STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968749	**02/16/2017**
NAME OF PROVIDER OR SUPPLIER **THE WILLOWS AT WILDWOOD**	STREET ADDRESS, CITY, STATE, ZIP CODE **4725 BELLWETHER LN** **OXFORD, FL 34484**	

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

0000 - Initial Comments

On , , 2017 through , , 2017, a Biennial Licensure Survey was conducted at The Willows At Wildwood (facility license number 12648). During the survey deficient practice was identified.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on interviews and record reviews the facility failed to honor resident rights by issuing a 45 day notice out of reprisal for grievances filed by 1 of 10 residents (Resident #1).

Findings:

On at approximately 12:24 PM, an interview was conducted with Resident #1. During the interview the resident stated she used to be the Resident Council President and the facility told her she was complaining too much and irritating staff and residents so she received a 45-day notice to move out of the facility. She stated, "I told the Administrator I did not want to move out of the facility and she stated she was not going to withdrawal the 45-day notice. The Administrator told me they knew I was not happy and they could not make me happy." Resident #1 stated the only complaints she had were the ones raised during the Resident Council Meetings. There were ants in some of the , staff were not cleaning residents' properly. We felt the dinning staff were not properly trained. We felt the porches around the facility needed to be cleaned because they hadn't been cleaned in a year. Resident #1 stated she felt she was being evicted because of all the complaints that were made during the Resident Council Meetings. Resident #1 stated other residents are afraid now to voice their complaints or concerns because they might be evicted. She stated she did raise some personal concerns like not being allowed to have enough milk for her and her husband to have cereal in their . She also suggested to staff that they place the snacks on the counter to a lower spot so residents in wheelchairs could have easier access to them. The residents felt the complaints were not being properly addressed so we contacted the Ombudsman to attend our Resident Council Meetings.

On at approximately 1:36 PM, an interview was conducted with the North Region Ombudsman Manager by phone. She stated that she did attend a Resident Council Meeting and Resident #1 had the same complaints over and over. She complained about ants being in her . She complained about the exhaust on the dryer being a fire hazard because they were not cleaned out. The Ombudsman Manager stated she did find a couple of ants in the residents' and there is a cleaning schedule for the dryer vents now. The Ombudsman stated the facility did try to dissolve the Resident Council Meeting sometime during the summer and they were advised they could not do that. She stated she would have the Ombudsman more familiar with the facility contact the surveyor with more details.

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On at approximately 3:30 PM, an interview was conducted with a family member, Family Member D, who chairs the Resident Council in the facility by phone. She said she had heard Resident #1 had received a 45-day notice of discharge from the facility and wondered why. Family Member D stated Resident #1 was the President of the Resident Council 6 months ago but she resigned because she felt threatened by management. Family Member D stated Resident #1 did not have any concerns or complaints about the facility that were unreasonable. Because the complaints were not being resolved satisfactory, I advised her she had three options, to move out, stop complaining or go over the Administrator's head. Resident #1 decided to go over the Administrator's head with a letter to the owners complaining about the lack of response from the Administrator concerning their complaints.

On at approximately 11:27 AM, an interview was conducted with Ombudsman E. He stated that Resident #1 had legitimate concerns and complaints about the facility and I was able to verify every one of them. He stated two meetings ago, at the Resident Council Meeting, many of the residents in attendance complained about being afraid of retaliation from management concerning their complaints. Residents told me the Administrator is intimidating and staff comes into resident without knocking all the time.

On , a record review was conducted on Resident Council Meeting minutes as far back as , 2016. No complaints appeared unreasonable or illegitimate. The records contained a letter dated , written by the Operations Director stating, "We have agreed to dissolve the Resident Council. In lieu of the Resident Council, monthly Town Hall Meetings and Activity Committee Meetings will be an efficient way to share information at a group level. Please bring your individual concerns to management immediately." It was observed in the record a hand written note dated which stated Resident #1 resigned as President of the Resident Council and they would be in violation if they did not have a Resident Council.

On at 12:53 PM, a follow-up interview was conducted with Resident #1. Resident #1 stated in 2016 she had a meeting with the Administrator and the Operations Director. During the meeting she asked them if she resigned from being the President of the Resident Council would that relieve the friction between her and the facility and they told her "yes," so she resigned. Resident #1 stated the Administrator never told her what needs or expectations they could not meet of hers.

On , a record review was conducted on Resident #1's Resident Health Assessment (AHCA Form 1823), dated , which showed she is completely independent with activities of daily living and with her medication. She has not had a significant change since moving into the facility.

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On , review of a letter sent to Resident #1 from the facility's management, dated , stated, "We are very pleased that you have selected our community as your home, and it is our intention to continue to provide you with the highest standard of services and the best living environment possible. Our goal is to meet your individual needs as effectively and efficiently as possible."

On , review of a letter sent to Resident #1 from the facility's management, dated , stated, "This letter is to inform you The Willows at Wildwood is officially providing you with a 45 Day Notice. We feel at this time, we are unable to meet your needs and expectations." The letter did not explain what those needs or expectations were.

On at 2:22 PM, an interview was conducted with the Administrator in reference to Resident #1's 45-day notice of discharge. The Administrator was asked if she could explain what needs and expectations the facility could not meet concerning Resident #1. The Administrator stated Resident #1 had constant complaints about how we do things in the community. I told her if she was not happy she should move out. I have had complaints about her negativity from other residents concerning a petition that the residents wanted to send to the owners but refused to sign. I even had a couple of family members complain about the petition. The letter was about unresolved issues in the facility. The Administrator was asked if she had documentation concerning the complaints against Resident #1 and she stated "no." The Administrator stated she has been meeting with Resident #1 from day one and even tried to assist in setting up the Resident Council (documentation shows the facility tried to dissolve the Resident Council). Administrator was asked if Resident #1 had violated any of the facilities rules, which she said no. The Administrator was asked if Resident #1 was behind on her rent, which she said "no," Resident #1 has paid her rent. The Administrator stated the discharge has nothing to do with Resident #1's or her husband's medical needs. The Administrator stated that Resident #1 told her she did not want to move. The Administrator was asked if the facility had any documentation showing or explaining what needs or expectations they could not meet for Resident #1, which she said "no." She was asked if there was any documentation of the meetings she had with Resident #1, which she said "no."

Based on this surveyor's investigation of Resident #1's complaint, about being discharged out of reprisal for her complaints to the facility, is being substantiated for the following reasons. There were no complaints verified from Resident #1 that were not substantiated. Resident #1 was encouraged by the facility management to step down from the Resident Council Presidency to ease tension, and she did. There is documentation showing the facility tried to disband the Resident Council and replace it with a Town Hall Meeting. It is evident from record review of the Resident Council minutes that complaints by the Resident Council were not being addressed adequately. It is also evident that the facility management was very unhappy with the letter that was sent to the owners concerning the facility

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management failure to respond to resident complaints. Based on interviews, it is apparent that Resident #1 is a strong resident advocate who holds the facility accountable. It appears the facility is blaming Resident #1 for the letter that was sent to the owners about the complaints not being resolved and are using the discharge as reprisal for her action.

Class II