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
	AL11964197	A. BUILDING: _____ B. WING _____	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE FORT MYERS THE COLONY	13565 AMERICAN COLONY BLVD FORT MYERS, FL 33912

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A 000	Initial Comments A re-licensure, limited nursing services, emergency power plan monitoring, and health facility reporting system survey was conducted at Brookdale Fort Myers The Colony on 11/18/25. Deficiencies were identified at the time of survey.	A 000		
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, 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.	A 052		

AHCA Form 3020-0001

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

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A 052	Continued From page 1 (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. (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	A 052		

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A 052	Continued From page 2 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 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	A 052		

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A 052	Continued From page 3 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. (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 who assisted with self administration of medications did so appropriately to ensure orally advising of the names and doses of their medications for 2 (Residents #7 and Resident #8) of 2 residents	A 052		

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A 052	Continued From page 4 reviewed for medication assistance. The findings included: Review of the Health Care Assessments (1823s) for Residents #7 dated and #8 dated . revealed both residents required assistance with self-administration of medications. There were no orders for the nurse to administer medications on file for Resident #7 and #8. On at 8:55 a.m., observed Licensed Practical Nurse (LPN) Staff A prepare medications for Resident #7. Staff A crushed the oral medication and mixed the medication with yogurt. Staff A walked to Resident #7 and without the resident holding the spoon or cup, Staff A "spoon fed" the medication into Resident #7's . Staff A did not orally advise the resident of the names or doses of the medication she was assisting with. There were no orders for the nurse to administer medications on file for Resident #7. On at 9:06 a.m., observed LPN Staff A prepare medications for Resident #8. Staff A crushed the oral medication and added it to yogurt. Staff A walked to Resident #8 and without the resident holding the spoon or cup, Staff A "spoon fed" the medication to resident #8. Staff A did not orally advise Resident #8 of the names or doses of the medications.There were no orders for the nurse to administer medications on file for Resident #8. On at 1:17 p.m., Staff A said she "spoon fed" both Residents #7 and #8. Staff A said she thought a nurse could "spoon feed" medications to residents that require assistance with their	A 052		

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A 052	Continued From page 5 medications. She said she did not orally advise either Resident #7 or Resident #8 of the names or the doses of their medications. On at 4:34 p.m., the Health and Wellness Director (HWD) said staff must tell the residents the names and doses of the medications she is assisting with. The HWD said there are no waivers excusing staff from that step in the process. The HWD said staff must not "spoon feed" medications from her own for the residents who require assistance with self-administration. Class III .	A 052		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have;	A 054		

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A 054	Continued From page 6 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure the medication administration record (MAR) was immediately updated after assistance with medication self-administration for 1 resident (#7) of 2 residents reviewed for medication observation. The findings included: Review of the facility policy for Medication & Treatment - Administration/Assistance - CS-40-2, last revised . Policy Detail: 8. The individual assisting with the medication should observe the resident ingesting the medication prior to documenting the administration/assistance on the resident's Medication record or eMAR and record it immediately after medication assistance. On at 8:55 a.m., observed Staff A prepare medications for Resident #7. Before Staff A took the medications to Resident #7, Staff A documented on the Electronic Medication Administration Record (EMAR)computer screen	A 054		

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A 054	Continued From page 7 the medications were given and ingested by Resident #7. (Observed computer screen color change from yellow to green, signifying Staff A documented the assistance on the resident's eMAR prior to the resident ingesting the medication.) On at 1:17 p.m., Staff A said she knew Resident #7 would not refuse and would swallow the medication without any problems, so she signed the eMAR immediately after she prepared the medication and before Resident #7 ingested them. On at 4:34 p.m., the Health and Wellness Director said staff must wait until residents ingest the medication before documenting completion on the eMAR. Class III .	A 054		
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) Resident demographic data as follows: 1. Name, 2. , 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 , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case	A 162		

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A 162	Continued From page 8 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, , 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 ◡ 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 ◡ 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 writing that ◡ 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.	A 162		

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A 162	Continued From page 9 (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 , , ( ), CF-ES 1006, , 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 , , of a 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	A 162		

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A 162	Continued From page 10 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 interviews and record reviews, the facility failed to ensure resident records contain an interdisciplinary care plan for 3 residents (Resident's #4, #5, and #6) of 3 residents reviewed for hospice services. The findings included: Review of the Facility Policy for Coordination of Services with Third Party Healthcare Providers/Agencies - CS-100-3 last revised revealed Third Party Healthcare Providers or Agencies (e.g. home health, hospice, podiatry, etc.) who wish to provide care and services to residents and have a Service Agreement with one or more residents, shall sign a third Party Provider Access Agreement (Healthcare) and will supply documentation of services planned and delivered for the resident's record...In addition, Third Party Healthcare	A 162		

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A 162	Continued From page 11 Provider/Agency personnel shall:...b. Complete the Home Health/Hospice/Third Party Provider Collaboration Note or other third Party applicable note for placement in the resident record. Review of Resident #6's Health Assessment (1823) dated . revealed the resident was receiving hospice services. Review of the Addendum to the 1823 (Health Assessment) - Clarification of Orders signed by the Nurse Practitioner on revealed Hospice Services were included for Resident #6. Further review of Resident #6's record revealed no interdisciplinary care plan in the records. On at 11:48 a.m., the Health and Wellness Director (HWD) said Resident #6 was admitted to the facility on with hospice services. The HWD said it is her responsibility to ensure the hospice care plan is in the record, which would indicate which services Hospice is providing to the resident. The HWD said there was no interdisciplinary care plan in the record Review of Resident #4's record included the Hope Hospice Form #1347 Revised revealing the resident was a Hope Hospice patient as of . Further review of the records revealed Resident #4 did not have an interdisciplinary care plan in the record. On at 12:26 p.m., the HWD said Resident #4 is on hospice. The HWD said she did not have a interdisciplinary care plan in the resident's record. Review of Resident ##5's record included the Hope Hospice Form #1347 Revised revealing the resident was a Hope Hospice patient as of . Further review of Resident	A 162		

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A	Continued From page 12 #5's record revealed a physician order sheet dated , referring the resident to Hope Hospice for start of care. There was no interdisciplinary care plan in the resident's record. On at 1:30 p.m., the HWD confirmed there was no interdisciplinary Care Plan in Resident #5's record. Class III .	A 162		