STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968845	**11/20/2018**
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 relicensure survey was conducted through at Discovery Village At Naples, an Assisted Living Facility (license number #12700) in Naples, Florida.

The following is a description of the deficiencies.

0008 - Admissions - Health Assessment - 429.26( ) FS; 58A-5.0181(2) FAC

Based on record review and staff interview the facility failed to ensure there was a complete and accurate health assessment (AHCA Form 1823) for 2 (Resident #7 and #10) of 2 resident records reviewed.

The findings included:

1. Review of the record, for Resident #7 on , revealed that a Resident Health Assessment (AHCA Form 1823) was completed on . The physician indicated that the resident needed help to take medications, but failed to document what type of help the resident needed in taking her medications. The physician failed to mark if the resident needs Assistance with Self-Administration, needs Medication Administration, Able to administer w/o (without) Assistance. The physician also failed to mark if the Assisted Living Facility (ALF) could meet Resident #7's needs.

2. Review of the medical record, for Resident #10 on , revealed that a Resident Health Assessment (AHCA Form 1823) was completed on . The physician indicated that the resident needed help to take medications but failed to document what type of help the resident needed in taking her medications. The physician failed to mark if the resident needs Assistance with Self-Administration, needs Medication Administration, Able to administer w/o (without) Assistance.

3. Upon interview on at 11:00 a.m., the Assistant Director of Nursing (ADON) acknowledged that the physician orders needed to be clarified due to the lack of a complete and accurate Resident Health Assessment.

Class III

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

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DISCOVERY VILLAGE AT NAPLES, LLC	**8417 SIERRA MEADOWS BLVD NAPLES, FL 34113**

SUMMARY STATEMENT OF DEFICIENCIES
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Based on observation and staff interview the facility failed to properly assist with self-administration of medications for 4 (Resident #3, #7, #11, and #14) of 4 residents observed for medication pass.

The findings included:

1. On at 10:17 a.m., Resident #7 was observed for medication pass. Staff D, a med tech, entered Resident #7's room with plastic container with multiple pill cards and bottles. Staff D then brought the resident a bottle of spray; she did not inform the resident what the medication was. The resident then administered 2 squirts into each of her nostrils then gave it to Staff D. Staff D then took the cards of pills and popped the pills into a medication cup, handed the cup to the resident along with a cup of water, and watched the resident take her pills. Staff D then left the room. Staff D did not informed Resident #7 of what the medications were. The label on the medications were not read aloud to the resident.

2. On at 8:40 a.m., Resident #11 was observed for medication pass. Staff D, med tech, entered resident
#11's room with plastic container with multiple pill cards and bottles. Staff D then brought the resident a bottle of spra. She did not inform the resident what the medication was. Resident #11 then administered 1 squirt into each of her nostrils then gave it to Staff D . Staff D then took the cards of pills and read off the name of the pills. She then popped the pills into a med cup, handed the cup to the resident along with a cup of water. The resident's family member then stopped Staff D and stated that Staff D should take the resident's , before giving one of the medications. After reading, the complete label on the , pill it did indicate to not give the medication if the , was below a certain amount. Staff D then took the resident's , and found it to be within the parameter. She then gave the pills to the resident and watched the resident take them. Staff D did not read the label on the medications aloud to the resident.

3. On at 9:17 a.m., Resident #14 was observed for medication pass. Staff E, med tech, enter Resident
#14's room with plastic container with multiple pill cards and bottles. Staff E used cleaner onl her , then took the medication cards over to the resident's wife, who was sitting in the living room, and said she was going to give the resident his pills. Staff E did not read off the medication labels to the wife (Resident had extreme hearing loss). Staff E then popped the pill into a med cup, handed the cup to the resident along with a cup of water. Staff E did not have any Medication Observation Record to compare medications to in the room. She then watched Resident #14 take his pills.

4. On at 9:50 a.m., Resident #3 was observed for medication pass. Staff B, med tech, entered

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

Resident
#3's room with plastic container with multiple pill cards and bottles. Staff B used ..... cleaner on her , then took the medication cards and read the name of the medication out loud from across the room from the resident. She then popped the pills into a med cup, handed the cup to the resident along with a cup of water. The resident was not informed of what the medications were. The label on the medications were not read aloud to the resident.

5. During an interview on ..... at 11:30 a.m., the Assistant Director of Nursing (ADON), acknowledge that the med techs needed to inform the residents of what each pill was.

6. Record Review of Exhibit 4 from resident contract which explains that the faciltiy is licensed to provide the following services and will provide to them included in their monthly rent. Number 2. Records. Assistance with self-administered medications. Includes reminders, opening med packaging, reading labels to residents, and observing resident taking ordered dose and documentation of same.

Class III