Shhh, Do Not Disturb!

The nursing home failed to provide residents with a private space to participate in resident groups and to ensure that staff attended resident group meetings only with the group invitation. This involved 10 residents participating in a Resident Council meeting.

The Activities Director (AD) and Resident Council President scheduled a Resident Council meeting which was held one day at 10:30 AM in the nursing home's dining room.

The AD advised all nursing home staff present in the area where the meeting was to be held to leave, as this was to be a resident-only meeting. The AD also placed a sign on the outside door which read:

Ssshhh RESIDENT COUNCIL MEETING IN SESSION. Please do not disturb!

There were 10 residents in attendance, including the President and Vice President of the Resident Council. During the meeting, multiple staff members were observed entering and exiting the area of the meeting causing the meeting to be paused.

The residents in attendance stated that they preferred to meet without the staff present. However, staff still came in and out of their meetings without regard to the sign placed on the door. The residents stated that this was a violation of their privacy, and they had made reports to the nursing home's staff. The residents voiced concerns with staff obtaining information discussed during the meeting and reporting it to other staff possibly resulting in retaliation.

During an interview, the Administrator and AD could not explain why staff would continuously come in and out of the Resident Council meeting. They agreed that this should not have been happening. They acknowledged previous concerns from the Resident Council regarding fear of reprisal.

In addition, a review of the meeting minutes provided by the AD revealed no concerns from the Resident Council during the meetings. When asked about this, the Resident Council President stated that the minutes were not accurate, and these were not the minutes that she had taken during the meetings. A record review revealed inconsistencies between the meeting minutes taken by the Resident Council President and the minutes provided by the AD for meetings held in January 2021 and February 2021. During the meeting in January 2021, the council documented concerns with being treated with respect and dignity from the staff. This information was not included in the meeting minutes for the same date provided by the AD. The Administrator stated she was not aware of concerns being raised. When asked about the discrepancies, the AD stated she sometimes re-wrote the minutes when the Resident Council President's writing was not legible. She did not address the inconsistencies.

Name of Nursing Home	St Augustine Health and Rehabilitation Center / Provider ID: 105315
Address	51 Sunrise Blvd, Saint Augustine, Florida
Date investigation completed	March 11, 2021
Type of deficiency issued	F565 – Resident/Family Group and Response
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 2; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/105315/health/standard?date=2021-03-11