

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105995	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2024
NAME OF PROVIDER OR SUPPLIER Adviniacare at Naples		STREET ADDRESS, CITY, STATE, ZIP CODE 7801 Airport Pulling Road N Naples, FL 34109	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on record review, review of facility policies and procedures, resident and staff interviews the facility failed to follow the established plan of care for safe transfer, resulting in an avoidable fall and fall related major injury for 1 (Resident #3) of 3 residents reviewed. The findings included: Review of the clinical record for Resident #3 revealed an admitted [DATE]. Diagnoses included morbid obesity and left artificial knee joint. The 5-day scheduled Minimum Data Set (MDS) assessment with a target date of 9/2/24 noted Resident #3 was dependent (Helper does all of the effort. Resident does none of the effort to complete the activity) for toilet transfer (Ability to safely get on and off a toilet or commode). Resident #3's cognition was intact with a Brief Interview for Mental Status score of 15. The care plan initiated on 7/5/24 noted the resident had Activities of Daily Living (ADL) Deficit with a goal to improve ADLs. The interventions included and specified the use of a full body mechanical lift with assistance of two for transfers. Resident #3 received Physical and Occupational Therapy. Review of Occupational Therapy discharge summary dated 10/17/24 noted Resident #3 required substantial/maximal assistance with toilet transfer. The Physical Therapy discharge summary dated 10/18/24 noted Resident #3 required partial/moderate assistance with toilet transfer. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/20/24 at 6:31 p.m., an incident progress note documented on 10/20/24 at approximately 4:45 p.m., the nurse was at the nurses station. Certified Nursing Assistant (CNA) Staff A came to the nurses station and said, Quick help. The nurse followed the CNA to Resident #3's room and observed the resident sitting on her buttocks on the floor in front of the toilet. The resident's right lower extremity was in abnormal alignment with the right foot externally rotated. Resident #3 complained of right foot pain and denied hitting her head. Resident #3 stated, It's my fault, I told her (CNA Staff A) I could do it with just her. The nurse immediately called 911 and prepared transfer paperwork as a Registered Nurse stayed with the resident to monitor. EMS (Emergency Medical Services) arrived and transferred Resident #3 to a local hospital. Resident #3 was diagnosed with a displaced comminuted (bone shatters into multiple pieces) fracture of the shaft of the right tibia requiring surgical repair. Resident #3 returned to the facility on [DATE]. Review of CNA Staff A's handwritten statement obtained during the incident investigation noted she did not see a sling (used to transfer resident with a full body mechanical lift) behind Resident #3 when the resident asked for assistance to the toilet. Resident #3 said she was no longer using the sling as she was better now. When CNA Staff A said she was going to get help, Resident #3 asked CNA Staff A to use the walker to put her on the toilet. CNA Staff A wrote she placed the walker in front of the resident and locked the wheelchair. Resident #3 had her hand on the walker while the CNA was holding the resident's left side to transfer her to the toilet. Resident #3 said, I am going to the floor. CNA Staff A tried to pull the wheelchair but it was locked. Resident #3 fell to the floor. Review of the facility's investigation analysis revealed CNA Staff A did not check the Individual Service Plan (Provides instruction for safe care) for proper instruction on how to transfer the resident. On 11/20/24 at 1:18 p.m., in an interview Resident #3 said she told CNA Staff A she did not need the mechanical lift or a second staff member to assist with the transfer. She said sometimes her knees give out. She told Staff A she was going down, but the CNA was by herself and could not prevent her from falling. On 11/20/24 at 4:14 p.m., in an interview CNA Staff A verified on 10/20/24 she did not use the full body mechanical lift and did not request assistance from a second staff to assist with the resident's transfer. She said when Resident #3 told her she no longer needed the full body mechanical lift or additional staff for transfer she did not verify the information with the nurse or the care plan. On 11/21/24 at 1:39 p.m., in an interview Physical Therapist Staff C said Resident #3 was receiving cortisone (steroid) injections for knee problems, and her knees give out on occasion. The plan was to provide additional training to the CNAs but the training did not occur since the resident was transferred to the hospital after the fall. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/21/24 at 3:43 p.m., in an interview the Director of Nursing (DON) said after Resident #3's fall, she provided training to the nurses and the CNAs on transferring dependent residents and use of mechanical lifts. The DON provided documentation of training for 19 of 39 direct care nursing staff (Licensed nurses and CNAs). She verified she did not train all the nurses and CNAs and the training did not include accessing individual service plans on the computer before transfer to ensure the safety of the residents. On 11/22/24 at 1:01 p.m., in an interview the Administrator said the DON was responsible for ensuring the nurses and CNAs were trained and competent to perform their duties. She said she could not locate documentation of transfer training, skills assessment, or use of the computer to access residents care plans in CNA Staff A personnel file.		