

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105816	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER Lilac at Bayview, The		STREET ADDRESS, CITY, STATE, ZIP CODE 161a Marine Street Saint Augustine, FL 32084	

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)
<p>F 0624</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Prepare residents for a safe transfer or discharge from the nursing home.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30969</p> <p>Based on a record review, interviews, and facility policy and procedure review, the facility failed to provide sufficient preparation and orientation to ensure a safe and orderly discharge for one (Resident #1) of two residents reviewed for facility-initiated discharge. Resident #1 was issued a 30-day notice of discharge for failure to comply with smoking rules, which was then rescinded the next day when she (and her family) was advised she had to leave immediately due to her endangering other residents in the facility. This was after having been provided with 1:1 staff supervision and demonstrating safe smoking practices since. The result was an abrupt, spontaneous discharge to a location 203 miles away from her husband and son/Power of Attorney (POA) which resulted in trauma to the resident and her family.</p> <p>The findings include:</p> <p>A closed record review for Resident #1 revealed she was admitted to the facility on [DATE] and was [AGE] years old. She was discharged from the facility on a facility-initiated discharge on 4/1/24. Her diagnoses included, but were not limited to, unspecified fracture of left pubis, malnutrition, major depressive disorder and generalized anxiety disorder.</p> <p>A review of the Discharge Return Not Anticipated Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 had a brief interview for mental status (BIMS) score of 11 out of 15 points, reflecting moderate cognitive impairment. She was independent with most activities of daily living, requiring only supervision with showering and lower body dressing. Resident #1 walked without supervision or assistance. Active discharge planning was already occurring for her to return to the community.</p> <p>A review of Resident #1's face sheet reflected she was her own responsible party; however, further review of the record revealed a local family member (son) was appointed as Power of Attorney (POA) on 2/20/24. Section 4.09 of the designation authorized the POA to make health care decisions on Resident #1's behalf.</p> <p>(continued on next page)</p>

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
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<p>F 0624</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Administrator on 5/16/24 at 10:30 am, she stated Resident #1 was issued a 30-day notice of discharge for violating smoking rules. Resident #1 was smoking with a resident who had oxygen on and gave that resident a cigarette. The administrator explained that as soon as a smoking facility became available, the resident moved. Resident #1 was her own responsible party and was happy with the move, but her son was not. The administrator stated that Resident #1's spouse said he had been trying to get his wife to stop smoking for years and he was fine with the move too. Resident #1 was moved to a facility in St. Petersburg where they have smoking privileges from 6:00 am to midnight. The Director at the receiving facility said Resident #1 loved it there. The Administrator added that Resident #1 had a son down there too, and that The Long-Term Care Ombudsman (LTCO) was involved in the discharge, and even spoke with Resident #1 about the dangers of smoking around oxygen.</p> <p>A Social Services Evaluation dated 1/30/24, noted Resident #1 was married and had a good relationship with her family. She had six children and a husband whom she was living with. Resident #1's memory was intact, she was alert and oriented to herself, family, time, place, and situation and able to establish her own goals. Resident #1 was unhappy with nursing home placement. The evaluation reported Resident #1's husband was in a nursing home in Jacksonville. She missed him and wanted to go home. She might possibly stay long term, but doesn't know what is going on.</p> <p>Resident #1 was care planned on 2/10/24 to discharge to an assisted living facility (ALF) with the goal to continue to progress in skilled therapy to discharge back to the community. Interventions included keep the resident, family involved in all care and treatment, updated on changes, and concerns. She was care planned on 3/1/24 for choosing to smoke. Resident is non-compliant to smoking policy. The goal was for no injury related to smoking through the next review date of 5/1/24. Will comply with smoking rules. Interventions included nurse to store cigarettes and lighter (3/1/24), observe for declines, remind of supervised smoking policy and smoke in designated areas only (3/1/23). Educate regarding the risk of smoking (3/26/24), One on One for smoking safety (3/28/24).</p> <p>A review of the Smoking Policy revealed Resident #1 had signed it, but it was not dated. Section 20 of the policy explains failure to comply with the rules may result in discharge.</p> <p>Further record review revealed Resident #1's husband moved into the facility on [DATE]. A room change documentation was completed noting Resident #1 changed rooms in order to share a room with him.</p> <p>A review of Resident #1's nursing progress notes revealed the following:</p> <p>3/7/24- Social Services Director (SSD) and Unit Manager (UM) spoke with resident outside as she was smoking without a staff present. The resident was reminded of the signed smoking policy. She became agitated and refused to allow the storage of contraband in a locked box. The SSD reminded her of possible consequences including a 30-day notice to discharge, but she still refused to abide. Resident #1's son was called but could not speak.</p> <p>3/8/24 (late entry) SSD had another conversation with Resident #1 on 3/7/24 regarding the smoking policy. Resident #1 agreed to store the cigarettes and lighter. SSD showed the resident the bill of rights, Ombudsman contact information and offered to assist calling the Ombudsman. Resident #1 declined. SSD confirmed the posted smoking times outside, accompanied by staff.</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>3/26/24- 8:55 am, Registered Nurse (RN) Supervisor noted Resident #1 was observed on 2nd floor balcony hiding behind a pillar, sitting on her walker smoking. When asked where she got it (cigarette), she said someone gave it to her but was not going to share who. She extinguished her cigarette on the walker wheel.</p> <p>3/26/24- 4:22 pm, RN Supervisor spoke with POA about Resident #1 smoking on the balcony. Was told about 30-day notice and he would need to come up with a place for her to stay or get Medicaid application completed as soon as possible and she could go to the ALF (next door). The POA spoke with Resident #1 and asked her to be compliant until the Medicaid application was completed. He stated he was sorry Resident #1 could not follow the rules.</p> <p>A review of Resident #1's Smoking Evaluation dated 3/26/24 noted she smoked 5-9 times per day, did not wish to quit, showed signs of confusion but remained alert at all times of smoking. She could communicate help if something fell on her. The policy was reviewed with the resident, she was able to acknowledge understanding. Resident does not require protective assistance during smoking. (Photographic evidence was obtained)</p> <p>A review of Resident #1's Resident/Family Education Record dated 3/26/24 at 8:00 pm noted she and her family were trained on safety and the smoking policy. Response to training was noted to be disinterest, denial and resistance. POA notified and stated he will call and speak with Resident #1 tomorrow about what was discussed. Resident allowed side table drawers and walker to be checked for cigarettes, and 2 cigarettes were taken. No other smoking materials were found. Resident #1 signed the form on 3/26/24. Another illegible signature at the bottom under son was also dated 3/26/24.</p> <p>Further review of Resident #1's progress notes revealed a note dated 3/27/24 at 4:45 pm that the Director of Nursing (DON) received notification on 3/26/24 at approximately 5:30 pm that Resident #1 was observed smoking at the 2nd floor balcony with another resident who was receiving oxygen. Staff intervened immediately. Resident #1 was placed on 1:1 supervision, re-educated on the smoking policy, and her care plan was updated. Spoke with the POA at 10:00 am on 3/27/24 to discuss non-compliance and that an emergency discharge was being issued for placing residents in danger. The nursing home administrator informed the POA that due to Resident #1 placing other residents at risk, she will need to discharge today. Discussed plan to discharge resident to son's care. Son verbalized understanding and said he could take her home at 4:30 pm today. The physician was notified and in agreement for safe discharge plan to go home with POA. At approximately 10:30, nursing home administrator and DON discussed emergency discharge notice to Resident #1. Resident refused to sign notice and stated that her son could sign the form. SSD sent referrals to other skilled nursing facilities (SNFs) as alternate discharge plan, per son's request. Resident currently continues on 1:1 supervision.</p> <p>A review of the Agency for Health Care Administration (AHCA) Nursing Home Transfer and Discharge Notice dated 3/27/24 revealed Resident #1 would discharge to a facility St. Petersburg, FL. The effective date of the discharge was listed as 3/27/24. The reason for discharge was listed as: The safety of other individuals in this facility is endangered. Resident violated the smoking policy by smoking during non-supervised smoking times and putting another resident in danger who had on oxygen. The form was signed by the administrator and physician. The form notes that the DON and Administrator notified Resident #1, but she said she refused to sign the form and wanted her son/POA to see it. The notice was presented to the son/POA when he came here.</p> <p>A review of Resident #1's additional nursing progress notes revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>4/1/24-On 3/29/24 SSD sent out referrals to other SNF/LTC facilities to determine eligibility/acceptance. There is no indication Resident #1 or the POA received any information on those facilities.</p> <p>4/1/24-4:26 pm: Phone call placed to reach resident's son to notify him that a safe facility was found to accept his mother. The facility also allows resident's to smoke. STAT transport currently transporting resident and her belongings to the next facility. Resident #1 was notified of safe transfer, safe transportation and safe facility to be transferred to. Nursing Home Administrator and DON present during this phone call to son/POA.</p> <p>4/1/24-4:36 pm: DON received notification today that resident was accepted to (a facility in St. Petersburg, FL) for admission today. Notified physician of safe discharge plan; telephone order received and signed by the physician. Also completed PASRR (Pre-Admission Screening and Resident Review) and 3008 (a hospital transfer form) with physician's signature. DON and ADON presented Resident #1 with a Nursing Home Transfer and Discharge notice- Resident #1 refused to sign. Discharge paperwork and resident's belongings discharged with STAT transport with 2 attendants. Son/POA notified via phone of resident's discharge.</p> <p>4/1/24-4:48 pm: (22 minutes after the resident was already in route) DON noted (Resident #1's) husband was notified in person of the discharge plan.</p> <p>4/1/24-4:51 pm: SSD and Administrator met with Resident #1's son/POA and reiterated that, per his request made on 3/29/24, referrals were sent to other facilities for safe discharge rather than discharging home with family. The address and contact information for admitting facility was provided during the meeting.</p> <p>A review of Resident #1's physician order revealed an order dated 4/1/22 at 11:44 am that read, OK to transfer to (facility in St. Petersburg). However, the record did not include any physician notes detailing dangerous behavior and no justification for an immediate discharge.</p> <p>A review of the AHCA Form 3008 (Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form) for Resident #1 completed by the physician on 4/1/24 revealed None Known noted under Patient Risk Alert section. (P)</p> <p>A review of the 1:1 supervision logs maintained for Resident #1 found she was able to safely smoke with supervision and without incident on the following dates: 3/27/24 at 6:00 pm, 3/28/24 at 8:00 am, 11:00 am, and 4:00 pm. 3/29/24 at 9:00 am, 10:30 am, and 4:00 pm. 3/30/24 at 10:30 am, 1:30 pm, 4:30 pm, and 6:15 pm. 3/31/24 at 7:30 am, 10:30 am, 1:30 pm, 4:30 pm, and 6:00 pm. 4/1/24 at 7:30 am, 10:30 am, and 1:30 pm. The form reflects discharge on 4/1/24 at 4:20 pm.</p> <p>An internet search was conducted using Driving Directions (https://www.google.com/search?q=driving+directions) revealed the facility in St. Petersburg that Resident #1 was discharged to is 203.2 miles away with a drive time of 3 hours and 48 minutes. (Photographic evidence was obtained)</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A telephone interview was conducted with Resident #1's son/POA on 5/16/24 at 1:39 pm. When asked if he could detail the circumstances of Resident #1's discharge, he first warned he might get upset talking about it. He explained Resident #1 had violated the facility smoking policy and was given 30 days to find a new place to live. They (facility staff) called him back the next day and said she would have to leave immediately. The Business Office Manager threatened to take her to a homeless shelter if he didn't come pick her up. The administrator was new, and very difficult to talk to in his opinion. Resident #1 was placed on 1:1 supervision so she wouldn't violate the smoking policy. The facility found a facility in St. Petersburg for Resident #1. He is the POA, but nobody told him of her transfer. The way they sent her down there, in his opinion, was gross. They told Resident #1 they were going to give her an early smoke break. Her husband was in their room at the time. Staff came into the room, boxed her belongings and put her on a van with 2 men. No bathroom break was even offered during the ride. Resident #1 called him in tears to tell him they were taking her to St. Petersburg. As soon as he received the message, he called the Administrator. He was very upset and said, You are not allowed to do that. I am coming down there as soon as I can; (Resident #1) better be there! The administrator told him Resident #1 had already gone and hung up on him. He couldn't believe what was happening. He called again. The administrator insisted she didn't have to tell him about Resident #1's discharge. Then she said she didn't realize he was the POA, even though he knew the papers were on file. The POA kept asking, Why would you do this? to both the SSD and Administrator. They responded that it was to look out for the facility. The POA said Resident #1 had always suffered depression and had a history of suicidal ideations, and she would say she didn't want to live any more. He said Resident #1 had not been at the new facility for even a week and was able to be moved back to the area. She was currently in a facility in Jacksonville (33 miles away). Her spouse was still at Bayview. Resident #1 told him she was trying to scream for help on the way out, but her husband, who is 92, couldn't help. The POA confirmed he resides close by in St. [NAME] and stated, This was very traumatic on the family.</p> <p>A telephone interview was conducted with Resident #1 on 5/16/24 at 2:11 pm. After introductions, Resident #1 was asked if she could talk about her discharge. Resident #1 replied in a clear, concise manner, It was very traumatic, unlawful, and unnecessary. My son/POA was supposed to give his approval and he didn't. She (the administrator) just up and moved me to St. Petersburg. It was traumatic. Resident #1 explained that her husband was still at the old facility and was devastated. This has been very terrible on us. Resident #1 said she wanted to be in St. [NAME] because her POA lives there. He is the closest son; she wanted to be near him, and of course, her husband. She said, This is so cruel beyond belief. I just can't believe it. Resident #1 stated she was not given a 30-day notice. She was following all the smoking rules at the time, therefore it was pointless and unnecessary to send her away from her husband. He is [AGE] years old and every day that goes by, he is without me! The day of the discharge was despicable, very traumatic and against the law. She said when she was asked if she wanted to be discharged, she said absolutely not. Resident #1 concluded by saying the Administrator made that terrible decision and it had horrible repercussions. It has been a whirlwind.</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/16/24 at 3:00 pm, Resident #6 (Resident 1#'s husband) was interviewed in his room. After brief introductions, he pointed to the empty bed closest to the door and said, She was real special, my wife. He explained the empty bed was hers. Back in January, (Resident #1), my wife She is gone. Resident #6 explained the administrator came into his room one day and sat on the corner of his bed. He was in the exercise room or outside on the deck at the time. Someone came and got him and said, Your wife is going to another institution. She violated one of our rules. He walked into his room and the administrator was sitting there, on the bed. He asked, What rule? The administrator said, the smoking rule. Resident #1 had given another lady a cigarette, but the lady had an oxygen tank. Resident #6 said the tank was small and was hidden; Resident #1 didn't notice the oxygen tank. Resident #6 lamented, We've been married [AGE] years and I love her. I lost her. Oh my God, the, it was an experience, it was like the Gestapo all over again. I remember it vividly. He continued, saying 6 or 7 people came into their room with boxes and spread them out all over Resident #1's bed. They started opening drawers and emptying everything into the boxes. He was told the van was outside, and Resident #1 was being taken to St Petersburg. The SSD was in the room too. Resident #6 said he did not even get to say goodbye to her. They offered to take him downstairs to say goodbye. He went, but it was an ordeal because he had to be supervised to go down the elevator. Then he had to walk all the way down the hall, but they had left already to St Petersburg. Resident #6 said Resident #1 was in St. Petersburg only one week when her son/POA called local nursing homes. The son/POA was told they had already been called and warned about Resident #1. At first, the staff wanted to send Resident #1 to the sons/POA's home, but he has two little kids and is in his early 40s. It is just a small house. Oh my God, there was just no way. There is no extra bed there or anything. The son/POA found Resident #1 a place in Jacksonville, and she is there now. Resident #6 insisted he never told the administrator he supported the move to St. Petersburg. That is over three hours away! The administrator suggested he and Resident #1 move next door to the assisted living facility (ALF) but told him he would have to pay all the money up front. He couldn't afford that. When asked how Resident #1 took the move, he said, Oh my God, she was crying. It is terrible what they did to both of us. Resident #6 then began to cry. He used a bath towel to wipe his eyes as he reiterated the experience, again repeating they came in with boxes. He told them, This is Gestapo! Do you know what you are doing? Resident #6 continued to cry and intermittently sob, wiping his tears with the towel. While sobbing he said, It is awful.</p> <p>The SSD was interviewed on 5/16/24 at 4:00 pm. She confirmed Resident #1 had a facility-initiated discharge for continuous violation of the smoking policy. The resident had been re-educated, but she felt this was communist Russia. She found Resident #1 smoking by herself. Resident #1 would extinguish her cigarette when she saw the SSD coming. Resident #1 was not an unsafe smoker, but it is facility policy that smokers be accompanied. The very day Resident #1 was warned, she was later seen lighting a cigarette for a resident who had oxygen on. The SSD stated she was not involved at all in the discharge location but was involved in a phone conversation with the Ombudsman's office seeking advice.</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the DON on 5/16/24 at 4:20 pm. She explained Resident #1 was a non-compliant smoker who would be found with paraphernalia but wouldn't report how she obtained it. The resident would smoke outside of smoking times without supervision. They educated her, presented the smoking policy again and tried to help her with compliance, but then lighting a cigarette for someone who was on oxygen presented a danger to our facility. In response a discharge was initiated. Resident #1 was given a 30-day notice, but she refused to sign. After the incident we worked on getting a discharge. The POA was going to take her home but then decided not to. Referrals were sent; we got one facility to accept her, got the order to transfer, set up transportation and she was transported. Resident #1 had gone on a 1:1 after giving the cigarette to the resident on oxygen and remained on 1:1 until discharge. The DON was asked about the abruptness of the discharge (4 days after the 30-day notice was issued). She said they had informed Resident #1 once they found a location, discharge would be presented immediately. Resident #1 didn't like the idea but understood her actions. Her husband was also informed the 30-day notice was issued and he was understanding of the situation. The DON was asked if Resident #1 had a preference as to where she would relocate. The DON said she did not know. When reminded Resident #1's husband and POA were local, the DON said, She does have a son over there, too. Referrals were sent locally but the facility in St. Petersburg accepted her. She could not recall if it was the same day she discharged. When asked if Resident #1 was able to say goodbye to her husband before leaving, she responded, yes. When asked, Are you sure about that? the DON fell silent. After explaining to the DON that Resident #1 was not able to say goodbye to her husband, the DON's response was that they did inform her she was going. She doesn't know for sure if the resident got to say goodbye. She didn't remember. She only explained transportation was here for Resident #1, and the travel was long. Resident #1 consented to go although initially, she did not want to go. She said local facilities had been sent referrals, but she did not know why they would not accept Resident #1.</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/16/24 at 5:26 pm, a follow up interview was conducted with the administrator regarding Resident #1's discharge. She was asked why Resident #1's 30-day notice was converted to a STAT discharge. The administrator explained Resident #1 had been re-educated, then violated the smoking policy again. They called the physician, put her on 1:1 supervision, and told the POA the discharge needed to be immediate. He initially agreed to take her, then decided not to; he asked us to call different discharge locations. The administrator called the Long-Term Care Ombudsman (LTCO) and asked her to explain the process for this discharge. Multiple referrals were sent, but nobody would take her since she smoked. When Residents #1 and #6 were told there wasn't anywhere local, Resident #1 said she didn't care where she went. They were advised the facility in St. Petersburg had accepted her to give them time to prepare. Resident #1 said to put her trinkets over there, next to her husband's. Then transportation came and moved her. The POA was called when transportation was on the way to pick up Resident #1. Both Resident #1 and the POA said a few things. The administrator understood the new facility was quite a ways, but the safety of the other residents in the facility was at risk. Referrals were sent to facilities in Jacksonville, Palm Coast and locally. The administrator was advised of the interviews conducted with Resident #1 and her family, and advised, this was not a 30-day notice. It was an abrupt, almost immediate discharge that occurred in 4 days. Resident #1 did not have an opportunity to say goodbye or participate in her discharge planning. The administrator was advised of the trauma the experience and distance caused the family. The administrator expressed unawareness that Residents #1 and #6 had no chance to say goodbye to each other. The administrator was reminded Resident #1 safely remained in the facility on a 1:1 staff assignment without incident, and there were still 26 days left to plan an agreeable discharge. That planning was denied. The administrator explained she offered Resident #1 and #6 to move to the ALF next door, but there were no Medicaid beds available. They would have to be private pay. There Resident #1 could smoke unsupervised. The administrator was asked to provide a list of facilities referrals were sent to. She stated the SSD had gone home but she would send the list tomorrow.</p> <p>A review of Florida Health Finder website (https://quality.healthfinder.fl.gov) found there are a total of 5 nursing homes in St. [NAME] and an additional 70 nursing homes within 50 miles of the facility. There was a total of 109 nursing homes within 75 miles of the facility. In addition, there were 13 ALFs within 15 miles of the facility and 160 ALFs within 60 miles.</p> <p>A telephone interview was conducted with the LTCO on 5/17/24 at 12:00 pm. She was asked about her involvement in Resident #1's discharge. The LTCO confirmed she had spoken with the administrator about Resident #1, but insisted she never knew this was going to be a same-day discharge. That was not the intent. She further denied ever speaking directly to Resident #1.</p> <p>On 5/17/24 at 5:23 pm, an email was received from the SSD providing the list of facilities referrals were sent to for Resident #1. Eight nursing homes across 4 local/adjacent counties (St. [NAME], [NAME], Volusia and [NAME]) were listed. The list contained no ALF referrals.</p> <p>Review of the facility's policy for Discharge Planning Process (implemented on 11/3/20 and last date reviewed/revised on 9/19/22) revealed the following::</p> <p>Policy: It is the policy of this facility to develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmission.</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Procedure:</p> <p>1. The facility will support each resident in the exercise of his or her right to participate in his or her care and treatment, including planning for discharge.</p> <p>10. The facility will assist residents and their representatives in choosing post-acute care provider (i.e. another SNF .) that will meet the resident's needs, goals and preferences.</p> <p>a. The SSD or designee shall compile available data on other post-acute care options to present to the resident, including, but not limited to:</p> <p>i. Data on providers within the resident's desired geographic area, where available .</p>		

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<p>F 0660</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30969</p> <p>Based on a record review, interviews, and facility policy and procedure review, the facility failed to involve the resident and/or their representative in a discharge plan that considered resident preferences and involved the resident and representative in selecting a post-discharge provider for one (Resident #1) of two residents reviewed for facility-initiated discharges. Failure to involve the resident and her representative in selection of potential discharge locations resulted in an abrupt, spontaneous discharge to a facility 203 miles away from her husband and family member who was her Power of Attorney (POA). As a result, the resident and her family experienced trauma.</p> <p>The findings include:</p> <p>During an interview with the Administrator on 5/16/24 at 10:30 am, she stated Resident #1 was issued a 30-day notice of discharge for violating smoking rules. Resident #1 was smoking with a resident who had oxygen on and gave that resident a cigarette. The administrator explained that as soon as a smoking facility became available, the resident moved. Resident #1 was her own responsible party and was happy with the move, but her son wasn't. The administrator stated that Resident #1's spouse said, he had been trying to get his wife to stop smoking for years and he was fine with the move too. Resident #1 was moved to a facility in St. Petersburg where they have smoking privileges from 6:00 am to midnight. The Director at the receiving facility said Resident #1 loved it there.</p> <p>A closed record review for Resident #1 revealed she was admitted to the facility on [DATE] and was [AGE] years old. She was discharged from the facility on a facility-initiated discharge on 4/1/24. Her diagnoses included, but were not limited to, unspecified fracture of left pubis, malnutrition, major depressive disorder and generalized anxiety disorder.</p> <p>A review of the Discharge Return Not Anticipated Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 had a brief interview for mental status (BIMS) score of 11 out of 15 points, reflecting moderate cognitive impairment. She was independent with most activities of daily living, requiring only supervision with showering and lower body dressing. Resident #1 walked without supervision or assistance. Active discharge planning was already occurring for her to return to the community.</p> <p>A review of Resident #1's face sheet reflected she was her own responsible party; however, further review of the record revealed a local family member (son) was appointed as Power of Attorney (POA) on 2/20/24. Section 4.09 of the designation authorized the POA to make health care decisions on Resident #1's behalf.</p> <p>Resident #1 was care planned on 2/10/24 to discharge to an assisted living facility (ALF) with the goal to continue to progress in skilled therapy to discharge back to the community. Interventions included keep the resident, family involved in all care and treatment, updated on changes, and concerns. She was also care planned on 3/1/24 for choosing to smoke. Resident is non-compliant to smoking policy. The goal was for no injury related to smoking through the next review date of 5/1/24. Will comply with smoking rules. Interventions included nurse to store cigarettes and lighter (3/1/24), observe for declines, remind of supervised smoking policy and smoke in designated areas only (3/1/23). Educate regarding the risk of smoking (3/26/24), One on One for smoking safety (3/28/24).</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the Smoking Policy revealed Resident #1 had signed it, but it was not dated. Section 20 of the policy explains failure to comply with the rules may result in discharge.</p> <p>A review of Resident #1's nursing progress notes revealed the following:</p> <p>3/7/24- Social Services Director (SSD) and Unit Manager (UM) spoke with resident outside as she was smoking without a staff present. The resident was reminded of the signed smoking policy. She became agitated and refused to allow the storage of contraband in a locked box. The SSD reminded her of possible consequences including a 30-day notice to discharge, but she still refused to abide. Resident #1's son was called but could not speak.</p> <p>3/8/24 (late entry) SSD had another conversation with Resident #1 on 3/7/24 regarding the smoking policy. Resident #1 agreed to store the cigarettes and lighter. SSD showed the resident the bill of rights, Ombudsman contact information and offered to assist calling the Ombudsman. Resident #1 declined. SSD confirmed the posted smoking times outside, accompanied by staff.</p> <p>3/26/24- 8:55 am, Registered Nurse (RN) Supervisor noted Resident #1 was observed on 2nd floor balcony hiding behind a pillar, sitting on her walker smoking. When asked where she got it (cigarette), she said someone gave it to her but was not going to share who. She extinguished her cigarette on the walker wheel.</p> <p>3/26/24- 4:22 pm, RN Supervisor spoke with POA about Resident #1 smoking on the balcony. Was told about 30-day notice and he would need to come up with a place for her to stay or get Medicaid application completed as soon as possible and she could go to the ALF (next door). The POA spoke with Resident #1 and asked her to be compliant until the Medicaid application was completed. He stated he was sorry Resident #1 could not follow the rules.</p> <p>Further review of Resident #1's progress notes revealed a note dated 3/27/24 at 4:45 pm that the Director of Nursing (DON) received notification on 3/26/24 at approximately 5:30 pm that Resident #1 was observed smoking at the 2nd floor balcony with another resident who was receiving oxygen. Staff intervened immediately. Resident #1 was placed on 1:1 supervision, re-educated on the smoking policy, and her care plan was updated. Spoke with the POA at 10:00 am on 3/27/24 to discuss non-compliance and that an emergency discharge was being issued for placing residents in danger. The nursing home administrator informed the POA that due to Resident #1 placing other residents at risk, she will need to discharge today. Discussed plan to discharge resident to son's care. Son verbalized understanding and said he could take her home at 4:30 pm today. The physician was notified and in agreement for safe discharge plan to go home with POA. At approximately 10:30, nursing home administrator and DON discussed emergency discharge notice to Resident #1. Resident refused to sign notice and stated that her son could sign the form. SSD sent referrals to other skilled nursing facilities (SNFs) as alternate discharge plan, per son's request. Resident currently continues on 1:1 supervision.</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the Agency for Health Care Administration (AHCA) Nursing Home Transfer and Discharge Notice dated 3/27/24 revealed Resident #1 would discharge to a facility St. Petersburg, FL. The effective date of the discharge was listed as 3/27/24. The reason for discharge was listed as: The safety of other individuals in this facility is endangered. Resident violated the smoking policy by smoking during non-supervised smoking times and putting another resident in danger who had on oxygen. The form was signed by the administrator and physician. The form notes that the DON and Administrator notified Resident #1, but she said she refused to sign the form and wanted her son/POA to see it. The notice was presented to the son/POA when he came here.</p> <p>A review of Resident #1's additional nursing progress notes revealed the following:</p> <p>4/1/24- On 3/29/24 SSD sent out referrals to other SNF/LTC facilities to determine eligibility/acceptance. There is no indication Resident #1 or the POA received any information on those facilities.</p> <p>4/1/24- 4:26 pm: Phone call placed to reach resident's son to notify him that a safe facility was found to accept his mother. The facility also allows resident's to smoke. STAT transport currently transporting resident and her belongings to the next facility. Resident #1 was notified of safe transfer, safe transportation and safe facility to be transferred to. Nursing Home Administrator and DON present during this phone call to son/POA.</p> <p>4/1/24- 4:36 pm: DON received notification today that resident was accepted to (a facility in St. Petersburg, FL) for admission today. Notified physician of safe discharge plan; telephone order received and signed by the physician. Also completed PASRR (Pre-Admission Screening and Resident Review) and 3008 (a hospital transfer form) with physician's signature. DON and ADON presented Resident #1 with a Nursing Home Transfer and Discharge notice- Resident #1 refused to sign. Discharge paperwork and resident's belongings discharged with STAT transport with two attendants. Son/POA notified via phone of resident's discharge.</p> <p>4/1/24- 4:48 pm: (22 minutes after the resident was already in route) DON noted (Resident #1's) husband was notified in person of the discharge plan.</p> <p>4/1/24- 4:51 pm: SSD and Administrator met with Resident #1's son/POA and reiterated that, per his request made on 3/29/24, referrals were sent to other facilities for safe discharge rather than discharging home with family. The address and contact information for admitting facility was provided during the meeting.</p> <p>A review of Resident #1's physician order revealed an order dated 4/1/22 at 11:44 am that read, OK to transfer to (facility in St. Petersburg). However, the record did not include any physician notes detailing dangerous behavior and no justification for an immediate discharge.</p> <p>A review of the AHCA Form 3008 (Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form) for Resident #1 completed by the physician on 4/1/24 revealed None Known noted under Patient Risk Alert section.</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A telephone interview was conducted with Resident #1's son/POA on 5/16/24 at 1:39 pm. When asked if he could detail the circumstances of Resident #1's discharge, he first warned he might get upset talking about it. He explained Resident #1 had violated the facility smoking policy and was given 30 days to find a new place to live. They (facility staff) called him back the next day and said she would have to leave immediately. The Business Office Manager threatened to take her to a homeless shelter if he didn't come pick her up. The Administrator was new, and very difficult to talk to in his opinion. Resident #1 was placed on 1:1 supervision so she wouldn't violate the smoking policy. The facility found a facility in St. Petersburg for Resident #1. He is the POA, but nobody told him of her transfer. The way they sent her down there, in his opinion, was gross. They told Resident #1 they were going to give her an early smoke break. Her husband was in their room at the time. Staff came into the room, boxed her belongings and put her on a van with 2 men. No bathroom break was even offered during the ride. Resident #1 called him in tears to tell him they were taking her to St. Petersburg. As soon as he received the message, he called the Administrator. He was very upset and said, You are not allowed to do that. I am coming down there as soon as I can; (Resident #1) better be there! The Administrator told him Resident #1 had already gone and hung up on him. He couldn't believe what was happening. He called again. The Administrator insisted she didn't have to tell him about Resident #1's discharge. Then she said she didn't realize he was the POA, even though he knew the papers were on file. The POA kept asking, Why would you do this? to both the SSD and Administrator. They responded that it was to look out for the facility. The POA said Resident #1 had always suffered depression and had a history of suicidal ideations, and she would say she didn't want to live any more. He said Resident #1 had not been at the new facility for even a week and was able to be moved back to the area. She was currently in a facility in Jacksonville (33 miles away). Her spouse was still at Bayview. Resident #1 told him she was trying to scream for help on the way out, but her husband, who is 92, couldn't help. The POA confirmed he resides close by in St. [NAME] and stated, This was very traumatic on the family.</p> <p>A telephone interview was conducted with Resident #1 on 5/16/24 at 2:11 pm. After introductions, Resident #1 was asked if she could talk about her discharge. Resident #1 replied in a clear, concise manner, It was very traumatic, unlawful, and unnecessary. My son/POA was supposed to give his approval and he didn't. She (the administrator) just up and moved me to St. Petersburg. It was traumatic. Resident #1 explained that her husband was still at the old facility and was devastated. This has been very terrible on us. Resident #1 said she wanted to be in St. [NAME] because her POA lives there. He is the closest son; she wanted to be near him, and of course, her husband. She said, This is so cruel beyond belief. I just can't believe it. Resident #1 stated she was not given a 30-day notice. She was following all the smoking rules at the time, therefore it was pointless and unnecessary to send her away from her husband. He is [AGE] years old and every day that goes by, he is without me! The day of the discharge was despicable, very traumatic and against the law. She said when she was asked if she wanted to be discharged, she said absolutely not. Resident #1 concluded by saying the Administrator made that terrible decision and it had horrible repercussions. It has been a whirlwind.</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/16/24 at 3:00 pm, Resident #6 (Resident 1#'s husband) was interviewed in his room. After brief introductions, he pointed to the empty bed closest to the door and said, She was real special, my wife. He explained the empty bed was hers. Back in January, (Resident #1), my wife She is gone. Resident #6 explained the Administrator came into his room one day and sat on the corner of his bed. He was in the exercise room or outside on the deck at the time. Someone came and got him and said, Your wife is going to another institution. She violated one of our rules. He walked into his room and the Administrator was sitting there, on the bed. He asked, What rule? The administrator said, the smoking rule. Resident #1 had given another lady a cigarette, but the lady had an oxygen tank. Resident #6 said the tank was small and was hidden; Resident #1 didn't notice the oxygen tank. Resident #6 lamented, We've been married [AGE] years and I love her. I lost her. Oh my God, the, it was an experience, it was like the Gestapo all over again. I remember it vividly. He continued, saying 6 or 7 people came into their room with boxes and spread them out all over Resident #1's bed. They started opening drawers and emptying everything into the boxes. He was told the van was outside, and Resident #1 was being taken to St Petersburg. The SSD was in the room too. Resident #6 said he did not even get to say goodbye to her. They offered to take him downstairs to say goodbye. He went, but it was an ordeal because he had to be supervised to go down the elevator. Then he had to walk all the way down the hall, but they had left already to St Petersburg. Resident #6 said Resident #1 was in St. Petersburg only one week when her son/POA called local nursing homes. The son/POA was told they had already been called and warned about Resident #1. At first, the staff wanted to send Resident #1 to the sons/POA's home. But he has two little kids and is in his early 40s. It is just a small house. Oh my God, there was just no way. There is no extra bed there or anything. The son/POA found Resident #1 a place in Jacksonville, and she is there now. Resident #6 insisted he never told the Administrator he supported the move to St. Petersburg. That is over 3 hours away! The administrator suggested he and Resident #1 move next door to the assisted living facility (ALF) but told him he would have to pay all the money up front. He couldn't afford that. When asked how Resident #1 took the move, he said, Oh my God, she was crying. It is terrible what they did to both of us. Resident #6 then began to cry. He used a bath towel to wipe his eyes as he reiterated the experience, again repeating they came in with boxes. He told them, This is Gestapo! Do you know what you are doing? Resident #6 continued to cry and intermittently sob, wiping his tears with the towel. While sobbing he said, It is awful.</p> <p>The SSD was interviewed on 5/16/24 at 4:00 pm. She confirmed Resident #1 had a facility-initiated discharge for continuous violation of the smoking policy. The resident had been re-educated, but she felt this was communist Russia. She found Resident #1 smoking by herself. Resident #1 would extinguish her cigarette when she saw the SSD coming. Resident #1 was not an unsafe smoker, but it is facility policy that smokers be accompanied. The very day Resident #1 was warned, she was later seen lighting a cigarette for a resident who had oxygen on. The SSD stated she was not involved at all in the discharge location but was involved in a phone conversation with the Ombudsman's office seeking advice.</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the DON on 5/16/24 at 4:20 pm. She explained Resident #1 was a non-compliant smoker who would be found with paraphernalia but wouldn't report how she obtained it. The resident would smoke outside of smoking times without supervision. They educated her, presented the smoking policy again and tried to help her with compliance, but then lighting a cigarette for someone who was on oxygen presented a danger to our facility. In response a discharge was initiated. Resident #1 was given a 30-day notice, but she refused to sign. After the incident we worked on getting a discharge. The POA was going to take her home but then decided not to. Referrals were sent; we got one facility to accept her, got the order to transfer, set up transportation and she was transported. Resident #1 had gone on a 1:1 after giving the cigarette to the resident on oxygen and remained on 1:1 until discharge. The DON was asked about the abruptness of the discharge (4 days after the 30-day notice was issued). She said they had informed Resident #1 once they found a location, discharge would be presented immediately. Resident #1 didn't like the idea but understood her actions. Her husband was also informed the 30-day notice was issued and he was understanding of the situation. The DON was asked if Resident #1 had a preference as to where she would relocate. The DON said she did not know. When reminded Resident #1's husband and POA were local, the DON said, She does have a son over there, too. Referrals were sent locally but the facility in St. Petersburg accepted her. She could not recall if it was the same day she discharged. When asked if Resident #1 was able to say goodbye to her husband before leaving, she responded, yes. When asked, Are you sure about that? the DON fell silent. After explaining to the DON that Resident #1 was not able to say goodbye to her husband, the DON's response was that they did inform her she was going. She doesn't know for sure if the resident got to say goodbye. She didn't remember. She only explained transportation was here for Resident #1, and the travel was long. Resident #1 consented to go although initially, she did not want to go. She said local facilities had been sent referrals, but she did not know why they would not accept Resident #1.</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/16/24 at 5:26 pm, a follow up interview was conducted with the administrator regarding Resident #1's discharge. She was asked why Resident #1's 30-day notice was converted to a STAT discharge. The Administrator explained Resident #1 had been re-educated, then violated the smoking policy again. They called the physician, put her on 1:1 supervision, and told the POA the discharge needed to be immediate. He initially agreed to take her, then decided not to; he asked us to call different discharge locations. The Administrator called the Long-Term Care Ombudsman (LTCO) and asked her to explain the process for this discharge. Multiple referrals were sent, but nobody would take her since she smoked. When Residents #1 and #6 were told there wasn't anywhere local, Resident #1 said she didn't care where she went. They were advised the facility in St. Petersburg had accepted her to give them time to prepare. Resident #1 said to put her trinkets over there, next to her husband's. Then transportation came and moved her. The POA was called when transportation was on the way to pick up Resident #1. Both Resident #1 and the POA said a few things. The Administrator understood the new facility was quite a ways, but the safety of the other residents in the facility was at risk. Referrals were sent to facilities in Jacksonville, Palm Coast and locally. The Administrator was advised of the interviews conducted with Resident #1 and her family, and advised, this was not a 30-day notice. It was an abrupt, almost immediate discharge that occurred in 4 days. Resident #1 did not have an opportunity to say goodbye or participate in her discharge planning. The Administrator was advised of the trauma the experience and distance caused the family. The Administrator expressed unawareness that Residents #1 and #6 had no chance to say goodbye to each other. The Administrator was reminded Resident #1 safely remained in the facility on a 1:1 staff assignment without incident, and there were still 26 days left to plan an agreeable discharge. That planning was denied. The Administrator explained she offered Resident #1 and #6 to move to the ALF next door, but there were no Medicaid beds available. They would have to be private pay. There Resident #1 could smoke unsupervised. The Administrator was asked to provide a list of facilities referrals were sent to. She stated the SSD had gone home but she would send the list tomorrow.</p> <p>A telephone interview was conducted with the LTCO on 5/17/24 at 12:00 pm. She was asked about her involvement in Resident #1's discharge. The LTCO confirmed she had spoken with the Administrator about Resident #1, but insisted she never knew this was going to be a same-day discharge. That was not the intent. She further denied ever speaking directly to Resident #1.</p> <p>Review of the facility's policy for Discharge Planning Process (implemented on 11/3/20 and last date reviewed/revised on 9/19/22) revealed the following::</p> <p>Policy: It is the policy of this facility to develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmission.</p> <p>Procedure:</p> <p>1. The facility will support each resident in the exercise of his or her right to participate in his or her care and treatment, including planning for discharge.</p> <p>10. The facility will assist residents and their representatives in choosing post-acute care provider (i.e. another SNF .) that will meet the resident's needs, goals and preferences.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105816	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER Lilac at Bayview, The		STREET ADDRESS, CITY, STATE, ZIP CODE 161a Marine Street Saint Augustine, FL 32084	
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 0660 Level of Harm - Actual harm Residents Affected - Few	<p>a. The SSD or designee shall compile available data on other post-acute care options to present to the resident, including, but not limited to:</p> <p>i. Data on providers within the resident's desired geographic area, where available .</p>		