STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968845	R 12/01/2017
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 through at Discovery Village At Naples, LLC, an assisted living facility (license #12700) in Naples, Florida.

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 for 2 (Resident #11 and #12) of 10 residents reviewed.

The findings included:

1. Record review of Resident #11 on at 9:00 a.m., showed she has a diagnosis of , , and D deficiency. The resident was ordered - D take 1 twice daily for D deficiency. The medication was sent to pharmacy for reorder . There was a note in the chart from the pharmacy that the medication cannot be supplied and the pharmacy is requesting - D dose. The physician rewrote his order for the dose.

Review of the resident's medication observation record showed she did not receive her medication 18 days in and 15 days in . There was no nursing notes in the chart to indicate the physician was notified the resident has not received her medications on those days.

Resident #11 was also ordered Rosuvastatin 5mg. This medication lowers and triglycerides in the . This drug may also reduce the risk of , , or other health problems in patients with risk factors for . The medication was ordered . Review of the resident's medication observation record showed she did not receive her medication for 20 days in . Review of the resident's chart showed there were no nurses notes to say whether or not they called the physician.

On at 9:18 a.m., a call was placed to the physician's office. The physician's office called back on at 2:30 p.m., The certified medical assistant stated that there are no messages or notifications from the facility that the resident has not received the medications.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968845	R 12/01/2017

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 11:00 a.m., Staff F (Licensed Practical Nurse) stated, "if we fax today to the pharmacy, the medication should be here tonight or tomorrow morning, except for . The hard script is needed by the pharmacy."

During an interview on at 11:00 a.m., Staff D (Medication Technician) stated, "we order the medications when they get down to the last 7 days worth. I tell the nurse and they order them."

2. Record review of Resident #12 showed there was an order dated for 4mg 1 tablet by mouth every 6 hours. The facility should be giving the medication at 6 a.m., 8 a.m., 12 p.m., and 6 p.m.. The schedule the facility was giving the medications is not according to the physician's order.

There was an order written for 15mg 1 tablet by mouth every 12 hours. The order was not transcribed correctly. Resident #12 was receiving 10mg by mouth every 10 hours. The facility was not following the physician's orders. Review of Resident #12 record showed there were no nurses notes stating they contacted the physician for clarification.

During an interview on at 1:00 p.m., the Director of Nursing had no response.

Class II