STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105672	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gulf Coast Village	1333 Santa Barbara Blvd Cape Coral, FL 33991

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 37256 Based on record review and interview, the facility failed to ensure physician's orders received via text for 1 (Resident #92) of 3 residents reviewed for change in condition were immediately documented, signed, dated, and implemented, creating the potential for a negative outcome. The findings included: On 4/28/25 at 12:32 p.m., in a telephone interview Resident #92's son said he visited his father on 12/23/24. He said his father had not been feeling right, had been cold and shaky. The son said he explained to the nurse that his father had problems in the past with potassium levels and asked if they could get the doctor to check his potassium levels. Record Review of Resident #92's chart revealed no progress notes were documented on 12/23/24, no documentation of notification to the physician was found for 12/23/24, no orders were found to be entered on 12/23/24 and no lab work was taken on 12/23/24. Further review of Resident #92's chart revealed a change of condition note dated 12/24/24 at 4:34 a.m., indicating the resident was exhibiting Altered mental status and Diarrhea. A progress note dated 12/24/24 at 5:16 a.m., documented the Resident was observed with acute change in condition at 4:15., a.m. EMS (Emergency Medical Services) was called, Resident #92 was emergently transferred to stretcher via EMS at 4:30 a.m. EMS noted Resident #92 was without pulse and breath as transferring to ambulance and began chest compressions. EMS observed coding patient while in ambulance in parking lot for approximately 20-25 minutes prior to departure for hospital and writer was told resident in cardiac arrest when departing parking lot at 5:05 a.m. Resident transferred to hospital. On 4/30/25 at 11:00 a.m., the Advanced Practice Registered Nurse (APRN) reviewed Resident #92's medical record. In an interview, she said she found nothing in the nursing log with a request from the family. She said his last lab draw was on 12/14/24, the potassium level was normal. The last time she saw Resident #92 on12/6/24, he was at baseline with no complaints. She said in the progress notes it looked like Resident #92's diarrhea started around December 20 or 21st. She said, normally they would order lab work with persistent diarrhea. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/25 at 11:57 a.m., the APRN returned and explained she found a text message in her phone dated 12/23/24 at 3:32 p.m. from the facility. The text message said Resident #92, is trembling and complaining of being cold, his son believes something isn't right since he recently was admitted to hospital for hypokalemia, vital signs within normal limits, alert and oriented times 3, blood sugar 148. Son is requesting lab work. Last labs was 12/14. The APRN responded to the text on 12/23/24 at 3:41 p.m. and ordered a Stat (Immediately) Complete Blood Count (CBC) with differential and a Comprehensive Metabolic Panel (CMP). (A CBC with differential measures the number and types of blood cells, including white blood cell subtypes. A CMP assesses various substances in the blood related to metabolism, liver, and kidney function - including potassium). The APRN said she couldn't say which nurse sent the text. The APRN said the order was never documented or carried out. On 4/30/25 at 12:26 p.m., in an interview the Interim Director of Nursing (DON) explained each unit has their own telephone to contact the provider via text. She said when the provider responds, staff are supposed to follow up with what the provider ordered and the order should be entered into the electronic health record. The DON reviewed the phone for Resident #92's unit. She found the same text to the APRN dated 12/23/24. Photographic evidence obtained. The DON verified the text message included an order for Stat lab work. The DON reviewed the Electronic Health Record and did not find an order for stat lab work for 12/23/24. She did not find any progress notes or documentation of Resident #92's condition or contact with the APRN for 12/23/24. DON said a Stat order should be documented and acted on immediately. She said the nurse assigned to the patient that day had been an agency nurse and hadn't worked at the facility since January. The DON said there is a double check of orders when entered into the electronic health record, but she was not sure if there was any double check of the phone to ensure texted orders were not missed. The DON said they had been discussing moving away from the text system for orders. On 5/1/25 10:05 a.m., in an interview the interim DON said at this time there was no policy and procedure for medication orders as far as written, verbal, telephone or text. She said this was something they will need to look into.