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	04/18/2023

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 review of facility policy and procedures, record review and staff interviews, the facility failed provide the necessary supervision and assistance to prevent avoidable accidents for 1 (Resident #900) of 3 residents reviewed who were identified as being at risk for falls and sustained multiple falls at the facility. The failure to implement appropriate supervision resulted in Resident #900 sustaining a fall with major injury requiring the residents transfer to a higher level of care. The findings included: The facility policy Fall Management Protocol (revised 10/24/22) 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 showed Resident #900 had an admitted [DATE] with diagnoses including cognitive communication deficit, hypertension, atrial fibrillation, and major depressive disorder. The Admission MDS (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date of 12/12/22 documented Resident #900 required limited assistance of 1 for ambulation in room. The MDS noted Resident #900's cognitive function was intact. The care plan initiated on 12/14/22 identified Resident #900 as at risk for falls and fall related injuries. The intervention included, keep needed items in reach, labs per physician order and report abnormal values, maintain a clear pathway free of obstacles. The Social Services progress note dated 12/20/22 documented a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. The progress note documented resident #900 was packing her belongings and going to the front lobby. A wander guard was placed on the resident's right ankle. Resident demonstrated disorganized thinking, rambling and illogical flow of ideas. The physician was notified and ordered blood work to be obtained. (continued on next page)

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	The nurse progress noted dated 12/21/22 documented Resident #900 refused the blood work and was observed to be upset. Certified Nursing Assistant (CNA) was staying close to resident for safety related to high fall risk and previous elopement incident on 12/20/22. Review of the nurse progress note dated 12/21/22 at 4:58 a.m., documented Resident #900 was observed more agitated and requesting to go home. Resident said if she was not allowed to go home by 1:00 p.m., she would walk out the door and leave. The Registered Nurse Practitioner (RNP) was notified. The RNP note dated 12/21/22 at 10:52 a.m., documented resident had episode of increased agitation/confusion/elopement yesterday, safety measures implemented. Today at assessment patient is alert, oriented, cooperative, back to her baseline, no behaviors noted. Per Social Services discussed with patient/family discharge home on Friday after tests are done and reviewed, psych to evaluate, no other concerns today, nursing to monitor for changes. Review of the nursing progress note dated 12/21/22 at 7:07 p.m., documented the resident was alert with some confusion. The CNA reported resident having medications from home in her room. Resident had 2 pill bottles, nurse asked to take them and store them until discharge or family can pick up at facility. The medications included amitriptyline (an antidepressant) and Xanax (medication used to treat anxiety and panic disorders) 0.5 milligrams. Resident continues to ambulate with walker unassisted, nurse reminded resident to use call light when assistance is needed, wander guard in place. Review of the RNP progress note dated 12/23/22 documented increased confusion and weakness today, increased anxiety. Will postpone discharge until next week when resident is more stable. Nursing to monitor. The Social Services progress note dated 12/23/22 documented Resident #900 was weaker, showing some confusion this morning. Planned discharge for today cancelled. Review of the nurse progress note dated 12/24/22 at 7:05 a.m., documented at 5:55 a.m., CNA called nurse to residents room. Resident #900 was lying on the floor, right side. Noted large amount of blood on resident and on floor. Large laceration to the left side of the resident's scalp. The resident was responding to voice by opening her eyes and looking at this writer. Breathing was normal at 16 respirations per minute. Resident was not verbally responsive. This writer called 911 per protocol. When this writer returned to the room after obtaining demographics, it was noted the resident was no longer breathing. Code status of full code was established. This writer was attempting to access facility phone to announce, Code Blue, EMS arrived and started code. After 30 minutes, EMS established a pulse and transported the resident to the hospital. On 4/18/23 at 11:15 a.m., in an interview CNA Staff A said she was working the 11 p.m., to 7 a.m., shift on 12/24/22 and received report from the previous shift CNA. I was informed Resident #900 was a fall risk and had been up ambulating. The resident used a 2 wheeled walker and a wheelchair and had days when she required more assistance than other days. No one informed me she had recent changes in her mental status or behaviors, I did not know that. She needed a good bit of help that night, she was anxious, and she wanted to go home so I sat with her and talked with her. I last checked on her at 1:00 a.m., she was in her bed sleeping. I checked on her again at 5:00 a.m. and found her on the floor next to her bed. She was breathing at that time, and I ran to get the nurse. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Post Incident Review dated 12/28/22 documented Resident #900 had a fall with suspected head injury. The form documented the incident could have been related to a change in condition. The document specified the resident was not utilizing her walker and the walker was against the wall away from the resident. The root cause of the incident specified, Resident has known gait and balance issues hence the need for assistive device. Due to lack of assistive device near her, it can be presumed that she may have lost her balance and fell . On 4/18/22 at 11:07 a.m., in an interview, Resident #900's daughter said the facility knew my mother was wandering and trying to elope and they placed a wander guard on her. My mother called me on 12/24/22 at 2:00 a.m., and was agitated, anxious and wanted to go home. I calmed her down and spoke with her for a while. At 7 a.m., the facility called to say she fell and was sent to the emergency room (ER). She passed away at the hospital on 12/26/22. The ER doctor told me she must have been on the floor for a while because her core body temperature was very low. They said she had a heart attack but did not know if the heart attack caused the fall or the fall caused the heart attack. My concern was how long was she on the floor before she was found.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41155 Based on observation, review of facility policy and staff interviews, the facility failed to ensure all medications were locked and secured in one medication cart and one treatment cart when not in direct view of the nurse. This had the potential for residents and others to have access to medications that could create hazardous health consequences for residents in the facility. The findings included: The facility policy Medication Practices, October 2018, specified, Centrally stored medications will be kept in a locked cabinet, locked cart or other locked storage receptacle room, or area. During an initial tour of the facility on 4/18/23 at 9:00 a.m., the D wing medication cart was unlocked and unattended. The Director of Nursing confirmed the observation and secured the medication cart. On 4/18/23 ay 9:07 a.m., during an observation on the B wing, the treatment cart was observed next to the nursing station. The cart was unlocked and unattended. At 9:11 a.m., Licensed Practical Nurse Staff C confirmed the cart was unlocked and said she was not aware the treatment cart was there.