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 _____	11/15/2021

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 for complaint #2021010490 and #2021015010 was conducted on at Naples Green Village an assisted living facility in Naples, Florida. Complaint #2021010490 was not substantiated. Complaint #2021015010 was substantiated and cited 0030. The following deficiency was found at the time of survey.	A 000		
A 034	59A-36.007(9) ASSISTIVE DEVICES (9) ASSISTIVE DEVICES. Facilities are responsible for ensuring the safe usage of a resident's assistive devices. (a) The facility must have policies and procedures that include the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. (b) Documentation of each assistive device a resident uses must be included in the resident's record. (c) Direct care staff using assistive devices while rendering personal services to residents must know how to operate and utilize the equipment. (d) All assistive devices must be clean, in good repair, and free of hazards. (e) The facility must encourage and allow the resident to function with independence when using the assistive device. This Statute or Rule is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure the safe	A 034		

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A 034	Continued From page 1 usage of assistive devices; failed to follow their policy and procedure for bedside mobility for 2 (#3 and #4) of 2 residents with half bed rails in the facility; and failed to ensure the policy and procedure contained all requirements under Florida Administrative Code 59A-36.007 (9) Assistive Devices. Failure to properly follow the facility's policy and procedure resulted in Resident #4's entrapment on . The findings included: Record review of the policy titled: "Bedside Mobility ." effective revealed: "Policy overview: In promoting a safe and free environment, while at the same time acknowledging individual residents mobility needs, Concordis Senior Living allows the use of certain bedside mobility with an appropriate physician/licensed prescriber order and after review by our Director of Operations DOO/Designee. The DOO or designee should be notified prior to the initiation of any bedside mobility aid. Bedside mobility should not be used as a restrictive device. Policy detail. 1 Full, half and quarter side rails are not approved mobility and are not allowed. 2. Floor-to-ceiling transfer poles, overhead trapeze bars or other bedside mobility may be used after the DOO or designee review and consult with the community. 3. All residents utilizing bedside mobility should be made aware of all risks using mobility may present. 4. A physician/licensed prescriber order for the use of any bedside mobility aid should be obtained prior to its use. The physician/licensed prescriber must indicate that the bedside mobility aid is to be used for movement and positioning.	A 034		

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A 034	Continued From page 2 5. Specific instructions related to bedside mobility and their use should be documented in the resident's personal care plan, reviewed with the staff, and updated regularly per existing standards or upon a change in condition. 6. Bedside mobility should be installed per manufacture's guidelines. 7. Adjustments to bedside mobility should be made only after consultation with a licensed healthcare professional and according to manufacturer's guidelines. 8. A physical and /or , , evaluation should be considered as part of the resident's overall plan of mobility. 9. The use of bedside mobility should be reviewed at the time of the scheduled personal care plan reassessment or upon a change in condition. 10. If the resident is on hospice, and hospice is providing a bed and any bedside mobility aid used must comply with this policy." 1. A review of the policy titled: "Bedside Mobility ." effective , revealed the policy and procedure did not address the methods for assessing the physical condition of assistive devices and procedures for recommending repair of the assistive devices. 2. Record review for Resident #4 found that on at approximately 11:30 a.m., caregiver Staff A went to Resident #4's room to check on him. When Staff A entered the room she observed Resident #4 kneeling on the floor and his was between the side rail and his mattress. Staff A ran immediately and asked the Maintenance Director to help her free the resident. The Maintenance Director freed the resident and placed him on the floor. 911 was called and resident was transferred to the	A 034		

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A 034	Continued From page 3 hospital. Record review for Resident #4 found no evidence of a physician's order and consent for the usage of half bed rails for Resident #4. Furthermore, there was no evidence that the facility's DOO was informed prior to the half bed rails installation. There was no evidence that facility discussed with Resident #4 or the representative the risks related to usage of half bed rails. Moreover, there was no care plan in place . . . . . usage of half bed rails and specific instructions related to the bedside mobility . . . . There was no evidence that half bed rails were installed based on manufacture's guidelines. There was no evidence of physical or , , evaluation related to the resident's mobility. There was no evidence that the facility was in communication with Hospice related to removing the half bed rails or attempts to obtain a physician order for the rails from the Hospice physician. Interview on . . . at 9:47 a.m., the Maintenance Director stated, "So, I was here when it happened. I was walking towards the dining room when [Staff A] came and told me that she needed help right away. I went into the room and found [Resident #4] kneeling on the floor and his . . . was between the side rail and the mattress. I released him from the rails and put him on the floor as they were calling 911. I thought he did not have a , . . , but I was wrong. Resident #4 had a , . . . and he was breathing better and better and he opened his , . My job is to make sure when they come in with a new bed to make sure the bed is installed properly. The hospice people brought in the bed and installed. I had nothing to do with the installation. I just checked afterwards and there was no gap between the mattress and the side	A 034		

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A 034	Continued From page 4 rails. No, I did not make sure to install based on manufacture's specification, it was not to be done by me. The hospice people were responsible to do that. But, I made sure there was no gap. When I found the resident it was a inch gap between the bed and the rail. I just checked the bed when it first came in, not again. I never went to check on the side rails. No, I did not ask hospice any questions related to installation of the side rails. No did not questioned them at all. After the incident I went around and checked and removed all side rails. At least I thought I did. Last Saturday the DON [Director of Nursing] found half rails in [Resident #3's] bed. I guess I missed that one. I called her family right away. I told them we need to remove the half rails. They insist on keeping them on." Interview on at 12:34 p.m., the Administrator said she serves as the organizations DOO and she was not aware Resident #4 had half rails installed on his bed. The Administrator said she was not on premises when the incident took place, but she was informed immediately. She acknowledged the lack of prescription and consent prior to installment of half bed rails of Resident #4. She acknowledged that facility failed to follow their policy and procedure regarding mobility . Interview on at 1:00 p.m., the DON said she was aware that half bed rails were delivered by Hospice. The DON said she was aware that per the facility's policy, side rails were prohibited. The DON said she notified the hospice provider to let them know that the facility prohibits the usage of side rails and they needed to replace them with Safety Rings [brand of a small round assistive device which attaches to the bed frame and has no opening larger than 4.5	A 034		

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A 034	Continued From page 5 inches). The DON confirmed the lack of care plan specific to half rail usage, lack of physician order and consent prior of Resident #'4's usage of the half bed rails. The DON said the hospice provider faxed them a prescription for half side rails after the incident and only because they questioned them about it. The DON acknowledged the facility failed to follow their policy and procedure related to bedside mobility devices. 3. Observation on at 9:55 a.m., with maintenance director present, found a set of half rails placed at Resident #3's bed. The upper side of the bed was elevated to 45 degrees and the resident was in bed. During the course of the observation, Resident #3 said she had being using the half bed rails since the time she was admitted to the facility. She said she is using them to "come in and out of the bed." The Maintenance Director, at time of observation, said, "I missed it. I did a full house audit after the incident with the other resident. It's my fault. No, I did not install the half rails. They were here when I started working in . . ,. But, the DON saw them on Saturday. She told me. I called the family and told them we are not allowed to have side rails in the building. They wanted to keep them. I will remove them right away." Maintenance Director removed the side rails and replaced them with . . . Safety Devices. Interview on . . .... at 2:10 p.m., Director of Nursing said she was in the facility on Saturday . . ... and she saw the half rails at Resident #3's bed. She said she immediately notified the Maintenance Director who in turn called the family and notified them that per their policy the resident can not have the side rails in her bed.	A 034		

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A 034	Continued From page 6 Interview on . . . . . at 2:50 p.m., the DON and Administrator /DOO confirmed the lack of documentation for Resident #3. They said it was an oversight. Class II	A 034		