STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965374	06/18/2015
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 TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced Complaint Survey, CCR #2015005602 was conducted on [redacted] through [redacted] at Juniper Village, an Assisted Living Facility in Naples, Florida

The complaint contained 6 allegations of which 0 allegations were substantiated. The following is a description of non-compliance.

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

Based on observation, record review and interview, the facility failed to report an incident of alleged [redacted] to the Department of Children and Families (DCF) and to request statements from staff for 1 (Resident #17) of 16 Residents' reviewed, for 16 days after the incident was reported to the facility.

The findings include:

1. On [redacted], the private duty aide reported to Administrative Staff, Resident #17 was observed with [redacted] on her neck approximately 2 x 2 cm. purplish in color.

2. On [redacted] 2 days after the [redacted] was reported, the facility completed a "Mini skin Integrity Form" which indicated, [redacted] was noted under the resident's chin. An Incident /Accident Report form was completed on [redacted], 2 days after the incident was reported. On [redacted], The Summary of Post Incident/Accident Investigation Report stated, "Unfounded. All statements correlate from Juniper staff." No written statements were completed at that time.

3. On [redacted] at 3:20 p.m., the Hospice Nurse said he originally saw a lump on the Resident's neck [redacted] and thought it could be a [redacted]. When he returned on [redacted], he saw the [redacted] on the neck. He said it he was not sure what caused the [redacted] area. The Hospice nurse said when the Resident is seated it is difficult to see the neck area, but is visible when resident is lying down.

4. On [redacted] at 1:45 p.m., the Executive Director (ED) said she completed the Incident /Accident Report form on [redacted], 2 days after the incident was reported. She said she did not report it to the police, DCF, nor did she request interview statements from staff working in the facility because she did not feel the injury was caused by [redacted]. She said she did notify the Physician, Hospice and the family. The ED also said, the family requested the facility to not report the incident until the Resident was moved to another facility for fear of retaliation. "I spoke with the daughter and she asked me not to report the incident until she removed her mother from the facility." After the Resident was moved, the daughter reported the incident to DCF on [redacted] and I reported it to DCF on [redacted]. Interview statements were not completed by staff until [redacted], after the facility met with the DCF services investigator.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965374	**06/18/2015**
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 TAGS AND REGULATORY IDENTIFYING INFORMATION)

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

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

RE: CCR #2015005602

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) 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. **Please forward documentation of correction to the Field Office.** Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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

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

Sincerely,

Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form

XG90

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Fort Myers, FL 33901
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