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 _____	01/20/2022

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

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A 000	Initial Comments An unannounced complaint survey for complaint #2021016019, #2021017454 and #2021016706 was conducted on through at Naples Green Village, an assisted living facility in Naples, Florida. Complaint #2021016019 was substantiated at A0052, A0026 and A0084. Complaint #2021017454 was not substantiated. Complaint #2021016709 was substantiated without deficiencies. The following is a description of the deficiencies.	A 000		
A 026	59A-36.007(2) FAC Resident Care - Social & Leisure Activities (2) SOCIAL AND LEISURE ACTIVITIES. Residents shall be encouraged to participate in social, recreational, educational and other activities within the facility and the community. (a) The facility must provide an ongoing activities program. The program must provide diversified individual and group activities in keeping with each resident's needs, abilities, and interests. (b) The facility must consult with the residents in selecting, planning, and scheduling activities. The facility must demonstrate residents' participation through one or more of the following methods: resident meetings, committees, a resident council, a monitored suggestion box, group discussions, questionnaires, or any other form of communication appropriate to the size of the facility. (c) Scheduled activities must be available at least 6 days a week for a total of not less than 12	A 026		

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A 026	Continued From page 1 hours per week. Watching television is not an activity for the purpose of meeting the 12 hours per week of scheduled activities unless the television program is a special one-time event of special interest to residents of the facility. A facility whose residents choose to attend day programs conducted at adult day care centers, senior centers, mental health centers, or other day programs may count those attendance hours towards the required 12 hours per week of scheduled activities. An activities calendar must be posted in common areas where residents normally congregate. (d) If residents assist in planning a special activity such as an outing, seasonal festivity, or an excursion, up to 3 hours may be counted toward the required activity time. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide an ongoing activities program and encourage residents' participation in social, recreational activities within the community in the Memory care unit. The findings included: A review of the activity calendar showed a scheduled activity every day on the calendar. However, there were no activities being conducted as per the calendar in the memory care unit. Observation on at 9:30 a.m., showed the activity calendar posted on the wall in the hallway in the memory care unit. The posted calendar indicated at 9:30 morning gathering in the memory care unit living room. There was no activity being conducted in the memory care unit. Interview with Activity Director states she has no	A 026		

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A 026	Continued From page 2 assistant and when she is having an activity on the Assisted Living the Memory Care unit will have not have the activity scheduled on the calendar. On at 9:35 a.m., no activity being conducted in the memory care unit as scheduled per calendar. On at 9:40 a.m., interview with Resident #4 states there is not a lot of activities. On at 9:45 a.m., interview with Resident #5 states there is not many activities at the facility, she wishes there were more activities to participate in at the facility. On at 10:05 a.m., interview with Staff B (Med Tech) confirmed there is no activities on the memory care unit when the Activity Director is having an activity on the Assisted Living unit. On at 10:35 a.m., posted activity calendar in memory care unit indicted church service at 10:30, observation of no activity being conducted in memory care unit as scheduled per calendar. Review of memory care unit activity calendar calls for laughter at 11:00 for the Assisted living and memory care unit. On at 11:16 a.m., observation of assisted living residents in the courtyard participating in laughter activity, no activity being conducted in the memory care unit. On at 11:21 a.m., interview with Activity Director confirmed no activity being conducted in the memory care unit at this time as per calendar schedule.	A 026		

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A 026	Continued From page 3 On at 1:36 p.m., Memory care unit activity calendar indicated Inspirational songs, no activity being conducted. On at 1:40 p.m., Staff H confirmed no activities being done in the memory care unit currently. On at 1:47 p.m., interview with Activity Director confirmed no activity being done on the assisted living and or memory care unit as per activity calendar schedule as she was doing a time visit for a resident. On at 2:50 p.m., observation of no activities in the memory care unit as per activity calendar schedule. On at 11:10 observation of no activities in the memory care unit, activity calendar indicated music and movement, at 11:00 in the memory care unit living room. Observation of two residents sleeping in the memory care living room, no activities being conducted. On at 1:16 p.m., interview with Staff A, states there are not enough activities in the memory care unit, even though there are activities posted on the activity calendar, and when the care partners can't help with activities the memory care unit do not have the activities as scheduled on the calendar. On at 1:30 p.m., Observation of no activity in the MC unit On at 2:00 p.m., Observation of no activity in the MC unit On at 2:30 p.m., Observation of no activity in the MC unit	A 026		

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A 026	Continued From page 4 On at 10:15 a.m., interview with the Activity Director confirmed there are days when the memory care unit does not receive scheduled activities as per the activity calendar. Activity Director states she cannot guarantee the care partners do the activities with the residents in the memory care unit as scheduled per the calendar on Saturdays and Sundays when she is not at the facility. Activity Director acknowledged the residents in the memory care unit do not receive scheduled activities on the weekend. On at 11:45 a.m., Interview with the Executive Director acknowledged there are times when there is no activity being done in the memory care unit as scheduled per the activity calendar. Class III	A 026		
A 052	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, including an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer, from where it is stored, and bringing it to the resident. (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	A 052		

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A 052	Continued From page 5 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. (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 . (h) Using a to perform - level checks. (i) Assisting with putting on and taking off stockings. (j) Assisting with applying and removing an but not with titrating the prescribed settings. (k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device. (l) Assisting with measuring vital signs. (m) Assisting with , bags. (4) Assistance with self-administration does not include: (a) Mixing, , converting, or	A 052		

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A 052	Continued From page 6 . . . . . , 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 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	A 052		

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A 052	Continued From page 7 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 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,	A 052		

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A 052	Continued From page 8 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 and interview the facility failed to ensure staff who assist residents with self-administration of medications do so in accordance with proper procedure for 4 (Residents # 7, #11, #14, # 15) of 4 medication observations. The findings included: On . . . at 8:39 a.m., Staff G (med tech) was observed assisting Resident #15 with medications. Staff G took Resident #15's medication from the medication cart, placed the dosage of the medications into a container without the resident being present. Staff G walked	A 052		

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A 052	Continued From page 9 the container with the medications to the resident in the dining room and placed the container with Resident #15's medications on the table without informing the resident what medications he was being assisted with and without taking the medications in their properly labeled container to read to the resident. Staff G took the cup with Resident # 15 medications from the table with a spoon and removed each medication from the cup with the spoon and fed them into Resident # 15's one at a time. Record review of Resident #15 medication list and medication cards revealed Staff G did not give Resident # 15 his medication, and gave the incorrect dosage of the . Resident #15 list showed for 500 mg 1 capsule every other day, and 2 capsules every other day, 2 capsules to be given on , Staff G only gave 1 capsule. The EMAR (elctronic mediation record) was documented as signed by Staff G indicating 2 capsules were given. On at 8:53 a.m., observation of Staff G (med tech) leaving the medication cart outside of the dining room in the hallway unlocked. On at 8:55 a.m., Staff G (med tech) was observed assisting Resident #14 with medications. Staff G took Resident #14's medication from the medication cart, placing the dosage of the medications into a container, without the resident being present. Staff G walked the container with the medications to the resident in the dining room, leaving the medication cart unlocked with medication cards on the top of the cart, and gave the resident the medications saying "here is your medications," without informing the resident what medications he was	A 052		

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A 052	Continued From page 10 being assisted with and without taking the medications in their properly labeled container to read to the resident. On [redacted] at 9:03 a.m., Staff G (med tech) was observed assisting Resident #11 with medications. Staff G took Resident #11's medication from the medication cart, placing the dosage of the medications into a container, without the resident being present, Staff G walked the container with the medications to the resident outside in the courtyard and gave the resident the medications. Resident #11 asked, 'how many pills do I have?" Staff G replied, "you have 5 or 6 pills" Staff G did not inform Resident #11 what medications he was being assisted with, and did not take the medications in their properly labeled container to read to the resident. Record review of Resident #11 medication list and medication cards revealed Staff G did not give Resident #11 his [redacted] medication. There was no medication card with the medication onsite at the facility. On [redacted] at 9:11 a.m., Staff G (med tech) was observed assisting Resident #7 with medications. Staff G took Resident #7's medication from the medication cart, and placed the dosage of the medications into a container, without the resident being present. Staff G walked the container with the medications to the resident in her room, knocked on the door and said to Resident #11 "here is your medications," Resident #7 asked, "is that all of them?" Staff G replied, "yes," and gave the resident the medications without informing the resident what medications she was being assisted with and without taking the medications in their properly labeled container to read to the resident.	A 052		

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A 052	Continued From page 11 Record review of Resident #7 medication list and medication cards revealed Staff G did not give Resident #7 her , , Chelated 5 mg medication. There was no medication card with the medication onsite at the facility. , 40 mg medication order indicates 1 tablet by at 6 AM. Staff G gave Resident #11 the medication at 9:15 a.m., 2 hours after required time, without notifying the physician. On at 9:24 a.m., interview with Staff G, who stated she did not inform the residents what medications they were being assisted with as it made her late giving the medications, Staff G confirmed that she did not follow the proper procedures when assisting with self-administration of medications. On at 10:50 a.m., review of medication cart with Staff G reveled an opened box solution 1.25mg/3ml with no prescription label, no name of resident and or instructions for use. Box of Retaine Ocusoft lubricant , , , , , with no resident name, and or prescription label. Box of , with Resident #16 name on the box, no physician orders. Staff G confirmed the findings, she stated she is not sure if Resident #16 takes the , medication, and she is not sure who the other medications belong to. Record review of the medication list for Resident #16 revealed no , on the medication list. On at 12:35 p.m., interview with the Director of Nursing, who confirmed when med techs are assisting the residents with self -administration of medications they are to read	A 052		

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A 052	Continued From page 12 the medications to the residents, and the medication cart is to be locked when the med tech steps away from the cart and no medications left on the top. On at 11:45 a.m., the Executive Director acknowledged the findings, he stated he will have an in-service for assisting with self-administration of medications with all med techs. Class III	A 052		
A 084	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be	A 084		

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A 084	Continued From page 13 experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, , dosage forms, and , , , , and dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and , that are prefilled by the manufacturer by taking the medication, in its	A 084		

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(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 084	Continued From page 14 previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with ; j. Use a to perform testing; k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels; l. Apply and remove stockings and hosiery; m. Placement and removal of bags, excluding the removal of the or manipulation of the site; and, n. Measurement of rate, temperature, and rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n.	A 084		

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 _____	01/20/2022

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NAPLES GREEN VILLAGE	101 CYPRESS WAY EAST NAPLES, FL 34110

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A 084	Continued From page 15 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure unlicensed persons who provide assistance with self-administered medications complete an initial 6-hour training and obtain annually, a minimum of 2 hours of continuing education on providing assistance with self-administered medications for 1 (Staff A) of 4 staff who assist with medication. The findings included: On at 1:16 p.m., Staff A (med tech) said she assists the residents with self-administration of medications. On at 3:30 p.m., review of employee list revealed a hire date of [redacted] for Staff A as a care partner. Documentation provided by the Executive Director indicated Staff A completed an initial 6 hours of training in Assistance with Self-Administration of medications on [redacted] & 30 2020. There was no further documentation of 2 hours of continuing education annually. On at 11:45 a.m., the Executive Director confirmed Staff A has been assisting with	A 084		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 084	Continued From page 16 self-administration of medications for the residents and there is no documentation for 2 hour continuing education annually as required.. Class III	A 084		