Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968805	A. BUILDING: _____ B. WING _____	01/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE BONITA SPRINGS	11400 LONGFELLOW LN BONITA SPRINGS, FL 34135

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A 000	Initial Comments An unannounced complaint survey for complaint #2019015504 was conducted . . . . . at American House Bonita Springs, an assisted living facility in Bonita Springs, Florida. Complaint #2019015504 was substantiated at A-0030 and A-0032. The following is description of the deficiencies.	A 000		
A 030	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free	A 030		

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A 030	Continued From page 1	A 030		

telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and universal precautions; and,
8. The requirements for coordinating the delivery of services to residents by third party providers.
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there

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A 030	Continued From page 2 must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical . . . by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.	A 030		

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A 030	Continued From page 3 (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making . . , for health care services, the provision of or arrangement of transportation to health care . . , ... and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the	A 030		

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A 030	Continued From page 4 case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that	A 030		

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A 030	Continued From page 5 retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder . . . . Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated . . . , . . . or . . . , ... under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to honor the rights of two residents (Resident #5 and Resident #6) of 6 residents surveyed by failing to allow the residents the right to individuality and the dignity of choosing which resident they wished to communicate and socialize with.	A 030		

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A 030	Continued From page 6 The findings included: Review of the "Resident's Rights" provided by the facility reads: "No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the state of Florida, or the Constitution of the United States as a resident of the facility. Every resident of a facility shall have the right to ... (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and need for privacy .... (e) Freedom to participate in the benefit of community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community." On at 9:30 a.m., Resident #5 was observed sitting by himself in a living room area in the memory care unit. The resident said he had one complaint. He had a lady friend and any time he tried to talk with her or have a relationship with her the staff members would speak sharply to him and tell him he could not do that. He said he did not understand why he could not have a relationship with his lady friend. He felt he had the right to speak with her if he wanted to. On at 10:02 a.m., Resident Assistant ( ) Staff C verified Resident #5 and Resident #6 had not been allowed to sit together because they had been affectionate toward one another. The staff member said they were holding . The staff member said she had not observed the residents acting inappropriately in public. On at 10:25 a.m., Staff E the activities aide verified staff were keeping Resident #5 and #6 apart. Staff E said the resident's daughter had moved the resident from the other wing of the	A 030		

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A 030	Continued From page 7 memory care because she had a relationship with a male resident there. The staff member said Resident #6's daughter had requested that the resident be kept from having a relationship with Resident #6. On . . . . . at 11:45 a.m., The Memory Care Manager verified staff were keeping Resident #5 and #6 from being social with each other. The Memory Care Manager verified there had been no public inappropriate behaviors from the residents other than the residents held with each other. Review of the Power of Attorney (POA) for Resident #5 showed it would allow his family member to only make his financial decisions. Review of the POA for Resident #6 showed it would allow her family member to only make her financial decisions. On . . . . . at 1:55 p.m., The Senior Wellness Director said she had not told the staff to keep Resident #5 and Resident #5 apart. She said she did not feel there was any problem with the residents holding . The Senior Wellness Director stated Resident #5 and Resident #6 had never been deemed to be . . . . , ... to make their own decisions. Class III	A 030		
A 032	59A-36.007(8) FAC Resident Care - Elopement Standards 59A-36.007 (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement.	A 032		

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A 032	Continued From page 8 All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must	A 032		

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A 032	Continued From page 9 provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to sections 429.41(1)(a)3. and 429.41(1)(i), F.S. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to develop an elopement policy to include ensuring residents at risk for elopement had identification and the address and phone number of the facility on their person at all times. The facility failed to follow the current elopement policy in ensuring all residents at risk for elopement were assessed and a profile with a photo for each resident was placed in a binder for access to all staff. The facility failed to ensure four residents (Resident #1, #2, #3, and #4) who had a history of attempted elopement, were identified by staff as having a potential to have sufficient supervision to prevent further attempts of resident elopement. The findings included: Review of the policy "Elopement Management"	A 032		

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A 032	Continued From page 10 Number E-3, page #1, reads, "Residents who have a history of , and/or a diagnosis of , Organic , , or related warrant further follow-up and evaluation with their healthcare provider. If warranted, complete a Missing Resident Detailed Profile including a resident photo for each of these residents and include it in an Unsupervised Absence Binder. Update annually or if a change occurs." Review of the current elopement policy revealed that it does not address ensuring residents assessed at risk for elopement had identification including the address and the phone number of the facility on their person. On at 9:47 a.m., Resident Assistant ( ) Staff A said Resident #1 and Resident #2 were the only residents she knew that had a history of attempting to elope from the facility. On at 9:54 a.m., Medication Technician, Staff B said she was not aware of any residents in the building who were attempting to elope or were at risk for elopement. On at 10:02 a.m., , Staff C identified Resident #2 as the only resident in the building that was an elopement risk. On at 10:17 a.m., , Staff D identified Resident #2 as the only elopement risk in the facility. On at 10:25 a.m., the Activities identified Resident #2 as the only resident in the building that was an elopement risk. Review of an observation note regarding	A 032		

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A 032	Continued From page 11 Resident #1 dated . . . . . reads: "He climbed out of the break room window." On at 10:40 a.m., Resident #1's record was reviewed. There was no documentation noted throughout the chart the resident was an elopement risk. The resident's Health Assessment AHCA Form 1823 was not dated. It was an older form from . . . . . The Health Assessment AHCA Form 1823 had no documentation the resident was examined by a healthcare provider for his risk for elopement. On at 10:57 a.m., the Senior Wellness Director said the only resident she knew was an elopement risk was Resident #2. On at 11:30 a.m., Resident #1 was observed that he had no identification on his person. This was verified by the Assistant Executive Director at that time. On . . . . . at 11:35 a.m., Resident #2 was observed. She had no identification on her person. This was verified with the Assistant Executive Director at that time. Review of an incident report dated shows Resident #3 eloped from the building at 1:30 a.m., and was found by local law enforcement the resident at her previous residence at 3:27 a.m. On at 12:30 p.m., Resident #3 was observed to have a purse on her person with a driver's license in the purse. The resident did not have the address and phone number of the facility on her person. This was verified by the at the time. The Senior Wellness Director verified she could provide no documentation	A 032		

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A 032	Continued From page 12 Resident #3 was an elopement risk. Review of Resident #3's Health Assessment AHCA Form 1823 dated showed Resident #3 was not an elopement risk. On at 12:45 p.m., the Assistant Executive Director provided an "Resident Elopement Profile Form" for Resident #1 and #2. The forms were dated . On at 1:30 p.m., The Senior Wellness Director said she was not going to lie, she had created the two elopement profiles ( ). She said she did not know why she had dated the forms . The Wellness Director verified there was not an updated Unsupervised Elopement Binder with photos and identification of the residents who were an elopement risk. The Senior Wellness Director said she was working on reassessing all the residents in the Memory Care Unit and the assisted living facility to assess residents who were an elopement risk and develop a binder with their profile. On at 1:45 p.m., Staff F said he knew Resident #4 who was in the assisted living facility and not in memory care had attempted to elope from the building. Review of an observation note dated at 8:08 p.m., showed Resident #4 had been upset when she was transferred to another room. The note reads: "received a call from the front desk that she was outside wheeling herself toward the road, staff went to her and she was escorted into the building." On at 1:50 p.m., Resident #4 was observed in her room. The resident did not have	A 032		

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AMERICAN HOUSE BONITA SPRINGS	11400 LONGFELLOW LN BONITA SPRINGS, FL 34135

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A 032	Continued From page 13 identification on her person or the address and phone number of the facility. The Senior Wellness Director said if the resident had left the facility she would have been concerned for her welfare and would have contacted the police. The Wellness Director verified she had not evaluated the resident as an elopement risk. Class III	A 032		