

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/11/2025
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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interviews, and record reviews, the facility failed to follow proper sanitation and food handling practices to prepare, distribute, and serve food in a safe and sanitary manner to prevent potential outbreak of foodborne illness. The findings included: Based on observation, staff interviews, and record reviews, the facility failed to follow proper sanitation and food handling practices to prepare, distribute, and serve food in a safe and sanitary manner to prevent potential outbreak of foodborne illness. The Environment policy revised October 2019 stated It is the center policy that all food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. The Dining Service Director will ensure that the physical plant is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation. On 9/8/2025 at 9:10 a.m., the Initial kitchen Tour was conducted with the Food Service Manager. The Initial Kitchen Tour started in kitchen by the prep area. The Food Service Manager said he started at the facility 2 years ago. He was labeling meat in a baggie. A delivery person was delivering milk via dolly to the refrigerator. The delivery person did not have his head or facial hair covered. The Food Service Manager said he should have it covered. The Food Service Manager was asked if his beard should be covered as well. He stated, only if I am preparing food. He said he doesn't wear the beard covering because it gets itchy. The tour of the walk-in refrigerator was conducted. The refrigerator door and floor area were dirty and had spots of black bio growth. The door jamb of the refrigerator also contained buildup and black bio growth. (Photographic evidence obtained). Next observed was the juice machine up next to the wall. The wall was damaged and dirty, and the floor had buildup of black bio growth. (Photographic evidence obtained). The ceiling and air vents over drink area, food prep area and steam table were observed with dust and black bio growth. (Photographic Evidence Obtained). The Food Service Manager said it was maintenances job to clean the ceiling vents and tiles. He said he did not know the last time the vents were cleaned and if they were on a cleaning schedule. He said he had put in work orders in the past. There was a dirty cooler on shelf under a coffee maker that was. The Food Service Manager said he was waiting for a new cooler lid so it could be used on units for drinks. (Photographic evidence obtained). All Appliances, stainless steel tables, steam table, walls, and floors all had food/grease/grimed build up. (Photographic evidence taken). The dry storage room was toured. A large dead insect was on the floor. The Food Service Manager said they had issues in the past, but that pest control had been spraying. He said they spray about once a month. On 9/9/2025 at 9:00 a.m., in an interview the Administrator said no one should be in the kitchen without hair being covered whether they are preparing food or not as the policy states. The facility policy for staff attire dated October 2019 stated it is the policy that all dining services employees wear approved attire for the performance of their duties. The Dining Services Director ensures that all staff members have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained. On 9/9/2025 at 12:15 p.m., a follow-up tour of the kitchen was conducted with The Regional Manager. The kitchen had been cleaned since the initial tour. The Regional Manager agreed that the kitchen was not well maintained and that everyone in the kitchen should have been wearing coverings for hair and facial hair. On 9/11/2025 at 10:45 a.m., in an (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 105864	If continuation sheet Page 1 of 7

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	interview the Maintenance Director said his maintenance department is responsible for cleaning the ceiling tiles and vents in the kitchen. He said they try to clean them quarterly but if the kitchen manager feels it needs cleaning he can send a work order. The work orders provided by the maintenance director for the past 6 months identify June 19, 2025, as being the last date, a work order was placed to clean ceiling vents above juice machine. *Photographic Evidence Obtained		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, review of facility policy and procedures and resident and staff interviews, the facility failed to maintain a homelike and sanitary environment by failing to properly store personal care items in shared spaces. The findings included: The facility policy CR-16 Resident Centered Care document This facility is committed to respecting and upholding the rights of all residents, fostering a home like atmosphere, and maintaining a safe and secure environment. Staff including CNA's will follow established guidelines and ensure residents' personal care items are stored safely, with access provided as needed. All personal care items must be stored to prevent cross contamination. CNA's will assist residents with labeling and organizing items in compliance with infection prevention standards. On 9/8/2025 at 8:52 a.m., during initial rounds, Resident #70 had a nebulizer and a mask lying uncovered on the bedside table next to personal care items. In the bathroom there was a wash basin and a urinal on the handrail without a name and uncovered. On the opposite handrail there was another wash basin that was not covered. On 9/8/2025 at 8:58 a.m., Resident #140 was observed with a BiPAP machine (a noninvasive ventilation that helps you breathe) and the mask was hanging from the dresser and was not bagged. On 9/8/2025 at 9:09 a.m., in an interview Licensed Practical Nurse (LPN) Staff A confirmed the findings in the rooms and said, no it should not be like that, it should be bagged. On 9/8/2025 at 9:12 a.m., in Resident #74's room in the bathroom there were large drops of blood on the floor. On 9/8/25 at 9:27 a.m., on the secured memory care unit, in Resident #165's bathroom there was a very strong and foul odor of urine. The toilet had an over the toilet raised seat that was stained with large black and brown stains. There were flying bugs in the room. There were 2 toothbrushes sitting uncovered on top of the paper towel holder on the wall. There was a soiled wash basin on the floor. The findings were verified with the Memory Care, LPN Unit Manager Staff B. On 9/9/2025 at 1:17 p.m., Resident #140 was observed in his bed. His BiPAP mask was uncovered and hanging from the dresser. He said the staff take care of the BiPAP machine for him. On 9/10/2025 at 9:33 a.m., Resident #74 was observed in his room in bed. There were crumbs of food at the bottom of the sheets. The fitted sheet the resident was lying on was wet from the center extending to the foot of the bed. The sheets and pillowcase were soiled with blood stains. Unit Manager Registered Nurse Staff C verified the findings. On 9/10/2025 at 2:22 p.m., in an interview the Director of Nursing said nebulizer and BiPAP/CPAP masks should be stored in a plastic bag when not in use. On 9/11/2025 at 8:46 a.m., in an interview the Administrator said the expectation is for personal care items including wash basins, urinals should be labeled with a resident name and placed in a plastic bag.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure resident received treatment and care in accordance with physician order and plan of care plan for 1 (Resident #60) of 1 resident reviewed for post-surgical care. The findings included: Record review of Resident #60's chart revealed he had been admitted to the facility on [DATE]. A skin/wound progress note dated 8/14/25 indicated Resident #60 was admitted with a diagnosis of Osteomyelitis (infection of the bone) of a chronic non pressure wound to left heel with grafted surgical incision on the left heel. Treatment orders placed including: Res on Air mattress, heel boots and pressure reduction cushion at all times. Further review of Resident #60's chart revealed an order dated 8/14/25 to float heels above bed surface (when in bed) using pillows and wedges and heel boots (bilateral) at all times. On 9/9/25 at approximately 10 a.m., Resident #60 was observed lying in bed with heel boots on both legs. There were no pillows or wedges noted to be propping legs up. Resident #60 said the facility staff does not always put the boots on him, especially when there is a shift change. On 9/11/25 at 9:15 a.m., Resident #60 was observed lying in bed with no heel boots on, legs not elevated on pillows and bandaged, grafted heel lying directly on mattress. Resident #60 said he had gone to the doctor the day prior, and the doctor had changed his bandage. He said the staff had not put his boots on but could not remember if they had been on overnight. Resident #60's heel boots were noted to be on the dresser well out of his reach. On 9/11/25 at 9:30 a.m., Record Review of Resident #60's Treatment Administration Record (TAR) showed Staff D (RN) had already signed off that on 9/11/25 for the 6 a.m. - 6 p.m. shift that his heels were floated above bed surface (when in bed) using pillows and wedges and that heel boots (bilateral) were on at all times. On 9/11/25 at 10 a.m., on return to Resident #60's room with the Director of Nursing (DON) he was again observed with no heel boots on, nothing propping up his legs/feet and his bandaged, grafted heel resting directly on the mattress. The DON placed the heel protectors on Resident #60 and said they were supposed to be on resident at all times. The DON had no comment when shown that they had already been signed off as being on resident the entire shift.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility policy and procedures, record review and staff and resident interview, the facility failed to follow physician orders for the application of positioning devices for 2 (Resident #116 and #39) of 4 residents reviewed with a limitation in range of motion (ROM). This had the potential to cause pain and further losses in ROM. The findings included: Review of the facility policy C-ADL-1q ADL Care Limited Joint Mobility and Restorative Splint/Brace Program documented A resident who is admitted without a limited range of motion (ROM)/joint mobility does not experience reduction unless the resident's clinical condition demonstrates that a reduction in ROM/joint mobility is unavoidable. A resident with a limited ROM/joint mobility receives appropriate treatment and services to increase ROM and or prevent further decrease in ROM. Review of the clinical record revealed Resident #116 was [AGE] years old and had an admission date of 6/17/22 with diagnoses including Vascular Dementia, muscle wasting and atrophy and schizoaffective disorder. Review of the Annual Minimum Data Set (MDS) dated [DATE] documented that the resident was dependent on most activities of daily living including transfers with a mechanical lift and 2 person assist. The MDS noted the residents' cognitive skills for daily decision making were moderately impaired. On 9/8/2025 at 9:43 a.m., Resident #116 was observed sitting in a high back wheelchair (w/c) at a table in the center of the unit eating her meal. She was noted to have no braces or splints on her arms/hands or legs. Review of the physician orders for September 2025 revealed a physician order for a Knee orthosis to address R knee flexion contracture to improve ROM, reduce incidence of skin breakdown, and facilitate increased performance during functional transfers. On 9/9/25 at 12:00 p.m., Resident #116 was seated in the center of the unit in a high back w/c with no brace or orthotic on the right knee. On 9/10/2025 at 11:12 a.m., Resident #116 was seated in her w/c in the center of the unit. No orthotic was noted on her right knee. On 9/10/2025 at 1:53 p.m., in an interview the Memory Care Unit Manager, was asked to demonstrate how the staff apply the right knee orthotic for Resident #116. He said she does not have one and does not have an order for one. He said he would check the electronic record to verify that there was not an order for a right knee orthosis. He returned and said, You're right, there is an order for the device to be applied, but I have never seen her with one. Let me check her room. The Unit Manager checked the resident's room and returned and said she had no brace and he would check into it. When asked who was responsible for checking that the physician orders were accurate and updated the Unit Manager said he did not know. (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/11/2025 at 9:19 a.m., in an interview the Director of Rehab said Resident #116 was receiving physical therapy (PT) services from 6/18/25 to 7/3/25 for positioning but there was no mention of a right knee brace. She said she was new to the facility but would print the residents' previous notes. Review of the PT progress note dated 8/3/23 revealed an evaluation for decline in function was completed. Diagnoses included Hemiplegia and hemiparesis, total right knee replacement, stiffness of right and left knee. The documentation showed the resident was discharged from PT on 10/31/23 with instructions Patient will wear a knee extender splint on right knee for up to 4 hours w/minimal s/s of redness, swelling, discomfort or pain in order to facilitate joint mobility and intact skin integrity, increase functional use of extremity and facilitate weight distribution during transfers. The Rehab Director said there was no plan to evaluate the resident. She said nursing would make referrals for residents to be screened or evaluated. Further review of the clinical record on 9/11/25 revealed the order for the right knee brace was still active and no referral to therapy was made. On 9/11/25 at 11:00 a.m., Resident #116 was seated in her w/c in the television area of the unit sleeping and she did not have a positioning device on her right knee. Review of the clinical record revealed Resident # 39 was [AGE] years old and had an admission date of 5/25/2019 and diagnosis including cerebral infarction (stroke), syncope (fainting) with collapse, vascular dementia, hemiplegia (paralysis) affecting the right dominant side. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] documented the resident was a substantial/maximum assistance for most activities of daily living (ADL). The MDS noted the residents' cognitive skills for daily decision making were intact. Review of Care Plan dated 2/29/24 revealed Resident #39 was at risk for an ADL self-care performance deficit related to impaired gait/balance, poor safety awareness and right sided hemiparesis. Interventions initiated 5/13/24 included right upper extremity resting hand splint. Review of Physician Order 8/6/24 Patient to wear right hand splint daily from 8:00 p.m. until morning, remove before breakfast. Inspect skin integrity following removal of splint daily. Review of Treatment Administration Records revealed no documentation for a right upper extremity resting hand splint for Resident #39. Physical Therapy Evaluation 7/9/25 said Resident #39 reports she had a splint for right hand however the staff does not assist with donning (putting on). On 9/9/25 at 2:00 p.m. in an interview with Staff E, RN verified Resident #39 had an active physician's order for a right resting hand splint. Staff E, RN said whoever entered the physician's order in the electronic medical record did not enter a schedule for the splint. Staff E, RN said the physician's order for the splint would not appear on the Treatment Administration Record. Staff E, RN said Resident #39 was not having the splint applied and could not answer when the last time it was applied.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff and resident interviews and review of facility policy and procedures, the facility failed to ensure medications were stored safely and securely for 1 (Resident #140) of 5 residents reviewed for medications. This failure had the potential for other residents to have access to medications that could potentially be harmful to them. The findings included: Based on observation, record review, staff and resident interviews and review of facility policy and procedures, the facility failed to ensure medications were stored safely and securely for 1(Resident #140) of 5 residents reviewed for medications. This failure had the potential for other residents to have access to medications that could potentially be harmful to them. The facility policy CM-11 Medication Storage documented Medications and biologicals are stored safely, securely, and properly, following manufacturers recommendations or those of the supplier. The medication supply is accessible only to nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Review of the clinical record revealed Resident #140 was an alert and oriented [AGE] year-old male with an admission date of 6/22/25. Diagnoses included acute and chronic respiratory failure, chronic obstructive pulmonary disease, and morbid obesity. On 9/8/2025 at 9:36 a.m., during an observation Resident #140 was noted to have a bottle of horse chestnut supplement, a tube of cortisone cream, a bottle of Afrin nasal spray and a bottle of Refresh eye drops in his room on the bedside table. The resident said his family and friends bring the items in for him and he uses them when he needs them. On 9/9/2025 at 1:38 p.m., in an interview Registered Nurse Unit Manager Staff C was notified of the medications at bedside. She confirmed the findings and replied, I know, I wrote orders for him to have them at bedside except for the horse Chestnut because the Registered Nurse Practitioner said she wanted to find out more information on its use first. He can have the medications, but they should be in a locked box. Right now, we do not have any, so I told him to just keep them in his top drawer. I assessed him and he was able to self-administer the medications. On 9/9/2025 at 2:41 p.m., in an interview Resident #140 said you got me in trouble, they came in yesterday after you left and they took my medications. He said he did not have the locked box, and the medications were put in the dresser drawer as instructed by the nurse.		