STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105379	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kissimmee Health and Rehabilitation Center	320 N Mitchell St Kissimmee, FL 34741

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on interview and record review, the facility failed to follow their grievance process related to expressed concerns for care for 2 of 3 residents reviewed for grievances, of a total sample of 8 residents, (#2 and #4). Findings: 1. Resident #2 was admitted to the facility on [DATE] and readmitted on [DATE] from an acute care hospital. Her diagnoses included stroke, dementia, and urinary tract infection. Review of the quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) of 3/17/24 revealed a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated moderate cognitive impairment. Review of resident #2's medical record showed her son was her responsible party. On 4/29/24 at 4:28 PM, during a telephone interview, resident #2's son stated he found out his mother sustained a fall in the facility when he visited her in the hospital on 4/06/24. He explained he saw a bruise on her left leg and wanted to know the details of her fall. He mentioned his mother mentioned the fall to the hospital staff and they told him that information was not included in the report from the facility. He indicated he called the facility and spoke with the Director of Nursing (DON). He stated he requested a meeting with the Interdisciplinary Team (IDT) to address his concerns about his mother's care, but no one had called him. Review of the Grievance Log for April 2024 revealed no grievances for resident #2. On 4/30/24 at 3:37 PM, the DON recalled receiving a phone call from resident #2's son a couple of days after she was transferred to the hospital. The DON reviewed the transfer to the hospital documentation and acknowledged it did not include information that resident #2 sustained a fall. She stated the documentation listed abdominal pain as the reason for the transfer. She said the resident had complained of abdominal pain that day, but it would have been important for the hospital to know she also fell . She indicated resident #2's son asked why his mother was sent to the hospital. She stated she explained to him the pain she was having during the morning, her refusal for pain medication and then the fall. She confirmed she told resident #2's son they would set up a care plan meeting after resident #2 returned from the hospital. She acknowledged she had not called him to set up the meeting or followed up with him since the phone call over 2 weeks ago. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #4 was readmitted to the facility on [DATE]. His diagnoses included hemiplegia (one-sided paralysis) and hemiparesis (one-sided weakness) following a stroke, convulsions, and anxiety. Review of the quarterly MDS assessment with ARD of 3/29/24 revealed resident #4 had a BIMS score of 15 which indicated he was cognitively intact. The assessment noted no rejection of care. On 4/29/24 at 11:06 AM, resident #4 stated his meal tray was periodically not included in the carts and it happened mostly for dinner. He explained the last incident happened on Saturday evening. He stated Certified Nursing Assistants (CNAs) were passing out trays to other residents, but his tray was not available. He stated the kitchen staff was, Not making up his tray on purpose. He said he knew when the tray was not included in the cart because his meal ticket would not be included with his tray. He said, It's a joke to them, they do it to be funny. He stated kitchen staff was supposed to include a ginger ale with his meals, but this was not always the case. He indicated he stopped complaining about things because nothing was done. He stated he had spoken to the Social Services Director (SSD) on more than one occasion about his concerns, but the facility did not do anything. He stated he had requested certain CNAs not be assigned to his care, but they still assigned them to him at times. He said, Abuse to an elderly person is a felony, and he required assistance from staff because he was paralyzed on his left side. He stated he called the police on Saturday because this facility did nothing to address his concerns. He mentioned the Administrator came to the facility after he called the police on Saturday but did not come to his room to speak to him. On 4/30/24 at 2:10 PM, during a telephone interview, the weekend supervisor explained her responsibilities included addressing any issues or concerns brought up by residents or families. She stated she completed grievance forms and dropped them in the SSD box. She recalled resident #5 called the cops last Saturday and complained about food portions and he was wet. She stated when staff checked resident #4, he was dry. She mentioned he did not inform staff about his concerns, just called the cops. She stated she accompanied the police officer to resident #4's room but he said he did not want to talk to her, and she left. She stated when the police officer finished talking to resident #4, the officer told her about his concerns which were food portion and being wet. She stated she tried talking to resident #4 again after the police left but he refused to talk to her. She indicated she called the Administrator while the police officer was in the facility. She stated she was not aware of any previous calls to the police by resident #4. She explained she spoke with resident #4's assigned nurse and CNA. She explained the nurse was unaware of any complaints. She indicated CNA A told her she had to go to the kitchen to get his tray because it was not included in the cart. She stated she was aware resident #4 did not want certain CNAs assigned to him so she accommodated his preference. She explained she would normally fill out a grievance form in a situation like this, but this time resident #4 did not want to speak to her, and she would have needed the interview to include it on the form. She stated this was the reason she called the Administrator. On 4/30/24 at 3:19 PM, during a telephone interview, CNA A explained she was assigned to the dining room during supper last Saturday. She stated the floor CNAs passed the trays to her residents. She mentioned the CNAs told her they did not see resident #4's tray in the cart and resident #4 had asked them, You don't see my food in the cart? She said the CNA told him she would get him a tray from the kitchen, and he repeatedly said he did not want it. She stated the CNA went to the kitchen and brought him a tray anyway, which he ate. She stated she did not know why the kitchen forgot his tray, because they have, To go slowly with him. She acknowledged he liked to get ginger ale with his meals and indicated he got mad when he did not get it, which sometimes happened. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/29/24 at 3:59 PM, the Administrator stated the SSD was the Grievance Officer, but was not available this week. He explained anyone could file a grievance and the forms were found at the nurses' station and the lobby. He explained they tried to resolve grievances within 72 hours. He explained grievances were discussed in the morning meeting. He stated if a resident or his/her family mentioned they felt neglected, abused, or unsafe, it was reported as required immediately and an investigation was initiated. He said he was the Abuse Coordinator. On 4/30/24 at 12:27 PM, the DON stated the weekend supervisor told her resident #4 had concerns about his food during the weekend. She indicated she went to talk to him and completed a grievance form. She explained resident #4 told her his tray was not included in the cart when staff was passing them. The Administrator stated resident #4 called the police and reported he was not getting enough food. The Administrator indicated he came to the facility last Saturday and spoke with the police. He confirmed he did not talk to resident #4 that day. The Administrator stated he talked to the weekend supervisor who confirmed resident #4 received a meal tray. When asked if resident #4 had called the police previously, both the Administrator and the DON stated he had not. The Administrator explained there were grievance forms by the nurses' station, the weekend supervisor should have completed a grievance form with resident #4's concerns. On 4/30/24 at 4:34 PM, the Unit Manager (UM) stated she was aware of at least 3 CNAs resident #4 did not want assigned to him. She said, Everybody knows which CNAs shouldn't be assigned to him, and confirmed nurses had assigned them at times. She explained last Wednesday she heard resident #4 called the police for the first time because of concerns with his meal. She stated his concerns were discussed with the psychiatrist last Friday. Later at 4:57 PM, the UM stated when she came in a few minutes before 9:00 AM last Wednesday, the police were in the facility talking to resident #4. She recalled the Administrator spoke with the police officer and later the DON and Administrator spoke with resident #4. She stated she learned on Sunday, resident #4 called the police about the same food issue. She indicated she did not write a grievance form last week because the police officer told her he had eaten his meal already and instead she contacted the physician and psychological services. On 4/30/24 at 5:46 PM, the Administrator stated he did not remember resident #4's call to the police last week. The DON indicated they were in a morning meeting when the police came in to speak with resident #4. The Administrator and DON stated they were unaware resident #4's food concerns were discussed during the care plan meeting on 4/17/24. The Administrator stated he did not speak with resident #4 last Wednesday or Saturday after the visit from the police. The Administrator stated a grievance and follow up should have been done to address resident #4's concerns. Review of the Care Plan Meeting Minutes dated 4/17/24 revealed resident #4 was in attendance. The Resident/Family Concerns section read, Some food concerns - all were addressed & noted by dietary. On 4/30/24 at 5:55 PM, the MDS Coordinator and the Dietary Manager explained the food concerns mentioned by resident #4 during the care plan meeting on 4/17/24 were related to food likes and dislikes. The Dietary Manager stated she updated his preferences the next day. The MDS Coordinator stated if a resident brought up a concern about food temperature or an actual concern they completed a grievance form. The MDS Coordinator stated resident #4's concerns, Did not seem like a grievance, to the IDT. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the police Event Report dated 4/27/24 at 6:42 PM, read, Subject was complaining of not getting the proper food for meals and staff taking too long to change his diapers. Head Administrator was contacted and wanted a statement from me regarding the incident for them to document. Review of the facility's policy titled Resident and Family Grievances revised on 3/08/22 read, It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination reprisal or fear of discrimination of reprisal. The policy included, The Grievance Officer is responsible for overseeing the grievance process; receiving and tracing grievances through to their conclusion; leading any necessary investigation by the facility; maintaining the confidentiality of all information associated with grievances, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations. The document indicated the grievance may be voiced by a verbal complaint to a staff member or the Grievance Official. The policy revealed the staff member who received the grievance was to record the nature and specifics of the grievance on the designated grievance form or assist the resident or family member to complete the form. The procedure directed staff to Take any immediate actions needed to prevent further potential violations of any resident right. It concluded with The facility will make prompt efforts to resolve grievances.