

ARE SENIORS LIVING A NIGHTMARE AT SOME CONSULATE NURSING HOMES?



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Consulate Healthcare Summary

Consulate Healthcare is America's sixth largest nursing home company with more than 22,000 beds in 202 nursing homes spread across 22 states. While the company continues to boast of soaring revenues and an annual operating budget of nearly \$2 billion dollars, the company's reputation is sullied with a high percentage of poor performing nursing homes.

Of those Consulate nursing homes operating in Florida:

- 61 percent are rated by Nursing Home Compare as 1 or 2 star-rated facilities
- Only 7 achieve a five-star rating
- 17 are on the state's watch list for chronically dangerous nursing home conditions
- 37 percent were imposed a sanction over the past three years, paying more than \$1 million dollars in federal and state fines cumulatively
- 100 percent were cited 10 or more deficiencies since 2012; 1 in 5 were cited a severe deficiency
- A mere 2 homes achieved a five-star rating in staffing levels
- Only 1 in 4 were rated above average in staffing

Media reports repeatedly reports show that Consulate Healthcare continues to be a highly profitable company with an abundance of resources available capable of improving nursing home quality for residents—namely by hiring more qualified caregivers to care for residents—but the company's leaders have historically shown they put profits above resident safety and care.

This tragic management decision has resulted in embarrassing consequences for the company nationwide, including hefty fines, numerous citations, and facility closures. But it's the residents who have suffered the most as each deficiency or sanction represents a mother, a grandfather, or a son who has suffered unnecessary injury, mistreatment, neglect, or even death.

The following illustrates a handful of cases of abuse of neglect that have occurred in Central and South Florida Consulate nursing homes as a result of the company's negligence (note: each of these facilities are rated as below average or much below average by the Center for Medicare and Medicaid Services)

Examples of resident neglect attributable to inadequate staffing

Broward County

Harbor Beach Nursing and Rehabilitation

POTENTIAL FOR MORE THAN MINIMAL HARM – 10/2/14 – Standard Inspection

- Resident observed with overgrown fingernails approximately a half-inch long. The fingernails were “heavily caked with brown debris” under each fingernail. Resident noted not enough staff to cut and clean the resident’s nails

POTENTIAL FOR MORE THAN MINIMAL HARM – 11/20/13 – Complaint

- The facility failed to maintain accurate and complete medical records. Medical records showed that a resident’s nurse did not sign and document disbursement of medications on multiple dates; medications were meant to control the resident’s seizures and hypertension.

POTENTIAL FOR MORE THAN MINIMAL HARM – 8/8/13 – Complaint

- Residents’ grievances were not addressed by the facility. Residents repeatedly complained about poor food and not enough staff in the evenings to respond to call lights in a timely fashion. Resident council minutes for the two previous months noted the concerns, but there was not enough follow through to resolve the issues.
- Surveyor noticed a resident with “excessively” long fingernails. The surveyor inquired when was the last time they were cut. The resident mentioned that it was more than three months earlier. The resident then removed his sock and showed very long toe nails with “a yellow spongy matter caked under the nails.”

Hillcrest Health Care and Rehabilitation

ACTUAL HARM – 6/19/15 – Complaint

- Resident who was diagnosed as a potential fall risk suffered a severe head injury after he fell trying to go to the bathroom. The resident was transported to the hospital more than three hours after the incident. His blood pressure was elevated and he was vomiting. A CT brain scan showed that the resident suffered an “extensive acute subdural hemorrhage”. The resident expired due to the fall related injuries. The facility failed to properly document that the resident was at risk of falling.

POTENTIAL FOR MORE THAN MINIMAL HARM – [3/21/2014](#) – Standard Inspection

- Facility in disrepair and filthy that endangered resident’s safety. Items included: torn bed frames; heavily soiled mats, medication bottles, and room sinks; missing handrails; torn cushions; exposed, sharp metal piping; bag missing from infectious waste; and a hole in the floor near several residents’ rooms.
- Resident suffered dental bleeding. Observation of his mouth showed extreme redness around his gums and an “odor emanating from his mouth.” Resident lost weight due to difficulty eating. The facility failed to schedule a dental appointment to address the oral issues.

POTENTIAL FOR MORE THAN MINIMAL HARM – [3/21/2014](#) – Standard Inspection

- Facility in disrepair and filthy that endangered resident’s safety. Items included: torn bed frames; heavily soiled mats, medication bottles, and room sinks; missing handrails; torn cushions; exposed, sharp metal piping; bag missing from infectious waste disposal; and a hole in the floor near several rooms.
- Resident suffered oral bleeding. Observation of his mouth showed extreme redness around his gums and an “odor emanating from his mouth.” Resident lost weight due to difficulty eating. The facility failed to schedule needed dental appointments to address his oral decay.

Orange County

Colonial Lakes Health Care

POTENTIAL FOR MORE THAN MINIMAL HARM – [7/31/2015](#) – Standard Inspection

- Several residents were not treated with dignity and respect by dining staff who failed to follow protocols when residents needed assistance. Surveyors noticed a resident get food all over his hand but was not helped to remove it, instead he wiped it on his shirt. Another resident needed help drinking her milk that was in a carton. Staff commented that she needed a cup. Instead of providing one, the resident drank the milk and it spilled down both sides of her mouth and onto her clothes.
- The facility failed to maintain safe water temperature levels for a number of residents’ rooms. Some temperature levels reached as high as 130 degrees. A plumber reported that the temperature gauge was broken and that the mercury inside of the thermometer was just “gone.”
- The facility failed to maintain routine dental services for two residents. A resident lost his dentures and the facility did an inadequate job in helping him locate or replace them. The resident said he wanted his dentures so he could eat meat and that he “missed chewing his food.” Another resident’s oral status was improperly assessed, noting that the resident had no tooth problems. But the resident was missing teeth and did not receive any dental screens nor were dental services offered.



POTENTIAL FOR MORE THAN MINIMAL HARM – [3/1/15](#) – Complaint

- Ten percent of the residents' rooms were in disrepair. Items included: cracked ceilings; water stains around the windows; sizeable holes caused from water damage; and rusted nails protruding through the ceiling over resident's bed.
- Unsanitary food practices caused cross contamination during preparation. The facility had no working soap dispensers nor a working paper towel dispenser next to the food preparation sink.
- The facility failed to properly ensure a quarterly care plan assessment after a resident suffered "significant" weight loss between over a one-month period, dropping nearly 7 percent body weight.

POTENTIAL FOR MORE THAN MINIMAL HARM – [1/20/15](#) – Complaint

- A surveyor observed a resident was left unattended in a sofa chair for more than 5.5 hours. He was finally moved to change his incontinence brief. When he was changed, two briefs were removed that "were soaked in urine." Facility protocols revealed that no resident should ever wear two briefs.

Parks Healthcare and Rehabilitation Center

ACTUAL HARM – [2/20/2014](#) – Complaint

- A 95-year-old resident was assessed at being at risk for falls. A registered nurse directed that the resident be placed on 1:1 observation. A surveyor's interview with staff revealed that the sitter was removed and that the nursing supervisor directed 15 minute checks. The nurse's notes failed to reflect the change in order. Shortly after the sitter was removed, the resident fell, suffering fractures to her rib, hip, and femur in addition to a laceration above her left eyebrow.

POTENTIAL FOR MORE THAN MINIMAL HARM – [6/6/2014](#) – Standard Inspection

- Resident informed surveyor that the facility "did not have enough staff" to care for the residents. She reported that she waits long periods of time for someone to respond to her call light. On one occasion, she waited from "1:30 AM to 4:30 AM" to go to the bathroom. She could not wait any longer so "she pooped all over" herself.
- Interviews with other residents echoed the lack of staff sentiment. Some residents stated they often wait upwards of an hour for someone to respond to a call light.
- Another resident reported that there was inadequate staff to assist with her shower needs. She preferred to be showered three times per week, but she was only receiving a shower one time per week because of the lack of help.
- An interview with a family member of a resident revealed that activities are sorely lacking. Her loved one does not attend activities because she is too often "left sitting for hours at a time." On one occasion the resident attended, the family member discovered her loved was soaked in urine and feces and no one had "taken her back to change her."



- The surveyor observed residents were left unattended for prolonged periods of time. One observed resident was resting in bed (elevated 30 degrees) on her back with the television on in the same position for two consecutive days.
- Multiple locations within the facility were observed to be in disrepair, that included: cracked, blackened wall tiles in the shower stalls; missing floor tiles; corroded faucets; a mirror so scratched that the view was obstructed; scattered debris and food stains on the floor; and wheelchair brakes wrapped with tape.
- The facility failed to properly develop and implement care plans for half of the sample residents who needed respiratory care.

Rosewood Health and Rehabilitation Center

POTENTIAL FOR MORE THAN MINIMAL HARM – [7/24/2015](#) – Standard Inspection

- 1 out of every 5 sampled residents’ rooms were unclean and in gross disrepair. Problems included: fans “caked with dust and dirt”; “severely” damaged floors; “buckled” tiles lifting from the off the wall in the bathroom; a hole in the wall; “shredded” resident’s chair with exposed stuffing; and the bathrooms smelled of urine.
- A hospice resident with moderate cognitive impairment was incorrectly assessed as being able to provide self-care. A surveyor observed that she had long fingernails with a “sticky, black substance” under under her nails. Another resident with severe hand contractures was also observed as having long and “jagged” fingernails. He told the inspector that no one had been able to cut his nails for “several weeks” and that they were “cutting into his skin.”
- Some residents’ rooms were equipped with broken or malfunctioning call light systems. One resident had no button to activate his light despite needing it for assistance.

ACTUAL HARM – [6/8/15](#) – Complaint

- Skin assessment showed resident had 2 reddened areas, one on the left foot and the other on his coccyx area. No specific data was documented regarding the wounds, e.g. color, odor, size, or drainage. Weekly skin integrity checks showed inconsistent documenting of the sores. The areas worsened, became infected (purulent draining), and dead tissue had to be removed, resulting in actual harm to the resident.

POTENTIAL FOR MORE THAN MINIMAL HARM – [4/28/2015](#) – Complaint

- A resident known to be at risk for falls had a disabled wheelchair alarm that would not have alerted staff if she had gotten out of the wheelchair.



Palm Beach County

Coral Bay Healthcare and Rehabilitation

POTENTIAL FOR MORE THAN MINIMAL HARM – [7/27/2015](#) – Complaint

- The facility failed to report the blood glucose results for a resident as prescribed by the resident’s physician. The results were needed to prevent the resident from suffering diabetic shock.

POTENTIAL FOR MORE THAN MINIMAL HARM – [4/9/2015](#) – Standard Inspection

- Inspectors found the facility in disrepair. Problem areas included: broken foot boards on resident’s bed; missing pull strings for overhead lighting; scuffed furniture; filthy and rusted wheelchairs; broken window blinds; water damaged windows; and torn wheelchair cushions.

POTENTIAL FOR MORE THAN MINIMAL HARM – [1/21/2015](#) – Complaint

- A resident suffered a right orbital floor fracture after he fell. The facility failed to properly implement the fall prevention protocols, namely that the “bed alarm was in place” when the resident went to bed.

POTENTIAL FOR MORE THAN MINIMAL HARM – [10/21/2013](#) – Complaint

- The facility failed to maintain clinical records that were immediately accessible and complete. Staff initiated CPR after a resident was found unresponsive. The resident was taken to the hospital and expired less than 45 minutes after his arrival. When the surveyor asked for the records, the facility had only partial records for the resident. None were available during the inspection.

POTENTIAL FOR MORE THAN MINIMAL HARM – [10/19/2012](#) – Complaint

- The facility failed to protect a resident from abuse. Staff noticed a resident was found “lying in bed” naked from the waist down with another resident. The resident was fondling the other resident against her will. The facility ordered 30-minute checks to prevent further occurrences of abuse. The facility later put the resident on 1:1 supervision, but only after the facility staff failed to maintain the safety checks at all times.

Renaissance Health and Rehabilitation

POTENTIAL FOR MORE THAN MINIMAL HARM – [5/15/2015](#) – Complaint

- A nurse left a medication cart unattended and unsecured in the hallway with multiple medications left sitting atop the cart that anyone could have easily accessed.

POTENTIAL FOR MORE THAN MINIMAL HARM – [9/16/2013](#) – Complaint

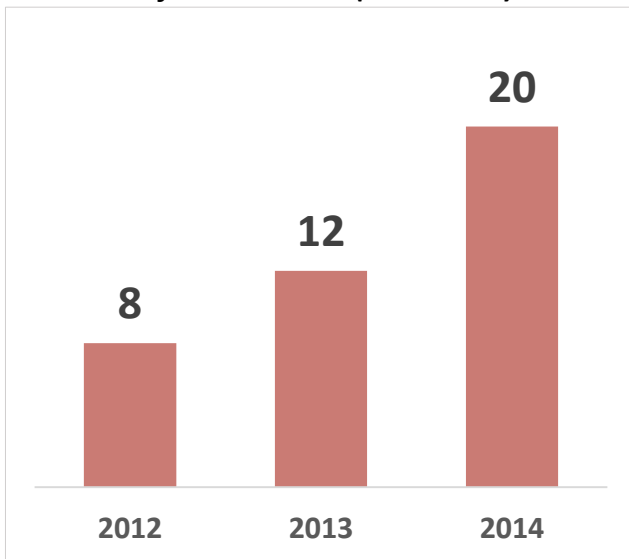
- A resident was taken to a physician’s appointment with an infection control specialist to check for MRSA without the spouse’s knowledge. She was unaware of the resident’s well-being or location.



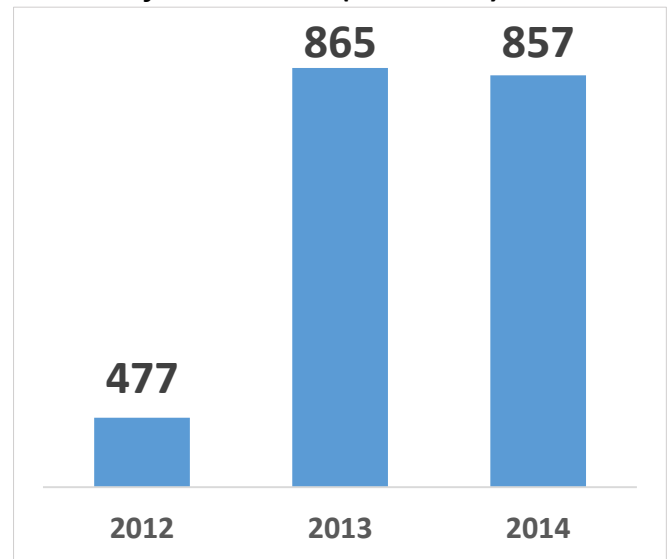
Deficiencies by year

The following shows the number of deficiencies by year for Consulate nursing homes in Florida:

Severe Deficiencies in FL (2012-2014)



Total Deficiencies in FL (2012-2014)



FACILITIES IN BROWARD, ORANGE AND PALM BEACH COUNTIES WITH 1 OR 2-STAR RATING

Broward County (2012-2015)

Facility Name	Deficiencies	Fed/State Penalties	Watch List
Harbor Beach Nursing and Rehabilitation	37		
Hillcrest Health Care and Rehabilitation	48		

Orange County (2012-2015)

Facility Name	Deficiencies	Fed/State Penalties	Watch List
Colonial Lakes Health Care	40		
Parks Healthcare and Rehabilitation Center	52	\$42,468	Yes
Rosewood Health and Rehabilitation Center	42		Yes

Palm Beach (2012-2015)

Facility Name	Deficiencies	Fed/State Penalties	Watch List
Coral Bay Healthcare and Rehabilitation	57		
Renaissance Health and Rehabilitation	39		

Consulate nursing home federal and state penalties-Florida (2012-2015)

NURSING HOME	FEDERAL PENALTY	STATE SANCTION
BRADENTON HEALTH CARE	\$3,900	\$0
CENTRAL PARK HEALTHCARE AND REHABILITATION	\$46,500	\$1,000
CONSULATE HEALTH CARE AT WEST ALTAMONTE	\$3,835	\$8,250
CONSULATE HEALTH CARE OF JACKSONVILLE	\$136,046	\$31,000
CONSULATE HEALTH CARE OF LAKE PARKER	\$11,375	\$8,000
CONSULATE HEALTH CARE OF LAKELAND	\$2,730	\$5,000
CONSULATE HEALTH CARE OF MELBOURNE	6 DAY PAYMENT DENIAL	\$5,000
CONSULATE HEALTH CARE OF NEW PORT RICHEY	\$1,451	\$5,000
CONSULATE HEALTH CARE OF NORTH FORT MYERS	\$20,443	\$24,000
CONSULATE HEALTH CARE OF PENSACOLA	\$4,095	\$6,500
CONSULATE HEALTH CARE OF PORT CHARLOTTE	\$18,720	\$5,000
CONSULATE HEALTH CARE OF ST PETERSBURG	\$9,842	\$2,750
CONSULATE HEALTH CARE OF TALLAHASSEE	\$9,503	\$2,000
CONSULATE HEALTH CARE OF WINTER HAVEN	\$3,315	\$25,250
COUNTRYSIDE REHAB AND HEALTHCARE CENTER	\$1,853	\$2,500
DELTONA HEALTH CARE	\$8,840	\$36,000
ENGLEWOOD HEALTHCARE AND REHAB	\$120,000	\$0
EVANS HEALTH CARE	\$87,930	\$15,500
GRAND OAKS HEALTH AND REHABILITATION CENTER	\$34,645	\$2,500
HEALTH CENTER AT BRENTWOOD	\$20,768	\$16,000
HERITAGE HEALTHCARE CENTER AT TALLAHASSEE	\$189,801	\$30,000
LAKESIDE OAKS CARE CENTER	\$2,730	\$16,000
LARGO HEALTH AND REHABILITATION CENTER	\$40,951	\$1,500
MAGNOLIA HEALTH AND REHABILITATION CENTER	\$12,058	\$8,000
OAKBRIDGE HEALTHCARE CENTER	\$2,100	\$1,250
PARKS HEALTHCARE AND REHABILITATION CENTER	\$38,968	\$3,500
RIO PINAR HEALTH CARE	\$5,330	\$750
WEDGEWOOD HEALTHCARE CENTER	\$121,095	\$12,700
TOTAL		\$1,233,774

Consulate nursing homes currently on the state's watch list for dangerous care

FACILITY NAME	CITY
BRANDON HEALTH AND REHABILITATION CENTER	BRANDON
CENTRAL PARK HEALTHCARE AND REHABILITATION CENTER	BRANDON
CONSULATE HEALTH CARE OF JACKSONVILLE	JACKSONVILLE
CONSULATE HEALTH CARE OF NORTH FORT MYERS	NORTH FORT MYERS
CONSULATE HEALTH CARE OF PENSACOLA	PENSACOLA
CONSULATE HEALTH CARE OF TALLAHASSEE	TALLAHASSEE
CONSULATE HEALTH CARE OF WINTER HAVEN	WINTER HAVEN
COUNTRYSIDE REHAB AND HEALTHCARE CENTER	PALM HARBOR
HEALTH CENTER AT BRENTWOOD	LECANTO
HERITAGE HEALTHCARE CENTER AT TALLAHASSEE	TALLAHASSEE
HERITAGE PARK REHABILITATION AND HEALTHCARE	FORT MYERS
LARGO HEALTH AND REHABILITATION CENTER	LARGO
MAGNOLIA HEALTH AND REHABILITATION CENTER	SARASOTA
PARKS HEALTHCARE AND REHABILITATION CENTER	ORLANDO
ROSEWOOD HEALTH AND REHABILITATION CENTER	ORLANDO
WEDGEWOOD HEALTHCARE CENTER	LAKELAND