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
	AL11965374	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUNIPER VILLAGE AT NAPLES	1155 ENCORE WAY 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 This is the Biennial and Limited Nursing Services survey conducted on ..... through ..... at Juniper Village at Naples, an Assisted Living Facility. The facility census on the day of survey was 56. There were seven residents currently receiving Limited Nursing Services.	A 000		
A 025	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, 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 individual. (c) 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; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in	A 025		

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A 025	Continued From page 1 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 family of 1 (Resident #5) of 5 residents interviewed, of the the appearance of a newly identified ... The facility also failed to update and/or address weight discrepancies in the written record for 1 (Resident #5) of 5 residents interviewed. The findings include: 1. On ... at 2:00 p.m., a ... was reported on Resident #5's ... Her private duty caretaker indicated the last time she had this it "broke" down and was very difficult to heal. The physician was notified and Nystatin ,000 units/gram crème was ordered, to be applied topically, ... times a day, for three weeks. The resident was started on the medication regime. There was no documentation in the resident's file that the family was notified of the presence of a rash ... the ordering of the medication. 2. Resident #5 was admitted to the facility on ... diagnoses that include but are not limited to Dementia; Hypertension; ... Fib; Mixed Hyperlipidemia; and ... Disorders. Her ... pressure ... was 128/74. ... on a low fat, low cholesterol, no ... salt diet. Her weight prior to coming to the facility on ... as 152, and her weight on admission was 152. Her weight on ...	A 025		

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A 025	Continued From page 2 208. Her weight on . . .. was 209. During a discussion with the Wellness Director at 2:00 p.m. on . the surveyor and Wellness Director discussed the weight difference of 56 pounds in a one month period. Considering the resident's diagnoses, asked what was the follow-up to the identified weights. He indicated he was not aware of the weight discrepancies, but said he would get back on it. The Wellness Director returned within about 15 minutes and presented the weight monitoring form for review, which indicated the same figures identified previously. He also said the facility has a weight monitoring policy and procedure that states the residents will be weighed upon move-in and at least monthly. He indicated the monitoring form will monitor for significant, unplanned or undesired weight loss or gain of 5% or more in one month or 6% in 6 months. On the monitoring form, it identified the weights for . and /12, but did not indicate the weight in ıy/12. The document also says the Wellness Director will notify the physician, resident, responsible party and dietician of any significant weight change. There was no documentation of any discussions or notification related to the discrepancies. The form also indicates residents with significant weight variances will be monitored weekly until the problem is solved. There are no weekly weights being documented. The Wellness Director said he is not sure the initial 152 pound weight was correct in the first place and said, "It should have been re checked right away. Fifty-two pounds is a lot."	A 025		

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A 025	Continued From page 3 Class III Correction Date:	A 025		
A 030	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (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 Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. (b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for 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 address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with , 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456. (d) The statewide toll-free telephone number of the Florida Hotline " 1(800)96 or 1(800)962-2873 " shall be posted in full view in a common area accessible to all residents. (e) The facility shall have a written statement of its house rules and procedures which shall be	A 030		

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A 030	Continued From page 4 included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility ' s policies with respect to such issues, for example, as resident responsibilities, the facility ' s alcohol and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements. (f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be 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. (g) The facility shall 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 shall not prohibit 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 shall be, at a minimum, an accessible telephone on each floor of each building where residents reside. (h) Pursuant to Section 429.41, F.S., the use of physical restraints [illegible] be limited to half-bed rails, and only upon the written order of the resident ' s physician, who shall review the order biannually, and the consent of the resident or the resident ' s representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical restraint.	A 030		

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A 030	Continued From page 5	A 030		

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 [illegible] 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 achieve the highest possible level of independence, 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 [illegible] his or her spouse if both are residents of the facility.

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A 030	Continued From page 6	A 030		

(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) Access to adequate and appropriate health care 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 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.

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A 030	Continued From page 7	A 030		

This Statute or Rule is not met as evidenced by:
Based on observation and medication record review, the facility failed to provide adequate and effective control and eye medication assistance techniques for 1 (Resident #3) of 6 residents who were receiving assistance with self- administration of medications. The facility also failed to insure 3 of 3 canisters for Resident #2, which were located in the resident's , were properly secured.

The findings include:

1. On during a medication pass in Cottage 5, Resident #3 was observed to receive assistance with self administration of medications before the evening meal. The resident was brought to the medication the Med Tech/CNA, who helped the resident into a chair. The resident first took two pills, as ordered, by mouth.
The resident also has a physician's order for , 1%, instill one drop in the right eye three times a day.

The Med Tech/CNA washed her hands and took the eye drops bottle from the medication cart. She removed the cap of the eye drop container with an ungloved hand and started to prepare for the resident's medication to be instilled, but stopped and went back to the med cart to get a tissue for the resident to use during instillation of the eye drop. At that time the resident took the tissue and dabbed both the right and left eyes with the tissue. He also was

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A 030	Continued From page 8 observed to wipe the tissues across his mouth and nose area. The Med Tech/CNA then took the opened medication container and placed it in the resident's hand, encouraging him to put the drop in his eye, while guiding the container with the Med Tech/CNA's ungloved hand. The Med Tech did not make an attempt to assist by pulling down the lower eye lid for installation of the medication into the lower lid area. Neither of the two drops attempting to be instilled by the resident in his right eye entered the eye, but instead fell his cheek, which he then used the same tissue to dab the cheek. The Med Tech continued to encourage the resident to instill the drops in his eye. Being unsuccessful in his two attempts, the resident appeared to become increasingly upset that the eye drops were taking so long to find their way in his eye. He kept saying, "You do it. Just do it. I want to go outside." The resident continued to use the same tissue to wipe the two drops off his cheek and both eyes. The resident was observed not to be able to put his head back,as requested, but rather, remained in an upright, sitting position in his chair. Finally, with the assistance of the Med Tech/CNA, the resident's drops were instilled into his eye. The Med Tech made no attempts to call the licensed registered nurse on duty in the facility, to assist with the installation of the drops for the resident; did not have a gloved hand; did not gently pull down the lower eye lid to ease instillation; did not use a different tissue for touching the eye, after touching the face; and did	A 030		

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A 030	Continued From page 9 not encourage the resident to put his head back further and/or complete the installation while the resident was lying in his bed. 2. Observation made on [redacted] at 10:38 a.m. revealed Resident #2 has a O2 sign located on her door. The resident was currently on O2 at 2L per minute. There were 2 unsecured O2 canisters that were adjacent to the concentrator. Observation made on [redacted] at 12:40 p.m. revealed that the resident was in the [redacted] two (2) canisters adjacent to the the O2 concentrator were still noted not to be secure. Observation made on [redacted] at 1:10 p.m. revealed 1 canister of O2 in metal basket, not secured. Observation made on [redacted] at 3:09 p.m. revealed Resident #2 was in bed laying down. There was one (1) O2 canister in metal basket which does not secure O2 canister properly. Observation made on [redacted] at 10:35 a.m. with the Wellness Director revealed that there was one O2 canister in metal basket which does not secure O2 canister properly. It was further commented that he would need to contact company and get proper O2 canister holders for the resident. Class III Correction Date: [redacted]	A 030		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

. 2012

Administrator
Juniper Village At Naples
1155 Encore Way
Naples, FL 34110

Dear Administrator:

This letter reports the findings of a Biennial and Limited Nursing Services survey that was conducted on . 17, 2012 through . 2012 by representatives of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after ... to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyors. Should you have any questions please call this office at 239-335-1315.

Sincerely,

for:
Harold D. Williams
Field Office Manager

bw
Enclosure

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
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Phone (239) 335-1315; Fax (239) 338-2372