Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 000	Initial Comments	A 000		

On , an unannounced biennial licensure survey including limited mental health was conducted at Robinson's Residential Care ALF. At the time of the survey there were deficiencies identified.

A 026 SS=D	58A-5.0182(2) FAC Resident Care - Social & Leisure Activities	A 026	

(2) SOCIAL AND LEISURE ACTIVITIES. Residents shall be encouraged to participate in social, recreational, educational and other activities within the facility and the community.
(a) The facility shall provide an ongoing activities program. The program shall provide diversified individual and group activities in keeping with each resident ' s needs, abilities, and interests.
(b) The facility shall consult with the residents in selecting, planning, and scheduling activities. The facility shall demonstrate residents ' participation through one or more of the following methods: resident meetings, committees, a resident council, suggestion box, group discussions, questionnaires, or any other form of communication appropriate to the size of the facility.
(c) Scheduled activities shall be available at least six (6) days a week for a total of not less than twelve (12) hours per week. Watching television shall not be considered an activity for the purpose of meeting the twelve (12) hours per week of scheduled activities unless the television program is a special one-time event of special interest to residents of the facility. A facility whose residents choose to attend day programs conducted at adult day care centers, senior centers, mental health centers, or other day programs may count those attendance hours towards the required twelve (12) hours per week of scheduled

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 026	Continued From page 1	A 026		

activities. An activities calendar shall be posted in common areas where residents normally congregate.
(d) If residents assist in planning a special activity such as an outing, seasonal festivity, or an excursion, up to three (3) hours may be counted toward the required activity time.

This Statute or Rule is not met as evidenced by:
Based on resident interview, staff interview and facility activity calendar review the facility failed to provide an ongoing activities program for the current residents and failed to post activities on a calendar in a common area.

The findings include:

An interview was conducted with resident #8 on at approximately 12:52 PM. Resident #8 stated the Life Management counselor comes every day for about an hour, and they have Bingo on Thursday, Friday and Saturday. She stated they have a shopping trip every other week on one day. She stated they need more activities and she gets bored. Residents #5 and 7 were also interviewed on and only mentioned activities of Bingo and the shopping every other week.

An tour of the facility was conducted on at approximately 9:43 AM. A blank calendar was observed in the dining on the wall. Employee B stated it was the activities calendar. She confirmed no activities were listed on the calendar and stated they had just found it.

A 030 SS=G	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures	A 030		

(6) RESIDENT RIGHTS AND FACILITY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 030	Continued From page 2	A 030		

PROCEDURES.
(a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C.
(b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint.
(c) The address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with , 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456.
(d) The statewide toll-free telephone number of the Florida Hotline " 1(800)96- or 1(800)962-2873 " shall be posted in full view in a common area accessible to all residents.
(e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility ' s policies with respect to such issues, for example, as resident responsibilities, the facility ' s and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 030	Continued From page 3	A 030		

administrative and housekeeping practices, schedules, and requirements.
(f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law.
(g) The facility shall provide residents with convenient access to a telephone to facilitate the resident ' s right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility shall not prohibit unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there shall be, at a minimum, an accessible telephone on each floor of each building where residents reside.
(h) Pursuant to Section 429.41, F.S., the use of physical shall be limited to half-bed rails, and only upon the written order of the resident ' s physician, who shall review the order biannually, and the consent of the resident or the resident ' s representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical

429.28 Resident bill of rights.-
(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:
(a) Live in a safe and decent living environment,

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 030	Continued From page 4	A 030		

free from and neglect.
(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.
(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.
(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.
(e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident ' s representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 030	Continued From page 5	A 030		

resident.
(j) Access to adequate and appropriate health care consistent with established and recognized standards within the community.
(k) At least 45 days ' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , the guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.
(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents ' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

This Statute or Rule is not met as evidenced by:
Based on observations, resident interviews, staff interviews and facility policy review the facility failed to ensure 7 of 28 resident's were free from and failed to ensure all resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 030	Continued From page 6	A 030		

had a safe, hazard free and decent living environment. (residents 3, 5, 8, 9, 10, 12 and 13)

The findings include:

An interview was conducted with resident #3 on at approximately 2 PM. Resident #3 stated employees A and B yell at her. She stated they yell at her, "go back to bed and get your ass in bed." She stated Employee A yelled at her last night, "get back in bed now." Resident #3 stated she cries about them yelling at her sometimes.

An interview was conducted with resident #5 on at approximately 1:20 PM. Resident #5 stated employee B yells at residents at times. Resident #5 refused give further information.

An interview was conducted with resident #8 on at approximately 12:52 PM. Resident #8 stated employee B yells at them a lot. She stated employee B yelled at her yesterday about bathing. She stated she has reported the yelling to the Administrator and he will talk to the employee, she will stop yelling for a time, then employee B will yell at her again later. Resident #8 stated sometimes it bothers her and makes her want to tear the employee up, but stated she (the resident) is not violent.

An interview was conducted with resident #9 on at approximately 1:50 PM. Resident #9 stated employee A yells at her. She refused to discuss further.

An interview was conducted with resident #10 on at approximately 1:45 PM. Resident #10 stated employee B yells at everyone. The resident stated she does not like it when she yells.

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	01/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 030	Continued From page 7	A 030		

An interview was conducted with resident #12 on at approximately 2:05 PM. Resident #12 stated employee B yells and curses at the residents.

An interview was conducted with resident #13 on at approximately 3:18 PM. Resident #13 stated employee B yells at her and makes her upset. Resident #13 stated she has reported it to the Administrator and he said just do what the staff say.

An interview was conducted with employee B on at approximately 3:10 PM. Employee B stated she does not really get frustrated with the residents, but sometimes the residents will argue with her. She stated she just walks away. She stated she has not been counseled by the Administrator concerning her tone with the residents.

An interview was conducted with the facility Administrator on at approximately 1:25 PM. The Administrator stated some of the residents have reported staff yelling at them and he has spoken with the staff. He stated the staff have been observed to raise their volume but not yelling at residents. He stated residents # 4 and 9 have reported the staff yelling at them. Further interview was conducted with the Administrator on at approximately 3:40 PM. The Administrator stated he interviewed employee A about a month ago related to the allegation of yelling at resident #9. He stated employee A told him that resident #9 yelled at him and he may have lost his cool and yelled back at her. The Administrator stated he has not reported the allegations to the hotline.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 030	Continued From page 8	A 030		

The facility policy for was reviewed on . The policy stated it would be the responsibility of anyone who witnesses or knows of any on any resident by a staff member or another resident to report it immediately to Administration. An adverse incident will be made on all cases by the Administrator and the police will be notified.

A tour of the facility was conducted on beginning at approximately 9:32 AM. The following were observed during the tour and survey:

Raised area of approximately 1 inch on linoleum floor in foyer with small dining table causing a trip hazard. Confirmed by Assistant Administrator and she stated 2 residents eat in that area. 2 residents were observed eating at that table during the lunch meal. The floor was also noted to be concave. At approximately 5:15 PM on the Administrator stated this portion of the floor was caving in. One chair at the table also had a torn arm and seat with exposed stuffing.

Electrical wall light switches and receptacles were observed to be uncovered with visible wiring in 2, 3, 4, 6 and the last the back door. The Administrator and Assistant Administrator confirmed these findings.

The wood floor at the entrance to the kitchen from the dining observed to be damaged and exposed concrete floor.

Uncovered attic access near with pink insulation hanging down.

Hall exiting the dining a hole in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	**11921 CARUSO DRIVE PANAMA CITY, FL 32404**

(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
A 030	Continued From page 9	A 030		

green wall papered sheet rock.

Blinds in front sitting 4 sliding glass doors are in disrepair with torn blinds laying on the floor.

Missing area of sheet rock near the sink in the 1st the long hallway.

Piano blue sofa with tears and exposed stuffing on arm and 1 cushion.

ceiling fan has large amount of dust.

had 1 dresser with missing handles. The resident stated he had some difficulty opening the drawers.

had 2 dressers with a missing handle.

had missing handles on 2 dressers.

had one dresser missing 4 handles and the closet door knob was very loose.

had one dresser with 1 missing handle.

resident #11 was observed on a mattress with stains and 2 tears approximately 4 inches each. 2 dressers missing handles. One light colored dresser with broken bottom drawer and dried brown substance on top of dresser and on handles. Smoke detector hanging by wires from ceiling.

had one dresser with missing handles.

had one dresser missing 2 handles on bottom drawer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 030	Continued From page 10	A 030		

Attic access #3 in hallway had wood boarder that was loose and hanging.

The wall on the left entrance to the laundry loose from the floor, moves when touched and appears rotten. Many of the walls and doors appeared soiled and stained.

An interview was conducted with the Assistant Administrator on at approximately 3:45 PM. She stated the Administrator was aware of the needed repairs and they would not provide the money for the needed repairs.

The following is an excerpt from the Electrical Safety Foundation International @ www.esfi.org:

Electrical Outlet and Light Switch Safety Tips
Department: Home
Type: Safety Tips
Switches are used to turn the power on and off. Outlets, or receptacles, are usually mounted on a wall or floor to supply electricity through a cord and plug to appliances, lamps, TV, etc. These are the key points in our electrical systems that give us our first line of control to our electrical use, and they are critical connection points. With time and use, these connections can become loose, creating potential hazards. Safety Tips Check to make sure outlet and switch plates are not unusually hot to the touch. If they are, immediately unplug from these outlets and do not use the switches. Have a qualified, licensed electrician check the wiring as soon as possible. Look for discoloration as another indication of potentially dangerous heat buildup at these connections. Stand across the ! look for a tear-drop shaped darkening around and above outlet and switch cover plates. With outlet and switch cover plates, warm to the touch may

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 030	Continued From page 11	A 030		

be okay, but hot is not. Check that all outlet and switch cover plates are in good condition so that no wiring is exposed. Replace any missing, cracked or broken cover plate. Exposed wiring is a hazard. Be sure to use safety caps with unused outlets.

A 032 SS=D 58A-5.0182(8) FAC Resident Care - Elopement Standards — A 032

(8) ELOPEMENT STANDARDS.
(a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement shall be identified so staff can be alerted to their needs for support and supervision.
1. As part of its resident elopement response policies and procedures, the facility shall make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility ' s name, address, and telephone number. Staff attention shall be directed towards residents assessed at high risk for elopement, with special attention given to those with ' s and related assessed at high risk.
2. At a minimum, the facility shall have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The photo identification shall be made available for the file within 10 calendar days of admission. In the event a resident is assessed at risk for elopement subsequent to admission, photo identification shall be made available for the file within 10 calendar days after a determination is made that the resident is at risk for elopement. The photo identification may be taken by the facility or provided by the resident or resident ' s family/caregiver.
(b) Facility Resident Elopement Response

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 032	Continued From page 12	A 032		

Policies and Procedures. The facility shall develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures shall include:
1. An immediate staff search of the facility and premises;
2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities;
3. The identification of staff responsible for contacting law enforcement, the resident ' s family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and
4. The continued care of all residents within the facility in the event of an elopement.
(c) Facility Resident Elopement Drills. The facility shall conduct resident elopement drills pursuant to Sections 429.41(1)(a)3. and 429.41(1)(l), F.S.

This Statute or Rule is not met as evidenced by:
Based on staff interview and record review the facility failed to maintain a photo identification that is accessible to all facility staff and law enforcement as necessary for Resident #4 who is identified as an elopement risk, and has wandered away from the facility on two occasions.

The findings:

On three sampled employees were interview and verified that Resident #4 had wandered away from the facility. on // : law enforcement was called and a missing person report was filed. The resident was located and returned to the facility by law enforcement later

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 032	Continued From page 13	A 032		

that same day. On resident #4 was again reported as missing to law enforcement. According to the sheriff's office incident report a facility employee (#B) stated resident #4 left the facility. The report indicated resident #4 is on medication for schizo-effective and mild mental . Employee #B stated to the officer it was not like him to be gone this long. Employee #B also stated resident #4's medication helps the resident "stay level" and if he does not take it he won't "act right and could do things he normally wouldn't". Law enforcement called the hospitals, jail and mission with no results.

Resident #4 stated during an interview at approximately 10:45 AM, that he left the facility and got in a car with an unknown man who took him to a local hospital. From there he walked to the rescue mission. The administrator brought the resident back to the facility the next day.

During review of Resident #4's medical record, a form asked the question, " is there photo ID if the resident is an elopement risk?" There was no photo ID of the resident in the file although resident #4 is identified as an elopement risk. An interview was conducted with the Assistant Administrator who reported that the Administrator stated that he wanted to take pictures of all the residents for their files, but no pictures have been taken. She stated maybe we will take a picture of everyone in the next week.

A 055 SS=G	58A-5.0185(6) FAC Medication - Storage and Disposal	A 055	

(6) MEDICATION STORAGE AND DISPOSAL.
(a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible,

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	**11921 CARUSO DRIVE PANAMA CITY, FL 32404**

(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
A 055	Continued From page 14	A 055		

residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises; or in their or apartments, which must be kept locked when residents are absent, unless the medication is in a secure place within the or apartments or in some other secure place which is out of sight of other residents. However, both prescription and over-the-counter medications for residents shall be centrally stored if:
1. The facility administers the medication;
2. The resident requests central storage. The facility shall maintain a list of all medications being stored pursuant to such a request;
3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed;
4. The resident fails to maintain the medication in a safe manner as described in this paragraph;
5. The facility determines that because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents; or
6. The facility ' s rules and regulations require central storage of medication and that policy has been provided to the resident prior to admission as required under Rule 58A-5.0181, F.A.C.
(b) Centrally stored medications must be:
1. Kept in a locked cabinet, locked cart, or other locked storage receptacle, , or area at all times;
2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration shall be refrigerated. Refrigerated medications shall be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 055	Continued From page 15	A 055		

by keeping the area in which refrigerator is located locked;
3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration, or administering medication. Such staff must have ready access to keys to the medication storage areas at all times; and
4. Kept separately from the medications of other residents and properly closed or sealed.
(c) Medication which has been discontinued but which has not expired shall be returned to the resident or the resident ' s representative, as appropriate, or may be centrally stored by the facility for future resident use by the resident at the resident ' s request. If centrally stored by the facility, it shall be stored separately from medication in current use, and the area in which it is stored shall be marked " discontinued medication. " Such medication may be reused if re-prescribed by the resident ' s health care provider.
(d) When a resident ' s stay in the facility has ended, the administrator shall return all medications to the resident, the resident ' s family, or the resident ' s guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident ' s medications are still at the facility, the medications shall be considered abandoned and may disposed of in accordance with paragraph (e).
(e) Medications which have been abandoned or which have expired must be disposed of within 30 days of being determined abandoned or expired and disposition shall be documented in the resident ' s record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness.
(f) Facilities that hold a Special-ALF permit issued

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 055	Continued From page 16	A 055		

by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C.

This Statute or Rule is not met as evidenced by:
Based on observation and staff interview the facility failed to appropriately store and dispose of expired medications and failed to store refrigerated medications in a locked compartment, which causes potential harm to residents who have access to the expired and accessible medications.

The findings include:

A tour of the facility was conducted on . At approximately 10:45 AM the surveyor opened the unlocked closet door in the foyer and it contained an unlocked filing cabinet. The top drawer of the filing cabinet contained 1 bottle of 200 mg with a label that read discard after , 1 bottle of Singulair 10 mg with a label that read discard after , and 1 bottle of 500 mg with a label that read discard after . The Assistant Administrator observed and confirmed these findings and stated the door should have been locked. The surveyor then checked the medication cart and observed 1 vial of 100 mg expired lot # 6100454. The vial was in the top drawer of the medication cart with other current medications.

On at approximately 3:23 PM 2 opened vials were observed in the door of the unlocked refrigerator. The vials were not in a locked compartment. This was confirmed by employee B. During the survey residents were observed in the kitchen area without the staff present.

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 075 SS=D	429.255 FS Use of Personnel; Emergency Care ( )	A 075		

Use of personnel; emergency care.-
(3)(a) An assisted living facility licensed under this part with 17 or more beds shall have on the premises at all times a functioning automated external defibrillator as defined in s. 768.1325(2)(b).

(b) The facility is encouraged to register the location of each automated external defibrillator with a local emergency medical services medical director.

(c) The provisions of ss. 768.13 and 768.1325 apply to automated external defibrillators within the facility.

(4) Facility staff may withhold or withdraw or the use of an automated external defibrillator if presented with an order not to executed pursuant to s. 401.45. The department shall adopt rules providing for the implementation of such orders. Facility staff and facilities shall not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing or use of an automated external defibrillator pursuant to such an order and rules adopted by the department. The absence of an order to executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing or use of an automated external defibrillator as otherwise permitted by law.

(5) The Department of Elderly Affairs may adopt rules to implement the provisions of this section relating to use of an automated external defibrillator.

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 075	Continued From page 18	A 075		

This Statute or Rule is not met as evidenced by:
Based on observation and staff interview the facility with 17 or more beds failed to obtain and maintain on the premises a functioning automated external defibrillator ( ).

The findings include:

The facility is licensed for a total of 32 beds. A tour of the entire facility was conducted on beginning at approximately 9:32 AM. No was observed in the facility. An interview was conducted with the Assistant Administrator (AA) on at approximately 3:28 PM. The AA stated the facility did not have an . She further stated the Administrator should be aware of the requirement because that information was relayed to them during their last course in which the Administrator attended.

On at approximately 3:00 PM (CST) an interview was conducted with the Assistant Administrator. During this interview she was asked to produce the ( ) Policies and Procedures training for the sampled employees. The Assistant Administrator reported that the facility does not have any residents with a .

A 081 SS=D	58A-5.0191(2) FAC Training - Staff In-Service	A 081	

(2) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff:
(a) Staff who provide direct care to residents,

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	**11921 CARUSO DRIVE PANAMA CITY, FL 32404**

(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
A 081	Continued From page 19	A 081		

other than nurses, certified nursing assistants, or home health aides trained in accordance with Rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions, and facility sanitation procedures before providing personal care to residents. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , may be used to meet this requirement.
(b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:
1. Reporting major incidents.
2. Reporting adverse incidents.
3. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.
(c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:
1. Resident rights in an assisted living facility.
2. Recognizing and reporting resident , neglect, and .
(d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with Rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects:
1. Resident behavior and needs.
2. Providing assistance with the activities of daily living.
(e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 081	Continued From page 20	A 081		

within 30 days of employment in safe food handling practices.
(f) All facility staff shall receive in-service training regarding the facility ' s resident elopement response policies and procedures within thirty (30) days of employment.
1. All facility staff shall be provided with a copy of the facility ' s resident elopement response policies and procedures.
2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.

This Statute or Rule is not met as evidenced by:
Based on staff interview and record review the facility failed to provide in-service training regarding the facility's resident elopement response policies and procedures for 1 of 3 sampled employees. (Employee #A).

The findings:
On a record review was conducted of (3) sampled employee's records for in-service training regarding facility's resident elopement response policies and procedures. The facility had policies and procedures in place regarding it response to elopement. Employee #A had no certificate or documentation in the file to indicate that he had the in-service training. Employee #B last update for elopement was dated . Employee #C last update for elopement was dated per the elopement log.

On at approximately 2:45PM, an interview was conducted with the Assistant Administrator who reviewed Employee #A's

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 081	Continued From page 21	A 081		

record and could not find the training. The Assistant Administrator produced the facility's elopement training's and drills log and the last training was dated . Employee #A's name was not listed on the in-service record. The Assistant Administrator stated that the facility had just gone through the training and drills, but she could not produce the training for Employee #A, nor could she provide documentation of any updated training or drills.

A 090 SS=D	58A-5.0191(11) FAC Training - Do Not Orders	A 090	

(11)
TRAINING.
(a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility ' s policies and procedures regarding within 60 days after the effective date of this rule.
(b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility ' s policy and procedures regarding within 30 days after employment.
(c) Training shall consist of the information included in Rule 58A-5.0186, F.A.C.

This Statute or Rule is not met as evidenced by:
Based on staff interview and record review the facility failed to provide at least one hour of training in the facility's policies and procedures regarding ( ) for 3 of 3 sampled employees. (Employee #A, #B

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	**11921 CARUSO DRIVE PANAMA CITY, FL 32404**

(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
A 090	Continued From page 22 and #C) The findings: On a record review was conducted of the 3 sampled employees records for documentation of the Training. There was no documentation found in the records. At approximately 3:00pm (CST) an interview was conducted with the Assistant Administrator. During this interview the Assistant Administrator was asked to produce the Policies and Procedures training for the sampled employees. The Assistant Administrator reported that the facility does not have any residents with a She stated that in the past the facility had one, but the resident is no longer at the facility. The Assistant Administrator reported that the Administrator was aware of the training but none of the staff members at the facility have been trained.	A 090		
A 152 SS=G	58A-5.023(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to Section 429.28(1)(a), F.S.; and 2. Must be maintained free of hazards; and 3. Must ensure that all existing architectural, mechanical, electrical and structural systems and appurtenances are maintained in good working order. (b) Pursuant to Section 429.27, F.S., residents shall be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident	A 152		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 152	Continued From page 23	A 152		

or sleeping area must have at least the following furnishings:
1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress a comfortable height to ensure easy access by the resident;
2. A closet or wardrobe space for hanging clothes;
3. A dresser, chest or other furniture designed for storage of personal effects;
4. A table, bedside lamp or floor lamp, and waste basket; and
5. A comfortable chair, if requested.
(c) The facility must maintain master or duplicate keys to resident to be used in the event of an emergency.
(d) Residents who use portable bedside commodes must be provided with privacy during use.
(e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility shall be free of tears, stains and not be

This Statute or Rule is not met as evidenced by:
Based on observations, resident interview and staff interviews the facility failed to ensure all resident's had a safe, hazard free and decent living environment.

The findings include:

A tour of the facility was conducted on beginning at approximately 9:32 AM. The following were observed during the tour and survey:

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	01/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 152	Continued From page 24	A 152		

Raised area of approximately 1 inch on linoleum floor in foyer with small dining table causing a trip hazard. Confirmed by Assistant Administrator and she stated 2 residents eat in that area. 2 residents were observed eating at that table during the lunch meal. The floor was also noted to be concave. At approximately 5:15 PM on the Administrator stated this portion of the floor was caving in. One chair at the table also had a torn arm and seat with exposed stuffing.

Electrical wall light switches and receptacles were observed to be uncovered with visible wiring in 2, 3, 4, 6 and the last the back door. The Administrator and Assistant Administrator confirmed these findings.

The wood floor at the entrance to the kitchen from the dining observed to be damaged and exposed concrete floor.

Uncovered attic access near with pink insulation hanging down.

Hall exiting the dining a hole in the green wall papered sheet rock.

Blinds in front sitting 4 sliding glass doors are in disrepair with torn blinds laying on the floor.

Missing area of sheet rock near the sink in the 1st the long hallway.

Piano blue sofa with tears and exposed stuffing on arm and 1 cushion.

ceiling fan has large amount of dust.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	**11921 CARUSO DRIVE PANAMA CITY, FL 32404**

(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
A 152	Continued From page 25	A 152		

had 1 dresser with missing handles. The resident stated he had some difficulty opening the drawers.

had 2 dressers with a missing handle.

had missing handles on 2 dressers.

had one dresser missing 4 handles and the closet door knob was very loose.

had one dresser with 1 missing handle.

resident #11 was observed on a mattress with stains and 2 tears approximately 4 inches each. 2 dressers missing handles. One light colored dresser with broken bottom drawer and dried brown substance on top of dresser and on handles. Smoke detector hanging by wires from ceiling.

had one dresser with missing handles.

had one dresser missing 2 handles on bottom drawer.

Attic access #3 in hallway had wood boarder that was loose and hanging.

The wall on the left entrance to the laundry loose from the floor, moves when touched and appears rotten. Many of the walls and doors appeared soiled and stained.

An interview was conducted with resident #8 on at approximately 12:52 PM. Resident #8 stated the tubs are not clean and she has to scrub them before she can bathe.

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	**11921 CARUSO DRIVE PANAMA CITY, FL 32404**

(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
A 152	Continued From page 26	A 152		

An interview was conducted with the Assistant Administrator on at approximately 3:45 PM. She stated the Administrator was aware of the needed repairs and they would not provide the money for the needed repairs.

The following is an excerpt from the Electrical Safety Foundation International @ www.esfi.org:

Electrical Outlet and Light Switch Safety Tips
Department: Home
Type: Safety Tips
Switches are used to turn the power on and off. Outlets, or receptacles, are usually mounted on a wall or floor to supply electricity through a cord and plug to appliances, lamps, TV, etc. These are the key points in our electrical systems that give us our first line of control to our electrical use, and they are critical connection points. With time and use, these connections can become loose, creating potential hazards. Safety Tips Check to make sure outlet and switch plates are not unusually hot to the touch. If they are, immediately unplug from these outlets and do not use the switches. Have a qualified, licensed electrician check the wiring as soon as possible. Look for discoloration as another indication of potentially dangerous heat buildup at these connections. Stand across the look for a tear-drop shaped darkening around and above outlet and switch cover plates. With outlet and switch cover plates, warm to the touch may be okay, but hot is not. Check that all outlet and switch cover plates are in good condition so that no wiring is exposed. Replace any missing, cracked or broken cover plate. Exposed wiring is a hazard. Be sure to use safety caps with unused outlets.

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 160	Continued From page 27	A 160		
A 160 SS=D	58A-5.024(1) FAC Records - Facility	A 160		

Records.
The facility shall maintain the following written records in a form, place and system ordinarily employed in good business practice and accessible to Department of Elder Affairs and Agency staff.
(1) FACILITY RECORDS. Facility records shall include:
(a) The facility ' s license which shall be displayed in a conspicuous and public place within the facility.
(b) An up-to-date admission and discharge log listing the names of all residents and each resident ' s:
1. Date of admission, the place from which the resident was admitted, and if applicable, a notation the resident was admitted with a [illegible] pressure [illegible]; and
2. Date of discharge, the reason for discharge, and the identification of the facility to which the resident is discharged or home address, or if the person is [illegible], the date of [illegible].
Readmission of a resident to the facility after discharge requires a new entry. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intends to return pursuant to Rule 58A-5.025, F.A.C.
(c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b).
(d) An up-to-date record of major incidents occurring within the last 2 years. Such record shall contain a clear description of each incident; the time, place, names of individuals involved; witnesses; nature of injuries; cause if known; action taken; a description of medical or other

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 160	Continued From page 28	A 160		

services provided; by whom such services were provided; and any steps taken to prevent recurrence. These reports shall be made by the individuals having first hand knowledge of the incidents, including paid staff, volunteer staff, emergency and temporary staff, and student interns.
(e) The facility ' s emergency management plan, with documentation of review and approval by the county emergency management agency, as described under Rule 58A-5.026, F.A.C., which shall be located where immediate access by facility staff is assured.
(f) Documentation of radon testing conducted pursuant to Rule 58A-5.023, F.A.C.;
(g) The facility ' s liability insurance policy required under Rule 58A-5.021, F.A.C.;
(h) For facilities which have a surety bond, a copy of the surety bond currently in effect as required by Rule 58A-5.021, F.A.C.
(i) The admission package presented to new or prospective residents (less the resident ' s contract) described in Rule 58A-5.0182, F.A.C.
(j) If the facility advertises that it provides special care for persons with ' s or related , a copy of all such facility advertisements as required by Section 429.177, F.S.
(k) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 58A-5.0182, F.A.C.
(l) All food service records required under Rule 58A-5.020, F.A.C., including menus planned and served; county health department inspection reports; and for facilities which contract for catered food services, a copy of the contract for catered services and the caterer ' s license or certificate to operate.
(m) All fire safety inspection reports issued by the

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	**11921 CARUSO DRIVE PANAMA CITY, FL 32404**

(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
A 160	Continued From page 29	A 160		

local authority or the State Fire Marshal pursuant to Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., issued within the last two (2) years.
(n) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years.
(o) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years.
(p) Additional facility records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively.
(q) The facility ' s resident elopement response policies and procedures.
(r) The facility ' s documented resident elopement response drills.

This Statute or Rule is not met as evidenced by:
Based on observation, staff interview and record review the facility failed to maintain the following records in a form, and system ordinarily employed in good business practice to Agency staff.

The Findings:

On a record review was conducted of three sampled employees records. The records had no system and contained expired information. There was no documentation in the major incident record of Resident #4 elopement. The Assistant Administrator was not able to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 160	Continued From page 30 produce any updated elopement training for Employee #A, Employee #B last update was dated [illegible] and the Assistant Administrator last update was dated [illegible]. On [illegible], an interview was conducted with the Assistant Administrator who reported that she needed to maintain the written records in a form and system that will be accessible to all agencies.	A 160		
A 162 SS=D	58A-5.024(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records shall be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name; 2. [illegible]; 3. Race; 4. Date of birth; 5. Place of birth, if known; 6. Social security number; 7. Medicaid and/or Medicare number, or name of other health insurance [illegible]; 8. Name, address, and telephone number of next of kin, responsible party, or other person the resident would like to have notified in case of an emergency, and relationship to resident; and 9. Name, address, and phone number of health care provider, and case manager if applicable. (b) A copy of the medical examination described in Rule 58A-5.0181, F.A.C. (c) Any health care provider ' s orders for medications, nursing services, therapeutic diets, [illegible], or other services to be provided. supervised, or implemented by the facility that require a health care provider ' s order. (d) A signed statement from a resident refusing a therapeutic diet pursuant to Rule 58A-5.020, F.A.C.	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 162	Continued From page 31	A 162		

(e) The resident record described in paragraph 58A-5.0182(1)(e), F.A.C.
(f) A weight record which is initiated on admission. Information may be taken from the resident ' s health assessment. Residents receiving assistance with the activities of daily living shall have their weight recorded semi-annually.
(g) For facilities which will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 58A-5.0181, F.A.C., if such consent is not included in the resident ' s contract.
(h) For facilities which manage a pill organizer, assist with self-administration of medications or administer medications for a resident, the required medication records maintained pursuant to Rule 58A-5.0185, F.A.C.
(i) A copy of the resident ' s contract with the facility, including any addendums to the contract, as described in Rule 58A-5.025, F.A.C.
(j) For a facility whose owner, administrator, or staff, or representative thereof serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required under Section 429.27, F.S.
(k) For any facility which maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required under Section 429.27, F.S.
(l) A copy of Alternate Care Certification for ( ) Form, CF-ES 1006, 1998, if the resident is an recipient. The absence of this form shall not be considered a deficiency if the facility can demonstrate that it has made a good faith effort

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 162	Continued From page 32	A 162		

to obtain the required documentation from the Department of Children and Family Services.
(m) Documentation of the appointment of a health care surrogate, guardian, or the existence of a power of attorney where applicable.
(n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required under Rule 58A-5.0181, F.A.C.
(o) For apartments, duplexes, quadruplexes, or single family homes that are designated for independent living but which are licensed as assisted living facilities solely for the purpose of delivering personal services to residents in their homes, when and if such services are needed, record keeping on residents who may receive meals but who do not receive any personal, limited nursing, or extended congregate care service shall be limited to the following:
1. A log listing the names of residents participating in this arrangement;
2. The resident demographic data required under this subsection;
3. The medical examination described in Rule 58A-5.0181, F.A.C.;
4. The resident ' s contract described in Rule 58A-5.025, F.A.C.; and
5. A health care provider ' s order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility.
(p) Except for resident contracts which must be retained for 5 years, all resident records shall be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents shall be provided a copy of their resident records upon departure from the facility.
(q) Additional resident records requirements for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 162	Continued From page 33	A 162		

facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively.

This Statute or Rule is not met as evidenced by:
Based on observation, record review and staff interview the facility failed to maintain current physician orders in the resident record for all medications resident's are provided assistance with administration for 4 of 7 residents observed during med pass. (#2, 9, 11 and 14). The facility also failed to initiate and record semi-annually weight for 1 of 2 sampled record review resident. (#1)

The findings include:

Observation of the Assistant Administrator assisting residents with medications was conducted on at approximately 11:50 AM. Resident # 2 was observed to take 1 mg by mouth and 25 mg by mouth. Resident #2's facility record contained no order for these medications. Resident #9 was observed to take 50 mg 1 by mouth. Resident #9's facility record contained no order for this medication. Resident #11 was observed to take 15 mg 1 by mouth. Resident #11's facility record contained no order for this medication. Resident #14 was observed to take 1 gram by mouth. Resident #14's facility record contained no order for this medication.

An interview was conducted with the Assistant Administrator on at approximately 1:10 PM. She stated she was not aware the facility should have orders for the resident's medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 162	Continued From page 34 in the resident record. A record review was conducted of Resident #1's facility record. Resident #1 was admitted to the facility on and there was no documentation of her weights in the record. The Assistant Administrator produced the facility's weight book with all of the residents weight. A review of the weight book revealed no weights for resident #1 in the book. The Assistant Administrator confirmed that there was no documentation for Resident #1 weights since admitted in the facility. Resident #1 has a diagnoses of , II, , , OA-M/sites, and and on a diet. During the resident interview, she stated that she does not receive second helping of food because she has to monitor her . Resident #1 stated that she takes one pill at night for .	A 162		
A 165 SS=G	429.23 FS; 58A-5.0241 FAC Risk Mgmt & QA; Adverse Incident Report Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, " adverse incident " means: (a) An event over which facility personnel could	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 165	Continued From page 35	A 165		

exercise control rather than as a result of the resident ' s condition and results in:
1. [illegible];
2. or spinal damage;
3. Permanent [illegible];
4. or of bones or joints;
5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives;
6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or
7. An event that is reported to law enforcement or its personnel for investigation; or
(b) Resident elopement, if the elopement places the resident at risk of harm or injury.
(3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility ' s investigation of the incident.
(4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility ' s investigation into the adverse incident.
(6) , neglect, or must be reported to the Department of Children and Family Services as required under chapter 415.
(7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 165	Continued From page 36	A 165		

reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.
(8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board.
(9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board.
(10) The Department of Elderly Affairs may adopt rules necessary to administer this section.

Adverse Incident Report.
(1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by Section 429.23(3), F.S., must be submitted within one (1) business day after the incident on AHCA Form 3180-1024, Assisted Living Facility Initial Adverse Incident Report-1 Day, 2006, and incorporated by reference. The form shall be submitted via electronic mail to riskmgmtps@ahca.myflorida.com; on-line at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 165	Continued From page 37	A 165		

http://ahca.myflorida.com/reporting/index.shtml; by facsimile to (850)922-2217; or by U.S. Mail to AHCA, Florida Center for Health Information and Policy Analysis, 2727 Mahan Drive, Mail Stop 16, Tallahassee, Florida 32308-5403, telephone (850)412-3731. AHCA Form 3180-1024 is available from the Florida Center for Health Information and Policy Analysis at the address stated above. The Initial Adverse Incident Report is in addition to, and does not replace, other reporting requirements specified in Florida Statutes.
(2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported under subsection (1) above, the facility shall submit a full report within fifteen (15) days of the incident. The full report shall be submitted on AHCA Form 3180-1025, Assisted Living Facility Full Adverse Incident Report-15 Day, dated 2006, and incorporated by reference. The methods for obtaining and submitting the form are set forth in subsection (1) of this rule.

This Statute or Rule is not met as evidenced by:
Based on resident interview and staff interviews the facility failed to report all allegations of to the hotline (Department of Children and Families) for 2 of 13 sampled residents. (#4 and 9). The facility also failed to maintain an adverse incident report for an elopement for 1 of 13 sampled residents. (Resident #4)

The findings include:

An interview was conducted with resident #9 on at approximately 1:50 PM. Resident #9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 165	Continued From page 38	A 165		

stated employee A yells at her. She refused to discuss further.

An interview was conducted with the facility Administrator on at approximately 1:25 PM. The Administrator stated some of the residents have reported staff yelling at them and he has spoken with the staff. He stated the staff have been observed to raise their volume but not yelling at residents. He stated residents # 4 and 9 have reported the staff yelling at them. Further interview was conducted with the Administrator on at approximately 3:40 PM. The Administrator stated he interviewed employee A about a month ago related to the allegation of yelling at resident #9. He stated employee A told him that resident #9 yelled at him and he may have lost his cool and yelled back at her. The Administrator stated he has not reported the allegations to the hotline.

On a record review was conducted of the facility's incident report log and there was no documentation of any client eloping from the facility.

During the staff interviews of (3) sampled employees, the question was asked on the interview form, has any resident wandered away from the facility? The following responses were given by the (3) sample employees:

On at approximately 9:43AM (CST) a staff interview was conducted with Employee #A responded, yes, about three weeks ago resident #4 who usually goes on a walk down the dirt road, signed out and we could not find him, we notified the Sheriff, and the next morning the rescue unit mission notified the facility that he was there, so I went and picked him up.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 165	Continued From page 39	A 165		

On , at approximately 10:00AM a staff interview was conducted with Employee #B responded that resident #4 had wandered away from the facility. Employee #B stated that the staff on duty at that time contacted Bay County Sheriff Department who does not like to cooperate with the facility because the sheriff department says that the residents are not court ordered here and they are grown adults who have freedom to walk away from the facility at will. The Administrator was notified of resident #4 wandering away from the facility. This incident happened about two to three weeks ago, resident stated that he wanted to walk down to the Methodist Church to talk to the Pastor. Resident #4 had signed out and then we got a phone call from a gentlemen who resides in a house past the church stating that resident had knocked on his door asking for money and for a ride to dollar general. The Administrator went and got resident from the area.

On , at approximately 10:19AM (CST) Employee #C, Assistant Administrator responded,Yes, one of the residents (identified as resident #4) left the facility on a day I was not at work, he wandered away, the sheriff was called and the next day the rescue mission called informing the facility that resident was there. After this incident we talked to him about leaving the facility without letting staff knows. He was informed that he has the right to walk down the dirt road, but just don't go on the pave road. The Assistant Administrator reported that the talk has been working and resident complies with what was asked of him.

At approximately 10:28AM (CST) Employee #B and #C reviewed the communication log for documentation from facility staff about resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 165	Continued From page 40	A 165		

#4 wandering away from the facility and they both confirmed that they could not find any documentation in the facility's staff communication log of resident wandering away from the facility. Employee #B stated that she would call the Sheriff's department and request the report.

At approximately 10:34AM (CST) during the resident interview resident #4 was asked concerning his wandering from the facility. Resident #4 stated that he did ask one of the staff if he could leave for a long walk down the dirt road. Resident #4 stated that as he was walking down the road an unknown man pulled up in a car and asked him where he was going? Resident #4 stated that the unknown man informed him that he was going to bay medical hospital. Resident #4 stated that he informed the unknown man that he was also going to bay medical. Resident #4 reported that he got in the car with the unknown man who was nice, he did not curse while in his presence, nor did he not say any dirty words while in his presence,and was very respectful to him. Resident #4 reported that the unknown man took him to bay medical. Resident stated that after he left bay medical he walked to the rescue mission.

A record review was conducted of the Bay County Sheriff's Office Offense/Incident report dated at 17:49. The incident occurred between at 16:30 and at 18:01. The narrative stated that a care giver at the facility called to report that Resident #4 as missing. The officer wrote that upon his arrival at the facility he collected Resident #4's information and description and learned he was seen in the facility at approximately 16:30 hours. The officer wrote that along with staff, they searched the premises

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 165	Continued From page 41	A 165		

for Resident #4 and no avail. The officer wrote that he was able to locate Resident #4 a short time later on HWY 2297 just north of the street the facility is located. Resident #4 was returned without incident.

A record review was conducted of the Bay County Sheriff's Office/Offense/Incident Report Case Number: 2012-090728 dated : at 17:42 with the incident occurring : about 12:00. The narrative wrote by the officer stated that on : at 17:42 hours, he was at the facility for another call when he was told about a missing resident. The staff worker, (identified as Employee #B) said Resident #4 has walked to the Methodist Church on 2297 even after she told him it probably was closed.
Employee #B said that Resident #4, gave the officer identifying information, was on medication for schizo-effective and mild mental : as per his medical chart, usually says he is going somewhere and comes back a few hours later and this is not like him to be gone this long. Employee #B also said that his medication helps him "stay level" and if he does not take it he " will not "act right and could do things he normally wouldn't".
The officer wrote that he called Employee #B back before submitting this report and she said that another staff member had just looked the area over for the past hour and Resident #4 was not found. They have no idea where he went and they have checked all of their residential addresses as well and he was not there and no one has saw him.
The officer wrote that a copy of this report was sent to dispatch (OPER#369 at 1925) for NCIC entry as a missing endangered adult. The officer wrote that he also called the hospitals, jail and mission with no results. This case is pending.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
A 165	Continued From page 42	A 165		

The report included: added at 10:16:18 with officer's name: On , 2012 the investigator's name verified that the missing person, identified as Resident #4, was located and obtained and a sworn statement from the administrator from the facility.

On at approximately 4:00PM (CST) an interview was conducted with the Administrator and the Assistant Administrator who verified that they both had knowledge of resident #4 wandering away from the facility, but did not see this as an elopement. The Assistant Administrator reported that there were no documentation sent to any outside agencies of resident #4 wandering away from the facility.

AL241 SS=D 58A-5.029(2) FAC LMH - Records — AL241

(2) RECORDS.
(a) A facility with a limited mental health license shall maintain an up-to-date admission and discharge log containing the names and dates of admission and discharge for all mental health residents. The admission and discharge log required under Rule 58A-5.024, F.A.C., shall be sufficient provided that all mental health residents are clearly identified.
(b) Staff records shall contain documentation that designated staff have completed limited mental health training as required by Rule 58A-5.0191, F.A.C.
(c) Resident records for mental health residents in a facility with a limited mental health license must include the following:
1. Documentation, provided by the Department of Children and Family Services within 30 days of the resident ' s admission to the facility, that the resident is a mental health resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
AL241	Continued From page 43	AL241		

Documentation that the resident is receiving social security or supplemental security income, , and any of the following shall meet this requirement.
a. An affirmative statement on the Alternate Care Certification for , , ( ) Form, CF-ES 1006, ; 1998, that the resident is receiving SSI/SSDI due to a , .
b. Written verification provided by the Social Security Administration that the resident is receiving SSI or SSDI for a mental . Such verification may be acquired from the Social Security Administration upon obtaining a release from the resident permitting the Social Security Administration to provide such information to the Department of Children and Family Services.
c. A written statement from the resident ' s case manager that the resident is an adult with severe and persistent mental illness. The case manager shall consider the following minimum criteria in making that determination.
(i) The resident is eligible for, is receiving, or has received state funded services from the Department of Children and Family Services ' and Mental Health program office within the last 5 years; or
(ii) The resident has been diagnosed as having a mental .
2. An appropriate placement assessment provided by the resident ' s mental health care provider within 30 days of admission to the facility that the resident has been assessed and found appropriate for residence in an assisted living facility. Such assessment shall be conducted by a psychiatrist, clinical psychologist, clinical social worker, or , , nurse, or person supervised by one of these professionals.
a. Any of the following documentation which contains the name of the resident and the name,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
AL241	Continued From page 44	AL241		

signature, date, and license number, if applicable, of the person making the assessment, shall meet this requirement:
(i) Completed Alternate Care Certification for ( ) Form, CF-ES Form 1006, 1998;
(ii) Discharge Statement from a state mental hospital completed within 90 days prior to admission to the ALF provided it contains a statement that the individual is appropriate to live in an assisted living facility; or
(iii) Other signed statement that the resident has been assessed and found appropriate for residency in an assisted living facility.
b. A mental health resident returning to a facility from treatment in a hopsital or crisis stabilization unit (CSU) will not be considered a new admission and not require a new assessment. However, a break in a resident ' s continued residency which requires the facility to execute a new resident contract or admission agreement will be considered a new admission and the resident ' s mental health care provider must provide a new assessment.
3. A Community Living Support Plan.
a. Each mental health resident and the resident ' s mental health case manager shall, in consultation with the facility administrator, prepare a plan within 30 days of the resident ' s admission to the facility or within 30 days after receiving the appropriate placement assessment under paragraph (c), whichever is later, which:
(i) Includes the specific needs of the resident which must be met in order to enable the resident to live in the assisted living facility and the community;
(ii) Includes the clinical mental health services to be provided by the mental health care provider to help meet the resident ' s needs, and the frequency and duration of such services;

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
AL241	Continued From page 45	AL241		

(iii) Includes any other services and activities to be provided by or arranged for by the mental health care provider or mental health case manager to meet the resident ' s needs, and the frequency and duration of such services and activities;
( ) Includes the of the facility to facilitate and assist the resident in attending appointments and arranging transportation to appointments for the services and activities identified in the plan which have been provided or arranged for by the resident ' s mental health care provider or case manager;
(v) Includes a description of other services to be provided or arranged by the facility;
(vi) Includes a list of factors pertinent to the care, safety, and welfare of the mental health resident and a description of the signs and symptoms to the resident that indicate the immediate need for professional mental health services;
(vii) Is in writing and signed by the mental health resident, the resident ' s mental health case manager, and the ALF administrator or manager and a copy placed in the resident ' s file. If the resident refuses to sign the plan, the resident ' s mental health case manager shall add a statement that the resident was asked but refused to sign the plan;
(viii) Is updated at least annually;
(ix) include the Agreement described in subparagraph 4. If included, the mental health care provider must also sign the plan; and
(x) Must be available for inspection to those who have a lawful basis for reviewing the document.
b. Those portions of a service or treatment plan prepared pursuant to Rule 65E-4.014, F.A.C., which address all the elements listed in sub-subparagraph a. above may be substituted.

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
AL241	Continued From page 46	AL241		

4. Agreement. The mental health care provider for each mental health resident and the facility administrator or designee shall, within 30 days of the resident ' s admission to facility or receipt of the resident ' s appropriate placement assessment, whichever is later, prepare a written statement which:
a. Provides procedures and directions for accessing emergency and after-hours care for the mental health resident. The provider must furnish the resident and the facility with the provider ' s 24-hour emergency crisis telephone number.
b. Must be signed by the administrator or designee and the mental health care provider, or by a designated representative of a Medicaid prepaid health plan if the resident is on a plan and the plan provides behavioral health services under Section 409.912, F.S.
c. cover all mental health residents of the facility who are clients of the same provider.
d. be included in the Community Living Support Plan described in subparagraph 3. Missing documentation shall not be considered a deficiency if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Family Services, or the mental health care provider under contract to provide mental health services to clients of the department.

This Statute or Rule is not met as evidenced by:
Based on staff interview and record review the facility failed to provide the Community Living Support Plan and the Alternate Care Certification for Form, CF-ES 1006 for 2 of 2 sampled Mental Health residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
AL241	Continued From page 47	AL241		

(Resident #1 and #4)

The Findings:

On a record review was conducted of Resident #1 and #4 medical records for required documentation for the limited mental health license. The following was found:
1. Resident #1 was admitted on /. The Community living support plan that was in the file was last updated on .
2. Resident #2 was admitted on / and there was not Community living support plan found in the record.

A log for all residents that are ( ) recipients was provided by the Administrator. A review of the list and confirmed by the Administrator, Resident #1 and #4 are on . A record review of both resident's record revealed no Alternate Care Certification for Forms, CF-ES 1006.
At approximately 2:45PM (CST) an interview was conducted with the Administrator, Assistant Administrator and Adult Target Case Manager from Life Management, (who was visiting the facility at the time of the survey). The Administrator reported that the case managers from life management are responsible for completing the support plans. The three verified that resident #1 last community support plan in the file was dated and resident #4 did not have a support plan in the record. The case manager informed the Administrator that she must not had given the facility the updated support plans and must have the two resident's forms at her office. The case manager stated that she would go to the office and return the information to this surveyor by the end of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
AL241	Continued From page 48 survey. The exit conference was conducted at 5:00PM (CST) and the case manager had not returned to the facility with the documentation, nor did she call the facility otherwise to report any finding of the documentation.	AL241		
AL243 SS=D	58A-5.0191(8) FAC LMH - Training (8) LIMITED MENTAL HEALTH TRAINING. (a) Pursuant to Section 429.075, F.S., the administrator, managers and staff, who have direct contact with mental health residents in a licensed limited mental health facility, must receive the following training: 1. A minimum of 6 hours of specialized training in working with individuals with mental health diagnoses. a. The training must be provided or approved by the Department of Children and Families and must be taken within 6 months of the facility ' s receiving a limited mental health license or within 6 months of employment in a limited mental health facility. b. Staff in " direct contact " means direct care staff and staff whose duties take them into resident living areas and require them to interact with mental health residents on a daily basis. The term does not include maintenance, food service or administrative staff, if such staff have only incidental contact with mental health residents. c. Training received under this subparagraph may count once for 6 of the 12 hours of continuing education required for administrators and managers pursuant to Section 429.52(4), F.S., and subsection (1) of this rule. 2. A minimum of 3 hours of continuing education, which may be provided by the ALF administrator or through distance learning, biennially thereafter in subjects dealing with one or more of the following topics:	AL243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

(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
AL243	Continued From page 49	AL243		

a. Mental health diagnoses; and
b. Mental health treatment such as mental health needs, services, behaviors and appropriate interventions; resident progress in achieving treatment goals; how to recognize changes in the resident ' s status or condition that may affect other services received or may require intervention; and crisis services and the procedures.
3. For administrators and managers, the continuing education requirement under this subsection will satisfy 3 of the 12 hours of continuing education required biennially pursuant to Section 429.52(4), F.S., and subsection (1) of this rule.
4. Administrators, managers and direct contact staff affected by the continuing education requirement under this subsection shall have up to 6 months after the effective date of this rule to meet the training requirement.
(b) Administrators, managers and staff do not have to repeat the initial training should they change employers provided they present a copy of their training certificate to the current employer for retention in the facility ' s personnel files. They must also ensure that copies of the continuing education training certificates, pursuant to subparagraph (a)2. of this subsection, are retained in their personnel files.

This Statute or Rule is not met as evidenced by:
Based on staff interview and record review the facility failed to provide documentation for Mental Health training for 1 of 3 sampled employees. (Employee #A)

The findings:
On a record review was conducted for

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910538	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSONS RESIDENTIAL CARE	**11921 CARUSO DRIVE PANAMA CITY, FL 32404**

(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
AL243	Continued From page 50	AL243		

Employee #A required training's for Limited Mental Health. There was no no certificated for Limited Mental Health training in the record.

On , at approximately 2:45PM (CST) an interview was conducted with the Assistant Administrator who confirmed that there was no certificate for Limited Mental Health training in Employee #A record. The Assistant Administrator reported that Employee #A had taken the training, but could not produce the documentation to support it.

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Robinsons Residential Care
11921 Caruso Drive
Panama City, FL 32404

Dear Administrator:

This letter reports the findings of a Biennial state licensure survey including limited mental health that was conducted on , 2013 by representatives of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit which includes 4 class II deficiencies. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after , 2013 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyors. Should you have any questions please call me at 850-412-4540.

Sincerely,

for Jonah Heiberg, M.S.W.
Field Office Manager

Enclosure DH/pm
XG90

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Tallahassee Field Office
2727 Mahan Drive, Mail Stop #46
Tallahassee, FL 32308
Phone 850-412-4540; Fax (850) 922-9162