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
	AL11969477	A. BUILDING: _____ B. WING _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMAVIDA AT LAKES PARK	7669 CALISTOBLE LOOP FORT MYERS, FL 33908

(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 change of ownership, limited nursing services, emergency power plan monitoring, visitation form and complaint survey for #2025001766 was conducted on through at Amavida At Lakes Park, an assisted living facility in Fort Myers, Florida. Complaint #2025001766 was substantiated without citation. The following is a description of the deficiencies: .	A 000		
A 036 SS=E	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of . (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or , . hygiene may include the use of -based rubs, , handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an , exposure to transmissible agents in , , , , , nonintact skin, and mucuous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, , protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by	A 036		

AHCA Form 3020-0001

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

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A 036	Continued From page 1 multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: . Based on observations, record review, and interview, the facility failed to follow hygiene procedures when assisting with self-administration of medications to reduce the risk of transmission of for 4 (Residents #12, #13, #15, #16) of 6 residents observed. The findings included: The facility policy: A0177 titled, " Handwashing" with an effective date of , Reviewed , . The policy stated, "Handwashing is the single most effective way to prevent the spread of . hygiene must be done with -based rubs, , handwash, and/or soap and water. The process included, Staff should wash their in the following situations: should be washed before: starting work, administering medications . . . should be washed when soiled or after... resident care, removing gloves. . . Staff members who provide personal care must also carry , sanitizer with them or utilize the dispensers provided in our community. sanitizers [are] not to be used in place of washing. It should be readily available for staff to use in situations where handwashing facilities or supplies are not immediately available (e.g. in resident's apartments). On at 12:05 p.m., during observation of medication pass, Medication Technician (MT) Staff C provided , , 25/100 mg	A 036		

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A 036	Continued From page 2 ('s) to Resident #12. MT Staff C did not perform hygiene before, during, and after assistance with self-administration of medication (med pass). On at 12:25 p.m., during observation of medication pass, MT Staff C provided 650 mg (, relief) to Resident #13. MT Staff C did not perform hygiene before, during, and after assistance with self-administration of medication. On at 12:13 p.m., during an interview, MT Staff C said that the procedure is to perform hygiene after each med pass. MT Staff C confirmed that she did not perform hygiene during assistance with self-administration of medication for Resident #12, and Resident #13. MT Staff C stated, "it was what I was supposed to do, but I got nervous." MT Staff C confirmed there was no sanitizer on the med cart. On at 12:35 p.m., during an interview, MT Staff D said the policy for the med pass is to "sanitize between residents and wash your with soap and water after the 3rd resident". On at 12:40 p.m., during an interview, the Director of Nursing (DON) said the handwashing policy is to sanitize between each resident, and then after the 3rd person has been assisted with self-medication, handwashing with soap and water is done. The DON acknowledged that not performing hygiene is against policy and restated that the procedure is to sanitize between residents. On at 8:55 a.m., during observation of medication pass, MT Staff E rolled the med cart to the hallway outside of Resident #15's room.	A 036		

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A 036	Continued From page 3 MT Staff E knocked on the door and entered the room with packages of meds, placed them on the dining room table where Resident #15 was seated, and donned gloves. MT Staff E asked the resident "do you have your , socks on? Resident # 15 replied, "No." MT doffed gloves went into Resident #15's bedroom searched the residents' room, bathroom drawers in the bathroom for socks, touching items on bathroom sink, opening drawers in bathroom and touching personal items in the drawers moving them around, opening drawers in bedroom and closet doors touching resident personal items. MT Staff E came to the dining room and assisted with lifting Resident #15 to stand from the chair under the arms. MT Staff E assisted Resident #15 to walk to the bathroom rubbing Resident 15's as he walked. MT Staff E assisted Resident #15 to the dining room and assisted him to be seated. No hygiene was performed. MT Staff E proceeded to prepare Resident # 15's medications, placing the dosages into a cup and gave the medications to Resident #15. MT did not perform hygiene after touching Resident #15, and assisting resident from his chair under the arms, rubbing his , and touching items in bathroom, on bathroom sink, and assisting Resident #15 to dining room, and to his chair. On at 9:10 a.m., during medication observation MT Staff E prepared Resident #16's medications. MT Staff E opened the bottles one at a time and removed the pills one at a time with her bare placing the pills into a cup. MT Staff E gave the cup to Resident #16, and watched her take the pills. No hygiene was performed. On at 12:26 p.m., during an interview,	A 036		

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A 036	Continued From page 4 the Executive Director said that hygiene should be done between each resident during each medication pass. Class III .	A 036		