

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
CZ816	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's _____ to the Federal Bureau of Investigation for a national criminal history record check unless the person's _____ are enrolled in the Federal Bureau of Investigation's national retained print _____ notification program. If the _____ of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit _____ electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the _____ to the Federal Bureau of Investigation for a national criminal history record check. The _____ shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print _____ notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person _____. The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or	CZ816		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/23/2022
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE COCONUT POINT			STREET ADDRESS, CITY, STATE, ZIP CODE 8460 MURANO DEL LAGO DR BONITA SPRINGS, FL 34135		
(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) COMPLETE DATE	
CZ816	Continued From page 1 professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers: (2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if _____ for any of the disqualifying offenses while employed by the employer. 59A-35.090 Background Screening. (2) Processing Screening Requests, Required Documents and Fees. (d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, _____, herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Service	CZ816			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
CZ816	Continued From page 2 s/Background_Screening/Regulations_Forms.sht ml. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if _____ for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to _____ to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the _____ report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to maintain the signed background screen Attestation in the employee's personnel file for 3 (Staff G, F, H, Administrator) of 4 personnel files reviewed.	CZ816		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
CZ816	Continued From page 3 The findings included Review of the facility employee list revealed staff H was hired on as a med tech. Staff H's employee file contained a background screen Attestation of compliance form that was signed but was not dated. Review of the facility employee list showed the administrator was hired on Review of the Administrator's employee record revealed no evidence of a backgrounds screen Attestation of compliance. On at 1:30 p.m., the Business Office manager reviewed the employee files and confirmed the findings. A review of Staff F's personnel record showed she was hired on A review of her Attestation of Compliance showed she signed this form but did not date it.	CZ816		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
A 000	Initial Comments An unannounced change of ownership, emergency power plan monitoring, limited nursing services and complaint survey for complaint #2022006839 was conducted on through at American House Coconut Point, an assisted living facility in Bonita Springs, Florida. Complaint #2022006839 was substantiated at A0152. The following is a description of the deficiencies.	A 000		
A 003	59A-36.003(2) FAC; 429.12(1) FS Licensure - Change of Ownership (CHOW) 59A-36.003 (2) CHANGE OF OWNERSHIP. In addition to the requirements for a change of ownership contained in Chapter 408, Part II, F.S., Section 429.12, F.S., and rule Chapter 59A-35, F.A.C., the following provisions relating to resident funds apply pursuant to Section 429.27, F.S.: (a) At the time of transfer of ownership, all resident funds on deposit, advance payments of resident rents, resident security deposits, and resident trust funds held by the current licensee must be transferred to the applicant. Proof of such transfer must be provided to the agency at the time of the agency survey and before the issuance of a standard license. This provision does not apply to entrance fees paid to a continuing care facility subject to the acquisition provisions in Section 651.024, F.S. (b) The transferor must provide to each resident a statement detailing the amount and type of funds held by the facility and credited to the resident. (c) The transferee must notify each resident in	A 003		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
A 003	Continued From page 1 writing of the manner in which the transferee is holding the resident's funds and state the name and address of the depository where the funds are being held, the amount held, and type of funds credited. 429.12 Sale or transfer of ownership of a facility.-It is the intent of the Legislature to protect the rights of the residents of an assisted living facility when the facility is sold or the ownership thereof is transferred. Therefore, in addition to the requirements of part II of chapter 408, whenever a facility is sold or the ownership thereof is transferred, including leasing: (1) The transferee shall notify the residents, in writing, of the change of ownership within 7 days after receipt of the new license. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to notify the residents/representatives in writing of a change of ownership as required pursuant to 429.12 (1) F. S. In an interview on _____ at 10:02 a.m., Resident #2 said she did not know the facility changed ownership. She said she knows there has been new staff in management but did not receive any notification about the facility changing owners. On _____ at 11:13 a.m., the Administrator stated she did not send any notification to the residents for the change of ownership. She said it was a change in investors but corporate felt as the name on the sign in front of the facility did not change they did not need to do a notification. The Administrator confirmed the facility did not notify the family/representatives of the facility change of ownership.	A 003		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/23/2022
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE COCONUT POINT			STREET ADDRESS, CITY, STATE, ZIP CODE 8460 MURANO DEL LAGO DR BONITA SPRINGS, FL 34135		
(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) COMPLETE DATE	
A 003	Continued From page 2 An interview was conducted with Resident #17's family member on _____ at 9:45 a.m. She said she was not aware of the facility having a change of ownership. She did not receive any type of written or verbal notification of this. She said she is the power of attorney and would be the person to receive this type of information. Class III	A 003			
A 030	59A-36.007(5) FAC; 429.28() FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) 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			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/23/2022
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE COCONUT POINT			STREET ADDRESS, CITY, STATE, ZIP CODE 8460 MURANO DEL LAGO DR BONITA SPRINGS, FL 34135		
(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) COMPLETE DATE
A 030	Continued From page 3 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 standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical _____. (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	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
A 030	Continued From page 4 capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 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. (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	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
A 030	Continued From page 5 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 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 must be set forth in writing and	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
A 030	Continued From page 6 provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. 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. (I) 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	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/23/2022
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE COCONUT POINT			STREET ADDRESS, CITY, STATE, ZIP CODE 8460 MURANO DEL LAGO DR BONITA SPRINGS, FL 34135		
(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) COMPLETE DATE
A 030	Continued From page 7 kept confidential pursuant to s. 400.0077 and that 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 record reviews, interview and observations, the facility failed to honor resident rights by notifying them of house rules in writing, failed to follow their grievance policy for complaints, and failed to have the required postings of information for residents and guests.	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
A 030	Continued From page 8 The findings included: 1. An interview was conducted with Resident #7 on at 10:10 a.m. He said he needs assistance from staff with some of his activities of daily living (ADLs) but has to wait over 30 minutes for staff to answer his call light. A review of his call light history for the past month (Alert request computer print out) showed for the month of he's had to wait over 9 hours on over one hour on over 3 hours on over 1 hour on over 1 hour on over 2 hours on 48 minutes on over 2 hours on 54 minutes on over 4 hours on over 2 hours on etc. An interview was conducted with Resident #8 on at 10:20 a.m. She said she has to wait a long time for staff to come help her. She was not able to say a specific amount of time but she said it takes a very long time. She has made complaints to the staff about this. A review of her call light history for the past month (Alert request computer print out) showed for the month of she had to wait 44 minutes on over 2 hours on over 8 hours over 2 hours on over 1 hour on over 1 hour on 53 minutes on over 2 hours on 41 minutes on over 1 hour on over 1 hour on over 4 hours on etc. An interview was conducted with Resident #9 on at 10:30 a.m. He said he needs help with showers and uses the call button. It takes up to one hour for staff to answer. He will call down stairs if no one comes. A review of his call light history for the past month (Alert request computer print out) showed for the month of he had to wait 18 hours on 53 minutes on	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/23/2022
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE COCONUT POINT			STREET ADDRESS, CITY, STATE, ZIP CODE 8460 MURANO DEL LAGO DR BONITA SPRINGS, FL 34135		
(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) COMPLETE DATE	
A 030	Continued From page 9 over 2 hours on ... , over 1 hour on ... , 58 minutes on ... , 35 minutes on ... , over 4 hours on ... An interview was conducted with Resident #10 on at 10:45 a.m. She said she needs help with her ADLs. She calls for the staff but they don't come for hours. She will call down stairs when the staff don't answer her call light. However, no one is down stairs after 8:00 p.m. so she cannot call at that time. She has voiced her complaints in the past. A review of her call light history for the past month (Alert request computer print out) showed for the month of ... she had to wait over 15 hours on ... , over 7 hours on ... , over 5 hours on ... , 34 minutes on ... , over 1 hour on ... twice, over 1 hour on ... , over 2 hours on ... , over 1 hour on ... , over 1 hour on ... twice, over 3 hours on ... Record review for Resident #12 revealed an admit date of Further review of Resident #12's clinical record revealed documentation of a Health Assessment dated ... that indicates Resident #12 needs assistance with ambulation, bathing, ... , self-care (grooming), toileting and transferring. Review of resident #12's call light history report (Alert request computer printout for the month of ... , revealed on ... , she had to wait over 1 hour three times, ... she had to wait 3 hours 54 minutes, and over 1 hour twice, on ... she had to wait for over 3 hours twice, 5 hours 19 minutes and almost 2 hours, ... over 2 hours, over 1 hour, ... over 1 hour twice, ... 1 hour 12 minutes, ... over 30 minutes twice, and 1 hour 46 minutes, and 2 hours 51 minutes, ... 1 hour 16 minutes, ... 1 hour, 2 hours 36 minutes, ... 7	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/23/2022
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE COCONUT POINT			STREET ADDRESS, CITY, STATE, ZIP CODE 8460 MURANO DEL LAGO DR BONITA SPRINGS, FL 34135		
(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) COMPLETE DATE	
A 030	Continued From page 10 hours 54 minutes, 2 hours 24 minutes, . . . 1 hour 57 minutes, . . . 2 hours 15 minutes, and over 1 hour twice, . . . 3 hours 6 minutes and over 1 hour, . . . 5 hours 11 minutes, . . . over 1 hour, . . . 5 hours 9 minutes, . . . over 2 hours twice, . . . 10 hours 51 minutes, 52 minutes and over 1 hour, . . . over 1 hour and . . . 4 hours 13 minutes. On . . . at 12:10 p.m., During an interview with the administrator regarding the call light response times, the Administrator said, "It's the aides, they are not following the policy, and answering the call lights when they are pushed." 2. Observations throughout the facility on and through the course of the survey to . . . showed the facility did not have the following information posted in the facility: - . . . , Right Florida and the phone number - Agency for Health Care Administration complaint Hot Line - Florida . . . number. An interview was conducted with the administrator on . . . at 11:00 a.m. She was not aware these items were not posted and will look into this. Another interview was conducted with the administrator on . . . at 1:00 p.m. and she confirmed these agencies and phone numbers are not posted in the facility. 3. An interview was conducted with Resident #10 on . . . at 10:45 a.m. She said her rights are being violated. She used be able to eat her meals in the independent dining room. Residents who live in the independent apartments have their own dining room. Her room is in the assisted living area of the facility. The other day the administrator told her she can no longer eat in	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
A 030	Continued From page 11 independent dining room, she has to eat in the assisted dining room. She does not like it there and now she eats in her room. She wants to eat in the independent dining room. She enjoys the people there better and they eat later. She does not eat well anymore because she eats by herself in her room. She said the administrator told her this is a rule in the facility. If a resident lives in the assisted living part of the building they have to eat in the assisted living dining room. A review of the facility admission packet, contract and facility Resident handbook showed there was no rule of where residents are supposed to eat their meals if they live in assisted living portion of the facility or in the independent portion of the facility. On at 9:00 a.m. an interview was conducted with the administrator. She said the rule is, residents who live in the assisted living portion of the facility have to eat their meals in the assisted living dining room and residents who live in independent portion of the facility eat in the independent dining room. However, she confirmed this is not written in the facility admission packet or house rules. 4. Policy and Procedure Manual - Administrative Section Resident Rights Grievance revised ,"Policy: American House has an established policy and procedure regarding (the filing of) grievances. Purpose: Residents, their family, their legal representative, or a resident advocate has the right to file a grievance or complaint with the community without fear of reprisal. American House investigates all grievances and complaints filed and responds in writing. Procedure: 1. When a grievance exists, any resident, family member, or resident advocate	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/23/2022
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE COCONUT POINT			STREET ADDRESS, CITY, STATE, ZIP CODE 8460 MURANO DEL LAGO DR BONITA SPRINGS, FL 34135		
(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) COMPLETE DATE	
A 030	Continued From page 12 may submit the grievance to the Executive Director. A copy is also sent to the Vice President of Marketing and Regional Director of Operations at the American House home office. 4. Grievances may be in writing and should include a date and signature. A formal grievance form is available. On at 11:00 a.m., Review of the grievance log revealed documentation of a grievance dated related to call lights response. The grievance form and supporting documentation for resolution was requested. On at 11:05 a.m., the Administrator stated she did not complete the grievance form, nor any grievance forms for any of the grievances documented on the log for the year. The Administrator confirmed she has not completed forms for any grievances as the facility policy requires. Class III	A 030			
A 052	429.256(. . .); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, including an . . . syringe that is prefilled with the proper dosage by a pharmacist and an . . . that is prefilled by the manufacturer, from where it is stored, and bringing it to the resident. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
A 052	Continued From page 13 name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her (d) Applying medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (h) Using a to perform level checks. (i) Assisting with putting on and taking off stockings. (j) Assisting with applying and removing an but not with titrating the prescribed settings. (k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device. (l) Assisting with measuring vital signs. (m) Assisting with bags. (4) Assistance with self-administration does not	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/23/2022
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE COCONUT POINT			STREET ADDRESS, CITY, STATE, ZIP CODE 8460 MURANO DEL LAGO DR BONITA SPRINGS, FL 34135		
(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) COMPLETE DATE
A 052	Continued From page 14 include: (a) Mixing, _____, converting, or _____ medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a _____ of the body. (d) Administration of _____ preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with _____, or _____ preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
A 052	Continued From page 15 SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be _____ or older, trained to assist with self-administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility. 2. The medication container may be given to the resident, a friend, or family member upon leaving	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
A 052	Continued From page 16 the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure staff who assist residents with self-administration of medications do so in accordance with proper procedure for 4 (Residents # 5, # 14, #15, # 16) of 4 medications observations. The findings included: On at 8:25 a.m., Staff I (med tech) was observed assisting Resident #14 with medications. Staff I parked the medication cart in the hallway outside of resident #14's room. Staff I	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/23/2022
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE COCONUT POINT			STREET ADDRESS, CITY, STATE, ZIP CODE 8460 MURANO DEL LAGO DR BONITA SPRINGS, FL 34135		
(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) COMPLETE DATE	
A 052	Continued From page 17 took Resident #14's medication from the medication cart and placed the dosage of the medications into a container, without the resident being present. She knocked on the door and entered the room with the container of medications. Staff I said to resident #14, "It's medicine time." giving resident #14 the medications without informing the resident what medications she was being assisted with and without taking the medications in their properly labeled container to read to the resident. On at 8:42 a.m., Staff I (med tech) was observed assisting Resident #15 with medications. Staff I parked the medication cart in the hallway outside of resident #15's room. Staff I took Resident #15's medication from the medication cart and placed the dosage of the medications into a container, without the resident being present. She knocked on the door and entered the room with the container of medications, giving resident #15 the cup with the medications. Resident #15 said to Staff I, "I already took the as I had some in my room and it is to be taken before breakfast." The resident removed the capsule form the cup of medications. Resident #15 then proceeded to take the remainder of the medication. Staff I gave resident #15 the cup of medications without informing the resident what medications she was being assisted with and without taking the medications in their properly labeled container to read to the resident. On at 8:55 a.m., Staff I (med tech) was observed assisting Resident #16 with medications. Staff I parked the medication cart in the hallway outside of resident #16's room. Staff I took Resident #16's medication from the medication cart and placed the dosage of the	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/23/2022
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE COCONUT POINT			STREET ADDRESS, CITY, STATE, ZIP CODE 8460 MURANO DEL LAGO DR BONITA SPRINGS, FL 34135		
(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) COMPLETE DATE
A 052	Continued From page 18 medications into a container, without the resident being present. She knocked on the door and entered the room with the container of medications. Resident #16 asked, "Do you have my meds?" Staff I said to resident #16, "I have your pills." Staff I assisted resident #16 to sit in her wheelchair, and poured the medications from the cup into resident #16's without informing the resident what medications she was being assisted with and without taking the medications in their properly labeled container to read to the resident. On at 9:03 a.m., Staff I confirmed there are no residents with medication waivers in the facility that permits the Med Techs not to inform the resident of the medications they are being offered. On at 9:08 a.m., Staff I (med tech) was observed assisting Resident # 5 with medications. Staff I parked the medication cart in the hallway outside of resident #5's room. Staff I took Resident #5's medication from the medication cart and placed the dosage of the medications into a container, without the resident being present. She knocked on the door and entered the room with the container of medications. Staff I said to resident #5, "I have your narcs and your gummies." giving resident #5 the medications without informing the resident what medications she was being assisted with and without taking the medications in their properly labeled container to read to the resident. On at 9:16 a.m., Staff I stated she knows she is required to read the medications to the resident when assisting with self-administration of medications. Staff I said, "Some of the residents already know what meds they are getting, so she	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
A 052	Continued From page 19 does not tell them what she is giving them when assisting with their medications, but if they ask, she will tell them." On at 9:54 a.m., Staff E (med tech) said there are no residents in the facility with medication waivers and as med techs they are to inform the resident what medications they are giving when assisting them with their medications. On at 10:51 a.m., the Administrator stated she does not know the exact process for how the med techs assist with self-administration of medications for the residents as she has not shadowed a med tech to know. On at 10:57 a.m., Staff A Licensed Practical Nurse (LPN) confirmed the med techs are to inform the resident what medications they are being given. Staff A said, "I do not see med techs telling the residents what meds they are being given."	A 052		
A 078	Class III 59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF: (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
A 078	Continued From page 20 a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable, such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
A 078	Continued From page 21 this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that within 30 days of employment staff submit a written statement from a health care provider documenting the individual is free from signs/symptoms of communicable and evidence of freedom from () documented annually thereafter for 3 (Administrator, Staff H and Staff F) of 4 employee records reviewed. The findings Include: On a review of the Administrators file revealed a hire date of The Administrators file contained an Employee Health statement of a screening conducted on with results of test negative. The Administrator's filed contained no evidence of a statement signed by a healthcare provider indicating freedom from signs and symptoms of a communicable On a review of Staff H's file revealed a	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11696059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
A 078	Continued From page 22 hire date of as a Med Tech/caregiver. Staff H's file contained no evidence of a written statement from a health care provider documenting that Staff H was free from signs and symptoms of communicable On at 1:30 p.m., The Business Office Manager confirmed the findings. On a review of Staff F's personnel record showed she was hired on There were no communicable and statement from a health care provider. Class III	A 078		
A 081	429.52(1 & 7) FS; 59A-36.011() FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/23/2022
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE COCONUT POINT			STREET ADDRESS, CITY, STATE, ZIP CODE 8460 MURANO DEL LAGO DR BONITA SPRINGS, FL 34135		
(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) COMPLETE DATE	
A 081	Continued From page 23 inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
A 081	Continued From page 24 offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to . . . borne . . . , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident . . . , neglect, and The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
A 081	Continued From page 25 response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure facility employees complete 2 hour preservice orientation prior to interacting with residents, and 3 hours of in-service training for Activities of Daily Living and Behavioral Needs, as required by Florida Administrative Code within 30 days of employment for 3 (Staff F, H and Administrator) of 4 employee files reviewed. The findings Include: On, Review of the facility employee list showed the administrator was hired on Administrator's file contained no documentation of completing 2 hour preservice orientation prior to interacting with residents. On, Review of the facility employee list showed Staff H was hired on as a Med Tech. Staff H's file contained no documentation of completing 2-hour preservice orientation prior to interacting with residents. On at 1:30 p.m., the Business Office Manager confirmed the finding.	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
A 081	Continued From page 26 A review of Staff F's personnel record showed she was hired on _____ as a resident assistant (_____). A review of the staff schedule shows she is a _____ and has a resident assignment to care for these residents. She provides direct care assistance to residents. A review of her training showed she does not have the required 3 hours of training in Activities of Daily Living. Class III	A 081		
A 086	59A-36.011(10) FAC Training - ADRD (10) _____ AND RELATED ("ADRD") TRAINING REQUIREMENTS. Facilities which advertise that they provide special care for persons with ADRD, or who maintain secured areas as described in Chapter 4, Section 464.4.6 of the Florida Building Code, as adopted in rule 61G20-1.001, F.A.C., Florida Building Code Adopted, must ensure that facility staff receive the following training. (a) Facility staff who interact on a daily basis with residents with ADRD but do not provide direct care to such residents and staff who provide direct care to residents with ADRD, shall obtain 4 hours of initial training within 3 months of employment. Completion of the core training program between _____ and _____ shall satisfy this requirement. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. Initial training, entitled " _____ and Related _____ Level I Training," must address the following subject areas: 1. Understanding _____'s _____ and related _____ ;	A 086		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
A 086	Continued From page 27 2. Characteristics of _____; 3. Communicating with residents with _____'s _____ 4. Family issues; 5. Resident environment; and, 6. Ethical issues. (b) Staff who have successfully completed both the initial one hour and continuing three hours of ADRD training pursuant to sections 400.1755, 429.917 and 400.6045(1), F.S., shall be considered to have met the initial assisted living facility _____ and Related _____. Level I Training. (c) Facility staff who provide direct care to residents with ADRD must obtain an additional 4 hours of training, entitled " and Related _____ Level II Training," within 9 months of employment. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. _____ and Related _____ Level II Training must address the following subject areas as they apply to these _____: 1. Behavior management, 2. Assistance with ADLs, 3. Activities for residents, 4. Stress management for the care giver; and, 5. Medical information. (d) A detailed description of the subject areas that must be included in an ADRD curriculum which meets the requirements of paragraphs (a) and (b) of this subsection, can be found in the document "Training Guidelines for the Special Care of Persons with _____'s _____ and Related _____, dated _____, incorporated by reference, available from the Department of Elder Affairs, 4040 Esplanade Way, Tallahassee, Florida 32399-7000.	A 086		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
A 086	Continued From page 28 (e) Direct care staff shall participate in 4 hours of continuing education annually as required under section 429.178, F.S. Continuing education received under this paragraph may be used to meet 3 of the 12 hours of continuing education required by section 429.52, F.S., and subsection (1) of this rule, or 3 of the 6 hours of continuing education for extended congregate care required by subsection (7) of this rule. (f) Facility staff who have only incidental contact with residents with ADRD must receive general written information provided by the facility on interacting with such residents, as required under section 429.178, F.S., within three (3) months of employment. "Incidental contact" means all staff who neither provide direct care nor are in regular contact with such residents. (g) Persons who seek to provide ADRD training in accordance with this subsection must provide the department or its designee with documentation that they hold a Bachelor's degree from an accredited college or university or hold a license as a registered nurse, and: 1. Have 1 year teaching experience as an educator of caregivers for persons with _____, or related _____, or 2. Three years of practical experience in a program providing care to persons with _____, or related _____, or 3. Completed a specialized training program in the subject matter of this program and have a minimum of two years of practical experience in a program providing care to persons with _____, or related _____. (h) With reference to requirements in paragraph (g), a Master's degree from an accredited college or university in a subject related to the content of this training program can substitute for the teaching experience. Years of teaching _____	A 086		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
A 086	Continued From page 29 experience related to the subject matter of this training program may substitute on a year-by-year basis for the required Bachelor's degree referenced in paragraph (g). This Statute or Rule is not met as evidenced by: Based on record review and staff interview the facility failed to ensure 2 (Staff H, Administrator) out of 4 staff reviewed completed 4 hours Level I training within 3 months of hire as required by the Florida Administrative code. The findings included: Record review found Staff H was hired on _____ as a Med Tech. Further review found no evidence of level I _____ training completed within 3 months as is required Record review found the Administrator was hired on _____. Further review found no documentation of level I _____'s training completed within 3 months as is required. On _____ at 1:30 p.m., The Business office Manager reviewed the employee files and acknowledged the findings of the missing required trainings. Class III	A 086		
A 091	59A-36.011(12) FAC Training - Documentation & Monitoring (12) TRAINING DOCUMENTATION AND MONITORING. (a) Except as otherwise noted, certificates, or copies of certificates, of any training required by	A 091		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
A 091	Continued From page 30 this rule must be documented in the facility's personnel files. The documentation must include the following: 1. The title of the training program, 2. The subject matter of the training program, 3. The training program agenda, 4. The number of hours of the training program, 5. The trainee's name, dates of participation, and location of the training program, 6. The training provider's name, dated signature and credentials, and professional license number, if applicable. (b) Upon successful completion of training pursuant to this rule, the training provider must issue a certificate to the trainee as specified in this rule. (c) The facility must provide the Department of Elder Affairs and the Agency for Health Care Administration with training documentation and training certificates for review, as requested. The department and agency reserve the right to attend and monitor all facility in-service training, which is intended to meet regulatory requirements. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to appropriately document required trainings for 2 (Staff F, H) of 4 employee records reviewed. The findings include: Record review for Staff H revealed a hire date of _____ as a Med Tech. Further review revealed certificates of completion for Do not Resuscitate Orders, _____ Control and Universal Precautions, Major Emergency Preparedness and Evacuation, Food Handling in Assisted living, Elopement and _____, and _____, Neglect	A 091		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/23/2022
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE COCONUT POINT			STREET ADDRESS, CITY, STATE, ZIP CODE 8460 MURANO DEL LAGO DR BONITA SPRINGS, FL 34135		
(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) COMPLETE DATE	
A 091	Continued From page 31 and ... The certificates failed to contain the instructors name, dated signature and credentials, and license number. A review of Staff F's personnel record showed she received several training certificates. A review of these training certificates such as: Food Handling in Assisted Living, ... Control, Major Emergency Preparedness and Evacuation, Pre-Service Orientation Training, ...; Elopement and ... and ... Neglect, and ... do not have the training provider's name, dated signature, credentials and license number, if applicable, on these certificates. On ... at 1:30 p.m., The Business Office manager confirmed the certifications on file did not meet regulatory requirements. Class III	A 091			
A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings:	A 152			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
A 152	Continued From page 32 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable _____ to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, _____ or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be _____. This Statute or Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to provide a safe environment free from pest for the residents to live in. The findings included: Observation on _____ at 10:30 a.m. in memory unit B kitchen showed there were several small live bugs located in the kitchen drawers. There were food crumbs, salt, pepper, and sugar particles scattered throughout the cabinets and drawers. On _____ at 10:30 a.m., interviewed Staff C - direct care and Staff D - med tech who work in	A 152		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/23/2022
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE COCONUT POINT			STREET ADDRESS, CITY, STATE, ZIP CODE 8460 MURANO DEL LAGO DR BONITA SPRINGS, FL 34135		
(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) COMPLETE DATE	
A 152	Continued From page 33 Unit B. They both confirmed they see live bugs in this kitchen. Staff C said she reported these bugs to the maintenance staff about two weeks ago. On at 11:15 a.m. an interview was conducted with the maintenance staff. He said he is aware of a report from staff in the memory unit that complained about live bugs about a week ago. He removed the microwave because he found these bugs living in it. He said a pest company comes in the facility, but he does not get a report from them. A review of the pest company visit log showed the last report was . However, the maintenance staff said they come to the facility on a regular basis. They do not get a report from them of what they saw during their treatments. A review of "Pest Sighting Log" sheet showed the pest company came out on . They come to the facility at least once a month. It does show where they spray but no information of pests sightings, activity and results. Class III	A 152			
A 160	59A-36.015(1) FAC Records - Facility The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or	A 160			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/23/2022
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE COCONUT POINT			STREET ADDRESS, CITY, STATE, ZIP CODE 8460 MURANO DEL LAGO DR BONITA SPRINGS, FL 34135		
(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) COMPLETE DATE
A 160	Continued From page 34 other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a _____; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of _____. (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's	A 160			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
A 160	Continued From page 35 contract) described in rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with _____'s _____ or related _____, a copy of all such facility advertisements as required by section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in rule 59A-36.007, F.A.C. (j) All food service records required in rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to section 429.41, F.S., and rule chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to section 381.031, F.S., and chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively.	A 160		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
A 160	Continued From page 36 This Statute or Rule is not met as evidenced by: Based on observation and interview the facility failed to display their license in a conspicuous and public place for anyone to view. The findings included: On at 12:00 p.m. observation throughout the facility showed the facility license was not visible. An interview was conducted with the administrator on at 12:55 p.m. She said the license is posted in the copy room. She said residents and guest do not have access to this room. On at 2:15 p.m. observation showed the facility license is posted in the staff copy room. Class	A 160		
A 161	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule.	A 161		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
A 161	Continued From page 37 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in section 429.174, F.S., and rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by rule 59A-36.010, F.A.C.	A 161		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
A 161	Continued From page 38 This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to maintain personnel records for each staff containing documentation required for compliance with Florida Administrative Code for 3 (Staff F, H, Administrator) of 4 employee files reviewed. The Finding Include: Review of the facility employee list showed the administrator was hired on Review of the Administrator's employee record revealed no evidence of a job application with references and a job description. Review of the facility employee list revealed staff H was hired on as a med tech. Staff H's employee record revealed no evidence of a job description. On at 1:30 p.m., the Business Office Manager confirmed the missing documentation from the employee files for Staff H and the Administrator. A review of Staff F's personnel record showed she was first hired on A review of the application was dated Staff F left the facility was rehired 10 month later on There was no new application in her file showing her previous work history. A review of the staff schedule shows she is a resident assistant (. . .). A review of Staff F's personnel record showed she has a job description for a culinary staff. An interview was conducted with the business	A 161		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1169059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
A 161	Continued From page 39 office manager (BOM) on She stated she is in the process of reviewing and fixing all personnel records. She confirmed Staff F works as an . . . Class	A 161		
A 162	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. . . . 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, . . . , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/23/2022
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE COCONUT POINT			STREET ADDRESS, CITY, STATE, ZIP CODE 8460 MURANO DEL LAGO DR BONITA SPRINGS, FL 34135		
(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) COMPLETE DATE
A 162	Continued From page 40 paragraph 59A-36.007(1)(e), F.A.C. (f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , (), CF-ES 1006, , , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004 . The absence of this form will not be	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
A 162	Continued From page 41 the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the . . . of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's . . . , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/23/2022
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE COCONUT POINT			STREET ADDRESS, CITY, STATE, ZIP CODE 8460 MURANO DEL LAGO DR BONITA SPRINGS, FL 34135		
(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) COMPLETE DATE
A 162	Continued From page 42 of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and staff interview the facility failed to ensure all required documents are found in the resident record for 1 (Residents #12) of 2 resident records reviewed. The findings include: On, a review of Resident #12's record revealed her contract was signed on by the person listed as Durable Power of Attorney on the Admission Record. Further review of Resident #12's record failed to reveal any documentation of the existence of a power of attorney (POA). On at 12:03 p.m., the Administrator said if there is no POA paperwork in the file, she does not have it. She confirmed there is no documentation of POA paperwork for Resident #12 elsewhere in the building. Class III	A 162			
AN278	59A-36.022(3) FAC; 429.07(3)(c)2, FS LNS - Records 59A-36.022 (3) RECORDS.	AN278			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
AN278	Continued From page 43 (a) A record of all residents receiving limited nursing services and the type of services provided must be maintained at the facility. (b) Nursing progress notes must be maintained for each resident who receives limited nursing services from facility staff. (c) A nursing assessment conducted at least monthly must be maintained on each resident who receives a limited nursing service. 429.07 (3)(c)2, FS A facility that is licensed to provide limited nursing services shall maintain a written progress report on each person who receives such nursing services from the facility's staff. The report must describe the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health... This Statute or Rule is not met as evidenced by: Based on interviews and record review the facility failed to follow physician orders, and have written progress notes and monthly nursing assessments for one (Resident #11) of one resident receiving limited nursing services(LNS). The findings included: An interview was conducted with the administrator on at 9:00 a.m. She said there are no residents receiving Limited Nursing Services (LNS). A review of their LNS book showed no residents identified as receiving LNS. An interview was conducted with Staff B, med tech on at 1:25 p.m. She identified Resident #13 as requiring the nurses to change her on her . This service conducted by the facility staff requires Resident #13 to receive LNS.	AN278		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
AN278	Continued From page 44 A review of Resident #13's record showed an order from the nurse practitioner dated _____, "Clarification to LNS: Nurse to change _____ to _____, every 3 days & PRN (and when needed)." A review of Resident #13's Medication Administration Record (MAR) for the past three months showed the following: - MAR showed missing treatments on _____, and _____, - MAR showed missing treatments on _____ and _____, - MAR showed missing treatments on _____ and _____. The facility failed to follow the orders of the nurse practitioner. A review of Resident #13's record showed there were no progress notes showing the skin condition of the site, the outcome of the treatment, etc. Further review of this record showed there were no monthly nursing assessments that are required when a resident is receiving LNS. An interview was conducted with the facility Staff A - Registered nurse on _____ at 1:45 p.m. She said she is doing LNS on Resident #13. She is changing the _____ on her _____ every three days. She documents this on the MAR. She is not aware of any monthly assessment being done for Resident #13. She has not done any monthly assessment. The MAR only shows the initial event of the nurse providing the treatment and no progress note. An interview was conducted with LNS nurse supervisor at 2:30 p.m. on _____. She said she	AN278		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE COCONUT POINT

**8460 MURANO DEL LAGO DR
BONITA SPRINGS, FL 34135**

(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) COMPLETE DATE
AN278	Continued From page 45 was not aware of anyone being on LNS. A review of the facility policy "LNS Criteria & Paperwork" showed the services the facility can provide to the residents under this license. There was no process or procedure to show what the staff are to do when a resident is on LNS. The policy does not show the staff provide progress notes and monthly assessments for residents receiving LNS. Class III	AN278		