Florida Agency for Health Care Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130471099 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 04/02/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| EAGLERIDGE HEALTH AND REHABILITATION CENTER | 13881 EAGLE RIDGE DRIVE , FORT MYERS, Florida, 33912 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| N0000 | INITIAL COMMENTS<br><br>An unannounced complaint survey for complaint numbers 2026000016, 2026003444, 2026003722, 2026004116 and 2026004846 was conducted through at Eagleridge Health and Rehabilitation Center, a nursing home in Fort Myers, Florida.<br><br>Deficiencies were identified at the time of the survey. | N0000 | | |
| N0505 SS = D | 30- Day Notice Required<br><br>CFR(s): 400.0255(7), FS<br><br>(7) At least 30 days prior to any proposed transfer or discharge, a facility must provide advance notice of the proposed transfer or discharge to the resident and, if known, to a family member or the resident's legal guardian or representative, except, in the following circumstances, the facility shall give notice as soon as practicable before the transfer or discharge:<br><br>(a) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility, and the circumstances are documented in the resident's medical records by the resident's physician; or<br><br>(b) The health or safety of other residents or facility employees would be endangered, and the circumstances are documented in the resident's medical records by the resident's physician or the medical director if the resident's physician is not available.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review, resident and staff interviews, the facility failed to ensure 1 (Resident #2) of 3 discharged residents reviewed received advanced notice of at least 30 days of the proposed non-emergency transfer.<br><br>The findings included:<br><br>Review of the clinical record for Resident #2 revealed an admission date of and a | N0505 | Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required.<br><br>N0505 30- Day Notice Required<br><br>(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br><br>On , Resident #2 was discharged from the facility.<br><br>(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.<br><br>On , NHA/Designee completed a quality review of residents discharged in the previous 30 days to ensure residents/responsible parties that refuse to sign the Nursing Home Transfer Discharge Notice for non-emergent situations are provided a full 30 day notice with an appropriate reason. Any concerns noted were immediately corrected.<br><br>(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur. | |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| N0505 SS = D | Continued from page 1<br>discharge date of . Diagnoses included Disc (condition where , discs lose structural integrity, water content and elasticity), Type-2 , due to other Mental and , Episodes.<br><br>Review of the ( ) dated revealed Resident #2 scored "15", indicating intact cognition.<br><br>A , , Progress Note dated noted current diagnoses of , other specified , episodes and Adjustment with mixed , and depressed . 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".<br><br>Review of the discharge summary dated 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.<br><br>Review of the physician's orders revealed a discharge order dated at 4:51 p.m. The order did not include a reason for transfer, level of care or assistance needed.<br><br>The "Nursing Home Transfer and Discharge Notice" form noted the date the notice was given to Resident #2 was with an effective date of . 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.<br><br>On 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 Venice, 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 when he was discharged from the hospital. Resident #2 said he had to pay $275.00 for a ride company to take him to Fort Myers and was currently living in hotels because he had no home. | N0505 | Continued from page 1<br>By , The NHA/Designee completed education with current social services staff and IDT team members on ensuring residents/responsible parties that refuse to sign the Nursing Home Transfer Discharge Notice for non-emergent situations are provided a full 30 day notice with an appropriate reason.<br><br>Newly hired Social Services staff and IDT team members will be educated on ensuring residents/responsible parties that refuse to sign the Nursing Home Transfer Discharge Notice for non-emergent situations are provided a full 30 day notice with appropriate reason, by the NHA/designee at orientation as a part of the systematic changes.<br><br>(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place:<br><br>The DON/Designee will audit 5 random non-emergent discharged residents to ensure residents/responsible parties that refuse to sign the Nursing Home Transfer Discharge Notice are provided a full 30 day notice with an appropriate reason, weekly x4 weeks and monthly x 2 months.<br><br>The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been met. | |

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| N0505 SS = D | Continued from page 2<br><br>On at 10:47 a.m., an interview was held with the Nursing Home Administrator (NHA), the Social Services Assistant and the Assistant Director of Nursing (ADON).<br><br>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 , Resident #2 refused to sign the transfer form and was unsure as to why he was transferred.<br><br>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.<br><br>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.<br><br>Class III | N0505 | | |

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| F0000 | INITIAL COMMENTS<br><br>An unannounced complaint survey for complaint numbers 2026000016, 2026003444, 2026003722, 20260004116 and 20260004846 was conducted through at Eagleridge Health and Rehabilitation Center, a nursing home in Fort Myers, Florida.<br><br>Eagleridge Health and Rehabilitation Center was not in compliance with Code of Federal Regulations (CFR) 42, Part 483, Requirements for Long-Term Care Facilities.<br><br>The following is a description of the noncompliance. | F0000 | | |
| F0627 SS = G | Inappropriate Discharge<br><br>CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2)<br><br>§483.15(c) Transfer and discharge-<br><br>§483.15(c)(1) Facility requirements-<br><br>§483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-<br><br>(A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;<br><br>(B)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;<br><br>(C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;<br><br>(D)The health of individuals in the facility would otherwise be endangered;<br><br>(E)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. Nonpayment applies if the resident does not submit | F0627 | Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required.<br><br>F627 Appropriate Discharge<br><br>(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br><br>On , Resident #1 was discharged from the facility.<br><br>On , Resident #2 was discharged from the facility.<br><br>(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.<br><br>On , NHA/Designee completed a quality review of residents discharged in the previous 30 days to ensure appropriate transportation was | |

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 reverse for further 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.

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| F0627<br>SS = G | Continued from page 1<br>the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or<br><br>(F)The facility ceases to operate.<br><br>§483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.<br><br>§483.15(c)(2) Documentation.<br><br>When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.<br><br>(i)Documentation in the resident's medical record must include:<br><br>(A) The basis for the transfer per paragraph (c)(1)(i) of this section.<br><br>(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).<br><br>(ii)The documentation required by paragraph (c)(2)(i) of this section must be made by-<br><br>(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and<br><br>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. | F0627 | Continued from page 1<br>provided and to ensure residents/responsible parties that refuse to sign the Nursing Home Transfer Discharge Notice for non-emergent situations are provided a full 30 day notice with an appropriate reason. Any concerns noted were immediately corrected.<br><br>(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur.<br><br>By , The NHA/Designee completed education with current social services staff and IDT team members on ensuring appropriate transportation was provided and to ensure residents/responsible parties that refuse to sign the Nursing Home Transfer Discharge Notice for non-emergent situations are provided a full 30 day notice with an appropriate reason. Any concerns noted were immediately corrected.<br><br>Newly hired Social Services staff and IDT team members will be educated on ensuring appropriate transportation was provided and to ensure residents/responsible parties that refuse to sign the Nursing Home Transfer Discharge Notice for non-emergent situations are provided a full 30 day notice with an appropriate reason. Any concerns noted were immediately corrected by the NHA/designee at orientation as a part of the systematic changes.<br><br>(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place:<br><br>The DON/Designee will audit 5 random discharged residents to ensure appropriate transportation was provided and to ensure residents/responsible parties that refuse to sign the Nursing Home Transfer Discharge Notice for non-emergent situations are provided a full 30 day notice with an appropriate reason. Any concerns noted were immediately corrected.<br><br>The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been met. | |

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| F0627<br>SS = G | Continued from page 2<br><br>§483.15(c)(7) Orientation for transfer or discharge.<br><br>A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.<br><br>§483.15(e)(1) Permitting residents to return to facility.<br><br>A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following.<br><br>(i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident-<br><br>(A) Requires the services provided by the facility; and<br><br>(B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services<br><br>(ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges.<br><br>§483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the , location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.<br><br>§483.21(c)(1) Discharge Planning Process<br><br>The facility must develop and implement an effective discharge planning 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, and the reduction of factors leading to preventable | F0627 | | |

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| F0627<br>SS = G | Continued from page 3<br>readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-<br><br>(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.<br><br>(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.<br><br>(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.<br><br>( ) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.<br><br>(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.<br><br>(vi) Address the resident's goals of care and treatment preferences.<br><br>(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.<br><br>(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.<br><br>(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.<br><br>(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.<br><br>(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the | F0627 | | |

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| F0627<br>SS = G | Continued from page 4<br>extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.<br><br>(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.<br><br>§483.21(c)(2) Discharge Summary<br><br>When the facility , discharge, a resident must have a discharge summary that includes, but is not limited to, the following:<br><br>( ) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>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.<br><br>The findings included:<br><br>Review of the facility "Transfer and Discharges" policy (last revised ) 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 | F0627 | | |

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| F0627<br>SS = G | Continued from page 5<br>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. . ."<br><br>1. Record review for Resident #1 revealed an admission date of , and a discharge date of . Diagnoses included with Acute (a life-threatening condition where a large clot blocks the ), Acute , , Failure, Type-2 , presence of a , , , , Unspecified Affective (significant , emotional symptoms that cause distress) and 's without Dyskinesia (involuntary movements).<br><br>The ( ) dated revealed Resident #1 scored 15 of 15 on the , indicating intact cognition.<br><br>The discharge summary dated at 11:00 a.m., revealed Resident #1 was given a copy of the discharge summary and after discharge instructions.<br><br>Review of the progress notes revealed that on 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."<br><br>The clinical record lacked documentation of the date and time Resident #1 was picked up by the transport company. | F0627 | | |

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| **EAGLERIDGE HEALTH AND REHABILITATION CENTER** | **13881 EAGLE RIDGE DRIVE , FORT MYERS, Florida, 33912** |

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| F0627<br>SS = G | Continued from page 6<br><br>On 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).<br><br>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 , she notified the ALF that transportation was arranged for Resident #1. On , she left work a little after 5:00 p.m. Resident #1 was in the activities room.<br><br>The ADON said that when he left the facility on 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 and wanted to leave. A few minutes later, he received another text message from RN Staff A telling him that Resident #1 had left.<br><br>The NHA said that from what she knew, on , 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 informed her that (Emergency Medical Services) called to say they were with Resident #1. The resident refused to go to the facility and was sent to the hospital.<br><br>Review of the physician's progress note from the Emergency Department (ER) dated 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. was called and patient was brought to the ER for further evaluation . . ."<br><br>On at 11:31 a.m., in a telephone interview, the ALF Administrator at Resident #1's place of residence said that on 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 brought the resident to the hospital ER. She said Resident #1 | F0627 | | |

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| | 106020 | A. BUILDING<br>B. WING | |

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| F0627<br>SS = G | Continued from page 7<br>arrived at the ALF via ambulance that night around midnight.<br><br>On at 3:40 p.m., Resident #1 was interviewed at the ALF where she resided. She said the nursing home discharged her on 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, or . She couldn't even call her daughter. Resident #1 started to cry during the interview. She said it was opening to be alone and scared.<br><br>On 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.<br><br>On 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 at 5:14 p.m., since they require 2-day notice for transportation and 3 to 4 hours' notice for medical transportation.<br><br>On at 12:13 p.m., in a telephone interview, the Advanced Practice Registered Nurse (APRN) said that Resident #1 was alert enough to decide to leave on her own and made a poor decision.<br><br>On at 2:20 p.m., in a telephone interview, Registered Nurse (RN) Staff A said when she arrived at work on 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 | F0627 | | |

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| F0627<br>SS = G | Continued from page 8<br>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.<br><br>On 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.<br><br>On 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.<br><br>2. Review of the clinical record for Resident #2 revealed an admission date of and a discharge date of . Diagnoses included Disc (condition where discs lose structural integrity, water content and elasticity), Type-2 due to other Mental and Episodes.<br><br>Review of the ( ) dated revealed Resident #2 scored 15 of 15, indicating intact cognition.<br><br>A Progress Note dated noted current diagnoses of , other specified episodes and Adjustment with mixed , and depressed . 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".<br><br>Review of the discharge summary dated 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.<br><br>Review of the physician's orders revealed a discharge order dated at 4:51 p.m. The order did not include a reason for transfer, level of care or assistance needed.<br><br>The "Nursing Home Transfer and Discharge Notice" form noted the date the notice was given to Resident #2 was with an effective date of | F0627 | | |

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| F0627<br>SS = G | Continued from page 9<br>. 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.<br><br>On 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 Venice, 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 when he was discharged from the hospital. Resident #2 said he had to pay $275.00 for a ride company to take him to Fort Myers and was currently living in hotels because he had no home.<br><br>On at 10:47 a.m., an interview was held with the Nursing Home Administrator, the Social Services Assistant and the Assistant Director of Nursing.<br><br>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 . Resident #2 refused to sign the transfer form and was unsure as to why he was transferred.<br><br>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.<br><br>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 | F0627 | | |

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| F0627 SS = G | Continued from page 10<br>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. | F0627 | | |
| F0582 SS = D | Medicaid/Medicare Coverage/Liability Notice<br><br>CFR(s): 483.10(g)(17)(18)(i)-(v)<br><br>§483.10(g)(17) The facility must--<br><br>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-<br><br>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;<br><br>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and<br><br>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.<br><br>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.<br><br>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.<br><br>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.<br><br>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. | F0582 | Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required.<br><br>F582 Medicaid/ Medicare Coverage / Liability Notice<br><br>(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br><br>By , Resident #3 refund was sent.<br><br>(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.<br><br>On , NHA/Designee completed a quality review of residents discharged in the previous 30 days to ensure refunds were provided in a timely manner. Any concerns noted were immediately corrected.<br><br>(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur.<br><br>On4/2/2026, Business Office Manager were educated by the NHA/designee on ensuring refunds are provided in a timely manner.<br><br>Newly hired Business Office Managers will be educated to ensure refunds are provided in a timely manner by the NHA/designee at orientation as a part of the systematic changes.<br><br>(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place: | |

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| F0582<br>SS = D | Continued from page 11<br>( ) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.<br><br>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>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.<br><br>The findings included:<br><br>Review of facility policy dated , revised , revealed, "In the event a credit balance has resulted on a resident private account. This balance will be refunded based on the following:<br><br>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.<br><br>Refund will be issued by check within 30 days of confirmation of the above items. . ."<br><br>Review of facility records revealed that Resident #3 was discharged on . At the time of discharge the resident had a balance due to Resident #3 in the amount of $7,582.31 from prepaid charges.<br><br>On at 1:00 p.m., in an interview, the Business Office Manager (BOM) confirmed that on , Resident #3 had prepaid the facility $11,067.31. She confirmed that after co-pays were paid, the total amount due 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.<br><br>On at 2:28p.m., the BOM provided documentation that a refund check for $4,011.31 was sent to Resident #3 on . On , a second refund check for $1,112.00 was sent to Resident #3. The BOM said that as of today, | F0582 | Continued from page 11<br>NHA/Designee to conduct audits of 5 random discharged residents to ensure refunds are provided in a timely manner weekly for 4 weeks then monthly for 2 months.<br><br>The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been met. | |

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| F0582<br>SS = D | Continued from page 12<br>, the facility still owed a refund of $2,459.00. | F0582 | | |