Staff #B LPN "are you having , ?" Resident #4 responded "yes." Staff B was then observed to remove , 325 mg 2 tablets from the medication cart and administered to Resident #4. Record review of the MAR for Resident #4 showed that , 325 mg 2 tablets was documented as "given" with a , assessment score of 3. Resident #4 was not asked for a , score before or during the administration of the , . Resident #5 was asked by staff #B LPN "are you having , , do you want your cream?" Resident #5 replied "yes the cream for my ." Staff B was then observed to remove [brand name]1% gel from the supply closet and brought a measured dose to the resident. Resident #5 was not asked for her , score before or during administration of the cream. Record review of the MAR for Resident #5 showed that the [brand name] 1% gel administration includes a , score of 1. On at 12:30 p.m., during an interview with Staff B, LPN, who said that she did not ask the residents about their , score because she knows them very well and can tell by looking at them. On at 2:15 p.m., an interview with the visiting DON confirmed that Staff B LPN would have to ask the Resident #5 their , score to accurately document a , number and administer an as needed medication.	{F 684}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105342	A. BUILDING _____ B. WING _____	R-C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 684}	Continued From page 8	{F 684}		

Class III

the facility failed to accurately document administration of physician ordered medications for 2 (#2, #3,) of 2 residents reviewed for medication administration during the follow up survey. The facility failed to accurately record the scale for 2 residents (#4 and #5) of 4 residents reviewed.

The findings included:

A policy titled Medication Administration dated which stated that "an individual who administers the medication dose, records the administration on the resident's medication administration record (MAR) immediately following the medication being given. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications." "When as needed (PRN) medications are administered, complaints or symptoms are documented as the reason for which the medication is given."

Record review of the plan of correction by the facility included "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."

1. Resident #2 was admitted to the facility on . He was diagnosed with systemic failure, wasting, and

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	105342	A. BUILDING _____ B. WING _____	R-C 03/25/2025

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{F 684}	Continued From page 9	{F 684}		

Record review of Resident #2's MAR, showed there was no documentation showing doses of the flowing medications on : Rosuvastatin 20MG scheduled for 9:00 p.m., , Oral Capsule 250 MG scheduled for 9:00 p.m., and , 25 MG, which were ordered to be given for 9:00 p.m.

On at 11:00 a.m., during an interview with the Director of Nursing (DON) and the Unit Manager who stated that MAR audits are self-explanatory, (we are) going through 24-hour reports. We follow up with physician and education is provided to the nurse regarding the process (of documenting the medications) and not just documenting medication not available also we ensure that someone let physician and let responsible party knows. The DON stated that she was aware of omitted doses on the MAR for Resident #2 but said she had verified with the charge nurse that those medications had been given by the nurse. The DON said that "the facility expectation for omitted doses is that the nurse would document the omitted holes/blanks on the MAR on the next working shift."

On at 11:05 a.m., The DON verified that she had not followed up as to whether the nurse had completed the documentation on her next shift. She sated "I would have to check to see if she has been to work since then, I don't know if she has."

Record review of the staff schedule showed that the nurse had worked the previous night, and did not update the clinical record for Resident #2.

On at 2:00 p.m., during an interview with

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	105342	A. BUILDING _____ B. WING _____	R-C 03/25/2025

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{F 684}	Continued From page 10 Staff A, LPN, who stated that "they just told me that they wanted me to document the medications 2 hours ago, I also worked last night, had I known it was an issue I would have corrected it on my shift." Staff A also stated that "sometimes we don't get around to documenting the meds we give, because there are a lot of , and my assignment was split on 2 hallways. If you look at other residents you will see that there others with missing documentation." Resident #3 was admitted to the facility on with , , , , , wasting, and . Resident #3's MAR for showed that there was no documentation for the following ordered doses of medications: 10 mg scheduled for 9:00 p.m., , 20 mg scheduled for 9:00 p.m., , 2.5 mg scheduled for 9:00 p.m., 100 mg scheduled for 9:00 p.m., , 25 MG scheduled for 9:00 p.m. and 6:00 a.m. On at 12:00 p.m., during an interview with the DON and the Unit Manager, the Unit Manager stated that "it appears that the same nurse omitted documentation for multiple residents." The DON then stated that she is unable to verify that her charge nurse contacted Staff A to document on her next shift. On at 2:00 p.m., interview with staff A confirmed that she gave all the residents their scheduled medications that evening, she just did not document them because "sometimes we have a lot of ." Staff #A LPN confirmed that she "passed the med pass	{F 684}		

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	105342	A. BUILDING _____ B. WING _____	R-C 03/25/2025

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{F 684}	Continued From page 11 competency." Record review of the Medication Pass Observation competency included "medications immediately documented following administration." 2. A medication pass was observed on at 9:45 a.m., with Staff B for Resident #4 and #5. Resident #4 was asked by Staff #B LPN "are you having , ?" Resident #4 responded "yes." Staff B was then observed to remove , 325 mg 2 tablets from the med cart and administered to Resident #4. Record review of the MAR for Resident #4 showed that , 325 mg 2 tablets was documented as "given" with a , assessment score of 3. Resident #4 was not asked for a , score before or during the administration of the , . Resident #5 was asked by staff #B LPN "are you having , , do you want your cream?" Resident #5 replied "yes the cream for my ." Staff B was then observed to remove [brand name]1% gel from the supply closet and brought a measured dose to the resident. Resident #5 was not asked for her , score before or during administration of the cream. Record review of the MAR for Resident #5 showed that the [brand name] 1% gel administration includes a , score of 1. On at 12:30 p.m., during an interview with Staff B, LPN, who said that she did not ask the	{F 684}		

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{F 684}	Continued From page 12 residents about their , score because she knows them very well and can tell by looking at them. On at 2:15 p.m., an interview with the visiting DON confirmed that Staff B LPN would have to ask the Resident #5 their , score to accurately document a , number and administer an as needed medication.	{F 684}		
{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; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	{F 880}		

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{F 880}	Continued From page 13 but are not limited to: (i) A system of surveillance designed to identify possible communicable or before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable or should be reported; (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: (A) The type and duration of the isolation, depending upon the agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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 (vi)The hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of . §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	{F 880}		

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{F 880}	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to provide appropriate control practices during care for 2 (Resident #1, and #6) of 2 residents reviewed for control. The findings included: Review of the Clean Change Competency Checklist stated ...9. "gather supplies needed for change i.e. cleanser/normal , tape, gauze, scissors, gloves, pads (for cleaning scissors) bag for disposal, cotton applicators and all applicable treatment (TX) medications ....12. "wipe scissors before and after use with , . . ." 1.Review of the clinical record revealed Resident #1 was admitted to the facility on . His medical history included , , , , type 2 , , wasting and atrophy. He had physician orders for "cleanse left lateral lower with cleanser, apply honey and cover with (ABD) and gauze daily and as needed (prn)" and "cleanse right lateral lower with cleanser, apply honey and cover with ABD and gauze daily and prn." On at 10:51 a.m., observation of the Unit Manager and Director of Nursing (DON) performing a change. The Unit Manager and DON performed hygiene, put on gowns and gloves, and entered the room with supplies. The DON set a barrier on the resident's bed for the Unit Manager to place care	{F 880}	F 880 - Prevention & Control 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A. Resident #1 and 6 have had no negative outcomes. 2: How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; A. A complete audit of residents with care and feeding was done to ensure appropriate orders and interventions are in place and any abnormal findings were corrected. 3: What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; A. The Director of Nursing and Unit Managers were educated on control and proper change procedure. B. License nurses were educated on proper feeding administration and change procedures/techniques. C. Competencies for changes are completed on current license nurses and will be completed on any new license	

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{F 880}	Continued From page 15 supplies on, and set a trash bag on the corner of the resident's bed. The Unit Manager began removing old ⌄ on the resident's right and left ⌄. She then removed her gloves, performed hygiene, put on new gloves and began cleaning the . Concurrently, the DON removed her gloves and performed hygiene and then went to the care cart outside of the room, removed a pair of black scissors from the top drawer that were not in a separate container or bag. The DON brought them into the room and placed them on the clean barrier. The Unit Manager used the scissors to cut foam ⌄ that were intended to be placed on the resident's skin. The DON then used her gloved to pick up a sock from the floor, and one from a nearby closet per the resident's request, placing them on the resident's . The DON did not perform hygiene or change her gloves prior to then placing her gloved directly on the clean foam ⌄ that the Unit Manager had placed on the resident's skin to cover the . The DON used both to hold the resident's left ⌄ in the air for the Unit Manager to finish one of the . The and foam ⌄ were then dressed with a gauze bandage. hygiene was performed prior to leaving the room. The scissors were then placed by the DON on the top of the care cart. The DON obtained a container of bleach wipes and stated the Unit Manager intends to clean the scissors and place them in the care cart. Continued observation of the cart in the presence of the DON and Unit Manager who verified that the scissors, once cleaned, will be placed in a purple basket that also contains an Orange Paste, ⌄ cream intended for a resident,	{F 880}	nurses hired. D. Nursing Managers will do weekly rounds to ensure appropriate treatment and healing of is followed. E. Education of staff on the components of F880 this will be provided 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. A. The Director of Nursing/Designee will do random audits of care, and feeding administration to ensure proper procedure/techniques are being utilized weekly for four weeks then monthly for one quarter. B. 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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{F 880}	Continued From page 16	{F 880}		

and three highlighters. There was no bag or container specifically for the scissors in the drawer.

On at 11:00 a.m., during an interview, the DON stated that "scissors don't need to be cleaned prior to bringing them into the room and using them to cut for a resident, it is not a sterile change it is a clean change." The DON acknowledged that she should have performed hygiene and changed her gloves after picking the sock up from the floor, rather than touching a clean ABD that is covering a resident's with soiled gloves.

On at 12:15 p.m., during an interview, the Unit Manager stated, "the facility expectation is that the scissors are cleaned when they are removed from the drawer."

On at 1:30 p.m., during an interview the Preventionist stated, "Scissors should be stored separately in the cart." "If they are not stored separately then they should be cleaned prior to use and they are to be cleaned after use."

2.On at 2:00 p.m., Staff B Registered Nurse (RN) was observed preparing to administer a via (a specific type of tube placed in the used for feeding) for Resident #6. Staff B, RN was observed in the hallway with her medication cart in front of . She approached the medication cart carrying an unopened container of , and new tubing. She pushed the cart to the doorway of Resident #6, # . She put her gloves on, labeled the bottle with a blue sharpie marker while wearing gloves. She did not use

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{F 880}	Continued From page 17	{F 880}		

sanitizer prior to putting on gloves. A stack of paper souffle medication cups off the medication cart onto the floor. She picked them up with her gloved , threw them in the trash and continued to finish labeling the container. She did not remove her gloves or sanitize. She put on a yellow gown, then proceeded to Resident #6's bedside where she was observed to insert the tubing into the new container of . She removed the used container and tubing and placed it in the trash wearing the same gloves. She connected the tubing to Resident #6's . She did not remove her gloves or sanitize her until after completion of the process.

add wash competency
On at 2:00 p.m., Staff B Registered Nurse (RN) was observed preparing to administer a via (a specific type of tube placed in the used for feeding) for Resident #6. Staff B, RN was observed in the hallway with her medication cart in front of . She approached the medication cart carrying an unopened container of , and new tubing. She pushed the cart to the doorway of Resident #6, # . She put her gloves on, labeled the bottle with a blue sharpie marker while wearing gloves. She did not use sanitizer prior to putting on gloves. A stack of paper souffle medication cups off the medication cart onto the floor. She picked them up with her gloved , threw them in the trash and continued to finish labeling the container. She did not remove her gloves or sanitize. She put on a yellow gown, then proceeded to Resident #6's bedside where she was observed to insert the tubing into the new container of . She removed the used

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{F 880}	Continued From page 18	{F 880}		

container and tubing and placed it in the trash wearing the same gloves. She connected the tubing to Resident #6's . She did not remove her gloves or sanitize her until after completion of the process.

F880
Based on observation, staff interview and facility policy review the facility failed to provide appropriate control practices during care for 2 of 2 residents reviewed for control.

The findings included:

The facility lacks a specific care or policy.
Review of the Clean Change Competency Checklist stated ...9. "gather supplies needed for change i.e. cleanser/normal , tape, gauze, scissors, gloves, pads (for cleaning scissors) bag for disposal, cotton applicators and all applicable treatment (TX) medications ....12. "wipe scissors before and after use with ."

Review of the clinical record revealed Resident #1 was admitted to the facility on . His medical history included , , , , type 2 , wasting and atrophy. He had physician orders for "cleanse left lateral lower with cleanser, apply honey and cover with , (ABD) and gauze daily and as needed (prn)" and "cleanse right lateral lower with cleanser, apply honey and cover with ABD and gauze daily and prn."

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{F 880}	Continued From page 19 On at 10:51 a.m., Direct Observation of the Unit Manager and Director of Nursing (DON) during an change observation. The Unit Manager and DON performed hygiene, put on gowns and gloves, and entered the room with supplies. The DON set a barrier on the resident's bed for the Unit Manager to place care supplies on, and set a trash bag on the corner of the resident's bed. The Unit Manager began removing old on the resident's right and left . She then removed her gloves, performed hygiene, put on new gloves and began cleaning the . Concurrently, the DON removed her gloves and performed hygiene, and then went to the care cart outside of the room and removed a pair of black scissors from the top drawer. The scissors were not in a separate container or bag, and they were not cleaned prior to the DON bringing them into the room and placing them on the clean barrier. The Unit Manager used the scissors to cut foam that were intended to be placed on the resident's skin. The DON then used her gloved to pick up a sock off of the floor, and one from a nearby closet per the resident's request and put them on the resident's . The DON did not perform hygiene or change her gloves prior to then placing her gloved directly on the clean foam that the Unit Manager had placed on the resident's skin to cover the . The DON used both to hold the resident's in the air for the Unit Manager to finish the . The and foam were then dressed with a gauze bandage. hygiene was performed prior to leaving the room. The scissors were then placed by the DON on the top of the care cart. The scissors were then placed on top of the cart	{F 880}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB & HEALTHCARE CENTER OF CAPE CORAL	2629 DEL PRADO BLVD CAPE CORAL, FL 33904

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{F 880}	Continued From page 20 and the DON obtained a container of bleach wipes and stated the Unit Manager intends to clean the scissors and place them in the care cart. Continued direct observation of the cart in the presence of the DON and Unit Manager who verified that the scissors, once cleaned, will be placed in a purple basket that also contains an Orange Paste, cream intended for a resident, and three highlighters. There was no bag or container specifically for the scissors in the drawer. On at 11:00 a.m. during an interview The DON stated that "scissors don't need to be cleaned prior to bringing them into the room and using them to cut for a resident it is not a sterile change it is a clean change." The DON acknowledged that she should have performed hygiene and changed her gloves after picking the sock up off of the floor, rather than touching a clean ABD that is covering a resident's round with soiled gloves. On at 12:15 p.m., during an interview the Unit Manager stated, "the facility expectation is that the scissors are cleaned when they are removed from the drawer." per the competency form. She stated "Yes they are supposed to be cleaned when they are taken out of the drawer." On at 1:30 p.m., during an interview the Preventionist, stated "Scissors should be stored separately in the cart. "If they are not stored separately then they should be cleaned prior to use and they are to be cleaned after use." On at 2:00 p.m., Staff B Registered	{F 880}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105342	A. BUILDING _____ B. WING _____	R-C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 880}	Continued From page 21 Nurse (RN) was observed preparing to administer a ˬ via (a specific type of tube placed in the used for feeding) for Resident #6. Staff B, RN was observed in the hallway with her medication cart in front of . She approached the medication cart carrying an unopened container of ˬ, and new tubing. She pushed the cart to the doorway of Resident #6, # . She put her gloves on, labeled the bottle with a blue sharpie marker while wearing gloves. She did not use sanitizer prior to putting on gloves. A stack of paper souffle medication cups off the medication cart onto the floor. She picked them up with her gloved , threw them in the trash and continued to finish labeling the ˬ container. She did not remove her gloves or sanitize. She put on a yellow gown, then proceeded to Resident #7's bedside where she was observed to insert the tubing into the new container of ˬ. She removed the used container and tubing and placed it in the trash wearing the same gloves. She connected the tubing to Resident #7's , ˬ . She did not remove her gloves or sanitize her until after completion of the process.	{F 880}		