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
	AL11953368	A. BUILDING: _____ B. WING _____	08/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAPLES GREEN VILLAGE	101 CYPRESS WAY EAST NAPLES, FL 34110

(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 complaint survey #2021008790, was conducted on [redacted] at Naples Green Village, an assisted living facility in Naples, Florida. Complaint #2021008790 was substantiated at A0025. The following is a description of the deficiency. .	A 000		
A 025	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 [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted]. 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 [redacted] 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 services appropriate to the needs of residents	A 025		

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A 025	Continued From page 1 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, staff and family interview, and observation, the facility failed to provide adequate staffing as appropriate for each resident to meet the needs for supervision and maintain general awareness of the general health, safety, physical and emotional wellbeing of the residents for 1 (Resident #1) of 1 resident reviewed for supervision.	A 025		

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A 025	Continued From page 2 The findings included: Record review of Resident #1's chart revealed she was admitted to the facility on , her health assessment indicated Resident #1 has a medical diagnosis of , emboli, mild , and . Review of health assessment and care level evaluation for Resident #1 revealed the resident needs supervision for bathing, , grooming, needs assistance for toileting and needs general oversight daily for observing whereabouts. Review of the facility's Adverse Incident Report indicated Resident #1's daughter on contacted the police to conduct a wellness check on her mother after contacting the facility multiple times from 11:45 p.m. through 1:51 a.m., with no answer from staff within the facility. The police and fire department gained access through a side entrance in the memory care unit and did multiple walk throughs in the facility without making contact with staff in the facility. Resident #1's daughter removed her from the facility's premises after accessing the facility with the police and finding no staff on site. Officers eventually made contact with a staff member around 2:45 a.m., on . Review of the police record revealed a call was placed to sheriff's office at 11:30 p.m. on for a suspicious incident. As officers arrived at the facility, they met with Resident #1's daughter who informed them she had been contacting the facility multiple times with no answer to check on Resident #1 and decided to drive to the facility after one call was answered by Resident #1. She arrived to find Resident #1 in the lobby unattended and no sign of staff in the facility with	A 025		

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A 025	Continued From page 3 no answers on the phone from facility staff. The officers tried doorbells, calling the facility multiple times with no answer, knocking on windows and doors of the facility with no answers and no sign of staff in the facility. The Department of Children and Families was notified by the Police. On . . . . . at 1:00 a.m., officers notified the fire department for assistance after multiple unanswered calls and still no sign of staff in the facility and with Resident #1 becoming agitated. The fire department accessed the facility through a side entrance of the building in the memory care unit and Resident #1 was removed from the facility with family. Deputies checked the facility for staff, re-secured the facility, remained onsite and conducted multiple checks of the facility with no observation of staff. Officers conducted a walk through at the facility on at 2:07 a.m., with no observation of staff. Another walk through of the facility was conducted by an officer remaining on site at the facility on at 2:30 a.m., with no observation of staff. Officers located Staff A on at 2:50 a.m., 3.5 hours after being dispatched to the facility. Review of the facility's punch cards for facility staff revealed Staff A clocked in for duty on at 9:51 p.m., and was the only staff member on duty at the facility until at 6:01 a.m. Interview on at 1:06 p.m., Staff A said the facility was always short staffed. She confirmed she was the only person on duty in the facility on . . . . . , she did not have the nurse's phone with her while in the break room and she said she did not know she was to carry it on her. She said she did not hear phones ringing or anyone calling or knocking on the doors or windows of the facility.	A 025		

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A 025	Continued From page 4 Interview on [redacted] at 10:00 a.m., Resident #5 said there are times when he cannot locate staff in the facility at night, he is not sure where they are and when he goes looking for staff, he can find no one when he needs help. Interview on [redacted] at 1:25 p.m., Resident #1's daughter she said her mother moved into the facility on the morning of [redacted], and she tried to contact the facility around 10:00 p.m., to check on Resident #1 with no answer via the telephone. Resident #1's daughter continued to call the facility multiple times with no answer from facility staff and drove to the facility while calling the facility until Resident #1 answered the facility telephone. Upon arrival to the facility, she found Resident #1 in the main lobby with no staff in sight and no staff answering the telephone. She proceeded to call the Collier County Sheriff's Office for assistance after arriving at the facility around 11:00 p.m., and being outside the facility for 45 minutes, calling the facility multiple times with no answer and seeing no signs of staff in the facility. She said her mother became agitated and started crying and had to be calmed by the officers through the lobby glass doors. She said the officers also called the facility telephone numbers multiple times with no answers from facility staff and observed no staff on sight in the facility while on the premises. After being outside until 1:00 a.m., on [redacted], they contacted the fire department for assistance to access the facility. The fire department accessed the facility through a side entrance in the memory care unit and a walk through of the facility was conducted. On [redacted] at 2:07 a.m., she was allowed to be with her mother and take Resident #1 home with her after finding her soiled and agitated, while officers remained at the facility. She said at the time of her leaving the facility there was still no	A 025		

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A 025	Continued From page 5 observation of staff in the facility. Interview on .. at 1:59 p.m., Licensed Practical Nurse (LPN) Staff B said the care partner scheduled to work the 2:00 p.m. to 10:00 p.m. and 10:00 p.m. to 6:00 a.m. shift on was a no-call no-show. He notified the Executive Director and informed him the care partner was scheduled to work multiple shifts and the Executive Director was responsible to find coverage for the shift. He confirmed Staff A was the only person on duty at the facility on , as the Executive Director had not brought additional staff to cover the shifts. He said the facility staff were working double shifts to cover the shifts as the facility was short staffed. On at 2:59 p.m., LPN Staff C, she said she did not receive any calls from facility staff regarding the care partner being a no-call no-show for her shifts on .. .. She confirmed Staff A was the only care partner on duty on .. .. on the 10:00 p.m. to 6:00 a.m. shift and the staff from the earlier shift left Staff A to work alone in the facility. She verified review of video surveillance that confirmed Staff A did not perform resident checks while on duty at the facility on , stayed in the breakroom for over 3 hours, and did not carry the nurse's phone on her person to answer calls to the facility. Interview on at 4:30 p.m., the Executive Director (ED) confirmed Staff B informed him of the care partner Staff G being a no-call no-show on .. .. . He did not review the schedule and was not aware Staff A was scheduled to work a double shift and he did not recruit additional staff to cover the shift. He confirmed Staff A did work in the facility on the overnight shift alone, she did not perform night checks and rounds on residents	A 025		

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A 025	Continued From page 6 as per their service plans while on duty at the facility. Staff A did not carry the nurse's phone on her person to answer calls to the facility or to be alerted if the residents pushed their pendants or call button. Staff A did not call the ED to inform him she was the sole care partner for the 10:00 p.m. to 6:00 a.m. shift. Staff A stayed in the breakroom for over 3 hours. The ED had informed LPN Staff B that staff were to perform hourly checks on Resident #1, and confirmed this was not done by facility staff and the facility had no documentation of progress notes with instructions and completion of hourly checks for Resident #1. On at 6:12 p.m., review of facility surveillance with the ED confirmed Staff A clocked in for duty on at 9:51 p.m., made rounds for approximately 20 minutes, pulled 2 chairs from the main area in the memory care unit and took them into the break room at 10:22 p.m., and remained there until 3:50 a.m. on . The ED confirmed there were no other staff on duty in the facility to monitor and observe residents' general awareness and for their physical and emotional wellbeing. The ED confirmed there was not adequate staff on duty at the facility to provide appropriate supervision for the residents on the 10:00 p.m. to 6:00 a.m. shift on , and not all the facility care partners on each shift had received the staff in-services as was required. Review of facility staff in-services on and for night checks, shift report, end of shift procedure, when to notify your supervisor, and overnight rounding waiver, revealed not all care partners received the in-service training. Interview on at 3:37 p.m., the Business	A 025		

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A 025	Continued From page 7 Office Director confirmed only 1 care partner Staff A worked on for the overnight shift. She reviewed the staff in-service sign in sheets and confirmed 6 of 21 care partners on all shifts did not received the post adverse incident in-services. Class II	A 025		