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.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, staff and resident interview, and record review, the facility failed to ensure physician orders were followed for 3 (Resident #8, #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 on . 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 were no nursing notes in the chart to indicate the physician was notified that 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 .
Observation of the resident's medication observation record shows she did not receive her medication for 20 days in . Review of the resident's chart showed there are 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.

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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 was giving the medication at 6 a.m., 8 a.m., 12 p.m., and 6 p.m.. The schedule the facility is giving the medication is not according to the physician's order.

Further review showed there was an order written on . . 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's record showed there were no nurses notes stating they contacted the physician for clarification.

3. An interview with Resident #8, along with her husband (Resident #7), took place on . . at 2:00 p.m. They said sometimes it takes a long time for assistance to be given.

Resident #7 noted he does not need assistance from staff, and sometimes it takes staff 2 hours after being called to get help for his wife.

Resident #8 stated, "I need help dressing and taking a shower. I am scheduled for 7:30 a.m. for my shower; several times, it took staff a long time for them to come, sometimes 1 ½ hours to 2 hours. My husband and I reported the issue to the previous Administrator and Director of Nursing (DON), although the both of them did not address the issue."

Resident #8's 1823 form dated documented the resident requires supervision for Activities of Daily Living (ADL) to include showers and dressing.

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

Class II