STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105547	A. BUILDING _____ B. WING _____	**09/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FLAGLER HEALTH AND REHABILITATION CENTER	**300 DR CARTER BOULEVARD BUNNELL, FL 32110**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0585 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility records, policies and procedures and interviews with staff, the Grievance Official failed to oversee the grievance process by failing to investigate concerns and prevent further potential violations of residents' rights, or to follow up with the resident to ensure satisfaction with the resolution for two (Residents #6 and #7) of five residents reviewed for grievances, from a total of seven sampled residents. The findings include: 1. A review of the Grievance Log found that on 8/10/20, a family member filed a grievance on behalf of Resident #7. It alleged that after using the call light for assistance, Resident #7 was left in a soiled adult protective undergarment and was not changed for two hours. Resident #7 was also alleged to have not received the right medication. On page two of the grievance form, it asked to Describe the findings of the incident. The facility's response was that data was collected and the resident had redness to her buttocks documented on 8/10/20. The Recommendations/ Corrective Action section noted the facility's correction as, Medications to be reviewed with resident upon admission. The section asking whether the grievance 'had been resolved to the satisfaction of all concerned' only stated that the resident was discharged this same day. There was no indication that any effort was made to investigate which staff member was assigned to the resident at the time of the incident, or why Resident #7 was soiled for two hours after attempting to solicit assistance from staff. There was no corrective action related to the allegations, even after confirming redness to Resident #7's buttocks as a possible result of the incident. The form was signed by the Social Services Director (SSD) on 8/13/20, indicating she was the person responsible for the investigative report. 2. Resident #6 filed a grievance on 7/23/20 alleging she was left on the toilet this same day for one hour with her call light on. An employee was noted to have been involved in the occurrence. The form noted the SSD immediately notified the Director of Nursing (DON) for intervention with the appropriate staff. The section asking whether the grievance 'was resolved to the satisfaction of the resident' only stated the resident left the faciity on [DATE]. There was no evidence of follow up with Resident #6 to ensure her satisfaction with the resolution to the situation. (Photocopies obtained) The SSD was interviewed at 3:59 p.m. on 9/16/20. She was asked about the grievance for Resident #7. She replied she was not involved in the incident with Resident #7. The prior Assistant Director of Nursing (ADON) handled the grievances at that time for all nursing issues, so she had no awareness of it. This ADON left the facility about a week ago. The SSD agreed that there appeared to be no investigation to determine the root cause of the incident, and she had no explanation for why her signature was on the form as the person responsible for the investigation. She was asked about the occurrence with Resident #6. The SSD said she did not know if an investigation was conducted or what the outcome was. Nothing was turned in to her. She agreed that the grievance process had fallen short and had not been implemented. When asked who the Grievance Officer was, she stated she was. The DON stated in an interview at 4:30 p.m. on 9/16/20, that she had spoken with the SSD and had recognized the grievance process was not working. Investigations into customer complaints were not being conducted thoroughly. She agreed the current grievance system was not working. A review of the Resident Grievance Program policy (not dated) found it stated all grievance reports would be forwarded to the Grievance Officer for investigation, initiation and follow through. (Photocopy obtained) .
F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews and a review of facility records, the facility failed to maintain sufficient nursing staff to provide services and assistance to residents in order to maintain the highest practicable well-being for two (Residents #2 and #3) of two residents interviewed, and for four (Residents #1, #4, #6 and #7) of five residents reviewed for grievances, from a total of seven residents in the sample. This had the potential to negatively impact all 81 residents in the facility at the time of the survey. The findings include: 1. An interview was conducted with Resident #2 on 9/16/20 at 10:35 a.m. She stated she had been waiting since 7:00 a.m. for her medication, and that it took two hours for staff to come assist her with toileting. Resident #2 insisted it was not the staff's fault; they just needed more staff. She stated once she waited two hours 40 minutes for assistance to the bathroom. As a result, she made a mess and was humiliated. A record review for Resident #2 revealed she was [AGE] years old and was admitted to the facility on [DATE]. She had [DIAGNOSES REDACTED]. Resident #2 had an Admission Minimum Data Set (MDS) assessment with an assessment reference date of 8/31/2020. She had a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. She required extensive assistance of one person for transfers, ambulation and toileting. Resident #2 was care planned on 8/24/2020 as a fall risk and for a history of UTIs. 2. During an interview with Resident #3 on 9/16/20 at 11:20 a.m., she stated she had been in the facility for three weeks. It took forever for staff to come when she rang her call bell. Sometimes they didn't come, period. Resident #3 said she felt they didn't care. A record review for Resident #3 found she was admitted to the facility on [DATE] with a readmission on 8/19/20. Resident #3 had an annual MDS with an assessment reference date of 8/26/20. She had a BIMS of 14, indicating no cognitive impairment, and she required extensive assistance with activities of daily living, including toileting. She had [DIAGNOSES REDACTED]. Resident #3 was care planned for requiring assistance with care due to weakness and unsteadiness. Employee A, Certified Nursing Assistant (CNA), was interviewed on 9/16/20 at 11:38 a.m. She stated she did not feel there was enough staff to respond to resident call lights in a timely manner. She had situations when she could not get to her residents soon enough and there had been (toileting) accidents. Employee A stated the aides would apologize and explain to the resident that it was not their fault that they had an accident. An interview was conducted with Employee B, CNA, on 9/16/20 at 11:45 a.m. He stated his job was getting harder due to a lot of staff leaving. Today on his unit, there were only two CNAs. There were usually three or four. He answered as many call lights as he could, but there were not necessarily enough staff right now to answer them in a timely manner. There were not enough CNAs. Employee B stated his unit had so many dependent residents who needed to be fed by staff. There were also quite a bit of residents who required toileting assistance or incontinence care. He checked on his residents for incontinence and toileting needs as often as he could, and tried to do as much as he could before lunch, but it was rare that he would accomplish that. It was hard to do. From time to time, residents were unable to hold their bowels/bladders. Sometimes, multiple residents had to use the bathroom or wet/soil their undergarments at the same time. He got to the residents as quickly as he could, but unfortunately, this sometimes resulted in residents remaining in wet or soiled undergarments. He stated he apologized to the resident(s). Employee B concluded by explaining it was more possible to meet resident needs when the facility had more staff. He stated he felt bad for the residents. A review of the facility's Grievance Log found

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

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 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) the following complaints regarding the lack of availability: On 2/20/20, a grievance was filed by a family member on behalf of Resident #1. It alleged Resident #1 had to wait up to an hour for anyone to answer her call light. Resident #6 filed a grievance on 7/23/20 alleging that on this day, she was left on the toilet for one hour with her call light on. Resident #7 reported that on 8/10/20, after using her call light for assistance, she was left in a soiled adult protective undergarment and was not changed for two hours. Resident #4 filed a grievance on 8/27/20 saying his call light was on 3-4 hours at a time. This was occurring on all shifts since his admission. (Photocopies obtained) A review of the facility's staffing calculations from 8/9/20 to 9/14/20, found the facility's licensed staff hours fell below the minimum daily state requirements of 1.0 licensed nurse hours per resident, and the 2.5 CNA hours per resident on 14 days. (Photocopies obtained) An interview was conducted with the Regional Nurse on 9/16/20 at 5:45 p.m. She reviewed the records and confirmed the facility had fallen below the staffing hours on the above-mentioned days. She acknowledged resident concerns. In an interview with the Administrator on 9/16/20 at 5:50 p.m., he reviewed the staffing hours calculations and confirmed the findings. .