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 _____	R 06/24/2020

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 Control Focused Visit was conducted on . . . . . at Naples Green Village, an assisted living facility in Naples, Florida. The following is a description of the noncompliance.	{A 000}		
A 030 SS=D	59A-36.007(6) FAC; 429.28(.) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; . . . . , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close	A 030		

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A 030	Continued From page 1 proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside.	A 030		

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A 030	Continued From page 2 (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . . . . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence,	A 030		

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A 030	Continued From page 3 autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , , , , , , , , , for health care services, the provision of or arrangement of transportation to health care , , , , , , , , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , , , , , , , , , the guardian shall be given at least 45 days' notice of a nonemergency	A 030		

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A 030	Continued From page 4 relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility	A 030		

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A 030	Continued From page 5 must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and . . . . , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to consistently implement prevention and control measures to maintain a safe environment for 29 memory care residents. The findings included: According to the publication titled " Prevention and Control (IPC) Guidance for Memory Care Units" from the CDC (Center For	A 030		

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A 030	Continued From page 6 . . . . . Control) updated on . . . . . , assisted living facilities providing memory care should consider the following: "Try to keep their environment and routines as consistent as possible while still reminding and assisting with frequent hygiene, social distancing, and use of cloth . . . coverings (if tolerated). Cloth coverings should not be used for anyone who has trouble breathing, or is , , , or otherwise unable to remove the mask without assistance. Provide safe ways for residents to continue to be active, such as personnel walking with individual residents around the unit or outside". 1. On at 8:45 a.m., during an interview the Administrator said all current 29 memory care residents were tested for the novel COVID-19 . . on . . . . . She said the results came in earlier today ( ) and 15 residents tested positive for the . . . The Administrator said all 15 residents were . . to their rooms. 2. On at 8:55 a.m., during a tour several residents were observed in the common area. Resident #1 was sitting on a couch. Resident #2 was lying on the couch with her . . . resting next to Resident #1. Resident #3 was wheeling herself around the room. She was not maintaining social distancing with other residents. Resident #5 was ambulating around the facility. Resident #7 and Resident #8 were each sitting at a table having breakfast. Staff C was observed pushing Resident #6 in a recliner through the common area. She did not encourage residents to stay 6 . . . apart. Care Manager Staff A was observed feeding Resident #4 at a table. She had her . . . to the other residents and was not encouraging them to	A 030		

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A 030	Continued From page 7 maintain social distancing. The residents were not wearing a mask. The Administrator was present during the tour and verified the observation. 3. On at 10:00 a.m., a review of the laboratory results revealed Resident #1, #2, #4, #5, #7 and #8 were positive for COVID-19. Resident #3 and #5 observed in the common area tested negative for COVID-19. Both residents are able to move independently. They were not wearing a mask. 4. On at 10:10 a.m., during an interview with Staff A she said Licensed Practical Nurse (LPN) Staff B told her this morning residents were positive for COVID-19. She verified feeding Resident #4 in the common area and said she knew the resident was positive for the . She said there are 4 residents on a pureed diet who need to be fed. She said there were only 4 assistants for all the residents so residents "outnumbered us." She said the residents could be fed in their rooms but it would take a lot longer. 5. On at 11:10 a.m., during a tour of the facility with LPN Staff B, Resident #3 was observed down the hall. She was not wearing a mask and no staff was walking with the resident. 6. On at 11:15 a.m., during an interview Licensed Practical Nurse Staff B said the residents only wear a mask if they're coughing and around. She said after dinner "it gets crazy and they sundown, then they mostly wear the mask." She verified Resident #1, #2, #3, #4, #5, #7 and #8 did not have any condition who would prevent them from wearing a mask. She	A 030		

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A 030	Continued From page 8 said Resident #3 . . . . . independently in her wheelchair and gets agitated if staff asks her to wear a mask. The nurse said Resident #3 frequently wheels herself into other residents rooms. LPN Staff B said when the testing results came through the fax at around 8:00 a.m., she was kind of . . . . . at first. She told the staff to put all the residents in their rooms because a lot of them were positive for COVID-19 but she did not tell them which residents were positive. 7. On at 11:30 a.m., the Administrator said they had no specific policy in writing to address the COVID-19 outbreak at the facility but they were in the process of developing one. They had planned to remodel a section of the facility to house only COVID-19 residents but the construction was suspended due to residents testing positive. She did not expect the construction to be finished until . Currently they do not have a separate unit to cohort positive residents. She said there are dedicated staff assigned to care for the COVID-19 positive residents but acknowledges the residents are scattered throughout the facility. 8. On . . . . . at 12:45 p.m., Resident #1 and Resident #9 were observed in the Cypress Cafe without . . . mask or staff supervising them to maintain social distancing. Both residents tested positive for the COVID-19. The Administrator verified the findings. Class III	A 030		