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	04/23/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility's policies and procedures, resident and staff interviews, the facility failed to protect the resident's right to be free from neglect for 1(Resident #1) of 3 residents reviewed.The facility failure to prevent the neglect of Resident #1 created a likelihood of serious harm or death of the resident from exposure to excessive heat which can cause heat related illness, including heat exhaustion and heat stroke and resulted in the determination of Immediate Jeopardy (IJ).On 4/23/26, after verification of an acceptable Immediate Jeopardy removal plan, the Immediate Jeopardy was removed, effective 4/16/26.The findings of Immediate Jeopardy were determined to be corrected on 4/21/26.The findings included:Review of the facility's policy and procedure titled, Abuse, Neglect, Exploitation, Misappropriation, Mistreatment, and Injury of Uknown Origin (ANEMMI) with a revision date of 03/2025 revealed, The resident has the right to be free from . neglect . Neglect. means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress .Review of the facility's policy and procedure titled, Facility Transportation with a revision date of 04/2026 revealed, Purpose: To ensure all residents are transported safely . Residents shall always remain under the continuous supervision of facility staff during transport, including while the vehicle is stationary, parked, or awaiting appointments. Under no circumstances shall a resident be left unattended in a vehicle . Drivers are strictly prohibited from leaving the vehicle unattended while residents are onboard . Drivers are responsible for maintaining visual and physical accountability of all residents during all phases of transport, including loading, transport, waiting periods, and unloading at destinations.Review of the clinical record for Resident #1 revealed an admission date of 3/3/26. Diagnoses included Surgical Aftercare Following Surgery On The Digestive System, Chronic Kidney Disease (progressive loss of kidney function) and Adjustment Disorder With Mixed Anxiety and Depressed Mood.Review of the Brief Interview for Mental Status (BIMS), screening tool used to evaluate a person's memory and orientation dated 3/4/26 revealed Resident #1 scored 13 of 15, indicating intact cognition.Review of the Care Plan initiated on 3/5/26 revealed that Resident #1 was at risk for fluid imbalance, related to the use of diuretic (medication that help eliminate excess water and sodium through urine) use, colostomy (opening in the abdominal wall to divert waste). The goal was for Resident #1 to be free from symptoms of dehydration.The care plan documented that Resident #1's participation with Activities of Daily Living varied due to fatigue, and chronic medical conditions. Resident #1 required maximum assistance of 1 for transfer.Review of a late entry nursing progress notes dated 4/17/26 at 8:40 a.m. revealed that while being transported to the hospital for evaluation for fistula (abnormal connection between two body parts) following her follow up appointment, the resident was left temporarily unattended and called 911. Resident had no signs of distress and was evaluated out of an abundance of caution.Review of the facility provided investigation revealed that on 4/16/26 at 11:15 a.m., a police officer contacted the facility Administrator and notified her that Resident #1 had called 911 stating that she was in the facility's transportation bus in a parking lot waiting for the driver who was in the Dentist office.Review of a (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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	redacted police report dated 4/16/26 revealed that at approximately 10:51a.m., officers were dispatched to assist an elderly female advising that she was locked in a bus and that it was getting warm inside. Upon arrival at approximately 11:03 a.m., officers met with the Fire Department who were attempting to remove an elderly female identified as (Resident #1) from a shuttle bus. The bus was not running and only had the driver door window down and the front passenger door ajar a couple inches. The officers noted that (Resident #1) was visibly sweating. The Fire Department removed Resident #1 from the van and stated that she was only dehydrated and did not appear to be in any further distress at that time.The police report noted that the officers were simultaneously looking for the driver of the shuttle bus who showed up on scene at approximately 11:30 a.m. The driver informed officers at first that he was at the dentist because he had an emergency and he only thought it would take between five and ten minutes.The police report noted that the temperature was approximately 83 degrees Fahrenheit outside and felt much warmer inside of the shuttle bus. The shuttle bus was not parked in a shaded area.The police report documented an offense code of Crimes against person-Neglect Elderly Disabled Adult WO (without) Great Harm.Review of the CDC Heat Health dated June 25, 2024, noted that Even in cool temperatures, cars can heat up to dangerous temperatures very quickly. Leaving a window open is not enough- temperatures inside the car can rise almost 20 degrees Fahrenheit within the first 10 minutes, even with a window cracked open. People age [AGE] or older are more prone to heat-related health problems. Older adults do not adjust as well as young people to sudden changes in temperature. They are more likely to have a chronic medical condition that changes normal body responses to heat. They are more likely to take prescription medicines that affect the body's ability to control its temperature or sweat.https://www.cdc.gov/heat-health/risk-factors/heat-and-older-adults-aged-65.html?CDC_AA_refVal=https of the Emergency Department Physician Progress note dated 4/16/26 revealed that the patient (Resident #1) was a [AGE] year-old female. She was seen by urology today and was told she needed to go to the ER (Emergency Room), she had abnormal labs. Patient was left in the van by driver. Patient reports she feels weak.On 4/22/26 at 10:22 a.m., in a telephone interview, an employee of the dentist's office where CNA Staff A attended an appointment on 4/16/26 said that CNA Staff A checked in at 10:21 a.m. for a routine appointment and checked out at 11:10 a.m.On 4/22/26 at 10:30 a.m., in a telephone interview CNA Staff A verified that on 4/16/26, he left Resident #1 unattended and strapped in a wheelchair in the back of the facility's transport van. He said, I was bleeding in my mouth. I had an appointment so I stopped off. I made a little mistake. The window was a little open. CNA Staff A said that he had already talked to the police and the Nursing Home Administrator and declined to continue the interview.Review of CNA Staff A's employee file revealed on 7/10/24, he signed a Certified Nursing Assistant (CNA)-Driver job description which included, Requirements/Qualifications for CNA-Driver position: . Must be knowledgeable of resident rights and ensures an atmosphere which allows for the privacy, dignity and well-being of all residents in a safe, secure environment.Review of the facility Fleet Management Manual manual revealed, Never leave a resident unattended. If assistance is required, then call a staff member to request assistance while remaining with the resident . Facility owned vehicles are to be used ONLY for facility business and activities .On 7/10/24, CNA Staff A signed the Fleet Safety Acknowledgement Form, acknowledging that he had received and read a copy of the Facility Fleet Management Program and agreed to comply with the policies and procedures contained in the program.On 4/22/26 at 11:59 a.m., in a telephone interview, Resident #1's son said his mother was a cancer patient, had many health concerns and remained hospitalized . On 4/16/26, she got directed to the ER from the urologist. She has a nephrostomy tube (a flexible tube inserted through the back into the kidney to drain urine into an external bag) and they were worried there was a fistula. She needed to go to the ER. His mother said that the van was not running, the windows were up and she could not get out. After some time, she started to get hot and worried. She remembered that she had her phone and she called 911. His mother said it felt like she was left in the van for an hour. Resident #1's son said that his mother was (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a strong lady, very strong. She got to the part about her not knowing what to do, she said she was stuck. She broke down and started crying while telling him the story. He could hear the fear in her voice. She said the unbelievability of how she could not get out of that situation.On 4/22/26 at 12:57 p.m., in an interview, the NHA said that on 4/16/26 she talked to CNA Staff A very briefly. He said that he was stupid and he should not have done it. He said that his gums were bleeding. She told him that he should not have done that (leave the resident in the van) and he said he knew.On 4/23/26 at 11:40 a.m., an interview was held with the Nursing Home Administrator (NHA), Assistant Director of Nursing (ADON) and the Director of Rehab (DOR).The ADON said Resident #1 was in a wheelchair and to his knowledge was not able to walk. He said that the van was equipped with an electric lift. They wheel the resident in the wheelchair into the van. Once the resident is in the van, they must secure them with a belt. He said that he had never seen Resident #1 ambulate and had only seen her in a wheelchair. The DOR said that Resident #1 could not walk. She would not have been able to get out of the wheelchair in the van.The NHA said Resident #1 was out of the van she got there. They said the Fire Department got her out but did not go into specifics. They said they had to force the door open. She said, I'm assuming they had to carry the wheelchair out. She had a lot of tubes coming out of her as well with the nephrostomy.On 4/24/26 at 10:01 a.m., in a telephone interview, Resident #1said, I hate to even think about it but here we go. She said that CNA Staff A took her to the doctor's office but she never got to see the doctor. The medical assistant said that she needed to go to the ER as soon as possible because the lab report saw something suspicious. From there, she thought that CNA Staff A was taking her to the ER but he turned into a shopping center. When she said that it didn't look like the ER, CNA Staff A said, Oh no, we are going there later. He then left her in the van. All the doors and windows were shut, it was hot and she was in the back of the van all by herself. Resident #1 said, It was so hot. Thank God I had my cell phone. I called 911. The Fire Department came within like 5 minutes. One of the big strong, nice firemen could not get the doors open. The doors were electric and we had no keys. They were getting desperate to get me out of there. She said the Fireman got the front door of the van open, picked her up and carried her out the driver's door. She said the Firemen took a good look at her and could not believe that the driver did that to her. Resident #1 appeared to be crying during the interview and said, If I had not been rescued, I would be dead right now.On 4/23/26, the immediate actions implemented by the facility and verified by the survey team included:On 4/16/26, the NHA immediately went to assist the resident.On 4/23/26, the survey team verified through interview with the NHA. She confirmed that on 4/16/26 at 11:15 a.m. immediately went to assist Resident #1 when the police officer called her.On 4/16/26, the NHA scheduled transportation for Resident #1 to go to the hospital.On 4/23/26, the survey team verified through interview with the NHA that on 4/16/26, she arranged transportation through a third party company and accompanied Resident #1 to the hospital.On 4/16/26, the NHA suspended CNA Staff A immediately pending investigation.On 4/23/26, the survey team verified through review of the suspension documents and interview with the NHA that on 4/16/26, CNA Staff A was immediately suspended. The NHA said CNA Staff A resigned later that day and provided CNA Staff A's resignation letter.On 4/16/26, the NHA immediately suspended all facility transports and rescheduled current and future transports with a 3rd party vendor to provide all facility transportation moving forward until a complete and thorough investigation can be completed.On 4/23/26, the survey team verified through review of the memo of suspension of transport, review of the rescheduling of transport and interview with the NHA that all facility transportation were immediately suspended and rescheduled with a 3rd party vendor. The NHA said that they had not restarted using their facility transportation at this time.On 4/16/26, the NHA rode with the transportation and Resident #1 to the hospital.On 4/23/26, the survey team verified through interview with the NHA who confirmed that on 4/16/26, she rode with Resident #1 to the ER and stayed with her.On 4/16/26, the facility staff scheduled 3rd party transportation for all residents currently scheduled with facility transportation.On 4/23/26, the survey team verified through review of orders to reschedule transportation through a third party vender for 6 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	residents.On 4/16/26, the NHA verified driver's Fleet Education and completion of training.On 4/23/26, the survey team verified through review of CNA Staff A's Fleet education training and interview with the NHA who confirmed she verified completion of CNA Staff A's education.On 4/16/26, the NHA verified drivers CNA certification, clearinghouse and background were completed and in good standing.On 4/23/26, the survey team verified through record review and interview with the NHA that CNA Staff A's background screening and CNA certification were complete and in good standing.On 4/16/26 at 3:00 p.m., the NHA started education with onsite staff (dietary, nursing, therapy, office staff, management) and contracted employees (laundry, housekeeping) regarding Keeping our Residents Safe- Transportation, Protecting from heat exposure, and Abuse/Neglect Training. All educations included a staff competency that had to be completed with a passing grade or they had to redo the education. No facility staff member/contracted employee was allowed to work without education. On 4/23/26, the survey team verified through review of the education provided and staff competencies and interviews with 6 staff members who verified completion of the education and competency. On 4/16/26, an Ad-Hoc (unplanned) Meeting was completed which included Temporarily suspending all facility transports, Education for Transporting residents, not leaving them alone, Protecting against Heat exposure, reviewed facility assessment. Removed van from facility. Staff included: (Administration, Dietary, Activities, Nursing, management, office, housekeeping, laundry, therapy) Staff must be educated prior to working. Updating the Fleet Safety Manual with additional safety acknowledgement page, Transportation policy with additional resident safety items for what to do in an emergency and never leaving a resident alone and adding driver checks in's so it doesn't happen again. Targeted Abuse/Neglect training leaving a resident alone and secured in van not running when it was 83 degrees on & not protecting residents. Reviewed and updated the facility assessment with above items.On 4/23/26, a copy of the Ad-Hoc sign in sheet was provided and verified.On 4/17/26, an Ad-Hoc Meeting was completed which included Continued review of effectiveness of education, Approved Updated Facility Assessment with training and education and competency's, POC (Plan of Correction) and continue suspension of Facility Transports, Education added to new hire orientation, Approve facility plan of correction. On 4/23/26, a copy of the Ad-Hoc sign in sheet was provided and verified.On 4/16/26, the facility interviewed other residents recently transported for potential other issues or concerns. No other residents had an issue with their transports and completed the driver for his kindness.On 4/23/26, the survey team verified through review of facility provided residents' interviews and interview with the NHA.On 4/16/26, the facility Updating the Fleet Safety Manual with additional safety acknowledgement page. Addition includes never leaving the resident alone and remaining with resident at all times. What to do in emergency and calling 911. Includes employee signature page as attestation that they will follow rules and keep the residents safe.On 4/23/26, the survey team verified through review of the updates to the Fleet Safety Manual and acknowledgment page and interview with the NHA. The NHA confirmed that transport was currently stopped.On 4/17/26, the facility transport communication education on Driver must call when Leaving appointments now. The facility transportation policy was updated. On 4/23/26, copies were provided and verified to include calling 911 in the event of an emergency, notify the facility and facility administrator and remain with the resident until appropriate authorities or assistance arrives. The facility also added that the driver will call and notify the facility prior to leaving the pickup location and the estimated time of return. If the drive does not return by the estimated time, the NHA will be notified.On 4/23/26, copies of the forms were provided and verified by the survey team.On 4/16/26, the Facility Bus was removed from property so that it cannot be used and NHA with all keys.On 4/23/26, the NHA provided a written statement that the Facility Bus was removed from property and she has the keys.Ongoing audits to monitor completion of education completed on 4/18/26, 4/19/26, 4/20/26 and 4/21/26.On 4/23/26, the survey team verified through review of the audits of staff education provided.On 4/16/26, 4/17/26, and 4/21/26, the Facility Assessment was reviewed by the IDT (Interdisciplinary Team) and the Medical Director. Updates or changes included: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Updated Fleet Safety Manual; Updated Transportation Policy; All education added to New Hire Orientation; All education must be at the start of the shift, prior to starting, regarding not leaving residents alone in Van, reviewed and updated Transportation Policy, and Transport Communication.On 4/23/26, the survey team verified through NHA interview and review of the facility assessment, the updates or changes to the Fleet Safety Manual, Transportation Policy, and education included in New Hire Orientation.