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
	AL11968845	A. BUILDING: _____ B. WING _____	04/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DISCOVERY VILLAGE AT NAPLES, LLC	8417 SIERRA MEADOWS BLVD NAPLES, FL 34113

(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 focused control and complaint survey for #2021001849 was conducted on at Discovery Village at Naples LLC, an assisted living facility in Naples, Florida. Complaint #2021001849 was substantiated at A0025, A0029 and A0030. The following is description of the deficiencies. .	A 000		
A 025 SS=D	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 An assisted living facility must provide care and	A 025		

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A 025	Continued From page 1 services appropriate to the needs of residents 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 staff interview, the facility failed to notify the resident's family after the resident had a change in condition for 1 (#1) out of 3 resident records reviewed. The findings included: Review of policy and procedure titled "Change of	A 025		

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A 025	Continued From page 2 Condition" (dated). Under Procedure 5. "Nurse notifies resident and/or responsible party of concern/change." Record review for Resident #1 revealed the following: On there was an order for 875 milligrams (mg) twice a day for 7 days due to ( ). There was no documentation of family notification on record. On there was a note on record indicating the home health agency (HHA) registered nurse reported to the facility and the Advanced Registered Nurse Practitioner (ARNP) that Resident #1 had plus 2 pitting and a to the right lower C-shaped 7.5 cm, covered with a steri-strip. On , a HHA nurse care progress note documented +2 pitting in lower extremities. No family notification was documented in the record. On , a HHA nurse note for right lower healing, edge with less , measuring 7.0 x 1.0 x 0.3 cm. No family notification was documented in the record. On , HHA Registered Nurse (RN) reported measurements of 5.5 x 2.5 x 0.3 cm skin flap off, is deeper. No family notification was documented in the record. On , the nurse documented an order for " , 500 mg 1 PO [by] [twice a day] x 7 days" with diagnosis of . No family notification was documented in the record. On , a HHA nurse reported	A 025		

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A 025	Continued From page 3 measurements of 6.0 x 3.0 x 0.3 cm. No family notification was documented in the record. On , a podiatrist note reported the reached the and . No family notification was documented in the record. On at 11:30 a.m., in an interview, the Health Wellness Director (HWD) said she did not know if the family had been notified. She could not find proof of notification. On at 1:00 p.m., in an interview, the HWD said Resident #1's family was very involved in the resident's care and talked to them daily but failed to document their conversations. She said, "I know if it is not documented, it did not happen. I know the nurses should have documented when they notified the family. I know the HHA nurse was talking to them all the time. I understand there is an issue here. We did not document as we should." Class III .	A 025		
A 029 SS=D	59A-36.007(5) FAC, 429.26(4) FS Resident Care - Nursing Services 59A-36.007 (5) NURSING SERVICES. (a) Pursuant to section 429.255, F.S., the facility may employ or contract with a nurse to: 1. Take or supervise the taking of vital signs, 2. Manage pill-organizers and administer medications as described in rule 59A-36.008, F.A.C., 3. Give prepackaged enemas pursuant to a physician's order; and,	A 029		

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A 029	Continued From page 4 4. Maintain nursing progress notes. (b) Pursuant to section 429.255(2), F.S., the nursing services listed in paragraph (a), may also be delivered in the facility by family members or friends of the resident provided the family member or friend does not receive compensation for such services. 429.26 (4) Persons licensed under part I of chapter 464 who are employed by or under contract with a facility shall, on a routine basis or at least monthly, perform a nursing assessment of the residents for whom they are providing nursing services ordered by a physician, except administration of medication, and shall document such assessment, including any substantial changes in a resident's status which may necessitate relocation to a nursing home, hospital, or specialized health care facility. Such records shall be maintained in the facility for inspection by the agency and shall be forwarded to the resident's case manager, if applicable. This Statute or Rule is not met as evidenced by: Based on record review, and staff interview, the facility failed to maintain nursing progress notes related to nursing services provided to 1 (Resident #1) out of 7 resident records reviewed. The findings included: Review of the policy titled "Skin integrity" (dated [redacted]) Under Procedure 2. "If skin concern is found by care managers the nurse is notified and findings recorded in the daily log." Review of the policy titled: "Resident Observation	A 029		

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A 029	Continued From page 5 Log/NursesNotes/Progress Notes (dated .) Policy: We will document all observations, communications, and/or changes regarding each resident. Under Procedure 2. "The Nurse or designee will make an entry of any relevant information on to the log as it occurs or as they are made aware." Under Procedure 6. "Every entry in the log will be dated and signed.' Record review for Resident #1 found a note dated indicating Resident #1 obtained a to the right lower C-shaped 7.5 cm, covered with steri-strip. Further review found no record of which nurse provided the treatment to the resident. The home health agency's (HHA) nurse which reported the or the facility's nurse which documented the information provided by the HHA nurse. Furthermore, there was no incident report or documentation of how the came about. On /21at 10:45 a.m., in an interview, the Health Wellness Director (HWD) said she did not know the specifics of the . She said she was sitting in her office and overheard one of the nurses (she did not recall who) saying the resident hit her on furniture or something. She said she did not know who the nurse was who provided the treatment. The HWD said the expectation is when they find a new skin issue to document the specifics on resident's record. On at 11:24 a.m., in a follow-up interview, the HWD said one of the Home Health Nurses texted Resident #1's daughter and told her the resident hit her against her wheelchair , but the HWD did not know the specifics.	A 029		

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A 029	Continued From page 6 On . . . . . at 12:02 p.m., in an interview, the Executive Director said the expectation is any skin related issue will be documented in the daily log with specific information as to how the . . . came about. Class III .	A 029		
A 030 SS=D	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) 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,	A 030		

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A 030	Continued From page 7 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 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 universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (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	A 030		

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A 030	Continued From page 8 telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . . . . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of 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	A 030		

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A 030	Continued From page 9	A 030		

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 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 [illegible] for health care services, the provision of or arrangement of transportation to health care [illegible], 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

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A 030	Continued From page 10 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 show good cause in a court of competent jurisdiction. (l) 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	A 030		

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A 030	Continued From page 11 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 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 interview, the facility failed to safeguard residents' well-being by failing to follow current control standards related to COVID-19 recommendations set forth	A 030		

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A 030	Continued From page 12 by Centers for Control and Prevention (CDC). Refer to https://www.cdc.gov/coronavirus/2019-ncov/hcp/assisted-living.html. The findings included: Record review found the facility had a Covid-19 outbreak in the memory care unit when 13 out of 25 residents tested positive on 5 residents , because of the Covid 19 On at 9:45 a.m., in an interview, the Health and Wellness Director (HWD) said only one resident had symptoms of The rest of the residents were . At the time of the outbreak the facility did not test residents in the main facility since they were not in contact nor shared staff with the residents in the memory care unit. On at 11:07 a.m., a progress note documented Resident #1 was sent to the hospital due to , (rapid beat) and (low). On at 2:48 p.m., a progress note documented Resident #1's daughter called the facility and told them Resident #1 had tested positive for COVID-19, and a . On at 11:00 a.m., in an interview, the Health and Wellness Director (HWD) and the Executive Director (ED) said they were not aware Resident #1 had COVID-19 since she did not have any symptoms. They said they had not tested the remaining residents after the new outbreak as they were told by the Department of Health Representative (DOH) that they needed to test only based on symptoms. They said they just	A 030		

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A 030	Continued From page 13 tested the staff that had direct contact with Resident#1 and all tested negative. On at 9:49 a.m, in an interview, the HWD said on , one of the nurses notified the her that she was exposed to COVID-19. She was advised to and expected to come to work on . The HWD said they performed a rapid test before the nurses entrance on which revealed the nurse was positive for COVID-19. On at 12:42 p.m., in an interview, the HWD and ED said they had not tested the staff that worked with the nurse since the DOH representative told them to test only if someone is . On at 5:05 p.m., in a telephone interview, the DOH representative said facility misunderstood her. They should have tested the remaining residents after the new outbreak. She said she explained to them even one resident meant a new outbreak and other residents should have been tested. She also said she did not tell them they had to test based on symptoms since in many cases residents or staff can be and spread the . Class III .	A 030		