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 _____	10/29/2024

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 relicensure, emergency power plan, health facility reporting system, visitation form and complaint survey for #2023008488, #2023013066, #2024007882, #2024010935, and #2024012711 was conducted on through , at American House Fort Myers, an assisted living facility, in Fort Myers, Florida. Complaint #2023008488 was not substantiated. Complaint #2024007882 was not substantiated. Complaint #2023013066 was substantiated at A0165 Complaint #2024010935 was substantiated at A032. Complaint #2024012711 was not substantiated. This survey was completed in conjuction with a revisit survey. The following is a description of the deficiencies.	A 000		
A 032 SS=D	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	A 032		

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A 032	Continued From page 1	A 032		

emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days.
1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times.
2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative.
(b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must 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

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A 032	Continued From page 2 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 the facility failed to follow its policy to ensure that residents deemed as an elopement risk have identification on their persons that included their name, the facility's name, address, and telephone number. The findings included: Requested and obtained elopement policy and procedure: WEL-36-Elopement. Effective date: . Revision Date: . . . .Policy: It is the American House policy to ensure safety procedures are implemented to strive to prevent, identify, and respond to resident elopements. Procedure: environment: The community's environment will support safe walking and . socialization and interaction: 10. For Florida only-Each resident identified as an elopement risk, will maintain on their person an identification that includes their name and the facility's name, address and the telephone number. Requested and obtained list of residents deemed as elopement risk. Per list provided all 22 residents in the facility's memory unit were deemed as an elopement risk. During an observation on at 12:00 p.m., none of the 22 residents in the memory was	A 032		

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A 032	Continued From page 3 observed having any identification on their persons that included their name, and the facility's name, address, and telephone number. During an interview with the Wellness Director (WD) on at 10:00 a.m., she confirmed no resident in the memory unit had identification on their persons that included their name, and the facility's name, address, and telephone number. The WD said she was not aware of the regulatory requirement. Second observation with the WD present on at 10:40 a.m., none of the residents in the memory unit had identification on their persons that included their name, the facility's name, address, and telephone number. During an interview the Administrator acknowledged on at 5:00 p.m., that none of the residents deemed as elopement risk had identification on their persons that included their name, the facility's name, address, and telephone number. 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	A 052		

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A 052	Continued From page 4 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 5 (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a , of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , , , , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with	A 052		

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A 052	Continued From page 6 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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A 052	Continued From page 7 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, interview, and record review, the facility failed to ensure employees who assist with self-administration of medications performed proper sanitization between residents to ensure control, for 3 residents (#18, #19, #26) of 3 reviewed for assistance with self administrations of medications. The findings included: Review of the Policy titled: Medication Administration policy Number: WEL-69-Medication Administration, Effective date: . Revision Date . . . Procedure: Before medication pass: . .3. wash your before beginning and before contact with each resident. Sanitizing wipes or gel may be used. On at 7:36 a.m., Staff C was observed assisting Resident #18 with self administration of medications. Staff C went to the medication cart	A 052		

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and began to prepare medications for Resident #18. Staff C did not sanitize or wash her prior to preparing medications for Resident #18. There was an empty bottle of sanitizer on the side of the medication cart. Staff C assisted with medication self-administration giving Resident #18 his medications in the bedroom. Staff C did not perform hygiene before, during, or after assisting Resident #18 with his medications and continued to the next resident.

On at 7:44 a.m., Staff C proceeded to the medication cart to prepare medications for Resident #19. Staff C did not sanitize or wash her prior to preparing the medications for Resident #19. Staff C entered the room and gave Resident #19 the medications. Staff C did not stop at the sink to wash her or apply sanitizer before, during or after assistance with medications for Resident #19. Staff C continued to the next resident.

On at 7:55 a.m., Staff C proceeded to the medication cart and began to prepare medications for Resident #26. Staff C did not sanitize her prior to medication assistance for Resident #26. Staff C did not wash her at the sink in the resident's room after she entered. Staff C assisted Resident #26 with medications and exited the room. Staff C did not wash or sanitize her before, during or after the assistance with medications for Resident #26.

On at 8:02 a.m., Staff C verified she did not wash or sanitize her between medication assistance for Resident's #18, and 19 Staff C acknowledged the sanitizer bottle on the side of the cart was empty, and there were no others for her to use.

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A 052	Continued From page 9 On at 8:05 a.m., Medication Technician Staff D said staff are supposed to sanitize their between residents, either by washing or using Based Rub (ABHR). She said the bottle of sanitizer on the medication cart was empty and there were no others in the area to use. On at 9:56 a.m., Medication Technician Staff E said sanitizing between residents is part of the process for control and must be done between residents during any type of care or medication assistance. On at 9:26 a.m., the Wellness Director said staff should be sanitizing between residents according to the facility policy when assisting with self-adminsitrtion of medications.. Class III .	A 052		
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For	A 165		

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A 165	Continued From page 10 purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be	A 165		

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reported to the Department of Children and Families as required under chapter 415.
(7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.
(8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board.
(9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board.
(10) The agency may adopt rules necessary to administer this section.

This Statute or Rule is not met as evidenced by:
Based on interview and record review, the facility failed to submit adverse incident reports within

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the required time frames for 4 residents (#3, #20, #21, and #22) of 4 residents reviewed. The facility failed to ensure Adverse incident reports were
submitted within day 1 for the preliminary report, and day 15 for the full report as required.

The findings included:

Review of the facility policy titled: Incident Reporting WEL-58-Incident Reporting, Effective Date: . Revision Date: .
Procedure: 7. "The executive director must notify the appropriate State agency within the required State regulations. The exact date, time, and name of contact with the State agency must be recorded on the appropriate investigation form."

1. Review of the confidential report for Resident #20 revealed an adverse incident on whereby Resident #20 complained of , , . and the inability to move on . Resident #20 had an unwitnessed earlier in the day.

Review of the progress note dated revealed Resident #20 was found in her bed in the morning complaining about severe , in her , . The resident could not move and was crying and moaning. 911 was called and Resident #20 was transported to the hospital.

Review of the facility progress note dated revealed resident #20 returned from hospital on with 5 broken .

Review of the confidential report submitted to the agency revealed the facility submitted the preliminary report on , which was not within the 1-day reporting requirement.

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A 165	Continued From page 13 Review of the confidential report submitted to the agency revealed the facility submitted the full report for Resident #20 on , 21 days after the incident involving broken bones, which was not within the 15 day requirement. 2. Review of the confidential report for Resident #3 revealed an adverse incident requiring transfer of the resident from the facility to a unit providing more acute care due to the incident. Resident #3 was found on the floor on at 1:18 a.m. Resident #3 sustained a , and 2 small hematomas and was transferred to Gulf Coast Hospital. Review of the confidential report revealed the facility submitted the preliminary report on , which was not within the 1 day requirement. 3. Review of the confidential report for Resident #21 revealed a on . Resident #21 was found on the floor by staff. Resident #21 complained of , to right , . Resident #21 was transferred to Gulf Coast Hospital with a right , . Review of the confidential report revealed the facility filed the preliminary report with the agency on , which was not within the 1 day requirement. 4. Review of the confidential report for Resident #22 revealed resident #22 had a condition that required transfer to a higher level for acute care due to an incident on . The resident was found on the floor and was unable to tell exactly the time the incident happened. The facility transferred resident #22 to Gulf Coast Medical Center. Resident #22 had a , and	A 165		

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	AL11969359	A. BUILDING: _____ B. WING _____	10/29/2024

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 165	Continued From page 14 underwent surgery on . On at 5:06 p.m. during an interview with Resident #22's daughter, she said someone from the facility called her in pre-op on before the resident's surgery. The daughter said she told the facility staff Resident #22 had a . Review of the confidential report revealed the incident involving Resident #22 occurred on 10 /5/24 at approximately 10:38 p.m. Review of the facility progress note revealed the facility was aware of the , on at 3:53 p.m. The facility did not submit the preliminary report to the state agency until at 6:31 p.m., which was not within the 1 day requirement. On at 3:35 p.m., during an interview, the Wellness Director said she is responsible for submitting adverse incident reports to the state agency. She said she realized the preliminary is due within 1 day, but sometimes she is not sure if the resident has broken bones or not. She said she thought she had 21 or 22 days to submit the full report. On at 4:21 p.m., during an interview, the Executive Director said the Wellness Director has been submitting the reports. She said she is aware of the 1-day preliminary report requirement and the 15-day full report requirement. The executive director said the preliminary reports should have been submitted within 1 day of the incident for anything involving transfer to a higher level of care, such as hospital. The executive director confirmed the adverse incident reports were not submitted within the required time frames as required.	A 165		

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A 165	Continued From page 15 Class III .	A 165		

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CZ830 SS=D	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 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	CZ830		

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CZ830	Continued From page 1	CZ830		

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 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

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CZ830	Continued From page 2 approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. 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 at 10:30 a.m. the Administrator provided documentation of a Comprehensive Emergency Management Plan (CEMP) approval letter dated . The letter indicated CEMP approval through . . The letter further indicated the CEMP needed to be submitted before , of each year for review. The Administrator provided further evidence of documentation of submittal of the Comprehensive Emergency Management Plan (CEMP) on . The letter indicated on the plan did not meet the Emergency Management criteria requirements and requested the facility resubmit the entire plan within 30 days. The Administrator provided further evidence of documentation of submittal of the Comprehensive Emergency Management Plan (CEMP) on . The letter indicated on the plan did not meet the Emergency Management criteria requirements and requested the facility resubmit the entire plan within 30 days. No CEMP resubmitting provided.	CZ830		

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CZ830	Continued From page 3 On at 5:00 p.m. Administrator acknowledged that the facility did not have an approved CEMP. The Administrator said that the person responsible to submit the facility's CEMP plan , . Corporate office was unaware of , the persons passing. When they were informed they made arrangements, but they are still in the process of completing the CEMP to resubmit. Class III .	CZ830		