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	05/26/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, review of facility's policy and procedure, resident and staff interviews, the facility failed to investigate a fall and implement individualized interventions to minimize the risk of further falls and fall related injuries for 1 (Resident #1) of 3 residents reviewed.The findings included:Review of the facility's policy and procedure titled, Fall Management Program with an effective date of 8/2018 and revision date of 10/24/2022 revealed, 1) All residents are assessed to identify risk for falls and individualized fall precautions will be developed on their care plan. 2) Preventative measures shall be taken to decrease the number of falls whenever possible. document fall as incident . following risk management/incident policy. The post Fall incident/Assessment form will be completed after each fall and any changes in interventions will be noted on the form, on the resident's care plan and Kardex (Provides instructions for care) and in the nurse's notes . A post fall huddle will be completed at the time of a resident fall . Use the huddle information to perform root cause analysis. Staff will work together to determine the underlying cause(s) and contributing factors . The interdisciplinary Team will meet daily and PRN (as needed) to review accident/incidents and determine if investigation of incident is needed and will assist with assessing for further intervention(s) . The interdisciplinary Team will evaluate the resident's fall risk in conjunction with the care plan to develop, review and revise.Review of the clinical record for Resident #1 revealed an admission date of 2/18/26. Diagnoses included ataxia (uncoordinated movements), vascular parkinsonism (condition causing movement issues like stiffness, slowness and walking problems), dysphagia (difficulty swallowing), pneumonia, moderate protein-calorie malnutrition, unspecified dementia, adjustment disorder with mixed anxiety and depressed mood, disorder of thyroid.Review of the End of (Prospective Payment System) PPS Medicare Part A Minimum Data Set (MDS) with an assessment date of 3/26/26 revealed that Resident #1 required supervision/touching assistance with bed mobility, sit to lying, sit to stand and transfers; substantial/maximal assistance with toileting hygiene and showering. The MDS documented that the resident's cognitive status was severely impaired.Review of the Post Incident Review form dated 5/19/26 revealed that on 5/19/26 at 11:35 a.m., Resident #1 was lying on the bed in her room when the family walked in. The family walked to the nurse and told the nurse to check the resident's eye. Upon the nurse's assessment, Resident #1 presented with bruises on the right eye area of the face. Resident #1 denied any discomfort, denied having pain. Resident #1 also presented with a minor right leg abrasion.Review of facility provided staff statements revealed that Occupational Therapy (OT) Staff B documented that on the morning of 5/19/26 she was going to attend to another resident when the resident pointed to Resident #1's room across the hall. OT Staff B said that Resident #1's legs were outside of the bed and both knees were resting on the floor mat next to the bed. She said the resident was assisted back to bed.Review of the care plan for falls initiated on 2/18/26 revealed the resident has a history of weakness and ataxia. The goal was to receive no injury due to falling. The interventions included to review information on past falls and attempt to determine cause of falls, record possible root causes; after, remove any potential causes if possible, educate as to causes. The fall care plan was not updated after the resident's fall on 5/19/26.Further review of the clinical (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record revealed that on 5/21/26, a Fall Incident Report documented that Resident #1 was found on the floor on provided floor mats. Resident #1 was confused and unable to express how the incident occurred. Resident #1 was assisted back to bed.On 5/26/26, the fall care plan was updated to include a perimeter defining mattress (raised borders to prevent rolling or climbing out of bed).On 5/26/26 at 9:07 a.m., Resident #1's room was observed. A perimeter mattress was in place on the bed with bilateral floor mats. In an interview, Resident #1 said that she fell and hit her eye. Resident #1 said she could not remember any other fall. A reddish purple discoloration was observed under the resident's right eye. On 5/26/26 at 1:00 p.m., in an interview OT Staff B said that on 5/19/26 around 11:00 a.m. she was walking in the hallway across from Resident #1's room. She said a resident alerted her to look at the resident across the hall. OT Staff B said that she observed Resident #1's legs out of bed with her knees on the floor mat. She notified RN Staff A. OT Staff B said that RN Staff A came in and assisted Resident #1 back to bed. OT Staff B said she observed the bruising around Resident #1's right eye.On 5/26/26 at 2:00 p.m., in an interview, the Director of Nursing (DON) said that a fall is any change in plane. She said someone being lowered to the ground, sliding out of a wheelchair, or two knees on the floor next to the bed is a fall. The DON said that she did not know that Resident #1 was found with her knees on the floor on 5/19/26 and must have missed the OT statement that Resident #1's knees were on the fall mats. She said the nurse should have done an incident report because it was a fall. She verified that no new fall interventions were put into place on 5/19/26 and verified that on 5/21/26 Resident #1 was found on the floor on the fall mats.On 5/26/26 at 2:40 p.m., in an interview, RN Staff A said he found out about the bruise to Resident #1's right eye on 5/19/26 around 11:30 a.m., when the family came in. He said that on 5/19/26 around 11:00 a.m., Resident #1 was slipping off the bed. He said Resident #1's legs were off the bed. RN Staff A, RN said OT staff B was in the room when he put Resident #1 back to bed. RN Staff A said that he did a full assessment and observed an abrasion to Resident #1's right lower leg. RN Staff A said that a fall is when a resident is lying on the ground. RN Staff A said he did not complete an incident report on 5/19/26 when Resident #1 was found with her knees on the floor mat next to the bed.On 5/26/26 at 4:14 p.m., during an interview, the Nursing Home Administrator (NHA) and the DON, said they were not aware of Resident #1's fall on 5/19/26 until today. The DON said that no one told her about the fall or the abrasion to Resident #1's right lower leg. The DON said they completed an investigation for the bruise to the resident's right eye but she did not read OT Staff B's statement during the investigation. The DON said that since they did not know about the fall, no interventions were put into place on 5/19/26. She said that RN Staff A did not mention the fall to her, the facility, or the police. The DON said that it was possible that the resident's fall on 5/21/26 could have been prevented if new interventions were put into place when Resident #1 fell on 5/19/26 but there was no way of knowing.