

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/09/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105895	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/09/2025
NAME OF PROVIDER OR SUPPLIER AVIATA AT SEMINOLE			STREET ADDRESS, CITY, STATE, ZIP CODE 9393 PARK BLVD SEMINOLE, FL 33777		
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F 000	INITIAL COMMENTS	F 000			
F 585 SS=D	<p>A complaint survey for complaint number 2025008021 was conducted on _____ at Aviaata at Seminole. The facility was not in compliance with 42 CFR 483, Requirements for Long Term Care Facilities.</p> <p>Complaint #2025008021 had deficiencies cited at F600 and F607.</p> <p>Grievances CFR(s): 483.10(j)(1)-(4)</p> <p>§483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.</p> <p>§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.</p> <p>§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.</p> <p>§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy</p>	F 585			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

/2025

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.

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F 585	Continued From page 1 to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; () Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, including injuries of unknown source, and/or misappropriation of resident property, by	F 585		

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F 585	<p>Continued From page 2</p> <p>anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;</p> <p>(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;</p> <p>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and</p> <p>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure a functioning grievance process for two residents (#1 and #9) of ten residents sampled.</p> <p>Findings included:</p> <p>A review of a Complaint / Grievance Report, dated _____, documented (Resident #1) communicated verbally to the Social Service Assistant (SSA) a concern: "Resident #1 stated 2 CNA's (Certified Nursing Assistants) were having</p>	F 585	<p>Resident #1 was interviewed regarding the incident, and upon conclusion of interview, the resident was satisfied with the outcome of the decision made by administration in relation to the submitted grievance. Reportable incident completed regarding this issue on _____.</p> <p>Additional services offered to resident to provide additional support. Nursing assessments completed to ensure there were no adverse effects to the resident. No adverse effects noted.</p>	

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F 585	<p>Continued From page 3</p> <p>personal conversations when providing care". The form was signed by the Social Services Director (SSD) on . The form had an area to document the concern type, treatment, Care, management of funds, behavior of other residents, missing items, violation of rights, and other. The latter area was blank. The form documented nursing was assigned the responsibility for the investigation. The findings of the investigation were documented: "Staff were identified and were noted to have personal conversations while providing care to residents". The plan to resolve the complaint: "Education to identified CNAs". Expected results of the actions taken: "Verbal education provided to identified CNAs on not having personal conversations while providing care to residents. CNAs expressed understanding". The form was signed by (Staff F, Licensed Practical Nurse) (LPN), Unit Manager (UM). The form documented the complaint was resolved. The form was blank to indicate if the resident was satisfied. The form documented the results and resolution steps were reported to the resident.</p> <p>A review of Resident #11's clinical chart showed an admission in . Medical diagnoses included but not limited to and following affecting left non-dominant side; generalized ; and post-stress . A review of the Minimum Data Set (MDS) dated revealed a () score of 13, which indicated the resident was .</p> <p>A review of the facility Grievance log from through the 06/09/2025, listed two complaints filed by Resident #1, dated</p>	F 585	<p>2. Grievance log and grievances reviewed for previous 3 months by NHA and Social Services Director (SSD). There were no other grievances that were found noted to be reportable events. Resident interviews completed for residents with above 10 to ensure that there were no outstanding concerns or allegations of that were not addressed. Skin assessments were completed for residents with a less than 10. No additional findings at the time of evaluation.</p> <p>3. Grievances are reviewed five times a week by the IDT to ensure timely response. Grievance log and grievances will be audited weekly by SSD or designee, and NHA, or designee to ensure that grievances are completed timely, and allegations of were addressed. This will be an ongoing practice implemented as part of the facility operations. Room rounds continue to be completed five times a week by IDT to ensure resident is monitored and has no concerns. Education completed with staff to review the grievance process. education was completed with staff in conjunction with posttest and scenarios. Education provided by IDT members to staff. IDT educated by company VP of Risk Management. Grievance process reviewed at resident council meeting with residents. Process reviewed by Activities Director. Residents confirmed understanding of the process.</p> <p>4. Audits will be reviewed at the QAA/QAPI meeting monthly for three months or until substantial compliance is</p>		

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F 585	<p>Continued From page 4 and</p> <p>An interview was conducted on _____ at 11:01 a.m. with Staff F, licensed Practical Nurse (LPN)/ Unit Manager (UM). She stated regarding Resident #1's complaint dated _____, "I was not aware of that one coming to me directly. When I did become aware, I spoke to the resident. I did give a statement to the CNAs. If it is the same situation that I was thinking about, those two CNAs were put on suspension". She stated the SSD came to her about the concern. Staff F stated she left the building and came on the following week. She stated she found out about the concern on _____ at the morning meeting. Staff F said, "I spoke to her (the resident) on _____ about the concern."</p> <p>On _____ at 12:35 p.m., an interview was conducted with the SSD. He stated the grievance for Resident #1 was communicated to the SSA.</p> <p>On _____ at approximately 12:40 p.m., an interview was conducted with the SSA with the Nursing Home Administrator (NHA) in the room. The SSA stated Resident #1 had reported regarding two staff members, she "did not like the behavior; the conversations they were having, their likes and dislikes for the residents. The SSA stated she relayed the concern to the Administrator In Training (AIT). "The AIT put it on the grievance form". The SSA said "I did not personally investigate". During the interview, the NHA said, "the grievance would have gone to the unit manager".</p> <p>On _____ at 2:22 p.m., an interview was conducted with the NHA regarding Resident #1's</p>	F 585	<p>achieved. The audits will be presented by the Social Services Director or designee.</p>	

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F 585	<p>Continued From page 5</p> <p>grievance dated . A request for documentation pertaining to an investigation for the grievance revealed there was no documentation. He stated there was nothing further. He confirmed he was the Coordinator. He stated he was out of the building from . and came . on . He stated the AIT was the assigned Coordinator in his absence.</p> <p>An interview was conducted on . at approximately 1:36 p.m. with the NHA regarding the reportable investigation he had conducted for the allegation reported by Resident #1 on . The NHA said, Resident #1 had reported on . she had a care concern about Staff A, CNA and Staff B, CNA. (Resident #1) reported them talking about residents and staff by name. At the time, she wanted her brief changed and she found out she was on her period. They refused to wipe her. That was the initial complaint. Both staff were suspended. The NHA said we did interviews with other residents and staff. Other residents had identified same issues. We chose people in the same assignment.</p> <p>An interview was conducted on . at approximately 2:30 p.m. with the AIT, she stated she did not interview (Resident #1), and she did not investigate. She stated she did not do anything about the complaint. Subsequently, at 3:58 p.m. the AIT stated she helped the SSA fill out the grievance form for resident #1 for the . She stated it looked like (Staff F, LPN, UM) did the investigation.</p> <p>On . at 1:26 p.m., an observation was conducted of Resident #1. She confirmed she had submitted a grievance to complain about two</p>	F 585			

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F 585	<p>Continued From page 6</p> <p>aides on . She stated no one came and talked to her about the concern. She stated she had not received a response from the facility about her grievance submitted on .</p> <p>A review of a complaint/ Grievance Report dated by (Staff G, CNA), documented a concern for treatment and care for Resident #9 showing: CNA reports that resident was covered in feces and he had been sitting for a while before anyone came to change him. The staff member assigned responsibility for the investigation was Staff F, LPN, UM. The investigation: This resident was found to be covered in feces. The Aide assigned to resident was (Staff B, CNA). She was educated about the importance of providing prompt care. Expectation showed: aide will work endeavor to ensure proper care. Written teachable moment was provided to aide, signed as completed . The section to be completed on whether the grievance was reportable to the state agency was not marked with either a yes or no indication.</p> <p>A review of Resident #9's clinical chart documented an admission of . His diagnosis list included but not limited to Type 2 with and</p> <p>A review of a dated, documented a score of 13, with a comment "Intact response".</p> <p>A review of Resident #9's clinical chart, the Care Plan, documented a focus area: Resident #9 has an ADL (Activity of Daily Living) self-care performance and at risk for decline. Interventions included: Toilet Use: The resident is totally dependent on staff for toileting</p>	F 585			

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F 585	<p>Continued From page 7 to , initiated</p> <p>A review of Staff B, Certified Nursing Assistant's (CNA) personnel file was conducted with the Human Resource Director (HRD). Present in the file was a document, "Teachable Moment", dated for Staff B, CNA, which documented a description of action: "(Resident #9) was found to be covered in feces. Good practice is we check and change residents every 2 hours. Resident states he had been asking to be changed all morning, and he had not been changed. When the p.m. aide came on duty, you were already out of the building. She didn't get to do bedside round (receive report) and upon entering the resident's room, found resident covered in feces". The form was not signed by any person as presenting the document or receiving the document. During the review of the "Teachable Moment" with the HRD, she stated she did not know about the form. She stated, "teachable moments are nursing documents. The HRD stated, "I assume it was nursing that wrote it up with the expectation of presenting. I cannot tell you who wrote it up".</p> <p>An interview conducted was conducted with the NHA On at 6:33 p.m. He stated residents should be changed, "At least every two hours". When asked, if a resident alleges, he had been sitting in a movement (BM) since 12:00 p.m., and not changed until between 3:00 and 3:30 p.m., if it was appropriate care, he stated, "I would say it is not". "It has the potential to be neglect". He stated the incident was not reported. He said, "I went and talked to the resident. And he said, he went to the bathroom in his brief. He said the girls were busy on the floor; he has a boisterous voice; (Staff G, CNA) thought</p>	F 585		

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F 585	Continued From page 8 he was yelling; and she went in and changed him." The NHA stated he asked the resident if he felt like he was neglected, and he said no, and he did not know why someone had reported it. He confirmed the staff member assigned to Resident #9 on during the 7:00 a.m. to 3:00 p.m. shift was Staff B, CNA. A review of the Complaint/ Grievance policies and procedures, last revised on , documented the policy. The Center will support each resident's right to voice a complain/ grievance without fear of discrimination or reprisal. The center will make prompt efforts to resolve the complaint/ grievance and inform the resident of progress towards resolution. Grievances discovered to meet the definition of , Neglect, , or Misappropriation will be handled per the facility Policy. The resident should have reasonable expectations of care and services, and center should address those expectations in a timely reasonable and consistent manner.	F 585		
F 600 SS=E	Free from and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from , Neglect, and . The resident has the right to be free from , neglect, misappropriation of resident property, and , as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary and any physical or chemical not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600		

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F 600	<p>Continued From page 9</p> <p>§483.12(a)(1) Not use verbal, mental, , or , corporal punishment, or involuntary ;</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record reviews, and interviews the facility failed to protect residents from neglect and by two staff members (A & B) for eight residents (#1, #2, #3, #4, #5, #6, #8, and #9) out of eight sampled for and neglect.</p> <p>Findings included:</p> <p>On at 10:00 a.m. Resident #1 was observed lying in bed and covered with blankets. The resident reported and neglectful behavior had occurred last week, had been on menstrual cycle, and was left saturated with all day. The resident stated having had problems several times with Staff A Certified Nursing Assistant (CNA) and Staff B CNA being disrespectful, calling names, had talked about this resident's children, and talked about other residents and staff all the time. Resident #1 stated the staff members spoke about how fat they (other residents) were and how difficult it was to roll them. The resident stated the staff members behavior had been reported before, did not remember when, and did not know what the facility response was to the report. Resident #1 stated the staff members worked with the resident every day and spoke of others every day "all the time".</p> <p>Review of Resident #1's Admission Record showed the resident was admitted on with diagnoses including but not limited to</p>	F 600	<ol style="list-style-type: none"> Residents #1, 2, 3, 4, 5, 6, 8, and 9 have been assessed by nursing and no adverse effects noted. Psych services offered to residents. Social services continue to offer support services to residents. Activities staff has worked with residents to ensure additional support is provided. There are no adverse effects noted and residents remain safe in the center. Residents interviewed by NHA and all stated that they feel safe and are grateful in the response from administration regarding the situation. Resident interviews completed for residents with above 10. Interview conducted questioned residents if they had witnessed with any other residents or were abused at any time. Skin assessments were completed for residents with a less than 10. Interviews and assessments completed and no additional findings at the time of the interviews and assessments. Any concerns noted in the interviews were reviewed by NHA, and NHA ensured that the concerns were previously addressed. education was completed with staff in conjunction with posttest and scenarios. education provided by IDT members to staff. IDT educated by company VP of Risk Management. Education will continue at times of allegations of and during new hire orientation. A sample of 		

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F 600	<p>Continued From page 10</p> <p>due to unspecified occlusion or of right medial and following affecting left non-dominant side, post-stress (), aphasia following and need for assistance with personal care.</p> <p>Review of Resident #1's Annual Minimum Data Set (MDS) dated showed the resident scored 13 of 15 for a Brief Interview of Mental Status () indicating an intact cognition. The MDS showed the resident was dependent upon staff for toileting hygiene, shower/bathing, upper and lower body , personal hygiene, sit to lying, and toilet transfers. The resident required substantial/maximal assistance for rolling left to right. The resident was frequently of and always with .</p> <p>Review of Resident #1's care plan revealed the following: Resident has . Trigger for may become easily agitated when staff not providing care timely (and) become from loud yelling from others. An intervention dated instructed "Provide CNA care timely". Resident #1 has an Activities of Daily Living (ADL) self-care performance related to () with (w/) hemi, balance, history of left aphasia, , major , generalized behaviors, (and) . The interventions included: 2 staff in the room while providing any care as the resident is totally dependent on staff and requires extensive (ext.) total assistance by 1 staff with personal hygiene and oral care (revised).</p>	F 600	<p>residents will be interviewed monthly by IDT to ask questions related to care/treatment and potential concerns. Room rounds continue to be completed five times a week by IDT to ensure resident is monitored and has no concerns. Audit of interviews will be completed by NHA or designee to ensure that there are no outstanding concerns.</p> <p>4. Audits will be reviewed at the QAA/QAPI meeting monthly for three months or until substantial compliance is achieved. The audits will be presented by the Administrator or designee.</p>		

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F 600	<p>Continued From page 11</p> <p>An interview was conducted with the Nursing Home Administrator (NHA) on _____ at 1:36 p.m. The NHA stated on _____ Resident #1 had asked the Staffing Coordinator to assist her to the NHA office where she reported an incident had occurred with Staff A and B. Resident #1 stated she had put the call light on to be changed. The resident reported during care Staff A and Staff B were talking about residents and staff by name. The resident had asked to have brief changed, found out she was on her menstrual period and the staff members refused to wipe her. The NHA stated during the investigation other residents and staff had voiced same (similar) issues. The NHA stated both staff members were suspended then terminated. The NHA reported other residents voiced the following concerns regarding Staff A and Staff B.</p> <p>An interview was conducted with the NHA on _____ at 7:03 p.m. the NHA stated an unidentified CNA who had showered Resident #1 after reporting the incident on _____, reported there was _____ in the resident's brief. On _____ at 10:14 a.m. Resident #2 was observed lying in a _____ bed. The resident stated staff some staff were unprofessional, they do talk about other people, a couple of staff members whom this resident had not seen recently. The resident stated they were disrespectful regarding other residents.</p> <p>Review of Resident #2's Admission Record showed the resident was admitted on _____ . The record included diagnoses not limited to _____ (severe) _____ due to excess calories, unspecified _____, and unspecified affecting left _____ nondominant side _____.</p>	F 600		

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F 600	<p>Continued From page 12</p> <p>Review of Resident #2's quarterly Minimum Data Set, dated _____ revealed a 7 of 15 score, indicating a severe _____.</p> <p>Review of the resident's care plan showed the resident required maximum to total assistance for bed mobility, personal hygiene, and toilet use.</p> <p>On _____ at 10:35 a.m. Resident #3 had stated Staff A and Staff B are rude and do not clean area well when changing her. The resident reported commenting to the staff members about doing it right the first time and they responded with rude comments.</p> <p>Review of Resident #3's Admission Record showed the resident was admitted on _____. The record included diagnoses not limited to _____ (severe) _____ due to excess calories, need for assistance with personal care, not elsewhere classified lymphedema, and unspecified _____ of _____.</p> <p>Review of Resident #3s quarterly Minimum Data Set, dated _____ revealed a 15 of 15 score indicating an intact cognition. Review of the resident's Kardex (a guide to patient care details), revealed the resident required a _____ bed with a low air loss mattress, required 2 staff members for turn and repositioning, was dependent on 2 staff for _____ toileting, and staff were to converse with the resident while providing care.</p> <p>On _____ at 1:36 p.m. the NHA stated Resident #4 had reported Staff A and Staff B would care for her together and if they changed her once, that was it. The resident stated they made her feel _____.</p>	F 600			

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F 600	<p>Continued From page 13</p> <p>bad when she soiled self.</p> <p>On at 10:05 a.m., Resident #4 stated the facility got rid of the girls that were "not talking appropriately". The resident was not descriptive about what happened, just that they were gone and they no longer worked at the facility. When asked if she had been abused or neglected, she said, "neglected". Resident #4 said, "they would only change me once."</p> <p>Review of Resident #4's Annual Minimum Data Set (MDS) dated revealed the resident was admitted on and scored 12 of 15 on the Brief Interview of Mental Status () indicating an intact cognition. The comprehensive assessment revealed the resident was dependent on staff for toileting hygiene, bathing/showering, lower body , and required substantial/ for personal hygiene. The MDS revealed the resident was always of and</p> <p>On at 1:36 p.m. the NHA stated Resident #5 had reported Staff A and Staff B did not get her out of bed when requested and they did not put her correctly. She stated the resident, a patient liked the bed set up in a way the resident felt comfortable and that the staff members had made her feel like a burden.</p> <p>On at 11:09 a.m. Resident #5 was observed lying in bed. The resident stated staff were disrespectful, not , giving an example as " they ignore you when the call light is on." The resident stated the staff spoke about other residents.</p> <p>Review of Resident #5's Admission Record</p>	F 600		

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F 600	<p>Continued From page 14</p> <p>revealed the resident was admitted on . The record included diagnoses not limited to (severe) due to excess calories, () 50.0 to 59.9 adult, need for assistance with personal care, and unspecified .</p> <p>On at 1:36 p.m. the NHA stated Resident #6 had reported Staff A and Staff B did not clean him well and would leave movement on . The resident had recalled an incident when the staff members left him in the shower room alone and when asked to be changed, they made him feel like a burden. The NHA stated Resident #6 was a double above- and should be supervised in the shower.</p> <p>Review of Resident #6's Quarterly MDS dated showed the resident was admitted on . The assessment revealed the resident had scored 12 of 15 on the indicating an intact cognition and required partial to for toileting hygiene, shower/bathing, and lower body . The MDS showed the resident was an .</p> <p>On at 1:36 p.m. the NHA stated Resident #8 reported both Staff A and Staff B antagonized him and other residents when they asked for assistance.</p> <p>On at approximately 4:30 p.m. Resident #8 was observed sitting in wheelchair dressed in seasonally appropriate clothing. The resident reported the ability to do a lot for self. He stated the facility had a problem with a couple of girls but understood they were gone. He did not explain what the problem was.</p>	F 600			

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F 600	<p>Continued From page 15</p> <p>Review of Resident #8s Annual Minimum Data Set (MDS) dated _____ revealed the resident was admitted on _____ and had scored 13 of 15 on _____, indicating an intact cognition. The assessment revealed the resident was independent with toileting and personal hygiene, requiring supervision with shower/bathing. The active diagnoses showed _____ (severe) due to excess calories.</p> <p>On _____ at 1:36 p.m. the NHA stated Resident #9 reported Staff A and Staff B had left him soiled in brief and told him to wait for the next shift. The resident stated the two staff members would shut off the call light, was quick to change him when soiled, and would talk about others when caring for him making him feel like he was not even in the room.</p> <p>Review of Resident #9's Annual MDS dated _____ revealed the resident was admitted on _____ and had scored 12 of 15 on _____ assessment indicating an intact cognition. The annual assessment revealed the resident had range of motion limitations to _____ upper and lower extremities, was dependent upon staff for toileting hygiene, showering, and lower body _____, and required substantial/ _____ with upper body _____, and personal hygiene. The MDS showed the resident had an _____ and was always _____ of _____. The active diagnoses for the resident included _____ (severe) due to excess calories, _____, and _____'s _____.</p> <p>Review of the resident census showed Resident #1, #2, #3, #4, #5, #6, #8, and #9 resided on the</p>	F 600			

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F 600	<p>Continued From page 16</p> <p>same unit and specifically on the 200 and 300 hallways of the unit.</p> <p>During the interview on at 1:36 p.m. the NHA stated the facility had asked other staff members similar questions asked of the residents regarding Staff A and Staff B. The NHA stated the following written staff statements were submitted:</p> <ul style="list-style-type: none"> - Staff C, Licensed Practical Nurse (LPN) reported both Staff A and Staff B talked to residents in an unprofessional way, resident meal trays were left in front of them for about 45 minutes and (they) speak to the residents "crazy". - Staff D, CNA reported when Staff A and Staff B work together they are rude to residents and how they talk to some residents was verbally aggressive or rude unprofessional. - Staff E, Medical Records/CNA reported Staff B did not want to care for difficult residents and Staff A did not want to care (named) resident, would refuse to go into the room to pass trays. When (Staff E) was working the floor Staff A and Staff B would disappear during meal and care times, they would complain about caring for Resident #1, talk bad about the resident, complain about how hard it was to care for the resident. Staff E reported they were very verbal about it, and spoke openly in front of everyone usually around the nursing station. <p>An interview was conducted with Staff E on at 2:28 p.m. Staff E stated Staff A and Staff B would refuse to care for some residents. Staff B would "intentionally" make a (named unsampled) resident wait for hours before getting the resident up. The staff member reported not informing anyone, "there wasn't really anything to report." Staff E reported informing Staff B the resident was ready, and Staff B would say she would get</p>	F 600			

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F 600	<p>Continued From page 17</p> <p>to him. The staff member stated she didn't know if this behavior was reportable. The staff member stated there was "hostility" between the nurses, the CNAs, and Staff A and B, when they were told to do something they didn't get done, and it went on "for a while". The staff member reported Staff A and B would work together with all their assigned patients and went room to room doing patient care, they had issues with Resident #1, and Resident #1 had issues with them. Resident #1 did not like them to be assigned to her, but they continued to assigned to the resident. Staff E stated it "was out of our (CNAs) once it was reported." The NHA, who was present during this interview responded by shaking acknowledging he was aware.</p> <p>An interview was conducted with Staff C, LPN on at 2:45 p.m. The staff member clarified "crazy" (in written statement) meant they were occasions she would hear Staff A and B speak rudely to patients. Staff C remembered one incident where a resident had told Staff B she was like a , dog and Staff B had responded to not ask her for anything if "I'm" a , dog. She stated she wrote a statement on Staff B being rude but no one followed up with her regarding the statement. Staff C stated it was always hard to talk to Staff A and B. She stated she did talk to management, but the facility has never had steady management but did not feel anything got done.</p> <p>An interview was conducted with the NHA on at 3:05 p.m. The NHA reported switching assignments for Staff A and B. They had called the compliance hotline they were "pissed" about being separated. The NHA stated they were aware of the working environment between Staff</p>	F 600			

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F 600	<p>Continued From page 18</p> <p>A and B and "the unit" but did not know about the issues with the residents at the time.</p> <p>An interview was conducted on _____ at 4:06 p.m. with Staff F, LPN/Unit Manager (UM). The staff member reported getting a complaint at 3 p.m. regarding a resident being "full" of feces, and Staff B had left before doing rounds with oncoming shift. Staff F LPN/ UM reported receiving complaints from different shifts about things not being done by Staff A and B. She stated sometimes the staff members could not be found when call lights were going off ("like a Christmas tree down there") and nurses would come to her regarding the staff members. Staff F reported having reported "constantly" to the current NHA, and have informed the Director of Nursing (DON) and HR.</p> <p>An interview was conducted on _____ at 5:25 p.m. with Human Resources (HR). HR reported getting "lots" of things under door but denied having received anything regarding Staff A and B.</p> <p>Review of the policy and procedure, N-1265 - Neglect, _____ & Misappropriation, revised _____, documented the policy: "It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from _____, neglect, mistreatment, _____ and/or misappropriation of property. The management of the facility recognizes these rights and hereby establishes the following statements, policies, and procedures to protect these rights and to establish a disciplinary policy, which results in the fair and timely treatment of occurrences of resident _____. Employees of the center are charged with a continuing _____ to treat residents, so they are free from _____, neglect,</p>	F 600		

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F 600	Continued From page 19 mistreatment, and/or misappropriation of property. No employee may at any time commit an act of physical, , , or emotional , neglect, mistreatment, and/or misappropriation of property against any resident. Violation of this standard will subject employees to disciplinary action, including dismissal, provided herein." The policy defined the following: - Mental is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation or degradation. - may be considered a form of mental . includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance regardless of age ability to comprehend or . - Neglect is the failure of the center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, , , mental anguish or emotional distress. Examples include but are not limited to: - Failure to take precautionary measures to protect the health and safety of the resident. - Intentional lack of attention to physical needs including, but not limited to, toileting and bathing. Failure to provide services that result in harm to the resident, such as not turning a bedfast resident or leaving a resident in a soiled bed. - Failure or refusal to provide a service for the purpose of punishing or disciplining a resident, unless withholding of a service is being used as part of a documented integrated behavioral management program. Procedure:	F 600			

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F 600	Continued From page 20 Acts of directed against residents are absolutely prohibited. Such acts are cause for disciplinary action, including dismissal and possible criminal prosecution. Questions may arise as to what actions constitute of a resident. Any action that may cause or causes actual physical, or emotional harm, which is not caused by simple negligence, constitutes . . . Acts such as teasing, humiliating, degrading, or intentionally ignoring a resident may constitute and will be dealt with no less severely than acts causing physical harm. Non-action, which results in emotional, , or physical injury, is viewed in the same manner as caused by improper or excessive action. All actions in which employees engage with residents must have their legitimate goal, the healthful, proper, and humane care and treatment of the resident. 2. Training: Employees of the center will receive education and training on Resident Rights, Resident , and Reporting during orientation and annually thereafter. Additional education and training will be provided as deemed necessary. Employee : All employees have a duty to respect the rights of all residents, to treat them with dignity and to prevent others from violating their rights. Any employee, who witnesses or has knowledge of an act of or an allegation of , neglect, , or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve or result in serious bodily injury, or not later than 24 hours if the events that	F 600			

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F 600	Continued From page 21 cause the allegation do not involve _____ and do not result in serious bodily injury, to the Administrator and to other officials in accordance with State law. In the absence of the Executive Director, the Director of Clinical Services is the designated _____ coordinator. 3. Prevention: The center is committed to the prevention of _____, neglect, misappropriation of resident property, and _____. The following systems have been implemented: - Resident Council - Grievance/Concern program including posted information on the grievance official. - Sufficient numbers of staff to meet the needs of the residents. - Department Heads and supervisors that monitor staff to identify inappropriate behavior. - Monitoring of residents who may be at risk is the responsibility of all facility staff. This includes monitoring residents who are at risk or for _____, for indications of changes in behavior, changes in condition or other non-verbal indication of _____. - Posted information on how to contact appropriate State agencies. 4. Identification: All reported events (_____, _____, inappropriate or _____ behaviors) will be investigated by the Director of Nursing/ designee. Patterns or trends will be identified that might constitute _____. This information will be forwarded to the Executive Director, who will serve as the facility's _____ Coordinator, and an _____ investigation will be conducted in the absence of the Executive Director, the Director of Nursing will serve as the _____ Coordinator. 5. Investigation: The _____ Coordinator or his/her designee shall investigate all reports or allegations of _____, neglect, misappropriation and _____. A Social Service representative	F 600			

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F 600	Continued From page 22 may be offered in the role of resident advocate during any questioning of or interviewing of residents. Investigations will be accomplished in the following manner Preliminary Investigation: - Immediately upon an allegation of . or neglect, the suspect(s) shall be segregated from residents pending the investigation of the resident allegation. - The nurse or Director of Nursing/ designee shall perform and document a thorough nursing evaluation and notify the attending physician. - An incident report shall be filed by the individual in charge who received the report in conjunction with the person who reported the . This report should be filed as soon as possible in order to provide the most accurate information in a timely fashion, and submitted to the Coordinator. Investigation: The Coordinator and/or Director of Nursing shall take statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged . He/ she shall also secure physical evidence. Upon completion of the investigation, a detailed report shall be prepared. 6. Protection: Any suspect(s), who is an employee or contract service provider, once he/she has (have) been identified, will be suspended pending investigation. - The resident will be evaluated for any signs of injury, including a physical exam and/ or . assessment, as appropriate. - Increased supervision of the alleged victim and residents. - Room or staffing changes, if necessary, to protect the resident(s) form (sic) the alleged	F 600			

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F 600	Continued From page 23 - Protection from retaliation. - Provide the resident with emotional support and counseling during and after the investigation, if needed. 7. Reporting/ Response: Any employee or service provider who witnesses or has knowledge of an act of or an allegation of neglect, or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve and do not result in serious bodily injury, to the Administrator and to other officials in accordance with State law. In the absence of the Executive Director, the Director of Nursing is the designated coordinator. Once an allegation of is reported, the Executive Director, as the coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations, including notifications of Law Enforcement if a reasonable suspicion of crime has occurred.	F 600			
F 609 SS= D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of neglect, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving neglect, or	F 609			

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F 609	<p>Continued From page 24</p> <p>mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interviews, the facility failed to ensure an allegation of neglect was reported to the appropriate Agencies for one (#9) of ten sampled residents.</p> <p>Findings included:</p> <p>A review of Resident #9's clinical chart documented an admission of . His diagnosis list included but not limited to Type 2 with , and .</p> <p>A review of a dated , documented a score of 13,</p>	F 609	<ol style="list-style-type: none"> 1. Resident #9 was assessed by nursing and social services and no adverse effects were noted. Resident remains in the center. Staff B was terminated. Resident #9 interviewed by NHA and resident stated that he felt safe in the center and had no additional concerns at the time of the interview. 2. Resident interviews completed for residents with above 10. Interview conducted questioned residents if they had witnessed with any other residents or were abused at any time. Skin assessments were completed for residents with a less than 10. 		

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F 609	<p>Continued From page 25 with a comment "Intact response".</p> <p>A review of Resident #9's clinical chart, the Care Plan, documented a focus area: Resident #9 has an ADL (Activity of Daily Living) self-care performance and at risk for decline. Interventions included: Toilet Use: The resident is totally dependent on staff for toileting ... to ... , initiated .</p> <p>A review of Staff B, Certified Nursing Assistant's (CNA) personnel file was conducted with the Human Resource Director (HRD). Present in the file was a document, "Teachable Moment", dated for Staff B, CNA, which documented a description of action: "(Resident #9) was found to be covered in feces. Good practice is we check and change residents every 2 hours. Resident states he had been asking to be changed all morning, and he had not been changed. When the p.m. aide came on duty, you were already out of the building. She didn't get to do bedside round (receive report) and upon entering the resident's room, found resident covered in feces". The form was not signed by any person as presenting the document or receiving the document. During the review of the "Teachable Moment" with the HRD, she stated she did not know about the form. She stated, "teachable moments are nursing documents. The HRD stated, "I assume it was nursing that wrote it up with the expectation of presenting. I cannot tell you who wrote it up".</p> <p>An interview conducted on at 6:15 p.m. with the NHA, while reviewing the Teachable moment for Staff B, he stated teachable moment was invalid. It was not signed; it was a worthless piece of paper that should not have been in the</p>	F 609	<p>Interviews and assessments completed and no additional findings at the time of the interviews and assessments. Any concerns noted in the interviews were reviewed by NHA, and NHA ensured that the concerns were previously addressed.</p> <p>3. education was completed with staff in conjunction with posttest and scenarios. education provided by IDT members to staff. IDT educated by company VP of Risk Management. Education will continue at times of allegations of and during new hire orientation. A sample of residents will be interviewed monthly by IDT to ask questions related to care/treatment and potential concerns. Room rounds continue to be completed five times a week by IDT to ensure resident is monitored and has no concerns. Audit of interviews will be completed by NHA or designee to ensure that there are no outstanding concerns.</p> <p>4. Audits will be reviewed at the QAA/QAPI meeting monthly for three months or until substantial compliance is achieved. The audits will be presented by the Administrator or designee.</p>		

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F 609	<p>Continued From page 26</p> <p>file. He said he did not know who had filled it out; after reading it he said he should have been "in on it".</p> <p>On _____ at approximately 6:20 p.m., an interview was conducted with Staff G, CNA. She recalled the concern with how she had found Resident #9. She said, "I came in at 3:00 p.m.; I was assigned (the _____ hall where Resident #9 resides). I heard someone yelling. I thought it was (Resident #9), so, I went in and checked on him. It was between 3:00 and 3:30 p.m., it was the first thing I heard. He was covered in feces from the waist, some of it was on his thighs, it was like _____. He told me he had been like that since noon. Some of the feces was dried on, some of it was not, I had to scrub him. The sheets were covered in it too. I changed everything." She stated normally there is report given during shift change, but at the time, there was no one to provide the report. She stated she shared the information with the nurse, Staff C, LPN and she went and got the Unit Manager, Staff F, LPN. Staff G stated she wrote a statement and gave it to the Unit Manager, Staff F.</p> <p>A review of a complaint/ Grievance Report dated _____ by (Staff G, CNA), documented a concern for treatment and care for Resident #9 showing: CNA reports that resident was covered in feces and he had been sitting for a while before anyone came to change him. The staff member assigned responsibility for the investigation was Staff F, LPN, UM. The investigation: This resident was found to be covered in feces. The Aide assigned to resident was (Staff B, CNA). She was educated about the importance of providing prompt care. Expectation showed: aide will work endeavor to ensure proper care. Written</p>	F 609			

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F 609	<p>Continued From page 27</p> <p>teachable moment was provided to aide, signed as completed . The section to be completed on whether the grievance was reportable to the state agency was not marked with either a yes or no indication.</p> <p>An interview conducted was conducted with the NHA On at 6:33 p.m. He stated residents should be changed, "At least every two hours". When asked, if a resident alleges, he had been sitting in a movement (BM) since 12:00 p.m., and not changed until between 3:00 and 3:30 p.m., if it was appropriate care, he stated, "I would say it is not". "It has the potential to be neglect". He stated the incident was not reported. He said, "I went and talked to the resident. And he said, he went to the bathroom in his brief. He said the girls were busy on the floor; he has a boisterous voice; (Staff G, CNA) thought he was yelling; and she went in and changed him." The NHA stated he asked the resident if he felt like he was neglected, and he said no, and he did not know why someone had reported it. He confirmed the staff member assigned to Resident #9 on during the 7:00 a.m. to 3:00 p.m. shift was Staff B, CNA. The NHA stated the process for reporting an allegation was, "I report it to our clinical team and the Regional Nurse Consultant, who is their Risk Manager. Then, I write up my initial findings, submit on the AIRS (AHCA Incident Reporting System) system; notify the Department of Children and Families, police, and any other parties necessary, and then. begin the investigation. The NHA confirmed this incident was not reported.</p> <p>Review of the policy and procedure, N-1265 - Neglect, & Misappropriation, revised , documented the policy: "It is</p>	F 609		

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F 609	Continued From page 28 inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from neglect, mistreatment, and/or misappropriation of property. The management of the facility recognizes these rights and hereby establishes the following statements, policies, and procedures to protect these rights and to establish a disciplinary policy, which results in the fair and timely treatment of occurrences of resident . . . Employees of the center are charged with a continuing to treat residents, so they are free from neglect, mistreatment, and/or misappropriation of property. No employee may at any time commit an act of physical, , or emotional neglect, mistreatment, and/or misappropriation of property against any resident. Violation of this standard will subject employees to disciplinary action, including dismissal, provided herein." 7. Reporting/ Response: Any employee or service provider who witnesses or has knowledge of an act of or an allegation of neglect, or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve and do not result in serious bodily injury, to the Administrator and to other officials in accordance with State law. In the absence of the Executive Director, the Director of Nursing is the designated coordinator. Once an allegation of is reported, the	F 609			

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F 609	Continued From page 29 Executive Director, as the coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations, including notifications of Law Enforcement if a reasonable suspicion of crime has occurred.	F 609			

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N 000	INITIAL COMMENTS A complaint survey for complaint number 2025008021 was conducted on _____ at Aviatat at Seminole. Deficiencies were identified at the time of the survey. Complaint #2025008021 had deficiencies cited at N204.	N 000			
N 188 SS=D	400.022(1)(d), FS. Right to File Grievances (d) The right to present grievances on behalf of himself or herself or others to the staff or administrator of the facility, to governmental officials, or to any other person; to recommend changes in policies and services to facility personnel; and to join with other residents or individuals within or outside the facility to work for improvements in resident care, free from _____, interference, coercion, discrimination, or reprisal. This right includes access to ombudsmen and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. The right also includes the right to prompt efforts by the facility to resolve resident grievances, including grievances with respect to the behavior of other residents. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a functioning grievance process for two residents (#1 and #9) of ten residents sampled. Findings included: A review of the Complaint/ Grievance policies and procedures, last revised on _____,	N 188	Resident #1 was interviewed regarding the incident, and upon conclusion of interview, the resident was satisfied with the outcome of the decision made by administration in relation to the submitted grievance. Reportable incident completed regarding this issue on _____. Additional services offered to resident to provide additional support. Nursing assessments completed to ensure there		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X8) DATE

/25

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N 188	<p>Continued From page 1</p> <p>documented the policy: The Center will support each resident's right to voice a complain/ grievance without fear of discrimination or reprisal. The center will make prompt efforts to resolve the complain/ grievance and inform the resident of progress towards resolution. Grievances discovered to meet the definition of Neglect, or Misappropriation will be handled per the facility Policy. The resident should have reasonable expectations of care and services, and center should address those expectations in a timely reasonable and consistent manner.</p> <p>A review of a Complaint / Grievance Report, dated , documented (Resident #1) communicated verbally to the Social Service Assistant (SSA) a concern: "Resident #1 stated 2 CNA's (Certified Nursing Assistants) were having personal conversations when providing care". The form was signed by the Social Services Director (SSD) on . The form had an area to document the concern type, treatment, Care, management of funds, behavior of other residents, missing items, violation of rights, and other. The latter area was blank. The form documented nursing was assigned the responsibility for the investigation. The findings of the investigation were documented: "Staff were identified and were noted to have personal conversations while providing care to residents". The plan to resolve the complaint: "Education to identified CNAs". Expected results of the actions taken: "Verbal education provided to identified CNAs on not having personal conversations while providing care to residents. CNAs expressed understanding". The form was signed by (Staff F, Licensed Practical Nurse) (LPN), Unit Manager (UM), . The form documented the complaint was resolved. The</p>	N 188	<p>were no adverse effects to the resident. No adverse effects noted.</p> <p>2. Grievance log and grievances reviewed for previous 3 months by NHA and Social Services Director (SSD). There were no other grievances that were found noted to be reportable events. Resident interviews completed for residents with above 10 to ensure that there were no outstanding concerns or allegations of that were not addressed. Skin assessments were completed for residents with a less than 10. No additional findings at the time of evaluation.</p> <p>3. Grievances are reviewed five times a week by the IDT to ensure timely response. Grievance log and grievances will be audited weekly by SSD or designee, and NHA, or designee to ensure that grievances are completed timely, and allegations of were addressed. This will be an ongoing practice implemented as part of the facility operations. Room rounds continue to be completed five times a week by IDT to ensure resident is monitored and has no concerns. Education completed with staff to review the grievance process. education was completed with staff in conjunction with posttest and scenarios. Education provided by IDT members to staff. IDT educated by company VP of Risk Management. Grievance process reviewed at resident council meeting with residents. Process reviewed by Activities Director. Residents confirmed understanding of the process.</p> <p>4. Audits will be reviewed at the QAA/QAPI meeting monthly for three</p>	
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N 188	<p>Continued From page 2</p> <p>form was blank to indicate if the resident was satisfied. The form documented the results and resolution steps were reported to the resident.</p> <p>A review of Resident #1's clinical chart showed an admission in . Medical diagnoses included but not limited to . . . and following affecting left non-dominant side; generalized . . . ; and post- stress A review of the Minimum Data Set (MDS) dated revealed a () score of 13, which indicated the resident was</p> <p>A review of the facility Grievance log from through the 06/09/2025, listed two complaints filed by Resident #1, dated and</p> <p>An interview was conducted on at 11:01 a.m. with Staff F, licensed Practical Nurse (LPN)/ Unit Manager (UM). She stated regarding Resident #1's complaint dated , "I was not aware of that one coming to me directly. When I did become aware, I spoke to the resident. I did give a statement to the CNAs. If it is the same situation that I was thinking about, those two CNAs were put on suspension". She stated the SSD came to her about the concern. Staff F stated she left the building and came on the following week. She stated she found out about the concern on at the morning meeting. Staff F said, "I spoke to her (the resident) on about the concern."</p> <p>On at 12:35 p.m., an interview was conducted with the SSD. He stated the grievance for Resident #1 was communicated to the SSA.</p>	N 188	<p>months or until substantial compliance is achieved. The audits will be presented by the Social Services Director or designee.</p>	

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N 188	<p>Continued From page 3</p> <p>On _____ at approximately 12:40 p.m., an interview was conducted with the SSA with the Nursing Home Administrator (NHA) in the room. The SSA stated Resident #1 had reported regarding two staff members, she "did not like the behavior; the conversations they were having, their likes and dislikes for the residents. The SSA stated she relayed the concern to the Administrator In Training (AIT). "The AIT put it on the grievance form". The SSA said "I did not personally investigate". During the interview, the NHA said, "the grievance would have gone to the unit manager".</p> <p>On _____ at 2:22 p.m., an interview was conducted with the NHA regarding Resident #1's grievance dated _____. A request for documentation pertaining to an investigation for the grievance revealed there was no documentation. He stated there was nothing further. He confirmed he was the Coordinator. He stated he was out of the building from _____ and came _____ on _____. He stated the AIT was the assigned _____ Coordinator in his absence.</p> <p>An interview was conducted on _____ at approximately 1:36 p.m. with the NHA regarding the reportable investigation he had conducted for the allegation reported by Resident #1 on _____. The NHA said, Resident #1 had reported on _____ she had a care concern about Staff A, CNA and Staff B, CNA. (Resident #1) reported them talking about residents and staff by name. At the time, she wanted her brief changed and she found out she was on her period. They refused to wipe her. That was the initial complaint. Both staff were suspended. The NHA said we did interviews with other residents and</p>	N 188		
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Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 55278	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/09/2025
NAME OF PROVIDER OR SUPPLIER AVIATA AT SEMINOLE			STREET ADDRESS, CITY, STATE, ZIP CODE 9393 PARK BLVD SEMINOLE, FL 33777		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 188	<p>Continued From page 4</p> <p>staff. Other residents had identified same issues. We chose people in the same assignment.</p> <p>An interview was conducted on _____ at approximately 2:30 p.m. with the AIT, she stated she did not interview (Resident #1), and she did not investigate. She stated she did not do anything about the complaint. Subsequently, at 3:58 p.m. the AIT stated she helped the SSA fill out the grievance form for resident #1 for the _____. She stated it looked like (Staff F, LPN, UM) did the investigation.</p> <p>On _____ at 1:26 p.m., an observation was conducted of Resident #1. She confirmed she had submitted a grievance to complain about two aides on _____. She stated no one came and talked to her about the concern. She stated she had not received a response from the facility about her grievance submitted on _____.</p> <p>A review of a complaint/ Grievance Report dated _____ by (Staff G, CNA), documented a concern for treatment and care for Resident #9 showing: CNA reports that resident was covered in feces and he had been sitting for a while before anyone came to change him. The staff member assigned responsibility for the investigation was Staff F, LPN, UM. The investigation: This resident was found to be covered in feces. The Aide assigned to resident was (Staff B, CNA). She was educated about the importance of providing prompt care. Expectation showed: aide will work endeavor to ensure proper care. Written teachable moment was provided to aide, signed as completed _____. The section to be completed on whether the grievance was reportable to the state agency was not marked with either a yes or no indication.</p>	N 188			

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N 188	<p>Continued From page 5</p> <p>A review of Resident #9's clinical chart documented an admission of . His diagnosis list included but not limited to Type 2 with , and .</p> <p>A review of a dated , documented a score of 13, with a comment "Intact response".</p> <p>A review of Resident #9's clinical chart, the Care Plan, documented a focus area: Resident #9 has an ADL (Activity of Daily Living) self-care performance and at risk for decline. Interventions included: Toilet Use: The resident is totally dependent on staff for toileting ... to , initiated .</p> <p>A review of Staff B, Certified Nursing Assistant's (CNA) personnel file was conducted with the Human Resource Director (HRD). Present in the file was a document, "Teachable Moment", dated for Staff B, CNA, which documented a description of action: "(Resident #9) was found to be covered in feces. Good practice is we check and change residents every 2 hours. Resident states he had been asking to be changed all morning, and he had not been changed. When the p.m. aide came on duty, you were already out of the building. She didn't get to do bedside round (receive report) and upon entering the resident's room, found resident covered in feces". The form was not signed by any person as presenting the document or receiving the document. During the review of the "Teachable Moment" with the HRD, she stated she did not know about the form. She stated, "teachable moments are nursing documents. The HRD stated, "I assume it was nursing that wrote it up with the expectation of presenting. I cannot tell you who wrote it up".</p>	N 188		

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N 188	<p>Continued From page 6</p> <p>An interview conducted was conducted with the NHA On at 6:33 p.m. He stated residents should be changed, "At least every two hours". When asked, if a resident alleges, he had been sitting in a movement (BM) since 12:00 p.m., and not changed until between 3:00 and 3:30 p.m., if it was appropriate care, he stated, "I would say it is not". "It has the potential to be neglect". He stated the incident was not reported. He said, "I went and talked to the resident. And he said, he went to the bathroom in his brief. He said the girls were busy on the floor; he has a boisterous voice; (Staff G, CNA) thought he was yelling; and she went in and changed him." The NHA stated he asked the resident if he felt like he was neglected, and he said no, and he did not know why someone had reported it. He confirmed the staff member assigned to Resident #9 on during the 7:00 a.m. to 3:00 p.m. shift was Staff B, CNA.</p> <p>Class III</p>	N 188		
N 204 SS=E	<p>400.022(1)(o), FS Right to be Free from , etc</p> <p>400.022, F. S. (1)(o)</p> <p>All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the following:</p> <p>(o) The right to be free from mental and , , neglect, , corporal punishment, extended involuntary , and , , corporal</p>	N 204		

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N 204	<p>Continued From page 7</p> <p>punishment, extended involuntary _____, and physical and chemical _____, except those _____ authorized in writing by a physician for a specified and limited period of time or as are necessitated by an emergency. In case of an emergency, _____ may be applied only by a qualified licensed nurse who shall set forth in writing the circumstances requiring the use of _____, and, in the case of use of a chemical _____, a physician shall be consulted immediately thereafter. _____ may not be used in lieu of staff supervision or merely for staff convenience, for punishment, or for reasons other than resident protection or safety.</p> <p>This Statute or Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to protect residents from neglect and _____ by two staff members (A & B) for eight residents (#1, #2, #3, #4, #5, #6, #8, and #9) out of eight sampled for and neglect.</p> <p>Findings included:</p> <p>On _____ at 10:00 a.m. Resident #1 was observed lying in bed and covered with blankets. The resident reported _____ and neglectful behavior had occurred last week, had been on menstrual cycle, and was left saturated with _____ all day. The resident stated having had problems several times with Staff A Certified Nursing Assistant (CNA) and Staff B CNA being disrespectful, calling names, had talked about this resident's children, and talked about other residents and staff all the time. Resident #1 stated the staff members spoke about how fat</p>	N 204	<p>1. Residents #1, 2, 3, 4, 5, 6, 8, and 9 have been assessed by nursing and no adverse effects noted. Psych services offered to residents. Social services continue to offer support services to residents. Activities staff has worked with residents to ensure additional support is provided. There are no adverse effects noted and residents remain safe in the center. Residents interviewed by NHA and all stated that they feel safe and are grateful in the response from administration regarding the situation.</p> <p>2. Resident interviews completed for residents with _____ above 10. Interview conducted questioned residents if they had witnessed _____ with any other residents or were abused at any time. Skin assessments were completed for residents with a _____ less than 10. Interviews and assessments completed and no additional findings at the time of</p>	

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N 204	<p>Continued From page 8</p> <p>they (other residents) were and how difficult it was to roll them. The resident stated the staff members behavior had been reported before, did not remember when, and did not know what the facility response was to the report. Resident #1 stated the staff members worked with the resident every day and spoke of others every day "all the time".</p> <p>Review of Resident #1's Admission Record showed the resident was admitted on with diagnoses including but not limited to due to unspecified occlusion or of right medial and following affecting left non-dominant side, post-stress (), aphasia following and need for assistance with personal care.</p> <p>Review of Resident #1's Annual Minimum Data Set (MDS) dated showed the resident scored 13 of 15 for a Brief Interview of Mental Status () indicating an intact cognition. The MDS showed the resident was dependent upon staff for toileting hygiene, shower/bathing, upper and lower body , personal hygiene, sit to lying, and toilet transfers. The resident required substantial/maximal assistance for rolling left to right. The resident was frequently of and always with .</p> <p>Review of Resident #1's care plan revealed the following: Resident has . Trigger for may become easily agitated when staff not providing care timely (and) become from loud yelling from others. An intervention dated instructed "Provide CNA care timely". Resident #1 has an Activities of Daily Living (ADL) self-care performance related to</p>	N 204	<p>the interviews and assessments. Any concerns noted in the interviews were reviewed by NHA, and NHA ensured that the concerns were previously addressed.</p> <p>3. education was completed with staff in conjunction with posttest and scenarios. education provided by IDT members to staff. IDT educated by company VP of Risk Management. Education will continue at times of allegations of and during new hire orientation. A sample of residents will be interviewed monthly by IDT to ask questions related to care/treatment and potential concerns. Room rounds continue to be completed five times a week by IDT to ensure resident is monitored and has no concerns. Audit of interviews will be completed by NHA or designee to ensure that there are no outstanding concerns.</p> <p>4. Audits will be reviewed at the QAA/QAP1 meeting monthly for three months or until substantial compliance is achieved. The audits will be presented by the Administrator or designee.</p>	

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N 204	<p>Continued From page 9</p> <p>() with (w) hemi, balance, history of left aphasia, , major , generalized , behaviors, (and) . The interventions included: 2 staff in the room while providing any care as the resident is totally dependent on staff and requires extensive (ext.) total assistance by 1 staff with personal hygiene and oral care (revised).</p> <p>An interview was conducted with the Nursing Home Administrator (NHA) on at 1:36 p.m. The NHA stated on Resident #1 had asked the Staffing Coordinator to assist her to the NHA office where she reported an incident had occurred with Staff A and B. Resident #1 stated she had put the call light on to be changed. The resident reported during care Staff A and Staff B were talking about residents and staff by name. The resident had asked to have brief changed, found out she was on her menstrual period and the staff members refused to wipe her. The NHA stated during the investigation other residents and staff had voiced same (similar) issues. The NHA stated both staff members were suspended then terminated. The NHA reported other residents voiced the following concerns regarding Staff A and Staff B.</p> <p>An interview was conducted with the NHA on at 7:03 p.m. the NHA stated an unidentified CNA who had showered Resident #1 after reporting the incident on , reported there was in the resident's brief. On at 10:14 a.m. Resident #2 was observed lying in a bed. The resident stated staff some staff were unprofessional, they do talk about other people, a couple of staff members whom this resident had not seen</p>	N 204		
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N 204	<p>Continued From page 10</p> <p>recently. The resident stated they were disrespectful regarding other residents.</p> <p>Review of Resident #2's Admission Record showed the resident was admitted on . The record included diagnoses not limited to (severe) , due to excess calories, unspecified , and unspecified affecting left nondominant side .</p> <p>Review of Resident #2's quarterly Minimum Data Set, dated revealed a 7 of 15 score, indicating a severe</p> <p>Review of the resident's care plan showed the resident required maximum to total assistance for bed mobility, personal hygiene, and toilet use.</p> <p>On at 10:35 a.m. Resident #3 had stated Staff A and Staff B are rude and do not clean area well when changing her. The resident reported commenting to the staff members about doing it right the first time and they responded with rude comments.</p> <p>Review of Resident #3's Admission Record showed the resident was admitted on . The record included diagnoses not limited to (severe) , due to excess calories, need for assistance with personal care, not elsewhere classified lymphedema, and unspecified of</p> <p>Review of Resident #3s quarterly Minimum Data Set, dated revealed a 15 of 15 score indicating an intact cognition. Review of the resident's Kardex (a guide to patient care details), revealed the resident required a bed with</p>	N 204		

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N 204	<p>Continued From page 11</p> <p>a low air loss mattress, required 2 staff members for turn and repositioning, was dependent on 2 staff for toileting, and staff were to converse with the resident while providing care.</p> <p>On at 1:36 p.m. the NHA stated Resident #4 had reported Staff A and Staff B would care for her together and if they changed her once, that was it. The resident stated they made her feel bad when she soiled self.</p> <p>On at 10:05 a.m., Resident #4 stated the facility got rid of the girls that were "not talking appropriately". The resident was not descriptive about what happened, just that they were gone and they no longer worked at the facility. When asked if she had been abused or neglected, she said, "neglected". Resident #4 said, "they would only change me once."</p> <p>Review of Resident #4's Annual Minimum Data Set (MDS) dated revealed the resident was admitted on and scored 12 of 15 on the Brief Interview of Mental Status () indicating an intact cognition. The comprehensive assessment revealed the resident was dependent on staff for toileting hygiene, bathing/showering, lower body , and required substantial/ for personal hygiene. The MDS revealed the resident was always of and .</p> <p>On at 1:36 p.m. the NHA stated Resident #5 had reported Staff A and Staff B did not get her out of bed when requested and they did not put her correctly. She stated the resident, a patient liked the bed set up in a way the resident felt comfortable and that the staff members had made her feel like a burden.</p>	N 204		

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N 204	<p>Continued From page 12</p> <p>On at 11:09 a.m. Resident #5 was observed lying in bed. The resident stated staff were disrespectful, not , giving an example as " they ignore you when the call light is on." The resident stated the staff spoke about other residents.</p> <p>Review of Resident #5's Admission Record revealed the resident was admitted on . The record included diagnoses not limited to (severe) due to excess calories, () 50.0 to 59.9 adult, need for assistance with personal care, and unspecified .</p> <p>On at 1:36 p.m. the NHA stated Resident #6 had reported Staff A and Staff B did not clean him well and would leave movement on . The resident had recalled an incident when the staff members left him in the shower room alone and when asked to be changed, they made him feel like a burden. The NHA stated Resident #6 was a double above- and should be supervised in the shower.</p> <p>Review of Resident #6's Quarterly MDS dated showed the resident was admitted on . The assessment revealed the resident had scored 12 of 15 on the indicating an intact cognition and required partial to for toileting hygiene, shower/bathing, and lower body . The MDS showed the resident was an .</p> <p>On at 1:36 p.m. the NHA stated Resident #8 reported both Staff A and Staff B antagonized him and other residents when they asked for assistance.</p>	N 204		

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N 204	<p>Continued From page 13</p> <p>On _____ at approximately 4:30 p.m. Resident #8 was observed sitting in wheelchair dressed in seasonally appropriate clothing. The resident reported the ability to do a lot for self. He stated the facility had a problem with a couple of girls but understood they were gone. He did not explain what the problem was.</p> <p>Review of Resident #8s Annual Minimum Data Set (MDS) dated _____ revealed the resident was admitted on _____ and had scored 13 of 15 on _____, indicating an intact cognition. The assessment revealed the resident was independent with toileting and personal hygiene, requiring supervision with shower/bathing. The active diagnoses showed _____ (severe) due to excess calories.</p> <p>On _____ at 1:36 p.m. the NHA stated Resident #9 reported Staff A and Staff B had left him soiled in brief and told him to wait for the next shift. The resident stated the two staff members would shut off the call light, was quick to change him when soiled, and would talk about others when caring for him making him feel like he was not even in the room.</p> <p>Review of Resident #9's Annual MDS dated _____ revealed the resident was admitted on _____ and had scored 12 of 15 on _____ assessment indicating an intact cognition. The annual assessment revealed the resident had range of motion limitations to _____ upper and lower extremities, was dependent upon staff for toileting hygiene, showering, and lower body _____ and required substantial/ _____ with upper body _____ and personal hygiene. The MDS showed the resident had an _____ and was always _____ of _____. The active diagnoses for the</p>	N 204			

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N 204	<p>Continued From page 14</p> <p>resident included (severe) , due to excess calories, , , , and 's</p> <p>Review of the resident census showed Resident #1, #2, #3, #4, #5, #6, #8, and #9 resided on the same unit and specifically on the 200 and 300 hallways of the unit.</p> <p>During the interview on at 1:36 p.m. the NHA stated the facility had asked other staff members similar questions asked of the residents regarding Staff A and Staff B. The NHA stated the following written staff statements were submitted:</p> <ul style="list-style-type: none"> - Staff C, Licensed Practical Nurse (LPN) reported both Staff A and Staff B talked to residents in an unprofessional way, resident meal trays were left in front of them for about 45 minutes and (they) speak to the residents "crazy". - Staff D, CNA reported when Staff A and Staff B work together they are rude to residents and how they talk to some residents was verbally aggressive or rude unprofessional. - Staff E, Medical Records/CNA reported Staff B did not want to care for difficult residents and Staff A did not want to care (named) resident, would refuse to go into the room to pass trays. When (Staff E) was working the floor Staff A and Staff B would disappear during meal and care times, they would complain about caring for Resident #1, talk bad about the resident, complain about how hard it was to care for the resident. Staff E reported they were very verbal about it, and spoke openly in front of everyone usually around the nursing station. <p>An interview was conducted with Staff E on at 2:28 p.m. Staff E stated Staff A and Staff B would refuse to care for some residents. Staff B would "intentionally" make a (named unsampled)</p>	N 204		
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N 204	<p>Continued From page 15</p> <p>resident wait for hours before getting the resident up. The staff member reported not informing anyone, "there wasn't really anything to report." Staff E reported informing Staff B the resident was ready, and Staff B would say she would get to him. The staff member stated she didn't know if this behavior was reportable. The staff member stated there was "hostility" between the nurses, the CNAs, and Staff A and B, when they were told to do something they didn't get done, and it went on "for a while". The staff member reported Staff A and B would work together with all their assigned patients and went room to room doing patient care, they had issues with Resident #1, and Resident #1 had issues with them. Resident #1 did not like them to be assigned to her, but they continued to assigned to the resident. Staff E stated it "was out of our (CNAs) once it was reported." The NHA, who was present during this interview responded by shaking acknowledging he was aware.</p> <p>An interview was conducted with Staff C, LPN on at 2:45 p.m. The staff member clarified "crazy" (in written statement) meant they were occasions she would hear Staff A and B speak rudely to patients. Staff C remembered one incident where a resident had told Staff B she was like a , dog and Staff B had responded to not ask her for anything if "I'm" a , dog. She stated she wrote a statement on Staff B being rude but no one followed up with her regarding the statement. Staff C stated it was always hard to talk to Staff A and B. She stated she did talk to management, but the facility has never had steady management but did not feel anything got done.</p> <p>An interview was conducted with the NHA on at 3:05 p.m. The NHA reported switching</p>	N 204			

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N 204	<p>Continued From page 16</p> <p>assignments for Staff A and B. They had called the compliance hotline they were "pissed" about being separated. The NHA stated they were aware of the working environment between Staff A and B and "the unit" but did not know about the issues with the residents at the time.</p> <p>An interview was conducted on . . . at 4:06 p.m. with Staff F, LPN/Unit Manager (UM). The staff member reported getting a complaint at 3 p.m. regarding a resident being "full" of feces, and Staff B had left before doing rounds with oncoming shift. Staff F LPN/ UM reported receiving complaints from different shifts about things not being done by Staff A and B. She stated sometimes the staff members could not be found when call lights were going off ("like a Christmas tree down there") and nurses would come to her regarding the staff members. Staff F reported having reported "constantly" to the current NHA, and have informed the Director of Nursing (DON) and HR.</p> <p>An interview was conducted on . . . at 5:25 p.m. with Human Resources (HR). HR reported getting "lots" of things under door but denied having received anything regarding Staff A and B.</p> <p>Review of the policy and procedure, N-1265 - Neglect, & Misappropriation, revised , documented the policy: "It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from neglect, mistreatment, and/or misappropriation of property. The management of the facility recognizes these rights and hereby establishes the following statements, policies, and procedures to protect these rights and to establish a disciplinary policy, which results in the fair and timely treatment of occurrences of</p>	N 204		
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N 204	<p>Continued From page 17</p> <p>resident . Employees of the center are charged with a continuing to treat residents, so they are free from , neglect, mistreatment, and/or misappropriation of property. No employee may at any time commit an act of physical, , , or emotional , neglect, mistreatment, and/or misappropriation of property against any resident. Violation of this standard will subject employees to disciplinary action, including dismissal, provided herein."</p> <p>The policy defined the following:</p> <ul style="list-style-type: none"> - Mental is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation or degradation. - may be considered a form of mental includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance regardless of age ability to comprehend or - Neglect is the failure of the center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, , mental anguish or emotional distress. Examples include but are not limited to: <ul style="list-style-type: none"> - Failure to take precautionary measures to protect the health and safety of the resident. - Intentional lack of attention to physical needs including, but not limited to, toileting and bathing. - Failure to provide services that result in harm to the resident, such as not turning a bedfast resident or leaving a resident in a soiled bed. - Failure or refusal to provide a service for the purpose of punishing or disciplining a resident, unless withholding of a service is being used as part of a documented integrated behavioral 	N 204		

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N 204	<p>Continued From page 18</p> <p>management program.</p> <p>Procedure:</p> <p>Acts of _____ directed against residents are absolutely prohibited. Such acts are cause for disciplinary action, including dismissal and possible criminal prosecution. Questions may arise as to what actions constitute _____ of a resident. Any action that may cause or causes actual physical, _____ or emotional harm, which is not caused by simple negligence, constitutes _____. Acts such as teasing, humiliating, degrading, or intentionally ignoring a resident may constitute _____ and will be dealt with no less severely than acts causing physical harm.</p> <p>Non-action, which results in emotional, _____, or physical injury, is viewed in the same manner as caused by improper or excessive action. All actions in which employees engage with residents must have their legitimate goal, the healthful, proper, and humane care and treatment of the resident.</p> <p>2. Training: Employees of the center will receive education and training on Resident Rights, Resident _____, and _____ Reporting during orientation and annually thereafter. Additional education and training will be provided as deemed necessary.</p> <p>Employee _____: All employees have a duty to respect the rights of all residents, to treat them with dignity and to prevent others from violating their rights. Any employee, who witnesses or has knowledge of an act of _____ or an allegation of _____, neglect, _____, or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve _____ or result in serious bodily</p>	N 204		
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N 204	<p>Continued From page 19</p> <p>injury, or not later than 24 hours if the events that cause the allegation do not involve _____ and do not result in serious bodily injury, to the Administrator and to other officials in accordance with State law. In the absence of the Executive Director, the Director of Clinical Services is the designated _____ coordinator.</p> <p>3. Prevention: The center is committed to the prevention of _____, neglect, misappropriation of resident property, and _____. The following systems have been implemented:</p> <ul style="list-style-type: none"> - Resident Council - Grievance/Concern program including posted information on the grievance official. - Sufficient numbers of staff to meet the needs of the residents. - Department Heads and supervisors that monitor staff to identify inappropriate behavior. - Monitoring of residents who may be at risk is the responsibility of all facility staff. This includes monitoring residents who are at risk or for _____, for indications of changes in behavior, changes in condition or other non-verbal indication of _____. - Posted information on how to contact appropriate State agencies. <p>4. Identification: All reported events (_____, _____, inappropriate or _____ behaviors) will be investigated by the Director of Nursing/designee. Patterns or trends will be identified that might constitute _____. This information will be forwarded to the Executive Director, who will serve as the facility's _____ Coordinator, and an investigation will be conducted in the absence of the Executive Director, the Director of Nursing will serve as the _____ Coordinator.</p> <p>5. Investigation: The _____ Coordinator or his/her designee shall investigate all reports or allegations of _____, neglect, misappropriation and _____. A Social Service representative</p>	N 204		
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N 204	Continued From page 20 may be offered in the role of resident advocate during any questioning of or interviewing of residents. Investigations will be accomplished in the following manner Preliminary Investigation: - Immediately upon an allegation of . or neglect, the suspect(s) shall be segregated from residents pending the investigation of the resident allegation. - The nurse or Director of Nursing/ designee shall perform and document a thorough nursing evaluation and notify the attending physician. - An incident report shall be filed by the individual in charge who received the report in conjunction with the person who reported the . This report should be filed as soon as possible in order to provide the most accurate information in a timely fashion, and submitted to the Coordinator. Investigation: The Coordinator and/or Director of Nursing shall take statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged . He/ she shall also secure physical evidence. Upon completion of the investigation, a detailed report shall be prepared. 6. Protection: Any suspect(s), who is an employee or contract service provider, once he/she has (have) been identified, will be suspended pending investigation. - The resident will be evaluated for any signs of injury, including a physical exam and/ or . . . assessment, as appropriate. - Increased supervision of the alleged victim and residents. - Room or staffing changes, if necessary, to protect the resident(s) from (sic) the alleged . . . - Protection from retaliation.	N 204		

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N 204	<p>Continued From page 21</p> <p>- Provide the resident with emotional support and counseling during and after the investigation, if needed.</p> <p>7. Reporting/ Response: Any employee or service provider who witnesses or has knowledge of an act of or an allegation of , neglect, or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve and do not result in serious bodily injury, to the Administrator and to other officials in accordance with State law. In the absence of the Executive Director, the Director of Nursing is the designated coordinator.</p> <p>Once an allegation of is reported, the Executive Director, as the coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations, including notifications of Law Enforcement if a reasonable suspicion of crime has occurred.</p> <p>Class III.</p>	N 204		
N 917 SS=D	<p>400.147(B), FS Report , Neglect, &</p> <p>(B) , neglect, or must be reported to the agency as required by 42 C.F.R. s. 483.13(c) and to the department as required by chapters 39 and 415.</p>	N 917		

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N 917	<p>Continued From page 22</p> <p>This Statute or Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure an allegation of neglect was reported to the appropriate Agencies for one (#9) of ten sampled residents.</p> <p>Findings included:</p> <p>Review of the policy and procedure, N-1265 - Neglect, & Misappropriation, revised , documented the policy: "It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from neglect, mistreatment, and/or misappropriation of property. The management of the facility recognizes these rights and hereby establishes the following statements, policies, and procedures to protect these rights and to establish a disciplinary policy, which results in the fair and timely treatment of occurrences of resident . Employees of the center are charged with a continuing to treat residents, so they are free from neglect, mistreatment, and/or misappropriation of property. No employee may at any time commit an act of physical, , or emotional neglect, mistreatment, and/or misappropriation of property against any resident. Violation of this standard will subject employees to disciplinary action, including dismissal, provided herein."</p> <p>7. Reporting/ Response:</p> <p>Any employee or service provider who witnesses or has knowledge of an act of , or an allegation of , neglect, , or</p>	N 917	<p>1. Resident #9 was assessed by nursing and social services and no adverse effects were noted. Resident remains in the center. Staff B was terminated. Resident #9 interviewed by NHA and resident stated that he felt safe in the center and had no additional concerns at the time of the interview.</p> <p>2. Resident interviews completed for residents with above 10. Interview conducted questioned residents if they had witnessed with any other residents or were abused at any time. Skin assessments were completed for residents with a less than 10. Interviews and assessments completed and no additional findings at the time of the interviews and assessments. Any concerns noted in the interviews were reviewed by NHA, and NHA ensured that the concerns were previously addressed.</p> <p>3. education was completed with staff in conjunction with posttest and scenarios. education provided by IDT members to staff. IDT educated by company VP of Risk Management. Education will continue at times of allegations of and during new hire orientation. A sample of residents will be interviewed monthly by IDT to ask questions related to care/treatment and potential concerns. Room rounds continue to be completed five times a week by IDT to ensure resident is monitored and has no concerns. Audit of interviews will be completed by NHA or designee to ensure that there are no outstanding concerns.</p>	

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N 917	<p>Continued From page 23</p> <p>mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve and do not result in serious bodily injury, to the Administrator and to other officials in accordance with State law. In the absence of the Executive Director, the Director of Nursing is the designated coordinator.</p> <p>Once an allegation of is reported, the Executive Director, as the coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations, including notifications of Law Enforcement if a reasonable suspicion of crime has occurred.</p> <p>A review of Resident #9's clinical chart documented an admission of . His diagnosis list included but not limited to Type 2 with , and .</p> <p>A review of a dated , documented a score of 13, with a comment "Intact response".</p> <p>A review of Resident #9's clinical chart, the Care Plan, documented a focus area: Resident #9 has an ADL (Activity of Daily Living) self-care performance and at risk for decline. Interventions included: Toilet Use: The resident is totally dependent on staff for toileting ... to , initiated.</p> <p>A review of Staff B, Certified Nursing Assistant's</p>	N 917	<p>4. Audits will be reviewed at the QAA/QAPI meeting monthly for three months or until substantial compliance is achieved. The audits will be presented by the Administrator or designee.</p>		

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N 917	<p>Continued From page 24</p> <p>(CNA) personnel file was conducted with the Human Resource Director (HRD). Present in the file was a document, "Teachable Moment", dated for Staff B, CNA, which documented a description of action: "(Resident #9) was found to be covered in feces. Good practice is we check and change residents every 2 hours. Resident states he had been asking to be changed all morning, and he had not been changed. When the p.m. aide came on duty, you were already out of the building. She didn't get to do bedside round (receive report) and upon entering the resident's room, found resident covered in feces". The form was not signed by any person as presenting the document or receiving the document. During the review of the "Teachable Moment" with the HRD, she stated she did not know about the form. She stated, "teachable moments are nursing documents. The HRD stated, "I assume it was nursing that wrote it up with the expectation of presenting. I cannot tell you who wrote it up".</p> <p>An interview conducted on at 6:15 p.m. with the NHA, while reviewing the Teachable moment for Staff B, he stated teachable moment was invalid. It was not signed; it was a worthless piece of paper that should not have been in the file. He said he did not know who had filled it out; after reading it he said he should have been "in on it".</p> <p>On at approximately 6:20 p.m., an interview was conducted with Staff G, CNA. She recalled the concern with how she had found Resident #9. She said, "I came in at 3:00 p.m.; I was assigned (the hall where Resident #9 resides). I heard someone yelling. I thought it was (Resident #9), so, I went in and checked on him. It was between 3:00 and 3:30 p.m., it was the first thing I heard. He was covered in feces</p>	N 917		
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N 917	<p>Continued From page 25</p> <p>from the waist, some of it was on his thighs, it was like . He told me he had been like that since noon. Some of the feces was dried on, some of it was not, I had to scrub him. The sheets were covered in it too. I changed everything." She stated normally there is report given during shift change, but at the time, there was no one to provide the report. She stated she shared the information with the nurse, Staff C, LPN and she went and got the Unit Manager, Staff F, LPN. Staff G stated she wrote a statement and gave it to the Unit Manager, Staff F.</p> <p>A review of a complaint/ Grievance Report dated by (Staff G, CNA), documented a concern for treatment and care for Resident #9 showing: CNA reports that resident was covered in feces and he had been sitting for a while before anyone came to change him. The staff member assigned responsibility for the investigation was Staff F, LPN, UM. The investigation: This resident was found to be covered in feces. The Aide assigned to resident was (Staff B, CNA). She was educated about the importance of providing prompt care. Expectation showed: aide will work endeavor to ensure proper care. Written teachable moment was provided to aide, signed as completed . The section to be completed on whether the grievance was reportable to the state agency was not marked with either a yes or no indication.</p> <p>An interview conducted was conducted with the NHA On at 6:33 p.m. He stated residents should be changed, "At least every two hours". When asked, if a resident alleges, he had been sitting in a movement (BM) since 12:00 p.m., and not changed until between 3:00 and 3:30 p.m., if it was appropriate care, he</p>	N 917			

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N 917	<p>Continued From page 26</p> <p>stated, "I would say it is not". "It has the potential to be neglect". He stated the incident was not reported. He said, "I went and talked to the resident. And he said, he went to the bathroom in his brief. He said the girls were busy on the floor; he has a boisterous voice; (Staff G, CNA) thought he was yelling; and she went in and changed him." The NHA stated he asked the resident if he felt like he was neglected, and he said no, and he did not know why someone had reported it. He confirmed the staff member assigned to Resident #9 on during the 7:00 a.m. to 3:00 p.m. shift was Staff B, CNA. The NHA stated the process for reporting an allegation was, "I report it to our clinical team and the Regional Nurse Consultant, who is their Risk Manager. Then, I write up my initial findings, submit on the AIRS (AHCA Incident Reporting System) system; notify the Department of Children and Families, police, and any other parties necessary, and then, begin the investigation. The NHA confirmed this incident was not reported.</p> <p>Class III.</p>	N 917		
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