STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105672	A. Building B. Wing	06/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gulf Coast Village	1333 Santa Barbara Blvd Cape Coral, FL 33991

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on record review, resident and staff interviews, the facility failed to follow care plan and therapy recommendations and ensure adequate supervision to prevent fall with injury for 1 (Resident #500) of 3 residents reviewed who were identified at risk for falls. The failure to follow the plan of care and implement appropriate interventions to prevent falls resulted in Resident #500 sustaining a fall with major injury requiring the resident's transfer to a higher level of care. The findings included: The facility policy Fall Data Collection Policy and Protocol specified, All residents are assessed to identify risk for falls and individualized fall precautions will be developed on their care plan. Preventive measures shall be taken to decrease the number of falls whenever possible . All staff will be responsible for fall prevention and monitoring. Review of the clinical record revealed Resident #500 was admitted to the facility on [DATE] with diagnoses including toxic encephalopathy, dementia, muscle weakness, glaucoma, and Alzheimer's disease. The Admission Minimum Data Set (MDS) with an assessment reference date of 5/15/21 documented Resident #500 scored a 14 on Brief Interview of Mental Status (BIMS), indicating intact cognition. Resident #500 required limited physical assistance of one for transfers and toileting. The Fall Scale Data Collection with an effective date of 5/13/21 noted Resident #500 scored 56, indicating the resident was at high risk for falls. The form noted the Resident had impaired gait, difficulty rising from chair, used chair arms to get up and bounced to rise. The form also noted under mental status,Resident #500 overestimated or forgot limit. The plan of care initiated on 5/13/21, identified resident #500 was at risk for falls. The interventions included to provide prompt assistance to all requests, anticipate and meet needs. The care plan also noted the resident had increased weakness and required assistance. The interventions specified Resident #500 used one person for transfers and required one person assistance for toileting. As of 5/14/21 the care plan noted to refer to the therapy updates, notes, documentation for current status or changes. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the Occupational Therapist (OT) notes with a start date of care of 5/14/21, revealed documentation as of 5/20/21 The patient is able to safely perform all toileting tasks utilizing walker requiring contact guard assist (contact with patient due to unsteadiness) . The Physical Therapist (PT) progress report noted as of 5/21/21, Toilet Transfer. Supervision or touching assistance- Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout activity or intermittently. Transfers sit to stand . Contact guard assist (Contact with patient due to unsteadiness) . A review of the Certified Nursing Assistant (CNA), Kardex (provided instruction on the care a resident required) with a handwritten date of 5/19/21, documented Resident #500 was Not steady during transitions/walking, moving on and off the toilet. Review of the progress notes revealed Registered Nurse (RN) Staff F documented on 5/22/21 at 5:40 a.m., CNA Staff E transferred Resident #500 with the walker to the bathroom and she lost her balance. CNA Staff E and Registered Nurse RN Staff F quickly went to the resident's room upon hearing the noise, finding the resident on the floor. CNA Staff E and RN Staff F tried to assist the resident to move her extremities and found she could not move her right leg and the area of the right thigh was bulging. RN Staff F documented, . when I asked (CNA Staff E) if he had helped her put her on the toilet he said yes, he assisted her by her side walking to the bathroom with her walker and that he gave her privacy after putting her on the toilet and she said that when she finished she would touch the call light and he would help her but apparently (Resident #500) tried to readjust her sitting position on the toilet and lost her balance and fell to the floor . The physician was notified and ordered to send the resident to the hospital for evaluation. Review of the Nursing Home Adverse Incident Report initially submitted on 6/4/21 to the Agency for Health Care Administration noted Resident #500 was immediately transferred to the hospital where she had imaging done and was found to have a comminuted (bone broken in more than two pieces) fracture of the distal right femur. The Resident had surgery the same day. The facility documented the analysis and apparent cause of the incident was the resident tried to readjust her sitting position on the toilet, lost her balance and fell on the floor. On 6/16/21 at 10:33 a.m., in a telephone interview, Resident #500 said she fell on [DATE] on the way to the toilet, but never made it to the toilet. Resident #500 said she was using a walker and the CNA assisted her. Resident #500 said the CNA walked her into the bathroom and left, shutting the door for privacy and she fell . The resident said the CNA did not assist her to pull her pants down or to get onto the toilet. Resident #500 said I never did make it to the toilet. I guess he was not aware of how I usually do it. I do not want to get anyone in trouble. I was doing good, walking with therapy, and planning to go home. Now I am in a leg brace, and I cannot bear weight. I cannot do anything now and I need help with toileting and changing my diaper, it is embarrassing. I was not wearing diapers before. It is unfortunate, I do not know when I will get to go home now, it has been a setback. Resident #500 confirmed three times during the interview she had her clothes on and did not make it to the toilet. She repeated I did not make it to the toilet, I was standing there, and I guess I lost my balance and fell . No one was with me, I guess they should have been. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/16/21 at 11:30 a.m., in a telephone interview CNA Staff E said on 5/22/21 at 5:30 a.m., I walked Resident #500 to the bathroom and pulled her pants down and sat her on the toilet. I left to give her privacy and within five seconds I heard a noise, and she is on the floor. The CNA said the resident was able to ambulate with a two wheeled walker and said she walked, I stood by her, and I put her on the toilet. The CNA said he gets his patient information and care needs from the CNA going off shift and the nurse during shift report. On 6/16/21 at 12:00 p.m., in a telephone interview RN Staff F, said on 5/22/21 at 5:30 a.m., she was in the hallway outside of the Resident #500's room getting ready to administer medications and saw the CNA walking her to the bathroom, so she walked back to the cart. The RN said she visually saw CNA pull the residents pants down and put her on the toilet with the walker in front of her. The RN said, we closed the door and within 5 seconds she was on the floor. On 6/16/21 at 12:30 p.m., in an interview Physical Therapy Assistant (PTA) Staff G said she was working with Resident #500 before her fall. PTA Staff G said Resident #500 was doing well before the fall but always required stand by assistance (SBA) of one for ambulation and toileting. PTA Staff G said, when toileting the resident was to always have a gait belt on and provide SBA. PTA Staff G said Resident #500 should not have been left alone on the toilet because she did not have good trunk control yet. The PTA said, that means, I stay with her by her side, but I turn my back while holding the gait belt to give her privacy, but you needed to be right there. PTA Staff G confirmed the resident was not safe to be left on the toilet alone. PTA Staff G said she reviews the therapy goals for the resident and what they are working on, with the nurse and CNA so they know what to do for the resident. PTA Staff G said the Occupational Therapist and her were both working with Resident #500 on toileting and our plan was the same, Resident #500 was not safe alone and required SBA with toileting. On 6/16/21 at 3:42 p.m., in an interview the Director of Nursing (DON) said the resident stated she was adjusting herself on the toilet and she fell off. The DON said she interviewed the two staff involved in the incident and had witness statements. The DON said the therapy communicates with the staff and the staff report to each other at change of shift. The DON confirmed she had no documentation of therapy communication with the nurse or CNA's regarding Resident #500 transfer and toileting abilities, goals and what the therapist was working on. She said the Resident had a care plan and staff could review the Plan of Care. The DON confirmed she did not have documentation of education with staff after Resident #500 had a fall, she said there was no need because, the resident said it was her fault that she fell , she lost her balance.