Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968805	A. BUILDING: _____ B. WING _____	07/12/2022

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

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CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; [illegible]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure 4 (Staff A, B, C and Administrator) of 4 staff records reviewed, had the Level 2 background screening employment status updated within 10 days on the Agency's Background screening clearinghouse website pursuant to chapter 435. This had the potential	CZ814		

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CZ814	Continued From page 1 for staff with disqualifying offenses to have access to adults. The findings included: Review of Staff A file revealed a hire date of as a resident aide/med tech. Staff A was not added to the clearinghouse until , 48 days after hire. Review of Staff B file revealed a hire date of as a resident aide/med tech. Staff B was not added to the clearinghouse until , 56 days after hire. Review of Staff C file revealed a hire date of as a resident aide/med tech. Staff C was not added to the clearinghouse until , 56 days after hire. Review of the Administrators file revealed a hire date of . The Administrator was not added to the clearinghouse until , 30 days after hire. On at 11:58 a.m., the Assistant Business Office Manger confirmed the staff were added to the background clearinghouse past the required 10 business days. Unclassified	CZ814		
CZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive	CZ830		

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CZ830	Continued From page 2	CZ830		

emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows:
(a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan.
(b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan.
(c) Submit necessary plan revisions within 30 days after notification that plan revisions are required.
(d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health.
(2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers.
(3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider:
1. Suffered damage to its operation during the

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CZ830	Continued From page 3 state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations.	CZ830		

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CZ830	Continued From page 4 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to submit annually and maintain documentation of a current Comprehensive Emergency Management Plan (CEMP), approved by the local emergency management agency to ensure the safety and welfare of all residents. The findings include: On the Administrator provided an Emergency Power Plan (EPP) approval letter date . The letter indicated the EPP is approved through , and must be included in the annual Comprehensive Emergency Management Plan (CEMP) submission as an annex/addendum. Further review revealed a Comprehensive Emergency Management Plan (CEMP) approval letter dated . The letter indicated the CEMP is approved through . On at 9:44 a.m., Request for documentation of the facility's CEMP with the approval letter was made to the Administrator. The Administrator stated she does not have a current CEMP with an approval letter, she has not submitted the CEMP for approval. The Administrator confirmed the facility does not have a current CEMP approved by the local emergency management for the facility. Unclassified	CZ830		

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A 000	Initial Comments An unannounced change of ownership, capacity increase, emergency power plan monitoring and complaint survey for complaint #2022003777 was conducted from . . . . . through . . . . . at American House Bonita Springs, an assisted living facility in Bonita Springs, Florida. Complaint #2022003777 was substantiated at A0010, A0025 and A0032. The following is a description of the deficiencies.	A 000		
A 010	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party.	A 010		

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A 010	Continued From page 1 (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . . . . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the	A 010		

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A 010	Continued From page 2 resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a may be retained provided that: 1. The resident contracts directly with a licensed	A 010		

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A 010	Continued From page 3 home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A [redacted] ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's	A 010		

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A 010	Continued From page 4 license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to update two (Resident #12 and #13) of three resident assessments after they exhibited significant changes. The findings included: 1. A review of the facility adverse incident reports showed Resident #12 eloped from the secured unit on . A review of his latest health assessment date showed he was not an elopement risk. This health assessment also showed he requires supervision with his eating and grooming. He is independent with his ambulation, bathing, , toileting and transfers. Resident #12 lives in the memory unit. In an interview on at 10:45 a.m., Staff E-Med Tech said she works with Resident #12 every day and he requires assistance with bathing, , grooming and toileting. 2. A review of the facility adverse incident reports showed Resident #13 eloped from the secured unit on . A review of his latest health assessment dated shows he is not an elopement risk. An interview was conducted with the memory unit director on at 10:50 a.m. He said he was	A 010		

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A 010	Continued From page 5 not aware the health assessments for Residents #12 and #13 showed they were not an elopement risk. He said he did not know that when there is a significant change in a resident's condition a new health assessment needs to be completed. Class III	A 010		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident,	A 025		

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A 025	Continued From page 6 including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to provide appropriate supervision for two residents (Residents #12 and #13) to prevent them from eloping from the facility and placing them at risk for harm and danger. The findings included: 1. A review of the facility's adverse incident dated showed Resident #12 eloped from the secured unit B in memory care. An interview was conducted with the Wellness Director on	A 025		

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A 025	Continued From page 7 at 1:00 p.m. She said Resident #12 was able to get out an exit door. When they investigated this the second fire alarm on the exit door did not work. This was fixed. One of the corrective actions is the med tech on each shift is to check the fire alarm doors to make sure they work. This corrective action started on . . . . . . On . . . . . at 3:00 p.m., the Assistant Wellness Director assigned to the memory care said all three shifts must document that staff check each exit door to make sure they work. The staff document this on a calendar for units A and B. He said the corrective action started in . . . . . A review of the . . . . documentation showed two shift checked the exit doors and on some days one shift checked the exit doors for both A and B units. In , some days there was one shift checking the exit doors and on some days there was no documentation showing the exit doors were checked on A and B units. Both the Wellness Director and Assistant Wellness Director reviewed this documentation and confirmed the corrective action for Resident #12's elopement was not being followed. 2. A review of the facility's adverse incidents dated . . . . . showed Resident #13 eloped from the secured unit B in memory care. Interviews with the administrator and Wellness Director was conducted on at 2:00 p.m. They both said Resident #13 exited the same door as Resident #12. A tour of the memory unit B was conducted with the administrator on . . . . at 3:00 p.m. The exit door through which both Residents #12 and #13 eloped was tested. The door alarm sounded when pressure was put on it for a full 15 seconds.	A 025		

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A 025	Continued From page 8 Once the door opened another alarm (which is louder then the first alarm) sounded. There were two staff observed in this unit. They were not told the exit doors were being tested. These two staff did not respond to the alarms. The administrator confirmed the two staff did not respond to this alarm and they should have. Class III	A 025		
A 026	59A-36.007(2) FAC Resident Care - Social & Leisure Activities (2) SOCIAL AND LEISURE ACTIVITIES. Residents shall be encouraged to participate in social, recreational, educational and other activities within the facility and the community. (a) The facility must provide an ongoing activities program. The program must provide diversified individual and group activities in keeping with each resident's needs, abilities, and interests. (b) The facility must consult with the residents in selecting, planning, and scheduling activities. The facility must demonstrate residents' participation through one or more of the following methods: resident meetings, committees, a resident council, a monitored suggestion box, group discussions, questionnaires, or any other form of communication appropriate to the size of the facility. (c) Scheduled activities must be available at least 6 days a week for a total of not less than 12 hours per week. Watching television is not an activity for the purpose of meeting the 12 hours per week of scheduled activities unless the television program is a special one-time event of special interest to residents of the facility. A facility whose residents choose to attend day programs conducted at adult day care centers,	A 026		

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A 026	Continued From page 9 senior centers, mental health centers, or other day programs may count those attendance hours towards the required 12 hours per week of scheduled activities. An activities calendar must be posted in common areas where residents normally congregate. (d) If residents assist in planning a special activity such as an outing, seasonal festivity, or an excursion, up to 3 hours may be counted toward the required activity time. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide activities as scheduled for residents living in the memory units. The findings included: 1. A review of the activity calendar posted in the memory unit showed the following for [redacted]: 10:00 a.m. seated yoga 1:30 p.m. Coloring 3:00 p.m. Pastor visit. Observations during these times and throughout day on [redacted] showed there were no activities offered to the residents living in memory units A and B. An interview was conducted with the memory unit director on [redacted] at 11:15 a.m. He said the activity staff works Tuesday through Saturday. He will make sure the activities for Monday are carried out. Class III	A 026		

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A 030	Continued From page 10	A 030		
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 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	A 030		

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A 030	Continued From page 11 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 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	A 030		

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A 030	Continued From page 12	A 030		

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 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

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A 030	Continued From page 13 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 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.	A 030		

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A 030	Continued From page 14 (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that 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.	A 030		

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A 030	Continued From page 15 429.27 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 observation and interviews, the facility failed to ensure one (Resident #14) of 15 residents eating in a dignified manner. The findings included: Observation on at 12:15 p.m. showed Resident #14 was served a pureed diet for his lunch. He was served vegetables, meat and potatoes. These food were separated on his plate. His private duty mixed all of his foods together. She was then feeding him his food by scooping his food on a spoon and feeding it to him. In an interview on at 12:40 p.m., the	A 030		

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A 030	Continued From page 16 private duty companion said he eats his food better this way. In an interview on at 1:30 p.m., the administrator said this is not an appropriate why to help a resident eat their food. Class III	A 030		
A 032	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement	A 032		

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A 032	Continued From page 17 at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to conduct elopement drill to ensure staff proficiency. The findings included:	A 032		

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A 032	Continued From page 18 A review of the facility adverse incident reports showed Residents #12 and #13 eloped from the memory unit B within 2 months of each other. See A0025 for more detailed information. A review of the facility's "Elopement Drill" policy #21-WEL-0137-PO-Elopement Drill shows when elopement drill occur "All community staff must participate, including all shifts and weekends." "All Elopement Drill Reports will be maintained in the Executive Director's office." A review of the elopement drills was conducted. The form "Missing Resident Drill Log" was reviewed. It showed there were seven elopement drills conducted from , through . In an interview on 22 at 12:00 p.m., the administrator said she has this log for the elopement drills, however, she does not fill out a form for each elopement. She does not have a list of staff who participated in the elopement drills and response times. The elopement drill policy was reviewed and she confirmed this policy is not being followed. Class III	A 032		
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, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper	A 052		

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A 052	Continued From page 19 dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication 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 . (4) Assistance with self-administration of medication does not 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.	A 052		

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A 052	Continued From page 20 (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 [illegible], of the body. (d) Administration of [illegible] preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with [illegible], or [illegible] 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 SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be [illegible] 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	A 052		

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A 052	Continued From page 21 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 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	A 052		

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

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A 052	Continued From page 22 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 5 (Residents #11, #15, #16, #17, #18) of 5 medications observations. The findings included: On at 10:51 a.m., Staff B (med tech) was observed assisting Resident #11 with medications. Staff B parked the medication cart at the end of the hallway on the 3rd floor. Staff B opened the computer to Resident #11's profile and proceeded to take Resident #11's medications from the cart, placing the dosage of the medications into a container, without the resident being present, and placing a check mark next to each medication on the Electronic Medication Administraition Record (EMAR). Staff B took the cup containing the medications down the hallway, knocked, and entered the resident's room. Staff B said: "Good morning, I have your	A 052		

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morning meds for you," giving Resident #11 the medications without informing the resident what medications he was being assisted with and without taking the medications in their properly labeled container to read to the resident.

On [redacted] at 12:15 p.m., Staff B was observed assisting Resident #15 with medications. Staff B opened the computer to Resident #15's profile and proceeded to take Resident #15's medications from the cart, placing the dosage of the medications into a container, without the resident being present, and placing a check mark next to each medication on the EMAR. Staff B took the medications to Resident #15's room, knocked and entered. Resident #15 was not in the room. Staff B exited the room and said, "she may be in the dining room." Staff B proceeded to the dining room located on the 2nd floor, with the container of medications. Staff B walked up to the table where Resident #15 was seated with other residents and said to Resident #15, "I have your 12 o'clock pills for you." Staff B 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 [redacted] at 12:35 p.m., Staff A (med tech) was observed assisting Resident #16 with medications. Staff A parked the medication cart in the hallway on the 2nd floor outside of the dining room. Staff A opened the computer to Resident #16's profile and proceeded to take Resident #16's medications from the cart, placing the dosage of the medications into a container, without the resident being present, and placing a check mark next to each medication on the EMAR. Staff A took the cup of medications down

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the hallway to the resident's room, knocked, and entered. Resident #16 was in the bathroom receiving care from another staff member. Staff A proceeded into the bathroom and said, "I have your morning medicine and . . . spray," giving Resident #16 the medications without informing the resident what medications he was being assisted with and without taking the medications in their properly labeled container to read to the resident.

On at 8:35 a.m., Staff G (med tech) was observed assisting Resident #17 with medications. Staff G parked the medication cart in the hallway on the 2nd floor outside of the dining room. Staff G opened the computer to Resident #17's profile and proceeded to take Resident #17's medications from the cart, placing the dosage of medications into her bare . . then placing it into the container, without the resident being present. Staff G took the cup containing the medications to the resident's room, knocked and entered. Staff G said to Resident #17, "I have your meds for you, I have something special for you it's your special thing," giving Resident #17 the medications without informing the resident what medications he was being assisted with and without taking the medications in their properly labeled container to read to the resident.

On at 8:51 a.m., Staff G was observed assisting Resident #18 with medications. Staff G opened the computer to Resident #18's profile and proceeded to take Resident #18's medications from the cart. Staff G put the dosage of the medications into her bare . . spilling some of the medication onto the top of the medication cart. Staff G picked up the medication with her bare placing it into a

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A 052	Continued From page 25 container. Staff G took the medications to Resident #18's room, knocked, and entered. Staff G said to Resident #18, "I have your meds for you," giving the resident the medications without informing her what medications she was being assisted with and without taking the medications in their properly labeled container to read to the resident. On at 9:04 a.m., Staff G stated she did not know she is required to read the medications to the resident when assisting with self-administration of medications. On at 9:09 a.m., Administrator confirmed there are no residents in the facility with medication waivers and as med techs they are to inform the resident what medications they are receiving when being assisted with their medications. On at 10:48 a.m., Administrator and Wellness Director confirmed the med techs were not following requirements when assisting with self-administration of medications. Class III	A 052		
A 078	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	A 078		

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A 078	Continued From page 26 does not include an employee transferring without 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	A 078		

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A 078	Continued From page 27 perform their assigned duties in accordance with 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 2 (Staff A, and C) of 4 employee records reviewed. The findings included: A review of Staff A's personnel record revealed a hire date of . . . . . as a Med Tech/Resident Aide. Staff A's file contained documentation of a . . . . , completed on . . . . . , and a Drug Screen Result Form dated . There was no documentation of freedom from signs and symptoms of communicable . and . . . . . statement from a health care provider. A review of Staff C's file revealed a hire date of	A 078		

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A 078	Continued From page 28 . . . as a Med Tech/Resident Aide. Staff C's file contained documentation of a , completed on . . . with results indicating No Radiographic evidence of active . . . . . Staff C's file contained no further documentation of freedom from annually thereafter. On . . .. at 11:58 a.m., the Assistant Business Office Manager confirmed the findings. Class III	A 078		
A 093	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~/media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a	A 093		

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A 093	Continued From page 29 licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to	A 093		

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document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility.
2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal.
(f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals.
(g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on
(h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local

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A 093	Continued From page 31 disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide the appropriate diet for one of three residents reviewed (Resident #14), failed to have their menus posted or made available for residents living in the memory unit and failed to have the required amount of food for their emergency supply. The findings included: 1. Observation on at 12:15 p.m. showed Resident #14 eating his lunch. He was served a pureed diet with thin liquids. A review of his health assessment dated showed a physician order for mechanical soft with nectar thick liquids. Further review of Resident #14's record showed the speech pathologist ordered mechanical ground with thin liquids on . There were no other diet orders in Resident #14's record. On at 12:40 p.m., the Administrator and Wellness Director both said they accepted the speech pathologist's diet order and that is was different from the physician's order. They were not aware the diet order had to be from a physician and not a speech pathologist. 2. Observation on at 12:15 p.m. showed a menu dated - posted in memory Unit A. There was no menu posted in memory Unit B. Observation on at 12:00 p.m. showed the same thing. In an interview on at 12:00 p.m., Staff D-Resident Assistant said she did not know where	A 093		

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A 093	Continued From page 32 the menu was for Unit A and B. On . . . . . at 1:00 p.m., director of the memory building said he was not aware the menus had to be either posted or available for the residents or responsible parties. 3. The facility's census is 92 on . The required amount of vegetables for their emergency supply is 3,312 ounces. Observation of the emergency food supply was conducted on at 12:20 p.m. The amount of vegetables in the facility was 1,504.25 ounces. In an interview on Tuesday at 12:20 p.m., the Culinary Director said she is receiving a delivery on Thursday and will have the required amount of vegetables. Class III	A 093		