STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963817	10/09/2015
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 unannounced Complaint Survey, CCR #2015010668, was conducted on / at Tuscany Villa of Naples, an assisted living facility in Naples, Florida.

Two of the three allegations were substantiated. As a result of this complaint survey the facility received citations.

0025 Resident Care - Supervision

Based on one of three closed resident records reviewed, paramedic report, staff and family interviews, the facility failed to initiate ( ) on an unresponsive resident (Resident #2) when no ( ) was located in the resident's record in the facility.

The findings included:

A review of Resident #2's closed record showed on / he was found "non responsive" at 12:24 p.m., 911 was called and he was brought to the hospital. Resident #2's family arrived at the facility later in the day to notify them Resident #2 expired.

Further review of Resident #2's chart showed a "Medical Care and Treatment" form showing the power of attorney requested to " " ( ) Resident #2. Resident #2's chart did not have a order written by the physician. When a resident does not have a order written by a physician with the physician's signature the resident remains a full code (meaning staff has to provide) until this order is written and placed in the resident's chart.

An interview was conducted with Resident #2's son at 11:30 a.m. on / by phone. He stated, "It was a family decision to do the ." He did not do the yellow form for the and felt the contract form he signed for the was good enough.

An interview was conducted with the Director of Nursing (DON) at 9:45 a.m. on /. She reviewed Resident #2's chart and confirmed there was no order in the chart. She was not sure if Resident #2 was breathing or not when he was found unresponsive.

An interview was conducted with Staff A at 12:25 p.m. on by phone. She was called to go into Resident #2's . She did not think Resident #2 was breathing. The nurse then came in took his pulse. The nurse left the . Less than 10 minutes later the paramedics arrived in Resident #2's they started .

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963817	10/09/2015
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)

An interview was conducted with Staff B at 12:35 p.m. on / by phone. She stated she found Resident #2 unresponsive and his eyes were open. She checked his pulse and there was no pulse. He was not breathing. She called out for help. Staff A came in to help. The nurse came in the took his , and pulse. She left told staff not to move or touch Resident #2. Both Staff A and B stayed with Resident #2 until the paramedics arrived. The paramedics performed on Resident #2.

Staff C was interviewed on at 2:13 p.m. by phone. She stated she was called to Resident #2's . She checked for vital signs and there was none. She ran to the office and called 911. She checked Resident #2's chart for a and there was none. She pulled out other papers for a paramedics. When she was coming back to Resident #2's paramedics were ahead of her in the hallway going to Resident #2's . When the staff entered the started . She said the facility's process when finding a resident unresponsive is to check their chart for papers. If there are no papers they are to perform . The papers are not in their . The residents' charts are located on the 3rd floor. If a resident is unresponsive on the first floor the nurse will have to go to the third floor and chart their chart.

An interview was conducted with the DON at 2:25 p.m. on / by phone. She confirmed what Staff C said. She confirmed that the papers for residents are located in their chart. The charts are accessible to all staff. The residents' charts are located on the third floor. She was not able to determine how much time past when Resident #2 was first found unresponsive to when was initiated by the paramedics.

A review of the paramedic report showed at 12:29 p.m. on the dispatcher was notified by the facility. The paramedics arrived at the facility and started at 12:35 p.m. This report also showed when the paramedics arrived at Resident #2's staff was "standing in hallway." The paramedics moved Resident #2 to the floor and was initiated.

Resident #2 was found unresponsive with no pulse and not breathing at 12:24 p.m. was not initiated until 12:35 p.m. by the paramedics. The facility neglected to initiate to Resident #2 as soon as he was found with no pulse or not breathing. The facility's process did not allow the staff to obtain the knowledge to know if Resident #2 was a or full code until the staff went to the third floor to obtain this knowledge in his chart. This resulted in an 11 minute delay in initiating .

Class II

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963817	10/09/2015
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)

0165 Risk Mgmt & QA: Adverse Incident Report

Based on resident record reviewed, paramedic report and staff interview, the facility failed to submit an adverse incident report when 1 (Resident #2) of 3 residents had a delay in care when he was found unresponsive.

The findings included:

A review of Resident #2's closed record showed on at 12:24 p.m. he was found unresponsive. Staff B found him unresponsive and took his pulse. There was no pulse and no breathing. She called the nurse. Staff A arrived at Resident #2's then Staff C (the nurse) arrived. The nurse took Resident #2's vital signs and found none. She left the went to the chart Resident #2's chart is kept. She reviewed the chart finding no ( ) papers. She called 911 and took papers out of the chart for the paramedics. When she was going back to Resident #2's paramedics were already in the facility going to his . When the paramedics arrived in Resident #2's initiated at 12:35 p.m. He was sent to the hospital and expired there. See A0030 for more detailed information.

An interview was conducted with the Director of Nursing (DON) at 9:45 a.m. on . She stated there have not been any adverse incident reports for the past three months. She did not know if Resident #2 was breathing or not when this incident happened. There was no investigation. She confirmed the facility did not initial when he was first found unresponsive. The facility's process is to review the resident's chart first to see if there is a order. The resident's charts are on the third floor. If a resident lives on the first floor the staff has to go up to the third floor to review this chart.

A review of the paramedic report showed was initiated by them at 12:35 p.m. From the time Resident #2 was found unresponsive with no pulse (12:24 p.m.) to the time was initiated by the paramedics at 12:35 p.m. eleven minutes passed without providing Resident #2 . Resident #2 expired at the hospital. The facility did not initiate timely and did not initiate an investigation in this incident.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

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

Dear Administrator:

This letter reports the findings of a Complaint (CCR#2015010668) survey conducted on , by a representative of the Agency for Health Care Administration Agency. Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **five business days** of receipt of this faxed report.

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0025 - 429.26(7) Fs; 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0165 - 429.23(1-4 & 6-10) Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Directed Corrective Actions:

1. The Assisted Living Facility is required to audit the records of each facility resident and compile an accurate list of residents with " " (hereinafter ")". Your facility must then designate locations for the list of residents and the residents' and implement a system for staff to identify whether a resident has a . This information must be communicated to direct care staff and the information must be accessible during each shift. This must be completed within 5 calendar days from the date of this letter.

2. The Assisted Living Facility is required to have a written policy on steps to take in emergency situations, including sudden illness of a resident. Your facility is directed to review and revise any current policies regarding emergency procedures, and resident to ensure they are consistent and do not contradict each other. The emergency/ policy must include:

Directions for staff on the initiation of (hereinafter " ") unless a resident has a .

Directions on calling emergency personnel. Directions on what staff in charge are to be notified and who are responsible for follow-up.

A plan for making all resident records (including medical records, medication records, resident emergency contacts and) available to direct care

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

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

staff and emergency personnel, including. The location of the list of residents and the location of the hard copies of resident .

This must be completed with 5 calendar days from the date of this letter.

3. The Assisted Living Facility is required to train staff on the facility's emergency policies including, ( ) and policy and procedures after the policies are written/revised. A roster of these employees and written verification of the training and training materials must be available for AHCA staff to review. This must be completed within 5 calendar days from the date of this letter.

4. The Assisted Living Facility is required to obtain training from an outside, reputable source regarding honoring advance directives in an emergency situation. This training must be provided to your Administrator, Health and Wellness Director, and Wellness Nurse, and any other similar personnel. This training must then be provided to all staff. Documentation of training provided must be available for review by AHCA. The Administrator is responsible to ensure compliance. The curriculum and original certificates for this training must be retained by the facility in the employees' records and are to be available for review within 5 calendar days from the receipt of this letter.

5. The Assisted Living Facility is required to to provide training to all staff regarding maintaining accurate and thorough written resident records, including but not limited to training on updating records of any significant changes, any illnesses that resulted in medical attention, and other changes that resulted in the provision of additional services. The curriculum and original certificates for this training must be retained by the facility in the employees' records and are to be available for review within 5 calendar days from the receipt of this letter.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact , Laura Manville, Survey and Certification Support Branch, at (727) 552-1955 or this office at 239-335-1315

Sincerely,

Jon Seehawer, RN
Field Office Manager

JS:

D7JR