STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967726	**07/06/2017**
NAME OF PROVIDER OR SUPPLIER **RESIDENCES OF NICEVILLE**	STREET ADDRESS, CITY, STATE, ZIP CODE **2300 NORTH PARTIN DRIVE NICEVILLE, FL 32578**	

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

0000 - Initial Comments

An unannounced biennial survey with Extended Congregate Care Services and Limited Nursing Services was conducted from through at , Residences of Niceville (state license #11712) in Niceville, Florida. Deficient practice was found at the time of the survey.

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

Based on observations, staff interviews, record reviews, and review of the facility's resident bill of rights, the facility failed to ensure residents received appropriate assistance with eating/feeding to maintain personal dignity, and failed to ensure the residents' rights were honored by failing to observe appropriate control standards while assisting residents to eat for 4 of 29 residents observed during meal service (#3, 6, 7, and 8).

The findings are:

On beginning at 12:17pm, observation was conducted of the lunch meal in the west hall main dining . Observations revealed approximately 20 residents in the dining . Staff were actively passing residents their plates of chicken alfredo, mixed vegetables, roll and beverage. Observation at approximately 12:21PM revealed sampled staff B, a housekeeper and resident aide, standing beside resident #3. The resident was sitting in a wheelchair with a clothing protector on, and sitting at a horseshoe shaped table with two other residents, #4 and #5. (The table was shaped like a horseshoe where the residents could sit on one side of the table, and the staff could sit on the other side of the table to comfortably and appropriately assist the residents with their meals). Sampled staff B was observed feeding resident #3 his lunch of chicken alfredo over noodles, mixed vegetables, roll and beverage from a standing position until 1:08pm. During this observation, at 12:48pm, staff B was observed to feed the resident a bite of his roll, which she handled with her bare hands while placing it in his mouth. At 12:49pm she was observed to leave the dining area, then return to the resident's side and began feeding the resident again, while continuing to stand beside him. At 12:50pm, she was observed again to feed the resident a bite of his roll using her bare right hand. At 12:53pm she again left the resident, entered into the kitchen, and then immediately returned and resumed feeding the resident with no observation of washing or sanitizing her hands. At 12:54pm she went over to resident #5, who was attempting to rise from his wheelchair, and assisted him to reposition back into his wheelchair. During this observation, staff B was observed to touch the clothing and wheelchair of resident #5 with her bare hands. She then returned to resident #3 and resumed feeding him. She was not observed to wash or sanitize her hands, and was again observed to give resident #3 a bite of his roll handing it to him with her bare hands. Observation continued, and staff B was again observed at 12:58pm to feed resident #3 a piece of his roll using her bare right hand. At 1:08pm, resident #3 had finished his meal.

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On at 12:41PM, during this same meal observation, sampled staff E, a Licensed Practical Nurse and the Assistant Director of Nurses (LPN/ADON), was observed to walk to table where 3 residents were seated, and began feeding residents #6 and #7 and verbally cueing resident #8 to eat. Observation of these residents between 12:41pm and 1:12pm revealed staff E to stand between resident #6 and #7 while she was feeding each of them. She stood, alternating feeding each of the residents, and occasionally addressing the residents. She also occasionally steped over to resident #8 and fed her, as she was not eating. During those observations, staff E was observed to touch the residents' on their shoulders, adjust their plates, and touch their wheelchairs with her bare hands, but never washed or sanitized her hands.

Observation of the evening meal on at 5:16pm in the same dining 29 residents to be present for hamburgers, potatoes and beverage. Residents #3, #4 and #5 were again seated at the same horseshoe dining table. At 5:25pm, sampled staff F, a resident aide, was observed to rub the hair of resident #14, before she sat down beside the resident and talked with her for a short time. At 5:36pm, staff E was observed to assist resident #15, with her dinner, but was not observed to wash or sanitize her hands. At 5:39pm, she was observed to go to resident #3 and assist him to sit up straight in his wheelchair, handling the resident's clothing and touching his wheelchair. She then returned to resident #14 to assist her with her meal.

An interview was conducted with the executive director on at approximately 5:41pm concerning how staff should assist residents with eating or with feeding them. The executive director stated the staff should be sitting to assist the residents with eating/feeding, and she then took staff F a chair to sit in. She returned and continued the interview and stated it was the "standard" that the staff who were assisting with eating and feeding sit down beside the resident while they are assisting the resident.

Continued observation revealed staff D behind the horseshoe shaped dining table with sampled residents #3, #4, and #5. Staff D was observed to be adjusting her personal clothing using her bare hands and then was observed to handle resident #3's with her bare right hand before feeding it to him. At 5:58pm she picked up his hamburger again with her bare right hand and fed the resident. At 6:00pm she again picked up the resident's hamburger with her bare hand, but this time she placed the hamburger in the resident's hand, and the resident began eating the hamburger.

Record review for residents #3, #6, #7 and #8 revealed they all required assistance with eating and all suffered with and were not interviewable.

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Interview with the executive director (ED) on . . . at approximately 8:20am, and again at 3:45pm, revealed it was the facility's standard that the staff should sit with the residents while assisting them to eat or feeding them. The ED stated this was to ensure the residents' were assisted in a dignified and respectful manner. She stated the staff should never handle the residents' food with their bare hands and should at least use hand sanitizer between resident contacts. Review of the facility's "Bill of Rights for Residents of the Assisted Living Community" revealed the residents had a right to be treated with respect and have access to adequate and appropriate care, which would include observing appropriate . . . . control measures such as not handling the residents' food with bare hands, and using hand sanitizer or washing hands after resident contacts during dining.

Class III