STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106020	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eagleridge Health and Rehabilitation Center	13881 Eagle Ridge Drive Fort Myers, FL 33912

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30599 Based on interview and record review the facility failed to ensure adequate supervision to prevent one resident (resident #1) of three residents sampled for falls to prevent multiple falls and major injuries to the resident, multiple falls, a fracture of to the right hip on 11/1/24 for which the resident was hospitalized for surgical intervention, and a fracture to the to the right humorous on 11/17/24. The findings included: Review of facility titled, Falls- Managing, Preventing and Documentation, revised 1/2024, which stated, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling . The staff will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) or with a history of falls .If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not have been previously identified. Resident #1 is an [AGE] year-old male who was admitted to the facility 10/15/24 with a history of Dementia, Post Traumatic Stress Seizures, Delerium, Dysphagia, Encephalopathy, Cirrhosis of the liver, and Stage III kidney disease. Clinical records for Resident #1 were reviewed. The Minimum Data Set (MDS) assessment completed on 10/28/24 documented in Section C Resident #1 had severe cognitive impairment with a brief interview for mental status (BIMS) score of 01. Section J Resident #1 had 2 or more falls since admission. Section GG documented that the resident is dependent on facility staff for ADL (activities of daily living) care including dressing, bathing and toileting needs. The Fall Risk Evaluation completed on 10/15/25, on admission, documented Resident #1 had a Lack of understanding of physical limitations, lack of understanding of cognitive limitations, history of multiple falls, needs assistance with toileting and taking two of the medications identified to increase risk of falls. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106020	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eagleridge Health and Rehabilitation Center	13881 Eagle Ridge Drive Fort Myers, FL 33912

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 - Actual harm Residents Affected - Few	Resident #1 had a care plan for falls initiated on 10/16/24. The care plan stated the resident is at risk for falls related to cognitive deficit, history of falls, and unsteady gait/ poor balance. The interventions listed on the care plan initiated on 10/16/24 included: Encourage and remind resident to use call bell and to wait for staff assistance with transfers, ambulation, toileting, etc. as indicated. Encourage and assist the resident to wear appropriate FOOTWEAR such as rubber-soled shoes, non-slip bedroom slippers, non-skid socks, etc. when ambulating, transferring, or mobilizing in w/c. The care plan was revised on 10/17/24 to add intervention frequent rounding during sleep hours. Resident #1 had 5 documented falls in the facility including 10/15/24, 10/16/24, 10/21/24, 11/1/24, and 11/17/24. Progress note dated 10/15/24 at 3:23 p.m. stated, Caregiver alerted nurse that resident was on the floor in room. Upon arriving to resident's room, nurse observed room door to be open, light in the room, and in front of closet, resident was laying face down on the floor with his head turned to the side . Resident is confused and unable to explain how he ended up on the floor . Resident educated on call light and his safety. On 10/15/24 at 9:49 p.m. the nurse charted for behavior charting, Resident restless, attempting to stand in the dining room, attempting to climb out of his bed, very impulsive and non-cooperative .resident redirected with no success, resident has to be one on one with staff in order to remain where seated or remain in bed for constant reminders to not climb out of bed or chair. On 10/16/24 at 10:00 p.m. the nurse documented resident #1 was found on the floor and became aggressive with staff when attempting to assess the resident. Resident #1 was administered Haldol 5 mg intramuscularly (an antipsychotic medication). A progress note dated 10/17/24 documented The IDT (Interdisciplinary team) met at 9:24 a.m. to discuss the resident's fall on 10/16/24. The progress note reads, Resident noted to be floor next to bed with mattress on top of him, resident was only wearing his brief. Resident was unable to provide details regarding how he ended up on the floor, resident was yelling profanities and threats . The Team determined the root cause analysis of the fall was secondary to the resident's onset of psychotic state. On 10/21/24 at 8:08 a.m., the Advanced Nurse Practitioner documented a progress note which read, Patient seen and examined today for follow-up visit. He had a fall while I was at the facility, he was found in the floor, apparently he didn't hit the head, upon my assessment a skin tear was noted to his Rt elbow, wound care provided, VS taken under baseline. He was alert to name only . Education provided w/ [with] verbalized understanding about call for help to avoid any fall. On 11/1/24 a post fall investigation found Resident #1 had been found on the floor by staff at approximately 5:30 a.m. The resident was described as confused and unable to respond. At around 7:00 a.m. Resident #1 was complaining of pain in his right hip. An x-ray obtained by the facility showed Resident #1 had a right hip fracture. A witness statement obtained on 11/1/24 by the certified nursing assistant, Staff A, documented she was doing frequent rounds on Resident #1 on the morning of 11/2/24. The Statement documents she assisted the resident to his bed at 3:00 a.m. and at 5:00 a.m. she found Resident #1 on the floor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106020	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eagleridge Health and Rehabilitation Center	13881 Eagle Ridge Drive Fort Myers, FL 33912

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 - Actual harm Residents Affected - Few	After Resident #1 had surgical intervention to repair his right hip and was readmitted to the facility another progress note documents Resident #1 had another fall on 11/17/24. On 11/20/24 at 9:10 a.m. the Advanced Nurse Practitioner documented, .he had another fall on 11/17 no apparent injury during this fall were reported by staff but today he is screaming in pain to his Rt Shoulder upon my exam, he can barely move the extremity, pt keep holding the arm, x-ray STAT was ordered. The shoulder x-ray obtained on 11/20/24 showed Resident #1 had an, Acute .overlapping fracture of the proximal right humerus predominantly involving the humeral neck. On 1/30/25 at 2:25 p.m., in an interview by phone Staff A said on 11/1/24 at 3:00 a.m. she put Resident #1 in his bed, and she did not see the resident again until 5:00 a.m. when she found the resident on the floor. Staff A was asked to define frequent rounds. She said frequent rounds would be every 15 minutes. On 1/30/25 2:45 p.m., The Director of Nursing (DON) said she had not been at the facility at the time of resident #1's falls. The DON could not show from the facilities documentation how staff were providing appropriate supervision to prevent Resident #1 from falling multiple times. The DON verified nursing staff currently did not have an adequate definition of frequent rounds.