

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105864	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER Page Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 N Airport Road Fort Myers, FL 33907	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155</p> <p>Based on observation, record review and staff interviews, the facility failed to ensure a safe, clean, comfortable and sanitary environment for residents in 4 of 4 units observed.</p> <p>The findings included:</p> <p>On [DATE] at 8:32 a.m., during an initial tour of the facility the following were observed:</p> <p>1. room [ROOM NUMBER]: A bed pan was stored on the floor of the shared bathroom. A urinal was stored on the floor next to the toilet.</p> <p>Photographic evidence obtained.</p> <p>On [DATE] at 8:37 a.m., Unit Manager Registered Nurse (RN) Staff B verified the bed pan and urinal were improperly stored on the floor.</p> <p>2. room [ROOM NUMBER]: A hole, and missing tiles were observed in the wall behind the toilet. The grout on the tiles near the toilet was black. Multiple unlabeled personal items, including toothpaste were stored on the sink of the shared bathroom. The faucet was rusted, and dirty.</p> <p>Photographic evidence obtained.</p> <p>3. room [ROOM NUMBER]: A roll of toilet paper, a toothbrush, a hairbrush and other personal items were stored uncovered and unlabeled on the sink of the shared bathroom. An unlabeled open package of wipes was stored on the towel rack.</p> <p>On the floor next to the bed were crumbs of food and garbage. The bedside table legs were covered with a layer of rust with large spots of dried substance.</p> <p>Photographic evidence obtained.</p> <p>4. room [ROOM NUMBER]: A wash basin was stored on the floor, under the toilet of the shared bathroom. An unlabeled bedpan was stored behind the raised toilet seat. An unlabeled urinal was stored on the floor, under the sink next to a plunger. On [DATE] at 8:52 a.m., Unit Manager RN Staff B verified the observation of the unlabeled and improperly stored items.</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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105864	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER Page Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 N Airport Road Fort Myers, FL 33907	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Photographic evidence obtained.</p> <p>5. room [ROOM NUMBER]: Two brown dead insects were observed on the floor.</p> <p>Photographic evidence obtained.</p> <p>6. room [ROOM NUMBER]: Two unlabeled wash basins and two bedpans were stacked and stored on a shower chair with soiled towels.</p> <p>Photographic evidence obtained.</p> <p>7. room [ROOM NUMBER]: An orange, unidentified pill, a French fry and a dead brown insect were observed on the floor outside the room. Unit Manager RN Staff B confirmed the findings.</p> <p>Photographic evidence obtained.</p> <p>8. room [ROOM NUMBER]: A hole was observed in the wall behind the toilet. The metal of the toilet seat arm rests were rusted.</p> <p>Photographic evidence obtained.</p> <p>9. In the television room of the secured memory care unit two cups with dried liquids were observed stored on a cabinet. Both cups had live crawling insects.</p> <p>Unit Manager RN Staff C verified the observation and removed the cups.</p> <p>Photographic evidence obtained.</p> <p>10. room [ROOM NUMBER]: Two large, brown dead insects were observed on the floor. There was dirt, rust and an accumulation of a brown substance around the base of the wall.</p> <p>RN Staff C verified the observation.</p> <p>Photographic evidence obtained.</p> <p>11. room [ROOM NUMBER]: A roll of toilet paper was stored on the sink of the shared bathroom. The sink faucet had a layer of rust and encrusted brown substance.</p> <p>Photographic evidence obtained.</p> <p>12. room [ROOM NUMBER]: The nightstand door next to bed B was broken and ajar. On [DATE] at 9:16 a.m. , RN Staff C and the Maintenance Director were present and verified the findings.</p> <p>Photographic evidence obtained.</p> <p>13. Small dead insects and an accumulation of black and brown dirt were observed on the floor of one corner of the memory care dining room.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105864	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER Page Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 N Airport Road Fort Myers, FL 33907	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Photographic evidence obtained.</p> <p>14. The front of the ice machine in the memory care unit kitchen area was covered in a layer of white film. The water collection tray of the machine had multiple areas covered with a white and brown substance.</p> <p>The waterspout of the ice machine had a dry white substance around it and was rusted.</p> <p>On [DATE] at approximately 9:23 a.m., RN Staff C verified the findings and said dietary staff were responsible for cleaning the ice machine.</p> <p>Photographic evidence obtained.</p> <p>15. The bottom of two storage drawers of the refrigerator of the secured unit were coated with a dried, brown substance in the bottom of the drawers. Three cartons of milk stored in the refrigerator had an expiration date of [DATE]. The bottom of the freezer had a dried, yellow substance. On [DATE] at 9:28 a.m., in an interview RN Staff C said she was uncertain who was responsible to clean the refrigerator and discarded the expired milk.</p> <p>Photographic evidence obtained.</p> <p>16. room [ROOM NUMBER]: The shared bathroom had a wash basin stored in the sink. Residents' unlabeled personal items were stored on top of the sink.</p> <p>On [DATE] at 3:02 p.m., in an interview, the Director of Nursing (DON) said the facility had no policy for the storage of personal items but the expectation was for resident personal items to be labeled with the resident name and placed in a plastic bag and stored in the closet or nightstand. The DON said she had recently educated the staff and gave them small zip lock bags to put toothbrushes, toothpaste and other small items when not in use.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105864	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER Page Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 N Airport Road Fort Myers, FL 33907	
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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155</p> <p>Based on record review, review of facility's policies and procedures, and staff interviews, the facility failed to protect residents' rights to be free from neglect by failing to re-evaluate Resident #999's elopement risk and prevent unsafe wandering and elopement with onset of paranoid behaviors such as distrust of staff and verbal expression of desire and intent to leave the facility.</p> <p>Resident #999 diagnoses included dementia and psychosis. The resident used a wheelchair for mobility and was ambulatory with supervision.</p> <p>On [DATE] the facility neglected to re-evaluate the resident's elopement risk and neglected to adequately supervise Resident #999 when the resident's son and law enforcement reported Resident #999 called them believing he was under attack and requested they come to evacuate him.</p> <p>On [DATE] at approximately 3:30 p.m., staff observed Resident #999 outside, to the left of the building and did not intervene.</p> <p>On [DATE] at 4:35 p.m., facility staff were not able to locate Resident #999 and contacted law enforcement to assist in the search.</p> <p>On [DATE] at approximately 8:15 p.m., law enforcement notified the facility Resident #999 was found deceased , in a parking lot approximately half a mile from the facility.</p> <p>The facility's failure to provide the necessary care and services to prevent neglect created a likelihood of serious harm, serious injury, or death of Resident #999 and other cognitively impaired residents from unsafe wandering. This failure resulted in the determination of Immediate Jeopardy (IJ) at a scope and severity of Isolated (J) starting on [DATE].</p> <p>On [DATE] at 10:11 a.m., the Administrator was informed of the determination of Immediate Jeopardy (IJ).</p> <p>The findings included:</p> <p>Cross reference to F689 and F867</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105864	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER Page Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 N Airport Road Fort Myers, FL 33907	
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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of the facility's Abuse Policy-Prevention and Management Policy with a review date of ,d+[DATE] noted, The facility prohibits the . neglect . of residents . The facility has designed and implemented processes, which strive to ensure the prevention of . resident . neglect . Neglect occurs when the facility is aware of or should have been aware of goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), resulting in, or may result in, physical harm, pain, mental anguish, or emotional distress . Examples of individual failures include, but are not limited to . Failure to identify, assess . for an acute change in condition, and/or a change in condition that requires the plan of care to be revised to meet the resident's needs in a timely manner; Failure to ensure staff respond correctly to medical or psychiatric emergencies; Failure to implement an effective communication system across all shifts for communicating necessary care and information between staff . Failure to monitor and/or provide adequate supervision to assure that environmental hazards are not present . Failure of the Quality Assurance and Assessment committee to develop and implement appropriate action plans to correct identified quality deficiencies .</p> <p>A review of the facility's Elopement Prevention and Management policy and procedure with a review date of , d+[DATE] noted, The facility will strive to identify residents at risk for unsafe wandering and exit seeking behavior and to develop individualized prevention and management interventions based on Exit Seeking/Elopement Evaluation. Elopement represents a risk to the resident's health and safety and places the resident at risk of heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle . Procedure: . Review evaluations and risk factor data. Determine if the resident is at risk for elopement; history of elopement prior to admission. Include resident and/or resident representative in development of the Plan of Care. Develop individualized interventions in the care plan to address the potential for elopement . Communicate risk and interventions to the care giving team . Review and revise Plan of Care as needed.</p> <p>Review of the clinical record for Resident #999 revealed an Admission Minimum Data Set (MDS) assessment with a target date of [DATE]. The MDS noted Resident #999's cognition was moderately impaired with a Brief Interview for Mental Status of 09. The resident required supervision or touching assistance for walking.</p> <p>The elopement evaluations completed on [DATE], [DATE], and [DATE] noted the resident had no history of elopement, was ambulatory or able to self-propel in a wheelchair. Each time the facility determined Resident #999 was not at risk for elopement.</p> <p>On [DATE] and [DATE] two physicians evaluated the resident and signed an incapacity statement noting Resident #999 lacked the capacity to give informed consent and make healthcare decisions based on advanced stage dementia and confusion.</p> <p>The care plan initiated on [DATE] noted the resident had impaired cognitive function/dementia or impaired thought processes related to dementia. The interventions included to monitor, document and report as needed any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness, mental status.</p> <p>Review of the clinical nurses notes revealed on [DATE] at approximately 4:40 p.m., Resident #999 could not be found. Staff searched the facility and the grounds but were unable to find him. The police were notified at approximately 5:00 p.m. The resident's wheelchair was found outside. On [DATE] at 8:15 p.m., the detective notified the facility the resident was found deceased in a bar parking lot just down the road from the facility.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105864	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER Page Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 N Airport Road Fort Myers, FL 33907	
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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the facility's incident investigations revealed on [DATE] the facility initiated an investigation of neglect related to Resident #999's elopement.</p> <p>The investigation noted Resident #999 was admitted to the facility in [DATE] with diagnoses including Dementia and Major Depressive Disorder. The admitting medications included Risperdal (antipsychotic) 0.5 milligram twice a day for Mood Disorder. The medication was discontinued on [DATE], due to the lack of diagnosis to support the use of the Risperdal. Resident #999 had not exhibited any behaviors since admission.</p> <p>On [DATE] at approximately 11:00 a.m., Resident #999's son called the facility and reported to the Director of Nursing (DON) his father was telling him there was going to be a war and that they needed to take cover. Resident #999 asked his son to come and get him. He said he thought his father was exhibiting paranoia regarding the staff at the facility and needed to be restarted on his antipsychotic medication. He also reported Resident #999 had been baker acted (involuntary admission for mental illness) several years ago.</p> <p>The Psychiatric APRN (Advanced Practice Registered Nurse) was at the facility and evaluated the resident on [DATE] at approximately 1:00 p.m., for medication review. She completed a note stating the resident was calm and without hallucinations. The resident was, Per usual and no changes. She reordered the Risperdal related to the son's concerns, but did not witness any type of issues with the resident during her evaluation. Nothing further was recommended as she felt that the resident was stable at this time.</p> <p>Review of the Psychiatric APRN progress note dated [DATE] revealed she saw Resident #999 as it was reported to her the resident was unstable requiring psychiatric assessment. The APRN documented Resident #999 appeared agitated, upset. His thought process was somewhat disorganized. His insight and judgement were impaired. The resident was oriented to person, with impaired recall and short term memory. Attention span and concentration were poor. Fund of knowledge was impaired.</p> <p>The practitioner documented the resident was unstable requiring medication changes. She wrote, As per collected information and interview, it appears that patient is unstable. I feel the symptoms are occurring due to exacerbation of underlying psychosis disorder. The symptoms are occurring almost daily and causing severe distress. Therefore, I decided to make medication changes to stabilize the symptoms.</p> <p>Further review of the incident investigation revealed on [DATE] at approximately 5:15 p.m., the police called the facility and stated Resident #999 had called them and claimed he was under attack and needed to be evacuated. The police came to the facility for a wellness check. They said the resident was fine and explained to him they could not take him out of the facility.</p> <p>The resident remained in his room and calm without behaviors.</p> <p>The investigation did not include nonpharmacological interventions, including an elopement re-evaluation to determine the need for increased supervision to maintain the resident's safety with the onset of paranoid behavior and voiced intent to leave the facility.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105864	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER Page Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 N Airport Road Fort Myers, FL 33907	
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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The description of the incident noted on [DATE] at 4:35 p.m., Licensed Practical Nurse (LPN) Staff D reported to the shift supervisor, Registered Nurse (RN) Staff H he could not locate the resident to administer his medications.</p> <p>Facility staff initiated a Code Pink (elopement), searched the facility and surrounding area. Staff were not able to locate Resident #999 and contacted law enforcement to assist with the search.</p> <p>On [DATE] at approximately 8:15 p.m., a detective notified the facility Resident #999 was found just down the road from the facility in a bar parking lot and that the resident was deceased .</p> <p>On [DATE] the facility completed the investigation and documented after chart review and interviews completed with staff and other members of the interdisciplinary team, the facility felt there was no neglect. The statements the resident made to the son and the new diagnosis of Bipolar on [DATE] were addressed by the Physician Assistant and the Psychiatric APRN. The police evaluated the resident on [DATE] and deemed that he was safe to remain at the facility.</p> <p>On [DATE] at 10:15 a.m., an interview was conducted with the Administrator and the Director of Nursing (DON) to review Resident #999's elopement, and the neglect investigation.</p> <p>The DON verified on [DATE] Resident #999's risk for elopement was not re-evaluated and the care plan was not updated to maintain the resident's safety and prevent unsafe wandering and elopement.</p> <p>The DON said after the elopement, she interviewed staff and was not able to determine the root cause of the elopement. She said, The Root cause of the event was inconclusive per our findings because we did not have all the facts yet. We did not know where the resident was found. Once we had all the facts, we concluded the neglect was not verified as the resident did not display any behaviors and had no elopement history. She said, We did not provide that level of supervision because he did not need it.</p> <p>On [DATE] at 1:28 p.m., in an interview LPN staff D stated on [DATE] no one alerted him to the resident's change in mental status or update to his medications when he received report. He said Resident #999 did not display any changes at the time and was surprised that he eloped. He said he was aware the resident had called the police on [DATE], through word of mouth.</p> <p>On [DATE] at 3:52 p.m., in an interview Certified Nursing Assistant (CNA) staff E said another CNA and LPN Staff D told her the resident had called the police but no one instructed her to increase supervision for the resident.</p> <p>On [DATE] at 4:17 p.m., in an interview Maintenance Tech Staff F said on [DATE] at approximately 3:30 p.m. to 4:00 p.m., he observed Resident #999 outside to the right of the building. He said Resident #999 never went outside. It was the very first time he had seen him outside. He did not try to get him to go inside and did not notify any staff.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105864	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER Page Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 N Airport Road Fort Myers, FL 33907	
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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 4:41 p.m., in a telephone interview Resident #999's son said he notified the facility on [DATE] that his father said he intended to flee the facility by any means possible. He thought someone there was going to kill him. He was a flight risk and wanted to elope. His father called 911 and told them the same information. A police officer came out on [DATE] and spoke with his father. The son said, I spoke to the DON on [DATE] and told her that my father wanted me to immediately evacuate him from the facility because they were going to kill him. I told her they needed to take precautions and adjust his medications. He was hallucinating thinking people were going to kill him. I told them he would try and find a way out of the facility. I thought he would go to the front door, and someone would try and stop him, and he would hurt someone. He was seeing Psych, but I never spoke to them. Psych never contacted me after they saw him. I explained his previous psychiatric history to the DON and where to obtain it.</p> <p>On [DATE] at 10:00 a.m., in an interview Unit Manager Staff B said Resident #999 walked in his room from the bed to the wheelchair and the bathroom. She said the nurse and the CNA knew the police were here to see the resident but she never told them the reason for law enforcement visit. The resident's behavior would have been communicated in the nurse-to-nurse report. The Unit Manager said on [DATE] she overheard the resident speak to the two police officers. He said, I want you to take me. I am in danger. I want you to remove me from the facility. She said the resident did not exhibit any other behavior. She did not feel the resident needed one to one supervision or 15 minutes checks just because he called the police once. She said she did not see a reason to place a wander alert bracelet (alarms staff when a resident leaves a designated safe area) on the resident.</p> <p>On [DATE] at 12:47 p.m., in an interview LPN Staff I said she did not know Resident #999. On [DATE] at approximately 3:45 p.m., she was walking down the hallway and observed residents outside just to the right of the front doors by the patio of the Ford unit. After Resident #999 eloped she realized he was one of the residents she observed outside from the description of the bright yellow shirt he was wearing.</p> <p>On [DATE] at 5:50 p.m., in a telephone interview Resident #999's attending physician said the resident had a history of paranoia but she was not aware the resident had a history of elopement. The physician said it was hard to say if the resident was safe to go outside on his own or not.</p> <p>On [DATE] at 10:08 a.m., in an interview Unit Manager LPN Staff J said Resident #999 was not an elopement risk, he had never tried to leave the facility. She said, We had no way to think he would get up and leave the facility. He had the right to go outside. LPN Staff J said they would be restraining the resident if they tried to stop him from going outside. LPN Staff J said, He had the right to leave, and the right to fall. Isn't it what you people always say? He did not have a lack of capacity when he was here. When showed the certificate of incapacity signed by two different physicians, the Unit Manager turned her head and did not answer any additional questions.</p> <p>On [DATE] at 10:16 a.m., in an interview the Physician Assistant said Resident #999 spoke about the war a lot since he met him. He did not always make sense; he was confused but always compliant. He said it was hard to say if Resident #999 was safe to be outside as residents' rights come into play and they have residents who go outside for fresh air. He said Resident #999 was safe to go outside, right out the front door if staff could see him. The resident never said he wanted to leave the facility.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105864	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER Page Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 N Airport Road Fort Myers, FL 33907	
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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 2:25 p.m., in an interview the Social Service Director said she was responsible to update the care plan for changes in behavior. The nurses document changes in condition in the alerts section of the electronic clinical record. She follows up on what nursing documents. She said there was no clinical alert documented for Resident #999 on [DATE]. The Social Service Director said no one told her the son had called and voiced concerns about his father. No one told her the resident had called the police. The Social Service Director printed a copy of the alerts report for [DATE] through [DATE]. The report listed Resident #999's new antipsychotic medications for [DATE] but did not document the resident's paranoid behavior and voiced intent to leave the facility.</p> <p>On [DATE] at 10:44 a.m., a joint interview was conducted with the Administrator, the DON and the Regional Director.</p> <p>The Regional Director said the DON saw the resident the day he eloped and he was fine, his usual self. She asked the DON if she documented her assessment of the resident, the DON said it was the one time she did not do it.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105864	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER Page Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 N Airport Road Fort Myers, FL 33907	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155</p> <p>Based on clinical record review, review of facility's policies and procedures, resident representative and staff interviews the facility failed to recognize risk factors for elopement and adequately supervise 1 (Resident #999) of 3 sampled confused residents when Resident #999 exhibited new symptoms of paranoia and voiced intent to leave the facility.</p> <p>On [DATE] the facility failed to implement adequate supervision when Resident #999's son and law enforcement notified the facility the resident reported he was under attack and requested they come to evacuate him.</p> <p>On [DATE] at approximately 3:30 p.m., Resident #999 who was cognitively impaired was not supervised and exited the facility. Facility staff saw him outside to the right of the building and did not intervene.</p> <p>On [DATE] at 4:30 p.m., facility staff could not find Resident #999 and notified law enforcement to assist with the search.</p> <p>On [DATE] at 8:15 p.m., law enforcement notified the facility Resident #999 was found deceased in a parking lot, approximately half a mile from the facility.</p> <p>The facility failure to adequately supervise cognitively impaired and confused residents to prevent elopement created a likelihood of avoidable accidents for Resident #999 and other cognitively impaired residents at risk for elopement which could result in serious harm, serious injury, serious impairment or death of the residents.</p> <p>This failure resulted in the determination of Immediate Jeopardy (IJ) at a scope and severity of Isolated (J) starting on [DATE].</p> <p>On [DATE] at 10:11 a.m., the Administrator was notified of the determination of Immediate Jeopardy.</p> <p>The findings included:</p> <p>Cross reference to F600 and F867</p> <p>A review of the facility's Change in Condition Policy and Procedure with a review date of ,d+[DATE] noted, The Clinical Nurse will recognize and appropriately intervene in the event of a change in resident condition.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105864	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER Page Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 N Airport Road Fort Myers, FL 33907	
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Procedure noted, . The nurse will communicate to the nurse manager/supervisor any change in resident condition as it occurs. This will also be communicated in the 24 hour/and or shift report as well . If a significant change in condition occurs, a physical and or mental assessment with be completed by the Registered Nurse and documented in the medical record . Documentation of the change in condition will be present in the nurses' progress note and will continue q (each) shift for at least 72 hours . This episodic documentation will occur for, but not limited to . mental/behavioral changes .</p> <p>A review of the facility's Leave of Absence (LOA) with a review date of ,d+[DATE] noted, It is the policy of this facility to encourage outside socialization for the resident/patient when appropriate . A cognitively impaired resident may leave the facility with family/resident representative, unless restrictions apply, with the appropriate physician order. The facility will tract the departure and return of a resident on the Release of Responsibility for LOA form . Procedure . When LOA is to occur: Evaluate resident for a change in condition, notify physician of any concerns/changes and document in the progress note .</p> <p>Review of the clinical record revealed Resident #999 was a vulnerable [AGE] year old admitted to the facility on [DATE] following hospitalization for altered mental status. Diagnoses included unspecified Dementia without behavioral disturbance, Psychotic disturbance, mood disturbance, Major Depressive Disorder, Anxiety, Bipolar II disorder (mood swings ranging from depressive lows to manic highs), and Generalized Muscle Weakness.</p> <p>The Admission Minimum Data Set (MDS) assessment with a target date of [DATE] noted Resident #999's cognition was moderately impaired with a Brief Interview for Mental Status of 09 (Moderate level of cognitive impairment). The resident was ambulatory with supervision or touching assistance.</p> <p>The care plan initiated on [DATE] noted the resident had impaired cognitive function/dementia or impaired thought processes related to dementia. The interventions included to monitor, document and report as needed any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness, mental status.</p> <p>On [DATE] and [DATE] two physicians evaluated the resident and signed an incapacity statement noting Resident #999 lacked the capacity to give informed consent and make healthcare decisions based on advanced stage dementia and confusion.</p> <p>The elopement evaluations completed on [DATE], [DATE], and [DATE] noted the resident was ambulatory or able to self-propel in a wheelchair. The potential risk factors for elopement, such as history of elopement, desire to return home, expressed desire to leave, attempted elopement, and psychiatric history were not checked off on the elopement evaluation forms.</p> <p>Each time the facility determined Resident #999 was not at risk for elopement.</p> <p>The Physician's orders dated [DATE] included to consult Psychiatry Service to evaluate and treat the resident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105864	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER Page Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 N Airport Road Fort Myers, FL 33907	
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the Psychiatric Advanced Practice Registered Nurse (APRN) progress notes for [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] noted Resident #999 was oriented to Person, insight and judgment were impaired, short-term and remote memory were impaired and the resident's fund of knowledge (used to determine if a patient has cognitive impairment) was impaired. The APRN documented in her notes Resident #999 did not exhibit behaviors or psychotic symptoms.</p> <p>Review of the Clinical Nurse's Note dated [DATE] at 10:56 a.m., noted Resident #999's son called and said his dad had called him and stated that he was under attack and that the son needed to come and evacuate him. The son stated that he knew the facility had discontinued one of his father's medications a while ago and that he probably needed it back. He stated his father had been diagnosed with Bipolar disorder, paranoia, schizoaffective disorder and had been [NAME] Acted a few years ago and started on Risperidone (antipsychotic). The psychiatric provider was at the facility and was notified of the son's concerns. The Psychiatric APRN ordered to restart Risperidone 0.5 milligram twice a day.</p> <p>On [DATE] the Psychiatric APRN documented in a progress note she saw Resident #999 as it was reported to her the resident was unstable requiring psychiatric assessment. Resident #999 appeared agitated, upset. His thought process was somewhat disorganized. His insight and judgement were impaired. The resident was oriented to person, with impaired recall and short term memory. Attention span and concentration were poor. Fund of knowledge was impaired.</p> <p>The practitioner documented the resident was unstable requiring medication changes. She wrote, As per collected information and interview, it appears that patient is unstable. I feel the symptoms are occurring due to exacerbation of underlying psychosis disorder. The symptoms are occurring almost daily and causing severe distress. Therefore, I decided to make medication changes to stabilize the symptoms.</p> <p>On [DATE] at 1:59 p.m., a nursing progress note documented Resident #999 was confused, and independent for all transfers, Will continue to monitor resident for behavior.</p> <p>The note did not describe what behavior was being monitored.</p> <p>On [DATE] at 5:23 p.m., a nursing progress documented the Fort [NAME] Police called the facility to say that Resident #999 had call them to report that he needed to be taken out of the facility. The resident said he was in danger of the war and needed evacuation.</p> <p>The police arrived at the facility and visited with the resident for about five minutes and left.</p> <p>There was no documentation on [DATE] Resident #999's risk for elopement was re-evaluated when the resident with a psychiatric history exhibited paranoid behavior and expressed desire, and intent to leave the facility.</p> <p>The care plan was not updated to address the acute change in behavior and ensure adequate supervision to maintain the resident's safety and prevent elopement.</p> <p>On [DATE] at 3:46 a.m., a nursing progress note documented Resident #999 was in bed and no behavior was observed at that time.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105864	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER Page Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 N Airport Road Fort Myers, FL 33907	
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 5:20 p.m., Licensed Practical Nurse (LPN) Staff D documented in a Late Entry Clinical Nurse Note the resident's mood was stable and pleasant that morning. He was sitting near the nurse's station after lunch. At around 4:15 p.m., he went to the resident's room to administer medications. Resident #999 was not there. He asked the assigned Certified Nursing Assistant to help him search for the resident from room to room and unit by unit and they could not find him. At 4:35 p.m., he notified the supervisor on duty. At around 4:40 p.m., the supervisor called a code pink for missing resident according to facility's protocol.</p> <p>On [DATE] at 8:15 p.m., a nursing progress note documented the facility notified law enforcement that Resident #999's was missing at approximately 5:00 p.m. Law enforcement arrived at the facility at 5:15 p.m. The resident's wheelchair was found outside by the Ford Unit. The police received a call for a possible civilian on [NAME] street just down from the facility. The police left to go to the area. On [DATE] at approximately 8:15 p.m., a detective notified the facility the resident was found deceased in a bar parking lot just down the road from the facility.</p> <p>On [DATE] at 10:15 a.m., an interview was conducted with the Administrator and the Director of Nursing (DON) related to Resident #999's elopement and the facility's process to prevent unsafe wandering and elopement.</p> <p>The DON said the facility used to have a sign out book at the front desk but they did not require residents to sign out if they just wanted to sit outside in front of the facility. Residents were free to get around, go outside, and sit there without staff supervision and there was no monitoring camera outside.</p> <p>The DON said Resident #999 lacked capacity. She verified on [DATE] Resident #999's son called and told her his father was acting fearful. He thought he was in the war and said he had to leave the facility. He requested the son come and get him. The son told her his father was prescribed antipsychotic medication for a diagnosis of schizophrenia and he was paranoid. He also was diagnosed with Bipolar disorder. He thought he should be put back on Risperidone, the antipsychotic medication which had been prescribed for paranoia. She said that same day the Psychiatric APRN assessed the resident and re-ordered the Risperdal (Risperidone). That afternoon, the police called the facility to inform them Resident #999 had called them requesting to be evacuated as he thought there was going to be a war and the staff were going to kill him. The police then came to the facility and spoke with Resident #999 for five minutes. They said he was fine and they left.</p> <p>The DON said she checked on the resident the next day and he was fine. She did not tell the staff of the concerns voiced by Resident #999's son. She did not feel he needed increased supervision.</p> <p>She verified the resident's elopement risk was not re-evaluated despite knowledge of the psychiatric history and expressed intent to leave the facility. She said the facility was not aware of the resident's elopement history. He had previously eloped from the Assisted Living Facility where he resided and was trying to get back to Missouri. He was [NAME] acted (involuntary hospitalization for mental illness).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105864	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER Page Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 N Airport Road Fort Myers, FL 33907	
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Administrator said on [DATE] at approximately 3:30 p.m., to 4:00 p.m., the Maintenance Assistant (Tech) observed Resident #999 outside to the left of the door. The resident was not visible from the front desk. He did not sign out in the leave of absence log per policy. The Maintenance Assistant tried to bring the resident back into the building but Resident #999 refused to go back inside. He left the resident outside and did not notify anyone.</p> <p>The Administrator said LPN Staff I observed Resident #999 sitting outside to the side of the building from a window of the Ford Unit. She did not report it to anyone.</p> <p>The Administrator said the facility did not have a policy specifying which residents could come and go from the facility. Resident #999 was not an elopement risk. He enjoyed the freedom to get fresh air.</p> <p>On [DATE] at 1:28 p.m., in an interview LPN Staff D said on [DATE] no one informed him of the resident's change in mental status or update to his medications. He became aware the resident had called the police on [DATE] through word of mouth.</p> <p>On [DATE] at 3:52 p.m., in an interview Certified Nursing Assistant (CNA) Staff E said LPN Staff D and another CNA told her Resident #999 had called the police on [DATE] but no one told her she needed to supervise the resident. She said Resident #999 never left the unit. If she had seen him outside she would have brought him back in as no resident should be left unsupervised outside.</p> <p>On [DATE] at 4:17 p.m., in an interview the Maintenance Tech said he had never seen Resident #999 outside of the facility prior to [DATE]. When he saw the resident outside around 3:30 p.m., to 4:00 p.m., he asked the resident if he was ok, and he said he was. He said, I did not try to get him to go inside. I did not bother because he gets very agitated and would swear at you. The Maintenance Tech said, If I had known he was not allowed to go outside, I would have gotten him and brought him inside. He said he tells residents to stay away from the road. The road is so close and he does not want them to get hurt.</p> <p>On [DATE] at 4:41 p.m., in a telephone interview Resident #999's son said, I notified the facility the day before he passed, that he wanted to flee the facility by any means possible. He thought someone there was going to kill him. He was a flight risk and wanted to elope. He told me he wanted to get out of the facility because they were going to kill him. He called 911 and told them the same information. I spoke to the DON on [DATE] and told her that my father wanted me to immediately evacuate him from the facility because they were going to kill him. I told her they needed to take precautions and adjust his medications. He was hallucinating thinking people were going to kill him. I told them he would try and find a way out of the facility. The son said his father had Dementia; the facility should have monitored him.</p> <p>On [DATE] at 10:00 a.m., in an interview Unit Manager Registered Nurse Staff B said LPN Staff D and CNA Staff E were aware the police came to the facility, everyone saw them. She overheard Resident #999 asking the police to take him, he was in danger. The resident said to the police officers, I want you to remove me from the facility. She said she did not relay that information to the direct care staff. She did not tell them about the resident's onset of behavior and expressed intent to leave the facility and did not instruct them to supervise the resident. She did not see a reason to place the resident on one-to-one supervision or every 15 minutes checks just because he called the police one time.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105864	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER Page Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 N Airport Road Fort Myers, FL 33907	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 5:50 p.m., in a telephone interview Resident #999's attending physician said it was hard to say if the resident was safe to go outside on his own. She was not aware of the change in his behavior but perhaps the Physician Assistant was notified.</p> <p>On [DATE] at 10:16 a.m., in an interview the Physician Assistant said, It is hard to say if (Resident #999) was safe to be outside. He said the resident lacked capacity; he was confused but compliant. He was safe to go outside, right out the front door where staff could see him. When asked if it was safe for Resident #999 to be outside on the side of the building, out of view of staff at the front desk, the Physician Assistant did not reply.</p> <p>On [DATE] at 12:47 p.m., in an interview LPN Staff I said she did not know Resident #999. On [DATE] at approximately 3:45 p.m., she was walking down the hallway and observed residents outside just to the right of the front doors by the patio of the Ford unit. After Resident #999 eloped she realized he was one of the residents she observed outside from the description of the bright yellow shirt he was wearing.</p> <p>On [DATE] at 2:25 p.m., in an interview the Social Service Director said she was responsible to update the care plan for changes in behavior. The nurses document changes in condition in the alerts section of the electronic clinical record. She follows up on what nursing documents. She said there was no clinical alert documented for Resident #999 on [DATE]. The Social Service Director said no one told her the son had called and voiced concerns about his father wanting to leave the facility. No one told her the resident had called the police requesting they remove him from the facility. The Social Service Director printed a copy of the alerts report for [DATE] through [DATE]. The report listed Resident #999's new antipsychotic medications ordered on [DATE] but did not document the resident's paranoid behavior and voiced intent to leave the facility.</p> <p>On [DATE] at 10:24 a.m., in a follow up interview related to the lack of supervision resulting in Resident #999's elopement, the Administrator said the resident died of natural causes. He said the police came to the facility and did not recommend more supervision. The Administrator said, Why didn't the police tell us that he needed more supervision? They thought he was fine. The police said he was safer at the facility.</p> <p>The Administrator said at the time Resident #999 wandered off the property, he was safe to be outside unassisted per their assessment. A lot of people saw the resident, and no one, including the police, the psychiatric APRN recognized he was an elopement risk.</p> <p>On [DATE] at 11:40 a.m., the Regional Director provided a care plan with a canceled date of [DATE] which noted Resident #999's well-being was promoted by spending time outdoors, at times as well as watching television. The diagnoses listed included unspecified dementia.</p> <p>The care plan initiated on [DATE] with a revision date of [DATE] and a target date of [DATE] noted the resident had impaired cognitive function/dementia or impaired thought processes related to dementia.</p> <p>The care plan did not include provision for supervision for outdoor activities and was not revised on [DATE] when the confused resident voiced intent to leave the facility.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105864	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER Page Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 N Airport Road Fort Myers, FL 33907	
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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155</p> <p>Based on observations, review of facility policies and procedures and staff interviews, the facility failed to ensure medications were stored in a safe and secure manner for 2 (Residents #950 and 900) of 10 rooms observed and 1 (Ford Unit) of 4 units observed.</p> <p>The findings included:</p> <p>A review of the facility's policy Medication Administration initiated 6/2018 (revised 9/6/23) documented Medications shall be administered in a safe and timely manner, and as prescribed by the physician . Medications and biologicals shall be administered by the same licensed staff member who prepared the dose for administration and will be given as soon as possible after the dose is prepared .</p> <p>On 1/2/25 at 8:32 a.m., during an initial tour of the facility the following was observed:</p> <p>1. Resident #950 was noted to have a clear, plastic medication cup on her bedside table. The medication cup contained a long, white pill inside. Resident #950 said it was her potassium pill, and she was waiting for someone to break it in half for her.</p> <p>Photographic evidence obtained.</p> <p>On 1/2/25 at 8:37 a.m., Unit Manager Registered Nurse (RN) Staff B verified the pill was left at the resident's bedside and said she would speak with the resident's nurse. RN Staff B said the pill should have been administered and not left with the resident.</p> <p>Review of the clinical record revealed Resident #950 did not have an order to self-administer medications.</p> <p>2. On 1/2/25 at 9:00 a.m., Resident #900 was noted to have an Albuterol Sulfate inhaler on the bedside table. The resident was not in his room and the inhaler was left unattended.</p> <p>Photographic evidence obtained.</p> <p>On 1/2/25 at 9:05 a.m., RN Staff B was notified of the inhaler left at the bedside and confirmed that the inhaler should not have been left at the bedside.</p> <p>Review of the clinical record revealed Resident #900 had not been assessed to safely self-administer the medication and had no physician order to do so.</p> <p>3. There was a round orange, unidentified pill on the floor outside of room [ROOM NUMBER]. RN Staff B was notified and removed the pill.</p> <p>Photographic evidence obtained.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105864	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER Page Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 N Airport Road Fort Myers, FL 33907	
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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. On 1/2/25 at 9:29 a.m., a large, long, white pill was observed on the floor of the Ford unit next to the sitting room entrance. Housekeeper Staff G was standing at the entrance to the sitting room and was informed there was a pill on the floor, but did not attempt to remove it. Unit Manager RN Staff A was notified and removed the pill.</p> <p>Photographic evidence obtained.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105864	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER Page Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 N Airport Road Fort Myers, FL 33907	
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)		
<p>F 0867</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155</p> <p>Based on record review, review of facility's policies and procedures, the facility failed to thoroughly investigate an elopement incident for 1 (Resident #999) of 3 sampled residents reviewed for elopement, and failed to implement systemic appropriate corrective actions to prevent further incidents of unsafe wandering and elopement of mobile confused residents.</p> <p>On [DATE] the facility failed to ensure Resident #999's safety when the son and law enforcement notified the facility the resident called, said he was under attack, voiced intent to leave the facility and requested they come and get him.</p> <p>On [DATE] at 4:35 p.m., staff became aware Resident #999 was missing and contacted law enforcement to assist with the search.</p> <p>On [DATE] at approximately 8:15 p.m., law enforcement notified the facility Resident #999 was found deceased , in a parking lot approximately half a mile from the facility.</p> <p>The facility's investigation did not include the failure to reassess the resident's elopement risk with the onset of paranoid behavior. The systemic corrective actions did not include documentation of behaviors and appropriate actions to ensure residents safety with the onset of new behaviors that may lead to elopement.</p> <p>The facility failure to have an effective Quality Assurance and Performance Improvement program that identify quality deficiencies and implement appropriate corrective actions created a likelihood of unsafe wandering and elopement of cognitively impaired, confused residents which could result in serious harm, serious injuries or death of the residents.</p> <p>This failure resulted in the determination of isolated ongoing Immediate Jeopardy.</p> <p>On [DATE] at 10:11 a.m., the Administrator was notified of the determination of Immediate Jeopardy (IJ).</p> <p>The finding included:</p> <p>Cross reference to F600 and F689.</p> <p>A review of the facility's Quality Assurance and Performance Improvement (QAPI) Plan with a review date of [DATE] noted, The Facility will maintain a quality management program which takes a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality . The purpose of a QAPI program is to ensure continuous evaluation of facility systems with the objective of:</p> <p>Ensuring care delivery systems function consistently, accurately, and incorporate current and Evidence-based practice standards where available.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105864	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER Page Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 N Airport Road Fort Myers, FL 33907	
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)		
<p>F 0867</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Preventing deviation from care processes, to the extent possible.</p> <p>Identifying issues and concerns with facility systems, as well as identifying opportunities for Improvement; and</p> <p>Developing and implementing plans to correct and/or improve identified areas.</p> <p>On [DATE] at 10:15 a.m., an interview was conducted with the Administrator and the Director of Nursing (DON) to review the incident investigation related to Resident #999's unsafe wandering and elopement, the root cause analysis and systemic corrective actions implemented to prevent recurrence.</p> <p>The DON verified on [DATE] at approximately 11:00 a.m., the resident's son called the facility to speak with her. He reported Resident #999 had been diagnosed with Bipolar disorder (mood swings ranging from depressive lows to manic highs) and paranoia (overly suspicious and thinking others are out to harm you). Resident #999 told his son there was going to be a war, they needed to take cover and to come and get him.</p> <p>She verified on [DATE], the Psychiatric Advanced Practice Registered Nurse assessed Resident #999 and re-ordered the antipsychotic Risperdal which had been discontinued in [DATE].</p> <p>She also verified on [DATE] at approximately 5:15 p.m., law enforcement called and informed the facility Resident #999 had called them and claimed he was under attack and needed to be evacuated.</p> <p>The DON verified Resident #999's risk for elopement was not re-evaluated and the care plan was not updated with nonpharmacological interventions, including adequate supervision to maintain the resident's safety and prevent unsafe wandering and elopement.</p> <p>The Administrator and the DON said on [DATE] the facility immediately initiated an investigation, held QAPI meetings to discuss the root cause of Resident #999's elopement, and corrective actions as appropriate to prevent further incidents of unsafe wandering and elopement of cognitively impaired residents.</p> <p>The DON said after the elopement, she interviewed staff and was not able to determine the root cause of the elopement. She said, The Root cause of the event was inconclusive per our findings because we do not have all the facts yet. We did not know where the resident was found. Once we found out all the information, we concluded it was not verified as he had no behaviors, and he had no elopement history. We did not provide that level of supervision because he did not need it and we did not substantiate the incident. The DON added she did not know the resident required that level of supervision. She said she assessed the resident on [DATE] and [DATE]. She did not document her assessment and Resident #999 did not need any higher level of monitoring or a wander alert bracelet (alerts staff when a resident leaves a determined safe area).</p> <p>The Administrator said the facility could not reach a conclusion due to Resident #999's pending autopsy result to determine the cause of death. He said they had no way of knowing the resident was an elopement risk despite the resident's son and law enforcement alerting them of the resident's voiced intent to leave the facility as he believed he was under attack and needed to take cover.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105864	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER Page Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 N Airport Road Fort Myers, FL 33907	
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)		
<p>F 0867</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility provided the minutes of a Risk Management/QAPI report dated [DATE] that read, Root cause determined that facility was not aware of the history of the resident. There was no information in the medical record nor did the family report any history of elopement. The facility determined that the neglect was not verified related to the incident based on evaluation of the medical record and history of the resident, the resident did not require an increased level of supervision . Facility still awaiting autopsy report and police report at this time.</p> <p>The facility's interventions consisted of staff interviews, education to the staff on resident elopements, code Pink for missing resident, the elopement binder, elopement policy and procedure, Leave of absence policy and procedure, elopement drills, sign-out binder at the front desk.</p> <p>The DON said she conducted the elopement drills; she placed an additional staff at the front door for three days to monitor since she did not know through which door the resident exited the facility.</p> <p>The facility's corrective actions did not include staff education on ensuring the elopement evaluations accurately reflected residents' risk factors, or recognizing, documenting and implementing adequate supervision with onset of behavior that may lead to unsafe wandering and elopement.</p> <p>On [DATE] at 10:24 a.m., in an interview related to the neglect of Resident #999 and systemic interventions to prevent further incidents of unsafe wandering and elopement of mobile, confused and cognitively impaired residents, the Administrator said the Psychiatric APRN (Advanced Practice Registered Nurse) assessed Resident #999 on [DATE] and changed the resident's psychotropic medications. He said Resident #999 died of natural causes. On [DATE] law enforcement came to check on Resident #999 when he called them to say he was under attack and requested assistance to leave the facility. They did not recommend increased supervision of the resident.</p> <p>On [DATE] at 10:44 a.m., in an interview the Regional Director said the staff did their due diligence in monitoring Resident #999. She said a change of behavior and a change in medication were the same thing. She said, You put a label on it but the facility did document and kept an eye on this resident throughout the shift.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105864	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER Page Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 N Airport Road Fort Myers, FL 33907	

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)
<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155</p> <p>Based on observation, review of facility policies and procedures, and resident and staff interviews, the facility failed to maintain an effective pest control program and a sanitary environment free from pests in 4 of 4 units observed.</p> <p>The findings included:</p> <p>A review of the facility's policy Pest Control initiated 11/2018 (revised 11/19) documented It is the responsibility of the Maintenance Department to coordinate the control of pests with a company engaged in the business of providing Pest Control Services . Pest Control Company will provide the control of roaches, ants, rodents, spiders and other insects that may be harmful to humans, equipment, supplies, or documents through direct or indirect contact or contamination.</p> <p>On 1/2/25 at 8:32 a.m., during an initial facility tour, the following was observed:</p> <ol style="list-style-type: none"> 1. On the secured memory care unit in the cabinet in the sitting room there were two cups with live crawling insects in the cups. The Unit Manager Registered Nurse Staff C verified the observation and discarded the cups. <p>Photographic evidence obtained.</p> <ol style="list-style-type: none"> 2. In room [ROOM NUMBER] there was a large, brown dead insect on the floor. RN Staff C verified the observation and removed it from the floor. <p>Photographic evidence obtained.</p> <ol style="list-style-type: none"> 3. In the memory care unit dining room next to the piano in the corner were dead insects, and an accumulation of black substance. <p>Photographic evidence obtained.</p> <ol style="list-style-type: none"> 4. A large dead, brown insect was observed on the floor in Resident #105's room. <p>On 1/2/25 at approximately 9:30 a.m., Resident #105 said there were large waterbugs as she calls them, big black things seen in her room last week. The resident said she did notify the nurse, and the nurse had observed the waterbugs as well.</p> <ol style="list-style-type: none"> 5. room [ROOM NUMBER]: A large and a small brown dead insects were observed on the bathroom floor. <p>On 1/2/25 at 8:55 a.m., in an interview Resident #850 said she sees big black crawling insects on the walls in the hallway. The resident said, I saw one the other day on the wall right across from my room in the hall. She said she did not tell staff because, They see them, they know they are in here.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105864	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER Page Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 N Airport Road Fort Myers, FL 33907	
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)		
<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/2/25 at 9:35 a.m., in an interview Resident #22 said she frequently observes large crawling insects in her bathroom and small ones on the bedside table. She reports it to staff. The resident said when the staff bring the meal tray and move things around on the table to place the tray, the bugs run away. Resident #22 said she also observed crawling insects on her dresser.</p> <p>On 1/2/25 at 9:45 a.m., Resident #129 said last week a bug crawled into her orange juice on her breakfast tray. She said she had seen crawling insects on her bedside table, but she did not report it to the staff.</p> <p>On 1/2/25 at 1:29 p.m., in an interview Resident #77 said he sees bugs in his room all the time by the air-conditioner vent but had not seen any in the last week.</p> <p>During random observations in the facility conference room on 1/2/25, 1/3/25 and 1/6/25, small flying insects were observed.</p> <p>Review of the pest control Service Inspection Reports dated 12/18/24, 12/4/24, 11/6/24, 10/16/24, and 10/3/24 revealed the exterminator documented, Today I applied a liquid insecticide around the foundation of your building to control any type of bugs crawling around or trying to get inside.</p> <p>Review of the facility Pest Sighting Log from July 2024 through December 2024 documented pests were observed on the units, and in residents' rooms each month.</p> <p>On 1/6/25 at 12:29 p.m., in an interview the Maintenance Director said there were pest logbooks at each nursing station. The pest control company checks the logbooks when they are here. Residents come to us and notify us if they see anything or have a problem with pests. The Pest Control company is here monthly but if needed they will come when notified. The Maintenance Director said he checks the logbooks to see if he needs to spray as well and said the residents have not reported any pest sightings to him. If anyone sees anything they notify him. He said no one from maintenance goes around the facility to check if there are pests in the building, the Pest Control company does that.</p>		