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	04/15/2026

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, review of facility policy and procedure and staff interview, the facility failed to store food in a sanitary manner, failed to maintain the kitchen and equipment in a sanitary manner, and failed to ensure staff washed their hands appropriately when handling sanitized dishes. These failures have the potential to cause food borne illness in residents receiving an oral diet.The findings included:Review of the facility policy and procedure for Equipment revised 9/2017 revealed, All foodservice equipment will be clean, sanitary and in proper working order. Procedures. All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials . All food contact equipment will be cleaned and sanitized after every use . All non-food contact equipment will be clean and free of debris.Review of the facility policy and procedure for Ice, revised 9/2017 revealed, Ice will be prepared and distributed in a safe and sanitary manner. The Dining Services Director will coordinate with the Maintenance Director to ensure that the ice machine will be disconnected, cleaned and sanitized quarterly and as needed, or according to manufacturer guidelines. The exterior of the ice machine will be cleaned weekly.Review of the facility policy for Warewashing 9/2027 revealed, All dishware, serviceware, and utensils will be cleaned and sanitized after each use. Procedures. The Dining Services staff will be knowledgeable in the proper technique for processing dirty dishware through the dish machine, and proper handling of sanitized dishware . All dishware will be air dried and properly stored.On 4/12/26 at 9:10 a.m., during an initial tour of the kitchen the following was observed:A sandwich with no date in the reach in refrigerator, and 18 covered food cups containing pudding and fruit without a date. Photographic evidence obtained.Two open bags of pasta with no date on them in the dry pantry room. Photographic evidence obtained.A mixing bowl with brown liquid at the bottom on a shelf in the kitchen. Photographic evidence obtained.Wet nesting (stacking wet pans creating moisture that fosters rapid bacteria and mold growth) of uncovered sheet pans on a rack by the stove. Photographic evidence obtained.Five open packages of rolls without an open date or expiration tab. Photographic evidence obtained.In the dry food storage area, a large white bin of flour was observed. The outside of the container had brown ingrained material. A dead bug was observed on top of the flour. Photographic evidence obtained.Dietary Aide Staff D was observed using the high temp dishwasher. Staff D used a dirty rack of dishware to push a clean rack of dishware out of the dishwasher. Dietary Aide Staff D was observed loading soiled dishware in the machine and removing sanitized dishes from the dishwasher, using the same gloves.The shelving unit for the clean dishware had a buildup of white substance. Food particles were observed on the shelves. Photographic evidence obtained.The front of the ice machine front was coated with white slime. A dead bug was observed between the inside and outside lids. The vents were dusty and had a white slime coating and had a dead bug where the lid on the inside meets the outside lid to close. The vents were dusty and had ingrained dirt. Photographic evidence obtained.The floor of the walk-in freezer was dirty with trash, debris, and dirt. The Certified Dietary Manager (CDM) verified the floor had dirt and debris and said she was looking for someone to clean the floor. Photographic evidence obtained.An opened undated bag of ravioli was observed in the freezer. Photographic evidence obtained.The spouts of eyewash station were coated with dust. A (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	brown film was observed in the sink of the eyewash station.The hot temp beverage log had not been completed for the evening shift of 4/11/26 or the day shift on 4/12/26. Photographic evidence obtained.The sanitizer concentration log for the 3-compartment sink was prefilled for the lunch meal of 4/12/26. Photographic evidence obtained.Brown dirt was observed on the wall and pipes behind the food preparation area and stove. Photographic evidence obtained.On 4/12/26 at 9:40 a.m., in an interview, the Certified Dietary Manager provided a blank cleaning schedule form. She said that she had been off for a few weeks and could not locate documentation verifying the dietary staff completed the scheduled cleaning.On 4/12/26 at 9:55 a.m., Dietary Aide Staff D was observed using the high temp dishwasher. Staff D loaded dirty dishes in the high temp machine. She walked to the other side of the machine and removed the sanitized dishes without changing her gloves or washing her hands.The Certified Dietary Manager verified the observation and instructed Dietary Aide Staff D to remove her gloves, wash her hands and rewash the dishes. On 4/13/26 at 3:07 p.m., in an interview, the Dietary District Manager said that the ice machine had to be gutted and cleaned.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, record reviews, residents and staff interviews, the facility failed to follow the planned menu to meet the needs and preferences of 11 (Residents #75, #4, #31, #55, #23, #7, #58, #63, #33, #54, and #76) of 37 residents reviewed. The findings included: On 4/13/26 at 12:37 p.m., Resident #75 was observed having lunch. The meal ticket noted 3/8 cup of spicy pork tips, 1/2 cup of pinto beans, 1/2 cup of seasoned okra, 1 square of corn bread, 1 margarine, 1 snickerdoodle cookie, 6 ounces of tea of choice and peach parfait was subbed for doubled chocolate brownie. Observation of the meal revealed Resident #75 received an unidentified ground meat with gravy, mashed potatoes with gravy, a vegetable medley that included carrots and green beans.In an interview, Resident #75 stated that he did not like that type of food and requested that his meal tray be removed without eating any food item on the plate.On 4/14/26 at 11:30 a.m. through 12:45 p.m., observation of tray line for the lunch meal revealed the planned menu was not followed to meet the needs and preference of residents. A sample of meal tickets observed during tray line revealed:Residents #4, #31, #55, and #23's received regular mashed potatoes instead of the fortified mashed potatoes per the meal tickets.Residents #7, #58, and #63 received regular mashed potatoes, instead of the potato wedges indicated on the meal tickets.Residents #33, #54, and #76 received fruit punch on their trays, instead of lemonade as noted in their meal tickets.On 4/14/26 at 2:00 p.m., in an interview, the Dietary Manager and the Regional Dietary Manager verified that the planned menu was not followed, lemonade was not available, many food items were substituted and the residents did not receive the food listed on the menu and per the residents' preferences.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, residents, resident's family members and staff interviews, the facility failed to provide housekeeping and maintenance services to ensure a safe, clean and comfortable environment in 5 (Rooms 121, 207, 209, 214 and 215) of 60 residents rooms observed. The findings included:On 4/12/26 at 8:30 a.m., observation during an initial tour revealed: room [ROOM NUMBER]: The floor planks in front of the air-conditioner were loose and lifting from the floor. A hole was observed to the right lower side of bed 207 A's footboard. room [ROOM NUMBER]: Several floor planks were taped down. room [ROOM NUMBER] A: The laminate of the bedside table was chipping, exposing the material underneath. The bedside table legs had a brown film and were soiled with dried up food residue. A telephone was hanging from the light fixture on the wall above the resident's bed. room [ROOM NUMBER] A: A wheelchair was observed with a stained wheelchair cushion. Food crumbs were observed on and underneath the cushion. On 4/14/26 at 11:27 a.m., observation of room [ROOM NUMBER] revealed a door and a bottom drawer were missing from the dresser. On 4/15/2026 at 8:35 a.m., in an interview the Maintenance Director said the planking in room [ROOM NUMBER] was re-glued and taped to keep it in place and prevent water from getting under the planks. He said that the nurses and Certified Nursing Assistants place work orders for needed repairs in the electronic record. He reviews the concerns during his monthly rounds. The Maintenance Director said that bedside tables are replaced when the laminate starts to come off. On 4/15/26 at 11:54 a.m., in an interview, the Maintenance Director said that he wasn't aware of the broken dresser in Resident #49's room. door and drawer in the resident's room. He said that staff have access to a work order application to report area in need of repairs and a work order is generated. In an interview, the Maintenance Director said the facility had no policy addressing repairs, We just do them.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interviews, review of facility policy and procedure, the facility failed to provide assistance with showers and personal hygiene as outlined in the resident's care plan and according to residents' preferences for 4 (Residents #88, # 5, #49, and #65) of 5 dependent residents reviewed.The findings included:Review of the clinical record revealed Resident #88 was admitted on [DATE] and discharged on 3/24/26. The resident's diagnoses included: Cognitive impairment, and bowel and bladder incontinence. Review of the certified nursing assistant (CNA) documentation revealed Resident #88 was dependent for all care. Review of the CNA documentation for February 2026 revealed Resident #88 was scheduled for showers on the 3:00 p.m. to 11:00 p.m., shift on Tuesdays and Fridays. The documentation revealed on 2/20/26 and 2/24/26 Resident #88 did not receive his scheduled showers. On 2/27/27 the documentation showed he refused his shower. The documentation revealed no hygiene care was provided on 2/21/26, 2/22/26 and 2/28/26 on the 11:00 p.m., to 7:00 a.m., shift. Review of the March 2026 CNA documentation revealed Resident #88 did not receive scheduled showers on 3/3/26, on 3/6/16 he received a partial bed bath, on 3/10/26 he received a bed bath, on 3/13/25 he refused, on 3/17/26 resident had a bed bath, on 3/20/26 the activity did not occur. The documentation revealed he refused hygiene care on the evening shift on 3/2/26, 3/4/26, 3/5/26, 3/15/26, N/A was documented on 3/14/26, 3/17/26, 3/23/24 and on 3/22/26 the documentation was not completed. On the 11-7 shift on 3/3/26, and 3/14/26 the record was blank. On 3/5/26, 3/8/26, 3/10/26, 3/12/26, 3/13/26, 3/16/26 3/17/26, 3/18/36, 3/19/26, 3/20/26, 3/21/26, 3/21/26 N/A was documented. Review of the clinical record revealed Resident #5 was admitted to the facility 1/20/23. Diagnosis included polyneuropathy, unspecified, other acute osteomyelitis, left ankle and foot, local infection of the skin and subcutaneous tissue, unspecified, type 2 diabetes mellitus without complications, moderate protein calorie malnutrition, venous insufficiency (chronic) (peripheral), peripheral vascular disease, unspecified Review of the Minimum Data Set (MDS) 5-Day admission Assessment with a reference date 2/20/26 documented the resident is dependent on staff for Activities of Daily Living (ADLs). The MDS documented the resident's cognitive status was intact. Review of the certified nursing assistant (CNA) documentation revealed Resident #88 was dependent for all care. Review of the certified nursing assistant (CNA) documentation for February 2026 revealed Resident #5 was scheduled for showers on the 3:00 p.m. to 11:00 p.m. shift on Wednesdays and Saturdays. The documentation revealed on 2/4/26, 2/11/26 and 2/14/26 the resident did not receive a shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The documentation revealed no hygiene care was provided on 2/9/26 on the 7:00 a.m. to 3:00 p.m. shift, the 3:00 p.m. to 11:00 p.m. shift and the 11:00 p.m. to 7:00 a.m. shift. On 2/10/26, 2/11/26, 2/12/26, 2/13/26, 2/14/26 and 2/15/26 there is no documentation for the 7:00 a.m. to 3:00 p.m. and the 3:00 p.m. to 11:00 p.m. shift. On 2/16/26 and 2/17/26 there is no documentation for the 7:00 a.m. to 3:00 p.m. and the 11:00 to 7:00 a.m. shift. Review of the March 2026 CNA documentation revealed Resident #5 did not receive a scheduled shower on 3/14/26. The documentation revealed no hygiene care was provided on 3/17/26 on the 7:00 a.m. to 3:00 p.m. shift, the 3:00 p.m. to 11:00 p.m. shift and the 11:00 p.m. to 7:00 a.m. shift. On 3/14/26 there is no documentation for the 7:00 a.m. to 3:00 p.m. shift or the 3:00 p.m. to 11:00 p.m. shift. On 3/20/26 there is no documentation for the 7:00 a.m. to 3:00 p.m. shift and the 11:00 p.m. to 7:00 a.m. shift. On 3/27/26 there is no documentation for the 7:00 a.m. to 3:00 p.m. shift and the 11:00 p.m. to 7:00 a.m. shift. On 3/29/29 there is no documentation for the 7:00 a.m. to 3:00 p.m. shift and the 11:00 p.m. to 7:00 a.m. shift. Review of the April 2026 CNA documentation revealed Resident #5 did not receive a scheduled shower on 4/1/26. On 4/1/26, 4/3/26, 4/10/26, 4/12/26, and 4/13/26 there was no documentation that personal hygiene was provided on the 7:00 a.m. to 3:00 p.m. shift and the 11:00 p.m. to 7:00 a.m. shift. Review of the medical record for Resident #49 showed that the resident was admitted to the facility 10/29/25 with diagnoses of COPD (Chronic Obstructive Pulmonary Disease), atrial fibrillation, vertebral compression fractures, moderate protein-calorie malnutrition and advanced neuropsychiatric disease including dementia and bipolar disorder. A review of the Residents care plan initiated 10/30/25 and revised 2/16/26 showed that Resident 49 was at risk for an Activities of Daily Living (ADL's) self-care performance deficit related to impaired gait/balance, weakness, deconditioning, decreased mobility, cognitive impairment, hearing impairment, narcotic and psychotropic medication use, malnutrition, depression, bipolar, mood disorder, poor pulmonary function, foley catheter, incontinence, pain, poor safety awareness, history of falls with fracture prior to admission and increased assistance needed with ADL's. The interventions included providing a sponge bath when a full bath or shower cannot be tolerated. Bathing or showering required assistance by 1 staff, dressing required assistance by 1 staff, personal hygiene and oral care required assistance by 1 staff and toilet use required assistance by 1 staff. A review of the Physician Note for Resident #49 dated 10/29/25 revealed, the resident remained with ongoing dependence for all activities of daily living and limited mobility due to generalized weakness and chronic vertebral fractures. Review of the Certified Nursing Assistant (CNA) documentation for January 2026 revealed Resident #49 was scheduled for showers on the 3:00 p.m. to 11:00 p.m. shift on Wednesdays and Saturdays and hygiene was to be performed every shift. The documentation revealed on 1/10/26 Resident #49 did not receive her scheduled shower. The documentation revealed no hygiene care was provided on 1/1/26, 1/5/26, 1/15/26 and 1/20/26 on the 11:00 p.m., to 7:00 a.m., shift. No hygiene care was provided on 1/13/26 and 1/20/26 on the 7:00 a.m. to 11:00 a.m. shift. No hygiene care was performed on 1/10/26, and 1/11/26 on the 3:00 p.m. to 11:00 p.m. shift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the CNA documentation for February 2026 revealed Resident #49 was scheduled for hygiene every shift. The Resident was not provided with hygiene care on 2/8/26 and 2/9/26, on the 11:00 p.m., to 7:00 a.m. shift and no hygiene care was performed on 2/1/26, 2/17/26, 2/23/26 and 2/26/26 on the 7:00 a.m. to 11:00 a.m. shift. Review of the CNA documentation for March 2026 revealed Resident #49 was scheduled for showers on the 3:00 p.m. to 11:00 p.m. shift on Wednesdays and Saturdays and hygiene every shift. The documentation revealed on 3/14/26 and 3/28/26, Resident #49 did not receive her scheduled shower. The documentation revealed no hygiene care was provided on 3/5/26, 3/8/26, 3/12/26, 3/20/26, and 3/30/26 on the 11:00 p.m., to 7:00 a.m., shift. No hygiene care was provided on 3/3/26 3/5/26, 3/8/26, 3/10/26, 3/12/26, 3/14/26, 3/15/26, 3/16/26, 3/20/26,3/22/26,3/25/26,3/27/26, 3/28/26, 3/30/26 and 3/31/26 on the 7:00 a.m. to 11:00 a.m. shift. No hygiene care was performed on 3/14/26, on the 3:00 p.m. to 11:00 p.m. shift. On 3/17/26, 3/23/26, 3/24/26 and 3/29/26 the hygiene documentation record was blank. Review of the CNA documentation for April 2026 revealed Resident #49 was scheduled for showers on the 3:00 p.m. to 11:00 p.m. shift on Wednesdays and Saturdays and hygiene every shift. The documentation revealed on 4/4/26 and 4/11/26, Resident #49 did not receive her scheduled shower. The documentation revealed no hygiene care was provided on 4/3/26, 4/5/26, 4/6/26, 4/7/26, and 4/10/26 on the 11:00 p.m., to 7:00 a.m., shift. No hygiene care was provided on 4/4/26, 4/5/26, 4/7/26, 4/10/26, 4/11/26, and 4/13/26 on the 7:00 a.m. to 11:00 a.m. shift. No hygiene care was performed on 4/2/26, 4/3/26, 4/4/26 and 4/6/26 on the 3:00 p.m. to 11:00 p.m. shift. On 4/1/26 and 4/12/26 the hygiene documentation record was blank. Observation on 4/13/26 at 12:04 p.m. showed the resident lying in bed still in her pajamas. Her hair appeared to be unbrushed. On 4/13/26 at 12:04 p.m., the resident said she has not gotten washed up and dressed yet and is still waiting for someone to come. On 4/12/26 at 11:18 a.m., during an interview with the Resident's family member, she said she thinks the Facility is short staffed. She said yesterday, it took over 2 hours for a brief change. She said she was at home talking on the phone to the resident, and the resident had to be changed. She said she called the front desk at 12:00 p.m. and the resident was not changed until 2:30 p.m. On 4/14/2026 at 11:36 a.m., during an interview with CNA Staff F, she said that she gets the resident up after lunch when she is too busy to get her up earlier. She said that when staff call out, they work short. On 4/12/26 at 11:10 a.m., Resident #65 was observed in his bed wearing a hospital gown. Resident #65 said since his admission to the facility, no one had assisted him in cleaning his upper and lower dentures. He said due to his arthritis in both hands he was unable to take out his dentures to be clean. He also said the facility had not provided a denture cup or the cleaning tablets so his dentures could soak and be sanitized overnight, so they could be clean in the morning before putting them back into his mouth. Review of Resident #65's medical record revealed he was admitted to the facility on [DATE] with diagnoses including but not limited to muscle wasting and atrophy, need for assistance with personal care, and aged related physical debility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A plan of care for Resident #65 was to wear upper and lower dentures with a potential of oral/denture health problems. Resident #65 would be free of infection, pain or bleeding in the oral cavity and Resident #65 would comply with mouth care at least daily-dated 3/10/26. Interventions include providing mouth care as per ADL personal hygiene procedures. Review of Resident #65's KARDEX used by the Certified Nursing Assistant (CNA) to know their residents' level/plan of care, did not state Resident #65 had upper and lower dentures which needed to be cleaned and stored in a labeled container on a daily basis. On 4/14/26 at 12:26 p.m., in an interview with Staff I CNA, she said she had been Resident #65's CNA since his admission to the facility in February 2026. She said if a resident had denture(s) they were required to remove the denture(s) daily, clean the denture(s), and store the denture(s) when not in use in a labeled denture container. She said if a resident had denture(s) they would be noted on the resident's KARDEX used by the CNA as the level/plan of care for the resident. Staff I said she was unaware Resident #65 had a full set of upper and lower dentures and confirmed none of the staff had removed Resident #65's upper and lower dentures on a daily basis, cleaned them with the required denture cleaning product, and stored them in a labeled denture container when not in use. On 4/14/26 at 12:48 p.m., in an interview with the MDS (Minimum Data Set) Licensed Practical Nurse (LPN), she said Resident #65 was admitted to the facility on [DATE] with a full set of upper and lower dentures. She said Resident #65 was care planned for ADL self-care performance deficit related to significant functional decline and pain on 1/12/26, with interventions to include personal hygiene requiring assistance of 1 staff member for oral/denture care and personal hygiene/grooming. She said the nursing staff were required to perform daily mouth care, to include daily denture care even if it was not documented on the resident's KARDEX. On 4/14/26 at 3:48 p.m., in an interview with the Director of Nursing (DON) and Regional Nurse Consultant (RNC), they confirmed Resident #65 was admitted to the facility on [DATE] with upper and lower dentures. They confirmed the nursing staff had not removed and cleaned Resident #65's dentures as per the facility's policy. They said they would complete a facility wide audit to ensure residents with dentures had the required denture cleaning products and would complete reeducation with the nursing staff about the facility's policy and procedure for Oral Care/Hygiene – Denture and Partial Denture Care. The Clinical Activities of Daily Living (ADL's) policy and procedure effective 4/1/22, stated the purpose was to ensure the resident's needs were met in a manner that promoted their quality of life, resident rights, preferences, and independence. The facility should provide care and services for the following activities of daily living as needed based on the individual care plan of each resident not limited to bathing, dressing, grooming and oral care. The Oral Care/Hygiene – Denture and Partial Denture Care policy stated the facility staff would assist residents with denture care as needed based on their assessed level of independence. Dentures and partial dentures would be cleaned daily using appropriate denture-cleaning products, rinsed thoroughly, and stored in a labeled denture container when not in use.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, record review and staff interview, the facility failed to ensure 1 (Resident #76) of 2 residents reviewed received necessary treatment and services to promote healing and prevent worsening of a pressure ulcer.The findings included:Review of the clinical record for Resident #76 revealed an admission date of 4/26/26.Review of the physician progress note dated 3/27/26 revealed that Resident #76 was treated during the hospital stay on 3/21/26 for a right buttock pressure ulcer.Review of the Nursing admission Evaluation completed on 3/26/26 and signed on 3/27/26 revealed documentation that no skin impairment was noted.Review of the wound report dated 4/12/26 revealed that Resident #76 had a facility acquired pressure wound to the sacrum measuring 4 centimeters in length by 2 centimeters in width. The form noted that the date acquired was 4/12/26.Review of the physician's orders dated 4/12/26 revealed to clean the right buttock wound every day shift with normal saline, apply calcium alginate (highly absorbent dressing which aids in faster healing) and cover with dry dressing.Review of the Treatment Administration Record (TAR) revealed that the last wound care was signed as completed on 4/13/26 at 7:00 a.m.On 4/14/26 at 9:27 a.m., in an interview Licensed Practical Nurse (LPN) Staff A stated that Resident #76 had daily dressing changes for the wounds on both feet. LPN Staff A stated that Resident #76 did not have any other wounds.On 4/14/26 at 3:03 p.m., in an interview, Resident #76 stated that she has had a wound on her bottom since prior to her admission to the facility. The resident's daughter also stated that Resident #76 has had a wound to her buttock since prior to her admission to the facility in March 2026.On 4/14/26 at 3:10 p.m., with the resident's permission, her buttocks were observed. LPN Staff A and Certified Nursing Assistant (CNA) Staff B rolled the resident to reveal a dressing on the Resident's right buttock dated 4/12/26. LPN Staff A removed the dressing to reveal an open wound measuring approximately 5.0 centimeters in length by 5.0 centimeters in width. The wound bed was pink. LPN Staff A said he was not aware prior to now that the resident had a wound to her buttock.

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	04/15/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews, the facility failed to follow the physician's orders for fluid restriction for 1 (Resident #75) of 2 residents reviewed for nutritional status.The findings included:Review of the clinical record for Resident #75 revealed an admission date of 2/23/26. Diagnoses included Acute Pulmonary Edema (excess fluid buildup in the lungs), heart failure.Review of the 5 Day Minimum Data Set (MDS) assessment with an assessment reference date of 3/2/26 revealed Resident #75 scored 8 of 15 on the Brief Interview for Mental Status, indicating moderate cognitive impairment. The resident required set up assistance with eating.The physician's orders dated 2/23/26 included to encourage the resident to comply with a fluid restriction of 1500 milliliters (ml) per day. Daily total from dietary 900 ml and 600 ml total from nursing.The baseline care plan dated 2/23/26 and the comprehensive care plan dated 2/23/26 did not include a focus, goal or interventions related to the fluid restriction.The Nutritional assessment dated [DATE] did not include the fluid restriction.On 4/13/26 at 11:01 a.m., a large Styrofoam cup filled with ice and water was observed on the resident's bedside table within his reach.On 4/13/26 at 12:40 p.m., Resident #75 was observed having lunch. A 1/2 full large Styrofoam cup was observed on the resident's over-the-bed table. A 6 ounce glass of juice was observed on the resident's meal tray.The meal ticket on the meal tray did not include the fluid restriction.On 4/13/26 at 2:55 p.m., in an interview, Licensed Practical Nurse (LPN), Unit Manager Staff C stated that she wasn't sure if Resident #75 was on a fluid restriction and didn't know how fluid restrictions were tracked. On 4/13/26 at 3:05 p.m., in an interview the Dietary District Manager said that residents on fluid restrictions show up in the dietary menu program and the amount of fluid allowed for each meal is listed on the meal ticket. The Dietary Manager who was present during the interview accessed the dietary menu program and said that the fluid restriction was not listed for Resident #75. She said that Resident #75 received more fluid than allowed on his breakfast tray.The District Manager said that the fluid restriction order should have pulled automatically from the electronic medical record into the dietary menu program.On 4/14/26 at 3:30 p.m., in an interview, the Registered Dietitian said that she was not aware that Resident #75 was on a fluid restriction. She said that several months ago, the facility began to move away from fluid restrictions, but there were some residents on dialysis who continue to have fluid restrictions.