

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105966	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2026
NAME OF PROVIDER OR SUPPLIER Larsen Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 13880 Shell Point Plaza Fort Myers, FL 33908	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, facility policy review, resident and staff interviews, the facility failed to provide care and services in accordance with the resident's individualized care plan to minimize the risk of avoidable accidents for 1 (Resident #1) of 3 dependent residents reviewed for transfers. The findings included: Review of the facility Transfer of Resident Using Support Devices policy (last revised on 11/2017) noted The Therapy Department will screen residents and determine a level of assistance. This determination will be incorporated into the plan of care for the resident and communicated to the staff by the means of the care plan. Review of the facility Care Plan- Interdisciplinary Resident policy (last revised on 1/2025) noted A comprehensive care plan will be developed for each resident that include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. All personnel who provide care to the resident, including private duty, shall have access to and be knowledgeable of the resident's care plan. On 6/24/26 at 8:28 a.m., Resident #1 was observed in bed with a stabilizing boot to her right lower leg. In an interview, Resident #1 said that at times she has pain in her right foot, and that wearing the boot was very uncomfortable. Resident #1 said that she did not know how she sustained the injury to her foot, she just woke up one day and the boot was on. Review of the facility provided investigation related to Resident #1's right foot injury revealed that on 6/15/26, the resident was diagnosed with a right ankle fracture. Resident #1 first complained of pain to her ankle to Certified Nursing Assistant (CNA) Staff A on 6/11/26. CNA Staff A provided a statement that as she was transferring Resident #1 from her recliner back to her bed, the resident began to complain of her foot hurting. I heard her yelp my foot I gently sat her down onto the bed laid her down and took off her gripper socks to examine her foot for blood scratches or anything else to indicate that she was hurt. I did not see anything immediately, so I continued with changing her brief and changing her clothes. occasionally, she would say her right foot hurt and she needed it to be looked at. I left her room when I was done and looked over at the nurses station. to notify her of the situation. Review of Registered Nurse (RN) Staff B's statement revealed, Upon helping (resident) back to bed, resident complained that her right foot was hurting, (CNA Staff A) finished transferring the resident and then came to get me. Resident's foot/ankle had some swelling and was warm to touch. Unit Manager and ARNP (Advanced Registered Nurse Practitioner) notified. Review of the results of Resident #1's right ankle X-ray completed on 6/12/26 revealed, Impression: Nondisplaced posterior right calcaneus (heel bone) fracture. The facility investigation noted It is stated that the CNA was alone while transferring from the recliner to the bed. Review of Resident #1's medical record noted an admission date of 10/27/23. Diagnoses included Dementia (date diagnosed: 11/2/23), Muscle Weakness (date diagnosed: 10/30/23), Unspecified Lack of Coordination (date diagnosed: 11/2/23), Other Abnormalities of Gait and Mobility (date diagnosed: 11/2/23), Pain in Right Ankle and Joints of Right Foot (date diagnosed: 6/12/26) and Nondisplaced Fracture of Right Calcaneus Initial Encounter for Closed Fracture (date diagnosed: 6/12/26). Review of the Brief Interview for Mental Status completed on 6/16/26 revealed Resident #1 scored 08 of 15, indicating moderately impaired cognition. Review of Resident #1's orders with a start date of 2/16/26 noted ADL (Activities of Daily (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: 105966
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	two-person assist with transfers since she's been at the facility. On 6/24/26 at 1:38 p.m., in an interview, CNA Staff D said they can look up residents' transfer status in the electronic chart. CNA Staff D said Resident #1 has always been a two-person assist with transfers. On 6/24/26 at 2:14 p.m., in an interview, the Director of Nursing (DON) said when CNA Staff A transferred Resident #1, she had some discomfort to her ankle. When Resident #1 voiced a second time that her ankle was hurting, the CNA notified RN Staff B. The DON said that the provider was notified, an X-ray was ordered and they went from there. The DON confirmed that the therapy note from September 2025 documented that Resident #1 required the use of a full body mechanical lift for transfers, for her safety. The DON confirmed that they cannot change the use of a full body mechanical lift to a 2 person assist with transfers without therapy seeing them. She said that the manager and MDS (Minimum Data Set) coordinator can enter the therapy recommendations in the resident's medical record. She said she would have to look back to see if she ever got an order for a full body mechanical lift. She said that the report sheets given to the CNAs at the beginning of their shift include residents transfer status. She said she reviewed CNA Staff A's report sheet for that day, it noted that Resident #1 was a two-person assist with transfers. She said CNAs can also look up resident transfer status in the electronic medical record. She said from her knowledge, CNA Staff A was alone during the transfer. She said CNA Staff A should not have transferred the resident alone. She confirmed that Resident #1 had an order for a two-person assist with transfers and that the resident's care plan and MDS specified a two-person assist with transfers. She said her expectation is that staff follow the current orders. On 6/24/26 at 3:20 p.m., in an interview, the Nursing Home Administrator (NHA) said if there is an order for a two-person assist with transfers for a resident, that is how they should be transferred. The NHA said that the order should have reflected the change of transfer status to a full body mechanical lift as noted in the Physical Therapy note for Resident #1. On 6/24/26 at 3:51 p.m., in an interview, the DON said that she was not able to locate an order for the full body mechanical lift at this time.		