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	02/13/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on observation, clinical record review, review of facility's policies and procedures, resident representative and staff interviews, the facility failed to adequately supervise 1 (Resident #900) of 3 sampled residents with cognitive impairment, confusion and poor safety awareness to prevent unsafe wandering and elopement.On 11/28/25 at approximately 9:45 a.m., Resident #900 who was cognitively impaired, ambulatory, confused and had poor safety awareness walked past the unattended front desk of the facility and exited the building through the unlocked front door.Resident #900 crossed a two lane road and walked 0.5 mile to the dorm of a State College through uneven terrain and near water ponds. The college staff found Resident #900 wandering in the dorm, confused, unsteady and shaking. The college staff called EMS (Emergency Medical Services) and Resident #900 was transferred to a local Emergency Room.The facility staff were not aware of the resident's exit until 11/28/25 at approximately 10:35 a.m., when the college campus officer notified the facility of the resident's transfer to a local emergency room via EMS.The facility failure to ensure adequate supervision to prevent unsafe wandering and elopement of cognitively impaired, and confused residents created a likelihood of avoidable accidents for Resident #900 and other cognitively impaired and confused residents which could result in serious harm, serious injury, serious impairment or death of the residents.This failure resulted in the determination of Immediate Jeopardy.On 2/12/26, after verification of an acceptable removal plan, the immediate Jeopardy was removed as of 2/12/26. The scope and severity for F689 was reduced to D, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.The findings included:Cross Reference to F835.On 2/9/26 at 10:12 a.m., in a telephone interview, Resident #900's family member said that on 11/28/25 the resident left the facility unsupervised and they were very upset that the facility did not notify them of the incident until 24 hours later. The family member said, What if he had made it to the main road and got hit by a car or laid down somewhere and could not get back up?.On 2/9/26 at 1:57 p.m., an interview was conducted with the Director of Nursing (DON) and the Administrator. The DON verified that on 11/28/25 Resident #900 exited the facility without staff knowledge and supervision. A request was made to see the investigation for Resident #900's elopement.The DON said, I want to change the topic and not call it an elopement.The Administrator said that on 11/28/25 Resident #900 went out for a walk and forgot to sign himself out. He was found on the cameras at the college at 9:54 a.m. The people who found him saw the PICC (Peripherally Inserted Central Catheter) line out, they freaked out. They called EMS and sent him to the Emergency Room. The facility staff knew he was missing at 10:30 a.m. The campus security came over and said that Resident #900 walked into a dormitory and was looking for a way back. The Administrator reiterated that no one saw Resident #900 leave the facility but he did not elope. He went out and he was just too tired to come back. She said the resident was cognitively intact and had a BIMS of 13 when he returned to the facility.The Administrator said they have initiated a new leave of absence (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	(LOA) process to sign residents in and out of the facility. The front desk now has a book with blue sign out sheets and white sign out sheets. Residents with a blue sign-out sheet are not allowed to leave the facility unattended. The Administrator said she only educated the front desk staff and managers on the new process for the white and blue sign out sheets. She said she did not think it was important for all the staff to be educated on the new process but educated the staff on the facility's elopement policy.Review of the clinical record for Resident #900 revealed an admission date of 11/5/25. Diagnoses included malignant neoplasm (cancer) of the esophagus, severe protein-calorie malnutrition, adult failure to thrive and history of immunosuppression therapy.Review of the Elopement Risk Evaluation with an effective date of 11/6/25 revealed Resident #900 was determined not to be at risk for elopement based on the potential risk factors listed. Unit Manager (UM) Staff B completed the Elopement Risk Evaluation and answered No to the questions, Is the resident cognitively impaired, Does the resident have poor decision-making skills, Has the resident demonstrated exit seeking behaviors? , Does the resident wander oblivious to safety needs? and Does the resident have a history of elopement?. UM Staff B answered yes to questions, Is the resident independently mobile (ambulatory or wheelchair)? and Does the resident have the ability to exit the facility?.Review of the Physical Therapy Evaluation and Plan of Treatment dated 11/6/25 revealed Resident #900 required Partial/moderate assistance to walk 150 feet. The evaluation noted that Resident #900, Presents with decreased insight, decreased functional capacity . gross motor coordination deficits, strength impairment, postural alignment/control, deficits in judgment and decreased safety awareness.Review of the care plan initiated on 11/6/25 revealed that Resident #900 was at risk for falls related to little energy, impaired balance, pain due to severe protein-calorie malnutrition, chemotherapy and anemia.Review of the Speech Language Pathology Evaluation and Plan of Treatment dated 11/6/25 revealed that Resident #900, Presents with moderate cognitive-communication deficit at this time with primary deficits and short term memory, problem solving and executive functioning skills . The goals included for the resident to demonstrate functional problem solving and safety awareness in 70% of opportunities given minimum-moderate verbal cues in order to promote safety within current/home environment and to enhance decision making skills and increase ability to function safely without additional assistance/supervision due to cognitive deficits to 76-90% of the time in order to demonstrate improved problem solving/cognition skills. The Speech Language Pathologist documented Resident #900 scored 16/30 on the SLUMS (St. Louis University Mental Status) assessment, indicating moderate cognitive impairment.Review of the admission Minimum Data Set (MDS) with an assessment reference date of 11/12/25 revealed Resident #900 scored 12 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. The triggered care areas addressed in the resident's care plan included cognitive loss/dementia and activities of daily living functional /rehabilitation Potential.On 11/12/25 at 6:00 p.m., a nursing alert note documented, Resident pulled out his PIC (Peripherally Inserted Catheter) line (Catheter inserted into a peripheral vein and threaded into a large central vein to administer long term intravenous therapy) and was holding it in his hand. He is confused and did not know what he was doing. Palliative consult was ordered earlier today for change in mental status and advanced cancer.The care plan initiated on 11/13/25 revealed that Resident #900 had impaired cognitive function or impaired thought process related to disease process. Resident #900 scored 12 on the BIMS assessment. The goal included for the resident to be able to communicate basic needs on a daily basis and maintain current level of cognitive function.On 11/14/25 an Advanced Practice Registered Nurse (APRN) progress note documented, Patient was noted to intermittently confused and repeatedly pulling at his IV tubing, requiring redirection and reinforcement of safety measures . Acute Confusion with IV (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	implemented by the facility and verified by the survey team included:Resident #900 no longer resides at the facility and was successfully discharged home as planned on 12/6/25.On 2/13/26, the survey team verified through clinical record review and interview with the Administrator that on 12/6/25, Resident #900 was discharged home.On 11/28/25 Resident #900 was immediately placed on 1:1 staff observation. A licensed nurse performed a complete skin inspection with no new skin concerns identified. The resident's cognitive status was re-evaluated using the BIMS assessment with a score of 13/15 indicating resident #900 was cognitively intact.On 2/13/26, the survey team verified through documentation and interview with the Administrator, and Unit Manager LPN Staff B that Resident #900 was placed on 1:1 staff observation and a skin assessment was completed on 11/28/25.From 11/28/25-12/3/25 the Administrator/Designee completed staff re-education on Missing Resident Drill and Elopement with 154/154 staff members to include following the policy with emphasis on: Responding to door alarms, using the elopement binder, performing a resident headcount and Administrator and DON notification.On 2/13/26 the survey team verified through review of the education and interview with Registered Nurse Staff F, Certified Nursing Assistant (CNA) Staff G, CNA Staff H, CNA Staff C, Licensed Practical Nurse (LPN) Staff I, LPN Staff B, LPN Staff J, and the DON.On 12/1/25, the Administrator modified the receptionist's process for resident's exiting the facility and added this to the education for newly hired staff. The new process education included: The newly created binder with blue or white sheets for each resident. The blue sheet indicates residents require supervision for LOA. The white sheets indicate the resident is safe for unsupervised LOA. The determination of supervision for LOA's is made by the clinical team. Residents must sign in and out for LOA each time they leave the center. The front door is opened by the remote or keypad. On 12/3/25, the facility's contracted vendor removed the automatic open option on the front double doors, allowing the doors to remain locked with access by staff remote or key-pad entry/exit only.On 2/13/26, the survey team verified through review of the receptionist's process for residents exiting the facility, interview with the receptionist, review of the newly created binder. Observation of the front door of the facility showed the door remains locked and can only be opened with a remote or by entering a code on the keypad.On 2/12/26 the facility extended the receptionist's hours from 7:00 a.m. -9:00 p.m., 7 days a week. The front desk coverage process was updated to include the extended receptionist hours. This process establishes coverage for the front desk when the receptionist is on break or needs to step away as well as the process between the hours of 9:00 p.m. -7:00 a.m., for assisting residents with LOA and/or visitors entering and exiting the facility.On 2/13/26, the survey team verified through review of the new receptionist schedule, and interview with the Administrator, the DON, Receptionist Staff E, and Receptionist Staff K. In interviews RN Staff F, CNA Staff G, CNA Staff H, and CNA Staff C said they worked the evening or night shift and had been educated on the new process for assisting residents entering and leaving the facility. On 2/12/26, 32/32 current residents admitted in the last 30 days were re-evaluated for accuracy of new admission assessments and documentation related to cognitive status and elopement risk by the Director of Nursing/Designee. No new like residents were identified to be at risk.On 2/13/26, the survey team verified through interview with the DON and review of the facility provided evaluations of new admission assessments, documentation related to cognitive status and elopement risk.On 2/12/26, the Administrator confirmed the LOA process is included in the new admission packet.On 2/13/26, the survey team verified through review of the admission packet and interview with the Administrator.On 2/12/26, the Director of Nursing/Designee completed a new elopement risk assessment on 103/103 current residents in the electronic medical record system. No new residents were identified as potentially being at risk for elopement.On 2/13/26, the survey team verified through (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	review of the new elopement risk assessment for 20 randomly selected residents, interview with the DON and Unit Manager LPN Staff B.On 2/12/26, the receptionist on duty for the 11/28/25 event was re-educated by the Administrator/Designee on ensuring residents exiting the facility were approved by the clinical staff prior to allowing the resident to exit. The newly created binder with blue or white sheets for each resident. The blue sheet indicates residents require supervision for LOA. The white sheets indicate the resident is safe for unsupervised LOA. The determination of supervision for LOA's is made by the clinical team. Residents must sign in and out for LOA each time they leave the center. The front door is opened by the remote or keypad.On 2/13/26, the survey team verified through review of the education provided, interview with the receptionist, review of the newly created binder. Interview with the DON, Unit Manager Staff A, and Unit Manager Staff B verified the determination of supervision for LOA is made by the clinical team.The Director of Nursing/Designee completed staff re-education regarding federal regulation F689, specifically the Center for Medicare and Medicaid Services (CMS) definition of elopement, the updated facility elopement policy, documentation of resident incidents in the clinical record, and the new receptionist process for resident's exiting the facility to include the newly created binder with blue or white sheets for each resident, the determination of supervision for LOA's is made by the clinical team, residents must sign in and out for LOA each time they leave the center and the front door is opened by the remote or keypad conducted on the following dates: 2/10/2026 with 103/142 staff members. 2/11/2026 with 32/142 staff members. 2/12/2026 with 7/142 staff members. In total 142/142 current employees were educated. The facility does not use any agency staffing.On 2/13/26, the survey team verified through review of the education provided and interviews with RN Staff F, CNA Staff G, CNA Staff H, CNA Staff C, LPN Staff I, LPN Staff B, LPN Staff J, and the DON.On 2/12/26, 31/31 current licensed nurses were educated by the Director of Nursing/Designee on communicating when a physician changes a residents' capacity to notify the Director of Nursing and/or the Administrator at the time of the determination to ensure timely re-evaluation of resident risk for elopement.On 2/13/26, the survey team verified through review of the content of the education, and interview with RN Staff F, LPN Staff I, LPN Staff B, LPN Staff J, and the DON.An ADHOC (unplanned) Quality Assurance (QA) meeting was held with the facility Medical Director in attendance via phone on 2/12/26. The facility completed QA Meetings on 12/10/2025 and 1/14/[TRUNCATED]

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility's policies and procedures, clinical record review, resident representative and staff interviews, the facility administration failed to provide effective oversight and implement processes to ensure the safety of residents, including unsafe wandering and elopement of 1 (Resident #900) of 3 cognitively impaired and confused residents reviewed.On 11/28/25 at approximately 9:45 a.m., Resident #900 who was cognitively impaired, ambulatory, confused and had poor safety awareness walked past the unattended front desk of the facility and exited the building through the unlocked front door.Resident #900 crossed a two lane road and walked 0.5 mile to the dorm of a State College through uneven terrain and near water ponds. The college staff found Resident #900 wandering in the dorm, confused, unsteady and shaking. The college staff called EMS (Emergency Medical Services) and Resident #900 was transferred to a local emergency room (ER).The facility staff were not aware of the resident's exit until 11/28/25 at approximately 10:35 a.m., when the college campus officer notified the facility of the resident's transfer to a local emergency room via EMS.The facility administration did not consider Resident #900's unsafe wandering incident an elopement, did not document the incident and measures implemented to prevent further incidents of unsafe wandering in Resident #900's clinical record. The facility implemented a new process to sign residents in and out of the facility but failed to have documentation that staff were educated on the new process.The facility administration failure to have processes in place to ensure adequate supervision created a likelihood of avoidable accidents for Resident #900 and other cognitively impaired and confused residents from unsafe wandering and elopement, which could result in serious harm, serious injury, impairment or death of the residents.This failure resulted in the determination of Immediate Jeopardy.On 2/12/26, after verification of an acceptable removal plan, the immediate Jeopardy was removed as of 2/12/26. The scope and severity for F835 was reduced to D, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.The findings included:Cross reference F689Review of the job description signed and dated 10/5/2025 by the Director of Nursing revealed the primary purpose of the position was to plan, organize, develop and direct the overall operation of the nursing services department in accordance with current federal, state and local standards, guidelines and regulations that govern the facility and as directed by the Administrator and the Medical Director to ensure the highest degree of quality of care is always maintained.Duties and responsibilities included to, Participate in risk management and safety committees to mitigate risk factors for residents . Ensure the resident environment remains as free of accident hazards as much as possible and residents receives [sic] adequate supervision and assistive devices to prevent accidents.Review of the job description signed and dated 3/26/2025 by the Administrator revealed the primary purpose of the job description was to direct the day-to-day functions of the Facility in accordance with current federal, state and local standards guidelines and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to the residents at all times.Duties and responsibilities included to, Develop and maintain written policies and procedures and professional standards of practice that govern the operation of the Facility . Assist department directors in the development, use, and implementation of departmental policies and procedures and professional standards of practice.Review of the clinical record revealed Resident #900 had a date of admission of 11/5/25. Diagnoses included adult failure to thrive, malignant neoplasm (cancer) of the esophagus, major depressive disorder, muscle wasting and atrophy.Review of the admission Minimal Data Set (MDS) with an assessment reference date of 11/12/25 revealed Resident #900 scored 12 on the Brief Interview for Mental Status (BIMS), (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	indicating moderately impaired cognition. The MDS noted Resident #900 required partial to moderate assistance with ambulation of 50 feet, transfers, personal hygiene and bathing.Review of the admission elopement assessment dated [DATE] documented a score of 00, indicating the resident was not at risk for elopement. The clinical record contained no additional elopement assessments.Review of the Speech Language Pathology Evaluation and Plan of Treatment dated 11/6/26 revealed that Resident #900, Presents with moderate cognitive-communication deficit at this time with primary deficits and short term memory, problem solving and executive functioning skills .The Care Plan initiated 11/13/25 and revised 12/9/25 documented Resident #900 had impaired cognitive function or impaired thought processes related to disease processes.On 11/14/25 an Advanced Practice Registered Nurse (APRN) progress note documented, Patient was noted to be intermittently confused and repeatedly pulling at his IV (Intravenous) tubing, requiring redirection and reinforcement of safety measures . Acute Confusion with IV Interference . Observed intermittent confusion leading to pulling at IV tubing, placing patient at risk for injury and catheter complications. Reinforce safety measures and monitor mental status.On 11/16/25 at 2:41 a.m., a nursing alert note documented, PT (patient) ripped out IV. When Pt was asked Pt stated I didn't do that, I'm ready to go to Vietnam. Pt is confused, AO X1 (Alert, Oriented to Person). No evidence of learning.On 11/17/26, a physician progress note documented, Cognitive impairment with treatment-interfering behaviors . Confusion leading to repeated removal of IV lines, refusal of replacement at times. Requires close supervision and safety monitoring. Ensure orientation cues and minimize environmental triggers.On 11/18/25, a Speech Language Pathology discharge summary noted that on 11/18/26 Resident #900 achieved 65 to 70% accuracy for the Short Term Goal of, The patient will demonstrate functional problem solving and safety awareness in 70% of opportunities given min-mod verbal cues in order to promote safety withing current/home environment and to enhance decision making skills.On 11/19/25, the Psychiatry Advanced Practice Registered Nurse (APRN) documented in a progress note in Resident #900's clinical record, In my opinion, this patient lacks the capacity to make decisions related to his/her need for healthcare, or long-term placement. Due to cognitive impairment, the patient is unable to understand the nature, extent or probable consequences of not receiving medical care. In addition, the patient is unable to make a rational evaluation of the burden, risks, and benefits of treatments. In my opinion, the patient can benefit from a guardian or POA (Power of Attorney).On 11/25/25 a Physical Therapy encounter note documented, Pt reported that he needed to go to the bathroom. However, he was walking out of the room into someone else room. The [sic] was redirected to his room to use the bathroom. Pt appears to be confused to today. The DOR (Director of Rehab) notify.On 11/26/25, an APRN progress note documented Resident #900 had mild confusion fluctuates per history.On 11/28/25 at 6:00 p.m., a nursing progress note documented that Resident #900's level of consciousness was, noted as oriented to person oriented to place. Behavioral problems are not noted.The next nursing progress note was dated 11/30/25 at 12:25 p.m., and noted, Level of consciousness was noted as oriented to person to place restless .On 2/9/26 at 10:12 a.m., in a telephone interview, Resident #900's family member said that on 11/28/25 the resident left the facility unsupervised and they were very upset that the facility did not notify them of the incident until 24 hours later. The family member said, What if he had made it to the main road and got hit by a car or laid down somewhere and could not get back up?.On 2/9/26 at 1:57 p.m., an interview was conducted with the Director of Nursing (DON) and the Administrator to discuss Resident #900's elopement and facility processes to prevent unsafe wandering and elopement of cognitively impaired and confused residents.The DON said, I want to change the topic and not call it an elopement.The Administrator said that on 11/28/25 Resident #900 went out for a walk and forgot to sign himself out. The people who (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	found him saw the PICC (Peripherally Inserted Central Catheter) line out, they freaked out. They called EMS and sent him to the Emergency Room. She said the resident was cognitively intact and had a BIMS of 13 on 11/28/25 when he returned to the facility. The Administrator reiterated that Resident #900 did not elope. He did not follow the leave of absence (LOA) policy. He went out and was just too tired to return on his own. She verified no one saw Resident #900 leave the facility and did not know where he was until the college campus security notified them at approximately 10:30 a.m. The Administrator said the resident would have come back to the facility, his intention was to get some sunshine not to leave the facility. The Administrator said that in December 2025, they initiated a new process to sign residents in and out of the facility. Residents are assigned a blue sign out sheet or a white sign out sheet. Residents with a white sign out sheet are able to leave the facility unsupervised. Residents with a blue sign out sheet need to have someone with them to leave the facility.On 2/9/26 at 4:39 p.m., in an interview the Administrator said she only educated the front desk staff and management staff on the new process. She said it was not important for all staff to be educated on the new process but educated the staff on the facility's elopement policy. She said, I did not write anything down on paper that I educated the staff.On 2/10/26 at 12:05 p.m., in an interview, Unit Manager Licensed Practical Nurse (LPN) Staff B verified that on 11/28/25 Resident #900 left the facility unsupervised. She said that a new elopement risk evaluation was not completed when the resident came back from the Emergency Room. She verified the lack of documentation in the clinical record that on 11/28/25 Resident #900 left the facility unsupervised. She said, I was told not to document anything, that the Administrator and DON would take care of that. She said Resident #900 was at baseline, always confused. On 2/10/26 at 12:10 p.m., an interview was held with the Administrator and DON to discuss facility practices for documentation, and elopement prevention.The DON said she wasn't at the facility on 11/28/25 but reviewed Resident #900's clinical record the following Monday when she came back to work. She verified the incident was not documented in the resident's record and said they should have probably been a note in the resident's clinical record when he returned to the facility. She said she saw there was no documentation and did not want to put a late entry in because the Administrator did the investigation. She said, I did not have anything to write in there. Sometimes I have the staff make late entries, sometimes. The DON said that a new elopement evaluation is done where there is a big change. If yesterday the resident had no desire to leave but today the resident wants to go out and does not make sense, then, they would reevaluate. She said after reviewing everything, she concluded that the resident wanted to go for a walk. The door opened and he walked out. Anybody coming in the building was able to push a button to open the door but that was no longer the case. The DON said she would allow cognitively impaired residents who do not have an incapacity statement to leave the facility and sit outside unsupervised. The DON said the root cause of the incident was that the resident wanted to go for a walk and he did not sign out.The Administrator said that they had a few issues with people coming into the building. The push button was replaced in December for safety concerns but it was not installed directly in response to the incident of Resident #900 leaving the facility without supervision on 11/28/25. She said when the resident came back to the facility, she interviewed him. He said he just wanted to take a walk. He then realized he probably needed some help to come back. He walked into the building to ask for a ride and the next thing he knew, EMS was there. She said Resident #900 was very apologetic for not signing out. The Administrator said she personally did the resident's BIMS upon his return and he scored 13. The Unit Manager was there to witness it. She said if a resident was cognitively impaired but did not have an incapacity statement, she would allow them to leave the facility unsupervised.The Administrator said on (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	11/28/25 they started to in-service staff on the facility's elopement prevention policy.On 2/10/26 at 1:30 p.m., in a telephone interview the psychiatric Advanced Practice Registered Nurse verified that she assessed Resident #900 on 11/19/26 at the request of the resident's attending physician and wrote the incapacity statement. She said Resident #900 scored very poorly on the SLUMS (St. Louis University Mental Status) exam. She said the resident scored 12 on the test. A score below 20 indicates dementia. She said if the resident is deemed incapacitated, he is not able to leave the facility on his own.On 2/10/26 at 3:23 p.m., in a telephone interview Resident #900's physician said the resident went out for a walk. He said he called his Nurse Practitioner and also reviewed the resident's clinical record. The physician said the resident was receiving Piperacillin (an antibiotic medication to treat infections), his mental status was clear. The resident's cognition was going in and out, Piperacillin can cause that. He went for a walk. He said, This guy was frail and he had cancer, he knew what was going on and he was aware of his condition. He was end-stage but clear and articulated all the time that he wanted out of here and was trying to leave. He wanted to go home. Then he would say okay and he would wait for his son. Reaffirmed with the physician that the resident constantly said he wanted to get out of the facility and go home. The physician replied, Yes. Review of the facility provided Brief Interview for Mental Status form dated 11/28/25 at 2:25 p.m., completed upon Resident #900's return from the ER revealed 13 was entered for BIMS Total Score (0-15). The form was not signed by the evaluator.The Administrator provided the facility's policy used to in-service the staff and the list of staff that were educated.Review of the facility provided policy titled, Nursing-Elopement Prevention with an effective date of 04/01/2022, and no revision date revealed, It is the policy of this facility to provide a safe environment for all residents and to eliminate and/or control elopement behavior of incapacitated residents. Definition: Elopement occurs when an incapacitated resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave or absence) and/or any necessary supervision to do so. Examples of wandering or elopement behaviors include but are not limited to: a history of wandering behavior or elopement or elopement attempts, oblivious to needs/safety, attempting to leave unescorted, exit seeking, without or without rational purpose, verbalization of plans to leave the facility whether or not authorized, or if resident has shown a repeated disregard for facility policy regarding passes previously granted . When an incapacitated resident not known to have or identified to have wandering/elopement behaviors wanders into an unsafe area or attempts to or actually leaves the building, an electronic monitoring device shall be applied, an Elopement Risk Assessment shall be completed, and a care plan initiated.Review of the facility provided policy and procedure for Medical Records-Documentation with an effective date of 04/01/22 and a revision date of 11/25/2025 revealed the purpose was, To ensure compliance with required medical record documentation per regulatory guidelines for both the paper and electronic medical record (EMR).Nurse's notes shall be written on each resident by licensed/qualified nursing personnel and shall address the resident's conditions. Frequency of entries shall be dependent on individual residents' needs and any pertinent change in condition. Documentation of observations should be specific and objective . Document normal behavior, progressive signs, attitudes, and moods as well as abnormalities and pathological signs .On 2/13/26, the Immediate Actions implemented by the facility and verified by the survey team included:Resident #900 was successfully discharged home as planned on 12/6/25.On 2/13/26, the survey team verified through record review and interview with the Administrator that on 12/6/25, Resident #900 was discharged home.From 11/28/25-12/3/25 the Administrator/Designee completed staff re-education on Missing Resident Drill and Elopement with 154/154 staff members to include following the policy with emphasis on: Responding to door alarms, using the (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	elopement binder, performing a resident headcount and Administrator and DON notification.On 2/13/26 the survey team verified through review of the education and interview with Registered Nurse Staff F, Certified Nursing Assistant (CNA) Staff G, CNA Staff H, CNA Staff C, Licensed Practical Nurse (LPN) Staff I, LPN Staff B, LPN Staff J, and the DON.The Administrator/Designee completed a Missing Resident Drill on 11/28/25, 11/29/25 (2), and 11/30/25 at varying times with 44 staff members participating collectively from each department.On 2/13/26, the survey team verified through review of documentation of the Missing Resident Drills and interview with 1 RN, 2 CNAs and 3 LPNs. All staff were able to verbalize the facility process for missing residents.On 12/1/25, the Administrator modified the receptionist's process for resident's exiting the facility and added this to the education for newly hired staff. The new process education included: The newly created binder with blue or white sheets for each resident. The blue sheet indicates residents require supervision for LOA (Leave of Absence). The white sheets indicate the resident is safe for unsupervised LOA. The determination of supervision for LOA's is made by the clinical team. Residents must sign in and out for LOA each time they leave the center. The front door is opened by the remote or keypad.On 2/13/26, the survey team verified through review of the new process, education provided and interview with the receptionist, the Administrator, the DON, Unit Manager Staff B, and LPN Staff J.On 12/3/25, the facility's contracted vendor removed the automatic open option on the front double doors, allowing the doors to remain locked with access by staff remote or key-pad entry/exit only.On 2/13/26, the survey team verified through review of the bill for service that a contracted vendor removed the automatic open option on the front double doors. Observation of the front double doors showed the door remained locked at all times and the doors open by staff remote or key-pad entry. Interview with CNA Staff H, CNA Staff C, LPN Staff I, the DON and the Administrator.On 2/12/26 the facility extended the receptionist's hours from 7:00 a.m.-9:00 p.m., 7 days a week. The front desk coverage process was updated to include the extended receptionist hours. This process establishes coverage for the front desk when the receptionist is on break or needs to step away as well as the process between the hours of 9:00 p.m.-7:00 a.m., for assisting residents with LOA and/or visitors entering and exiting the facility.On 2/13/26, the survey team verified through review of the new receptionist schedule, and interview with the Administrator, the DON, Receptionist Staff E, and Receptionist Staff K. In interviews RN Staff F, CNA Staff G, CNA Staff H, and CNA Staff C said they worked the evening or night shift and had been educated on the new process for assisting residents entering and leaving the facility. On 2/12/26 the Chief Nursing Officer re-educated the facility Administrator and Director of Nursing on the Center for Medicare and Medicaid Services (CMS) definition of elopement, their individual roles to ensure the safety of residents under their care and the expectation of completing a risk management report for resident elopement events.On 2/13/26, the survey team verified through review of the education provided and interview with the DON and Administrator. In an interview, the Chief Nursing Officer (CNO) said the facility had changed their elopement policy to reflect CMS's definition of an elopement.On 2/12/26, the members of the interdisciplinary team were re-educated on reporting and documenting resident incidents in the clinical record, the alleged deficient practice outlined on the immediate jeopardy template, and federal regulation F835 by the Chief Nursing Officer with an emphasis on ensuring the facility policies and procedures are followed related to medical record documentation.On 2/13/26, the survey team verified through review of the education provided and interview with the Administrator, the DON, RN Staff F, LPN Staff I, LPN Unit Manager Staff B, and LPN Unit Manager Staff J.On 2/12/26, 32/32 current residents admitted in the last 30 days were re-evaluated for accuracy of new admission assessments and documentation related to cognitive status and elopement risk by the Director (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	of Nursing/Designee. No new like residents were identified to be at risk.On 2/13/26, the survey team verified through interview with the DON and review of the facility provided evaluations of new admission assessments, documentation related to cognitive status and elopement risk.On 2/12/26, the receptionist on duty for the 11/28/25 event was re-educated by the Administrator/Designee on ensuring residents exiting the facility were approved by the clinical staff prior to allowing the resident to exit.The newly created binder with blue or white sheets for each resident. The blue sheet indicates residents require supervision for LOA. The white sheets indicate the resident is safe for unsupervised LOA. The determination of supervision for LOA's is made by the clinical team. Residents must sign in and out for LOA each time they leave the center.The front door is opened by the remote or keypad.On 2/13/26, the survey team verified through review of the LOA binder, the blue and white sign-in sheets and interview with the receptionist, RN Staff F, CNA Staff G, CNA Staff H, CNA Staff C, LPN Staff I, LPN Staff B, LPN Staff J, and the DON.On 2/12/26, the Director of Nursing/Designee completed a new elopement risk assessment on 103/103 current residents in the electronic medical record system. No new residents were identified as potentially being at risk for elopement.On 2/13/26, the survey team verified through review of the new elopement risk assessment for 20 randomly selected residents, interview with the DON and Unit Manager LPN Staff B. On 2/12/26, 31/31 current licensed nurses were educated by the Director of Nursing/Designee on communicating when a physician changes a residents' capacity to notify the Director of Nursing and/or the Administrator at the time of the determination to ensure timely re-evaluation of resident risk for elopement.On 2/13/26, the survey team verified through review of the education and interview with RN Staff F, LPN Staff I, LPN Staff B, LPN Staff J, and the DON.The Director of Nursing/Designee completed staff re-education regarding the CMS definition of elopement, the updated facility elopement policy, documentation of resident incidents in the clinical record, and the new receptionist process for resident's exiting the facility to include the newly created binder with blue or white sheets for each resident, the determination of supervision for LOA's is made by the clinical team, residents must sign in and out for LOA each time they leave the center and the front door is opened by the remote or keypad conducted on the following dates: 2/10/26 with 103/142 staff members. 2/11/26 with 32/142 staff members. 2/12/2026 with 7/142 staff members.In total 142/142 current employees were educated. The facility does not use any agency staffing.On 2/13/26, the survey team verified through review of the content of the education provided and interviews with RN Staff F, CNA Staff G, CNA Staff H, CNA Staff C, Licensed LPN Staff I, LPN Staff B, LPN Staff J, and the DON.An ADHOC (unplanned) Quality Assurance meeting was held with the facility medical director in attendance via phone on 2/12/26. The facility completed QA Meetings on 12/10/25 and 1/14/26 to include review of the new receptionist process for residents exiting the facility. The following team members were in attendance: Facility Administrator, Director of Nursing, Assistant Director of Nursing, and Maintenance Director. The ADHOC QAPI (Quality Assurance and Performance Improvement) Committee approved of the recommendations.On 2/13/26, the survey team verified through review of the ADHOC QAPI meeting and interview with the Administrator, and the DON.

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	02/13/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review, review of facility's policy and procedure and staff interviews, the facility failed to maintain a medical record on 1 (Resident #900) of 3 residents reviewed that was completely and accurately documented.The findings included:Review of the facility's policy and procedure titled, Medical Records - Documentation with an effective date of 04/01/22 and a revision date of 11/25/2025 revealed, Nurse's notes shall be written on each resident by licensed/qualified nursing personnel and shall address the resident's conditions. Frequency of entries shall be dependent on individual residents' needs and any pertinent change in condition. Documentation of observations should be specific and objective. Each entry will be signed with the writer's name and credentials .Review of the clinical record for Resident #900 revealed an admission date of 11/5/25 and a discharge date of 12/6/25.Review of the admission Minimal Data Set (MDS) with an assessment reference date of 11/12/25 revealed Resident #900 scored 12 on the Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition.On 11/28/25 at 6:00 p.m., a nursing progress note documented that Resident #900's level of consciousness was, noted as oriented to person oriented to place. Behavioral problems are not noted.The next nursing progress note was dated 11/30/25 at 12:25 p.m., and noted, Level of consciousness was noted as oriented to person to place restless .On 2/9/26 at 10:12 a.m., in a telephone interview, Resident #900's family member said that on 11/28/25 the resident left the facility unsupervised, and they were very upset that the facility did not notify them of the incident until 24 hours later. The family member said, What if he had made it to the main road and got hit by a car or laid down somewhere and could not get back up?.On 2/9/26 at 1:57 p.m., in an interview the Director of Nursing (DON) and Administrator verified that on 11/25/25, Resident #900 exited the facility without staff knowledge and supervision. The Administrator said Resident #900 walked into the dormitory of a nearby state college campus. The people who found him called EMS (Emergency Medical Services) and sent Resident #900 to the Emergency Room. She said the facility staff knew that the resident was missing at 10:30 a.m. The campus security came over and said that the resident walked into a dormitory and was looking for a way back.On 2/10/25 at 10:15 a.m., in an interview, the Sergeant of Security training at the college where Resident #900 was found said that on 11/28/25 Resident #900 wandered to a college campus dorm that is half a mile from the facility. The receptionist at the dorm said the resident was confused, disoriented, unsteady and shaking and she called the campus police who called EMS. EMS transported Resident #900 to a local emergency room Clinic.Review of the EMS Patient Care Record dated 11/28/25 revealed that EMS was on scene at 10:20 a.m., departed at 10:44 a.m., arrived at destination at 10:51 a.m. and transferred the resident at 11:05 a.m.On 2/10/25 at 12:05 p.m., in an interview, Unit Manager Staff B verified that on 11/28/25 Resident #900 left the facility without staff knowledge or supervision. When asked about the lack of documentation of the resident's elopement in the clinical record, Unit Manager Staff B said that she was told not to document anything about the incident in the resident's clinical record, that the DON and Administrator would take care of that.On 2/10/26 at 12:10 p.m., in an interview was held with the DON and Administrator to discuss the lack of documentation of Resident #900's elopement, emergency room visit and return to the facility in the clinical record.The DON verified that on 11/28/25 Resident #900 exited the facility without staff knowledge and supervision. She verified that the incident was not documented in the resident's clinical record and said sometimes she asks staff to go back and make a late entry, but she did not for Resident #900.The Administrator said that on 11/28/25 Resident #900 went out for a walk. She said the resident was found in the dorm of a nearby state college. They called EMS and sent the resident to a local Emergency Room. She (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said upon Resident #900's return to the facility, Unit Manager Staff B watched her personally administer a BIMS (Brief Interview for Mental Status) test to Resident #900. He scored 13 on the BIMS test, indicating intact cognition.The facility provided BIMS test for Resident #900 was dated 11/28/25 at 2:25 p.m. The form was not signed with the writer's name and credentials.On 2/10/16 at 1:45 p.m., in an interview, Unit Manager Staff B said that upon Resident #900's return on 11/28/25, he was placed on one-on-one supervision but could not recall for how long. She reiterated that she was told not to document anything in the clinical record about the resident leaving the facility on 11/28/25 without staff knowledge or supervision.