STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963817	09/24/2015
NAME OF PROVIDER OR SUPPLIER **TUSCANY VILLA OF NAPLES**	STREET ADDRESS, CITY, STATE, ZIP CODE **8901 TAMIAMI TRAIL EAST** **NAPLES, FL 34113**	

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

0000 Initial Comments

An off hour unannounced Complaint Survey, CCR# 2015007111, was conducted on beginning at 3:30 a.m. at Tuscany Villa of Naples, an Assisted Living Facility (ALF) in Naples, Florida.

The complaint contained 3 allegations. One was substantiated with deficiencies. The following is description of deficiencies:

0028 Resident Care - Activities of Daily Living

Based on record review and interview, the facility failed to offer supervision or assistance with Activities of Daily Living (ADLs) for 3 (Residents #4, #5 and #7) out of 7 Residents sampled.

The findings include:

1. On at 9:00 a.m., Resident #4 stated, "I need help getting to the sink in the . When I ask the staff to assist me in brushing my , they do. But I forget to ask them sometimes. In the last 2 months I have gone 2 weeks, without brushing my ."

Record review of Resident #4's current Health Assessment AHCA Form 1823 revealed Resident #4 needs assistance with all Activities of daily Living (ADLs), such as ambulation, bathing, dressing, eating, , toileting and transferring.

2. On / at 9:28 a.m., Resident #5 stated, "On Sundays in the afternoon at times, if I have to use the commode, the staff will leave me on it for 45 minutes and if I call, they do not come right away. I need assistance with bathing. On Saturday and Sunday, they have not washed my face, they did it only once on a Sunday."

On at 1:00 p.m., Staff G stated, "Resident #5 has caregivers during the week through Hospice Services. On the weekends, the facility caregivers are assigned to the resident. I was not aware the resident had these issues."

3. Record review of Resident #7 revealed at the facility on , , , , /, , and . Resident had on , , /, and . Resident had on /, /, /, and . In , the resident on /, /, and /. Resident #7 did not require hospital exam after each . Resident #7's current Health Assessment AHCA Form 1827 dated /, revealed Resident was independent with ADLs. The

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resident's doctor and family were notified after each .

On at 1:00 p.m., Staff G reported the facility did not have a plan in place, revised after each resident to prevent future .

Class III

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0030 Resident Care - Rights & Facility Procedures

Based on record review and interview, the facility failed to treat 2 (Residents #5 and #6) of 7 residents sampled with consideration and respect with recognition of personal dignity and need for privacy.

The findings include:

1. On at 9:28 a.m., Resident #5 reported some staff do not speak English to him. They speak Creole behind his back. He said this bothers him. He feels they are talking about him. He said he needs assistance with bathing. He said on the weekends, instead of putting deodorant under his arms, the staff sprays his body with it. He said on the weekends, if he needs to go to the , he is told by staff he needs to wait until after breakfast.

2. On at 10:00 a.m., Resident #6 said he shares his another resident. He said his screams out at night while he is sleeping and this disrupts his sleep. He said he had spoken to the Director.

On / at 1:15 p.m., Staff G said Resident #6's has a medical problem that causes him to yell out at times. She was not aware this issue disturbed Resident #6 from sleeping.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

_____, 2015

Administrator
Tuscany Villa Of Naples
8901 Tamiami Trail East
Naples, FL 34113

RE: CCR #2015007111

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on _____ 2015 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than _____, 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form

XG90

Fort Myers Field Office
2295 Victoria Avenue, _____
Fort Myers, FL 33901
Phone:(239) 335-1315; Fax:(239) 338-2372
AHCA.MyFlorida.com