STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105864	A. Building B. Wing	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Page Rehabilitation and Healthcare Center	2310 N Airport Road Fort Myers, FL 33907

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, record review and staff interview the facility failed to treat residents with respect and dignity for 1 (Resident #110) of 28 cognitively impaired residents on the memory care unit. The findings included: The facility policy ADL Care-Supporting Resident-General (revised 4/2022), documented Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL's). If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Review of the clinical record revealed Resident #110 had an admitted [DATE] with diagnoses including paranoid schizophrenia, dementia, anxiety, mood disturbance, major depressive disorder and psychotic disturbance. The Annual Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date of 6/20/23 documented Resident #110 required extensive assistance of 1 for personal hygiene, dressing and dependent on staff for bathing. The MDS noted Resident #110's cognitive skills for daily decision making was moderately impaired. The plan of care revised on 6/23/23 identified Resident #110 had an activities of daily living deficit related to dementia and schizophrenia and refused care at times. The goal of care was for Resident #110 to have her needs met by staff. On 7/24/23 at 10:00 a.m., Resident #110 was observed sitting in her wheelchair (w/c) by the exit door on the secured memory care unit. Upon approach, it was noted the resident was naked from the waist down with no pants or undergarments on. On 7/24/23 at 10:05 a.m., Certified Nursing Assistant (CNA) Staff E said Resident #110 sits all day at the back door. When informed of the resident's lack of clothing the CNA said, she is very combative and would not let you do anything for her. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105864	A. Building B. Wing	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Page Rehabilitation and Healthcare Center	2310 N Airport Road Fort Myers, FL 33907

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/23 at 10:30 a.m., an observation with Registered Nurse (RN) Staff F, noted Resident #110 in the same state of undress with male residents wandering up and down the hall. Staff F said she would get a CNA to assist the resident. On 7/24/23 at 10:45 a.m., RN Staff F said she spoke with the CNA and the resident is very combative and won't let you touch her. On 7/24/23 at 1:03 p.m., Resident #110 was observed in the back hall in her w/c with no clothing on her lower body and no brief. RN Staff F said, I don't know what we can do with her, she refuses care. On 7/24/23 observations at 2:54 p.m., 3:33 p.m., and 6:00 p.m., Resident #110 was in her w/c at the end of the hallway facing the main center area of the unit. She has no clothing on her lower body and no undergarments. There were male residents who were coming and going in the same hallway. On 7/25/23 at 11:30 a.m., Resident #110 was sitting in the back hallway without clothing on her lower body and no brief. She said she did not know what happened to her clothes and did not answer questions appropriately. On 7/25/23 at 4:04 p.m., in an interview the Unit Manager RN Staff J said Resident #110 is very combative and we can't force her to put clothes on. She will remove her clothing. We can't medicate her to provide care because it would be a restraint and we don't restrain the residents. On 7/26/23 at 10:13 a.m., in an interview the Director of Nursing (DON) was notified of the concerns with Resident #110 being in the hallway with no clothing or brief on her lower body, while male residents were in the hall. The DON said the residents behaviors should not have prevented the staff from providing care or placing something on the resident to cover her.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105864	A. Building B. Wing	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Page Rehabilitation and Healthcare Center	2310 N Airport Road Fort Myers, FL 33907

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46824 Based on record review, interview and facility policy, the facility failed to refer 1 (Resident #34) of 4 resident reviewed for a Preadmission Screening and Resident Review (PASARR) level II screening after a newly diagnosed mental disorder. Resident #34 was admitted to the facility on [DATE]. The Minimum Data Set (MDS) with ARD of 6/21/22 listed diagnoses of Urinary Tract Infection, Stroke, Non-Alzheimer's Dementia, Hemiplegia, Anxiety. The Quarterly MDS review on 12/20/22 first noted resident to be diagnosed with Schizophrenia. The findings included a Level 1 screen was completed prior to admission on 4/8/22. There was no documentation of the Schizophrenia diagnoses until 12/20/22. On 7/25/23 at 2:21 p.m., The Social Service Director (SSD) verified Resident #34 was admitted [DATE]. A level one was completed but SSD stated there was no diagnosis of Dementia or Schizophrenia on the Level 1 PASSAR. The SSD stated the facility process is to complete a Level 2 PASSAR if any type of psychiatric diagnosis is made. SSD stated her department would be responsible for requesting a Level 2. SSD stated now that I am aware we will get consent to obtain the level 2 and request it be completed. The SSD said she did not know why a referral was not made to the state/keppro agency. I was not here at that time, but we are doing one today. The Level 2 should have already been done. Resident #34's spouse will be in tomorrow to complete the paperwork. On 7/26/23 at 4:37 p.m., the MDS nurse verified resident had a new diagnosis of Vascular Dementia and Schizophrenia which should have triggered a level 2 with the Social Work Department. On 7/27/23 at 1:48 p.m., the Director of Nursing said staff are now reviewing all the PASARR's for the building and were working with KEPPRO to complete them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105864	A. Building B. Wing	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Page Rehabilitation and Healthcare Center	2310 N Airport Road Fort Myers, FL 33907

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, review of facility policy, record review and staff interview the facility failed to provide the necessary care and services to maintain personal hygiene for 1 (Resident #110) of 6 residents reviewed for ADL care. The findings included: The facility policy ADL Care-Supporting Resident-General (revised 4/2022), documented Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL's). If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Review of the clinical record revealed Resident #110 had an admitted [DATE] with diagnoses including paranoid schizophrenia, dementia, anxiety, mood disturbance, major depressive disorder, and psychotic disturbance. The Annual Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date of 6/20/23 documented Resident #110 required extensive assistance of 1 for personal hygiene, dressing and dependent on staff for bathing. The MDS noted Resident #110's cognitive skills for daily decision making was moderately impaired. The plan of care revised on 6/23/23 identified Resident #110 had an activities of daily living deficit related to dementia and schizophrenia and refused care at times. The goal of care was for Resident #110 to have her needs met by staff. On 7/24/23 at 10:00 a.m., Resident #110 was observed sitting in her wheelchair (w/c) in the hallway by the exit door on the secured memory care unit. Upon approach, it was noted the resident was naked from the waist down with no pants or undergarments on. The resident's hair was greasy and uncombed. Her fingernails were very long extending approximately 1 1/2 inch to 2 inches past the tip of her fingers. The fingernails had a brown substance under the nailbeds and some of the fingernails were so long they were curling upward. Resident #110 did not have socks or shoes on and her toenails were approximately 1 inch in length past the tip of her toes. On 7/24/23 at 10:05 a.m., Certified Nursing Assistant (CNA) Staff E said Resident #110 sits all day at the back door. When informed of the resident's lack of clothing the CNA said, she is very combative and would not let you do anything for her. On 7/24/23 at 10:30 a.m., an observation with Registered Nurse (RN) Staff F, noted Resident #110 in the same state of undress with male residents wandering up and down the hall. Staff F said she would get a CNA to assist the resident. On 7/24/23 at 10:45 a.m., RN Staff F said she spoke with the CNA and the resident is very combative and won't let you touch her. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105864	A. Building B. Wing	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Page Rehabilitation and Healthcare Center	2310 N Airport Road Fort Myers, FL 33907

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/23 at 1:03 p.m., Resident #110 was observed in the back hall in her w/c with no clothing on her lower body and no brief. RN Staff F said, I don't know what we can do with her, she refuses care. On 7/24/23 observations at 2:54 p.m., and 3:33 p.m., Resident #110 was in her w/c at the end of the hallway facing the main center area of the unit. She had no clothing on her lower body. On 7/24/23 at 6:00 p.m., Resident #110 was observed naked from the waist down in the hallway, eating her meal, dropping food in her lap, picking it up and eating it. On 7/25/23 at 11:30 a.m., Resident #110 was sitting in the back hallway without clothing on her lower body and no brief. She said she did not know what happened to her clothes and did not answer questions appropriately. On 7/25/23 at 3:22 p.m., in an interview, CNA Staff H confirmed the condition of the resident's finger and toenails and said I know they are long but she won't let us touch her so we leave her alone. The resident can get up and walk and she showers herself when she wants to. We can't make her do it. She fights you so we don't touch her. On 7/25/23 at 3:29 p.m., CNA Staff K confirmed Resident #110's finger and toenails were very long and dirty. Staff K said the resident won't let you touch them, she refuses care and will hit you, so we don't touch her. The CNA said the resident showers herself; we just leave the towels in the bathroom for her. She does what she wants, she gets in and out of the w/c and sometimes she sleeps right here in the w/c, we can't do anything about it. On 7/25/23 at 4:04 p.m., in an interview the Unit Manager RN Staff J said Resident #110 is very combative, and we can't force her to put clothes on. She will remove her clothing. We can't medicate her to provide care because it would be a restraint and we don't restrain the residents. On 7/26/23 at 10:13 a.m., in an interview the Director of Nursing (DON) said nail care should be provided every shower day and as needed. The DON said Resident #110's behaviors should not have prevented the staff from providing care. On 7/27/23 at 8:07 a.m., the DON, she said she observed Resident #110 nails and asked her if she could trim them. The DON said the resident agreed to have the podiatrist cut her nails.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105864	A. Building B. Wing	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Page Rehabilitation and Healthcare Center	2310 N Airport Road Fort Myers, FL 33907

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46824 Based on observation, record review, resident, staff and physician interview, the facility failed to change Central Venous Catheter dressing in accordance with physician's orders for 1 (Resident #76) of 1 resident reviewed for Central Venous Catheter. The finding Included: Facility policy titled Central Venous Catheter Dressing Changes, revised 1/17/2019, stated Central Venous Catheter dressings will be changed at specific intervals, or when needed to prevent catheter related infections that are associated with contaminated, loosened, soiled, or wet dressings. Preparation indicated to verify with state nurse practice act the scope of practice for Registered Nurses and Licensed Practical Nurses regarding this procedure. A provider order is not needed for this procedure. Dressing must stay clean, dry, and intact. Change transparent semi-permeable membrane dressing at least every 5-7 days and as needed when wet, soiled or not intact. The following information should be recorded in the resident's medical record including the date and time the dressing was changed, the type of dressing used and wound care [NAME], and problems, complaints, or complications. If the resident refused the treatment, the reason for refusal and the resident's response to the explanation of the risks of refusing the procedure, the benefits of accepting and available alternatives. Document family and physician notification of refusal. Notify the supervisor if the resident refuses the dressing change. A policy titled Monitoring and Removal of Midline Catheters and PICC Lines revised 1/2023 stated: immediately upon removal (of the catheter), cover insertion site with Vaseline gauze dressing, then gauze, then tape. Leave on for 72 hours. Measure the catheter length and inspect the catheter and tip. Resident #76 was admitted to the facility on [DATE]. Medical Diagnoses included Muscular Sclerosis, Sepsis, UTI. Resident #76 Electronic Health Record contained hospital notes from prior to facility admission. Resident #76 had a Central Venous Catheter inserted, called a double lumen power line which was 23 centimeters, 5 French to receive antibiotics once discharged from the hospital. The Physician order with an effective date of 7/7/23 was to Change PICC/ Midline dressing weekly and as needed, one time a day every Wednesday and as needed for Dressing Change. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105864	A. Building B. Wing	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Page Rehabilitation and Healthcare Center	2310 N Airport Road Fort Myers, FL 33907

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #76 care plan initiated on 6/29/23 indicated resident is receiving intravenous (IV) therapy related to IV antibiotics. Central line right chest. Care plan interventions included monitor site every shift and as needed for redness, swelling, or dislodging; flush per pharmacy protocol; change dressing weekly and as needed for soilage and dislodgement; change cap and extension set weekly and as needed for soilage or dysfunction. Review of the electronic health record progress notes from 6/28/23 through 7/24/23 showed no documentation of central venous catheter dressing change or cap change. Resident #76 Medication administration record indicated the CVC catheter dressing was to be changed weekly and as needed on Wednesday. On 7/12/23, LPN Staff X documented the dressing had been changed, but later stated it had not been done because it fell outside the scope of her license. On 7/19/23 staff documented resident refused to have the dressing changed. No progress note was entered to reflect the refusal or attempts to retry the dressing change on another day. On 7/25/23 at 11:25 a.m., Resident #76 was observed in bed on her back. The Central Venous Catheter (CVC) intravenous line was exposed. The CVC sterile dressing was dislodged on three sides, only attached by a lower corner leaving the CVC insertion site open to air and uncovered. The antibiotic disk was stuck on the dislodged catheter, not near the CVC line insertion site. The dislodged dressing was dated 6/27/23. On 7/25/23 at 11:32 a.m., Licensed Practical Nurse (LPN) Staff P stated the dressing should be changed weekly and does not know why it has not been changed. LPN Staff X, said no one informed her of Resident #76 refusal to have dressing changed. On 7/25/23 at 11:33 a.m., the weekend supervisor stated she was not aware the dressing had not been changed. On 7/27/23 at 8:30 a.m., Resident #76 was observed in bed. She stated the CVC catheter was removed yesterday by the physician. A dry gauze dressing was in place secured with a piece of paper tape. It was not dated or initialed. On 7/27/23 at 8:40 a.m., LPN Staff P said she was present when the CVC line was removed. It was not measured and only the dry gauze dressing was applied. She stated she learned about IV therapy in school but could not recall if she was IV certified. LPN Staff P said she was not aware of the facility policy to apply a vaseline gauze dressing. On 7/27/23 at 8:47 a.m., the Assistant Director of Nursing (ADON) said we do not check nurses for IV competency. We recognize this is an issue. Human Resources does not ask about IV certification or the 4-hour competency upon hire. LPN Staff X documented the dressing change had been completed but the care was not provided. After the physician removed the CVC a dry gauze dressing was applied with paper tape, no Vaseline gauze per facility policy. An IV certified nurse would have known the expectations for safe CVC care and documentation. When a resident refused the care, the nurses should have tried again the same day or next day and let their supervisor know. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105864	A. Building B. Wing	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Page Rehabilitation and Healthcare Center	2310 N Airport Road Fort Myers, FL 33907

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/27/23 at 4:05 p.m., during an interview with LPN Staff P and The Medical Director, he said he removed the CVC line. He stated he was not aware the dressing had not been changed to the central line, since the resident was admitted to the facility. Staff P said she had not notified the physician the dressing had not been changed per his orders. The Medical Director said the staff contact him all the time. He wanted to be informed if there was a problem with a resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105864	A. Building B. Wing	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Page Rehabilitation and Healthcare Center	2310 N Airport Road Fort Myers, FL 33907

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38570 Based on observation, record review, interview, and review of the facility policies, the facility failed to ensure treatment and services for prevention and management of pressure ulcers were provided in accordance with accepted standards of practice for 3 (Resident #42, #107 and #160) of 8 residents reviewed for pressure ulcers. The findings included: Review of the facility's policy titled, Clean Non-Sterile Dressing Change. Dated 8/2016, showed the facility nurses will use non-sterile but clean aseptic technique for dressing changes. Procedure: Preparation for dressing change item 4. Assemble the equipment and supplies as needed. Steps in the procedure: 2. Place the clean equipment on the clean field. Arrange the supplies so they can be easily reached. Review of the facility's policy titled Risk Assessment and Prevention, . Dated 4/2023 documented The facility will strive to ensure that a resident entering the facility without pressure ulcers/pressure injuries does not develop pressure ulcers/pressure injuries unless the residents clinical condition demonstrates unavoidable skin breakdown. Prevention of pressure ulcers/injuries requires early identification of at risk residents and the implementation of prevention stratigies. 1. A Review of Resident #107's Admission record revealed the facility admitted the resident on 6/20/23 with a Post-Surgical Wound on her buttocks (surgical flap to cover and repair a pressure ulcer). The resident also had the following diagnosis: diabetes, cerebral infarction with left sided weakness (stroke), muscle wasting and atrophy. A Review of the admission Minimum Data Set (MDS), dated [DATE] revealed Resident#107 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderately impaired cognition. The MDS indicated the resident required extensive assistance of two or more people for bed mobility, dressing, and personal hygiene. MDS also indicated that resident was dependent and needed assistance of two or more people for transfers, eating and toilet use. The resident was a risk for pressure ulcers/injuries and had a surgical would that had been associated with a prior pressure ulcer on her buttocks. A Review of Care Plan, dated 6/21/2023 and updated 7/05/2023, revealed Resident #107 is at risk of pressure ulcer development/impaired skin integrity related to history of stage 4 pressure ulcer with flap repair to sacrum (dehisced) and right heel (graft site). Sacral flap reopening-surgical consult 7/05/2023. Interventions include administering treatments as ordered and monitoring effectiveness. On 7/26/2023 at 7:35 a.m., the wound care physician said the resident had been admitted to the facility with a surgical flap to her buttocks that had started to fail, and he was called in to evaluate and treat. The wound care physician said he sees the resident weekly and the nurses change the dressing daily and as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105864	A. Building B. Wing	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Page Rehabilitation and Healthcare Center	2310 N Airport Road Fort Myers, FL 33907

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of Resident #107 physician's orders indicated the following wound care orders. Cleanse post-surgical wound on sacrum with normal saline (N/S), gently pat dry. Apply Dankins 1/4 solution in a loose packing with single Kerlix. Apply a foam border dressing as a secondary. Change daily and as needed. On 7/26/2023 at 7:15 a.m., observed wound care nurse Staff Q change Resident #107's sacrum dressing. The nurse did not place a clean barrier down after removing the soiled dressing. Staff Q used his gloved hands to search three of his uniform pockets to find his scissors. He cut the Keflex with the scissors that had not been cleaned, placed the scissors on the tray table and pushed the remaining Kerlix into the wound. On 7/26/2023 at 1:30 p.m., Staff Q said he should have placed a clean barrier down after removing soiled dressing from Resident #107's sacral wound. Staff Q also said he should not have retrieved his scissors from his pocket with his gloved hands and used them to cut the clean dressing before putting the remaining packing dressing into the wound. Staff Q said this did not follow infection control guidelines. On 7/26/2023 at 1:40 p.m., the Infection Control Nurse said Staff Q should have placed a clean barrier down on resident bed after soiled dressing was removed from wound and before starting clean procedure. She also said Staff Q should not have gone through his pockets wearing his gloves to find his scissors and then used the dirty scissors to cut the Kerlix gauze and place the remainder in the wound. She said this was not according to infection control guidelines. 41155 2. On 7/24/23 at 11:49 a.m., in an interview Resident #42 said she had a wound on her coccyx. She said the staff are treating the wound but said she was not consistently repositioned and turned. She was positioned on her right side and was on an air mattress. She said she had been in this position since 10 a.m., but at night she lays in the same spot for 6 hours or more. On 7/24/23 at 1:02 p.m., Resident #42 remained in bed positioned on her right side. On 7/25/23 during observations at 7:34 a.m., 7:48 a.m., 10:08 a.m.,12:29 p.m., and 12:59 p.m., Resident #42 was observed in bed lying on her back. Review of the clinical record revealed Resident #42 had an admitted [DATE] with diagnoses including Parkinson's disease, osteoarthritis, protein calorie malnutrition, and dementia. The Admission Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date of 1/16/21 documented Resident #42 required extensive assistance of 1 for bed mobility, transfers, personal hygiene, and dressing. The MDS noted Resident #42 had no pressure wounds and was not on a turning program. The MDS identified the resident was at risk for pressure ulcers. The care plan initiated on 1/29/21 and revised on 5/10/23 identified Resident #42 was at risk for pressure ulcer development/impaired skin integrity related to incontinence, history of pressure ulcers, decreased mobility, and fragile/thin skin. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105864	A. Building B. Wing	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Page Rehabilitation and Healthcare Center	2310 N Airport Road Fort Myers, FL 33907

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	The goal was for Resident #42 was to maintain skin integrity. The interventions included to assist with the turning and repositioning as needed. Do not leave me on bony areas or in one position for long periods of time, administer treatments as ordered and monitor for effectiveness. On 6/16/22 the skin/wound progress documented; Coccyx area assessed. She has chronic redness to this area. Resident positioned on side. She was encouraged to get up to wheelchair daily. On 10/30/22 the nursing progress note documented open wound on coccyx 1 x 1 centimeter (cm), wound cleansed and covered with foam dressing. The care plan was not updated with the new pressure wound and no new interventions were initiated to prevent the worsening of the pressure ulcer. On 10/31/22 the skin wound note documented, attending nurse called Wound Care Nurse to notify of a pressure injury on resident sacrum. Upon evaluation a stage 3 pressure ulcer measuring 1.2 x 1.2 x 0.3 with light serous exudate. New treatment is established. Order for air mattress as well. Turning and positioning program as per facility protocol. Resident will be followed by wound care team. The care plan was not updated with the new interventions to promote wound healing once the stage 3 wound was identified. Resident continued to be evaluated weekly by the Wound Care Nurse. On 1/25/23 the Wound Care Physician completed, an initial evaluation of the coccyx wound and documented, A thorough wound care assessment and evaluation was performed today. She has a stage 3 pressure wound coccyx for at least 7 days duration. Wound size (length x width x depth) 2.5 x 1.5 x 0.2 cm. A Significant change MDS was completed with ARD 7/6/23 documented Resident #42 required extensive assistance with bed mobility, toileting, and personal hygiene. The MDS documented the resident had an in house acquired stage 3 pressure ulcer. The MDS showed the resident's cognitive skills for daily decision making were intact. On 7/12/23 the care plan goal was revised to will minimize risk of skin breakdown. The pressure wound was not identified in the care plan and no new interventions were implemented to address the pressure wound. On 7/24/23 the treatment was changed to Sodium Hypochlorite External Solution 0.25 % (Sodium Hypochlorite). Apply to coccyx topically every evening shift for pressure ulcer for 30 days, pack impregnated 4 x4 gauze. Cover with foam silicone dressing and apply to coccyx topically as needed for pressure ulcer for 30 days (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105864	A. Building B. Wing	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Page Rehabilitation and Healthcare Center	2310 N Airport Road Fort Myers, FL 33907

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	On 7/25/23 at 3:53 p.m., in an interview the Hospice RN said Resident #42 was admitted to hospice services on 7/17/23 with a diagnosis of end stage Parkinson's disease. The Hospice nurse said the resident had a wound on her coccyx that is more than 168 days in duration. The RN said when Resident #42 was admitted to services the wound was a stage 2. The RN said the resident's comfort was managed with tramadol 50 milligrams(mg) every 12 hours, but she had recently reported increased pain in the wound, so the hospice physician increased the tramadol to 50 mg every 8 hours and it seems to be helping her. The Hospice RN said the facility does the wound care, but she does ask the CNA to assist her to observe the wound and she collaborates with staff and the Wound Care Physician. On 7/26/23 at 7:49 a.m., observation of Resident #42's wound and wound care with the Wound Care Registered Nurse (RN) Staff Q and the Wound Care Physician. Upon entering the room, it was noted that the air mattress was deflated and not functioning. LPN Staff M was notified and managed to get the air mattress functioning and said she would notify the Hospice of the problem. The Wound Care Physician measured the wound at 6.1 x's 5.1 x with undermining at 0.5 cm at 12:00. The wound was identified as a stage 4 with 90% devitalized necrotic tissue and 10% muscle. The Physician said the wound was getting worse with greater than 176 days duration. On 7/27/23 at 9:39 a.m., interview LPN Staff M said she did not know how long Resident #42 bed was deflated on 7/26/23. I had not been in the room yet, but you can tell when it is not working, it is flat. I just played around with it and got it working again and called hospice to have someone come and fix it. On 7/27/23 at 9:48 p.m., in an interview CNA Staff L said when I arrived on duty yesterday the bed was not on, it was flat and I do not know when it stopped working. On 7/26/23 at 10:50 a.m., interview with LPN Staff M she said she provides a report to her CNA'S every morning, even the ones that have been here forever. They should be turning residents every 2-3 hours and with Resident #42 it should be more often. I was off for 7 days and I can tell you I have noticed a decline in her since I got back today. Resident # 42 can refuse care; she will not drink the protein supplement and she refuses meals at times. She has sun-downing and sometimes she sleeps all day and is up all night. Before she was hospice she started declining and she has continued to decline. The LPN said there was no turning or positioning sheet, but the staff should be documenting in the CNA documentation that they are turning the residents. On 7/26/23 at 12:00 p.m., in an interview with the RN Regional Clinical Director said the facility does not require the CNA's to document a resident is turned and repositioned, it is the expectation that not only residents with wounds, but all residents are turned every 2 hours. The RN said she understood if it was not documented there was no proof the resident was turned, and she said all residents are turned every 2 hours. On 7/26/23 at 12:38 p.m., in an interview the Wound Care Nurse, confirmed the wound to Resident #42's coccyx for was an in house acquired wound. 46824 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105864	A. Building B. Wing	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Page Rehabilitation and Healthcare Center	2310 N Airport Road Fort Myers, FL 33907

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	3. Resident #160 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, encephalopathy, and muscle wasting. Resident #160 weighed 145 pounds. Resident #160's clinical record revealed a quarterly Minimum Data Set 3.0 (MDS) assessment completed on 2023-06-15. The MDS indicated the resident did not have any pressure ulcers and was dependent on the assistance of 2 staff members for bed mobility. The Comprehensive Nutrition Assessment completed 6/14/23 indication Resident #160 was at risk for malnutrition. Resident #160's care plan indicated resident had moisture associated skin damage to both buttocks. Interventions included to turn and reposition as needed or requested; treatment as ordered, monitor wound weekly for location, highest stage, measure length, width, and depth, color of drainage, color of wound bed, presence of odor, tunneling. Pressure reducing support surface for the bed and chair. Review for improvement, report decline to the physician. Braden Scale assessments were completed on 6/14/23 and 6/18/23, and indicated the resident was at Moderate Risk for developing a pressure ulcer. On 6/26/23 resident was At Risk for developing a pressure ulcer. A weekly skin check completed on 7/3/23 indicated resident #160 had redness to the sacrum. A wound documentation form was completed on 7/20/23 recorded Resident #160 with a newly observed unstageable pressure ulcer measuring 2.1cm X 2.0 cm X .2 depth to the sacrum. Wound was covered by 40% granulation tissue, 50% slough and 10% eschar with moderate serous drainage. Recommendation was documented to continue treatment as directed, Air Mattress, Turning and reposition often, every shift and notify Wound Care Team if worsen or concerns. On 7/24/23 at 10:05 a.m., Resident #160 was observed in bed, flat on his back, air mattress was in place on static mode (does not alternate air pressure), the weight setting dial was set between 250-280 (photo obtained). On 7/25/23 at 10:52 a.m., and 2:27 p.m., Resident #160 was observed in bed, flat on his back. No wedges or positioning devices were in his bed at either time. On 7/26/23 at 8:30 a.m., Resident #160 refused to allow the wound care physician to evaluate his wound for the first time. The physician said he did not know resident #160 was refusing wound care. On 7/26/23 at 4:47 p.m., Licensed Practical Nurse (LPN) Staff Y, said when checking the function of the air mattress on bed, be sure the air mattress fits the frame and the pump in on. On 7/26/23 at 4:48 p.m., Registered Nurse (RN) Staff Q verified the static button should not have been on unless care was being provided. Staff Q said the weight setting on the bed was incorrectly set at 270 pounds. It should be close to the resident actual weight which was documented in the clinical record at 145 pounds. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105864	A. Building B. Wing	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Page Rehabilitation and Healthcare Center	2310 N Airport Road Fort Myers, FL 33907

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	On 7/27/23 at 9:31 a.m., the Assistant Director of Nursing confirmed Resident #160 had a facility acquired pressure ulcer that began with documented redress by the certified nursing assistants. The ADON verified a nursing progress note was written on 7/19/23 which indicated 2 pressure sores and notified all parties. No new interventions were implemented until Resident #160 was seen by Staff Q on 7/20/23. New orders were entered to cleanse with normal saline, apply Santyl Ointment 250 units/gram applied to sacrum, daily for pressure ulcer. Air mattress and, turn and reposition often, notify wound care team if worsens. The ADON said if staff were to use Santyl, the wound is bad, and the wound care team should have been notified. The ADON stated the static button should only be on while care is being provided to the resident. It keeps the mattress from alternating and should not be on continuously which prevents pressure from being relieved to different areas. On 7/27/23 10:08 a.m., LPN Staff P, said any resident in bed should be turned and repositioned every 2 hours and as needed. Staff P stated I'm not seeing any documentation where the Certified Nursing Assistants (CNA) documented they repositioned Resident #160. When the nursing staff sign the Medication Administration record, they are verifying the air mattress is set to the correct patient setting according to the resident weight. The air mattress should be checked every shift and as needed to be certain the settings are correct for the resident. On 7/27/23 at 10:35 a.m., LPN Staff P verified air mattress on bed had the static button on and pressure was set to over 250 which was incorrect. Staff P verified there were no wedges in the room to assist with positioning. On 7/27/23 at 2:16 p.m., Registered Nurse (RN) Staff W said the air mattress will massage patient. We check to see that it is plugged in and working. We just make sure it is on. The static button should be on all the time and the dial is for the pressure setting. On 7/27/23 2:21p.m., CNA Staff AA said if the resident is confused you help them turn onto their side, then back to other side every 2 hours. On 7/27/23 at 3:10 p.m., the maintenance assistant said maintenance will put the air mattress on the bed with the nurse who will establish the settings for the mattress. The setting should reflect the weight of the resident. It can be oscillating but should not be on static mode. Static means to make the pressure constant. If the resident is in the bed, the goal is for the air to be moving back and forth. The static button should not be on unless care is being provided. The CNAs are aware and know when to turn it on and off. There was no evidence found of any interventions other than treatment orders to Resident #160's sacral area after redness was identified on 7/3/23. The resident's wound continued to worsen, increasing in size and stage to become a full thickness wound over the sacrum. The facility staff were not aware the air mattress was not set up correctly, or potential need for other support surfaces to reduce pressure, offloading the wound, or a more frequent turning schedule to promote healing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105864	A. Building B. Wing	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Page Rehabilitation and Healthcare Center	2310 N Airport Road Fort Myers, FL 33907

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46824 Based on observation, record review and staff interview, the facility failed to provide oxygen therapy, in accordance with physician orders for 1 (Resident #72) of 1 sampled resident reviewed. The failure to adequately maintain the oxygen concentrator had the potential to cause inadequate oxygenation for a resident dependent on oxygen. The findings included: The facility's policy NO: C-RP-11, Revised 3/27/2020, stated Oxygen therapy will be administered by Licensed Nurses with a Physicians order to provide a resident with sufficient oxygen to their blood and tissues. The goals of oxygen therapy include to reverse or prevent hypoxia Oxygen equipment will be checked daily for: Correct flow and concentration Properly filled humidification system Correct set up of equipment. Resident compliance with therapy The oxygen set up procedure included: 1. Connect the tubing to the stylet on the oxygen concentrator and adjust the liter flow according to the order. 2. Date tubing when initiated, and at least every 2 weeks when changed, more often if malfunction or visibly soiled. 3. When humidification is used, bottled water will be changed every 24 hours. 4. Oxygen concentrators will be maintained for calibration or maintenance by designated vendor per facility. A review of the medical record revealed Resident #72 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease and dependence on supplemental oxygen. The physician's order dated 3/21/2023 included to administer oxygen at 3 liters per nasal cannula continuously. The Admission Minimum Data Set (MDS) assessment dated [DATE] noted the resident's cognition was severely impaired with a Brief Interview of Mental Status (BIMS) of 0. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105864	A. Building B. Wing	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Page Rehabilitation and Healthcare Center	2310 N Airport Road Fort Myers, FL 33907

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #72's care plan initiated 3/22/23 interventions which included to position resident to position with the head of the bed upright, use high Fowlers position when possible. On 7/24/23 at 10:11 a.m., Resident #72 was observed flat in bed, with oxygen on at 3 liters per nasal cannula. The oxygen concentrator was alarming loudly enough to be heard from the hallway. (Photo obtained) On 7/24/23 at 12:28 p.m., Resident #72 was observed lying flat on his back without the head of the bed elevated. The oxygen concentrator was alarming, and yellow light was on. On 7/24/23 at 3:26 p.m., Resident remained in bed wearing oxygen via nasal cannula. The oxygen concentrator continued to alarm and yellow light was on. (photo obtained) On 7/25/23 at 8:16 a.m., Resident #72 was observed sleeping flat on his back, the oxygen concentrator was alarming. On 7/25/23 at 8:30 a.m., the Respiratory Therapist (RT) said he worked for the facility one day a week. He stated he heard the concentrator alarming. Upon checking the concentrator, he said it needed to be replaced with one that is stored in the oxygen supply room. He said the alarming concentrator with the yellow light indicated the oxygen concentration was less than 85% and not adequate for resident use. He stated the concentrator needed to remain 4-6 inches away from a curtain or wall to allow for adequate air flow into the back of the machine and through the filter, and can not be against the wall like this one was. The unit would not deliver adequate oxygen if it is not getting adequate air flow if it was alarming. The RT said the water bottle should have been dated and he replaced both the concentrator and a new bottle and dated it 7/25/23. On 7/25/23 at 2:34 p.m., RN Staff W said if a concentrator was beeping and the light was yellow she would turn it off and back on again. If it keeps beeping, then contact maintenance. 07/25/23 at 2:46 p.m., LPN Staff Z, said if there was something wrong, she would check the error message see what to do next. On 7/26/23 at 4:45 p.m., LPN Staff P said the unit should be replaced if it is alarming. On 7/27/23 at 8:30 a.m., LPN Staff X said if the oxygen concentrator is alarming, I try to troubleshoot it. If that doesn't work, I get the respiratory therapist. We must replace the water bottle when it starts to run out. That one has probably another day or two left in it. On 7/27/23 at 8:47 a.m., the ADON said the yellow light is indicating there is a malfunction. The nurse should replace the concentrator with one from oxygen storage and place a note on it to be checked by respiratory therapy. Someone should have addressed it on Monday.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105864	A. Building B. Wing	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Page Rehabilitation and Healthcare Center	2310 N Airport Road Fort Myers, FL 33907

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, record review, and resident and staff interviews, the facility failed to maintain documentation of a thorough interdisciplinary approach to address the mental and psychosocial status of 2 (Residents #103 and #133) of 5 residents reviewed to ensure their highest practicable mental and psychosocial well-being. The findings included: 1. Review of the clinical record revealed Resident #103 resided on the secured memory care unit with an admitted [DATE]. Diagnoses included Alzheimer's disease, dementia with sever agitation, major depression, and anxiety. The Quarterly Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date (ARD) of 6/21/23 noted Resident #103's cognitive skills for daily decision making were severely impaired. The care plan initiated 10/15/20 documented resident #103 had behaviors including yelling and screaming, affectionate with other residents, holding hands with other residents, getting in same bed with other residents, increased agitation, restlessness, exit seeking behavior, not redirectable at times, takes off wander guard, unable to focus, loud and intrusive with poor impulse control at times, verbally aggressive, helplessness, distractibility, excessive worry, decreased sleep, pacing which results in impairment of functional capacity, also exposes his penis to others occasionally. The interventions instructed to monitor my mood and behaviors for changes and notify psych doctor of any concerns. Reassure and redirect me when I am behavioral. Refer me to psych services as needed with the direction of my primary care doctor or potential adjustments to my medications and let my family know of the plan. The psychiatric progress note dated 7/6/23 documented Hispanic male with advanced dementia with history of psychosis with physical aggression, behavioral disturbance, anxiety was seen in the unit. He continues to show confusion with wandering behavior and needs close monitoring and redirection often. He needs assistance with most of the daily routines. No report of recent aggressive behavior. Patient continues to show confusion and unable to pay attention or concentration. 2. Resident #133 had an admitted [DATE] with diagnoses including Alzheimer's disease, severe dementia with behavioral disturbances, and depression. The Quarterly MDS with an ARD of 5/25/23 documented Resident #133 had severe cognitive impairment. The psychiatric progress note dated 7/17/23 documented Spanish-speaking Hispanic female with dementia with history of behavioral disturbance, depression with anxiety with multiple medical problems was seen in the unit she continues to show severe confusion with intrusive behavior such as touching other residents especially male peers. She needs redirection often. No report of aggressive behavior or agitation. She has been cooperative with care and medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105864	A. Building B. Wing	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Page Rehabilitation and Healthcare Center	2310 N Airport Road Fort Myers, FL 33907

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/23 at 9:30 a.m., Resident #103 was observed in his room in bed with Resident #133. The residents were fully dressed and embracing. Certified Nursing Assistant (CNA) Staff G was informed of the observation and escorted Resident #133 from the room. On 7/24/23 at 9:40 a.m., in an interview Licensed Practical Nurse (LPN) Staff D said the CNA had informed her of the residents being in bed together and she said, they always are together. On 7/25/23 during multiple random observations, Resident #133 was observed with Resident #103 holding hands, ambulating together, and sitting and hugging in the day room with no redirection form the staff. On 7/25/23 at 4:50 p.m., in an interview the Unit Manager Registered Nurse Staff J said Resident #133 and #103 enjoyed being together and both resident family members thought it was wonderful the two were so happy. The RN said we had a meeting with the two families and they both are happy with the relationship because it is not sexual. The RN said she was aware of the two residents being in bed together and said nothing happened. The RN confirmed she was not working on 7/24/23 when the incident occurred. The RN said the special relationship was care planed and a progress note was written regarding the family consent for Resident #103 and #133. A review of the clinical record for Resident #103 and Resident #133 revealed no documentation of notification or family consent for either resident. On 7/27/23 at 9:00 a.m., Resident #133 was observed in bed with Resident #103. The privacy curtain was pulled extending from the wall to the foot of the bed. The residents were not visible from the doorway of Resident #103's room. Upon greeting the residents, they smiled and remained in bed under the covers. On 7/27/23 at 9:15 a.m., CNA Staff N was asked if he had seen Resident #133 and the CNA instructed the surveyor to check Resident #103's room. The surveyor informed Staff N the residents were in the bed, under the covers with the privacy curtain pulled to obstruct the view. Staff N replied, they are always together there is nothing we can do. On 7/27/23 at 9:21 a.m., LPN Staff D was notified of the observation and informed the two residents were in Resident #103's room in bed. The LPN replied oh, and did not attempt to redirect either resident. On 7/27/23 at 9:24 a.m., CNA Staff E went to Resident #103's room and escorted Resident #133 to a chair in the center area of the unit for an activity. The CNA said she assisted the resident out of the room because she wanted to keep an eye on her. On 7/27/23 at 11:02 a.m., in an interview, CNA Staff S said Residents #133 and #103 stay together and get mad if you try to separate them, so we leave them alone. On 7/27/23 at 11:15 a.m., CNA Staff E said Resident #133 is the aggressor, and she seeks out Resident #103. The CNA said Resident #133 had the behavior for a while and was seeking out another male resident on the unit. The CNA went to separate the two residents seated together in the day room and sat them away from each other. Resident #133 immediately stood up from the chair to seek out Resident #103. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105864	A. Building B. Wing	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Page Rehabilitation and Healthcare Center	2310 N Airport Road Fort Myers, FL 33907

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/27/23 at 9:34 a.m., the Director of Nursing (DON) was notified of the observations of Resident #133 and Resident #103 in bed together and no redirection from the staff to separate them. The DON was informed there was no documentation in Residents #103 and #133 clinical records of family consent to the relationship. The DON said she was not aware of the situation until 7/24/23. The DON said both residents are cognitively impaired and because they could not give consent, it was a concern. On 7/27/23 at 2:21 p.m., the Social Service Director (SSD) said other than psychiatrist and psychologist referrals, there is not any type of counseling for the residents on the memory care unit and no medical social worker. The SSD said she really did not know what could be provided for them. The SSD said she found out today about Resident #133 being in bed with Resident #103 and since they can't consent, the facility needs to get consent from the family for them to have a relationship.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105864	A. Building B. Wing	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Page Rehabilitation and Healthcare Center	2310 N Airport Road Fort Myers, FL 33907

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 46824 Based on observations, record review, staff interview and resident interviews, the facility failed to provide food that is palatable, attractive, and at an appropriate temperature for 7 residents (#14, #38, #67, #77, #116, #141, #91) of 7 residents reviewed for dietary needs. The findings included: Review of the facility resident council meeting minutes from April 2023 through July 2023 revealed numerous dietary complaints from resident council. The complaints included hot foods being served cold to the residents, missing meal items listed on meal ticket, multiple requests for coffee and milk that was not received. On 7/24/23 at 3:13 p.m., Resident #91 stated the food is terrible, I wouldn't feed it to my dog. I rarely get milk on my tray; the food is cold and is missing condiments. On 7/24/23 at 5:30 p.m., Resident #38 was observed drinking milk out of a carton that was served on her meal tray. Resident #38 stated she would prefer to drink milk out of a cup, no cup was on the meal tray. On 7/24/23 at 5:31 p.m., observation of dinner trays passed on the memory care unit. Melon was served in Styrofoam bowls. There were no cups for any residents with milk. On 07/24/23 at 5:32 p.m., Resident #77 was served a watery pureed dinner, missing vegetable juice, hot coffee. The Melon was liquid without any consistency (Photo obtained). On 7/24/23 at 5:51 p.m. Resident #67 said she can't eat what was served. Her meal ticket stated Cream of Tomato Soup, Cottage Cheese. She was served a hamburger and smashed tator tots. (Photo obtained). On 7/25/23 at 8:18 a.m., Resident #91 complained his orange juice was watered down (Photo obtained). On 7/25/23 at 8:19 a.m., Resident #116 did not receive coffee, tea or toast as listed on his meal ticket. (Photo obtained). On 7/25/23 9:08 a.m., observation of memory care breakfast noted residents were served milk without cups. Residents stated they would like a cup. On 7/25/23 at 12:23 p.m., Resident #14 did not receive her Chocolate Chip cookie, desert, or garlic bread. (Photo obtained). On 7/25/23 at 12:24 p.m., Resident #141 did not receive cranberry juice, milk, or garlic bread. (Photo obtained). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105864	A. Building B. Wing	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Page Rehabilitation and Healthcare Center	2310 N Airport Road Fort Myers, FL 33907

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/26/23 at 8:45 a.m., observed rehabilitation meal cart, multiple meals being served in Styrofoam containers. (Photo obtained). On 7/26/23 at 11:00 a.m., tray line was started. Mechanical Rice, Pureed Rice, green beans, mashed potatoes, pureed vegetables, and pureed rice did not meet minimum temperatures for serving. Items had to be removed from the steam table and placed back in the oven until thoroughly heated at 11:40 a.m. Tray line was resumed, until staff ran out of the metal hot plates. Tray line was stopped while a staff person gathered and washed used dishes from the dining room. At 1:30 p.m., the final lunch cart was filled and passed to residents. On 7/26/23 at 2:50 p.m., the Regional Dietary Manager agreed the food served to the residents was not consistently what was meal planned, attractive and palatable. On 7/27/23 at 8:30 a.m., the Assistant Director of Nursing (ADON) said all staff passing the meal trays are responsible for checking the ticket to ensure all items listed are on the tray. If something does not match or is missing the staff should go to the kitchen to obtain it for the resident. The ADON said any staff member can write a grievance or concern and it will be discussed in the morning meeting and resolved by the department head. On 7/27/23 at 10:36 a.m., the Administrator stated he was aware of problems in the kitchen and was working with the kitchen staff to resolve the dietary issues.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105864	A. Building B. Wing	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Page Rehabilitation and Healthcare Center	2310 N Airport Road Fort Myers, FL 33907

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25618 Based on interviews and record review, the facility failed to ensure collaboration of Hospice services for 3 (Residents #140, #139, and #88) of 4 residents reviewed of the 12 residents currently receiving Hospice services. Hospice is a specialized form of medical care that provides comfort and quality of life while facing a life-limiting disease or terminal condition. Coordination of care between facility services and Hospice services to ensures the highest level of comfort and care during the end-of-life. The findings include: The Hospice Clinical Manual/Social Services Manual policy #CH-5/SS-21 created 08/2015, last reviewed on 4/2023, stated the facility would participate in Hospice care as an approach to caring for the terminally ill residents that required palliative care based on Federal guidelines. Hospice Guidelines stated a communication process would include how the communication would be documented between the Facility and the Hospice provider, to ensure the needs of the resident were addressed and met 24 hours a day. The facility would designate a member of the facility's interdisciplinary team (IDT) who was responsible for working with the Hospice representatives to coordinate care for the resident provided by the Hospice staff. The facility must ensure that each resident's written plan of care included both the most resident Hospice Plan of Care and a description of the services furnished by the facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. On 7/27/23 review of Resident #139's medical record revealed her initial admission to the facility was 2/27/23 with a readmitted [DATE]. On 4/26/23 the Hospice physician wrote due to Resident #139's terminal illness and, more likely than not, had a prognosis of 6 months or less to live if the illness ran its expected course and, therefore Resident #139 was certified for Hospice services. The Hospice Interdisciplinary Care Plan and Hospice Admission Orders / Hospice Certification forms were completed and dated 4/26/23. Further review of Resident #139's medical record revealed the Certification of Terminal Prognosis, and the Hospice Interdisciplinary Care Plan and Hospice Admission Orders which were signed and created on 4/26/23, were not uploaded into Resident #139's medical record until 6/13/23, which was a total of 48 days after they were created and signed by Hospice staff. On 7/27/23 at 9:25 a.m., in an interview, Unit Manager Staff R , said the Hospice nurse visits their residents 1 time a week. She said the Hospice nurse would assess their resident(s) and talk with the facility staff about any care and/or service concerns the facility staff may have related to the residents. Staff R said all Hospice documentation were uploaded to the Resident's medical record which could be reviewed by all staff. Staff R said after reviewing Resident #139's medical record she could only find the Certification of Terminal Prognosis and Hospice Interdisciplinary Care Plan, both dated 4/26/23 which were uploaded into Resident #139's medical record on 6/13/23. Staff R said she was unable to find any other Hospice documentation and/or assessment from the Hospice nurse in Resident #139's medical record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105864	A. Building B. Wing	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Page Rehabilitation and Healthcare Center	2310 N Airport Road Fort Myers, FL 33907

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/27/23 at 9:38 a.m., in a phone interview with Resident #139's Hospice nurse and the Patient Care Administrator (PCA), they said they visited their Hospice residents at the nursing home facility once weekly. They said the Hospice nurse did a full head-to-toe assessment of the Hospice resident and uploaded the assessment into their computer system at the main office. They said they did not have access to the facility's computer system and/or the Hospice resident's medical record at the facility. The PCA said the facility could request the Hospice resident's assessments and/or other documentation at any time, which they would send to the facility but only if the facility requested the documentation. They said they were invited to Resident #139's IDT care plan meeting but when the Hospice nurse arrived at the facility, Resident #139's IDT care plan meeting had been completed several days earlier. The Hospice nurse said she did speak with the Social Service Worker who gave her an update about the IDT care plan meeting. They said as of this date the facility had not requested any Hospice progress notes and/or documentation for Resident #139. On 7/27/23 at 10:15 a.m., interview with the Medical Data Set (MDS) Coordinator Director, and MDS Assistants Staff EE and Staff FF, they confirmed Resident #139's initial admission was 2/27/23 with a readmitted [DATE]. They said Resident #139's Hospice service was started on 4/27/23. The MDS Director said the Hospice providers are an integral part of the overall team to ensure the Hospice residents receive the best care possible. They said they sent an invitation on 5/10/23 asking Hospice to participate in Resident #139's IDT care plan meeting to be held on 5/18/23. They said no one from Resident #139's hospice provider attended the 5/18/23 IDT care plan meeting and/or provided any documentation for the IDT to use in developing Resident #139's plan of care. The MDS Director said after reviewing Resident #139's medical record the only Hospice documentation in Resident #139's medical record was uploaded into Resident #139's medical record on 6/13/23 which was after the IDT care plan meeting held on 5/18/23. They said they did not know why and/or have documentation why the Hospice representative did not attend and/or provided Hospice documentation to IDT care plan team meeting held on 5/18/23 to be used in the coordination and development of a plan of care between the Hospice provider and the nursing facility to ensure Resident #139 receiveed the highest level of comfort and care during the end-of-life. On 7/27/23 at 11:21 a.m., in interview with the Hospice Social Service Worker, she said when she visited a Hospice resident, she would complete her assessment of the Hospice resident and turn in her documentation to her office who then would upload her documents into the Hospice computer system. She said she didn't know what happened to her documentation after she turned it into the office. On 7/27/23 at 12:10 p.m., during an interview with the Hospice Social Service Worker, she said she just spoke with her office, and they told her, when their staff are done with their Hospice visit, they would turn in their documentation at that time to the nursing facility so the facility could upload the Hospice documentation/assessment at that time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105864	A. Building B. Wing	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Page Rehabilitation and Healthcare Center	2310 N Airport Road Fort Myers, FL 33907

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/27/23 at 1:00 p.m., in an interview with the Director of Nursing (DON), she said the Hospice provider for Resident #139 currently had 3 Hospice residents at their facility. She said when a Hospice provider/staff did a resident assessment, created or updated their plan of care, they were required to share the information with the nursing facility, so they could upload the information into the resident's medical record to ensure coordination between the Hospice provider and the nursing facility were completed to ensure the needs of the Hospice resident(s) were being met in order to ensure their well-being. On 7/27/23 at 2:53 p.m., in an interview with the Medical Records Manager (MRM), she said she tried to upload all documents into the resident's medical record within 24 to 48 hours. Every morning she would go to each nursing station and collect the medical documentations to upload into each resident's electronic medical record. She said each nursing station had a basket where the Hospice provider is required to leave the resident's Hospice documentation, which she collected each day and uploaded those documentation into the resident's medical record. The MRM said Resident #139's Hospice provider also provided Hospice services for 2 other residents in the facility, Residents #88 and #140. The MRM said after she reviewed Resident #139's medical records, the only Hospice documentation uploaded into Resident #139's medical record was on 6/13/23. She said as of 7/27/23, Resident #139's Hospice provider had not provided the Hospice plan of care and/or any other Hospice documentation to upload into Resident #139's medical record since 6/13/23 as required. The MRM said after she reviewed Resident #88's medical records, Resident #88 was admitted to the facility on [DATE] with Hospice services already in place. She said she had uploaded the hospital Hospice documentation on 6/9/23 into Resident #88's medical records. The MRM said since 6/9/23 Resident #88's Hospice provider had not provided the facility with any Hospice documentation, the Hospice plan of care and/or Hospice assessments to upload into Resident #88's medical record as required. The MRM said after she reviewed Resident #140's medical records, Resident #140 was admitted to the facility on [DATE] with Hospice service already in place. The MRM said since Resident #140's admission to the facility on [DATE], Resident #140's Hospice provider had not provided her with any Hospice documentation, the Hospice plan of care for Resident #140 and/or Hospice assessments to be uploaded into Resident #140's medical record as required.