STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965374	08/20/2014
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)		

Revisit Corrected Tags:
0025-Resident Care - Supervision
0055-Medication - Storage And Disposal-C
0152-Physical Plant - Safe Living
0165-Risk Mgmt & Qa; Adverse Incident Report-0

Revisit Repeat Tags:
0000-Initial Comments-
0031-Resident Care - Third Party Services-58a-5.0182(7) Fac
0052-Medication - Assistance With Self-Admin-58a-5.0185(3) Fac
0056-Medication - Labeling And Orders-58a-5.0185(7) Fac
0093-Food Service - Dietary Standards-58a-5.020(2) Fac
N277-Lns - Resident Care Standards-58a-5.031(2) Fac

Specific Tag Findings:
These are the results of an unannounced follow-up to the Biennial survey conducted on at Juniper Village, an Assisted Living Facility (ALF) located in Naples, Florida.

The following is a description of non-compliance:

0025-Resident Care - Supervision 58A-5.0182(1) FAC

0031-Resident Care - Third Party Services 58A-5.0182(7) FAC
Based on record review, observation and interview, the facility failed to coordinate care and the delivery of services provided for Resident #5 who is receiving hospice care.

The findings include:

Review of the medical record revealed that Resident #5 was admitted to the facility on with diagnoses that include, but are not limited to, , History of and Ankle as identified on the AHCA 1823 assessment dated There were 14 current medications prescribed on this assessment by the Hospice physician. Further review of the record revealed that the facility physician, assigned to the care of this resident, was not notified regarding the admission.

Upon interview on at 5:30 p.m., the facility Administrator acknowledged that the facility physician was not notified and stated, "He will be here tomorrow

Observation of the medication pass for Resident #5 at on at 9:55 a.m., review of the Medication Observation Record (MOR) and physician orders listed on the AHCA 1823 assessment of revealed that 3 medications and one treatment were not listed on the MOR. One of the medications was a treatment to be given 2 times a day. In addition, "O2 use" was listed on the assessment, but not on the MOR; and the resident was not receiving Limited Nursing Services (LNS) relating to administration.

The Hospice care plan dated included Dilitiazem 180mg by mouth daily, Urea 40% twice a day to feet, 2.5-0.5/3 inhalation twice a day, 81mg by mouth daily as listed on the AHCA 1823 assessment, but not included on the facility MOR (3 medications/one treatment).

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965374	08/20/2014
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)

This Hospice care plan also has an entry, dated [redacted] 2 liters, via nasal cannula, continuous. In addition, an entry dated [redacted] states [redacted] 250mg, 1 tablet, oral (by mouth), [redacted] (twice a day) times 7 days." and "Fungi Foam, [redacted] apply to toes daily for [redacted]

Upon interview at 5:30 p.m. on [redacted] the Administrator acknowledged that there was no current order for [redacted] to be administered and no record that [redacted] had been given to Resident #5 since his admission of [redacted] The Administrator could not provide any explanation as to why [redacted] (an [redacted] and "Fungi Foam" was not given to the resident since admission; although an order was on record, dated [redacted] for these 2 medications.

The Administrator also acknowledged, at this time, that none of the foregoing medications had been ordered from the pharmacy.

A Hospice Physician Visit Note, dated [redacted] states, "The patient remains with severe [redacted] He is getting more [redacted] I wonder if some of this is the [redacted] (lack of [redacted] I encouraged him vigorously to use the [redacted] because it may help him with his [redacted] Lungs have very diminished, very distant breath sounds."

Resident #5, on Hospice for severe [redacted] with an estimated 4 months left to live, experienced harm because of the failure of the facility to provide "comfort care" (primarily related to [redacted] and [redacted] treatments) as identified in the Hospice care plan.

Class II

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observation, record review and interview, the facility failed to ensure unlicensed staff followed the proper procedure to assist with the self-administration of eye drops for 1 (Resident #6) out of 6 Residents observed receiving self-administration of medications.

The findings include:

On [redacted] at approximately 12:45 p.m. Staff A was observed in Cottage [redacted] preparing to instill eye drops for Resident #6. Resident #6 was taken into the Medication [redacted] Staff A explained she would be instilling the eye drops into both eyes.

The eye drops were removed from the medication cart and checked against the Electronic Medication Observation Record (E-MOR). Staff A explained the medication to Resident #6. Staff A washed her hands and donned a pair of gloves. Staff A instilled 1 drop of medication into the Resident's left eye. Dabbed the eye to remove the excess medication. Staff A instilled 1 drop of medication into the Resident's right eye and dabbed the right eye with same tissue she used on the Resident's left eye.

Staff A did not wash hands or change gloves between the right and the left eye and used the same tissue on both eyes.

Review of the facilities policy for "Administration of Eye Drop" revealed, "Change gloves and wash hands between each eye." Under General Instructions: "Always use separate tissue wipes or cotton balls for each eye."

During an interview with the Corporate Nurse on [redacted] at 2:00 p.m., it was agreed Staff A did not follow the

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965374	08/20/2014
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)

facility's policy for instilling eye drops.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on record review, observation and interview, the facility failed to ensure that residents had prescription drugs filled in a timely manner and had medications accurately labeled and documented as given.

The findings include:

1. Review of the Medication Observation Record (MOR) for Resident #4 (admitted revealed 5 medications ordered with a start date of . The 5 medications were not given to the resident until .

Review of the MOR for Resident #5 (admitted revealed 6 medications ordered with a start date of . The 6 medications were not given to the resident until .

Review of the MOR for Resident #7 (admitted revealed 5 medications ordered with a start date of . The 5 medications were not given to the resident until . In addition 0.5mg, ordered to be given 3 times a day, was not documented as given on at 1400 (2:00 p.m.) and 0.25 mg, ordered to be given three times a day, was not documented as given on at 2:00 p.m.

Upon questioning on at 2:00 p.m., the Acting Director of Nursing stated, "The pharmacy in located in Tampa, FL and it takes several days to obtain medications."

2. During medication pass observation, on at 8:30 a.m., Resident #1 had medication labeled 325 mg give 2 tablets (650 mg) by mouth 3 times a day." The physician's order was the same. The MOR, however, stated, 650 mg give 2 tablets by mouth 3 times a day." During 2014, (8/1 through nurses and med techs documented that the resident was receiving 1300 mg three times a day.

When questioned at this time, Staff B stated, "We have other medications like that too (label does not agree with MOR). That probably needs to be changed."

3. During medication pass observation, on at 9:25 a.m., Resident #3 had medication labeled "Oyst-Cal 500 mg + D take 1 tab by mouth every day." The MOR and physician orders state "Oyst=Cal mg +D3 take 1 tab by mouth every day. This resident also had a medication labeled "Thera M one tab by mouth every day." The MOR and physician orders state, "Thera M 400 mg one tab by mouth every day." The discrepancy was brought to the attention of Staff C by the surveyor.

4. At 9:45 a.m. on Resident #5's daughter was observed talking to Staff C. She stated, "I am going to work and wanted to see what pills the father is getting. He's been here 3 days and the medications are still wrong."

During medication pass observation,on at 9:55 a.m. Resident #5 had a clear plastic bag containing 3 Excelon (4.6 mg/24 hours) patches. The plastic bag had a pink post-it type label attached stating "Echelon patch to be applied on Tuesday, at 3 p.m. Apply every other day." The MOR and physician orders state

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965374	08/20/2014
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)

"Excelon patch 4.6 mg/24 hours TD apply every 24 hrs (hours) every day."

When questioned why the Excelon patch did not have a proper label, Staff D did not know. When questioned as to why the pink post-it type note stated that the patch had been applied a 3:00 p.m. yesterday , and that the patch should be applied every other day, Staff D stated that she removed an Excelon patch dated (not and that "Excelon patches are removed, and a new one applied, every 24 hours."

Review of the MOR revealed that there was no documentation that the Excelon patch was applied on or

In addition, Resident #5 had medication labeled Lax take one tab by mouth every day (with 'PM' written on the label)." The MOR and physician orders state 8.5 mg by mouth, take 8.5 mg every day." When the resident was given this medication he stated "I take this pill at night too."

Resident #5 also had medication labeled 0.6 mg take one tab every day." The MOR and physician orders state 0.6 mg take 1 tab by mouth daily."

Class II

0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on record review, observation and interview, the facility failed to adhere to the posted meal menu and dietician recommendations, provide assistance with eating/drinking to Resident #8, ensure adequate space for access and egress from dining and maintain proper control during the noon meal in Cottage 3.

The findings include:

1. The posted lunch (noon) meal menu for states crackers, 2% milk, beverage of choice, and bread of choice. The dietician recommended portion size for the crackers was listed as "3 packets" and 1/2 cup for the milk.

Observation of the beverage service revealed that no milk was distributed or offered until the surveyor questioned why the milk was not given.

Observation of the soup service revealed that no bread of choice was offered or served; and one packet of crackers, was broken into pieces, and placed in each bowl of soup (not 3 packets). Resident #7, while eating the soup, stated, "Give me some more of the crackers. How cheap can you get."

Upon interview at on at 1:30 p.m., the Food Service Manager stated, "1/2 cup of 2% milk is part of the beverage of choice. If the resident asks for milk, they would get a 6 oz. cup. It is not intended for the resident's to get both milk and another beverage of choice. The surveyor brought the posted menu to the Food Service Manager's attention for not stating 2% milk "or" beverage of choice. The Food Service Manager acknowledged the discrepancy and stated it needed to be corrected.

Upon interview on at 2:00 p.m. via telephone, the consultant dietician also stated it was not intended for all residents to get 2% milk, milk was considered a beverage of choice. She continued to state that milk is only listed on the portion listing menu, not the posted menu. The surveyor advised that 2% milk was listed on the posted menu, at the facility, as a separate entity.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965374	08/20/2014
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)		

Observation of Resident #9 revealed Staff E serving the resident a peanut butter sandwich prior to the main entree (Pasta Primavera or Open-Faced Roast Beef Sandwich) being offered or served to him. When questioned, Staff E said "I gave it to him (Resident #9) because he likes it." The resident was not given the main entree until the surveyor questioned Staff F at 12:40 p.m. when dessert was being served. Staff F provided Resident #8 with the Pasta Primavera and the resident ate 1/2 of this entree.

2. Resident #8 was observed sitting at a table in the Dining 12:00 noon. She was served 2 beverages at 12:15 p.m. and solid food at 12:25 p.m.

At 12:45 p.m. the resident had not eaten any of her solid food and had not drunk any of her beverages. Staff F was sitting next to Resident #8 and was feeding another resident. When questioned, Staff F asked Staff E to feed Resident #8. Staff E sat down next to Resident #8 at 12:50 p.m. and started to feed her. The surveyor questioned the temperature of Resident #8's food (sitting on the table for 25 minutes) and Resident #8 was given a replacement meal.

At this time, the other residents at Resident #8's table had completed their meal and were leaving the area. Resident #8 had to be moved in order to allow several residents to leave the table, resulting in another delay in feeding assistance being provided.

Upon interview on at 5:30 p.m., the Administrator and Corporate Nurse acknowledged that the Cottage 3 dining needed to be changed in order to provide access and egress without having to move other residents sitting at the table.

3. During distribution of milk, Staff F gave a glass of milk to Resident #7. The resident pushed the glass away and said, "Take it away." Staff E placed the glass of milk on the counter where other glasses of milk were prepared and waiting to be served. Another employee picked up this glass of milk and started to give it to another resident. The surveyor intervened and advised the employee to discard the glass of milk because it was contaminated.

Staff E was observed wearing gloves while assisting residents. She moved a resident's wheelchair (to allow for another resident to leave the dining and touched another resident with her gloved hands. She then sat down and started to feed Resident #8. Staff E then removed her two gloves and placed them on the chair and sat on them. The surveyor approached Staff E and requested that she wash her hands. Staff E stated, "I already did." The Acting Director of Nursing, who was present at the time, acknowledged that Staff E failed to maintain proper control standards by not washing her hands after removing her gloves.

Class III

0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC

0165-Risk Mgmt & QA; Adverse Incident Report 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

N277-LNS - Resident Care Standards 58A-5.031(2) FAC
Based on record review, observation and interview, the facility failed to ensure that Limited Nursing Services (LNS) were ordered for the administration of for Resident 5.

The findings include:

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965374	08/20/2014
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)

Resident #5 was admitted to the facility with an AHCA1823 assessment stating "O2 use." This resident is receiving Hospice services and the Hospice care plan states "O2 at 2 liters via nasal cannula continuously."

Review of the medical record revealed that the facility did not contact a physician to obtain an order for LNS to ensure the administration of the by a licensed nurse. In addition, there was no documentation that the resident had available or had it administered since admission to the facility.

Upon interview at 5:30 p.m. on the Administrator stated that there is no one in the facility overseeing the LNS program on a daily basis. He also stated that he observed in Resident #5's The Administrator acknowledged that the resident was not included in the LNS program and stated he did not know if the (in the resident's was ever administered by any facility staff or used by the resident.

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 State Licensure Revisit Survey conducted on 20, 2014 by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit and uncorrected deficiencies deficiencies that were identified on the day of the visit.

You will not receive a copy of this report in the mail; you will only receive this faxed report.

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,

Harold D. Williams
Field Office Manager

sh
Enclosure: State Form

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