

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969359	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE FORT MYERS			STREET ADDRESS, CITY, STATE, ZIP CODE 14001 METRO PKWY FORT MYERS, FL 33912		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 000	Initial Comments An unannounced complaint survey for #2025001674 was conducted on _____ at American House Fort Myers, an assisted living facility in Fort Myers, Florida. Complaint # 2025001674 was substantiated at A 0025, A 0030. The following is a description of the deficiencies: .	A 000			
A 025 SS=H	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 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	A 025			

AHCA Form 3020-0001

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

TITLE

(X8) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969359	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE FORT MYERS			STREET ADDRESS, CITY, STATE, ZIP CODE 14001 METRO PKWY FORT MYERS, FL 33912		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 025	Continued From page 1 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. (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 adequate supervision, and maintain the general awareness of resident whereabouts in support of the safety and well-being of 1 (Resident #1) of 1 resident reviewed. The findings included:	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969359	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE FORT MYERS		STREET ADDRESS, CITY, STATE, ZIP CODE 14001 METRO PKWY FORT MYERS, FL 33912		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 2 Review of Resident #1's progress notes on showed that Resident #1 was found outside, he could barely walk, when staff tried to talk to him, he could not speak, and kept asking for help, he did not look good, and was transported by (emergency medical services) to the hospital. Review of Emergency Department provider notes on showed that Resident #1 was found sitting outside sweating, with an elevated temperature of 106 degrees Fahrenheit, upon assessment by , and appeared to have mild sunburns to the lower extremities as well as . The resident had to his and was unknown if he had suffered a . The resident was treated and discharged to the facility on . Review of Resident #1's progress notes on showed that Resident #1 suffered a while outside in the courtyard of the memory care unit. The resident had a injury, multiple on both arms and and was transported to the hospital. Review of Service Plan Resident Service Sign Off sheet which included a signoff chart in which all 3 shifts each day were required to verify all resident needs per the service plan have been provided during the initialed shift and day. Resident #1 sign off sheet was blank. During an interview on at 2:25 p.m., Staff B said that she received a call on from another resident on the second floor of the facility who had witnessed a resident somewhere outside. She then called staff over the pager to alert them of the resident.	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969359	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/19/2025
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE FORT MYERS

**14001 METRO PKWY
FORT MYERS, FL 33912**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 3 Review of Emergency Department (ED) notes on for Resident # 1 indicated Resident #1 went to the ED after being found down on the ground with an unwitnessed outside of the memory care unit. This is the second ER visit within 24 hours. He was and received fluids. During an interview on at 1:53 p.m., Staff C said that he responded in the memory care unit to the pager alert and that they could not find Resident #1 at first, but then they found him outside in the corner in the courtyard. Further review of Emergency Department provider notes showed that when Resident #1 arrived, he was noted to be wearing 6 shirts and 1 jacket. His body was covered in sunburn and multiple and . He was also noted to be covered in feces. Resident #1 was admitted to the hospital for concerns of neglect, continued evaluation, and care. Review of Resident #1's sheet shows a move in date of . His resident health assessment (Form 1823) dated , revealed his or behavioral status to be very , restless, and agitated. It stated that Resident #1 needed assistance with ADLs (activities of daily living). It also indicated he was a risk. During an interview on at 3:09 p.m., the Executive Director said that memory care staff are trained to always have an awareness of where the residents are. They are to round and check on them if they do not know where they are. Class III	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969359	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE FORT MYERS			STREET ADDRESS, CITY, STATE, ZIP CODE 14001 METRO PKWY FORT MYERS, FL 33912		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 025	Continued From page 4	A 025			
A 030 SS=H	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	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969359	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE FORT MYERS			STREET ADDRESS, CITY, STATE, ZIP CODE 14001 METRO PKWY FORT MYERS, FL 33912		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 030	Continued From page 5 pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed 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	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969359	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/19/2025
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE FORT MYERS

**14001 METRO PKWY
FORT MYERS, FL 33912**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 6 any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from _____ and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the 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	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969359	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE FORT MYERS		STREET ADDRESS, CITY, STATE, ZIP CODE 14001 METRO PKWY FORT MYERS, FL 33912		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 7 several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making . . . for health care services, the provision of or arrangement of transportation to health care . . . and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally . . . , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and 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	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969359	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE FORT MYERS			STREET ADDRESS, CITY, STATE, ZIP CODE 14001 METRO PKWY FORT MYERS, FL 33912		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 030	Continued From page 8 show good cause in a court of competent jurisdiction. (1) 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	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11693359	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE FORT MYERS			STREET ADDRESS, CITY, STATE, ZIP CODE 14001 METRO PKWY FORT MYERS, FL 33912		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 030	Continued From page 9 Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated or under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure that resident rights were honored by providing a safe and decent living environment, free from and neglect, for 1 (Resident 1) of 1 resident reviewed. This puts a population at risk of significant to their physical, mental, or emotional health. The findings included: & Neglect policy; effective date , revision date . Policy: "It is the policy of American House to protect all resident rights,	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969359	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE FORT MYERS			STREET ADDRESS, CITY, STATE, ZIP CODE 14001 METRO PKWY FORT MYERS, FL 33912		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 030	Continued From page 10 prohibit , neglect, and misappropriation of resident property. All reports of suspected will be investigated in a timely manner, with emphasis on protection of the resident after report of an incident and during the investigation." ...Purpose: to ensure resident safety.Procedure: Definitions; "...a pattern of conduct or inaction of a care provider that fails to provide goods or services that maintain physical or mental health or that fails to avoid or prevent physical or mental harm or , or an act of omission that constitutes a clear and present danger to health, welfare, or safety of a resident." Review of Resident #1's progress notes on showed that Resident #1 was found outside, he could barely walk, when staff tried to talk to him, he could not speak, and kept asking for help, he did not look good, and was transported by (emergency medical services) to the hospital. Review of Emergency Department provider notes on showed that Resident #1 was found sitting outside sweating, with an elevated temperature of 106 degrees Fahrenheit, upon assessment by , and appeared to have mild sunburns to the lower extremities as well as . The resident had to his and was unknown if he had suffered a . The resident was treated and discharged to the facility on . Review of Service Plan Resident Service Sign Off sheet which included a signoff chart in which all 3 shifts each day were required to verify all resident needs per the service plan have been provided during the initialed shift and day. Resident #1 sign off sheet was blank. Review of Resident #1's progress notes on	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969359	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE FORT MYERS			STREET ADDRESS, CITY, STATE, ZIP CODE 14001 METRO PKWY FORT MYERS, FL 33912		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 030	Continued From page 11 showed that Resident #1 suffered a while outside in the courtyard of the memory care unit. The resident had a injury, multiple on both arms and and was transported to the hospital. During an interview on at 2:25 p.m., Staff B said that she received a call on from another resident on the second floor of the facility who had witnessed a resident somewhere outside. She then called staff over the pager to alert them of the resident. Review of Emergency Department (ED) notes on for resident # 1 indicated Resident #1 went to the ED after being found down on the ground with an unwitnessed outside of the memory care unit. This is the second ER visit within 24 hours. He was and received fluids. During an interview on at 1:53 p.m., Staff C said that he responded in the memory care unit to the pager alert and that they could not find Resident #1 at first, but then they found him outside in the corner in the courtyard. Further review of Emergency Department provider notes showed that when Resident #1 arrived, he was noted to be wearing 6 shirts and 1 jacket. His body was covered in sunburn and multiple and . He was also noted to be covered in feces. Resident #1 was admitted to the hospital for concerns of neglect, continued evaluation, and care. Review of Resident #1's sheet shows a move in date of . His resident health assessment (Form 1823) dated revealed his or behavioral status to be	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969359	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE FORT MYERS			STREET ADDRESS, CITY, STATE, ZIP CODE 14001 METRO PKWY FORT MYERS, FL 33912		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 030	Continued From page 12 very , restless, and agitated. It stated that Resident #1 needed assistance with ADLs (activities of daily living). It also indicated he was a risk. During an interview on at 3:09 p.m., the Executive Director said that memory care staff are trained to always have an awareness of where the residents are. They are to round and check on them if they do not know where they are. Class III .	A 030			