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 _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE 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 Biennial survey was conducted at Homewood Residence in Naples on . . . . through . . . . The following is a description of non-compliance:	A 000		
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)9€ or 1(800)962-2873 " shall be posted in full view in a	A 030		

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 _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE 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 030	Continued From page 1	A 030		

common area accessible to all residents.
(e) The facility shall have a written statement of its house rules and procedures which shall be 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 . . . . 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 . . . . . shall 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

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 _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE 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 030	Continued From page 2	A 030		

and can remove or avoid without assistance shall not be 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 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

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 _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE 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 030	Continued From page 3	A 030		

provided in s. 429.27.
(g) Share a [illegible] 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) 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

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 _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE 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 030	Continued From page 4	A 030		

active in, and to associate with advocacy or special interest groups.

This Statute or Rule is not met as evidenced by:
Based on record review, observation, and interview the facility failed to ensure they posted a copy of the Resident Bill of Rights; and failed to provide access to adequate and appropriate health care, including privacy and control, for 3 (Residents #11, #13, and #14) of 6 residents observed during a medication pass.

The findings include:

1. Tour of the facility, including the first, second and third floor (with the inclusion of the first floor Memory Care unit), on between 9:30 a.m. through 11:30 a.m., revealed that the facility did not have a posting of the Resident Bill of Rights.

Interview of the facility Administrator, at 11:30 a.m. on revealed that she was unaware that a posting was required and that no posting was available at any location in the facility.

In addition, upon interview of Residents #7, #8, #9, and the responsible party for Resident #1 they stated that they did not know their rights as a resident of the facility.

2. Observation of a medication pass on 4/1(4:00 p.m., revealed that Resident #11 received Sinemet and 1/2 pills, as stated on the bubble pack medication label. Review of April Medication Observation Record (MOR) and the Physician orders dated 3/1(Form

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 _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE 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 030	Continued From page 5	A 030		

1823) state [redacted] 25-100mg, 1/2 tab, 12.5/[redacted] 900, 1300, 1700."

The LPN (Licensed Practitioner Nurse) Charge Nurse was interviewed at this time. She stated that the [redacted] 2013 MOR must be wrong, because the [redacted] 2013 MOR stated [redacted] 1 and 1/2 pills, three times daily. The LPN continued to explain that the procedure is to verify the new MOR [redacted] 2013) with the old MOR [redacted] 2013) to make sure it is correct. When asked if the physician orders are checked to make sure the MOR is correct, the LPN said, "No, we check the last MOR."

The Health and Wellness Director was interviewed, on [redacted] at 4:45 p.m., and acknowledged that the physician order, dated [redacted] was not followed; and concurred that the resident had been receiving [redacted] 1 and 1/2 tablets since [redacted] instead of Sinement, 1/2 tablet (12.5/[redacted] She also stated that the physician would be notified and a medication error report would be initiated.

3. Observation of a medication pass on [redacted] at 8:30 a.m., in the second floor medication revealed that the Med Tech did not give medication [redacted] 400mg as stated on the Medication Observation Record and ordered by the physician. The Med Tech told Resident #14. The Med Tech told the resident that her daughter would be contacted because the dosage on the bottle label stated 500mg and the order was for 400mg. The container of medication had the resident's name and [redacted] on it. The container stated that there were 100 pills.

Upon interview at this time, the Health and Wellness Director acknowledged that the

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 _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE 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 030	Continued From page 6	A 030		

container appeared to have pills at the half way mark, which would indicate 50 pills left; and, concurred that the resident had been receiving the wrong dosage since the medication had been supplied by the resident's daughter.

4. Resident #13 was observed receiving medications on [redacted] at 9:00 a.m. During the procedure, the Med Tech was observed to crush the medications. Review of the medical record, "1823 Clarification of Orders", did not note the medications were to be crushed.

An interview with the Med Tech on [redacted] at 10:00 a.m., revealed the resident has always had her medication crushed and placed in applesauce. The Med Tech continued to state, "She (Resident #13) has been here for three years and she always has her meds (medications) crushed. Look on her other Medication Observation Records (MOR), you will see it there." While reviewing the MOR's for [redacted] and [redacted] of 2013, the hand written word "Crush" was observed at the bottom of each page.

During an interview with the Health and Wellness Director, on [redacted] at 2:00 p.m., she was in agreement that an order for crushed meds was not on the residents chart, although "Crush" was hand written at the bottom of the resident's previous MOR records, but was not written on the [redacted] MOR records.

On [redacted], the DON called the resident's physician and received an order to "Crush all medications unless contraindicated."

5. On [redacted] at 9:00 a.m., Resident #13 was observed to receive an [redacted]

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 _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE 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 030	Continued From page 7	A 030		

medication patch to her left upper chest wall. The Med Tech applied the patch in the medication ... at least three other residents present. No privacy was provided provide while applying the patch. The Med Tech then removed the patch that was applied, to the resident's right upper chest wall, on ... No privacy was provided during the procedure.
An interview was conducted with the DON on ... at 2:00 p.m. She stated, "Ok, I will look into that."
Review of a facility policy entitled "Application and Removal of ... Medication Patch" dated ... 2012 revealed "Ask the resident to accompany you to a private area of the residence and explain the procedure to the resident."

6. On ... at 9:00 a.m., Resident #13 was observed to receive an ... medication patch to her left upper chest wall. The Med Tech was then observed to remove ... patch, from the right upper chest wall, that was applied on ...

According to the facilities policy on "Application and Removal of ... Medication Patch", dated ... 2012, the procedure is to "Remove the previous patch and discard in a secure container. Remove gloves/wash hands and apply new gloves." The existing patch should have been removed before applying the old patch..

A review of the Resident #13's ... Patch Application Sites" record, shows 35 different sites for the application of transdermal patches.

According to the facilities policy "Some patches may not be reapplied to the same skin site for specific periods of time. For example (i.e.

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 _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE 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 030	Continued From page 8	A 030		

Excelon) may not be reapplied to the same skin site for 14 days. Alternate the skin sites to avoid irritation." The policy for applying [redacted] Patches is not being followed according to the [redacted] Patch Application Sites" sheet. The [redacted] patch is being rotated between site 34 and site 35 which is the right and left upper chest wall.

An interview with the DON on [redacted] at 2:00 p.m., revealed she was unaware of the this deficient practice and she stated she would discuss it with the med-techs.

7. On [redacted] at 4:00 p.m., a Medication Technician was observed carrying empty plastic medication cup and empty water cup with her fingers (ungloved) inside each container. Med Tech then placed containers on top of medication cart and stated she was going to give meds to Resident #11. When asked if she was using the medication cup and glass, she said yes; and surveyor advised regarding the breach in [redacted] control. The Med Tech acknowledged the same, placed the containers in the trash receptacle and obtained a clean water and medication cup.

Class III

A 052	58A-5.0185(3) FAC Medication - Assistance with Self-Admin	A 052		

(3) ASSISTANCE WITH SELF-ADMINISTRATION.
(a) For facilities which provide assistance with self-administered medication, either: a nurse; or an unlicensed staff member, who is at least [redacted] trained to assist with self-administered medication in accordance with Rule 58A-5.0191, F.A.C., and able to demonstrate to the administrator the ability to accurately read and

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 _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE 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	A 052		

interpret a prescription label, must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S.
(b) Assistance with self-administration of medication includes verbally prompting a resident to take medications as prescribed, retrieving and opening a properly labeled medication container, and providing assistance as specified in Section 429.256(3), F.S. In order to facilitate assistance with self-administration, staff may prepare and make available such items as water, juice, cups, and spoons. Staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, shall not be returned to the container.
(c) Staff shall observe the resident take the medication. Any concerns about the resident ' s reaction to the medication shall be reported to the resident ' s health care provider and documented in the resident ' s record.
(d) 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 which coincides with the resident ' s presence in the facility;
2. The medication container may be given to the resident or 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

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 _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE 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	A 052		

dispensed in an easier to use form, such as unit dose packaging;
(e) Pursuant to Section 429.256(4)(h), F.S., the term " competent resident " means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication.
(f) Pursuant to Section 429.256(4)(i), F.S., the terms " judgment " and " discretion " mean interpreting vital signs and evaluating or assessing a resident ' s condition.
(4) Assistance with self-administration 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 through intermittent positive pressure breathing machines or a
(d) Administration of medications by way of a tube inserted in a cavity of the body.
(e) Administration of preparations.
(f) Irrigations or debriding agents used in the treatment of a skin condition.
(g) , or preparations.
(h) 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 at the request of a competent resident.
(i) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the

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 _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE 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	A 052		

reason for administration requires judgment or discretion on the part of the unlicensed person.

This Statute or Rule is not met as evidenced by:
Based on record review, observation and interview the facility failed to ensure that 4 (Residents #13, #14, #16 and #17) out of a sample of 6 residents receive assistance with self-administration of medications as ordered by the physician.

The findings include:

1. During the observation of a medication pass in the second floor medication between 8:30 a.m. and 9:00 a.m. on , the following was noted: The Medication Technician (Med Tech) removed medication containers from the medication cart and proceeded to place one medication D which was crushed) into a medication cup with applesauce. Another medication D which was not crushed) was placed in a separate medication cup. Resident #14 was sitting in a chair and was not able to see what pills were dispensed from the containers. The Med Tech handed the resident the medication cup, with the applesauce, without advising the resident that the D medication was in the cup.

Resident #13 was observed sitting in a chair at this time. From her vantage point, Resident #13 could not see the top of the medication cart that the Med Tech was standing at. The Med Tech removed medication containers from the medication cart and proceeded to place 8 pills in a medication cup, then crushed the pills and placed them in a medication cup containing applesauce. One medication was placed in a separate medication cup

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 _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE 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 052		

uncrushed. The Med Tech gave the medication cup (with applesauce/8 pills) to the resident stating, "Here is your medicine." She also gave the medication cup, with the [illegible], and glass of water to the resident. At no time did the Med Tech explain what the medications were or what they were for.

The Med Tech's observed procedure was discussed with the Health and Wellness Director, on [illegible] at 8:45 p.m., who acknowledged that the facility policy/procedure was not followed related to providing assistance with self-administration of medications.

Review of the medical record for Resident #13 revealed that she had physician orders stating she requires assistance with self-administration of medications. The resident had no order to crush her medications.

Review of the medical record for Resident #14 revealed that she had physician orders stating she requires assistance with self-administration of medications.

2. During the observation of a medication pass on the facility Memory Care Unit, at 8:20 a.m., on [illegible], the following was noted: Sampled Resident #16 was called by the Medication Technician (Med Tech) to the medication cart to obtain his medications. The Med Tech took the Resident's bubble packed medications from the medication cart drawer and proceeded to push them from the bubble pack into a medication cup. She told the resident what the name of the medication was each time she pushed them into the cup. The medications were an [illegible] (relieves pain and [illegible] lowers [illegible], and reduces [illegible] clotting), Ducolax (used for the

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 _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE 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 relief of occasional and a multi (a dietary supplement with dietary and other nutritional elements). The purpose of the medication was not explained. This same procedure was repeated for sampled Resident #17. His medications included drug used for the management of and associated with drug used for the management of and associated with and fish oil (used for conditions related to the and system). The medication technician was interviewed at this time and stated that she "Had been taught to name the medication not explain their use." During an interview with the facility Health and Wellness Director, on at 11:30 a.m., she confirmed that the facility policy for Medication & Treatment - General Guidelines for Medication Administration/Assistance #12 documented "The community associate (Med Tech) should explain the purpose of the medications administered and answer questions from the resident or family if present." Review of the physician orders for Residents #16 and #17 revealed that both residents had physician orders to receive assistance with self-administration of medications. Class III	A 052		
A 055	58A-5.0185(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL.	A 055		

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 _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE 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 055	Continued From page 14	A 055		

(a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises; or in their . . . or apartments, which must be kept locked when residents are absent, unless the medication is in a secure place within the . or apartments or in some other secure place which is out of sight of other residents. However, both prescription and over-the-counter medications for residents shall be centrally stored if:

1. The facility administers the medication;
2. The resident requests central storage. The facility shall maintain a list of all medications being stored pursuant to such a request;
3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed;
4. The resident fails to maintain the medication in a safe manner as described in this paragraph;
5. The facility determines that because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents; or
6. The facility ' s rules and regulations require central storage of medication and that policy has been provided to the resident prior to admission as required under Rule 58A-5.0181, F.A.C.

(b) Centrally stored medications must be:

1. Kept in a locked cabinet, locked cart, or other locked storage receptacle, , or area at all times;
2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration shall be refrigerated.

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 _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE 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 055	Continued From page 15	A 055		

Refrigerated medications shall be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which refrigerator is located locked;
3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration, or administering medication. Such staff must have ready access to keys to the medication storage areas at all times; and
4. Kept separately from the medications of other residents and properly closed or sealed.
(c) Medication which has been discontinued but which has not expired shall be returned to the resident or the resident ' s representative, as appropriate, or may be centrally stored by the facility for future resident use by the resident at the resident ' s request. If centrally stored by the facility, it shall be stored separately from medication in current use, and the area in which it is stored shall be marked " discontinued medication. " Such medication may be reused if re-prescribed by the resident ' s health care provider.
(d) When a resident ' s stay in the facility has ended, the administrator shall return all medications to the resident, the resident ' s family, or the resident ' s guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident ' s medications are still at the facility, the medications shall be considered abandoned and may disposed of in accordance with paragraph (e).
(e) Medications which have been abandoned or which have expired must be disposed of within 30 days of being determined abandoned or expired and disposition shall be documented in the resident ' s record. The medication may be taken to a pharmacist for disposal or may be destroyed

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 _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE 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 055	Continued From page 16 by the administrator or designee with one witness. (f) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure that medications were stored at the proper temperature. The findings include: During tour of the facility on at approximately 11:00 a.m., observation of the locked medication refrigerator, in the medication the second floor of the facility, revealed a thermometer indicating "Warning Zone" in red and reading 46 degrees. A log attached to the front door of this refrigerator recorded temperatures (of the refrigerator) to be 40 degrees daily, for the time period through Upon interview at this time, the Medication Technician acknowledged that the thermometer was indicating 46 degrees and stated she would contact maintenance to look at the refrigerator. Ten syringes of , labeled with resident names, were observed to be stored in this refrigerator. Class III	A 055		
A 093	58A-5.020(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The Tenth Edition Recommended Dietary	A 093		

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 _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE 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 093	Continued From page 17	A 093		

Allowances established by the Food and Nutrition Board - National Research Council, adjusted for age, . . . and activity, shall be the nutritional standard used to evaluate meals. Therapeutic diets shall meet these nutritional standards to the extent possible. A summary of the Tenth Edition Recommended Dietary Allowances, interpreted by a daily food guide, is available from the DOEA Assisted Living Program.

(b) The recommended dietary allowances shall be met by offering a variety of foods adapted to the food habits, preferences and physical abilities of the residents and prepared by the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the recommended dietary allowances to be made available to each resident daily by the facility are as follows:

1. Protein: 6 ounces or 2 or more servings;
2. Vegetables: 3 5 servings;
3. Fruit: 2 4 or more servings;
4. Bread and starches: 6 11 or more servings;
5. Milk or milk equivalent: 2 servings;
6. Fats, oils, and sweets: use sparingly; and
7. Water.

(c) All regular and therapeutic menus to be used by the facility shall be reviewed annually by a registered dietitian, licensed dietitian/nutritionist, or by a dietetic technician supervised by a registered dietitian or licensed dietitian/nutritionist, to ensure the meals are commensurate with the nutritional standards established in this rule. Portion sizes shall be indicated on the menus or on a separate sheet. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. This review shall be documented in the facility files and include the signature of the

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 _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE 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 093	Continued From page 18	A 093		

reviewer, registration or license number, and date reviewed. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents.
(d) Menus to be served shall be dated and planned at least one week in advance for both regular and therapeutic diets. Residents shall be encouraged to participate in menu planning. Planned menus shall be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, shall be kept on file in the facility for 6 months.
(e) Therapeutic diets shall be prepared and served as ordered by the health care provider.
1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining or family style dining are not required to document what is eaten unless a health care provider ' s order indicates that such monitoring is necessary. However, the food items which enable residents to comply with the therapeutic diet shall be identified on the menus developed for use in the facility.
2. The facility shall document a resident ' s refusal to comply with a therapeutic diet and notification to the resident ' s health care provider of such refusal. If a resident refuses to follow a therapeutic diet after the benefits are explained, a signed statement from the resident or the resident ' s responsible party refusing the diet is acceptable documentation of a resident ' s preferences. In such instances daily documentation is not necessary.
(f) For facilities serving three or more meals a day, no more than 14 hours shall elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals shall be evenly

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 _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE 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 093	Continued From page 19	A 093		

distributed throughout the day with not less than two hours nor more than six hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks shall be offered at least once per day. Snacks are not considered to be meals for the purposes of _____ the time between meals.
(g) Food shall be served attractively at safe and palatable temperatures. All residents shall be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, shall be on hand.
(h) A 3-day supply of non perishable food, based on the number of weekly meals the facility has contracted with residents to serve, and shall be on hand at all times. The quantity shall be based on the resident census and not on licensed capacity. The supply shall consist of dry or canned foods that do not require refrigeration and shall be kept in sealed containers which are labeled and dated. The food shall be rotated in accordance with shelf life to ensure safety and palatability. Water sufficient for drinking and food preparation shall also be stored, or the facility shall have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority.

This Statute or Rule is not met as evidenced by:
Based on record review, observation and interview, the facility failed to ensure dietary services include an annual review of menus by a registered dietician; the provision for therapeutic diets and water at meal time, the identification of food portions and posting of menus; preparation

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 _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE 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 093	Continued From page 20	A 093		

of menus a week in advance, and the maintenance of safe food temperatures during meal service.

The findings include:

1. On at 11:30 a.m., the facility Administrator was contacted and advised that there was no menu posted anywhere in the facility. The Administrator stated, at this time, that copies of the menu were available at the front reception area and gave the surveyor a copy of the menu for Wednesday, The Administrator also stated that today's menu was displayed on the television at the entrance to the Main Dining

Observation of the television display revealed that a lunch menu, dated , did not match anything listed on the copy of the menu that was located at the front reception area. When this was brought to the Administrator's attention, by the surveyor, the Administrator stated she was not aware that the menus were different. The menu from the front desk listed "Farmer's Market Salad, Salmon, French Fries, Glazed Carrots, Almond Cake."

The residents, in the Main Dining , were observed to receive a different menu at their table, that was dated Wednesday, (wrong date) and listed "Filet Mignon, Salmon, Quiche Loraine and Whole Wheat Pasta with Marinara Sauce" as main entrees; with "Asparagus Soup, Salad Bar, Baked Potato, Carrots and Almond Cake."

The Memory Care Unit was also observed this date from 11:30 a.m. through 12:30 p.m. No menu was posted on the unit and the residents

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 _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE 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 093	Continued From page 21	A 093		

were given the same menu that was given to residents in the Main Dining . . . . . It was noted that no water was served at the dining tables and the Memory Care residents were not offered or given a salad.

2. Upon interview on . . . . . at 3:00 p.m., the Food Service Manager (FSM) with the Administrator present, stated that at "Chef Chat" meetings last week and yesterday (every Tues.) residents were encouraged to inform the chef what they wanted to see on the menu. The FSM stated, "So I tried to get those items on the menu and that's what you see today besides the featured item, which is the Salmon. No french fries were served (or available today) based on the residents stating that they do not like fried foods." When asked how many residents attended the meetings, the FSM stated "10 to 12."

When asked why the menu on the television, at the entrance to the Main Dining was completely different than what was served at the noon meal , the FSM stated that the menu (on the television) has been wrong since Monday. The Administrator advised, at this time, that there was a problem with the program that she did not know how to correct and she was unable to shut off the television.

When asked for the yearly menu, reviewed as approved by a registered dietician to include the signature of the reviewer, registration or license number and date of review; the FSM and Administrator could not present one.

The FSM also stated that menus were on the computer and were available for printing 3 months at a time. When asked for a menu

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 _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE 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 093	Continued From page 22	A 093		

prepared a week in advance (listing the timeperiod . . . . . through the FSM stated that one was not prepared yet.

A concern, regarding the temperature of food on the steam table in the Memory Care Unit, was identified by the surveyor. It was observed, at the lunch meal , that the food containers from the kitchen did not fit the steam table properly. The FSM acknowledged that the containers did not fit correctly and needed to be replaced.

2. Observation of the breakfast meal served to Memory Care residents, on between 8:15 a.m. and 9:00 a.m. revealed: No menu was posted on the Memory Care Unit. Residents in the dining area were not asked what they wanted for breakfast. It was noted that all residents had oatmeal given to them. When asked why there were no menus at the tables, the staff gave the residents a copy of the breakfast menu listing "Hot Cereal (Oatmeal), Assorted Box Cereal, Eggs Your Way, Pancakes with Syrup, Pork Sausage, Crispy Bacon, Grilled Ham, Bread (White, Wheat, Raisin, Rye or English Muffin." It was observed that no bread, of any type, was available/given to the residents and no water was served at the tables.

Eggs, sausage and pancakes had temperatures tested at 8:35 a.m. Eggs were 115 degrees, sausage 110 degrees and pancakes 102 degrees. These items arrived in a food warmer, from the kitchen, at approximately 8:15 a.m. The cook, at this time, presented the 7:30 a.m. temperature log, from the Main Kitchen, that recorded eggs 170 degrees, sausages 160 degrees, and pancakes as not tested. This log was dated 4/1 . . . . . presented by the cook.

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 _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD RESIDENCE 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 093	Continued From page 23 The foregoing was discussed with the FSM on [redacted] at 2:30 p.m., who acknowledged that the food temperatures were unacceptable and menu service needed to be corrected. 3. Review of the diet (ordered by the physician) and weight record, listing all facility residents, was reviewed on [redacted] at 2:00 p.m. It was noted that there were physician orders listed, on this record, for therapeutic diets. When questioned at 2:30 this date, the FSM stated he did not have this record/information, regarding residents ordered to received therapeutic diet, in the kitchen. In addition, the FSM was asked for a listing of food portions that correlated with the meals being served on [redacted] and [redacted]. The FSM stated there was no listing available. A meeting with the Administrator and FSM at 3:00 p.m. this date revealed that there was no mechanism in place to ensure that residents received therapeutic diets as ordered by the physician. Both the Administrator and FSM acknowledged that this was a problem that needed correction. In addition, the Administrator concurred that there was no listing of food portions being served at mealtimes. Class III	A 093		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Homewood Residence At Naples
770 Goodlette Road, North
Naples, FL 34102

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2013 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 , 2013 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,

Harold D. Williams
Field Office Manager

sh
Enclosure: State Form

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Fort Myers Field Office
2295 Victoria Avenue,
Fort Myers, FL 33901
Phone (239) 335-1315; Fax (239) 338-2372