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	04/02/2026

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interview, the facility failed to ensure that the full amount of funds owed to a resident upon discharge were refunded within 30 days of discharge for 1, Resident #3 of 3 residents reviewed for refund of funds due.The findings included:Review of facility policy dated March 10, 2023, revised January 29, 2024, revealed, In the event a credit balance has resulted on a resident private account. This balance will be refunded based on the following:Resident account is clear except for the said credit. (Insurance, Medicaid, and/or Third Party Payers are paid and show no deducible or copays) as prescribed by the appropriate State regulations for Killed Nursing Facilities as directed by state Medicaid and Federal programs. Refund will be issued by check within 30 days of confirmation of the above items.Review of facility records revealed that Resident #3 was discharged on 6/9/2025. At the time of discharge the resident had a balance due to Resident #3 in the amount of $7,582.31 from prepaid charges.On 3/31/26 at 1:00 p.m., in an interview, the Business Office Manager (BOM) confirmed that on 5/9/2025, Resident #3 had prepaid the facility $11,067.31. She confirmed that after co-pays were paid, the total amount due back to Resident #3 upon discharge for over payment was $7,582.31. The BOM said that the turnaround time for a refund to be issued from the facility is about 30-60 days.On 3/31/26 at 2:28p.m., the BOM provided documentation that a refund check for $4,011.31 was sent to Resident #3 on 7/14/25. On 10/22/25, a second refund check for $1,112.00 was sent to Resident #3. The BOM said that as of today, 3/31/26, the facility still owed a refund of $2,459.00.

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

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F 0627 Level of Harm - Actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews, the facility failed to provide a safe and appropriate discharge for 2 (Residents #1and #2) of 3 residents reviewed for transfer and/or discharges. The facility failed to confirm Resident #1's transportation, causing the resident to leave the facility in her wheelchair after waiting over two hours and attempt to wheel herself to her discharge location which is located 10 miles from the facility.The findings included:Review of the facility Transfer and Discharges policy (last revised 2/2024) revealed, The facility will develop and implement an effective discharge process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care . A resident, and/or his or her representative (sponsor), will be given thirty (30)- day advanced notice of an impending transfer or discharge from our facility when feasible. The policy specified the notice will be given as soon as it is practicable but before the transfer or discharge under the following circumstances, The transfer is necessary for the resident's welfare and the residents needs cannot be met in the facility; The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; The safety of individuals in the facility is endangered; The health of individuals in the facility would otherwise be endangered; The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility; An immediate transfer or discharge is required by the resident's urgent medical needs; The resident has not resided in the facility for thirty (30)days; and/or the facility ceases to operate. The reason for the transfer or discharges will be documented in the resident's medical record.1. Record review for Resident #1 revealed an admission date of 3/6/26, and a discharge date of 3/24/26. Diagnoses included Pulmonary Embolism with Acute Cor Pulmonale (a life-threatening condition where a large clot blocks the lungs arteries), Acute Respiratory Failure, Type-2 Diabetes, presence of a Cardiac Pacemaker, Anxiety Disorder, Depression, Unspecified Affective Mood Disorder (significant impairing emotional symptoms that cause distress) and Parkinson's Disease without Dyskinesia (involuntary movements).The Brief Interview for Mental Status (BIMS) dated 3/9/26 revealed Resident #1 scored 15 of 15 on the BIMS, indicating intact cognition.The Discharge summary dated [DATE] at 11:00 a.m., revealed Resident #1 was given a copy of the discharge summary and after discharge instructions.Review of the progress notes revealed that on 3/24/26 at 4:52 p.m., the Social Service Director documented she contacted the resident's insurance and arranged transportation through an outside transport company to take Resident #1 to her place of residence, an Assisted Living Facility (ALF). The note specified the transportation was arranged for today at 4:50 pm.The clinical record lacked documentation of the date and time Resident #1 was picked up by the transport company.On 3/31/16 at 1:23 p.m., an interview was held with the Nursing Home Administrator (NHA), the Assistant Director of Nursing (ADON) and the Social Services Director (SSD).The SSD said when a resident is discharged , We usually walk them to the door and help them with all their personal belongings. She said the nurse usually documents when the resident is discharged from the facility. She said that on 3/24/26, she notified the ALF that transportation was arranged for Resident #1. On 3/24/26, she left work a little after 5:00 p.m. Resident #1 was in the activities room.The ADON said that when he left the faciity on 3/24/26 around 5:45 p.m., Resident #1 was at the nurse's station asking about her ride. He told Resident #1 that the ALF was coming to pick her up, her ride was coming. He said 30 minutes later, Registered Nurse (RN) Staff A notified him via a text message that Resident #1 was anxious and wanted to leave. A few minutes later, he received another text message from RN Staff A telling him that Resident #1 had left.The NHA said that from what she knew, on 3/24/26, Resident #1 was sitting in the lobby. She did not want to wait for her transportation, so she left. The nurses thought the resident had left the facility with her ride. The Director of Nursing then (continued on next page)

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F 0627 Level of Harm - Actual harm Residents Affected - Few	informed her that EMS (Emergency Medical Services) called to say they were with Resident #1. The resident refused to go back to the facility and was sent to the hospital.Review of the physician's progress note from the Emergency Department (ER) dated 3/24/26 at 9:02 p.m. revealed that the resident was being discharged to her ALF. Patient states she was waiting all day. Patient states she got sick of waiting and left. Patient was found on the side of the street in her wheelchair. EMS was called and patient was brought to the ER for further evaluation .On 3/31/26 at 11:31 a.m., in a telephone interview, the ALF Administrator at Resident #1's place of residence said that on 3/24/26 at approximately 7:00 p.m., the ALF staff notified her that the nursing home staff had called to say the ALF had not picked up Resident #1. She sent a text message to the NHA who replied that Resident #1 had left half an hour ago. The ALF Administrator said she then received a phone call from the hospital's case manager, informing her that someone had found Resident #1 on the side of the road and EMS brought the resident to the hospital ER. She said Resident #1 arrived at the ALF via ambulance that night around midnight.On 3/31/26 at 3:40 p.m., Resident #1 was interviewed at the ALF where she resided. She said the nursing home discharged her on 3/24/26 at 11:00 a.m. Staff removed her from her room around 3:00 p.m. and put her in the activities room. The staff kept telling her that transportation was on their way. Resident #1 said, Then the big wigs left and the night nurses did not know what to do with her. She said she finally left the facility between 7:00 p.m., to 8:00 p.m. She said she just pushed on the door and left; no one even knew she had left. When she got to the end of the driveway, she did not know the way to get to her ALF, so she took a left. She said a woman and a man stopped to help her and called 911. Resident #1 said that she was self-propelling her wheelchair in the road, going left and right, trying to find a major road. She felt abandoned, scared, afraid and alone. She did not have her phone, hearing aids or dentures. She couldn't even call her daughter. Resident #1 started to cry during the interview. She said it was eye opening to be alone and scared. On 4/1/26 at 10:12 a.m., in an interview, the NHA said that discharged residents waiting for transportation after business hours can wait in their room, the activities room or anywhere in the building until transport gets there. The NHA said that after hours, it was the nurses responsibility to make sure discharged residents get in their transportation. The NHA said no one saw Resident #1 get in her ride, but it was assumed she did.On 4/1/26 at 10:22 a.m., in a telephone interview, a representative of the transport company said that the transportation was scheduled at 4:49 p.m., for a pick-up time of 4:50 p.m. The request for transport was cancelled on 3/24/26 at 5:14 p.m., since they require 2-day notice for transportation and 3 to 4 hours' notice for medical transportation.On 4/1/26 at 12:13 p.m., in a telephone interview, the psychiatric Advanced Practice Registered Nurse (APRN) said that Resident #1 was alert enough to decide to leave on her own and made a poor decision.On 4/1/26 at 2:20 p.m., in a telephone interview, Registered Nurse (RN) Staff A said when she arrived at work on 3/24/26 at 3:00 p.m., Resident #1 was in the dining room. The resident told her she had been waiting for transportation since 12:00 p.m. Sometime later (no time), the Social Worker at the hospital called to notify them that Resident #1 was at the hospital. RN Staff A said it was unusual for residents to wait alone in the lobby for transportation. She said the nursing staff were responsible to make sure discharge residents get in the transportation vehicle.On 4/1/26 at 3:47 p.m., in an interview, Licensed Practical Nurse (LPN) Staff C said she primarily works the 3:00 p.m. to 11:00 p.m. shift. She said residents waiting for transport or discharge can wait in their rooms or by the nurses station. LPN Staff C said if a resident's ride does not show up, they notify the on-call staff, or the Director of Nursing.On 4/1/26 at 3:57 p.m., in an interview, LPN Staff B said she primarily works the 3:00 p.m. to 11:00 p.m. shift. She said that discharged residents waiting for transportation can wait by the nurses station. She said if the transportation does not show up, they must call to find out what happened.2. Review of the clinical record for Resident #2 revealed an admission date of 5/7/2020 and a discharge date of 3/2/26. Diagnoses included Intervertebral Disc Degeneration (condition where spinal discs lose structural integrity, water content and elasticity), Type-2 Diabetes, Insomnia due to other Mental Disorder and Depressive Episodes.Review of the Brief Interview for Mental Status (continued on next page)

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F 0627 Level of Harm - Actual harm Residents Affected - Few	(BIMS) dated 11/25/25 revealed Resident #2 scored 15 of 15, indicating intact cognition.A Psychology Progress Note dated 2/27/26 noted current diagnoses of Insomnia, other specified depressive episodes and Adjustment Disorder with mixed anxiety and depressed mood. The note stated, There has been a minor complication. (Resident #2) is unstable and is having episodes of agitation. Due to situational concerns of being transferred to a new nursing home next week.Review of the Discharge summary dated [DATE] revealed Resident #2's status during stay at the nursing home was Long Term Care. The summary noted that the resident was being discharged to a nursing home located in another county.Review of the physician's orders revealed a discharge order dated 3/2/26 at 4:51 p.m. The order did not include a reason for transfer, level of care or assistance needed.The Nursing Home Transfer and Discharge Notice form noted the date the notice was given to Resident #2 was 3/2/26 with an effective date of 3/2/26. The Reason for Discharge or Transfer was Your health has improved sufficiently so that you no longer need the services provided by this facility. The form noted, Resident refused to sign. The form was signed by the Social Services Assistant.On 4/2/26 at 9:20 a.m., in a telephone interview, Resident #2 said he was given 3 options of places to go. He said he was told that he would be evicted if he didn't choose a place. Resident #2 said the facility told him that they needed to free up his room since it was being converted to a different type of care. Resident #2 said he chose a nursing home in [NAME], Florida but was transported to a nursing home in Sarasota, Florida. Resident #2 said 2 days later he ended up in the hospital due to medical complications. The new nursing home would not take him back when he was discharged from the hospital. Resident #2 said he had to pay $275.00 for a ride company to take him back to Fort [NAME] and was currently living in hotels because he had no home.On 4/2/26 at 10:47 a.m., an interview was held with the Nursing Home Administrator, the Social Services Assistant and the Assistant Director of Nursing.The Social Services Assistant said Resident #2 chose to go to the nursing home in Sarasota. She said if a resident refuses to sign the form and wants to stay, they can stay. The Social Services Assistant said Resident #2 was not given a 30-day notice of transfer but was given a 3-week verbal notice of transfer. She confirmed there was no documentation that the resident received a verbal notice of transfer. She also confirmed that on 3/2/26, Resident #2 refused to sign the transfer form and was unsure as to why he was transferred.The NHA said they give residents a 72-hour notice if they cannot provide the skills or services to meet the resident's maximum potential. The NHA said Resident #2 was transferred because they are transitioning to more short-term beds. She said, We asked if they have any community ties and if they are ok with going. The NHA said the forms were not filled out correctly and there was no documentation to prove Resident #2 was ok with transferring facilities. The NHA confirmed that Resident #2 ended up at a facility in Sarasota, Florida.The ADON said there was no medical reason for Resident #2 to be transferred, he was not a danger to himself or others. He said Resident #2 still needed to be in a long-term care facility. The nursing home in Sarasota did not provide any additional care that their facility could not provide.