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
	AL11965121	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLLIER AT NAPLES	770 GOODLETTE ROAD, NORTH NAPLES, FL 34102

(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 relicensure, limited nursing services, emergency power plan monitoring and complaint survey for complaint #2022010100 was conducted on .. .. through ..... at The Collier at Naples, an assisted living facility in Naples, Florida. Complaint #2022010100 was substantiated without deficiency. The following is a description of the deficiencies found at the time of the visit.	A 000		
A 009	59A-36.006(3) FAC; 400.0078(2) Admissions - Admission Package (3) ADMISSION PACKAGE. (a) The facility must make available to potential residents a written statement(s) that includes the following information listed below. Providing a copy of the facility resident contract or facility brochure containing all the required information meets this requirement. 1. The facility's admission and continued residency criteria; 2. The daily, weekly or monthly charge to reside in the facility and the services, supplies, and accommodations provided by the facility for that rate; 3. Personal care services that the facility is prepared to provide to residents and additional costs to the resident, if any; 4. Nursing services that the facility is prepared to provide to residents and additional costs to the resident, if any; 5. Food service and the ability of the facility to accommodate special diets; 6. The availability of transportation and additional costs to the resident, if any;	A 009		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965121	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLLIER AT NAPLES	770 GOODLETTE ROAD, NORTH NAPLES, FL 34102

(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 009	Continued From page 1 7. Any other special services that are provided by the facility and additional cost if any; 8. Social and leisure activities generally offered by the facility; 9. Any services that the facility does not provide but will arrange for the resident and additional cost, if any; 10. The facility rules and regulations that residents must follow as described in Rule 59A-36.007, F.A.C.; 11. The facility policy concerning . . . . . pursuant to Section 429.255, F.S., and Rule 59A-36.009, F.A.C., and Advance Directives pursuant to Chapter 765, F.S.; 12. If the facility is licensed to provide extended congregate care, the facility's residency criteria for residents receiving extended congregate care services. The facility must also provide a description of the additional personal, supportive, and nursing services provided by the facility including additional costs and any limitations on where extended congregate care residents may reside based on the policies and procedures described in Rule 59A-36.021, F.A.C.; 13. If the facility advertises that it provides special care for individuals with 's and related . . . . . , a written description of those special services as required in Section 429.177, F.S.; and, 14. The facility's resident elopement response policies and procedures. (b) Before or at the time of admission, the resident, or the resident's responsible party, guardian, or attorney-in-fact, if applicable, must be provided with the following: 1. A copy of the resident's contract that meets the requirements of Rule 59A-36.018, F.A.C., 2. A copy of the facility statement described in paragraph (a) of this subsection, if one has not	A 009		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965121	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLLIER AT NAPLES	770 GOODLETTE ROAD, NORTH NAPLES, FL 34102

(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 009	Continued From page 2 already been provided, 3. A copy of the resident's bill of rights as required by Rule 59A-36.007, F.A.C.; and, 4. A Long-Term Care Ombudsman Program brochure that includes the telephone number and address of the district office. (c) Documents required by this subsection must be in English. If the resident is not able to read, or does not understand English and translated documents are not available, the facility must explain its policies to a family member or friend of the resident or another individual who can communicate the information to the resident. 400.0078 (2) Upon admission to a long-term care facility, each resident or representative of a resident must receive information regarding: (a) The purpose of the State Long-Term Care Ombudsman Program. (b) The statewide toll-free telephone number and e-mail address for receiving complaints. (c) Information that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. (d) Other relevant information regarding how to contact representatives of the State Long-Term Care Ombudsman Program. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure all components of the admission packet comply with the regulations including 59A-36.006(3) Admission Package and the facility's policy and procedures under 59A-36.007(5) Resident Rights. Failure to provide a complete admission packet may result in omitting necessary information to resident or	A 009		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965121	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLLIER AT NAPLES	770 GOODLETTE ROAD, NORTH NAPLES, FL 34102

(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 009	Continued From page 3	A 009		

representative. This has the potential for misunderstanding between the resident or their representative and the facility.

The findings included:

Record review of the facility's admission packet revealed the following information was not included:

1. Personal care services that the facility is prepared to provide to residents and additional costs to the resident, if any.
2. Nursing services that the facility is prepared to provide to residents and additional costs to the resident, if any.
3. Admission and retention policy;
3. policy; tobacco usage policy.
4. Medication storage policy;
5. Reporting , neglect and , policy;
6. control, sanitation, and universal precaution policy;
7. Social and leisure activities generally offered by the facility;
8. Any services that the facility does not provide but will arrange for the resident and additional cost, if any.
9. The facility's admission and continued residency criteria policy.
10. Assistive devices other than scooters; and
11. Physical policy.

The facility's contract review found that the following was excluded:

1. A written bed hold policy and provisions for terminating a bed hold agreement if a facility agrees in writing to reserve a bed for a resident who is admitted to a nursing home, health care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965121	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLLIER AT NAPLES	770 GOODLETTE ROAD, NORTH NAPLES, FL 34102

(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 009	Continued From page 4 facility, or , , facility. The resident or responsible party must notify the facility in writing of any change in status that would prevent the resident from returning to the facility. Until such written notice is received, the agreed upon daily, weekly, or monthly rate may be charged by the facility unless the resident's medical condition prevents the resident from giving written notification, such as when a resident is comatose, and the resident does not have a responsible party to act on the resident's behalf; 2. A provision stating whether the facility is affiliated with any religious organization and, if so, which organization and its relationship to the facility; 3. The facility's policies and procedures for self-administration, assistance with self-administration, and administration of medications, if applicable, pursuant to Rule 58A-5.0185, F.A.C. This also includes provisions regarding over-the-counter (OTC) products pursuant to subsection (8) of that rule. Facility provided policy titled medication management policy #12.26 Rev , . The policy in place did not meet regulatory requirements pursuant to Rule 58A-5.0185, F.A.C. 4. The facility's policies in regard to third party coordination with the facility as to the resident's condition and the services being provided as indicated by 58.50182(7) FAC. 5. A provision that residents must be assessed upon admission pursuant to subsection 58A-5.0181(2), F.A.C., and every 3 years thereafter, or after a significant change, pursuant to subsection (4) of that rule;	A 009		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965121	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLLIER AT NAPLES	770 GOODLETTE ROAD, NORTH NAPLES, FL 34102

(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 009	Continued From page 5 6. Page 7 of the agreement under Termination,Transfer and Discharge by the community under paragraph (2) the following language was used: If the community initiates a discharge of the resident .....the executive director will provide at least a 30-day prior written notice. Regulatory requirement for discharge is 45 day notice in accordance with Section 429.28, F.S. 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 mentally , , the guardian shall be given at least 45 days' notice of a non-emergency 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. 7. Page 10 of the agreement 2.10.2 used the following language: The resident must establish an account with the pharmacy utilized by the community even if the resident supplies their own medication. That is a violation of resident rights as indicated in Section 429.27. 8. No reference was made in relation to residents not being required to perform any work in the	A 009		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965121	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLLIER AT NAPLES	770 GOODLETTE ROAD, NORTH NAPLES, FL 34102

(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 009	Continued From page 6 facility without compensation, except that facility rules or the facility contract may include a requirement that residents are responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated at a minimum, at an hourly wage consistent with the federal minimum wage law. 9. 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; [redacted], Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida [redacted] Hotline, 1(800)96-[redacted] 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. 10. Attachment Q titled informed consent to assist with medication by unlicensed personal indicated that the unlicensed individual who will be providing "assistance" must have completed a 4- hour training course and has demonstrated their ability to assist. Regulatory requirement is 6 hours of initial training in accordance with 59A-36.011.429.52 (6) Staff assisting with the self-administration of medications under Section. 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. On [redacted] at 12:11 p.m., the Executive Director	A 009		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965121	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLLIER AT NAPLES	770 GOODLETTE ROAD, NORTH NAPLES, FL 34102

(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 009	Continued From page 7 said the corporate office was responsible for putting the agreement together and she was not aware that it did not meet regulatory requirements. She said the corporation was utilizing the same agreement across United States and she was not sure the agree was tailored to meet regulatory requirements for the State of Florida. Class III	A 009		
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, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an . . syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (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 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 . .	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965121	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLLIER AT NAPLES	770 GOODLETTE ROAD, NORTH NAPLES, FL 34102

(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 052	Continued From page 8 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 . (4) Assistance with self-administration of medication does not include: (a) Mixing, , converting, or 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	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965121	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLLIER AT NAPLES	770 GOODLETTE ROAD, NORTH NAPLES, FL 34102

(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 052	Continued From page 9 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 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	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965121	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLLIER AT NAPLES	770 GOODLETTE ROAD, NORTH NAPLES, FL 34102

(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 052	Continued From page 10 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, 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 staff interview facility failed to provide appropriate assistance with self	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965121	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLLIER AT NAPLES	770 GOODLETTE ROAD, NORTH NAPLES, FL 34102

(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 052	Continued From page 11 administration of medications for 1 (#6) out of 3 residents observed. 1. On at 8:33 a.m., Staff A (medication technician) was observed placing crushed medications in a plastic cup. The medications belonged to resident #6. Resident #6 was observed sitting in the dining room eating oatmeal independently. Staff A approached Resident #6 and told him, " here is your morning medication". Staff A spoon fed the medications to Resident #6 and observed him taking the medications. During an interview on at 8:39 a.m., Staff A said she did not read the labels of medications given because Resident #6 told her in the past that he knew the names of his medications and he did not want them to be read to him. Staff A said she did not know what a waiver was and as far as she knew she was suppose to read the medications to residents. Staff A said she spoon feed the crushed pills to Resident #6 even though he was independent with eating , because he would have refused to take the spoon and place it in his himself. Staff A acknowledged she is a medication technician and not a licensed nurse. Record review for Resident # 6 found no evidence of physician order indicating that staff can crush medications for Resident #6. On at 11:45 p.m. during an exit interview with executive director, she acknowledged Staff A did not follow appropriate procedure when assisting Resident #6 with his self administration of medication. She said she was not aware of a waiver exception form and subsequently none were utilized. According to the executive director, all medication technicians were to follow proper procedure and to read medication labels with dosages. She also acknowledged that Staff A was	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965121	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLLIER AT NAPLES	770 GOODLETTE ROAD, NORTH NAPLES, FL 34102

(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 052	Continued From page 12 a medication technician and not a licensed nurse and therefore she was prohibited from administer medications. On . . . . . at 1:31 p.m., the resident wellness director (RWD)acknowledged that staff did not follow appropriate procedure when assisting Resident #6 with his self administration of medications. On . . . . . at 9:03 a.m., executive director (ED) said he could not find the order indicating that staff may crush pills for Resident #6. On . . . . . at 9:25 a.m., Staff A said she has been crushing medications for Resident #6 since she started working here in . . . . She said the staff member that trained her told her the resident needed his medications crushed because he had issues swallowing. Staff A said she did not remember the name of the staff member and the staff member is no longer working here. Staff A also said she never checked for the medication orders as she thought they were there from before. She said she just continued crushing the medications since the resident had issues with swallowing and has to follow a mechanical soft diet. 2. On at 9:47 a.m., Staff A was observed assisting Resident #14 with her self administration of medication. Staff A consulted the Medication Observation Record (MOR) . Staff A placed the medications in a plastic cup and went to Resident #14 who was sitting in her bed. Staff A told Resident #14, "Here is your Metoprorol, your . . . . . , and a . . . . . Here is your four pills and your gummies". The resident replied, " what is that?" Staff A responded, "your gummies." Staff A did not tell resident #14 all the	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965121	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLLIER AT NAPLES	770 GOODLETTE ROAD, NORTH NAPLES, FL 34102

(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 052	Continued From page 13 names of the medications she received. On ..... at 10:00 a.m., RWD provided a physician order dated (date of survey) indicating that staff may crush medications for Resident #6. On at 1:18 p.m., the ED and RWD acknowledged that Staff A did not follow appropriate procedure when assisting Residents #6 and #14 with their self administration of medications. Class III	A 052		
A 078	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of ..... testing materials satisfies the annual	A 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965121	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLLIER AT NAPLES	770 GOODLETTE ROAD, NORTH NAPLES, FL 34102

(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 078	Continued From page 14 . . . . . examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . . . . . . 2. If any staff member has, or is suspected of having, a communicable . . . . . , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . . . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility . . . . . to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and,	A 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965121	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLLIER AT NAPLES	770 GOODLETTE ROAD, NORTH NAPLES, FL 34102

(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 078	Continued From page 15 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff . . . . . by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that within 30 days of employment staff submit a written statement from a health care provider documenting the individual is free from signs/symptoms of communicable . . . . . and evidence of freedom from ( ) documented annually thereafter for 1 (Staff A) of 4 employee records reviewed. The findings included: On . . . a review of Staff A's file revealed a hire date of as a Resident Aide/Med tech. Staff A's file contained documentation of Drug Test screening and disclosure form completed . . . . . , an Associate Health Examination form for ( ) test consent completed by staff A on . . . . . Further review of Staff A's file contained documentation of a Mantoux . . . . . skin test form with no information documented on the form for the test being done, and a Comprehensive Occupational Medicine for Business and Industry Examination/Limited Functional capacity evaluation. Staff A's file contained no documentation of a statement from a health care provider that indicated that Staff A was free of signs and or symptoms of communicable . . . . . . On . . . . . at 12:00 p.m., Business Office Manager reviewed Staff A's employee file and the forms for and physical testing and confirmed there was no documentation signed by the	A 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965121	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLLIER AT NAPLES	770 GOODLETTE ROAD, NORTH NAPLES, FL 34102

(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 078	Continued From page 16 healthcare provider indicating Staff A was free from signs and symptoms of communicable . . . . . . Class III	A 078		
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 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	A 084		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965121	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLLIER AT NAPLES	770 GOODLETTE ROAD, NORTH NAPLES, FL 34102

(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 17 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 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;	A 084		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965121	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLLIER AT NAPLES	770 GOODLETTE ROAD, NORTH NAPLES, FL 34102

(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 18 k. Assist residents with [illegible] and continuous positive airway pressure (CPAP) devices, excluding the titration of the [illegible] levels; l. Apply and remove [illegible] stockings and hosiery; m. Placement and removal of [illegible] bags, excluding the removal of the [illegible] or manipulation of the [illegible] site; and, n. Measurement of [illegible] rate, temperature, and [illegible] 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. 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	A 084		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965121	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLLIER AT NAPLES	770 GOODLETTE ROAD, NORTH NAPLES, FL 34102

(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 19 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-administration of medications complete and obtain an initial 6-hour educational training and annual 2-hour training on providing assistance with self-administered medications for 1 (Staff A) of 4 staff records reviewed. The findings included: On . . . . at 8:33 a.m., Staff A was observed assisting facility residents with self-administration of medications. Record review of Staff A's employee file revealed a hire date of as a Resident Aide/Med Tech. Staff A's file contained documentation of completing 4 hours of educations for assistance with self-administration of medications on . Staff A's file contained no documented evidence of completing initial 6-hour educational training and no annual 2 hour continuing education for assistance with self-administration of medications as required per regulations. On at 12:00 p.m., the Business Office Manager reviewed Staff A's employee record and confirmed the findings. Class III	A 084		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965121	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLLIER AT NAPLES	770 GOODLETTE ROAD, NORTH NAPLES, FL 34102

(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 162	Continued From page 20	A 162		
A 162	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. [illegible], 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance [illegible], 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, [illegible], or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A [illegible] record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their [illegible] recorded semi-annually.	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965121	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLLIER AT NAPLES	770 GOODLETTE ROAD, NORTH NAPLES, FL 34102

(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 162	Continued From page 21 (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an . . . recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , ... ' ' ( ), CF-ES 1006, . . , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy,	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965121	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLLIER AT NAPLES	770 GOODLETTE ROAD, NORTH NAPLES, FL 34102

(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 162	Continued From page 22 guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's [redacted], DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020,	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965121	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLLIER AT NAPLES	770 GOODLETTE ROAD, NORTH NAPLES, FL 34102

(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 162	Continued From page 23 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and staff interview the facility failed to ensure all required documents are found in the resident record for 1 (Residents #15) of 4 residents sampled. The facility failed to maintain documentation of an interdisciplinary care plan for residents admitted to hospice services for 2 (#11, #15) of 4 residents sampled for record review. The findings include: Director of Wellness provided documentation of a list of facility residents receiving hospice services. On . . . . . , a review of Resident #15's record revealed her contract was signed on by the person listed as Durable Power of Attorney on the Admission Record. Further review of Resident #15's record failed to reveal any documentation of the existence of a power of attorney (POA). On . . . . . , a review of Resident #11's clinical record revealed a form 1823 medical examination dated . . . . . for initial admission to the facility, an updated 1823 signed revealed Nursing/Treatment/ . . . , Service Requirements for Hospice services, further review of resident #11's file contained documentation of physician orders for Avow hospice consult dated . . . . . Resident #11's file contained no documentation of an Interdisciplinary Care Plan for services being provided by Avow. On , a review of Resident #15's clinical	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965121	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COLLIER AT NAPLES	770 GOODLETTE ROAD, NORTH NAPLES, FL 34102

(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 162	Continued From page 24 record revealed on the 1823 under Section 1, Health Assessment, the section titled Nursing/Treatment/ , Service Requirements was blank and did not indicate resident #15 was receiving hospice services. Further review of Resident #15's file contained no documentation of physician orders for a hospice services consult or admission and contained no documentation of an Interdisciplinary Care Plan for services being provided by Avow. On at 10:15 a.m., the Director of Wellness verified and confirmed all residents documented on the list of hospice residents are receiving hospice services including Resident #15. On at 12:11 p.m., the Administrator confirmed there is no documentation of POA paperwork in the file for Resident #15, and confirmed there are no Interdisciplinary Care Plans for residents #11 and #15 admitted to hospice services. Class III	A 162		