STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911081	11/08/2017
NAME OF PROVIDER OR SUPPLIER **CITIES PAVILION**	STREET ADDRESS, CITY, STATE, ZIP CODE **1053 JOHN SIMS PARKWAY** **NICEVILLE, FL 32578**	

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0000 - Initial Comments

An unannounced complaint survey for allegations contained within CCR#2017011222 & CCR#2017010552 was conducted from through at Cities Pavilion, license #5462. Deficient practice was identified at the time of the survey.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on resident interview, staff interview, facility rules and record review, the facilty failed to ensure residents continued to meet residency requirements, failed to recognize a significant change in condition and have an updated AHCA Form 1823 completed, and failed to discharge a resident when their medical condition (wounds) failed to improve within 30 days for 1 of 3 residents sampled (#1).

The findings include:

Review of the medical record for resident #1 showed he was admitted to the facility in 2017 with a sacral . The resident's health assessment, dated , revealed resident #1 needed assistance with activities of daily living and medications.

Resident #1 was receiving home health services and review of his home health notes showed that on the home health nurse was documenting that the resident had an area of friction to his right measuring 2.0cm x 0.5cm x 0.1cm and on his left measuring 3.0cm x 0.2cm x 0.1cm with facility staff to apply barrier cream for healing. The nurse's note indicated that resident #1 had reported that he could not get to the commode and that the staff told him to go in his brief. The note by the nurse questioned this and then stated that facility staff should call the home health agency (HHA) for assistance with resident #1 when needed. An Oasis assessment completed by the HHA on indicated resident #1 had a , to his left measuring 2.0cm x 1.0cm x 0.4cm and a , to his right measuring 1.5cm x 1.2cm x 0.4 cm with facility staff to apply barrier cream for healing. On the HHA nurse documented that the resident's sacrum had deteriorated to a and his sacral had also deteriorated to a . The note went on to again instruct staff not to allow the resident to use the his brief, and to contact the HHA for assistance with the resident when needed. There were additional notes written on and stating that the wounds for resident #1 remained at a . On there was an HHA note that indicated the wounds had decreased in size and were at that time. On a HHA note indicated the wounds were still , but that there was no dressing in place at the time of the visit and that the resident had bowel movement on his bottom. On and HHA notes indicated that the wounds were still the same size with degregration to the surrounding tissue and again noted that there was no dressing in place and no barrier cream observed on the resident's

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skin. On the HHA nurse made a note that care at the facility had been ineffective and included a assessment that indicated the resident's wounds continued to be a but showed increase in measurements with the on his right measuring 2.5cm x 8.0cm x 0.1cm.

Review of the resident's weights showed that he weighed 173 pounds in 2017 and 160 pounds in 2017 for a 13 pound decline in one month.
Further review of his record showed no updated AHCA Form 1823, and no indication that the resident had been assessed for a significant change or continued residency at the facility.

Interview with aide D on at approximately 3:00 pm indicated she had heard other staff say that they didn't change resident #1, or get him up, and that if he didn't get up to go to the medication medications or the dining meals, they would not give his his medications or food.

Interview with aide E on at approximately 3:10 pm indicated she was aware that resident #1 was of and bowel, and he had 5-6 wounds on his bottom that home health provided care for. She stated that the dressings would not stay on his wounds, and he would moan in pain when she cleaned him. She stated that resident #1 had called 911 (emergency medical services) one time saying the staff wouldn't get him out of bed, but stated they normally only have 2 aides on the evening shift, and it took a long time to get to the resident when he needed something.

Interview with aide F on a 10:52 am indicated resident #1 had sores on his bottom and they looked really bad. The aide stated that the resident experienced loose stools frequently and that the dressings would not stay on the wounds.

Interview with staff B on 11/ at 2:15 pm indicated she was aware that the resident had "a couple of sores to his bottom." She stated that resident #1 was receiving home health services including physical , , and that he had lost some weight, which she thought was a result of the increased activitiy from the , , services, and that the physician had been notified of the weight loss and its cause.

On at approximately 12:00 noon an interview was conducted with resident #1 who stated that he was neglected by staff and would often sit in a soiled brief for hours , one time having to stay in the soiled brief for approximately 36 hours. He confirmed that he did have wounds on his bottom and stated that they were very painful. He stated home health provided care of the wounds, but that the dressings that were placed would not stay on due to his chronic . He went on to explain that there was not enough staff at the facility between 4:00 pm and 9:00 pm nightly to care for the residents and that with only 2 staff present it often took about five hours to get assistance. He also stated that there was a rule

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at the facility that all residents had to go to the medication receive their medications, but he had to have assistance to get up and get to the medication , and that at times he was not able to go due to his from his medical conditions, chronic , and pain from his wounds. He stated that on the occassions he has not been able to go to the medication , and as a result, had not received his medications on those occassions. He stated that the same rule applies to meals and that residents are required to get up and go to the dining get their food. He stated that on the occassions he has not been able to get up and go to the dining , he has gone without food and has experienced weight loss due to this. He stated that he has asked, but staff refuse to bring his food or medications to his he is not able to get up.

Interview with aide H on at 2:00 pm indicated the rule at the facility was that residents had to go to the dining all meals. She stated that if the resident didn't go to the dining , they would hold a plate for the resident in the kitchen, but the resident would have to get up and go to the kitchen to get the plate of food, warm it up, and eat it.

An interview was conducted with the facility administrator on at 4:30 pm. She indicated the facility didn't have rules that the residents had to go to the medication the dining order to get food or medications, but stated that it is highly encouraged for each resident as there is not enough staff to go to all the during medication administration times.

Review of the facility rules provided to all residents at the time of admission made no mentions that residents would be asked or required to go to a medication receive their medications; however, it did state that meals would only be served in a resident's a seven day time period unless prescribed otherwise by a physician.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review, review of facility rules, and resident and staff interview, the facility failed to provide adequate resident supervision to appropriately monitor the general health and well-being, related to meals and medications, for 2 of 3 residents sampled (#1 and #6)

The findings include:
Interview with aide D on at approximately 3:00 pm indicated she had heard other staff say that they didn't change resident #1, or get him up, and that if he didn't get up to go to the medication medications or the dining meals, they would not give his his medications or food. She also

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stated that resident #6 had shortness of breat ( ) and used . She stated that one evening he was really short of breath and refused to get up to go get his medications. She stated that she went and asked the medication technician if she would take the resident's medications to him because of his and she stated that she would not because it was a facility rule that residents had to come to the medication get their medications, so she had to assist resident #6 to get up and go to the medication , even though he was really short of breath.

Interview with aide E on at approximately 3:10 pm indicated that resident #1 had called 911 (emergency medical services) one time saying the staff wouldn't get him out of bed, but stated they normally only have 2 aides on the evening shift, and it took a long time to get to the resident when he needed something.

Interview with staff G on at approximately 5:00 pm revealed that residents were required to get up and go to the medication all their medications. She stated that staff pick and choose who they will take medications to, but this practice didn't happen very often at all. She stated that if the residents didn't get up, they made a really big deal out of it to the resident and then they would circle the resident's medications on the medication observation record (MOR) to indicate that the resident had refused the medications. She stated that they do the same thing with meals, and if the resident didn't get up and go to the dining , they may not get food. She stated that sometimes they will keep a plate in the kitchen for residents who do not get up at meal time, and sometimes they won't, which means the residents who did not get up had to go without food. She further stated that resident #6 was short of breath due to his illness, and was on . She stated that one evening he was extremely short of breath and said he couldn't go get his medications, so she went to tell the medication technician this, and they said "no, he has to come to the med ." I explained he was but they stated "no, it is a rule that all residents come to the med meds." I went back and assisted resident #6 and he said, "I am too ," but I helped him to the med .

Interview with staff B on at 2:15 pm indicated that resident #1 was receiving home health services including physical , and that he had lost some weight, which she thought was a result of the increased activitiy from the , services, and that the physician had been notified of the weight loss and its cause.

On at approximately 12:00 noon an interview was conducted with resident #1 who stated that he was neglected by staff and would often sit in a soiled brief for hours, one time having to stay in the soiled brief for approximately 36 hours. He confirmed that he did have wounds on his bottom and stated that they were very painful. He stated home health provided care of the wounds, but that the dressings that were placed would not stay on due to his chronic . He went on to explain that there was not

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enough staff at the facility between 4:00 pm and 9:00 pm nightly to care for the residents and that with only 2 staff present it often took about five hours to get assistance. He also stated that there was a rule at the facility that all residents had to go to the medication receive their medications, but he had to have assistance to get up and get to the medication , and that at times he was not able to go due to his from his medical conditions, chronic , and pain from his wounds. He stated that on the occassions he has not been able to go to the medication , and as a result, had not received his medications on those occassions. He stated that the same rule applies to meals and that residents are required to get up and go to the dining get their food. He stated that on the occassions he has not been able to get up and go to the dining , he has gone without food and has experienced weight loss due to this. He stated that he has asked, but staff refuse to bring his food or medications to his he is not able to get up.
The resident's health assessment, dated , revealed resident #1 needed assistance with activities of daily living and medications. Review of the resident's weights showed that he weighed 173 pounds in , 2017 and 160 pounds in 2017 for a 13 pound decline in one month.

Interview with aide H on at 2:00 pm indicated the rule at the facility was that residents had to go to the dining all meals. She stated that if the resident didn't go to the dining , they would hold a plate for the resident in the kitchen, but the resident would have to get up and go to the kitchen to get the plate of food, warm it up, and eat it. She stated that resident #6 would sometimes refuse to come down to get his medications and they would circle them on the resident's medication observation record (MOR) as refused.

On at 3:12 pm an interview was conducted with resident #6. He stated that staff at the facility treated the residents awful and that the administrator didn't care about them either. He stated that it was a rule at the facility that all residents had to go to the dining eat and to the medication receive their medications and that staff would not bring either to them. He went on to explain that staff actually make a big deal when he wouldn't get up to go to the dining would make him feel bad about it. He stated that he required assistance with ambulation, and that he was always short of breath ( ) and had to use supplemental to help with this chronic condition. He stated that because of his condition, he was not always able to get up and go to the medication the dining .
Review of the resident's health assessment, dated showed that resident #6 required assistance with ambulation and required supplemental .

An interview was conducted with the facility administrator on at 4:30 pm. She indicated the facility didn't have rules that the residents had to go to the medication the dining order to get food or medications, but stated that it is highly encouraged for each resident as there was not enough staff to go to all the during medication administration times.

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Review of the facility rules provided to all residents at the time of admission made no mentions that residents would be asked or required to go to a medication receive their medications; however, it did state that meals would only be served in a resident's a seven day time period unless prescribed otherwise by a physician.

Class III

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

Based on record review, resident interview and staff interview, the facility failed to ensure the residents' rights for an environment free of neglect was honored by failing to ensure each resident received adequate and appropriate health care by failing to provide care in a timely manner, failing to provide physician ordered medication and failing to provide food and nutrition services for 2 of 3 residents sampled (#1 and #6). The facility also failed to ensure that staff reported concerns related to resident incidents and accidents to the appropriate facility staff for 2 of 3 residents sampled (#9 and #10).

The findings are:

Review of the medical record for resident #1 showed he was admitted to the facility in 2017 with a sacral . The resident's health assessment, dated , revealed resident #1 needed assistance with activities of daily living and medications. Review of the resident's weights showed that he weighed 173 pounds in , 2017 and 160 pounds in 2017 for a 13 pound decline in one month.

Resident #1 was receiving home health services and review of his home health notes showed that on the home health nurse was documenting that the resident had an area of friction to his right measuring 2.0cm x 0.5cm x 0.1cm and on his left measuring 3.0cm x 0.2cm x 0.1cm with facility staff to apply barrier cream for healing. The nurse's note indicated that resident #1 had reported that he could not get to the commode and that the staff told him to go in his brief. The note by the nurse questioned this and then stated that facility staff should call the home health agency (HHA) for assistance with resident #1 when needed. An Oasis assessment completed by the HHA on indicated resident #1 had a , to his left measuring 2.0cm x 1.0cm x 0.4cm and a , to his right measuring 1.5cm x 1.2cm x 0.4 cm with facility staff to apply barrier cream for healing. On the HHA nurse documented that the resident's sacrum had deteriorated to a and his , sacral had also deteriorated to a . The note went on to again instruct staff not to allow the resident to use the his brief , and to

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contact the HHA for assistance with the resident when needed. There were additional notes written on and stating that the wounds for resident #1 remained at a . On there was an HHA note that indicated the wounds had decreased in size and were at that time. On a HHA note indicated the wounds were still , but that there was no dressing in place at the time of the visit and that the resident had bowel movement on his bottom. On and HHA notes indicated that the wounds were still the same size with degregration to the surrounding tissue and again noted that there was no dressing in place and no barrier cream observed on the resident's skin. On the HHA nurse made a note that care at the facility had been ineffective and included a assessment that indicated the resident's wounds continued to be a but showed increase in measurements with the on his right measuring 2.5cm x 8.0cm x 0.1cm.

Interview with aide D on at approximately 3:00 pm indicated she had heard other staff say that they didn't change resident #1, or get him up, and that if he didn't get up to go to the medication medications or the dining meals, they would not give his his medications or food. She also stated that resident #6 had shortness of breat ( ) and used . She stated that one evening he was really short of breath and refused to get up to go get his medications. She stated that she went and asked the medication technician if she would take the resident's medications to him because of his and she stated that she would not because it was a facility rule that residents had to come to the medication get their medications, so she had to assist resident #6 to get up and go to the medication , even though he was really short of breath.

Interview with aide E on at approximately 3:10 pm indicated she was aware that resident #1 was of and bowel, and he had 5-6 wounds on his bottom that home health provided care for. She stated that the dressings would not stay on his wounds, and he would moan in pain when she cleaned him. She stated that resident #1 had called 911 (emergency medical services) one time saying the staff wouldn't get him out of bed, but stated they normally only have 2 aides on the evening shift, and it took a long time to get to the resident when he needed something.

Interview with staff G on 11/ at approximately 5:00 pm revealed that residents were required to get up and go to the medication all their medications. She stated that staff pick and choose who they will take medications to, but this practice didn't happen very often at all. She stated that if the residents didn't get up, they made a really big deal out of it to the resident and then they would circle the resident's medications on the medication observation record (MOR) to indicate that the resident had refused the medications. She stated that they do the same thing with meals, and if the resident didn't get up and go to the dining , they may not get food. She stated that sometimes they will keep a plate in the kitchen for residents who do not get up at meal time, and sometimes they won't, which means the

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residents who did not get up had to go without food. She further stated that resident #6 was short of breath due to his illness, and was on . . She stated that one evening he was extremely short of breath and said he couldn't go get his medications, so she went to tell the medication technician this, and they said "no, he has to come to the med . ." I explained he was but they stated "no, it is a rule that all residents come to the med meds." I went back and assisted resident #6 and he said, "I am too ," but I helped him to the med .

Interview with aide F on a 10:52 am indicated resident #1 had sores on his bottom and they looked really bad. The aide stated that the resident experienced loose stools frequently and that the dressings would not stay on the wounds.

Interview with staff B on 11/ at 2:15 pm indicated she was aware that the resident had "a couple of sores to his bottom." She stated that resident #1 was receiving home health services including physical , , and that he had lost some weight, which she thought was a result of the increased activitiy from the , services, and that the physician had been notified of the weight loss and its cause.

On at approximately 12:00 noon an interview was conducted with resident #1 who stated that he was neglected by staff and would often sit in a soiled brief for hours, one time having to stay in the soiled brief for approximately 36 hours. He confirmed that he did have wounds on his bottom and stated that they were very painful. He stated home health provided care of the wounds, but that the dressings that were placed would not stay on due to his chronic . He went on to explain that there was not enough staff at the facility between 4:00 pm and 9:00 pm nightly to care for the residents and that with only 2 staff present it often took about five hours to get assistance. He also stated that there was a rule at the facility that all residents had to go to the medication receive their medications, but he had to have assistance to get up and get to the medication , and that at times he was not able to go due to his from his medical conditions, chronic , and pain from his wounds. He stated that on the occassions he has not been able to go to the medication , and as a result, had not received his medications on those occassions. He stated that the same rule applies to meals and that residents are required to get up and go to the dining get their food. He stated that on the occassions he has not been able to get up and go to the dining , he has gone without food and has experienced weight loss due to this. He stated that he has asked, but staff refuse to bring his food or medications to his he is not able to get up.

Interview with aide H on at 2:00 pm indicated the rule at the facility was that residents had to go to the dining all meals. She stated that if the resident didn't go to the dining , they would hold a plate for the resident in the kitchen, but the resident would have to get up and go to the kitchen to get the plate of food, warm it up, and eat it. She stated that resident #6 would sometimes refuse to come

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down to get his medications and they would circle them on the resident's medication observation record (MOR) as refused.

On at 3:12 pm an interview was conducted with resident #6. He stated that staff at the facility treated the residents awful and that the administrator didn't care about them either. He stated that it was a rule at the facility that all residents had to go to the dining eat and to the medication receive their medications and that staff would not bring either to them. He went on to explain that staff actually make a big deal when he wouldn't get up to go to the dining would make him feel bad about it. He stated that he required assistance with ambulation, and that he was always short of breath ( ) and had to use supplemental to help with this chronic condition. He stated that because of his condition, he was not always able to get up and go to the medication the dining . Review of the resident's health assessment, dated showed that resident #6 required assistance with ambulation and required supplemental .

An interview was conducted with the facility administrator on at 4:30 pm. She indicated the facility didn't have rules that the residents had to go to the medication the dining order to get food or medications, but stated that it is highly encouraged for each resident as there was not enough staff to go to all the during medication administration times.

Review of the facility rules provided to all residents at the time of admission made no mentions that residents would be asked or required to go to a medication receive their medications; however, it did state that meals would only be served in a resident's a seven day time period unless prescribed otherwise by a physician.

An interview was conducted with staff aide D on 11/ at approximately 3:00 pm. She stated that residents at the facility are neglected by some staff and that she has overheard another staff member laugh and joke about "flicking the nose" of a resident (#9), and was aware of an incident with resident #10 where a staff member caused a to the resident's leg with her fingernail while trying to hold the resident down by the legs. She stated that neither incident had been reported to administration at the facility.

An interview was conducted with staff aide G on 11/ at approximately 5:00 pm. Aide G stated that she had witnessed the incident involving resident #10 and stated that some staff were rough with the residents. She stated that the resident was kicking his legs, and that another staff member was attempting to hold his legs down and gouged her nail into the back of the resident's calf, causing a that " a lot." She stated that staff wrapped the resident's leg with a gauze, but did not report the incident to anyone else within the facility. Aide G stated that resident #9 was and could

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become combative with staff at times, but stated that while receiving report from the offgoing staff one day, the same staff member involved in the incident with resident #10 was bragging about "flicking" the nose of resident #9 when the resident became combative with her. She stated that this incident had also not been reported to anybody as far as she knew.

Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on record review, resident and staff interview, and review of facility rules, the facility failed to ensure that 2 of 3 residents sampled (#1 and #6) obtained the assistance required to receive their physician ordered medications.

The findings include:

Interview with aide D on at approximately 3:00 pm indicated she had heard other staff say that they didn't get resident #1 up, and that if he didn't get up to go to the medication medications, they would not give his his medications. She also stated that resident #6 had shortness of breat ( ) and used . She stated that one evening he was really short of breath and refused to get up to go get his medications. She stated that she went and asked the medication technician if she would take the resident's medications to him because of his and she stated that she would not because it was a facility rule that residents had to come to the medication get their medications, so she had to assist resident #6 to get up and go to the medication , even though he was really short of breath.

Interview with aide E on at approximately 3:10 pm indicated that resident #1 had called 911 (emergency medical services) one time saying the staff wouldn't get him out of bed, but stated they normally only have 2 aides on the evening shift, and it took a long time to get to the resident when he needed something.

Interview with staff G on at approximately 5:00 pm revealed that residents were required to get up and go to the medication all their medications. She stated that staff pick and choose who they will take medications to, but this practice didn't happen very often at all. She stated that if the residents didn't get up, they made a really big deal out of it to the resident and then they would circle the resident's medications on the medication observation record (MOR) to indicate that the resident had refused the medications. She further stated that resident #6 was short of breath due to his illness, and was on . She stated that one evening he was extremely short of breath and said he couldn't go get his medications, so she went to tell the medication technician this, and they said "no, he has to come

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to the med ." She stated that she explained he was , but they stated "no, it is a rule that all residents come to the med meds." I went back and assisted resident #6 and he said, "I am too ," but I helped him to the med .

On at approximately 12:00 noon an interview was conducted with resident #1 who stated that there was not enough staff at the facility between 4:00 pm and 9:00 pm nightly to care for the residents and that with only 2 staff present it often took about five hours to get assistance. He also stated that there was a rule at the facility that all residents had to go to the medication receive their medications, but he had to have assistance to get up and get to the medication , and that at times he was not able to go due to his from his medical conditions, chronic , and pain from his wounds. He stated that on the occassions he has not been able to go to the medication , and as a result, had not received his medications on those occassions. He stated that he has asked, but staff refuse to bring his medications to his he is not able to get up.
The resident's health assessment, dated , revealed resident #1 needed assistance with activities of daily living and medications.

Interview with aide H on at 2:00 pm indicated that resident #6 would sometimes refuse to come down to get his medications and they would circle them on the resident's medication observation record (MOR) as refused.

On at 3:12 pm an interview was conducted with resident #6. He stated that staff at the facility treated the residents awful and that the administrator didn't care about them either. He stated that it was a rule at the facility that all residents had to go to the medication receive their medications and that staff would not bring medications to them. He went on to explain that staff actually make a big deal when he wouldn't get up to go to the medication would make him feel bad about it. He stated that he required assistance with ambulation, and that he was always short of breath ( ) and had to use supplemental to help with this chronic condition. He stated that because of his condition, he was not always able to get up and go to the medication .
Review of the resident's health assessment, dated showed that resident #6 required assistance with ambulation and required supplemental .

An interview was conducted with the facility administrator on at 4:30 pm. She indicated the facility didn't have rules that the residents had to go to the medication order to get medications, but stated that it is highly encouraged for each resident as there was not enough staff to go to all the during medication administration times.

Review of the facility rules provided to all residents at the time of admission made no mention that

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residents would be asked or required to go to a medication receive their medications.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on record review and resident and staff interview, the facility failed to ensure it had enough staff to provide resident supervision, and to provide care and services related to care, medications and meal service for 2 of 3 residents sampled (#1 and #6).

The findings include:

Interview with aide D on at approximately 3:00 pm indicated she had heard other staff say that they didn't change resident #1, or get him up, and that if he didn't get up to go to the medication medications or the dining meals, they would not give his his medications or food. She also stated that resident #6 had shortness of breat ( ) and used . She stated that one evening he was really short of breath and refused to get up to go get his medications. She stated that she went and asked the medication technician if she would take the resident's medications to him because of his and she stated that she would not because it was a facility rule that residents had to come to the medication get their medications, so she had to assist resident #6 to get up and go to the medication , even though he was really short of breath.

Interview with aide E on at approximately 3:10 pm indicated that resident #1 had called 911 (emergency medical services) one time saying the staff wouldn't get him out of bed, but stated they normally only have 2 aides on the evening shift, and it took a long time to get to the resident when he needed something.

Interview with staff G on at approximately 5:00 pm revealed that residents were required to get up and go to the medication all their medications. She stated that staff pick and choose who they will take medications to, but this practice didn't happen very often at all. She stated that if the residents didn't get up, they made a really big deal out of it to the resident and then they would circle the resident's medications on the medication observation record (MOR) to indicate that the resident had refused the medications. She stated that they do the same thing with meals, and if the resident didn't get up and go to the dining , they may not get food. She stated that sometimes they will keep a plate in the kitchen for residents who do not get up at meal time, and sometimes they won't, which means the residents who did not get up had to go without food. She further stated that resident #6 was short of breath due to his illness, and was on . She stated that one evening he was extremely short of breath and said he couldn't go get his medications, so she went to tell the medication technician this,

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and they said "no, he has to come to the med ." I explained he was but they stated "no, it is a rule that all residents come to the med meds." I went back and assisted resident #6 and he said, "I am too ," but I helped him to the med .

Interview with staff B on 11/ at 2:15 pm indicated that resident #1 was receiving home health services including physical , , and that he had lost some weight, which she thought was a result of the increased activitiy from the , , services, and that the physician had been notified of the weight loss and its cause.

On at approximately 12:00 noon an interview was conducted with resident #1 who stated that he was neglected by staff and would often sit in a soiled brief for hours, one time having to stay in the soiled brief for approximately 36 hours. He confirmed that he did have wounds on his bottom and stated that they were very painful. He stated home health provided care of the wounds, but that the dressings that were placed would not stay on due to his chronic . He went on to explain that there was not enough staff at the facility between 4:00 pm and 9:00 pm nightly to care for the residents and that with only 2 staff present it often took about five hours to get assistance. He also stated that there was a rule at the facility that all residents had to go to the medication receive their medications, but he had to have assistance to get up and get to the medication , and that at times he was not able to go due to his from his medical conditions, chronic , and pain from his wounds. He stated that on the occassions he has not been able to go to the medication , and as a result, had not received his medications on those occassions. He stated that the same rule applies to meals and that residents are required to get up and go to the dining get their food. He stated that on the occassions he has not been able to get up and go to the dining , he has gone without food and has experienced weight loss due to this. He stated that he has asked, but staff refuse to bring his food or medications to his he is not able to get up. The resident's health assessment, dated , revealed resident #1 needed assistance with activities of daily living and medications. Review of the resident's weights showed that he weighed 173 pounds in , 2017 and 160 pounds in 2017 for a 13 pound decline in one month.

Interview with aide H on at 2:00 pm indicated the rule at the facility was that residents had to go to the dining all meals. She stated that if the resident didn't go to the dining , they would hold a plate for the resident in the kitchen, but the resident would have to get up and go to the kitchen to get the plate of food, warm it up, and eat it. She stated that resident #6 would sometimes refuse to come down to get his medications and they would circle them on the resident's medication observation record (MOR) as refused.

On at 3:12 pm an interview was conducted with resident #6. He stated that staff at the facility

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treated the residents awful and that the administrator didn't care about them either. He stated that it was a rule at the facility that all residents had to go to the dining eat and to the medication receive their medications and that staff would not bring either to them. He went on to explain that staff actually make a big deal when he wouldn't get up to go to the dining would make him feel bad about it. He stated that he required assistance with ambulation, and that he was always short of breath ( ) and had to use supplemental to help with this chronic condition. He stated that because of his condition, he was not always able to get up and go to the medication the dining . Review of the resident's health assessment, dated showed that resident #6 required assistance with ambulation and required supplemental .

An interview was conducted with the facility administrator on at 4:30 pm. She indicated the facility didn't have rules that the residents had to go to the medication the dining order to get food or medications, but stated that it is highly encouraged for each resident as there was not enough staff to go to all the during medication administration times.

Review of the facility rules provided to all residents at the time of admission made no mentions that residents would be asked or required to go to a medication receive their medications; however, it did state that meals would only be served in a resident's a seven day time period unless prescribed otherwise by a physician.

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on record review and resident and staff interview, the facility failed to ensure that the nutritional needs for 1 of 3 residents (#1) were met, and failed to offer meals in alternate locations (other than the dining) for 2 of 3 residents (#1 and #6) whose physical limitations prevented them from eating in the dining times.

The findings include:

On at approximately 12:00 noon an interview was conducted with resident #1 who stated there was a rule at the facility that all residents had to go to the dining meals, but that at times he was not able to go due to from his medical conditions, chronic , and pain from his wounds. He stated that on those occassions he has not been able to get up and go to the dining , he has gone without food and has experienced weight loss due to this. He stated that he has asked, but staff refuse to bring his food to his he is not able to get up.
The resident's health assessment, dated , revealed resident #1 needed assistance with activities of daily living and medications. Review of the resident's weights showed that he weighed 173 pounds in 2017 and 160 pounds in 2017 for a 13 pound decline in one month.

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On at 3:12 pm an interview was conducted with resident #6. He stated that staff at the facility treated the residents awful and that the administrator didn't care about them either. He stated that it was a rule at the facility that all residents had to go to the dining eat and staff would not bring their meals to them. He went on to explain that staff actually make a big deal when he wouldn't get up to go to the dining would make him feel bad about it. He stated that he required assistance with ambulation, and that he was always short of breath ( ) and had to use supplemental to help with this chronic condition. He stated that because of his condition, he was not always able to get up and go to the dining .
Review of the resident's health assessment, dated showed that resident #6 required assistance with ambulation and required supplemental .

Interview with aide D on at approximately 3:00 pm indicated she had heard other staff say that they didn't get resident #1 up, and that if he didn't get up to go to the dining meals, they would not give him his food.

Interview with aide E on at approximately 3:10 pm indicated that resident #1 had called 911 (emergency medical services) one time saying the staff wouldn't get him out of bed, but stated they normally only have 2 aides on the evening shift, and it took a long time to get to the resident when he needed something.

Interview with staff G on at approximately 5:00 pm revealed that residents were required to get up and go to the dining all their meals. She stated that if the resident didn't get up and go to the dining , they may not get food. She stated that sometimes they will keep a plate in the kitchen for residents who do not get up at meal time, and sometimes they won't, which means the residents who did not get up had to go without food.

Interview with staff B on at 2:15 pm indicated that resident #1 was receiving home health services including physical and that he had lost some weight, which she thought was a result of the increased activitiy from the services, and that the physician had been notified of the weight loss and its cause.

Interview with aide H on at 2:00 pm indicated the rule at the facility was that residents had to go to the dining all meals. She stated that if the resident didn't go to the dining , they would hold a plate for the resident in the kitchen, but the resident would have to get up and go to the kitchen to get the plate of food, warm it up, and eat it.

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An interview was conducted with the facility administrator on at 4:30 pm. She indicated the facility didn't have rules that the residents had to go to the dining order to get food.

Review of the facility rules provided to all residents at the time of admission stated that meals would only be served in a resident's a seven day time period unless prescribed otherwise by a physician.