STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968845	04/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DISCOVERY VILLAGE AT NAPLES, LLC	8417 SIERRA MEADOWS BLVD NAPLES, FL 34113

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

An unannounced complaint survey for CCR #2016003427 was conducted from through at Discovery Village, an Assisted Living Facility in Naples, Florida.

The complaint contained 2 allegations, of which 1 - allegation was substantiated with a deficiency.

The following is description of the deficiency:

0010 Admissions - Continued Residency

Based on record review and interview, the facility failed to obtain a new health assessment (state form 1823) for 2 (Resident #5 and #7) of 6 residents reviewed when a significant change occurred.

The findings include:

1. Resident #5 was admitted to the facility on . The initial 1823 form was obtained on . She was admitted to hospice services on . No 1823 form was obtained when the resident was admitted to hospice services.

2. Resident #7 was admitted to the facility on . The initial 1823 form was obtained on . The resident was accepted onto hospice services on . There was no new 1823 obtained when this resident went onto hospice services.

3. Interview with the Executive Director and Director of Nursing on at 1:10 p.m., revealed they did not think another 1823 was required for hospice since they did not consider this a significant change in condition.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Discovery Village At Naples, LLC
8417 Sierra Meadows Blvd
Naples, FL 34113

RE: CCR #2016003427

Dear Administrator:

This letter reports the findings of a state licensure Complaint survey that was completed on , 2016 by representatives of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiency that was identified in relation to this complaint on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for the deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of the identified deficiency. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiency identified on your Complaint survey, which may include a desk review or onsite revisit.

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,

Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form

XG90

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