STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105995	A. Building B. Wing	07/07/2022

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on clinical record review, review of facility policy and procedure, and resident and staff interviews, the facility failed to provide the necessary care and services to maintain the urinary catheter for 1 (Resident #323) of 1 resident reviewed for indwelling catheter care. The findings included: The facility policy Indwelling Urinary Catheter Insertion and Maintenance-Male Resident (revised 2/3/33), documented.Assessment: Physician's order for catheterization, type and or specimen collection . Purpose of catheterization. .Urinary Catheter (tube inserted into the bladder to drain urine) Maintenance: .Maintain unobstructed urine flow by: Keeping the catheter and collection tube free from kinking. Keeping the collection bag below the level of the bladder at all times. Emptying the collecting bag regularly using a separate, clean collecting container for each resident. On 7/5/22 at 1:00 p.m., in an interview Resident # 323 said no one takes care of me here. I had to hire an aide to take care of me. Resident # 323 said he has a catheter, but staff do not provide care for it, my aide does it. Resident #323 said he had a long history of urinary retention, and said the indwelling catheter was placed during a recent hospital admission because he fractured his leg and was on bed rest. On 7/5/22 at 2:50 p.m., in an interview private duty Home Health Aide, (HHA) Staff B said was employed by a nursing agency and sits with Resident #323 from 8:00 a.m., to 8:00 p.m. The HHA said, I empty the drainage bag when I am here. The HHA said she had not seen a facility aide or nurse empty the drainage bag and said she has been assigned to Resident #323 for the last 3 days. The HHA said when she leaves at 8:00 p.m., another HHA from the nursing agency comes to sit with the resident. On 7/5/22 a review of Resident #323's clinical record showed an admitted [DATE]. Diagnoses included: obstructive and reflux uropathy (urine is not able to flow into the bladder and flows backward into the kidneys). (continued on next page)

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record showed an Admission Nursing Review and Data Collection form dated 6/29/22, documented Resident #323 had urinary retention, was frequently incontinent and had an indwelling catheter. The clinical record contained a baseline care plan dated 6/29/22. The care plan identified Resident #323 had an indwelling catheter. Interventions for the catheter instructed facility staff to monitor patency, monitor signs or symptoms of infection. Provide catheter care every shift and as needed. On 7/6/22 at 2:37 p.m., the Director of Nursing (DON), confirmed there was no documentation or physician orders for the care of Resident #323's catheter since his admission to the facility. The DON confirmed there was no documentation Resident #323 had received the necessary care and services to maintain the function of the catheter. The DON said the nurse received orders for catheter care on 7/5/22 but did not add it to the record until today. On 7/7/22 at 1:00 p.m., in an interview, Certified Nursing Assistant (CNA) Staff D said she was assigned to the same hallway when working. CNA Staff D said she had not provided catheter care to Resident #323 because he had a private duty HHA.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, record review, review of facility's policy and procedure, and staff interview, the facility failed to have documentation of consistent monitoring of weight, meals, and prescribed supplement intake to evaluate the effectiveness of nutritional interventions for 3 (Resident #16, #9, and #174) of 5 sampled residents identified at risk for impaired nutrition and weight loss. The findings included: The facility Policy, Weight Policy (revised 2/7/21) documented, It is the policy of Pointe Group Care that residents maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless the residents clinical condition demonstrates that this is not possible. Weight-Weight can be a useful indicator of nutritional status, when evaluated within the context of the individuals personal history and overall condition . Procedure: 1. Each resident should be weighed on admission or readmission (to establish a baseline weight), weekly for the first 4 weeks and at least monthly thereafter to help identify and document trends such as insidious weight loss. 2.The last weight obtained in the hospital may differ markedly from the initial weight upon admission and should not be used in lieu of actually weighing the resident. 3. Weights may be ordered more frequently if there is a significant change in condition, food intake has declined and persisted (e.g., for more than a week), or there is other evidence of altered nutritional status or fluid and electrolyte imbalance. 1. On 7/5/22 at 9:45 a.m., Resident #16 was observed sitting in her wheelchair in her room. The bedside table was in front of her with the a.m., meal of scrambled eggs, sausage patty and biscuit untouched. Resident #16 said she liked the food but would not answer questions. Resident #16 appeared thin, frail with sunken eyes and hollow cheeks. Review of the clinical record for Resident #16 showed an admitted [DATE]. The Admission Nursing Review and Data Collection dated 6/7/22 documented resident #16 had +1 edema of the lower extremities. The Admission Minimum Data Set (MDS) assessment with an assessment reference date of 6/14/22 noted the resident's weight was 134 pounds (lbs.) The diagnoses included Type 2 diabetes mellitus, dementia, dysphagia (difficulty swallowing foods or liquids) and unspecified edema (swelling caused by excess fluid trapped in the body's tissues). The MDS assessment noted Resident #16 required supervision and set up help for eating and drinking. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Registered Dietitian's (RD) Initial Nutrition Review dated 6/12/22, documented . #6 problem: need x [for] therapeutic diet, potential x [for] weight changes. #10 Monitoring/Evaluation Plan: Monitor nutrition parameters and adjust diet regime prn [as needed]. The Initial Nutrition Review noted Resident #16's most recent weight was 134.2 pounds (lbs), and noted, Scale: Hospital record. Review of the care plan initiated on 6/8/22 did not document a problem with nutrition or hydration for Resident #16. Review of the Physician progress note dated 6/15/22 documented, . Lower extremity edema [swelling] thought to be due to overhydration during hospital stay. Responded to Lasix [a diuretic used to treat edema] and potassium, resolved. Monitor- no problem at present. Decreased appetite. Family want [sic] to stop the med we added-done. OK for Glucerna supplement. Follow weights. Review of the Physician orders included Lasix 40 milligrams one tablet one time a day for edema, and Glucerna one bottle twice a day with a start date of 6/24/22. Review of the weight summary in Weights/Vitals tab of Point Click Care revealed on 6/12/22 at 2:58 p.m., Resident #16's weight was 134.2 lbs (Hospital Record). No other weight was listed in the electronic record for the resident. The meal intake documentation from 6/8/22 through 7/6/22 was incomplete. The percentage of meal consumption was not documented for the breakfast meal of 6/10/22, 6/12/22, 6/17/22, 6/23/22, 6/25/22, 6/26/22, 6/28/22, 6/29/22, 6/30/22, 7/1/22 and 7/2/22. The percentage of meal consumption was not documented for the lunch meal on 6/10/22, 6/12/22, 6/17/22, 6/19/22, 6/23/22, 6/25/22, 6/26/22, 6/29/22, 6/30/22 and 7/2/22. The percentage of meal consumption was not documented for the dinner meal on 6/9/22, 6/19/22, 6/27/22, 6/28/22 and 7/5/22. Review of the Medication Administration Record for 6/2022 and 7/2022, documented the Glucerna was administered by the nurse as ordered but did not document the amount of the supplement the resident had accepted. On 7/7/22 at 9:35 a.m., Resident #16 was observed in her bed. She appeared thin, with sunken eyes and hollow cheeks. She was not able to answer questions appropriately. The bed side table was against the wall and approximately six feet away, out of the resident's reach. An unopened bottle of Glucerna supplement, a Styrofoam cup with a red liquid and half a cup of a milky drink were observed on the bedside table out of the resident's reach. Photographic evidence obtained. On 7/7/22 at 9:40 a.m., in an interview Registered Nurse (RN) Staff C said the resident's intake was poor but she was accepting liquids. The RN said I gave her the ensure and she drank it. RN Staff C said the certified nursing assistants (CNA) tell her when resident eats poorly. The RN said Resident #16 drinks liquids, well and likes the ensure. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/7/22 at 9:42 a.m., CNA Staff D said Resident #16 required assistance with meals and ate little bites, not good. She drinks the juice and supplement. The CNA said she notifies the nurse when the resident does not eat. The CNA said Resident #16 had not been eating well for a long time and sometimes refuses meals. On 7/7/22 the Director of Nursing (DON) provided a weight sheet for resident #16. The weight sheet documented a hospital admission weight of 134.2 lbs. A weight was documented on 7/6/22 of 116.4 lbs. The form documented Resident #16 had a weight loss of 17.8 lbs. On 7/7/22 at 10:31 a.m., the DON confirmed the weight sheet indicated Resident #16 had a 17.8 lbs. weight loss. The DON said resident #16's weight loss was just identified on 7/6/22 when the weight was obtained. The DON said weekly weights were not ordered by the physician and the policy of the facility was to obtain a weight at admission and monthly. The DON said the physician was aware of Resident #16's decreased intake and had ordered Remeron (an antidepressant medication used to stimulate the appetite), but the Resident's daughter did not want her to take the medication. On 7/7/22 at 10:40 a.m., the Administrator said, We knew prior to admission (Resident #16) had a poor intake, we spoke with the daughter and recommended hospice for her, but the daughter declined. (Resident #16) would not be discussed in QAPI (Quality Assurance and Performance Improvement) meetings yet because we meet at the end of the month for the previous month, and (Resident #16) was not identified as a weight loss until yesterday. On 7/7/22 at 10:57 a.m., the Certified Dietary Manager (CDM) said meal percentages are reviewed and discussed in a weekly risk meeting. The CDM said they discussed Resident #16 and recommended weights be obtained. The CDM said he spoke with the RD regarding weights not being done and the resident's poor intake but did not have anything documented intervention wise because they didn't know weight loss was an issue. On 7/7/22 at 11:20 a.m., the RD said Resident #16 had edema upon admission and was expected to lose weight. She was on Lasix 40 milligrams a day, so I expected her to lose the 17.8 lbs., it was expected. I anticipated a weight loss it was planned because of the edema. The RD said there was a problem getting weights here, and residents do refuse to be weighed at times. She asks what their usual weights are and uses the hospital weight for the MDS and the initial weight to do the assessment. The RD said resident #16 was started on Glucerna because physicians think it's a magic bullet going to fix everything. We offer her snacks and alternates. The RD provided no documentation of the alternate foods offered to Resident #16. The RD said We are providing nutrient dense foods not caloric dense foods. We are trying to optimize her intake and the supplement will do that. It was brought to my attention that her intake was declining but at the time of the assessment she was eating 50% of most meals. The RD confirmed she was expecting the resident to have the 17.8 lb., weight loss and said she knew it would be a big loss. She looked at her labs and they were good, she would recommend the physician decrease the Lasix but she was not a pharmacist, and couldn't make that referral. The RD said the DON knew the weights were not done and said she had requested the weights for Resident #16. 41212 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Clinical record review on 7/7/22 revealed Resident #9 was admitted to the facility on [DATE]. The Admission Minimum Data Set (MDS) assessment documented active diagnoses including Depression, Diabetes Mellitus, Anemia. Resident #9 had Complaints of difficulty or pain with swallowing. The resident's weight was documented as 126.0 lbs. On 6/6/22 the discharge MDS assessment noted the resident was discharged to an acute care hospital with return anticipated. The MDS assessment noted Resident #9 returned to the facility on [DATE] with diagnoses including syncope and collapse, major recurrent depressive disorder, type 2 Diabetes Mellitus with ketoacidosis without coma. Review of the weight records showed an entry dated 6/14/22 noting Resident #9 weighed 125.2 lbs. The entry specified Hospital record. No other weight was documented in the clinical record for Resident #9. 3. On 7/7/22, clinical record review showed Resident #174 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, pain, lack of coordination and unsteadiness on feet. Resident #174 had a pressure ulcer to the right and left buttock. Review of the weight summary revealed on 6/18/22 the resident's weight is documented as 178.2 lbs. The summary specified Hospital record. No other weight was documented in the clinical record for the resident. On 7/7/22 at 1:15 p.m., the Registered Dietician said she used the weights from the hospital record for Resident #9 and #174. The RD said she felt obtaining actual weights was a problem in the facility.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, record review, policy review, staff and resident interviews, the facility failed to ensure 1(Resident #323) of 12 residents reviewed for accidents was assessed for alternative interventions prior to the use of grab bars. This had the potential to have grab bars installed when alternatives with less chance of negative consequences could be utilized. The findings included: The facility policy Side Rails (revised 2/10/21) documented, .No matter the purpose for use, bed rails and other bed accessories, although prescribed to improve functional independence with bed mobility and transfers, can increase resident safety risk. Procedure: 1. Resident Assessment a. Before admission, prospective residents will be screened to help determine if care needs may necessitate specialized beds or accessories. c. Assess the resident to identify appropriate alternative prior to installing bed rails On 7/5/22 at 2:14 p.m., Resident #323 was observed in bed with grab bars raised on both sides of the bed. Resident #323 said he asked for the grab bars to assist with turning himself in bed. Resident # 323 said, I broke my left hip, and they did not do surgery. I'm on bed rest and I need them to move myself. Review of the clinical record for Resident #323 showed an admitted [DATE] with diagnoses including fracture of the left acetabulum (the socket of the hip bone, into which the head of the femur fits). The clinical record contained no documentation of alternate interventions attempted prior to the use of the grab bars. On 7/6/22 at 2:29 p.m., the Director of Nursing (DON) said she initiated the grab bars on 7/3/22 because the resident requested them. She confirmed at the time of the interview, there was no documentation of an assessment or alternative interventions attempted prior to the use of the grab bars for Resident #323.

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F 0791 Level of Harm - Actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 44307 Based on staff and resident interviews, clinical records review, and facility policy review the facility failed to assist in obtaining routine or emergency dental care for 1 (Resident #2) complaining of chronic dental pain of 12 sampled residents reviewed for dental. The findings included: Review of facility policy titled, Dental Services, reviewed 2/3/2021 stated, The resident shall retain the right to go to a dentist of his/her choice in preference to the dentist contracted by the facility. The facility shall arrange for transportation for residents, if dental services are provided outside of the facility. If at any time a resident, family or staff member believes that a resident needs a dental evaluation, arrangement will be made with a dental consultant . On 7/5/22 at 1:11 p.m., Resident #2 said, My tooth hurts. It is hard to eat. she said she wanted to see her dentist and the facility was not helping to make arrangement to see the dentist. On 7/6/22 at 12:30 p.m., Resident #2 was observed eating lunch. The resident was on a soft mechanical diet. When asked about her tooth Resident #2 said, I have told them it is hard to eat. I don't know why I don't get to see the dentist. On 7/6/22 at 2:30 p.m., reviewed clinical records for Resident #2. Resident had physician progress note dated 3/24/22 at 10:54 a.m., which read, She is complaining about her dental situation and a tooth which has to be removed. She wants her daughter to be more involved with the dental plans and she says she is disappointed in her. I cannot locate the offending tooth in her mouth visually. I will have staff call family, for scheduling. Resident #2's care plan noted she was on a soft diet for ease of chewing. There was no care plan addressing the resident's dental services. The Quarterly Minimum Data Set (MDS) assessments dated 4/1/22 and 7/1/22, did not document any dental, or pain concern. Review of the order summary showed Resident #2 saw a dentist in 12/8/2019 and 12/16/2020. On 7/7/22 at 9:47 a.m., the Social Services Director (SSD) said, I just started in March 2022 so that probably why I missed it with her (Resident #2) complaining about her tooth. The SSD said, I have a dentist who comes in for the residents for emergent care or complaints. I don't have any for routine stuff. Most of residents are here for short term care but I will look for one. The SSD said as far as she knew the facility did not have a program offering routine screening and dental services for the residents. The SSD verified Resident #2's payor source was Medicaid. She said it was hard to find a dentist for the long-term residents on Medicaid. On 7/7/22 at 9:55 a.m., in an interview about dental services at facility the Director of Nursing (DON) said, We call the emergent dentist if a family or resident requests them. The DON said she didn't think the facility offered routine dental services to the residents. (continued on next page)

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F 0791 Level of Harm - Actual harm Residents Affected - Few	On 7/7/22 at 10:04 a.m., the MDS coordinator said Resident #2, hasn't mentioned any dental care concerns to me. Sometimes the doctor will write the note and then forget to say anything to the staff. There is really no set program for any routine dental care here. I know the long-term residents are on Medicaid so that is a challenge to find a dentist. I have been here for over three years, and it has come up before in passing but I don't think they have established any set routine program. The MDS coordinator described the following process for completing the Dental Status on the MDS, On admission I ask if they are having any pain or dental concerns. Same with quarterly review but if they are not complaining when I interview them, and the look back at the notes do not show a concern in the seven days look back then I do not code them as having dental issues. Maybe she didn't have any pain the day I saw her (Resident #2). She never complained to me. There is no routine maintenance program for dental care here and there should be. On 7/7/22 at 10:46 a.m., a follow up interview with Resident #2 was done with Registered Nurse (RN), Staff C, present. RN, Staff C, asked Resident #2 about any tooth or mouth discomfort. Resident #2 said, Yes, I can't eat. The tooth at the top hurts. I need to see a dentist, but they haven't taken me. Upon exiting the room, RN Staff C said, She has never told me that her mouth hurts, but she clearly said it to me today. She had COVID maybe she lost weight and the dentures aren't fitting right now. I don't know. On 7/7/22 at 11:31 a.m., in a telephone interview the Medical Director who wrote progress note dated 3/24/22 said, Yes, I remember that Resident #2 was complaining about her tooth. I told the staff to contact her family to arrange for her to go to her dentist. I don't think we have any dentists coming in routinely. I did not see anything wrong with her mouth which is why she needs to go to the dentist since she was complaining of pain. I will call the family today as well to see what they are doing about getting her to the dentist. Thanks for bringing it to our attention. On 7/7/22 at 11:53 a.m., RN, Staff C, confirmed resident last went to dentist in December 2020. On 7/7/22 at 12:11 p.m., the DON and Administrator confirmed the facility does not have an established program to assist residents in obtaining routine dental services. On 7/7/22 at 2:14 p.m., the DON said we could all recognize not having routine dental care can cause lots of problems. She said, You could lose your teeth, not be able to eat and lead to other health issues.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 41212 Based on observation resident and staff interview, the facility failed to honor food preferences for 1 (Resident #177) of 3 residents reviewed. This has the potential for complications if allergies to certain foods are served. The findings included: On 7/7/22 record review revealed documentation Resident #177 had a Gluten allergy. The meal ticket noted allergies, none; dislikes, No Gluten, no Barley, no Bread, no Cake, no Cookies, no Pasta, and no Pies. The bottom of the meal ticket noted, Allergic to gluten. Photographic evidence obtained. On 7/5/22 at 1:00 p.m. and on 7/6/22 at 12:10 p.m., Resident #177 was observed having lunch. He was served bread on both days. On 7/6/22 at 12:10 p.m., Resident #177 said he receives bread with his meals and he is not suppose to have it. Resident #177's spouse was present during the interview and confirmed he shouldn't have bread and receives it with his meals. On 7/7/22 at 11:30 a.m., The Director of Dietary said if residents have an allergy or a dislike for a food item listed on their meal tickets, then they should not be receiving it.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, review of policies and procedure and staff interview, the facility failed to ensure the hand washing sink in the kitchenette was functioning for staff use. The failure to maintain the function of the sink had the potential for water borne pathogens to grow in the standing water. The facility failed to properly date and label resident food items stored in the facility kitchenette refrigerator. The failure to date, label and dispose of expired foods placed residents at risk for developing food borne illnesses. The findings included: The facility policy Food Storage-Resident Food (revised ,d+[DATE]), documented, Purpose: To ensure food safety and prevent the risk of food borne illness. Policy: .If storage units are provided in community areas, those units shall be equipped with thermometers and shall hold foods which are sealed, labeled and dated. Units shall be routinely cleaned and monitored by the Housekeeping Department with the assistance of the Dietary Manager to maintain sanitary units and to discard expired foods. On [DATE] at 9:05 a.m., during a tour of the kitchenette with Dietary Aide Staff A the following observations were made in the kitchenette's refrigerator: 1. Two plastic bags of food stored on the top shelf of the refrigerator were not labeled or dated. Dietary Aide Staff said the bags contained residents' food from an outside source and did not know how long they had been in the refrigerator. 2. A large pitcher with approximately three inches of a brown liquid covered with plastic wrap not labeled. Dietary Aide Staff A said the pitcher contained iced tea and confirmed there was no labeled or dated. Photographic evidence obtained. 3. The kitchenette hand washing sink had approximately three inches of standing water in the sink, and was not draining and. Dietary Aide staff A confirmed the sink was not functioning and said it had been broken for a few weeks. Photographic evidence obtained. On [DATE] at 9:56 a.m., the Maintenance Director said the kitchenette sink had problems draining for a month and has been clogged in the last week it. The Maintenance Director said he was waiting for a new drain snake to unclog the drain because the current drain snake was not effective. The Maintenance Director said, the kitchenette sink is one on my projects and I am working on it today.