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
	AL11969059	A. BUILDING: _____ B. WING _____	07/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE COCONUT POINT	8460 MURANO DEL LAGO DR BONITA SPRINGS, FL 34135

(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 A complaint investigation for #2026006425, #2026010927, #2026011596 and a generator monitoring visit was conducted at American House Coconut Point on through . Deficiencies were identified at the time of the survey.	A 000		
A 032 SS=E	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), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times.	A 032		

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A 032	Continued From page 1 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 observation, record review, and interview, the facility failed to ensure residents deemed an elopement risk have identification on their persons to include their name, the facility's name, address, and telephone number for 4 (Resident #5, Resident #6, Resident #7, Resident	A 032		

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A	Continued From page 2 #8) of 4 residents reviewed as an elopement risk. The findings included: Title: Elopement Effective Date: Revision Date ; Policy: It is American House policy to ensure safety procedures are implemented to strive to prevent, identify, and responds to elopements. Procedure: 10. For Florida Only- Each resident identified as an elopement risk, will maintain on their person identification that includes their name and the facility's name, address and the telephone number. On , review of Resident #5's record revealed a Resident Health Assessment Form 1823 dated , indicating Resident #5 was an elopement risk with a diagnosis of 's , , , D deficiency, history of falling, and or behavioral status of alert with . On , review of Resident #6's record revealed a Resident Health Assessment Form 1823 dated , indicating Resident #6 was an elopement risk with a diagnosis of , , Type 2 , , and , 3, speech disturbances, and or behavioral status of alert with .	A 032		

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A 032	Continued From page 3 On , review of Resident #7's record revealed a Resident Health Assessment Form 1823 dated , indicating Resident #7 was an elopement risk with a diagnosis of , , , D , , , sarcopenia, and or behavioral status of alert with . On , review of Resident #8's record revealed a Resident Health Assessment Form 1823 dated , indicating Resident #8 was an elopement risk with a diagnosis of , , Valve Replacement, , , and or behavioral status of alert and Oriented x 2; episodes of . On at 4:08 p.m., during an interview, Caregiver Staff A said that they have identification bracelets for residents, but they always take them off so it's hard for us to keep track of who has them and who doesn't. She said that everybody is at risk for elopement. Caregiver Staff A said that right now they don't have any on. On at 4:15 p.m., during an observation of the Memory Care unit, Resident #5 was observed walking in the hallway. Resident #5 was not observed to be wearing any identification. Resident #6 was observed sitting in the dining room. Resident #6 was not observed to be wearing any identification. Resident #8 was observed sitting in # . Resident #8 was not observed to be wearing any identification. On at 8:50 a.m., during an observation of the Memory Care unit, Resident #6 was observed	A 032		

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A 032	Continued From page 4 sitting in the dining room eating breakfast. Resident #6 was not observed to be wearing any identification. Resident #7 was observed sitting at a table in the dining room. Resident #7 was not observed to be wearing any identification. On at 8:55 a.m., during an interview, Resident #8 said that he has never worn any identification on his person. Resident #8 was not observed to be wearing any identification. On at 9:00 a.m., during an interview, Medication Technician Staff B said that they are supposed to check for identification when they administer medications, but the residents always take them off. On at 10:25 a.m., during an interview, the husband of Resident #5 said that he lives locally and is pretty much here every day. He said that he can't remember the last time his wife had on identification. On at 12:45 p.m., during an interview, the Wellness Director said that the staff needs to try to make sure that they have ID's on them at all times. She said that the challenge is that they take them off. She said that she did not have tour the Memory Care unit and acknowledged that none of the residents assessed as an elopement risk had identification on. On at 2:10 p.m., during an interview, the Executive Director said that he understood and acknowledged that the residents in the Memory Care unit did not have identification on and	A 032		

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A 032	Continued From page 5 that they need to.	A 032		