STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968845	**09/25/2018**
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 complaint survey for CCR#2018010922, 2018010586, and 2018012268 was conducted through at Discovery Village at Naples, an assisted living facility (license #12700), in Naples, Florida.

Complaint #2018010922 contained two allegations of which one was substantiated with a deficiency.
Complaint #2018010586 contained three allegation of which one was substantiated with deficiencies.
Complaint #2018012268 contained one allegation which was unsubstantiated.

The following is a description of the deficiencies.

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record review, resident, staff and ombudsman interview, the facility failed to maintain documentation of medication administration and medication error for 1 (Resident # 7) of 6 records reviewed.

The findings included:

1. Review of the facility's policy and procedure for medication standards (, 2015, page 58) revealed residents receiving assistance with self-administration of medication or medication administration must be properly recorded in the medication observation record (MOR).
At a minimum the MOR shall contain the following information:
A chart for recording each time the medication is taken, any missed dosages, refusals to take medications as prescribed or medication errors.
The MOR must be immediately updated each time the medication is offered or administered.

2. On at 11:15 a.m., Resident #7 said he is capable to administer his own medications and keeps them in his apartment. The resident was able to answer questions appropriately and identified the medications he was taking. Resident #7 showed the surveyor a bottle of ear drops with instructions to instill 4 drops into the left ear 3 times a day. He said he recently had an ear for which the nurses instilled the prescribed drops. He said once a nurse mistakenly instilled the ear drops in his eye. Resident #7 described Licensed Practical Nurse Staff A, who was on duty that day.

On at 1:05 p.m., telephone interview with the facility's ombudsman revealed on she observed Resident #7 asking Licensed Practical Nurse Staff A to help him with his ear drops. She said

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the nurse instructed the resident to sit and tilt his head. She observed the nurse instilling the ear drops into the resident's eye. The ombudsman said Resident # 7 immediately started screaming and told the nurse the drops were for his ears. She shared her observation with Licensed Practical Nurse Staff A and also reported it to the nurse in charge.
The nurse in charge is no longer employed at the facility.

On at 2:30 p.m., interview with Licensed Practical Nurse Staff A revealed the ombudsmen frequently visit the building and he has spoken to them several times. He said he does not recall speaking to them about any specific incident related to Resident #7. He said his supervisor never questioned him about any medication error related to Resident #7.

Review of the facility schedule revealed on Licensed Practical Nurse Staff A was the nurse on duty and fit the description reported by Resident #7.

Clinical record review revealed a medication self-administration evaluation form signed and dated by a licensed nurse on indicating Resident #7 is deemed able to safely self-administer medications. The clinical record lacked documentation the nurse administered ear drops to resident #7. The clinical record and the incident log lacked documentation of the medication error described by Resident #7 and the ombudsman.

On at 3:00 p.m., interview with Licensed Practical Nurse Staff B revealed a while back Resident #7 had an order for ear drops. He would bring the drops to the wellness center and the nurses instilled the drops into his ear. Licensed Practical Nurse Staff B confirmed the lack of documentation the nurses administered the ear drops.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation, review of policies and procedures and staff interview, the facility failed to maintain medications secured in a locked receptacle at all times.

The findings included:

Review of the facility's policy and procedure for medication storage (DHS policy) revealed medications will be properly stored, accessed and secured.
The medications stored by the community will be stored in locked area. Medication carts and

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medication . . be used to store resident medications. Both shall be kept locked when not in use by staff.

On . . . . . at 2:10 p.m., 5 large unlocked bins of medications were observed on the floor in the wellness center. The medications were not secured, the doors to the wellness center were unlocked. The medications were easily accessible to staff, residents and visitors. The observation continued until at 2:20 p.m., when Licensed Practical Nurse Staff B returned to the wellness center.

On at 3:05 p.m., Licensed Practical Nurse Staff B confirmed the medications were left unsecured and unattended. She said she is aware medications shouldn't be left unlocked and unattended.

Class III