

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

Printed: 09/27/2024
Form Approved OMB
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 07/11/2024
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45951 Based on observations, interviews, and record reviews, the facility failed to maintain residents' dignity while dining related to staff standing while assisting with meals and tablemates not being served trays together for six (Residents #106, #4, #8, #75, #21, and #6) of eight residents reviewed for dignity, from a total of 44 residents in the survey sample. The findings include: 1. On 7/8/24 at 5:33 PM, Resident #106 was observed being assisted with his dinner tray by Certified Nursing Assistant (CNA) G, who was observed standing while assisting the resident with his meal. Resident #106 was admitted to the facility on [DATE] with a medical history significant for paraplegia, right hand contracture, and macular degeneration. A review of Resident #106's Quarterly Minimum Data Set (MDS) assessment, dated 5/24/24, revealed he had a Brief Interview for Mental Status (BIMS) Score of 12 out of 15 possible points, indicating moderate cognitive impairment. He was also documented as requiring set up assistance for his meals. Additional observations of Resident #106 were made during the survey week as follows: On 7/9/24 at 11:53 AM, Resident #106 was observed being assisted with his lunch tray by CNA H, who was observed standing while assisting the resident with his meal. On 7/9/24 at 5:13 PM, Resident #106 was observed being assisted with his dinner tray CNA I, who was observed standing while assisting the resident with his meal. On 7/10/24 at 11:50 AM, Resident #106 was observed being assisted with his lunch tray CNA G, who was observed standing while assisting the resident with his meal. An interview was conducted with Resident #106 on 7/10/24 at 9:50 AM. He stated he would like it if the staff sat with him while assisting him with his meals. 2. On 7/8/24 at 5:30 PM, Resident #4 was observed being assisted with her dinner tray by CNA P, who was observed sitting on Resident #4's bed while assisting the resident with her meal. (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 9

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4 was last readmitted to the facility on [DATE] with a medical history significant for dementia, malnutrition, failure to thrive, anxiety, and depression. A review of Resident #4's Significant Change MDS assessment, dated 6/27/24, revealed that Resident #4 had a BIMS score of 2 out of 15 points, indicating severe cognitive impairment. She was also documented as dependent on staff for assistance with her meals. Additional observations were made of Resident #4 during the survey week as follows: On 7/9/24 at 5:15 PM, Resident #4 was observed being assisted with her dinner tray by CNA Q, who was observed sitting on Resident #4's bed while assisting the resident with her meal. On 7/10/24 at 11:48 AM, Resident #4 was observed being assisted with her lunch tray by CNA R, who was observed sitting on Resident #4's bed while assisting the resident with her meal. 3. On 7/8/24 at 5:50 PM, Resident #8 was observed being assisted with her dinner tray by CNA L, who was observed standing while assisting the resident with her meal. Resident #8 was admitted to the facility on [DATE] with a medical history significant for encephalopathy, difficulty swallowing, mini-stroke, hemiparesis, and dementia. A review of Resident #8's Admission MDS assessment, dated 5/24/24, revealed Resident #8 had a BIMS score of 0 out of 15 points, indicating severe cognitive impairment. She was also documented as requiring moderate assistance from staff for her meals. Additional observations were made of Resident #8 during the survey week as follows: On 7/9/24 at 5:38 PM, Resident #8 was observed being assisted with her dinner tray CNA M, who was observed standing while assisting the resident with her meal. On 7/10/24 at 12:04 PM, Resident #8's roommate received her lunch tray but Resident #8 did not. Resident #8 received her lunch tray at 12:17 PM, but no staff were present in the room to assist her with dining. By 12:32 PM, no staff had arrived to assist Resident #8 with her meal. Registered Nurse (RN) N was interviewed at this time. The concern that Resident #8 was left with food in her room and no way to eat it for almost 30 minutes was shared with the nurse. RN N reviewed the CNA assignment log and stated the CNA who was assigned to assist Resident #8 with her meal was also assigned to the dining room, and was therefore unavailable to assist Resident #8 with her meal. RN N was asked if Resident #8 would be left without assistance until the CNA returned from the dining room, and she replied that she would go to Resident #8's room and assist her with her meal. 4. On 7/8/24 at 5:18 PM, Resident #75's roommate received their dinner tray, but Resident #75 did not. At 6:40 PM, Resident #75's dinner meal had still not arrived. Licensed Practical Nurse (LPN) J was interviewed at this time. She stated Resident #6 typically went to the dining room and therefore would have to wait until the last cart of meals was delivered to receive her meal. LPN J stated this was how it always worked and that it often took a long time for the residents to receive their meals if they did not go to the dining room. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #75 was admitted to the facility on [DATE] with a medical history significant for encephalopathy, dementia, malnutrition, mini-stroke, and communication deficit. A review of Resident #75's End of Part A Stay MDS assessment, dated 6/7/24, revealed a BIMS score of 0 out of 15 points, indicating severe cognitive impairment. The resident was also documented as independent with meals. On 7/9/24 at 5:10 PM, Resident #75's roommate received their dinner tray, but Resident #75 did not. At 6:45 PM, Resident #75's dinner meal had still not arrived. LPN J was interviewed at this time and was asked if Resident #75 would be served dinner this evening. LPN J asked for clarification. She was made aware that all other residents had received their dinner trays at 5:10 PM and the other residents had been taken to the dining room at 6:30 PM by the CNAs, but that Resident #75 had been left asleep in her bed. LPN J was again asked if the resident would be served dinner this night. LPN J picked up the phone and said, Oh, she's going to get dinner. and called the kitchen to bring a tray. 5. On 7/10/24 at 11:33 PM, Resident #21 was observed in bed with her eyes closed. The lunch trays were served to the residents on the hallway, but Resident #21 did not receive a lunch tray. Her roommate was taken to the dining room at 12:17 PM along with other residents from the units, but Resident #21 was left asleep in her bed. At 12:30 PM, Resident #21 had still not been taken to the dining room for her meal. RN N was interviewed at this time. She stated Resident #21 typically went to the dining room for lunch, and that she would call to see if a tray was going to be sent since the resident was asleep. RN N spoke to the kitchen and was told they would send a tray to her room. Resident #21 was last readmitted to the facility on [DATE] with a medical history significant for dementia, diabetes, difficulty swallowing, and esophageal obstruction. A review of Resident #21's Quarterly MDS, dated [DATE], revealed a BIMS score of 3 out of 15 points, indicating severe cognitive impairment. She was also documented as able to eat her meals independently. 6. On 7/8/24 at 5:18 PM, Resident #6's roommate received their dinner tray, but Resident #6 did not. At 6:40 PM, Resident #6's dinner meal had still not arrived. LPN J was interviewed at this time. She stated Resident #6 typically went to the dining room, and therefore would have to wait until the last cart of meals was delivered to receive her meal. LPN J stated this was how it always worked, and that it often took a long time for the residents to receive their meals if they did not go to the dining room. Resident #6 was last readmitted to the facility on [DATE] with a medical history significant for stroke, difficulty swallowing, malnutrition, dementia, and Parkinson's syndrome. A review of Resident #6's Annual MDS assessment, dated 5/24/24, revealed a BIMS score of 3 out of 15 points, indicating severe cognitive impairment. She was also documented as able to eat her meals independently. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 at 1:02 PM, an interview was conducted with the facility's Certified Dietary Manager (CDM). He stated the facility had started serving the meal trays in a new way on 4/24/24 based on nursing suggestions. He further stated they used to serve residents in the dining room mid-meal service but that the nursing staff had recommended they serve the trays to the resident rooms first and serve the dining room last. It was explained that the concern was that the facility was assuming which residents were going to go to the dining room for each meal, the other residents on the floor were served first, and if a resident did not go to the dining room for some reason, they then had to wait a very long time for their meal tray to be served to them. He stated the kitchen had a list of which residents were supposed to be served in the dining room and which residents were receiving restorative dining services. He said the kitchen staff removed the meal tickets from the hall service piles and placed them aside for the dining room service. They would then serve the resident halls, then the dining room, and then review which tickets were left over and serve those residents in their rooms last. He agreed that it could take up to two hours for a resident to receive a meal tray if they decided to not go to the dining room, but that it was ultimately not up to him or his staff in what order the trays were served because they make 110 trays regardless of how they are served to the residents. He further stated he had not been made aware that roommates were not being served their meals together, but he agreed that it was a concern. When asked if he felt the current process for serving meals to the residents was efficient, he stated he did not. When asked if he had expressed any concerns about the current meal service process to the administration staff, he stated he had not. On 7/10/24 at 1:16 PM, an interview was conducted with the facility's Director of Nursing (DON), Administrator, and Regional Director of Clinical Services (RDCS). The abovementioned concerns regarding staff standing while assisting residents with their meals and roommates not being served meals at the same time were shared with them. The DON stated she rounded the floor daily to watch how residents were being cared for and she had not observed the shared concerns, but she and the Administrator agreed that these were concerning for residents' dignity. The Administrator confirmed that the tray line order was changed in April based on nursing suggestions. The Administrator and the DON both verbalized that they had not followed up with staff or residents since the change to see whether the new process was effective. They said they would attempt to change the order of service making the dining room first to be served, so that all residents who chose to stay in their rooms would be served trays together and in a timely manner. On 7/11/24 at 9:40 AM, an interview was conducted with LPN J, who stated the nurses typically did not assist with dining, but she was aware that staff were expected to sit in a chair while assisting a resident with dining and not stand or sit on the resident's bed. On 7/11/24 at 9:45 AM, an interview was conducted with CNA R, who stated she was aware that staff were expected to sit in a chair while assisting a resident with dining and not stand or sit on the resident's bed. On 7/11/24 at 9:55 AM, an interview was conducted with CNA C, who stated she was aware that staff were expected to sit in a chair while assisting a resident with dining and not stand or sit on the resident's bed. On 7/11/24 at 10:05 AM, an interview was conducted with RN N, who stated she was aware that staff were expected to sit in a chair while assisting a resident with dining and not stand or sit on the resident's bed. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled Dignity (Issued: 5/6/19, Reviewed: 9/25/23) revealed: Each resident has the right to be treated with dignity and respect. Interactions and activities with residents by staff must focus on maintaining and enhancing the residents' self-esteem including promoting resident independence and dignity while dining, such as avoiding staff standing over residents while assisting them to eat.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 45951 Based on observations and interviews, the facility failed to ensure a sanitary and orderly interior, by failing to maintain the shower rooms on the 100, 200 and 600 hallways in an orderly and sanitary manner. The findings include: On 07/11/24, during a tour of the facility with the facility's Housekeeping and Laundry Director from 1:18 PM through 2:00 PM, the facility's shower rooms were observed. In the shower room on the 600-hallway, numerous used razors, deodorant sticks/canisters, and hairbrushes were present throughout the shower room, all of which were unlabeled. (Photographic evidence obtained) In the shower room on the 200-hallway, two shower basins were observed, in which were unlabeled, used bath products including used razors, a shower puff, deodorant sticks/canisters and hairbrushes. (Photographic evidence obtained) In the shower room on the 100-hallway, numerous used razors and deodorant sticks/canisters were observed, all of which were unlabeled. There was also a pile of soiled laundry and two bags of linens located on the floor near the toilet. (Photographic evidence obtained) An interview was conducted with Certified Nursing Assistant (CNA) V on 07/11/24 at 1:30 PM. She confirmed that part of her job duties was to assist in showering residents. When asked if she could identify who the bath products in the 600-hallway shower room belonged to, she stated she could not confirm which products belonged to which residents. She further stated she did not know if any of the products were being used by the staff on the residents. An interview was conducted with CNA T on 07/11/24 at 2:00 PM. She confirmed that part of her job duties was to assist in showering residents. When asked if she could identify who the bath products in the 100- or 200-hallway shower rooms belonged to, she stated she could not confirm which products belonged to which residents.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45951 Based on observations and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment, and to help prevent the transmission of communicable diseases and infections, by failing to ensure proper infection control practices during insulin administration, resident dining, gloving, and linen handling. This impacted two (Residents #54 and #4) of 44 residents in the total survey sample, as well as numerous residents in the dining room on 7/10/24 during the breakfast meal, and potentially more receiving assistance with meals and other care from Certified Nursing Assistants (CNAs) Y and C. The findings include: 1. On 7/11/24 at 11:26 AM, an observation was made of Licensed Practical Nurse (LPN) J administering Novolog Insulin (a medication used to control elevated blood sugars) to Resident #54. LPN J did not clean the hub of the Novolog Flex Pen with alcohol prior to inserting the needle. On 7/11/24 at 11:30 AM, an interview was conducted with LPN J, who acknowledged that she did not clean the hub of the Novolog Flex Pen prior to inserting the needle to the insulin syringe. She confirmed that this would be considered an infection control issue, and further stated she should have cleaned the syringe hub with an alcohol prep prior to inserting the needle. On 7/11/24 at 11:58 AM, an interview was conducted with the Director of Nursing (DON), who stated it was her expectation that nursing staff clean the hub of the Flex pen prior to inserting the needle. The DON confirmed that failure to do so would be considered an infection control issue. A review of the facility's policy titled Insulin Pen Administration (Issued: 08/10/22; Revised: 8/30/23), revealed under Policy: The facility will ensure residents with orders for insulin administration through the use of a pen delivery device is performed in accordance with current standards of practice and manufacturer's guidance. A review of the Manufacturer's Guidance revealed: Under Prepare to inject: 5. Wipe the pen tip with an alcohol pad. 6. Remove the seal on the needle cap 7. Twist or push (based on the needle type) the needle straight onto the pen tip. 2. During a tour of the facility on 7/8/24 at 5:30 PM, Resident #4 was observed being assisted with her dinner tray by Certified Nursing Assistant (CNA) P, who was sitting on Resident #4's bed while assisting her with her meal. A review of the medical record revealed that Resident #4 was last readmitted to the facility on [DATE] with a medical history significant for dementia, malnutrition, failure to thrive, anxiety, and depression. A review of the resident's Significant Change minimum data set (MDS) assessment, dated 6/27/24, revealed a brief interview for mental status (BIMS) score of 2 out of 15 possible points, indicating severe cognitive impairment. Resident #4 was documented as dependent on staff for assistance with her meals. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/9/24 at 5:15 PM, Resident #4 was observed being assisted with her dinner tray by Certified Nursing Assistant (CNA) Q, who was sitting on Resident #4's bed while assisting her with her meal. On 7/10/24 at 11:48 AM, Resident #4 was observed being assisted with her lunch tray by CNA R, who was sitting on Resident #4's bed while assisting her with her meal. On 7/10/24 at 1:16 PM, an interview was conducted with the Director of Nursing (DON), Administrator, and Regional Director of Clinical Services (RDCS). The abovementioned concern regarding staff sitting on Resident #4's bed while assisting with her meals was shared. The DON and Administrator agreed that this was a concern. Concerns regarding staff handling resident dinnerware/trays incorrectly, improper handling of linens, wearing gloves in the hallway, and improper procedures for insulin administration were also shared. 3. On 7/10/24, beginning at 8:20 AM, an observation of the dining room during the breakfast meal revealed the following: A dietary staff member was observed bringing a tray of coffee mugs from the kitchen into the dining room. The dietary staff member touched each cup at the top rim/lip with bare hands while placing them on the rack for use in the dining room and before re-entering the kitchen area. CNA Y was observed preparing drinks/coffee and serving beverages while picking up the cups and touching the top rim/lip of the cups, then placing the cups in front of the residents. She did not wash her hands or use hand sanitizer prior to making the beverages, or between serving the cups to different residents. On 7/10/24 at 10:00 AM, CNA C was observed walking in the hallway from a resident's room in front of the nurses' station with gloves on. She entered the oxygen utility room, removed an oxygen tank, and walked back to the nurses' station and down the hallway to a resident's room. She was observed touching doorknobs and key pads with gloves on, and she did not remove the gloves until she completed care for the resident. On 7/10/24 at 10:20 AM, CNA C was observed walking into the clean linen room on the nursing unit, then walking through the hallway with clean linens in both arms cradled against her chest area and against her clothing. She then entered two different residents' rooms to place the linens in them. On 7/10/24 at 11:00 AM, an interview was conducted with CNA C, who stated she had been employed with the facility since April 2024. She received orientation training upon hire. Orientation training consisted of videos and a skills lab check off. She received infection control training via video with an understanding of appropriate hand hygiene, personal protective equipment (PPE), and when and how to use PPE. She stated she had not received any other training to date. She acknowledged that she should not wear gloves in the hallway or place clean linens against her clothing due to possible contamination and risk of spreading germs and infection. On 7/10/24 at 11:20 AM, an interview was conducted with Unit Manager/Registered Nurse (RN) B, who stated the appropriate process for removing clean linens from the linen room on the nursing unit was that staff should go to the clean linen closet, place needed linen in a clean plastic bag, and transport it to the resident's room. She further stated staff were not to wear gloves in the hallway after providing care to a resident due to infection control prevention policies. (continued on next page)		

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