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
	AL11969359	A. BUILDING: _____ B. WING _____	05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE FORT MYERS	14001 METRO PKWY FORT MYERS, FL 33912

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A 000	Initial Comments An unannounced change of ownership, relicensure, limited nursing service, generator verification, visitation verification, healthcare facility reporting system verification, and complaint survey for #2022001119, #2022003460, #2022006297, #2022008217, #2022009485, #2022012257, and #2023005088 was conducted - at American House, an Assisted Living Facility in Fort Myers, Florida. Complaint #2022001119 was substantiated at tag# A032, A052, A025, and A164. Complaint #2022003460 was substantiated at tag# A032, A052, A025, and A164. Complaint #2022006297 was substantiated at tag# A032, A052, A025, and A164. Complaint #2022008217 was substantiated at tag# A032, A052, A025, and A164. Complaint #2022009485 was substantiated at tag# A032, A052, A025, and A164. Complaint #2022012257 was substantiated at tag# A032, A052, A025, and A164. Complaint #2023005088 was substantiated at tag# A032, A052, A025, and A164. The following is a description of the deficiencies.	A 000		
A 025 SS=D	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 , 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	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1	A 025		

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, 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.

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A 025	Continued From page 2 (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 interview, the facility failed to maintain a written record of any significant changes resulting in medical attention or the provision of additional services for 1 (Resident #15) of 1 resident reviewed for current hospitalization. The facility also failed to contact the resident's family/health care surrogate if the resident exhibits a significant change for 1 (Resident #22). The facility also failed to provide care, services and personal supervision as appropriate for 2 (Residents # 34 and 37) of 3 current residents reviewed for . . The findings included; Facility policy WEL-21-Change of Condition Reporting effective date indicated: 1. All staff must report any change in a resident's status/condition to the Wellness Director. 3. In the event the Wellness Director cannot be reached the Executive Director will be called. 6. Documentation entries of changes in resident status must be reported to the Wellness Director for follow up documentation of reassessment (if necessary) by the Wellness Director. Notification of such occurrences shall be documented in the resident's record. 7. The Wellness Director shall contact the resident's physician's and family/responsible party regarding any serious accident	A 025		

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A 025	Continued From page 3 Facility Policy WEL-42- . Revision date 1. All residents will be evaluated for risk at every occurrence of an American House assessment. Once identified, risk factors will be communicated to community staff by: a. verbal report b. Service Plan c. Interdisciplinary communication. 5. Follow "Incident Reporting" policy for documentation and notifications. An incident report needs to be completed for every witnessed and unwitnessed . The incident report needs to include interventions added to protect/limit future . 6. Investigating a : After a occurs there should be a post investigation to determine the cause of the and the need for additional or modified interventions. The investigation should identify the date, time, location, description of what the individual was doing, assistive devices in use and their condition, environment status, and physical or mental condition of the person prior to the . 1. On at 10:04 a.m., Resident #2 said her brother was also a resident at the facility (Resident #15) and had been sent out to the hospital a few days prior. A review of Resident #15's filed revealed no progress notes or charting that he had been sent out to the hospital a few days prior. On at 12:16 p.m., the Director of Nursing (DON) said she was not aware Resident #15 was in the hospital. She checked the Leave of Absence file on the computer and said he had been out with family since . She said if he was in the hospital the family must have taken him there.	A 025		

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A 025	Continued From page 4 On at 12:20 p.m., Staff B (med tech) said Resident #15 was sent to the hospital, but she didn't know when or why. On at 12:22 p.m., Resident #2 said her brother, Resident #15, was sent from the facility to the hospital on due to difficulty swallowing and . She said since he was admitted they found a , and elevated ammonia levels. She said he remained in the hospital at that time. On at 12:29 p.m., the Administrator said Resident #15 was in the hospital, Administrator said he didn't know if he went to the hospital from the facility or if he was out with family but he would look into it. At 12:30 p.m., the Administrator said Resident #15 was transferred to hospital from the facility. He said he had no specifics as there was nothing in the notes. 2. On at 7:25 p.m., Resident #34's daughter said her mother had a on which resulted in her whole missing skin. Resident #34's daughter said she was never called and that she was the emergency contact. She said she does not know why she wasn't called. She said her mother called her the next day at 7:00 a.m. and told her and they spent the entire next day in the Emergency Room (ER). Daughter said it's something so simple, if she had been called she could have taken the resident to the ER that night and it wouldn't have been so so bad. The daughter said her mother has and can't tell her how she damaged her , but if she'd talked to her that night, she would have been able to tell her. Reviewed progress notes. The notes for	A 025		

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A 025	Continued From page 5 discuss with injury, however there was no documentation that family was contacted about the . Review of incident reporting form for date was left blank under the notification log. Resident # 34's Service plan was dated and indicated no in last 90 days. The Service Plan was not updated to reflect the recent and any specific interventions to prevent further . . On at 8:18 a.m., the Administrator said he was aware Resident #34 had . He said the resident aide did not notify the Assistant Director of Nursing (ADON), the DON or himself. He was aware the family had not been notified and said policy was not followed. On at 10:45 a.m., the Regional Operations Director agreed nothing was documented about the and there was no way to verify the family was notified. She also acknowledged the service plan was not updated to reflect . . 3. Record review of Resident #37's file revealed the facility reported a on resulted in a of on the right . Progress notes revealed 3 further without injury on , and . Resident #37's Service Plan was dated and indicated she had no . It had not been updated to reflect interventions for a resident with multiple . On at 11:26 a.m., the Regional Operations Director agreed the Service Plan had not been updated and no specific interventions were in place.	A 025		

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A 025	Continued From page 6 On . . . . . at 2 p.m., the Director of Nursing said they had work to do. 4. On at 9:05 a.m. in an interview, Resident #22's daughter stated the facility gave her mother medication for the treatment of . . . . . and never informed her of her mother of a change in health status or asked permission to give her mother the medication. Review of facility admission and discharge log revealed Resident #22 was admitted to the facility on . . . . and discharged on . . . . . . On . . . . . at 1:22 p.m., Resident #22's Power of Attorney (POA) stated she was never informed of the new medication ordered and given to her mother for the treat . The POA said no facility staff called and asked for permission for the medication to be given and no one informed her of her mother having a change in health status with . On at 2:30 p.m., the DON stated she has no documentation in the progress notes for Resident #22 that the POA was notified of the new medication ordered or of the health status change for treatment of . On at 10:12 a.m., the Regional Operations Director confirmed Resident #22 was seen by the facility dermatologist without consent from her POA for treated of . . . . . and not notified of the change of condition. Class III	A 025		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards	A 032		

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A 032	Continued From page 7 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 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	A 032		

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A 032	Continued From page 8 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 reviewed and staff interview facility failed to implement elopement policy and procedure in response to elopements related to 6 out of 6 (#24,#29,#38,#39,#40,#41) residents reviewed for elopements. Facility failed to ensure that its resident elopement response policies and procedure included measures the facility must take, at a minimum, of a daily effort to determine that at risk residents have identification on their persons that included their name and the facility's name, address, and telephone number. Facility failed to ensure staff were generally aware of the location of all residents assessed at high risk for elopement at all times. Findings included:	A 032		

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A 032	Continued From page 9 Reviewed the elopement policy and procedure: WEL-36-Elopement. Effective date: . . . . . Revision Date: . Procedure: 1. An Elopement Risk Assessment will be conducted on all prospective assisted living or memory care residents upon move-in, every six moths and change of condition to determine his/her potential for wonder, elope. # 4. Person-centered elopement interventions will be noted in the service plan and communicated to staff members by the wellness director/designee. Environment: 1. A current census should be accessible daily to reference while conducting headcounts at change of shifts and during elopement drills Training: 1. Elopement Drills will conducted quarterly by the Executive/Designee on each shift. 3. Staff will be retrain immediately if an actual elopement occurs. 4. Elopement competency Checklists will be utilized to measure staff performance during the elopement drill. 5. Huddles will be held immediately following any actual elopement. 6. Elopement drill response will be reviewed during Quality Assurance Committee meetings with corrective actions, as necessary. 7. Picture identification of residents at risk for elopement will be placed on the Resident room. A copy of each resident's identification form filed alphabetically. Drills: 1. Elopement drills will be conducted quarterly by the Executive Director/Designee on each shift. 2. All community staff must participate, including all shifts and weekends. 7. The Executive Director/designee will ensure	A 032		

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A 032	Continued From page 10 that staff receives proper training pertaining to elopement procedures during initial orientation and yearly. 8. Elopement drills will be critiqued for staff performance and system vulnerabilities using the Elopement investigation- Root Cause form. Improvements will be made to the policy based on this evaluations and incorporated into the Quality Assurance Committee meetings. 9. Staff will be retrained immediately if an actual elopement occurs. 10. Each community will prepare a tool kit to be used in the event of an elopement. Policy and procedure did not include measures, the facility must take, at a minimum, of a daily effort to determine that at risk residents have identification on their persons that included their name and the facility's name, address, and telephone number. Record review showed Resident #24 eloped on . . . . . Resident #29 eloped on . . . . . Resident #38 eloped on . Resident # 39 eloped on . . . . . Resident #40 eloped on . . . . . Resident #41 eloped on . Further review found no evidence that the facility followed its policy and procedure. There was no evidence of elopement drills after the actual elopements. There was no evidence of staff education after each elopement. There was no evidence that the facility discussed elopements during Quality Assurance meetings. In an interview on . . . at 10:00 a.m. the Director of nursing (DON) said she did not have evidence of staff education after each elopement. The DON said the previous administrator should have documented the staff re-education. The DON said she reassessed all residents, but she	A 032		

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A 032	Continued From page 11 did not have a list of residents that had exit seeking behaviors or were identified as elopement risks. In an interview on [redacted] at 7:30 a.m., the maintenance director said he is the one that is responsible for conducting the elopement drills. He said they are conducted every 6 months on [redacted] and [redacted] each year. Record review of elopement drills provided by the maintenance director were in agreement with his statement that drills were conducted on [redacted] and [redacted] each year. He said he conducted drills on the first or second shift. He said he was not aware that there was an elopement policy and procedure indicating that the drills needed to be completed quarterly on all 3 shifts. He said he did not conduct any elopement drills after actual elopements and he did not have a competency tool. He also said he did not know they were suppose to have prepared an elopement tool kit. In a telephone interview on [redacted] at 7:40 a.m. the regional operations director (ROD) said the facility should have evidence of quarterly elopement drills. ROD said evidence of quarterly elopements were to be submitted to the corporate office. She also said that the previous administrator should have a record of the in-service after each elopement drill and actual elopement. ROD said she will provide them when she arrives at the facility, however, no additional information was provided. In an interview on [redacted] at 8:00 a.m., the receptionist said she has been working at the facility since last year in [redacted]. She said she did not have a list of residents that were exit seeking or were identified as elopement risks. The receptionist said, to her knowledge, all	A 032		

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A 032	Continued From page 12 residents in the main facility were alert and were able to come in and out with out any restrictions. She said she makes sure they sign the log. The receptionist said the facility had a locked memory unit and she assumed the residents in the memory unit, maybe, would be identified as exit seeking, but she was not sure. The receptionist said she did not have a list of residents in the memory unit. She said she had elopement training when she was hired last year and an elopement drill but did not recall the specifics. On .. .... at 9:35 a.m., Caregiver C, in memory unit, stated the following: "There is no one here that is an elopement risk. None of the residents here have exit seeking behaviors. We used to have a resident, she passed long time ago." On .. .... at 9:38 a.m., Caregiver D, in memory unit, stated the following: "There is no one here that is exit seeking. No elopement risks. We don't have any. We used to have one but she a long time ago." On .. .... at 9:38 a.m., a tour was conducted and no resident in the memory unit was observed to have an identification on their person. No pictures of the residents were available. No residents in the facility had identification on their person during the course of the 3 day survey. No resident pictures maintained in resident rooms identifying them as at risk of elopement. On at 10:00 a.m., Regional Operation Director (ROD) provided a list of 18 residents that were identified as elopement risks. ROD acknowledged that none of the residents identified as elopement risks had identification on their person as they should. ROD could not provide the exact date the identifications was no	A 032		

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A 032	Continued From page 13 longer used. She said it was some time ago. ROD said 9 of 18 at risk residents were in the memory unit and the rest in the main building. ROD acknowledged that the receptionist was not given the list of residents that were identified as elopement risks. ROD acknowledged that none of the staff in the facility monitor residents identified as elopement risk on a daily basis. ROD acknowledged that the facility has no method to monitor residents identified as elopement risks. ROD said they began their Quality Assurance program recently, , but have not discuss any elopements. ROD acknowledged that there was no evidence of staff education, root cause analysis of each elopement, or additional elopement drills after each elopement. ROD acknowledged the facility failed to follow their policy and procedure related to elopements for resident #24, #29, #38, #39, #40, and #41. Class III	A 032		
A 052 SS=D	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 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,	A 052		

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A 052	Continued From page 14	A 052		

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.
(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.

Agency for Health Care Administration

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A 052	Continued From page 15 (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 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	A 052		

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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
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.

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A 052	Continued From page 17 (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, record review and interview, the facility failed to properly assist with self-administration of medication for 3 (Resident #12, #13, and #14) of 3 residents observed being assisted with medications. The findings included: On at 11:55 a.m., Staff D (med tech) was observed assisting Resident #12 with medications. Staff D placed the medication into a medication cup with applesauce, scooped it out of the medication cup and fed the spoon with the medication directly into Resident #12's . . . . Resident #12 provided no assistance with taking the medication. On . . . . at 11:57 a.m., Staff D was observed assisting Resident #13 with medications. Staff D placed the medication into a medication cup. She then took the cup to the resident and poured the cup directly into Resident #13's . . . with no assistance from the resident. On at 12:00 p.m., Staff D was observed assisting Resident #14 with medications. Staff D crushed the pill, and mixed it in the medication cup with applesauce. She then scooped it out on a spoon and fed it directly into Resident #14's	A 052		

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A 052	Continued From page 18 . . . with no assistance from the resident. On .. .... at 12:05 p.m., Staff D said she had taken the med tech training and knew the residents were supposed to assist, but Resident #12 drops it, Resident #13 can't hold anything, and Resident #14 will just drop it on the floor. On .. .... at 12:36 p.m., the Director of Nursing (DON) said the staff have been trained on medications assistance vs medication administration. The DON said med techs are definitely supposed to have the resident assist. The DON said they had discussed that multiple times and she will have to train again. Class III	A 052		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to	A 056		

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A 056	Continued From page 19 another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , . . . , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled	A 056		

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A 056	Continued From page 20 or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure that prescriptions for residents who receive assistance with self-administration of medications are refilled in a timely manner for 3 (Residents #2, #12 and #15) of 3 residents reviewed for medication refills. The findings included: Facility Policy WEL-73-Medication Order, effective date [redacted] indicated under Medication	A 056		

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A 056	Continued From page 21 ordering bullet #4: Reordering Mediations for Residents utilizing the Community's Preferred Pharmacy: a. when medications have reached a 3 day supply, complete the pharmacy's medication reorder form. Fax to the supplying pharmacy. Review of contract for Residents #2, #12 and #15 revealed all 3 chose to have their prescriptions filled through the Community's Preferred Pharmacy. 1. On [redacted] at 10:04 a.m., Resident #2 said there were two times that she did not get her [redacted] meds and it resulted in her having a [redacted]. She also said her brother Resident #15 did not receive his medications to keep his ammonia levels in check and was currently in the hospital with high ammonia levels. Record review of Resident #2's Medication Observation Record for [redacted] revealed [redacted] ([redacted]) was not given on [redacted] and [redacted], Divaloproex ([redacted]) was not given on [redacted] and [redacted] (lowers [redacted]) was not given on [redacted] and [redacted]. These medications were marked as not in the cart. Record review of Resident #15's Medication Observation Record for [redacted] revealed [redacted] (supplement) was not given on and [redacted] ([redacted]) was not given on [redacted] (ammonia reducer) was not given on [redacted], and [redacted] ([redacted]) was not given on [redacted] and [redacted] (for high [redacted]) was not given on [redacted] and [redacted]. All of these were marked as not in the cart.	A 056		

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A 056	Continued From page 22 Progress notes reveal Resident #15 was sent to the hospital on and another note dated indicating he was admitted for elevated ammonia level. There was no documentation as to his return and on at 12:16 p.m., the Director of Nursing said he returned to the facility on . On a record review of the Medication Observation Record for for Resident #15 revealed was not given on and was not given on . Per resident #15's sister he was admitted to the hospital on with elevated ammonia levels. No documentation was found in the chart about this. 2. On at 11:55 a.m., Staff D (med tech) was observed assisting Resident #12 with medications. Staff D said he was supposed to get (,) but there was none available on the cart and they would not get it in until the 17th. She said he got the last one on . Record review of Resident #12's Medication Observation Record for , revealed (,) was not given on , 15, 16, 21, and 22. , powder (lowers) was not given on , 16, 21, 22, 28, 29, and 30. (assists with sleep) was not given on , 13, and 24. (,) was not given on , 4, 6, 7, 8, 9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, and 28. All were documented not on cart or waiting for meds. Record review of Resident #12's Medication Observation Record for , revealed	A 056		

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A 056	Continued From page 23 . . . . . was not given on . . . . . Powder was not given , 13, and 16. Acetominophen was not given . . . . , (, ,) was not given , 4, 5 x 2 doses , 6 x 2 doses, and 9th. . . was not given on , 14, and 15th. All were marked ordered not in yet, not on cart or waiting on meds from pharmacy. On at 10:30 a.m., the Director of Nursing (DON) said the missing medications depended on who filled the prescriptions. She said if it was the facility pharmacy they should order them ahead of time. If a resident does their own ordering the family will have to bring them in and if they don't we don't have them on . She said she was not sure who filled Resident #2, #12, and #15's meds and she would have to follow up with that. Class III	A 056		
A 160 SS=D	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. 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 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	A 160		

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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 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,

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A 160	Continued From page 25 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 429.435, 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) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.;	A 160		

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A 160	Continued From page 26 (w) 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. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an up to date admission and discharge log to include the date of discharge, and the facility or home address resident was discharged to for 4 (Residents #38, 39, 40, and 41) of 4 residents reviewed for discharge date. The findings included: 1. Facility reported Resident #38 had an elopement event on , and upon investigation need was discovered for memory care but the facility had no memory care vacancy. Progress notes were not available for this resident due to facility changed over in computer systems. Review of the provided admission/discharge log to did not contain Resident #38, when or where they had been discharged to. 2. Facility reported Resident #39 had an elopement event on . Progress notes were not available for this resident due to facility changed over in computer systems. Review of the provided admission/discharge log to did not contain Resident #39, when or where they had been discharged to. 3. Facility reported Resident #40 had an elopement event on , and upon investigation need was discovered for memory care placement, but the facility had no memory care vacancy. Progress notes were not available	A 160		

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	AL11969359	A. BUILDING: _____ B. WING _____	05/17/2023

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A 160	Continued From page 27 for this resident due to facility changed over in computer systems. Review of the provided admission/discharge log . . . to . . . . . did not contain Resident #40, when or where they had been discharged to. 4. Facility reported Resident #41 had an elopement event on , and upon investigation need was discovered for memory care placement, but the facility had no memory care vacancy. Progress notes were not available for this resident due to facility changed over in computer systems. Review of the provided admission/discharge log to did not contain Resident #41, when or where they had been discharged to. On at 9:33 a.m., the Regional Operations Director said the log they are using is computerized and it doesn't have everything on it. She said they had used a . . . written log which she said they should be using. She showed me the log and last time it was documented in was 2019. On at 12:16 p.m., the Regional Operations Director explained they were having difficulty getting legible progress notes and other documents off the old computer system and to move forward with what they had given us. She said if you don't have it after 3 days, just assume we don't have it. Class III	A 160		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include:	A 162		

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A 162	Continued From page 28 (a) Resident demographic data as follows: 1. Name, 2. [illegible], 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 [illegible], 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 resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, [illegible], 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 paragraph 59A-36.007(1)(f), F.A.C. (f) A [illegible] 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 [illegible] recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in	A 162		

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A 162	Continued From page 29 writing that [illegible] not be taken. (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 [illegible] ([illegible]), CF-ES 1006, [illegible], 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 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 [illegible] of a	A 162		

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A 162	Continued From page 30 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 a log listing the names of residents participating in this arrangement. (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 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 interview the facility failed to ensure and maintain all required documentation and resident records onsite at the facility for 4 (Resident #22, 38, 39, 40, and 41) of 4 resident records and documentation requested. The findings included:	A 162		

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A 162	Continued From page 31 On . . . . . at 10:40 a.m., a request was made to the Director of Nursing for the clinical record inclusive of progress notes, and physician orders for Resident #22. On at 1:00 p.m., second request for records for Resident #22 and no documentation provided. On at 2:25 p.m., a third request was made to the Director of Nursing and Executive Director of documents including progress notes, Form 1823, and incident reports for Resident #22. On at 10:00 a.m., records requested again for Resident #22 with progress notes, physician orders, and Form 1823. No documentation were provided. On . . . . . at 10:40 a.m., DON stated the clinical record for Resident #22 was in the old computer system used by the facility and she has no access to the record as the facility no longer uses the system. The Director of Nursing (DON) acknowledged the facility is required to keep resident records for 2 years and currently they don't have the records requested for Resident #22. On . . . . . at 2:30 p.m., the DON stated she has no documentation of progress notes for Resident #22. On . . . . . at 8:59 a.m., the Director of Nursing confirmed she has no clinical record inclusive of Form 1823, and physician orders for Resident #22 The facility reported that Resident #38 eloped on	A 162		

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A 162	Continued From page 32 . . . . . , Resident #39 eloped on . . . . , Resident #40 eloped on . . . . , and Resident #41 eloped on . . . . . Multiple requests were made throughout the 3 day survey for progress notes surrounding the incidents. The facility was unable to provide the the requested documents by end of survey. On . . . . . at 12:16 p.m., Regional Operations Director said if she can't give the documentation, she does not have it. She said at this point it's been 3 days and if we have not gotten it, she does not have the documentation." Class III	A 162		