STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965374	05/28/2014
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 - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0031 - 58a-5.0182(7) Fac - Resident Care - Third Party Services S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= G
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= G
St - A - 0165 - 429.23(1-4 & 6-10) Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D
St - A - N277 - 58a-5.031(2) Fac - Lns - Resident Care Standards S-S= D

Specific Tag Findings:
These are the results of an unannounced Biennial survey which was conducted on ..... through ..... at Juniper Village, an Assisted Living Facility (ALF) located in Naples, FL.

The following is a description of non-compliance:

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on record review and interview, the facility failed to provide appropriate supervision for 1 (Resident #2) resident with a history of ..... on admission, and 9 ..... after admission to the facility.

The findings include:

Review of the medical record revealed that Resident #2 was admitted to the facility on ..... The most recent AHCA 1823 (Resident Health Assessment) dated ....., documents Resident # 2's Medical History and Diagnosis as ....., Ablation and ....., ..., ..., ... of the lower ..... tract and ..... The Resident Assessment also states the resident requires assistance with ambulation, bathing, dressing, ..., toileting and transferring. The Resident Assessment also reveals Resident #2 was at risk for .....

According to the Progress Notes, Resident #2 had the following history of ..... and 9 additional ..... since admission to the facility on ..... On ....., found on floor, no injuries, ... found on floor, no injuries, ... found on ....., lump on head, ... found on floor of dining ....., no injuries, ... found on floor in dining ....., no injuries. On ..... found on floor in ....., no injuries, ... found on floor, no injuries, ... found on floor with head injury, ... (negative) and ..... in back of head. On ..... out of wheelchair and hit face on floor laceration above right eye. According to the Progress notes, 8 of 9 ..... were unwitnessed by staff.

Resident #2 was sent to the Emergency ..... (ER) for evaluation after the ..... with injuries on ..... The resident had ..... (negative) and received 4 ..... in the back of her head.

A nurses note from Hospice Nurse to Physician written ..... "After looking closer at ..... 's ..... on back of head, I saw 4 white stitches (very hard to see with ..... 's white hair) they were placed ..... at the hospital ED." A physician's order was obtained on ..... to remove 4 stitches.

Interview with Hospice Nurse on ..... at approximately 2:00 p.m., revealed she was unaware resident had

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stitches in her head.

During an interview with the Administrator on at 3:00 p.m., she stated. "We have done everything to ensure Resident #2's safety, we have a chair alarm, we did a Physical Evaluation. The resident's process is causing her to and slide out of the chair, but we can't be there every minute. She's on Hospice now and her are not preventable. The family is in agreement to not send her to the hospital when she

Class II

0031-Resident Care - Third Party Services 58A-5.0182(7) FAC
Based on observation, record review and interview, the facility failed to coordinate care and the delivery of services provided for 1 (Resident #2) receiving hospice care.

The findings include:

Review of the medical record revealed that Resident #2 was admitted to the facility on The most recent AHCA 1823 (Resident Health Assessment) dated documents Resident #2's Medical History and Diagnosis as Ablation and of the lower tract and The Resident Assessment also states the resident requires assistance with ambulation, bathing, 4/1/dressing, toileting and transferring. The Resident Assessment also reveals Resident #2 was at risk for

According to the Progress Notes for Resident #2 had the following history of found on floor, no injuries, found on floor, no injuries, found on , lump on head, found on floor of dining no injuries, found on floor in dining , no injuries. On found on floor in , no injuries, found on floor, no injuries, found on floor with head injury, (negative) and in back of head. On out of wheelchair and hit face on floor laceration above right eye.

Resident #2 was admitted to Hospice Services on A "Plan of Care Report" from Hospice, states "At risk for due to progression. Goal: Maintain desired level of safety (no future or injuries). Interventions Demonstrates tasks /skills/information learned most of the time. Sometimes performs them independently/ makes some decisions. Required occasional reinforcement of instructions. And/or verbalizes goal mostly met. Results no or injuries reported since last review period." The Plan of Care Report was not individualized to meet the resident's needs.

Observation of Resident #2's Resident Record revealed the facility had a Service Plan for Resident #2 but the Service Plan did not address the resident's or injuries since admission to facility.

During an interview with the Director of Nursing (DON) on at 11:00 a.m., she stated, "Resident #2 is on Hospice, we follow their care plan, we don't have one."

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on record review, observation and interview, the facility failed to ensure unlicensed staff followed the

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proper procedure to assist with self-administration of medication during a medication pass observed for 1 (Resident #1) out of a sample of 4 residents observed receiving assistance with self-administration of medications.

The findings include:

On at 9:45 a.m., Staff D was observed, in the medication Cottage V, pouring medications into a medication cup. He advised the surveyor that the medications were for Resident #1.

Staff D brought the medications to the resident Resident #1 was sitting in her chair. Staff D was then observed to pour the medications, from the cup, into the resident's hand. He told her what the medications were and she said, "You need to show me what each medication is." Staff D proceeded to touch lift and turn each pill with his bare hands. He did not wash his hands prior to this time and he did not wear gloves. The Director of Nursing (DON) entered the resident's this time and advised Staff D that he needed to re-pour the medications in front of the resident; and requested that Staff D bring Resident #1 to the medication perform this procedure.

At the surveyor's request, Staff D washed his hands after he escorted Resident #1 to the medication The DON was told (by the surveyor) that she was welcome to stay and observe the procedure; but she declined to do so. Again, Staff D was observed touching pills with his bare hands; including breaking a pill in half. Staff D was also observed removing each pill (a total of 5 pills) from its container and telling the resident the name of the medication. Staff D did not, however, provide Resident #1 with the opportunity to look at the label on the medication container. On several occasions, Resident #1 stated, let me see that (referring to the medication container). Staff D responded, "What do you want to know?"

Upon interview at 10:10 a.m. on , the DON stated that Staff D was not feeling well and was being relieved of duty. The DON also acknowledged, at this time, that Staff D had not followed the correct procedure for assisting Resident #1 with the self-administration of medications.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observation and interview, the facility failed to secure the storage of medications.

The findings include:

During observation of a medication pass on at 10:00 a.m., Staff D was observed leaving Resident #1 in an unlocked medication ; with the door ajar and medication containers unsecured on the counter in the This happened on two occasions. No explanation was given prior to Staff D leaving the medication in this manner.

Staff D was observed leaving the medication at 10:05 a.m., for the third time with Resident #1 still in the medications unsecured on the counter. Staff D was stopped by the surveyor and the activity was reported to the Director of Nursing (DON) who was in the adjacent hallway.

Upon interview, at this time, Staff D stated that he had to leave to get something to drink for Resident #1. When advised that he was leaving medications unsecured, Staff D stated, "I usually don't give medications in the

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medication

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on record review, observation and interview, the facility failed to ensure that one (Resident #1), out of a sample of 4 residents observed during medication pass, had prescription drugs filled in a timely manner.

The findings include:

Review of the medical record, on for Resident #1, revealed that she was admitted to the facility on A Resident Health Assessment for Assisted Living Facilities (ALF), dated lists a primary diagnosis of and additional diagnoses of Chronic Pain, and Dependence. This assessment also states that the resident "Needs assistance with self-administration of medications."

During medication pass on at 10:00 a.m., the Med Tech (Medication Technician) stated that the resident did not have Fish Oil (used as a supplement twice a day), (used for once a day) and (used for 3 times a day). Review of the Medication Observation Record (MOR) revealed that the following prescriptions were not filled in a timely manner and were recorded as "9 - Not Here" and not given:

25mg on for 1 dose, for 1 dose, for 1 dose and for 1 dose (ordered

0.5mg on for 3 doses and for 1 dose (ordered

Fish Oil 1000mg on for 2 doses and for 1 dose (ordered

50 mg (used for pain every 6 hours) on for 1 dose and for 1 dose (ordered

500mg (used as a supplement) on for 1 dose and for 1 dose (ordered

On at approximately 10:00 a.m., Resident #1 was observed sitting in her She appeared very and refused to take her medications stating, "I don't know what these medications are. Look at my face. Someone gave me the wrong medication last night. I don't think I am getting what I am supposed to get. I don't feel right." The left side of the resident's face appeared flaccid, with her lower lip drooped on the left side.

Resident #1 was observed again during the lunch meal on at 1:00 p.m. She refused to eat her meal and left the dining "I've got to get out of here. I can't eat anything. Please help me, I don't feel right." The resident was observed again on at 5:00 p.m. and stated, "I still don't feel right, I need to get out of here."

Upon interview on at 10:30 a.m., the Director of Nursing (DON) acknowledged that Resident #1 had not received her medication since 5:00 p.m. on and had not received her medication since it was ordered on The DON stated, "It was the holiday weekend, and the medications were not delivered; and there was no follow up regarding them." The DON also stated, "I know the resident (Resident #1) is very and I am setting up a meeting with the team, for tomorrow, to meet with her. The

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doctor will be here."

In addition, review of Resident #1's medical record revealed a physician's order, dated , for 0.5mg, 1 tab, every 4 hours, by mouth, prn (as necessary), for severe . Observation of the prescription medication supply, for Resident #1, revealed that this medication was not in the facility and available as ordered by the physician. This medication was listed on the Medication Observation Record as not given since the order was written.

Class II

0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on observation, documentation and interview, the facility failed to adhere to the menu as planned by the Registered Dietician; and failed to offer assistance and/or provide a substitute meal to 3 residents observed not eating their noon meal.

The findings include:

1. During tour of the facility on a menu was found posted in the dining areas of Cottage I, II, III, and V. The menu stated "Tuesday, (Lunch), Beef Noodle Soup, Bread of Choice, Seafood Salad Plate, Steak Salad (alternate), Macaroni Salad, Pineapples, 2% milk, Beverage of Choice."

The signed Registered Dietician menu, for this date/meal, states "Beef Noodle Soup, Assorted Crackers, Bread of Choice, Seafood Platter, Steak Salad Bites (alternate), Tater Tots, Dessert of the Day, 2% milk, Beverage of Choice. "

Observation of this meal revealed that the Registered Dietician menu was not followed, in Cottage I, II, and III, as follows:

Soup served was tomatoe and there were no crackers and bread of choice served or offered or available. A seafood sandwich was served (not Seafood Platter), along with macaroni salad on the same plate.

Upon interview at 2:30 p.m. on , the Food Service Manager acknowledged that beef noodle soup should have been served, and that crackers, bread of choice and tator tots were unavailable as recommended by the Registered Dietician. He also acknowledged that there was no standardized recipe for the "Seafood platter" available (as approved by the dietician); and a recipe for a "Seafood salad plate" was served (as observed by the surveyor).

Review of the alternate menu records revealed no entrees prior to or during the lunch meal, served on that would explain why the Dietician's approved menu was not followed.

In addition, observation of the serving of this meal in Cottage III revealed that 2% milk was not served to the residents. The residents were given only their beverage of choice.

2. During the noon meal served, in Cottage III on , Residents #20, #21 and #22 were observed sleeping and not eating their entree. No assistance or encouragement was provided by facility staff in attendance. The residents were left to sleep over their meal with no attempt to awaken them. When this was brought to the attention of the Food Service Manager, present at this time, the residents were

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asked if they would like something else to eat.

Resident #20 responded by picking up his eating utensil, ate one mouthful of food and then ... asleep again. No further encouragement was offered and he was not provided with an alternate/substitute entree. He was then served pineapple (dessert). He took a few bites of the pineapple and ... asleep again. He was then removed from the table.

Residents #21 and #22 did not respond when asked if they wanted "Something else to eat" and were not given an alternate/substitute entree. They did not consume any part of the seafood salad sandwich. They were both given the pineapple dessert, ate it all; and then were taken from the table.

Class III

0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC
Based on observation, record review and interview, the facility failed to ensure safe water temperatures in 10 out of a sample of 12 resident ; affecting 10 residents.

The findings include:

During an initial tour of the facility on between 9:30 a.m. and 10:45 a.m., the hot water in resident felt very hot to the surveyor's touch.

Thermometer readings, done by the surveyor at 11:15 a.m. in a sample of 5 resident in Cottage , revealed hot water temperatures of 122 degrees in A/B, 409 and 412; and 130 degrees in A/B. The residents in Cottage have diagnoses and evidenced of was observed on

Thermometer readings, done by the surveyor at 11:30 a.m. in a sample of 5 resident in Cottage V, revealed hot water temperatures of 122 degrees in and ; and 130 degrees in The residents in Cottage V have diagnoses and evidenced on

The Environmental Service Manager was advised regarding the high water temperatures at 11:45 a.m. The Manager advised that he has not been testing the hot water, in resident , to ascertain if the temperature was within safe limits (not above 120 degrees). Re-interview of the manager at 3:00 p.m. on , revealed he confirmed the hot water temperatures were too high and stated he adjusted the controls to bring hot water to a safe temperature in all resident within the facility. He also presented documentation, to the surveyor that all hot water (affecting residents) was tested and was found to be at 120 degrees or below after this adjustment was made.

A telephone call was placed, this date, to the Collier County Health Department, Environmental Health Division, informing them of the unsafe hot water temperatures. This department responded to the surveyor on stating this has been a continuing problem at the facility.

Class II

0165-Risk Mgmt & QA; Adverse Incident Report 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC
Based on Record review and interview, the facility failed to initiate an adverse incident report for Resident #2 who

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received head injuries after a on

The findings include:

Review of the medical record revealed that Resident #2 was admitted to the facility on . The most recent AHCA 1823 (Resident Health Assessment) dated , documents Resident #2's Medical History and Diagnosis as , Ablation and of the lower tract and The Resident assessment also states the resident requires assistance with ambulation, bathing, dressing, , toileting and transferring. The Resident assessment also reveals Resident #2 was at risk for .

The Risk Evaluation Form states a score of 10 or above represents High Risk for .

Risk Evaluation Form dated had a score of 17.

Risk Evaluation Form dated had a score of 15.

Risk Evaluation Form dated had a score of 12.

According to the Progress Notes Resident #2 had the following history of , found on floor, no injuries, found on floor, no injuries, found on , lump on head, found on floor of dining , no injuries, , found on floor in dining no injuries. On found on floor in , no injuries, found on floor, no injuries, found on floor with head injury, (negative) and in back of head. On out of wheelchair and hit face on floor laceration above right eye.

Resident #2 was sent to the Emergency evaluation after the with injuries on

The facility did not complete an AHCA Form 3180-1024, Adverse Incident Report related to this

During an interview with the Administrator on at approximately 3:00 p.m., she stated she did not feel it was necessary to complete an Adverse Incident Report because Resident #2's process causes Resident #2 to and the facility cannot prevent the resident from falling.

Class III

N277-LNS - Resident Care Standards 58A-5.031(2) FAC
Based on record review, observation and interview the facility failed to ensure Limited Nursing Services (LNS) standards of care are met for one (Resident #7) out of a sample of 2 residents receiving LNS.

The findings include:

Review of the medical record, on , revealed that Resident #7 is receiving LNS services for application of a leg brace to the right lower leg. There is a physician order for this service dated . The application and removal of the brace is documented daily by the licensed nurse on duty.

Resident #7 was observed sitting in a chair in her at 1:45 p.m. wearing a leg brace on her right

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lower leg. Upon interview at this time, the resident did not vocalize any discomfort with this appliance.

Review of the LNS documentation records revealed that licensed nurses were administering this service; however, during an interview on at 11:00 a.m., Staff A, who is a Certified Nursing Assistant (CNA) stated that she puts the brace on the resident in the morning. During an interview on at 3:07 p.m., Staff B. who is also a CNA stated that she removes the brace at night.

Upon interview on at 4:02 p.m., the Director of Nursing acknowledged that the brace should be applied and removed by licensed nurses and that more oversight of this procedure is required.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

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

Dear Administrator:

This letter reports the findings of a biennial re-licensure inspection survey conducted on , 2014 through , 2014, by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **five business days** of receipt of this report.

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0031 - 58a-5.0182(7) Fac - Resident Care - Third Party Services S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= G
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= G
St - A - 0165 - 429.23(1-4 & 6-10) Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D
St - A - N277 - 58a-5.031(2) Fac - Lns - Resident Care Standards S-S= D

Directed Corrective Actions:

1. The facility, in consultation with medical and physical professionals, will develop Prevention policies and procedures to be implemented in the facility. These policies and procedures will be implemented no later than , 2014.

2. The facility will evaluate all residents in the facility for risk and medication interactions. These evaluations will be completed by a Registered Nurse or the Resident's primary physician and will be completed no later than , 2014.

2295 Victoria Avenue,
Fort Myers, FL 33901
AHCA.MyFlorida.com

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3. The facility will develop an individualized plan to reduce the risk of falling for each resident identified as a ...l risk. These plans will be developed by a Registered Nurse and will be completed no later than . 2014. Each individualized plan to reduce the risk of falling for each resident who is a Hospice resident will be shared/coordinated with the resident's hospice provider.

4. All staff will be in-serviced on the facilities newly developed . I Prevention policies and procedures no later than . 2014.

5. All staff will be in-serviced on each resident's plan to reduce the risk of ..... by no later than , 2014.

6. The facility administrative staff will monitor the implementation of the facility's ...I Prevention policies and procedures, as well as monitor the implementation of each individual resident's plan to prevent ..... This monitoring will take place on all shifts and will continue for at least 90 days.

7. The facility will employ a Licensed Consultant Pharmacist other than the pharmacist currently consulting for the facility. The initial onsite Consultant Pharmacist visit must take place within 14 days of this notification of the Class II Medication deficiency (A0056) identified on .

The facility must have available for review by the Agency a copy of the Consultant Pharmacist's license.

The facility must submit the Consultant Pharmacist's corrective action plan to the Agency no later than 10 working days subsequent to the initial onsite consultant visit.

Mail a copy of the Consultant Pharmacist's corrective action plan to:

Harold D. Williams, Field Office Manager

Agency for Health Care Administration

Health Quality Assurance

2295 Victoria Avenue, ...

Fort Myers, Florida 33901

The Consultant Pharmacist must be retained and provide quarterly updates until such time as the Agency has verified the correction of all medication systems.

8. The facility will check hot water temperature at all faucets including sinks and bathing areas daily for one week beginning . 2014 to ensure that the hot water does not exceed 120 degrees. The facility will develop a monitoring system to monitor the hot water to ensure that it does not exceed 120 degrees. The facility will continue to monitor hot water for 3 months.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose

administrative sanctions as provided by law.

Should you have any questions, please call this office at 239-335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

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

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