STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968845	R 10/03/2017
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)

0000 - Initial Comments

An unannounced revisit survey was conducted on through at Discovery Village At Naples LLC, an assisted living facility (license #12700) in Naples, FL. This was a follow-up to the revisit survey completed on .

The following is description of the deficiencies found at the time of the visit.

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation, interview, and record review, the facility failed to ensure physician orders were followed. The facility also failed to monitor levels in reference to appropriate clotting of for 1 (Resident #1) of 5 residents sampled for monitoring/supervising of medication. This was evidence by physician discontinuing an medication on and the resident continuing to receive the medication until without the physician's knowledge. The facility also failed to supervise/monitor Resident #1's need to receive a (Prothrombin)-INR (International Normalized Ratio) to monitor the clotting time to determine the stability of the resident's levels; and staff failing to notify the physician the test was not ordered. The facility also failed to identify the resident was a risk, and had and injured herself on several occasions. This deficient practice has the potential of causing a resident on an anti- drug to , which in turn may cause serious complications.

The finding included:

On , Resident #1 was sent to the hospital due to a . The resident returned to the facility on . After returning from the hospital a new form 1823 (recommendation/order form) was initiated and dated documenting the resident special precautions as " ." The form also includes a physician order for (anti-) 4 mg given by mouth daily. Included was an order for resident to be assisted with medications by staff. The doctor signed the 1823 on . A separate physician's order was noted on for an INR test, and administered on , , and . There was no documentation in the chart after the resident was ordered to receive the INR test for monitoring the ability for the resident to clot, although the resident continued to take the anti- medication until .

During an interview on at 2:00 p.m., the Director of Nursing (DON) noted the resident had gone home for a visit with her family on and returned to the facility on . While at home the resident sustained a , where she injured her arm. The family brought the resident back with a bandaged arm, which was . The resident was sent to the hospital to stabilize the , and

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968845	R 10/03/2017

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)

returned to the facility on at 5:00 p.m.. Upon return to the facility on , a new 1823 was initiated for the resident. Documented on the 1823 was special precautions for ambulation and resident was to be assisted with medications. Medication ordered on the 1823 did not include any . The 1823 was signed and dated by the doctor on .

Review of the form titled "Medication Passing Detail documents" showed 4 mg tablet. Instructions go on to say; " 4 mg tablet to be discontinued on at 9:44 a.m. prescribed by the attending physician." Also includeed were instruction from the medication warnings (in bold capital letters); "Monitor for . Check for with medication charges. Notify Doctor if noted."

Further review of the "Medication Passing Record" documents showed that even though the physician discontinued the medication on , staff continued to give the medication until .

Continued interview with the DON on at 2:00 p.m. validated the medication was discontinued by the physician, staff continued to give the medication until . She also said the monitoring of the anti- should have been done, and the physician was never made aware the medication continued after the order to be discontinued. The DON said she would discuss the concerns when he comes in for a visit on .

On at 10:30 a.m., Resident #1 was observed in her apartment. Attempts were made to interview the resident, but due to the resident's mental status, an interview was not possible. The resident was observed to be watching TV at the time of her observation. Resident #1's two hands and wrist observed to be very mottled, which is an indication and a side effect of .

During an interview on , the nurse Staff A said the resident had been transferred to the memory care unit on due to her decline in memory and worsening issues. Staff A said the resident order for anti- had been discontinued. Staff A said she was not ordered to have an INR done presently as the was discontinued on .

Review of the 1823 initiated as the resident was transferred to the memory care unit on documented the resident is a " Risk.", and ordered to receive 4 mg by mouth in the evenings.

During an interview on at 10:10 a.m., Staff B said she did not communicate or question the doctor on why INR was not done on the resident. Staff B also said she should have been paying closer attention to the discontinued order for the anti- .

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968845	R 10/03/2017

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)

During an interview on at 10:17 a.m., Staff C, another nurse in charge of the residents care, said she was aware the resident was not receiving the INR test monitoring, but never thought to call the doctor. Nurse C also validated she did not follow doctor's order when the resident continued on the after the discharge order.

During an interview on at 1:11 p.m., the doctor in charge of Resident #1's care said he was not aware of the resident continuing on (anti- medication) after he originally discontinued the medication on . The Doctor said staff had not communicated this with him, and he would not order an INR if a patient were not on anti- . The Doctor added he did meet with the family back in and explained the risks and benefits of anti- with them. The Doctor felt due to Resident #1 advanced age, being a risk, and diagnosis of , outweighed the benefits of the continuing with the medication. The Doctor also commented the nursing staff be more vigilant about monitoring INR were not being done for a patient on anti- . The Doctor added he would be having a discussion with the facility, as he is the Medical Director.

Class II