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
	AL11910486	A. BUILDING: _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRILL GARDENS AT BARKLEY PLACE	36 BARKLEY CIRCLE FORT MYERS, FL 33907

(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 relicensure, emergency power plan monitoring, health facility reporting system and visitation form survey was conducted on through at Merrill Gardens at Barkley Place, an assisted living facility in Fort Myers, Florida. The following is the description of the deficiencies: .	A 000		
A 032 SS=F	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c),	A 032		

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A 032	Continued From page 1 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 subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record review, and interviews, the facility failed to ensure all administrators and direct care staff participated in an Elopement	A 032		

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A 032	Continued From page 2 drills twice a year, which must include a review of the facility's procedures to address resident elopement for 15 (Staff A, B, C, H, I, J, K, L, M, N, O, P, Q, the Resident Care Director and the General Manager) of the 15 staff currently hired who worked in 2023 and 2024. The findings included: 1. Review of the Elopement Drill Forms from through showed the following: On at 3:05 p.m., an elopement drill was conducted at the facility. 5 direct care staff were documented as attending with the staff members signatures. On at 7:30 p.m., an elopement drill was conducted at the facility. 4 direct care staff were documented as attending. No staff members' signatures were documented. On 6/2823 at 6:30 a.m., an elopement drill was conducted at the facility. 3 direct care staff were documented having attended with signatures. On 7/ 31/23 at 11:00 a.m., an elopement drill was conducted at the facility. 3 direct care staff were documented as attending with signatures. On at 6:00 a.m., 8:00 a.m., and 5:00 p.m., elopement drills were conducted at the facility. A total of 6 direct care staff were documented attending with signatures. On at 7:30 p.m., an elopement drill was conducted at the facility. 3 direct care staff were documented as attending with signatures. On at 12:00 p.m., an elopement drill was conducted at the facility. 2 direct care staff	A 032		

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A 032	Continued From page 3 were documented attending with signatures. On at 10:00 a.m., an elopement drill was conducted at the facility. The only staff listed as participants was the Resident Care Director and the Senior Maintenance Director. No signatures were documented. Record Review of Employee Status listing showed 63 staff listed of which 15 were listed as administrative or direct care and hired between , and . Of those 15 current direct care or administrative staff record review revealed the following: Caregiver Staff A was hired on . Caregiver Staff A was not documented to have attended any of the 5 elopement drills conducted in 2023 and only 1 of 3 elopement drills conducted in 2024. Caregiver Staff B was hired on . Caregiver Staff B was documented to have attended only 1 of 3 elopement drills conducted in 2024. Caregiver Staff C was hired on . Caregiver Staff C was documented to have attended 2 of the 5 elopement drills conducted in 2023 but only 1 of 3 elopement drills conducted in 2024. Caregiver Staff H was hired on . Caregiver Staff H was documented to have attended 2 of the 5 elopement drills conducted in 2023 but did not have any of 3 elopement drills conducted in 2024. Caregiver Staff I was hired on . Caregiver Staff I was not documented to have attended any of 3 elopement drills conducted in 2024.	A 032		

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A 032	Continued From page 4 Caregiver Staff J was hired on . Caregiver Staff J was not documented to have attended any of the 2 elopement drills conducted in 2023 after Staff J's date of hire, and only 1 of 3 elopement drills conducted in 2024. Caregiver Staff K was hired on . Caregiver Staff K was not documented to have attended any of 2 elopement drills conducted in 2024 after Staff K's date of hire. Caregiver Staff L was hired on . Caregiver Staff L was not documented to have attended any of 3 elopement drills conducted in 2024. Caregiver Staff M was hired on . Caregiver Staff M was not documented to have attended any of the 5 elopement drills conducted in 2023, or any of 3 elopement drills conducted in 2024. Caregiver Staff N was hired on . Staff N was not documented to have attended any of 2 elopement drills conducted in 2024 after Staff N's date of hire. Caregiver Staff O was hired on . Staff O was not documented to have attended any of 3 elopement drills conducted in 2024. Caregiver Staff P was hired on . Caregiver Staff P was not documented to have attended any of the 5 elopement drills conducted in 2023, or any of 3 elopement drills conducted in 2024. Caregiver Staff Q was hired on . Staff Q was not documented to have attended any of 3 elopement drills conducted in 2024. The General Manager (GM) was hired on	A 032		

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A 032	Continued From page 5 , The GM was was not documented to have attended any of the 5 elopement drills conducted in 2023 nor any of 3 elopement drills conducted in 2024. The Resident Care Director (RCD) was hired on . The RCD was was not documented to have attended any of the 5 elopement drills conducted in 2023 and only 1 of 3 elopement drills conducted in 2024. 2. On at 11:40 a.m., during an interview, the Caregiver Staff C said she did not recall attending an elopement drill or any training. She said an elopement has never happened here. On at 1:05 p.m., during an interview, the General Manager said the facility does 2 elopement drills a year, but I didn't know that all the staff needed to participate. The only people that participate in the drills are on site at the time of the drill. We are not calling staff in for drills. The General Manager confirmed that there was no evidence that all direct care and administrative staff participated in elopement drills as required. On at 1:45 p.m., during an interview with the Senior Maintenance Director, he said the elopement drills needed to be done twice a year. Class III .	A 032		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256	A 052		

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A 052	Continued From page 6 (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, 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	A 052		

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A 052	Continued From page 7 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. (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	A 052		

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A 052	Continued From page 8 with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record,	A 052		

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A 052	Continued From page 9 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure staff providing assistance with self-administration of medications do so appropriately and according to the facility policy for 2 (Residents #11, #12) of 2 residents observed. The findings included: Facility's Policy: Assistance with Self-Administration of Medication by Unlicensed Caregivers, Revised , under "Assistance with Self-Administration of Medication: The trained unlicensed Caregivers may perform the following activities: . . . b. In the presence of the resident, reading the label, opening the container, removing a prescribed	A 052		

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A 052	Continued From page 10 amount of medication from the container, and closing the container." 1. On at 12:19 p.m., record review of the Medication Administration Record for Resident #12 showed an order for External Gel 1%, 1% , Gel, with the directions to "Apply , to Four Times Daily". DX: with a start date of . On at 12:20 p.m., observation of Caregiver Staff A providing assistance with self-administration of medications to Resident #12, revealed Staff A removed the 1% Gel tube from the cart then brought the tube into Resident #12's room, squeezed out a small amount of gel into her gloved and administered the gel to Resident #12's right . Staff A failed to administer the medication as ordered to Resident#12's . Staff A failed to tell Resident #12 the name and dose of the medication given. On at 2:50 p.m., during an interview, Caregiver Staff A said she put the medication on his because that is where he was having right now. He does not have in his anymore. 2. On at 4:00 p.m., record review of Resident #11's Medication Administration Record showed an order for Oral Tablet 5 MG, Take 1 tablet by twice daily with meals. The medication was to be given at 8:00 a.m. and 5:00 p.m. daily. The medication was recorded as not given 12 times from to . On , record review of Resident #11's	A 052		

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A 052	Continued From page 11 chart revealed a request from the facility to discontinue the order for from Resident's Primary Care Physician (PCP), on and . Response from the PCP on was for the facility to contact the resident's for refills for this medication. No further response was noted in the resident's file. No follow-up with was noted in the file. On at 9:57 a.m., during an interview, the Resident Care Director (RCD) said, "I don't know if the was notified." On at 11:45 a.m., during an interview, Caregiver Staff B said they notified the pharmacy that the medication needed to be refilled. The primary care physician will not discontinue or refill the medication because the needs to refill it. I don't know if she has an with the . On at 4:00 p.m., observation showed Staff B provided assistance with self-administration of medications to Resident #11. Observation showed Staff B placed a Oral Tablet 7.5MG in a cup, she then dissolved a tablet of in juice and handed the juice and tablet to Resident #11. Staff B did not tell Resident #11 the name or dosage of the medications given. On at 9:57 a.m., during an interview, the Resident Care Director (RCD) said, "If a medication doesn't come in the Caregiver will put a note in and let me know." Class III	A 052		

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A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their	A 078		

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A 078	Continued From page 13 qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure that staff had evidence of a negative or evidence of freedom from signs and symptoms of communicable annually thereafter for 1 (Administrator) of 3 employee files reviewed. The findings included: Record review revealed the Administrator was hired on . Further review revealed initial documentation of a negative ( ) test dated . There was no annual updated	A 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910486	A. BUILDING: _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRILL GARDENS AT BARKLEY PLACE	36 BARKLEY CIRCLE FORT MYERS, FL 33907

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A 078	Continued From page 14 test or documentation of freedom of communicable for 2023 and 2024. On at 3:45 p.m., during an interview, the Administrator said that he hadn't had a test in quite a while. On at 1:10 p.m., during an interview the Administrator stated, "No, I have not had a recent or communicable update." Class III .	A 078		
A 152 SS=E	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for	A 152		

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A 152	Continued From page 15 storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide a safe, homelike environment free from roaches and ensure completion of building repairs for broken glass to the door to the courtyard. The findings included: 1. On at 10:45 a.m., during an interview, Resident #10 said that she has roaches in her room and has notified the facility. "It's a common occurrence." On , at 1:45 p.m., during an interview, the Maintenance Director (MD) verified that there were some roach concerns. He said he contacts the pest control vendor and adds the unit number to the Pest Control binder. The MD then spreads poison dust behind kitchen equipment in resident units until the pest control company comes out during their next scheduled visit. On , at 3:00 p.m., during an interview, the	A 152		

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A 152	Continued From page 16 Administrator said that he has been in constant contact with the pest control company. The Administrator verified that there are multiple apartments with roach issues throughout the building. On at 9:20 a.m., during an interview, Housekeeper Staff D said there was a constant roach issue. On at 9:25 a.m., during an interview, Cook Staff F said that there are roaches in the kitchen, and he killed one that morning. Staff F said he kills them as he sees them, he does not report them to anyone. On at 10:30 a.m., during an interview, Resident #13 stated he moved into his unit in and immediately saw roaches. After 3 days, he was told by maintenance that his apartment would need to be fogged. On , at 2:00 p.m., during a telephone interview, the Pest Control manager stated that it was "non-compliant" for the facility to provide its own pest control products. He stated, "The Maintenance Director is not a certified operator and should not be putting bait or dust in the building. That should be done by a certified applicator in the State of Florida." 2. On during the tour of the McGregor Room at the facility, a broken glass panel was observed in the door leading out to the courtyard. On at 12:20 p.m., during an interview, the Senior Maintenance Director, he said, "I don't know how it broke. I noticed it a couple months ago. He said he had gotten a quote but had not sent the quote to the General Manager for review	A 152		

Agency for Health Care Administration

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A 152	Continued From page 17 yet. On , record review of facility records revealed documentation of a quote from Access Door and Glass included ¼" Gray Laminated Safety Glass, was written on . The documentation noted: "This quote is valid for the next 30 days, after which values may be subject to change." Class III .	A 152		