

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105756	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER Life Care Center of Hilliard		STREET ADDRESS, CITY, STATE, ZIP CODE 3756 W Third St Hilliard, FL 32046	
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30969 Based on a record review, interviews, and facility policy review, the facility failed to thoroughly investigate allegations of abuse for two (Residents #1 and #5) of three residents reviewed for abuse, from a total sample of 5 residents. The findings include: 1. A record review for Resident #1 found she was admitted on [DATE] and readmitted on [DATE]. Her diagnoses included fracture of the upper end of the left humerus (the long bone between the shoulder and elbow). A review of Resident #1's Discharge Return Anticipated minimum data set (MDS) assessment with a reference date 12/24/24 noted Resident #1 had OK memory and was independent with daily decision making. She required substantial to maximum assistance with toileting and partial to moderate assistance to move from sitting to standing and transfers. On 1/13/25 at 2:00 pm, an interview was conducted with Resident #1. She explained she had fallen and broke her humerus in two places which resulted in a loss of dignity with her decline in activities of daily living (ADL). She complained that recently, she had asked for assistance wiping herself due to her broken shoulder. Her CNA told her staff was there to encourage her independence. Resident #1 felt that was abuse, given the way the CNA said it, so she reported it. She was fearful of retaliation, so she hesitated at first. Resident #1 had never had a problem with that CNA (she did not recall her name) but only had her once. When asked if she was satisfied with the facility response and resolution, Resident #1 shrugged and said she and her daughter were told in her care plan meeting the CNA had been suspended. She was not sure if she was fired or still worked in the facility. A review of nursing progress notes revealed on 12/6/24, Resident #1 was found on the floor in her bathroom. She was laying on her back, holding her left shoulder and complaining of pain. Staff called paramedics and she was transferred to the emergency room . She returned with a diagnosis of left humerus fracture with a sling on that shoulder. A progress note dated 12/10/24 revealed Resident #1 had a care plan meeting with her daughter present. Concerns with staffing were discussed, and the DON informed the resident/daughter she was having the situation investigated. There were no further details. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 105756	Facility ID: 105756 If continuation sheet Page 1 of 4

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Nursing Home Federal Report authored by the Director of Nursing (DON) revealed on 12/8/24 at 3:06 pm, Resident #1 made an allegation of physical abuse by Certified Nursing Assistant (CNA) A. After being assisted to the bathroom and calling the CNA back, Resident #1 instructed the CNA to wipe her with a wet wipe then dry her with toilet paper. CNA A told Resident #1 they were there to encourage her to be independent. Resident #1 explained she had broken her arm and could not do it for herself. When Resident #1 attempted to raise herself from the toilet, CNA A roughly helped her up, roughly wiped her buttocks, then did not assist her to walk back to her chair. Resident #1 later informed Licensed Practical Nurse (LPN) A that she didn't want CNA A for the rest of the night. The investigation section of the report noted the Unit Manager spoke with Resident #1 and asked permission to write down her statement. The weekend supervisor spoke with Resident #1's daughter. CNA A was interviewed by the DON and was suspended pending investigation. Conclusion: a statement was collected from the resident and all associates and allegations were found to be unverified. A final warning was given to CNA A related to customer service. (Photographic evidence was obtained) A review of the facility's investigation file revealed written statements were obtained from the Unit Manager, LPN A and CNA A. There was no indication other staff, or residents on CNA A's assignment, were interviewed about their care or concerns. (Photographic evidence was obtained) On 1/13/25 at 3:23 pm, the DON was interviewed and confirmed she was the Abuse Coordinator. She stated that when she receives a resident grievance, she talks with the resident or family about their concern(s). If the concern rises to the level of neglect or abuse, that triggers her to investigate. This would involve obtaining written statements, reporting to Department of Children and Families and to the Agency. An in-house investigation is conducted and staff who were assigned to that resident around the time of the incident are interviewed. Other alert and oriented residents on the same hall are also interviewed about the CNA. Resident #1 had an incident over a weekend, and the DON was advised on that Monday. The Unit Manger took a written statement from Resident #1, who alleged she needed help with wiping wet to dry. The CNA did not help her back to the bed and had told the resident staff were there to encourage independence. Resident #1 told the nurse she didn't want that CNA any more. As a result of the allegations, CNA A was removed from the schedule and suspended. CNA was allowed to return and received a corrective action for poor customer service/ job performance. When the DON was asked if she had interviewed residents on the same hall about CNA A's care. She said no, but she should have. The DON said she was handling so many reportable incidents at that time; she had never seen so many and was learning as she goes. The DON acknowledged the missed opportunity to identify residents on same hall who may have similar concerns. She expressed an understanding that some may be fearful of reporting. The DON said Resident #1 and her daughter were notified the incident was reported, and CNA A was suspended pending investigation. She did not advise them of the final outcome of the investigation. She was not sure she could tell the resident(s) that. 2. A record review for Resident #5 found she was admitted [DATE]. Her diagnoses included orthopedic aftercare and fracture of the right femur. A review of the Quarterly MDS assessment dated [DATE] revealed Resident #5 had a brief interview for mental status (BIMS) score of 4 out of 15 points, indicating severe cognitive impairment. She required substantial to maximum assistance with ADLs. No anticoagulant medication (blood thinner) was used. A skin check assessment dated [DATE] reported no skin issues. The following assessment dated [DATE] noted bilateral dark bruising to both of Resident #5's hands. (Photographic evidence was obtained) (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Nursing Home Federal Report authored by the DON found on 12/16/24, Resident #5's family notified the Administrator and DON of bruising on both of her hands. Assessment confirmed bruising on the top of each hand. Because of a diagnosis of dementia, Resident #5 was unable to explain what happened. An investigation was conducted, revealing the resident stated the bruises 'just come up' there sometimes. Her diagnoses included cognitive communication deficit and dementia, with a BIMS of 4. The weekly skin check 12/13/24 was noted to reveal bruising. The investigation summary concluded by reporting Resident #5 was complaining of hand pain. Conclusion: the allegation was not verified due to evidence obtained during the investigation. It was not determined how bilateral bruising occurred. Weekly skin checks were conducted by the nurse per policy. Staff was interviewed and ongoing education with staff about transfers and timely reporting were being conducted. Review of the investigation file contained only two written witness statements. One was the DON's, which reported she accompanied a DCF worker to speak with Resident #5. Resident #5 told the worker the bruises just come up there. Resident #5 denied being struck by anyone. The second statement in the file was from a CNA who remembered a large bruise on one of Resident #5's hand; the second bruise was newer to when she last had this resident. (Photographic evidence was obtained) There was no indication that any residents on the same hall were interviewed about their care or rough transfers or treatment by staff. On 1/13/25 at 3:55 pm, an interview was conducted with the DON. She stated as part of her investigation, she interviewed two employees on the schedule who had nothing to report. She admitted she did not interview other residents on the hall. A review of the facility's policy titled, Abuse-Conducting an Investigation issued 10/4/22, reviewed 6/17/24 instructs: Policy: It is the policy of this facility that allegations of abuse (abuse, neglect, mistreatment, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated . .3. When an incident or suspected incident of resident abuse and/or neglect, injury of unknown source, exploitation, or misappropriation of resident property is reported, the administrator/designee will investigate the occurrence. Protection will be provided to the alleged victim and other residents, such as room or staffing changes as needed to protect the resident(s) from the alleged perpetrator. a. If the investigation is being conducted by the designee, the administrator will be consulted daily concerning the progress of the investigation . .8. The written summary of the investigation should include, but is not limited to: .h. Interviews with staff members on all shifts having contact with the resident at the time of the incident. i. Interviews with the resident's roommate, family, and/or visitors who may have information regarding the incident. j. Interviews other residents who received care or services from the alleged perpetrator. (continued on next page)		

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