STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105387	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ambassador Healthcare at College Park	13755 Golf Club Pkwy Fort Myers, FL 33919

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52390 Based on record review, review of facility's policies and procedures and staff interviews, the facility failed to protect the resident's rights to be free from neglect by failing to follow safety precautions specified in the care plan to prevent avoidable accident with injury for 1 (Resident #1) of 3 dependent residents reviewed. The findings included: Review of facility Policy titled Abuse, Neglect, Exploitation, Misappropriation, Mistreatment, Injury of unknown source and Investigations, effective date 4/01/22 revealed neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of facility Policy titled Nursing - Activities of Daily Living (ADL's), effective date 4/01/22 revealed its primary goal is to ensure all resident's needs are met in a manner that promotes their quality of life and preference. (3) A resident who is unable to carry out activities of daily living shall receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Review of medical records revealed Resident #1 was admitted to the facility on [DATE] with diagnosis including Alzheimer's Disease (a progressive neurodegenerative disorder that primary affects the brain, causing a gradual decline in memory, symptoms affecting memory, thinking and social abilities), anxiety disorder (feeling of fear, dread or uneasiness), and major depressive disorder (persistent feelings of sadness or hopelessness). The Admission Minimum Data Set (MDS) with a target date of 4/23/25 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 3 indicating severely impaired cognition. Review of Care Plan dated 3/8/23 revealed Resident #1 has an ADL self-care performance deficit related to Alzheimer's Disease. Resident #1 was weak with impaired balance and mobility. Interventions included Resident #1 was dependent on staff for ADL's and required substantial/maximum assistance of two staff with bed mobility (changing positions while in bed). Review of Kardex (an electronic system used to summarize resident information) revealed Resident #1 required substantial/maximum assistance of two staff with bed mobility. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of incident note dated 4/6/25 revealed that Certified Nursing Assistant (CNA) Staff A was providing care to Resident #1 and Resident #1 experienced a fall out of the bed. Review of a progress note dated 4/6/25 revealed Resident #1 was observed lying on her right side on the floor next to her bed and in between her tray table. Resident #1 was visibly upset and crying. Resident #1 was bleeding from the left side of her forehead above her eyebrow. Review of Change in Condition Form dated 4/6/25 revealed during ADL care Resident #1 fell from the bed during ADL care resulting in an injury to Resident #1's forehead. Review of medical record revealed Resident #1 was transferred to the hospital and required seven sutures to the forehead injury related to the fall reported. On 4/29/25 at 3:13 p.m., in an interview Certified Nursing Assistant (CNA) Staff A said she was doing a linen change for Resident #1 alone. Staff A said she rolled Resident #1 toward her and the resident fell out of bed. Staff A said she was not told Resident #1 was a fall risk or a two person assist. Staff A said she has had Resident #1 multiple times and always did Resident #1's care by herself. Staff A said she received a call later that day from the Director of Nursing (DON) explaining Resident #1 was a two person assist with bed mobility. Staff A said the fall and injury was neglect because the care she provided was not done properly since Resident #1 required two people and she was doing care alone. On 4/29/25 at 3:53 p.m., in an interview Licensed Practical Nurse (LPN) Staff B said CNA Staff A came to get her because the resident fell off the bed. Staff B said Staff A told her she was changing Resident #1, put her on the side and Resident #1 fell off the bed. Staff B said staff use the Kardex to know each resident's individual needs and they are supposed to be trained on the Kardex in orientation. Staff B said neglect would include performing care alone when the resident requires two staff members for care. On 4/30/25 at 10:33 a.m., the DON said she was called about Resident #1 going to the hospital and that Resident #1 had a gash on her forehead. The DON confirmed she reviewed the staff witness statements and Resident #1 Kardex and concluded the staff did not follow the plan of care. The DON said Staff A told her she has been doing care for Resident #1 by herself all along and that she did not know about the Kardex. The DON said at that point we realized there was a breakdown in the system. The DON said Staff A was not in-serviced on the Kardex and did not receive Kardex training during orientation. The DON said not following the resident's plan of care is neglect. On 4/30/25 at 11:23 a.m., Licensed Nursing Home Administrator (LNHA)said she worked with the DON on the investigation for Resident #1's fall together. The LNHA said they found out Staff A had not followed the Kardex plan of care when she was providing care for Resident #1. The LNHA said her investigation revealed CNA, Staff A while providing care alone, turned Resident #1 towards her and the resident ended up falling out of bed. The LNHA said the conclusion of the investigation was Staff A was not following the Kardex and the plan of care for Resident #1 which is neglect. She said the facility substantiated neglect and confirmed Neglect is a never event.

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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** 44307 Based on record review, review of facility's policies and procedures and staff interviews, the facility failed to provide care as specified in the care plan resulting in an avoidable fall with injury for 1 Resident #1) of 3 dependent residents reviewed. The findings included: Review of facility Policy titled Nursing - Activities of Daily Living (ADL's), effective date 4/01/22 revealed its primary goal is to ensure all resident's needs are met in a manner that promotes their quality of life and preference. (3) A resident who is unable to carry out activities of daily living shall receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Review of medical records revealed Resident #1 was admitted to the facility on [DATE] with diagnosis including Alzheimer's Disease (a progressive neurodegenerative disorder that primary affects the brain, causing a gradual decline in memory, symptoms affecting memory, thinking and social abilities), anxiety disorder (feeling of fear, dread or uneasiness), and major depressive disorder (persistent feelings of sadness or hopelessness). The Admission Minimum Data Set (MDS) with a target date of 4/23/25 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 3 indicating severely impaired cognition. Review of Care Plan dated 3/8/23 revealed Resident #1 has an ADL self-care performance deficit related to Alzheimer's Disease. Resident #1 was weak with impaired balance and mobility. Interventions included Resident #1 was dependent on staff for ADL's and required substantial/maximum assistance of two staff with bed mobility (changing positions while in bed). Review of Kardex (an electronic system used to summarize resident information) revealed Resident #1 required substantial/maximum assistance of two staff with bed mobility. Review of incident note dated 4/6/25 revealed that Certified Nursing Assistant (CNA) Staff A was providing care to Resident #1 and Resident #1 experienced a fall out of the bed. Review of a progress note dated 4/6/25 revealed Resident #1 was observed lying on her right side on the floor next to her bed and in between her tray table. Resident #1 was visibly upset and crying. Resident #1 was bleeding from the left side of her forehead above her eyebrow. Review of Change in Condition Form dated 4/6/25 revealed during ADL care Resident #1 fell from the bed during ADL care resulting in an injury to Resident #1's forehead. Review of medical record revealed Resident #1 was transferred to the hospital and required seven sutures to the forehead injury related to the fall reported. On 4/29/25 at 9:10 a.m., observed Resident #1 in bed with visible healing pink scar on forehead. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/29/25 at 3:13 p.m., in an interview Certified Nursing Assistant (CNA) Staff A said she was doing a linen change for Resident #1 alone. Staff A said she rolled Resident #1 toward her and the resident fell out of bed. Staff A said she was not told Resident #1 was a fall risk or a two person assist. Staff A said she has had Resident #1 multiple times and always did Resident #1's care by herself. Staff A said she received a call later that day from the Director of Nursing (DON) explaining Resident #1 was a two person assist with bed mobility. Staff A said the fall and injury was neglect because the care she provided was not done properly since Resident #1 required two people and she was doing care alone. On 4/29/25 at 3:53 p.m., in an interview Licensed Practical Nurse (LPN) Staff B said CNA Staff A came to get her because the resident fell off the bed. Staff B said Staff A told her she was changing Resident #1, put her on the side and Resident #1 fell off the bed. Staff B said staff use the Kardex to know each resident's individual needs and they are supposed to be trained on the Kardex in orientation. Staff B said neglect would include performing care alone when the resident requires two staff members for care. On 4/30/25 at 10:33 a.m., the DON said she was called about Resident #1 going to the hospital and that Resident #1 had a gash on her forehead. The DON confirmed she reviewed the staff witness statements and Resident #1 Kardex and concluded the staff did not follow the plan of care. The DON said Staff A told her she has been doing care for Resident #1 by herself all along and that she did not know about the Kardex. The DON said at that point we realized there was a breakdown in the system. The DON said Staff A was not in-serviced on the Kardex and did not receive Kardex training during orientation. The DON said not following the resident's plan of care is neglect. On 4/30/25 at 11:23 a.m., Licensed Nursing Home Administrator (LNHA)said she worked with the DON on the investigation for Resident #1's fall together. The LNHA said they found out Staff A had not followed the Kardex plan of care when she was providing care for Resident #1. The LNHA said her investigation revealed CNA, Staff A while providing care alone, turned Resident #1 towards her and the resident ended up falling out of bed. The LNHA said the conclusion of the investigation was Staff A was not following the Kardex and the plan of care for Resident #1 which is neglect. She said the facility substantiated neglect and confirmed Neglect is a never event.