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	10/08/2021

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 22651 Based on record review, policy review, and staff interviews, the facility failed to report an alleged violation involving abuse to the appropriate officials, including to the State survey and certification agency, and adult protective services in accordance with State law for 1 (Resident #1) of 3 sampled residents reviewed for abuse. The findings included: The facility's policy for abuse, neglect, mistreatment and misappropriation of resident property with a review date of 9/2019 read, It is the policy of this facility that abuse allegations . are reported per Federal and State law. The facility ensures that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long term care facilities) in accordance with State law through established procedures . The grievance/concern form dated 8/1/21 noted Resident #1's daughter filed a grievance on behalf of her mother in which the resident complained being abused by two aides that morning in the shower room. The form read Resident #1 was grabbed in a bear hug and man-handled during her shower, the aide grabbed me with such force I couldn't get out and she hurt my knee and it hurts continually. The summary statement of grievance read, Physical abuse happened during this am [morning] shower in the shower room by aides . The investigation did not contain documentation the allegation of physical abuse was reported to the State Survey Agency and Adult Protective Services in accordance to State laws. On 10/8/21 at 1:30 p.m., in an interview the Director of Nursing (DON) verified the facility did not report the allegation of abuse to Adult Protective Services and the State Survey Agency as required per the regulations.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 22651 Based on record review, policy review, and staff interview, the facility failed to have evidence of a thorough investigation, including effective measures to protect 1 (Resident #1) of 3 sampled residents during investigation of an allegation of physical abuse. The findings included: The facility's Abuse, Neglect, Mistreatment and Misappropriation of Resident Property with revised date of 9/2019 noted under investigation of abuse, . The designated facility personnel begin the investigation immediately. A root cause investigation and analysis is completed. The information gathered is given to administration . Protection: . The alleged perpetrator is immediately removed and the resident is protected. Employees accused of alleged abuse are immediately removed from the facility remain removed pending the results of a thorough investigation . The grievance/concern form dated 8/1/21 noted Resident #1's daughter filed a grievance on behalf of her mother in which the resident complained being abused by two aides that morning in the shower room. The form read Resident #1 was grabbed in a bear hug and man-handled during her shower, the aide grabbed me with such force I couldn't get out and she hurt my knee and it hurts continually. The summary statement of the grievance read, Physical abuse happened during this am [morning] shower in the shower room by aides . On 10/8/21 the facility's investigation was reviewed. It included a statement dated 8/1/21 in which a Certified Nursing Assistant (CNA) said she showered Resident #1 and called the nurse to help her transfer the resident back to the chair. The nurse's statement dated 8/1/21 noted she helped the CNA apply a gait belt and pivot the resident to and from chair and the transfer was safe per protocol. On 8/4/21, four days after the alleged abuse incident the Director of Nursing (DON) documented she met with the Unit Manager and the nurse involved in the transfer. The nurse demonstrated how they transferred the resident to and from the shower chair. There was no documentation the CNA participated in the demonstration. On 10/8/21 at 11:45 a.m., in an interview the Social Worker said a therapist, the Administrator, and herself met with the Resident's daughter to address several concerns, including the allegation of being man handled by two staff members during the shower. The Social Worker said the facility initiated an incident report but was not aware if the incident was reported to the State Survey Agency. She said she was not part of the investigation and did not document the meeting with the resident's daughter. On 10/8/21 at 1:30 p.m., in an interview the DON said on 8/1/21 they obtained statements from staff involved in showering Resident #1 but did not complete the investigation until 8/4/21. She said Resident #1 did complain of knee pain on 8/1/21 after the shower but the physician was not notified until 8/2/21 and ordered medications. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator who was participating in the interview verified a meeting was held with the Resident's daughter on 8/3/21 as part of the investigation but was not documented. The DON also said the staff involved in the alleged physical abuse were not suspended during the investigation. The Administrator and DON verified the facility failed to immediately remove the alleged perpetrators to protect the resident during the investigation. The facility allowed them to continue to work and have access to Resident #1.

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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 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** 22651 Based on medical record review, policy review, and interview the facility failed to have documentation of timely preventive measures in accordance with professional standards of practice to prevent the development of pressure ulcers for 2 (Resident #1 and #22) of 3 sampled residents at risk for pressure ulcers. The findings included: The Pressure Injury Prevention Points as outlined in the National Pressure Injury Advisory Panel (NPIAP) noted, Risk Assessment . Use heel offloading devices or polyurethane foam dressings on individuals at high-risk for heel ulcers . https://npiap.com/page/PreventionPoints The quick reference guide for repositioning for Preventing Heel Pressure Ulcers noted, Ideally, heels should be free of all pressure- a state sometimes called floating heels . Heel suspension devices are preferable for long term use, or for individuals who are not likely to keep their legs on the pillows . Prevention and Treatment of Pressure Ulcers: Quick Reference Guide. National Pressure Ulcer Advisory Panel. Review of the facility policy, Treatment/Prevent Pressure Ulcers created 2010, and revised 7/2018, 4/2019, and 10/2019 read, It is the policy of [Organization] to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures . the facility provides care and services consistent with standards of practice to: Promote the prevention of pressure ulcer/injury development . 1. Record review revealed Resident #1 was admitted to the facility on [DATE]. The Admission Minimum Data Set (MDS) assessment with a reference date of 5/2/21 noted Resident #1 required extensive physical assistance of two persons for bed mobility, transferring, dressing, toilet use and personal hygiene including bathing. The diagnoses included hip fracture. The assessment noted the resident was at risk of developing pressure ulcers. The Care Assessment Summary (identifies key issues) listed Pressure Ulcers as a target care area for additional assessment and review and noted it was addressed in a Care Plan. The admission data collection form dated 4/29/21 noted Resident #1 had a surgical incision to the left hip and was not able to reposition self while lying in bed. Resident #1 scored 18 on the Braden Scale (used to predict pressure ulcer risk), indicating she was at risk for developing pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The care plan initiated on 4/30/21 listed diagnoses of displaced fracture of the base of the neck of the left femur, difficulty in walking, muscle weakness, acute embolism (blocking of an artery) and thrombosis (clotting of blood) of deep veins of left distal lower extremity. The care plan noted the resident was status post a left hip repair, has impaired mobility and was at risk for skin breakdown. The goal included to minimize the risk for complications in skin integrity. The interventions initiated on 4/30/21 included a pressure reducing device for the bed and the chair, weekly skin assessment by licensed nurses, assistance of one person for bed mobility and assistance of two persons for transfer. The care plan did not list preventive measures to keep Resident #1's heels offloaded to minimize the risk of developing a pressure ulcer. On 5/26/21 at 11:58 p.m., the nurse bath skin document noted Resident #1 had developed a left heel fluid filled blister. On 5/27/21 the physician ordered to offload the left heel when in bed and apply Cavilon no sting barrier film (skin protection film for people with damaged skin or at risk for damage) daily to the left heel. On 6/10/21 the physician ordered a heel medix (offloading) boot to the left foot as tolerated every shift for pressure offloading. There was no documentation the facility initiated preventive measures to minimize the risk of developing a pressure ulcer to the right heel. On 7/27/21 the nurse's weekly wound documentation noted Resident #1 had a new right heel unstageable pressure ulcer as evidenced by dark purple tissue that does not blanch. On 7/27/21 the facility initiated a physician's order for a heel medix boot to the right foot. On 7/28/21 the wound care physician documented in an initial wound evaluation and management Resident #1 had an unstageable (due to necrosis) pressure ulcer to the left heel and an unstageable deep tissue injury of the right heel. The wound care physician recommended to float heels in bed, off-load wounds and Prevalon (off-loading) boots for both heels. The objective was to heal both heels' wounds. On 7/30/21 the physician ordered a culture of the left heel for wound sepsis. The result of the culture dated 7/31/21 and reported on 8/2/21 noted moderate growth of normal skin flora (bacteria normally found on the skin). On 7/30/21 the physician ordered Doxycycline (antibiotic) 100 milligrams by mouth twice a day for 10 days for left heel wound sepsis (presence of bacteria in the wound). On 8/4/21 the wound care physician documented both heel wounds had deteriorated and performed a surgical excisional debridement procedure of the left heel to remove necrotic (dead) tissue. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/7/21 at 1:30 p.m., in an interview the MDS Coordinator confirmed Resident #1 did not have a pressure ulcer on admission. He said the development of the two wounds on two different sites triggered a significant change assessment. He said the left heel pressure ulcer worsened from a stage II to an unstageable and the resident developed a new right heel deep tissue injury. On 10/7/21 at 3:25 p.m., in an interview the wound care nurse said she was notified on 7/27/21 of the pressure ulcer of both heels for Resident #1. She said the wound care physician assessed the heels on 7/28/21. The physician did not document the pressure ulcers were unavoidable. The physician's assessment noted the goal was for them to heal. She said Resident #1 was diagnosed on [DATE] with peripheral vascular disease after several tests were done. She had a regular mattress at the time of admission. She said, we decided it was safer than to give her an air mattress because she would roll out of bed. We decided to use a Medix heel boot on 6/10/21 for the left heel because she had the hip surgery on that side. She verified the lack of preventive measures for the left and right heel until after the resident developed a pressure ulcer of the left and right heel. 30599 2. Record review revealed Resident #22 was admitted to the facility on [DATE]. The Admission Minimum Data Set (MDS) assessment with a reference date of 8/16/21 noted Resident #22 required extensive physical assistance of two persons for bed mobility and transfer. The MDS noted the resident's diagnoses included insulin Diabetes Mellitus with neuropathy and Peripheral Vascular Disease (PVD). Resident #22 had a history of left leg amputation due to poor vascular flow to the lower extremities. The Care Area Assessment (CAA) summary noted Resident #22 triggered for Pressure ulcer and an initial care plan was developed. The care plan for activities of daily living initiated on 8/13/21 noted Resident #22 has decreased mobility and required assistance. The interventions as of 8/13/21 included assistance of two persons for bed mobility and transfers. The care plan for at risk for skin breakdown noted Resident #22 had decreased mobility and required assistance. The goal was to minimize the risk for complications in skin integrity. The interventions as of 8/18/21 included a pressure reducing device for the bed and the chair. The care plan did not list measures to keep Resident #22's right heel offloaded to minimize the risk of developing a pressure ulcer. The post incident review form dated 8/26/21 noted Resident #22 developed an unstageable ulcer to the right heel related to pressure and medical condition of PVD and Diabetes Mellitus (DM). Review of the Treatment Administration Record (TAR) for 8/2021 showed on 8/26/21 the physician issued an order to offload the right heel while the resident was in bed. The physician also issued wound care orders for the newly identified right heel pressure ulcer. There was no documentation facility staff were offloading the resident's right heel prior to him developing the wound. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 8/30/21, during an initial wound visit with the physician, Patient #22 was diagnosed with a pressure wound to his right heel. The wound care physician note dated 8/30/21 noted a stage 3 pressure wound of the right heel. The plan included a foot elevator or foam heel offloading boot to the right lower extremity when in bed or 24/7 (24 hours, 7 days a week). On 10/8/21 at 3:30 p.m., the Director of Nursing (DON) verified staff were not offloading Resident #22's right heel prior to the development of the pressure ulcer to his right heel, and could not provide documentation Resident #22's right heel was offloaded. The Director of Nursing said the Nurse Manager told her she felt since Resident #22 had an air mattress, it was sufficient at the time of admission to prevent the resident from developing a pressure ulcer to his right heel.