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 03/26/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments An unannounced revisit survey was conducted on [redacted] at Naples Green Village, an assisted living facility in Naples, Florida. This was a follow up to the survey completed on [redacted]. This is an uncorrected deficiency at A025. The following is a description of the deficiences. .	{A 000}		
{A 025} SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making [redacted] for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.	{A 025}		

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 03/26/2024

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 025}	Continued From page 1 (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to notify the residents guardian/family of a change in condition for health status and after an injury for 1 (Resident #3) of 3 residents reviewed. The Findings Include: Review of facility Policy: Change in condition, effective [redacted], Policy Detail: Emergent	{A 025}		

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 03/26/2024

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 025}	Continued From page 2 #3 The physician and legally responsible party will be notified of the resident change in condition and transported to the hospital. #4. The resident record will be updated as appropriate. Non-Emergent, #1 The physician and legally responsible party will be notified of the residents change in condition. #2 All necessary medical and treatment measures will be initiated and provided at the direction of the physician; #3 the resident record will be updated as appropriate. #4, Personal care plans may require updating as well. Review of facility policy Incident Management and Reporting, effective date . Policy detail: All incidents or adverse incidents occurring in the community or on community property must be reported immediately to the Executive Director, immediate supervisor, or Wellness Director. All incidents/adverse events that occur in the community are investigated to assure appropriate actions are taken to reduce the potential of reoccurrence and or reduce risk of injury. These reports must be made by individuals having firsthand knowledge of the incidents, including paid staff, volunteer staff, emergency and temporary staff, and student interns. On at 9:00 a.m. during an interview, Resident #1's legal guardian stated she arrived at the facility on at 12:00 p.m. to find her mother sitting in the . . . of the facility living room during an activity in her wheelchair; holding her . . . . Upon further inspection the guardian noted a large hematoma on her mother's forehead. Resident #1's legal guardian stated she was not informed by any facility staff that her mother had	{A 025}		

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 03/26/2024

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 025}	Continued From page 3 and or received any injuries. Resident #1's legal guardian stated that in of 2023, her mother had not eaten for about 5 days. She said the facility staff did not inform her until she came to the facility on about the change with her mother not eating and she saw her mother had a jaw. Review of the medical record for Resident #1 revealed an admission date of . Further review revealed medical diagnosis of On at 12:10 p.m. in an interview, Licensed Practical Nurse (LPN) Staff A stated that at 12:00 p.m. on , Staff B came and informed her that while preparing Resident #1 for a shower that morning, during transfer the resident hit her on the wall. Staff A confirmed, at the time of the injury Staff B never called the daughter to notified her of the injury. Staff A confirmed the daughter found out about the injury when she came to visit her mom at the facility later in the afternoon. On at 12:24 p.m. in an interview, Staff B stated that the day of the incident was Resident #1's shower day and the resident was a 2 person assist. Staff B stated she tried, on her own, to assist Resident #1 with showering. Staff B said she placed Resident #1 in the wheelchair and took her to the bathroom, lifted Resident #1 putting her on the shower chair, and she gave her a shower. Staff B said after giving Resident #1 her shower she tried to transfer Resident #1 from the shower chair to the wheelchair, and while trying to lift Resident #1 to the wheelchair her hit the wall. Staff B said she knows she is supposed to tell the nurse what happened but	{A 025}		

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 03/26/2024

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 025}	Continued From page 4 she did not. Staff B stated she got Resident #1 dressed and took her to the dining room for her meal about 8:30 a.m. Staff B stated, at the time she took Resident #1 to the dining room, there was no bump on her . . . , but during the time she was sitting in the dining room, after 25 minutes, the hematoma appeared. Staff B confirmed she did not tell the facility nurse, the Director of Nursing, or the Executive Director about the incident or the injury to Resident #1. Staff B confirmed she did not inform the resident's legal guardian about the incident. Staff B confirmed she informed the nurse what happened around 12:00 p.m. after Resident #1's daughter had arrived at the facility and saw the hematoma on the resident's forehead. Staff B confirmed she did not complete an incident report form at the time of the incident. On at 1:00 p.m. in an interview, the Executive Director (ED) stated that on . . . . . around 12:00 p.m., Staff A came to her and the Director of Nursing (DON) and informed them Resident #1 had a bump on her and her legal guardian was at the facility and very distraught about it. The ED stated she and the DON went to Resident #1's room and noted Resident #1' legal guardian was very upset and crying, saying her mom had hit her . . . and had a bump yet no one had called to notified her. On at 1:15 p.m., the ED stated she spoke with Staff B, who had given Resident #1 her shower and dressed her for the day, and was informed by Staff B that during the shower when she reached up too grab the held shower wand, Resident #1 leaned over and hit her . . . on the wall. The ED confirmed Staff B did not notify any staff members, the physician, or the legal guardian about the incident and should have	{A 025}		

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 03/26/2024

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 025}	Continued From page 5 waited for additional staff to assist her with the resident, who was a 2 person assist. The Executive director confirmed no other staff member had informed her of noticing the hematoma on Resident #1's . . until Resident #1's legal guardian visited and informed the staff. In at 1:42 p.m. during an interview, the DON confirmed no one had informed Resident #1's legal guardian about the injury/hematoma until she arrived at the facility and noticed the injury. The DON confirmed Staff B did not tell her, any of the supervisors, or the nurse on duty about the injury incident with Resident #1. The DON stated the facility policy is for staff to report any incident/injury or change in condition or health status to their immediate supervisor, nurse on duty, the DON, and ED. Record review of Resident #1's clinical chart progress notes revealed there was no documentation of the injury that occurred on . . . . . , no documentation that stated the Resident #1 refused to eat or drink during the month of . . . . . , and no documentation indicating Resident #1's guardian was notified of the injury incident or that the resident was not eating for 5 days during the month of . . . . . On . . . . . at 2:00 p.m., Staff A stated in . Resident #1 had a change and was not eating for about . days. Staff A said she notified the DON Resident #1's jaw looked slightly . . . . . Staff A stated she did not document in the chart about the resident not eating and she did not notify the daughter. Class III	{A 025}		

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 03/26/2024

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