STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105439	A. BUILDING _____ B. WING _____	C 04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAPLES HEALTH AND REHABILITATION CENTER	2900 12TH STREET N NAPLES, FL 34103

(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) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint survey for #2024015993 was conducted on at Naples Health And Rehabilitation Center, a skilled nursing facility in Naples, Florida. Complaint #2024015993 was substantiated with a citation at F604. Naples Health And Rehabilitation Center 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 604 SS=D	Right to be Free from Physical CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from , neglect, misappropriation of resident property, and , as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary and any physical or chemical not required to	F 604		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105439	A. BUILDING _____ B. WING _____	C 04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAPLES HEALTH AND REHABILITATION CENTER	2900 12TH STREET N NAPLES, FL 34103

(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) COMPLETION DATE
F 604	Continued From page 1 treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for . This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to protect residents' right to be free from physical for 1 (Resident #1) of 1 resident reviewed for . The findings included: Review of the clinical record revealed Resident #1 was re-admitted to the facility on . Diagnoses included (in the), Aphasia (language affecting ability to speak) following , and . The Admission Minimum Data Set (MDS) assessment with a target date of noted the resident's cognition was severely , with a score of "05". Review of the facility's incident investigations revealed on at 7:45 a.m., the Director of Rehab reported to the Administrator when the Certified Occupational Assistant (COTA) went to get Resident #1 for , she	F 604	Preparation and submission of this Plan of Correction does not constitute ab admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of requirements under state and federal laws. F 604- Right to Be Free from Physical The gait belt was immediately removed from the resident and chair by the certified assistant (COTA). The COTA immediately notified her supervisor the director of rehabilitation (DOR) who immediately reported to the facility Administrator. Administrator immediately spoke to the staff member and relieved of her of duty until further investigation is completed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105439	A. BUILDING _____ B. WING _____	C 04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAPLES HEALTH AND REHABILITATION CENTER	2900 12TH STREET N NAPLES, FL 34103

(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) COMPLETION DATE
F 604	Continued From page 2 found the resident in his room, in his wheelchair with a sitter. The resident had a gait belt around his abdomen and secured to the of the wheelchair. The resident was assessed and there were no injuries. The investigation noted Resident #1's sitter said in an interview that she was assigned to provide one to one supervision to Resident #1 during the alleged incident. She said she had been assigned to the resident for a double shift starting at 10:00 p.m. She said Resident #1 for up at around 5:00 a.m. Resident #1 kept getting up. The , came by and said she would be right to bring the resident to , , . The sitter said she put the gait belt on because Resident #1 kept getting up. She said she was holding onto the gait belt with the resident in the wheelchair waiting for the , to return. It was only a few seconds and she did not attach the gait belt to the wheelchair. The investigation noted the COTA said when she went to get the resident for , , , she saw the gait belt around the resident's abdomen and attached to the wheelchair. It wasn't tight to cause injury but secured to keep the resident in the chair. The facility's conclusion noted Resident #1 kept getting up and the sitter used the gait belt to keep the resident from getting up until , , returned. On at 10:50 a.m., in an interview the Social Services Director said he has been at employed at the facility for about three years. He could not remember exactly what the resident said but he assisted in conducting interviews with	F 604	Resident was assessed and found to have no injuries nor , affected but this use of the gait belt. - 100 % audit of all residents in the facility to assess if were being utilized anywhere else with no observations of use were observed. - Ten residents were interviewed by Social Services to determine if the staff treated them with dignity and respect and if they had ever been in a situation that made them feel uncomfortable , do they feel safe? 100 % of the interviewees had no negative responses. - Ten staff members were interviewed to see if they had ever observed a staff member , family member or another resident or restrain a resident. 100% of the responses received no indication that it had ever been observed. 100 % Staff education completed by on , Neglect and Misappropriation and post test administered to ensure comprehension or received education that gait belts cannot be used as a form of . As part of a systematic change, Nursing Home Administrator/Designee while on rounds will observe for the use of . Education was provided to Department Heads on the addition of observation for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105439	A. BUILDING _____ B. WING _____	C 04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAPLES HEALTH AND REHABILITATION CENTER	2900 12TH STREET N NAPLES, FL 34103

(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) COMPLETION DATE
F 604	Continued From page 3 other residents. He said all staff were educated on and neglect training. He said he has never seen a staff member restrain a resident and would report to a supervisor if he did. On at 11:15 a.m., in an interview , , , Assistant Staff A said on when she went into Resident #1's room for , , she noticed the gait belt was wrapped around Resident #1 and the wheelchair. His caregiver was in the room next to him. She reported it to her Supervisor immediately. She said the resident was fine with no injuries. She said she removed the gait belt. She said the belt was around the residents waist to the of wheelchair. She said she has never seen any other resident restrained and if she did she knew what to do. On at 11:20 a.m., in an interview Sitter Staff B said she has worked for the facility since 2001. She said she remembers Resident #1 and was working as a sitter for him on the day in question. She said Resident #1 was trying to jump out of bed and she put him in wheelchair and put gait belt around him but did not fasten it. She said she was just holding it to keep him from falling out of the wheelchair. She said the , , lady said she was coming to get the patient and she forgot to remove the belt. She said she had never seen the gait belt in the room before that day. She said she was sent home while there was an investigation. She said she has since had training for and neglect and not to use gait belt anymore. She now works only in dietary. She said she has never seen any resident restrained but if she did she would report it.	F 604	the us of and completed on . Round sheets will be turned into Administrator daily Monday- Friday indicating if anything is observed that needs to be evaluated as a possible so that immediate action can be taken. Weekend Supervisor will complete facility rounds observing each room looking for any item that could be identified as a . If found proper notifications to be completed if possible are observed. The rounds will be completed daily for a period of 4 weeks , then twice for one month and then weekly for one month until substantial compliance is met. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been met	

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
	81103	A. BUILDING: _____ B. WING _____	C 04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAPLES HEALTH AND REHABILITATION CENTER	2900 12TH STREET N NAPLES, FL 34103

(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 complaint survey for #2024015993 was conducted on at Naples Health And Rehabilitation Center, a skilled nursing facility in Naples, Florida. Complaint #2024015993 was substantiated with a citation at N204. The following is the description of the deficiencies.	N 000		
N 204 SS=D	400.022(1)(o), FS Right to be Free from , , etc 400.022, F. S. (1)(o) All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the following: (o) The right to be free from mental and , , , , neglect, , , corporal punishment, extended involuntary , and , , corporal punishment, extended involuntary , and physical and chemical , except those authorized in writing by a physician for a specified and limited period of time or as are necessitated by an emergency. In case of an emergency, may be applied only by a qualified licensed nurse who shall set forth in writing the circumstances requiring the use of , and, in the case of use of a chemical , a physician shall be consulted immediately thereafter. may not be used in lieu of staff supervision or merely for staff convenience, for punishment, or for reasons	N 204		

AHCA Form 3020-0001

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

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
	81103	A. BUILDING: _____ B. WING _____	C 04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAPLES HEALTH AND REHABILITATION CENTER	2900 12TH STREET N NAPLES, FL 34103

(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 204	Continued From page 1 other than resident protection or safety. This Statute or Rule is not met as evidenced by: Based on record review and staff interviews the facility failed to protect residents' right to be free from physical for 1 (Resident #1) of 1 resident reviewed for . The findings included: Review of the clinical record revealed Resident #1 was re-admitted to the facility on . Diagnoses included (in the), Aphasia (language affecting ability to speak) following , and . The Admission Minimum Data Set (MDS) assessment with a target date of noted the resident's cognition was severely , with a score of "05". Review of the facility's incident investigations revealed on at 7:45 a.m., the Director of Rehab reported to the Administrator when the Certified Occupational Assistant (COTA) went to get Resident #1 for , , she found the resident in his room, in his wheelchair with a sitter. The resident had a gait belt around his abdomen and secured to the of the wheelchair. The resident was assessed and there were no injuries. The investigation noted Resident #1's sitter said in an interview that she was assigned to provide one to one supervision to Resident #1 during the alleged incident. She said she had been assigned to the resident for a double shift starting at 10:00	N 204	Preparation and submission of this Plan of Correction does not constitute ab admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of requirements under state and federal laws. Tag 0024- Right to Be Free from , , etc The gait belt was immediately removed from the resident and chair by the certified , , assistant (COTA). The COTA immediately notified her supervisor the director of rehabilitation (DOR) who immediately reported to the facility Administrator. Administrator immediately spoke to the staff member and relieved of her of duty until further investigation is completed. Resident was assessed and found to have no injuries nor , , , affected but this use of the gait belt. - 100 % audit of all residents in the facility to assess if were being utilized anywhere else with no observations of use were observed. - Ten residents were interviewed by Social Services to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	81103	A. BUILDING: _____ B. WING _____	C 04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAPLES HEALTH AND REHABILITATION CENTER	2900 12TH STREET N NAPLES, FL 34103

(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 204	Continued From page 2 p.m. She said Resident #1 for up at around 5:00 a.m. Resident #1 kept getting up. The , came by and said she would be right to bring the resident to . . . The sitter said she put the gait belt on because Resident #1 kept getting up. She said she was holding onto the gait belt with the resident in the wheelchair waiting for the , to return. It was only a few seconds and she did not attach the gait belt to the wheelchair. The investigation noted the COTA said when she went to get the resident for , , she saw the gait belt around the resident's abdomen and attached to the wheelchair. It wasn't tight to cause injury but secured to keep the resident in the chair. The facility's conclusion noted Resident #1 kept getting up and the sitter used the gait belt to keep the resident from getting up until , returned. On at 10:50 a.m., in an interview the Social Services Director said he has been at employed at the facility for about three years. He could not remember exactly what the resident said but he assisted in conducting interviews with other residents. He said all staff were educated on and neglect training. He said he has never seen a staff member restrain a resident and would report to a supervisor if he did. On at 11:15 a.m., in an interview , , Assistant Staff A said on when she went into Resident #1's room for . . , she noticed the gait belt was wrapped around Resident #1 and the wheelchair. His caregiver was in the room next to him. She reported it to her Supervisor immediately. She	N 204	determine if the staff treated them with dignity and respect and if they had ever been in a situation that made them feel uncomfortable , do they feel safe? 100 % of the interviewees had no negative responses. . - Ten staff members were interviewed to see if they had ever observed a staff member , family member or another resident or restrain a resident. 100% of the responses received no indication that it had ever been observed. 100 % Staff education completed by on , Neglect and Misappropriation and post test administered to ensure comprehension or received education that gait belts cannot be used as a form of . As part of a systematic change, Nursing Home Administrator/Designee while on rounds will observe for the use of . Education was provided to Department Heads on the addition of observation for the us of and completed on . Round sheets will be turned into Administrator daily Monday- Friday indicating if anything is observed that needs to be evaluated as a possible so that immediate action can be taken. Weekend Supervisor will complete facility rounds observing each room looking for any item that could be identified as a . If found proper	

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
	81103	A. BUILDING: _____ B. WING _____	C 04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAPLES HEALTH AND REHABILITATION CENTER	2900 12TH STREET N NAPLES, FL 34103

(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 204	Continued From page 3 said the resident was fine with no injuries. She said she removed the gait belt. She said the belt was around the residents waist to the of wheelchair. She said she has never seen any other resident restrained and if she did she knew what to do. On at 11:20 a.m., in an interview Sitter Staff B said she has worked for the facility since 2001. She said she remembers Resident #1 and was working as a sitter for him on the day in question. She said Resident #1 was trying to jump out of bed and she put him in wheelchair and put gait belt around him but did not fasten it. She said she was just holding it to keep him from falling out of the wheelchair. She said the lady said she was coming to get the patient and she forgot to remove the belt. She said she had never seen the gait belt in the room before that day. She said she was sent home while there was an investigation. She said she has since had training for and neglect and not to use gait belt anymore. She now works only in dietary. She said she has never seen any resident restrained but if she did she would report it. Class III	N 204	notifications to be completed if possible are observed. The rounds will be completed daily for a period of 4 weeks , then twice for one month and then weekly for one month until substantial compliance is met. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been met	