STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968845	09/20/2016
NAME OF PROVIDER OR SUPPLIER **DISCOVERY VILLAGE AT NAPLES, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **8417 SIERRA MEADOWS BLVD** **NAPLES, FL 34113**	

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

Resident #1. She stated she does not normally work in that unit, and she is not very familiar with all of the residents. Staff A indicated some of the residents require frequent checks, no longer than every 30 minutes. She stated because of this, it is not always possible to check on all of the other residents every 2 hours. She stated Resident #1 is able to get up on his own and use the get back into bed without assistance. Staff A stated she did not check on Resident #1 between 1:30 a.m. and when she left at 7:00 a.m., because she was busy with other residents.

On / at 3:00 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated they have a meeting every Wednesday with physical to discuss the residents. She stated they are provided handouts by the physical department with updates on the residents. The DON stated she does not keep the handouts. She stated she does not remember what was discussed regarding Resident #1. The DON stated that despite the fact that the physical department notified the facility staff verbally and in writing of Resident #1's physical and functional status, she did not know the level of assistance or supervision the resident needed for his daily activities of daily living.

On / at 6:05 p.m., an interview was conducted with Staff F. Staff F stated she checks on the residents at a minimum of every two hours because she is trained as a certified nursing assistant, and she "knows her job." Staff F was not able to say how frequently she was told to check on residents when she was hired. She stated Resident #1 sometimes needed help to get out of bed. She stated he didn't have a call light so he would just call out for help until someone heard him. Staff F stated if she assisted him to the could normally stand up and return to the bed on his own.

On at 6:41 p.m., a continued interview was conducted with the Executive Director. The Executive Director stated there are video cameras in all hallways. She stated she personally reviewed the videotape from the night of / from 8:00 p.m. until at 8:15 a.m., and the two employees who worked from 11:00 p.m. until 7:00 a.m. never entered Resident #1's . She stated the last person to enter Resident #1's / was Staff D when she entered at 8:20 p.m. to provide Resident #1 with his medications. The video showed the next person to enter the Staff E on at 8:15 a.m. when she went to get Resident #1 up for the day. The Executive Director stated that although they do not have an exact time frame of how often the residents are to be observed overnight, the expectation is that each resident will be observed "frequently" on the 11:00 p.m. to 7:00 a.m. shift.

On at 1:24 p.m., an interview was conducted with the physical . The physical stated she had been working with Resident #1 regarding recent loss of coordination. She stated staff had noticed and reported a functional decline, whereas he was using his wheelchair more than his walker. The physical stated he needed "constant supervision" when walking, and that he was not at all independent. She stated she suggested the caregivers watch and supervise him due to

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and are to be checked on "frequently" through the night by the staff. She stated these checks are not documented. The Executive Director stated Staff E entered into the Resident #1 to wake him up on at 8:15 a.m. Staff E found him in his his torso and upper body face down on the bed, and his feet on the floor. The Executive Director stated that Resident #1 was found in an inverted "V" with his resting on the grab bar at the top of the bed. She stated there are no call lights in the resident , and although some of the residents have a pendant to call for assistance, Resident #1 did not have one. The Executive Director stated Resident #1 was a more independent resident, and was able to get up by himself overnight and use the .

A record review was conducted of the Agency for Health Care Administration health assessment form 1823 (1823) for Resident #1, dated . The 1823 indicated Resident #1 required supervision for ambulation, toileting, transferring, dressing, and self-care ( ). Further review of the 1823 indicated that the resident was diagnosed with , had a history of and , and he needed special precautions due to his risk for .

A record review was conducted of the Resident Assessment dated / for Resident #1, a form which is completed by the facility for each resident to assess their needs and the level of care required. An identified issue for Resident #1 was that he was not able to call for assistance. The note read "needs to be checked on and asked if he needs assistance at times."

A record review was conducted of the assessment summary of the physical dated . The , indicated Resident #1 had delayed balance recovery, needed constant cues for awareness, and proper assisted device management. Resident #1 also demonstrated poor and unsafe standing initiation. Resident #1 was assessed for mobility, and received a score of 33 out of 84. Under the heading "Basic Mobility" the assessment indicated Resident #1 required supervision/touching assistance for the following: lying to sitting on side of bed; sit to lying; and rolling left & right. The assessment indicated Resident #1 required partial/ for the following: sit to stand; chair or bed to chair transfer; and toilet transfer.

A record review was conducted of the written statement for Staff E. Staff E wrote that she entered the Resident #1 on at 8:15 a.m. The statement read that she entered the saw him with half of his body out of the bed and "saw his left leg purple." Staff E stated Resident #1 could not explain how he had ended up in that position.

On at 3:27 p.m., an interview was conducted with Staff A. Staff A stated on the night of / she went into the Resident #1 around 11:30 p.m. and asked if he was ok. She stated Resident #1 indicated he was fine. She stated she went in a second time around 1:30 a.m., but she did not physically touch him or speak to him. Staff A indicated she did not document when she observed

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0000 Initial Comments

An unannounced complaint survey for CCR #2016010505 was conducted from through at Discovery Village at Naples (license #12700) an Assisted Living Facility located in Naples, Florida.

The folloing deficiency was identified during the survey.

0025 Resident Care - Supervision

Based on interview and record review, the facility failed to provide adequate assisted living services to 1 (Resident #1) out of 1 sampled resident by not properly supervising the level of care the resident required to promote his safety and well-being. Specifically, 1 (Resident #1) out of 1 sampled resident was not observed for almost 12 hours, during which time he received an injury that required an above the knee amputation. Additionally, the facility failed to comply with requests of the attending physician at the hospital for information to allow the physician to provide the best care possible for the resident.

The findings included:

A record review of the hospital medical records for Resident #1 was conducted of an emergency dated at 15:25 (3:25 p.m.) by the emergency physician. It read: "The extremity feels as though it has been for many hours." The emergency consulted with the surgeon, and both agreed the leg was not salvageable. Both doctors stated the attempt to save the leg could "Quite easily kill this patient." The emergency stated he called the facility and requested to speak to the nurse who had been caring for Resident #1, but was told she was at home and unavailable. He then asked to speak with the nurse who found Resident #1 and they refused to make that nurse available. "Once again, I reiterated multiple times that as the treating attending physician at the bedside, I did want to speak with the nurse who specifically found the patient to discuss exactly what was seen and to discuss timelines to potentially help my patient acutely. I was again rebuffed multiple times." The memory care unit director stated she was called to the bedside "at some point" and that the leg was draped over a guard rail on the bed and that there was "nothing else of significance." The emergency attempted to determine how long the potential time was as this would be "clinically significant." He stated he was told the last time the patient was seen without his leg over the rail was approximately around midnight, "but they were still working on confirming that. That would put the potential time at 8 hours and 30 minutes. It was clear that further discussion with that facility was going to prove to be fruitless."

On at 10:55 a.m., an interview was conducted with the Executive Director of the Assisted Living Facility. The Executive Director stated the residents in the memory care unit require closer supervision

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balance issues and loss of coordination. She stated she "constantly told them he needed supervision." A record review had been conducted of notes written by the physical . The physical confirmed that the rankings were accurate, and Resident #1 would have required assistance lying to sitting on side of bed, sit to lying, sit to stand, and toilet transfer. The stated Resident #1 was discharged from physical because he was admitted to the hospital, not because he reached his goals.

On at 3:35 p.m., an interview was conducted with the spouse of Resident #1. The spouse stated when Resident #1 was admitted to the facility on , the Executive Director told her that the staff in the memory care unit would check on Resident #1 every two hours. She stated she wrote notes on the contract during the initial conversation. The spouse stated after Resident #1 was admitted to the facility, she had two meetings with the Executive Director and one of those meetings included someone from the corporate office. She expressed her concerns in those meetings that the employees overnight were not checking on Resident #1 like they were supposed to. The Executive Director told her they have video cameras in all of the hallways and they will monitor which employees are performing their jobs and which ones are not. The spouse stated she spoke with Resident #1 when she saw him at the hospital, and he was not able to tell her how he hurt himself, or how long he had been in the position in which he was found. The spouse stated she spoke with the emergency and the surgeon at the hospital following the incident, and both told her Resident #1 would have had to remain in the position in which he was found for 8-10 hours in order for the injury to become as severe as when they found him.

Class II

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

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

Dear Administrator:

This letter reports the findings of a complaint inspection survey (CCR# 2016010505) conducted , 2016 through , 2016, by a representative of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there was a deficiency noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC).

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

St - A - 0025 - 429.26(7) Fs; 58a-5.0182(1) Fac - Resident Care - Supervison Class II

Directed Corrective Actions:

1. The facility must create a written policy regarding resident checks and supervision. This policy must include timeframes as to how often residents must be observed, and by which staff member on each shift. These resident checks must be documented, and the documentation must be maintained in the facility for review by the Agency. This must be completed by **, 2016.**

2. The facility must provide in-service training for all staff regarding resident supervision as it pertains to Florida Administrative Code 58A-5.0182(1). The in-service must have an agenda and a sign-in sheet. The documentation of the completion of this training must be kept on file at the facility, and be available for review by the Agency. This must be completed by **, 2016.**

3. The facility must create a written policy on communication with the physical department and any other provider to ensure that all information regarding a residents' treatment is disseminated to the assisted living facility staff in charge of the resident, and that the recommended level of supervision is followed by staff. This must be completed by **, 2016.**

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Discovery Village At Naples, Llc
, 2016

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 contact . Amanda Beagles, Survey and Certification Support Branch, at (850) 412-4662 or Jon Seehawer, R.N. Fort Myers Field Office Manager at (239) 335 1315.

Sincerely,

Jon Seehaw . . .N.
Field Office Manager

D7JR

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