STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965374	**08/08/2013**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Juniper Village At Naples	**1155 Encore Way Naples, FL 34110**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D

Specific Tag Findings:
These are the results of a Compliant Survey, CCR# 2013007584 which was conducted on through at Juniper Village of Naples, an Assisted Living Facility (ALF).

The following is a description of non-compliance:

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS

Based on observation and interview, the facility failed to treat 1 (Resident #4) resident with dignity during the lunch meal.

The findings include:

On at 12:28 p.m., residents in cottage #1 was observed eating their lunch meal. Resident #4 was observed sitting at the table not touching his food (he had only eaten his bread). At 12:53 p.m., Resident #4 was observed sitting at the table and still not touching his plate. Staff was observed walking past Resident #4 several times during the meal.

On 12:57 p.m., Resident #4 was interviewed, he stated he did not like his food and he complained the staff did not ask or offer him another option. Resident #4 stated that he would like a cup of coffee and cottage cheese.

On 1:02 p.m., Staff D was interviewed. She acknowledged Resident #4 had not touched the main course of his food and asked the surveyor what Resident #4 wanted to eat. Staff D was redirected to ask Resident #4 what he wanted to eat.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC

Based on observation and interview, the facility failed to ensure unlicensed staff followed the procedure to assist residents with the self-administration during a medication pass for 4 (Residents #6, #9, #10, and #13) of 7 residents observed receiving medications, by not preparing the medications and reading the label in the presence of residents and allowed unlicensed staff to administer oral medications to two residents.

The findings include:

1. Three residents were observed for medication pass in cottage #2 starting at 12:05 p.m. on Resident #9 received 2 medications (LoDivalprox Na and Staff C crushed the medication and put into

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pudding. Staff C left the medication in the medication (with the surveyor) and went to retrieve the resident from the living . The resident was brought into the medication . medications were given to Resident #9. There was no mention of what the medications were and no preparing the medications in front of the resident.

2. Resident #10 received (anti-ε drug) during the continued medication pass. The tablet was punched from the card (containing a 30 day supply of medications) and place in a medication cup. The card was returned to the locked medication cabinet. The medication was taken to the resident where the staff identified the medication as a pain pill while handing the cup to the resident.

3. Medication observation continued in cottage #1 at 4:20 p.m. on . Residents #6 and #13 were observed to receive medications. In each case, the medication was pulled from the medication cart (separately for each resident) taken to the resident, and the staff stated, "Here's your medicine." Resident #6 received the medications in pudding and had to be assisted with positioning to enable to get the medication off the spoon and into the mouth.

On 4:26 p.m., Staff B was observed crushing medications in the medication cottage 2. He poured the crushed medication into a small plastic medicine cup and mixed it with vanilla pudding. At 4:28 p.m., Staff B located Resident #13 in the hallway and assisted her to a seat at a dining . Staff B spoon fed Resident #13 the pudding/medication mix.

On at approximately 4:30 p.m., Staff A was observed walking around cottage #1 with a small plastic cup of vanilla pudding and crushed medications. Staff A located Resident #6 walking down the hallway and spoon fed Resident #6 the pudding/medication mix.

On at approximately 4:31 p.m., Staff A was interviewed. Staff A stated she was not aware of what medications were in the cup for Resident #6, because the medications were crushed and prepared by Staff B, who was currently in cottage #2. Staff A confirmed she is not a nurse.

On at approximately 4:32 p.m., Staff B confirmed giving Staff A the cup of medicine mixed with pudding for Resident #6. Staff B reported the cup contained , and . Staff B also confirmed the medication he spoon feed to Resident #6 was 125 MG of . Staff B confirmed he is not a nurse.

4. On at 9:52 a.m., the Administrator was interviewed. The Administrator stated the staff should bring the resident into the medication at a time and prepares the medications in front of the resident, she added the unlicensed staff should not prepare medication before the resident is in the medication . The Administrator also stated, "They (staff) should tell them (Resident) what they are taking."

Class III

0054-Medication - Records 58A-5.0185(5) FAC

Based on record review and interview the facility failed to ensure 1 (Resident #1) of 2 residents reviewed

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received medications as ordered.

The findings included:

Resident #1 was readmitted to the facility on . . . . . Review of the record revealed the resident had a new health assessment dated . . . . . This health assessment contained a list of medications. Review of the medication observation record for Resident #1 reveal no medications were given starting on . after admission through . . . . . .

Interview with the Wellness Director on . . . . . at 8:30 a.m., indicated agreement there was no documentation in the record to indicate the reason the medications were not given. He stated he thought it had something to do with . . . . . with what the daughter had to pay for and what hospice would pay for. He agreed there was no documentation about this issue in the progress notes.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC

Based on observation and interview, the facility failed to ensure medication was properly labeled with the correct time the medications was to be given for 1 (Resident #12) of 7 residents observed receiving medications.

The findings include:

At Approximately 12:10 p.m., Resident #12 was observed to receiving Divalproez.
A review of the Medication Observation Record (MOR) indicated the medication was to be given at 12:00 p.m.
The label on the medication stated the medication was to be given every day at 8:00 p.m.

A review of the physician's order was confirmed the medication was to be given at to 12:00 p.m. There was no change label attached to this medication.

On . . . . at 12:30 p.m., the Director of Wellness was interviewed. He confirmed the findings and placed and alert label on the medication container.

Class III

0162-Records - Resident 58A-5.024(3) FAC

Based on a record review and interview, the facility failed to ensure there was a care plan delineating those responsibilities that were hospice and those belonging to the Assisted Living Facility (ALF) for 2 (Residents #1 and #2) of 3 residents reviewed receiving hospice services who were receiving hospice care and interview with a hospice nurse and facility staff.

The findings include:

1. Resident #1 received hospice care from the date of admission to the facility in 2012. Review of the resident record revealed there was no hospice care plan in the record. There was no evidence with a care plan between hospice and the facility.

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Interview with the Wellness Director on . at approximately 3:30 p.m., revealed the facility requires a service provision plan on each resident. However, this does not involve hospice in any way.

A review of Residents #1's record revealed this facility requires care plans for all residents in the facility upon admission, and quarterly thereafter. The service provision plan includes such things as Activities of Daily Living (ADL) and who is providing them, transportation appointments and scheduling, housekeeping and laundry services, spiritual and cultural needs, leisure and recreation, and mobility. This continued for many more issues and not once is hospice mentioned as providing any care. There was no hospice care plan in the record.

During an interview on at 1:30 p.m. a hospice Nurse Clinical Manager indicated agreement the care plans for Hospice do not include the assisted living facilities responsibilities.

2. Resident #2 was admitted to the facility on . This resident is also receiving hospice care. This resident received care from a different hospice than Resident #1. A review of the hospice plan of care established for this resident on starting on revealed there was no assisted living duty noted in the care plan. Review of the service plan established by the facility revealed under special services the hospice name. This plan was established on On the plan the goals were for the resident to receive special services based upon needs as required. The interventions stated provide other services hospice name 5 times per week. There was no care plan for this resident involving both hospice and the ALF.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

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

RE: REVISED

Dear Administrator:

Enclosed you will find the REVISED State (3020) Form showing Tag A165 has been dropped.

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 surveyor. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

for

Harold D. Williams
Field Office Manager

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Enclosure: Revised State (3020) Form

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