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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105672 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/01/2025 |
| NAME OF PROVIDER OR SUPPLIER Gulf Coast Village | | STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>44824</p> <p>Based on observation, record review, review of facility's policies and procedures, resident and staff interviews the facility failed to protect the residents' right to be free from verbal and mental abuse resulting in feeling of humiliation for 1 (Resident #35) of 3 residents reviewed.</p> <p>The findings included:</p> <p>Review of the facility's policy and procedure titled, Freedom from Abuse, Neglect and Misappropriation revealed, Mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. The facility policy also stated, Emotional or psychological abuse is the verbal or nonverbal infliction of anguish, pain, or distress that results in mental or emotional suffering which includes demeaning statements, harassment, threats, insults, humiliation and intimidation.</p> <p>Review of facility a posttest for the education for Freedom from Abuse, Neglect and Exploitation dated 1/20/2025 noted, A caregiver reportedly uses derogatory and humiliating language when talking to, and about a patient on the unit. What type of abuse is this behavior?.</p> <p>Record review revealed Resident #35 had a date of admission of 1/8/25. Diagnoses included difficulty in walking, unsteadiness on feet, need for assistance with personal care.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment with a target date of 4/17/25 revealed Resident #35's cognition was moderately impaired with a Brief Interview for Mental Status score of 11.</p> <p>Resident #35 was frequently incontinent of bowel and bladder and required partial/moderate assistance with toileting hygiene.</p> <p>Review of the progress notes revealed on 4/28/25 at 4:50 a.m., Licensed Practical Nurse (LPN) Staff G documented, Resident observed crying and when approached by writer and asked what was wrong, she replied, just leave me alone. Writer offered PRN (as needed) medications for pain and anxiety to which she replied she wanted, and positive effect noted thus far.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>On 4/28/2025 at 3:11 p.m., in an interview Resident #35 said last night she was having diarrhea. Certified Nursing Assistant (CNA) Staff H was upset at her for having incontinent episodes of diarrhea. Resident #35 said that when she reported having diarrhea to CNA Staff H, she yelled, Again at her. She said they gave her dirty looks while providing incontinent care. Resident #35 said, It made me feel humiliated. Resident #35 was observed crying.</p> <p>On 4/28/2025 at 3:42 p.m., in an interview Registered Nurse (RN) Staff F said Resident #35 was total care for incontinent care and needed help with everything. RN Staff F said she was unsure if Resident #35 had diarrhea last night.</p> <p>On 4/29/25 at 1:27 p.m., in a telephone interview Licensed Practical Nurse (LPN) Staff G said Resident #35, can get tearful from time to time but this was a little different. When asked about Resident #35 cognitive status, LPN Staff G said Resident #35 is one hundred percent with it. LPN Staff G said Resident #35 has baseline loose stool. When asked about the note written on 4/28/2025 at 4:50 a.m., LPN Staff G said Resident #35 did not come out and say why she was crying. LPN Staff G said Resident #35 was very dismissive and said to leave her alone. LPN Staff G said, It just felt like something was a little bit different about this situation.</p> <p>On 4/28/2025 at 2:25 p.m., in a follow up interview, Resident #35 said she could not stop crying after the incident. The resident said, It made me feel mortified. Resident #35 said she told CNA Staff H she was going to report her. CNA Staff H replied, Go ahead, I don't work here.</p> <p>On 4/30/25 at 8:00 a.m., in a telephone interview, CNA Staff H verified she was from a staffing agency and took care of Resident #35 that night.</p> <p>CNA Staff H said the resident, kept calling me over and over for a bowel movement in the bed. CNA Staff H said when she went in the room Resident #35 was crying. She told the resident, you don't have to cry. CNA Staff H said she told Resident #35 to give her a minute because she was with another resident, and I'll be with you. CNA Staff H denied yelling at Resident #35.</p> <p>On 5/1/2025 at 9:14 a.m., in an interview the Director of Nursing (DON) said, If abuse is suspected we should be notified right away. We separate the staff member and resident. We get statements and suspend the staff member involved. We then do a full investigation and report it to the state.</p> <p>On 5/1/2025 at 10:05 a.m., in a follow up interview the DON said they interviewed Resident #35. The resident said she felt the CNA was rude but not abusive. The DON said they have removed CNA Staff H from the schedule, launched an investigation and reported the incident.</p> <p>On 5/1/2025 at 11:04 a.m., in an interview the Administrator said Resident #35 didn't think she was abused but, we are going to file a report out of caution.</p> | | |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44824</p> <p>Based on observation, interviews and records review, the facility failed to provide the necessary service to maintain grooming for 1 (Resident 12) of 3 sampled residents dependent on staff for Activities of Daily Living.</p> <p>The findings included:</p> <p>Review of the facility's Activities of Daily Living Policy updated 4/29/25 noted, A resident who is unable to carry out ADLs will be provided the necessary care and services to maintain good nutrition, grooming, and personal and oral hygiene. The policy also noted, The resident's or representative's decision to refuse care and treatments will be documented in the resident's medical record.</p> <p>Record review for Resident #12 revealed an admitted [DATE]. Diagnoses included unspecified dementia.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment with a target date of 4/13/25 revealed Resident #12's cognition was severely impaired with a Brief Interview for Mental Status score of 03. Resident #12 required partial/moderate assistance for personal hygiene.</p> <p>On 4/28/2025 at 11:09 a.m. Resident #12 was observed in bed. The resident's left hand fingernails were tightly curled inward. The fingernails extended approximately 3/4 of an inch from the fingertips with a brown substance under the nails.</p> <p>Photographic evidence obtained.</p> <p>Review of the Certified Nursing Assistant (CNA) Kardex (a medical-patient information system) revealed Resident #12's bathing preference was on Monday, Wednesday and Friday during the 7:00 a.m., to 3:00 p. m. shift. The CNAs were to clean and trim the resident's nails on shower days.</p> <p>Review of the CNA documentation for bathing from 3/31/25 through 4/28/25 revealed Resident #12 received assistance with bathing on 3/31/25, 4/2/25, 4/4/25, 4/9/25, 4/12/25, 4/13/25, 4/14/25, 4/25/25, and 4/28/25.</p> <p>Review of the CNA documentation for the task of Nails cleaned and trimmed by nursing assistant on shower days for a look back period of 30 days failed to reveal documentation Resident #12's nails were cleaned or trimmed on shower days. The documentation for the question, Did you complete the task? showed, No data found.</p> <p>On 4/29/2025 at 1:24 p.m., Resident #12's left hand fingernails remained long, extending approximately 3/4 of an inch from the fingertip with a brown substance under the nails. In an interview, Resident #12 said no one had come around to cut her nails. She said she would like to have them cut. When asked, Resident #12 was not able to say the last time her fingernails were trimmed.</p> <p>(continued on next page)</p> | | |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 4/30/25 at 10:10 a.m., in an interview CNA Staff I said someone comes around to cut residents' toenails. CNA Staff I said she was not sure are who cuts the residents' fingernails. Resident #12's fingernails were observed with CNA Staff I. She said they shouldn't be that long. CNA Staff I verified the lack of documentation in the CNA task that Resident #12's fingernails were cleaned and trimmed in the last 30 days. She said someone should have documented something.</p> <p>On 4/30/25 at 10:21 a.m., Resident #12's fingernails were observed with Registered Nurse (RN) Staff J. RN Staff J said, They are too long. Staff J said the Activities Director does nails but she wasn't sure if they trim the residents' nails.</p> <p>On 4/30/25 at 10:35 a.m., in an interview the Activities Director said they do not trim nails, they only paint them.</p> <p>On 5/1/2025 at 11:04 a.m., in an interview the Administrator said she did not want to misspeak for the nursing team on who is responsible for trimming nails. She said, if the Kardex noted, nails cleaned and trimmed by nursing assistant on shower days, then it should have been done.</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>52199</p> <p>Based on observations, facility policy, and staff interviews, the facility failed to maintain sanitary conditions during food service, including a visibly soiled ice machine, inadequate sanitizer levels in the three-compartment sink, and kitchen staff without proper hair restraints, posing a risk of food contamination and potential foodborne illness.</p> <p>The findings included:</p> <p>On 4/28/2025 at 9:30 a.m., during the initial kitchen tour with the Certified Dietary Manager (CDM), the ice scooper was observed lying unholstered on the ice machine.</p> <p>Photographic evidence obtained.</p> <p>On 4/29/2025 at 11:35 a.m., during a follow up observation of the kitchen, the ice machine scooper was again observed lying unholstered on the edge of a table next to the ice machine.</p> <p>Photographic evidence obtained.</p> <p>On 4/30/2025 at 11:15 a.m., black biofilm buildup and crust-like debris were observed on the interior and exterior of the ice machine.</p> <p>Photographic evidence obtained.</p> <p>The CDM verified the observation. In an interview the CDM said the kitchen's policy was to clean and sanitize the ice machine monthly.</p> <p>Review of the cleaning log for the ice machine provided by the facility were for February 2024, and March 2024. The logs had no documentation the ice machine was cleaned and sanitized.</p> <p>On 4/30/2025 at 2:54 p.m., in an interview Lead Chef, Staff C, said the exterior cleaning expectation is daily. Staff C verified the logs were for January and February of 2024 and said the logs were for January and February of 2025 but staff forgot to change the year. Staff C said that the new kitchen staff, probably forgot to sign off.</p> <p>When asked about the missing documentation verifying the ice machine was cleaned and sanitized in the last two months, the CDM stated, I do not have an answer for that.</p> <p>Review of the Ice Machine installation, operation, and maintenance manual revealed, You are responsible for maintaining the ice machine in accordance with the instructions in this manual, and Exterior cleaning: Clean area around the ice machine as often as necessary to maintain cleanliness and efficient operation.</p> <p>(continued on next page)</p> | | |

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| F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many | On 4/30/2025 at 11:15 a.m. to 12:00 p.m., during tray line prep and observation, three individuals were observed walking through the kitchen without hairnets. One staff member was starting her shift and was redirected by CDM to put on a hairnet after the observation. | | |