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 _____	R

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 On , a Licensure-revisit survey was conducted at Robinsons Residential Care Assisted Living Facility. At the time of the revisit five of the citations were cleared and eight of the citations were not cleared.	{A 000}		
{A 030} SS=G	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (6) RESIDENT RIGHTS AND FACILITY 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	{A 030}		

AHCA Form 3020-0001

TITLE (X6) DATE

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

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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 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 [redacted] 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

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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, 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

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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 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

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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 4 of 10 resident's were free from . (residents 8, 9, 10, and 13). The facility failed to maintain an environment free of pests (bed bugs). The facility has been having problems with bed bugs since at least 2012 (over 1 year). The facility also failed to allow residents to retain their clothes and personal property in their immediate living quarters. The facility failed to ensure a decent living environment. There was dust in a food preparation area, dressers were not maintained in good repair in 5 of 10 sampled (#3, 4, 5, 7, and 11), and 1 of 3 sampled mattresses (resident #6) were not comfortable.

The Findings:

1. Failure to be free from .

An interview was conducted with resident #13 on at approximately 10:33a.m. During this interview the question was asked of resident if she had experienced any physical or since the survey of . Resident #13 that there has been no improvement with the . Resident #13 reported that Employees #B, #E and #J yell at her, calling her names which include the "B" word. Resident #13 stated that this occurs nearly every day. Resident #13 reported that she has informed the Administrator and Assistant Administrator and

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they do not do anything. They say they will talk to these employees. Resident #13 stated that she feels and angry sometimes when these employees yell at her.

An interview was conducted with resident #8 on at approximately 10:53a.m. During this interview resident #8 reported that Employee #E who used to work at the facility in the past is now back as the part-time cook and he also lives at the facility. Resident #8 reported that since Employee #E has returned to the facility to work he yells at me when I go to the kitchen and ask for any food items out of the kitchen. Resident #8 reported that Employee #B continues to yell at her, stating the last time she yelled at her was on this past Friday. Resident #8 Stated that she was tired of Employee #B yelling at her and that she reported the to the Administrator who is over the facility because the has gotten worst.

An interview was conducted with resident #10 on at approximately 11:02a.m. Resident #10 reported that she has experienced and it could get worse. Stated that Employee #B yelled at her not to long ago. Stated she yells at me to get up out of bed even when I am not feeling well. Resident #10 stated that Employee #J yells at her also.

An interview was conducted with resident #9 on at approximately 11:19a.m., who reported and nodding her head pointed out Employee #B who was in the laundry , stating that she does not do anything to Employee #B and she yells at me for no reason. Resident #9 reported that she witnessed two residents arguing and Employee #B went in the residents' started yelling and arguing with the residents.

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Resident #9 stated that employee #B is not supposed to argue with the residents, she should be fired. At approximately 12:12p.m. client returned and stated that she changed her mind that Employee #B should not be fired, but needs to receive a warning for yelling at the residents.

An interview was conducted with the Administrator and Assistant Administrator on at approximately 2:22p.m. The Administrator reported that he had not received any reports from any residents that they were being by any employees and if he did, he would have taken action. The Administrator reported that Employee #B was suspended after the survey in pending the investigation with the Department of Children and Families investigator. The Administrator reported that the investigator came to the facility and interviewed one resident and stated that he found no indicator of and that the employee could return to work. The Assistant Administrator reported that she re-trained all staff members on . The Administrator reported that one resident reported that Employee #B talks in a loud tone of voice. The Administrator reported that he had an informal meeting with Employee #B, he described, "parking lot meeting." The Administrator and Assistant Administrator stated that they have not received any report from any resident or staff that any staff members were verbally to them. The Administrator or the Assistant Administrator could not provide documentation that an investigation had taken place to validate the allegations of from the residents.

An interview was conducted with the Assistant Administrator (AA) on at approximately 1:45p.m. concerning Employee #E returning back

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to work at the facility. The AA confirmed that this was the same employee that was fired in 2011 for admitting to to one of the residents at the facility. The AA confirmed that she and Employee #A witnessed the to the resident. The AA stated that Employee #E verbally threatened the resident, "Calling the resident a one legged bastard and threatened to dump the resident out of his wheelchair." The AA reported that she was the staff that called the hotline and reported the incident. The AA reported that Employee #E came to the facility in 2012 and informed her that he came to get his job back. The AA reported that the Administrator had the final decision, sent Employee #E to get a background screening and he returned back to work at the facility. The AA reported that Employee #E works part time on the weekend in the position as a cook.

An interview was conducted with the Administrator on at approximately 3:00p.m. concerning Employee #E returning to work at the facility. The Administrator reported that Employee # E continued to call him almost every day wanting his job back. The Administrator reported that he informed Employee #E that he admitted to to the residents. The Administrator reported that Employee #E informed him that he had changed. The Administrator reported that Employee #E informed him that he was homeless, living out of his car and had a break up with his lady friend. The Administrator reported that in 2012 Employee #E came to the facility asking for his job back. The Administrator stated that someone from the Agency informed him if Employee #E received a clear background check that Employee #E could return to work. The

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Administrator stated he got tired of Employee #E calling asking for his job so he sent him to get a background screening and it was clear and he re-hired Employee #E as a part-time cook on the weekends. The Administrator reported that Employee #E does not live at the facility, but he is on the schedule and have been working back at the facility since 2012. The Administrator did not report if he would investigate the allegations of from the residents concerning Employee #E.

The facility policy for was reviewed again 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.

2. Bed Bugs

On a complaint survey to CCR #2012000835 was conducted due to an allegation of bed bugs. Bed bugs were confirmed by a local Pest Control company. The company treated # for bed bugs on , and / .

A tour of the facility was conducted with Staff B (care giver) and staff F (maintenance, cook and care giver) on beginning at approximately 10:05am. Staff F was in the process of painting . The door trim and closet trim was missing. Staff F stated he removed the trim when he removed the paneling. The paneling was removed on advice of the pest control company. They came out here last week. There was an

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ongoing bed bug problem at the facility. The pest control company stated that the bed bug problem should be resolved. They suggested that the paneling be removed, as the bugs can live behind it. I found bed bugs when I removed the paneling. The trim will be replaced after the second coat of paint.

An interview was conducted with Staff F and the Assistant administrator on at approximately 2:00pm. They stated that the Department of Health (DOH) inspector was out at the facility about 3 weeks ago. They stated that the pest control company came out again last week due to a night shift worker's report of seeing bed bugs. The pest control company stated with the amount they have sprayed, they should be gone. They might be behind the paneling. The facility has removed the paneling in the in question. Bed bugs were only seen in 1, 2, 3 and 4. (Per pest control company documentation, also).

On at approximately 1:33pm, a phone call was place to the DOH health inspector. A voicemail message was left. Telephone contact was made with the DOH inspector on at approximately 1:15pm. The inspector stated that he was last out at Robinson's at the beginning of 2013. No bugs were observed at that time. The facility had not informed DOH of the continuing bed bug problems and pest control treatment at the end of . The DOH inspector stated that he would be contacting the facility and the pest control company.

On at approximately 8:10am, an interview was conducted with the pest control company representative. The pest control company confirmed that they have been treating

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Robinson's Residential Care facility for bed bugs for over a year. The company stated that the facility had not been following the instructions provided in order to eradicate the bed bugs. The company had instructed facility staff on numerous occasions regarding the importance of removing clutter from the resident . Any property remaining in the should be placed in plastic bins with lids. There should be nothing under the beds. The mattresses should be enclosed in mattress covers. All linens should be treated in the laundry under high heat. Robinson's Residential Care was not following these instructions. The pest control company stated that when instructions are followed, only 1 treatment is necessary 90% of the time. Bed bugs were living in the walls and ceiling and under the paneling at Robinson's Residential Care. You could see their feces. The facility was instructed to either seal the cracks in the paneling or removed the paneling and replace with dry wall, and to seal all the holes near the ceiling and around the trim. (During tour on in , there was up to a 1 inch gap between the dry wall and the door frames). The pest control company stated that when they sprayed behind the walls via the cracks that the bed bugs came flying out. Resident belongings were packed under their beds, and the closets were stuffed. The pest control company was unable to spray due to resident belongings. Feces could be seen on the mattresses. The pest control company had recommended that the whole facility be treated, but this is very costly, and the facility was not interested. The company has just kept spraying where bed bugs were seen.

3. Retain clothes and personal property in immediate living quarters. (Resident rights regarding their property being bagged up and in

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storage for an indefinite amount of time).

On at approximately 2:00pm, Resident #8 stated, "I only have 2 outfits, the rest is in storage. They have them bagged up. They have to be dried/steamed at high heat. I am really tired of wearing the same 2 outfits. I wear one and wash one. I want more of my clothes back. When can I get my clothes back?" Resident #8 denied any bed bugs at present. "They sprayed, and I haven't seen any more."

An observation of the storage shed in the yard was conducted with Staff F. There were multiple - over 20 - clear bags containing resident belongings. The bags were labeled and tied shut. An interview was conducted with Staff F during the observation. Staff F stated that the resident's property was out in the shed due to the bed bugs. They needed to be exposed to heat to kill the bugs. Some of this stuff has been out here a long time. Staff F was unaware as to when the property would be returned to the residents. Pest control was here again last week. Pest control stated with the amount they have sprayed, the bugs should be gone. Pest control advised that the bugs might be behind the paneling. Staff F has removed the paneling in the in question (1, 2, 3 and 4). Staff F confirmed finding the bugs behind the paneling.

An interview was conducted with the assistant administrator. The assistant administrator confirmed that pest control was here again last week. A night shift worker reported a bed bug. Bed bugs have only been seen in 1, 2, 3 and 4. Pest control advised that the paneling be removed, and we have done so. The pest control company will be back out now that the paneling has been removed. The assistant administrator

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stated that the resident ' s clothes needed to be dried on high heat before being returned to the residents. No timeframe estimate was provided as to when the clothes would be returned to the residents.

4. Furniture issues (dressers and mattress) and dust in kitchen

A tour of the facility was conducted with Staff B (care giver) and staff F (maintenance, cook and care giver) on beginning at approximately 10:05am.

The ceiling vent over the food preparation counter in kitchen was thick with visible hanging dust. Later, at approximately 3:15pm, hard boiled eggs were observed being chopped on a cutting board directly underneath the dusty vent. Staff were also observed to wave away tiny flying insects from the eggs.

had four dressers. Two of the dressers were each missing 1 drawer, and a third dresser was missing a handle.

, 5 and 7 each had 1 dresser with a missing handle.

had one dresser missing handles on all 3 drawers.

An interview was conducted with Staff F on at approximately 11:30am. Staff F stated that he thought that all of the dresser handles had been replaced.

On at approximately 1:40pm, Resident #16 stated, "there is something wrong with my mattress. I feel like I am going to out of the

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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 13 bed. It is not comfortable. It is really low on the right side. Also, I keep bumping my on the metal bar that sticks out". An observation of the bed-frame and mattress was conducted with staff Hand resident #16. The box springs was smaller than the bed frame. The right side of the frame was sticking out about 2 inches past the mattress. Staff H came in and stated that the mattress was off the track, and adjusted the mattress. After the adjustment there was a 2 inch gap on the other side with the metal bar sticking out. The box spring was sagging in the frame. There was a definite downward slope to the side of the top mattress where the resident indicated. The bed did not appear comfortable, and the bed frame sticking out was hazardous. Class II	{A 030}		
{A 081} SS=D	58A-5.0191(2) FAC Training - Staff In-Service (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, 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	{A 081}		

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{A 081}	Continued From page 14	{A 081}		

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 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.

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{A 081}	Continued From page 15	{A 081}		

This Statute or Rule is not met as evidenced by:
Based on inservice record review, review of incident reports and staff interview, the facility failed to provide training on the reporting of both major incidents and the reporting of adverse incidents for 5 of 5 sampled employees, (Staff A, B, E, F, and G).

The findings:

Personnel records were reviewed for incident report training for Staff A, B, E, F, and G. According to the personnel records, Staff B, E, F, and G received inservice training on incident reports on , and staff A received the training on . The assistant administrator signed the certificates as the trainer.

The agenda from the incident report training was requested from the assistant administrator. The assistant administrator stated, "There is none". The assistant administrator stated that she just went over the AHCA (Agency for Healthcare Administration) form and how to complete it.

On at approximately 2:02pm, the policy and procedure on incident reports was requested. The assistant administrator stated "there's a grievance policy, would that help " ? The assistant administrator then stated that the policy on the reporting of incidents " might be in the policy book " . We went through the policy book cover to cover. No policy was found on facility incident reports or on adverse incident reports. The administrator, who was also present, stated that he does not recall a policy on the incident reports.

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{A 081}	Continued From page 16	{A 081}		

Per staff interviews, and review of reports from Bay County Sheriff's Office, Resident #4 had eloped on and again on . Per staff interview, Resident #15 had eloped on . There were no incident reports or adverse incident reports for any of these elopements. The most recent incident report was dated .

On at approximately 1:22pm a phone call interview was conducted with the Complaint Administration Unit (CAU) at AHCA. CAU stated that AHCA had not received any adverse incident reports from Robinson's Residential Care. (See A0160 and A0165)

Class III

{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.

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{A 090}	Continued From page 17	{A 090}		

This Statute or Rule is not met as evidenced by:
Based on employee personnel record review and staff interview, the facility failed to provide at least one hour of training in the facility's policies and procedures regarding (. . . . .) for 5 of 5 sampled employees. (Employee A, B, E, F, and G)

The findings:

Employee personnel record reviews for Training ( ) were conducted on .

Employee A, B, E, F, and G were sampled. All had been employed for 4 or more months. There was no documentation found on training in any of the records.

An interview was conducted with the assistant administrator on at approximately 12:45pm. The assistant administrator also looked through the employee files and was unable to locate the missing trainings.

An interview was conducted with the administrator on at approximately 3:00pm. The administrator stated that he was not sure if the facility had a policy.

Class III

{A 152} SS=D	58A-5.023(3) FAC Physical Plant - Safe Living Environ/Other	{A 152}		

(3) OTHER REQUIREMENTS.
(a) All facilities must:
1. Provide a safe living environment pursuant to Section 429.28(1)(a), F.S.; and

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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 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 observation, resident interview and staff interview, the facility failed to maintain an

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environment free of pests (bed bugs). The facility has been having problems with bed bugs since at least 2012 (over 1 year). The facility also failed to provide a comfortable mattress for 1 of 3 sampled mattresses (Resident #16) and dressers in good repair in 5 of 10 sampled (, 4, 5, 7 and 11).

The findings:

On a complaint survey to CCR #2012000835 was conducted due to an allegation of bed bugs. Bed bugs were confirmed by a local Pest Control company. The company treated # for bed bugs on , and .

A tour of the facility was conducted with Staff B (care giver) and staff F (maintenance, cook and care giver) on beginning at approximately 10:05am. Staff F was in the process of painting . The door trim and closet trim was missing. Staff F stated he removed the trim when he removed the paneling. The paneling was removed on advice of the pest control company. They came out here last week. There was an ongoing bed bug problem at the facility. The pest control company stated that the bed bug problem should be resolved. They suggested that the paneling be removed, as the bugs can live behind it. I found bed bugs when I removed the paneling. The trim will be replaced after the second coat of paint.

An interview was conducted with Staff F and the Assistant administrator on at approximately 2:00pm. They stated that the Department of Health (DOH) inspector was out at the facility about 3 weeks ago. They stated that the pest control company came out again last

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{A 152}	Continued From page 20	{A 152}		

week due to a night shift worker's report of seeing bed bugs. The pest control company stated with the amount they have sprayed, they should be gone. They might be behind the paneling. The facility has removed the paneling in the in question. Bed bugs were only seen in 1, 2, 3 and 4. (Per pest control company documentation, also).

On at approximately 1:33pm, a phone call was place to the DOH health inspector. A voicemail message was left. Telephone contact was made with the DOH inspector on at approximately 1:15pm. The inspector stated that he was last out at Robinson's at the beginning of 2013. No bugs were observed at that time. The facility had not informed DOH of the continuing bed bug problems and pest control treatment at the end of . The DOH inspector stated that he would be contacting the facility and the pest control company.

On at approximately 8:10am, an interview was conducted with the pest control company representative. The pest control company confirmed that they have been treating Robinson's Residential Care facility for bed bugs for over a year. The company stated that the facility had not been following the instructions provided in order to eradicate the bed bugs. The company had instructed facility staff on numerous occasions regarding the importance of removing clutter from the resident . Any property remaining in the should be placed in plastic bins with lids. There should be nothing under the beds. The mattresses should be enclosed in mattress covers. All linens should be treated in the laundry under high heat. Robinson's Residential Care was not following these instructions. The pest control company stated that

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when instructions are followed, only 1 treatment is necessary 90% of the time. Bed bugs were living in the walls and ceiling and under the paneling at Robinson's Residential Care. You could see their feces. The facility was instructed to either seal the cracks in the paneling or removed the paneling and replace with dry wall, and to seal all the holes near the ceiling and around the trim. (During tour on in , there was up to a 1 inch gap between the dry wall and the door frames). The pest control company stated that when they sprayed behind the walls via the cracks that the bed bugs came flying out. Resident belongings were packed under their beds, and the closets were stuffed. The pest control company was unable to spray due to resident belongings. Feces could be seen on the mattresses. The pest control company had recommended that the whole facility be treated, but this is very costly, and the facility was not interested. The company has just kept spraying where bed bugs were seen.

Mattress:

On at approximately 1:40pm, Resident #16 stated, "there is something wrong with my mattress. I feel like I am going to out of the bed. It is not comfortable. It is really low on the right side. Also, I keep bumping my on the metal bar that sticks out." An observation of the bedframe and mattress was conducted with staff H and resident #16. The box spring was smaller than the bed frame. The right side of the frame was sticking out about 2 inches past the mattress. Staff H came in and stated that the mattress was off the track, and adjusted the mattress. After the adjustment there was a 2 inch gap on the other side with the metal bar sticking out. The box spring was sagging in the frame.

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There was a definite downward slope to the side of the top mattress where the resident indicated. The bed did not appear comfortable, and the bed frame sticking out was hazardous.

Furniture:

A tour of the facility was conducted with Staff B (care giver) and staff F (maintenance, cook and care giver) on beginning at approximately 10:05am. Several recent repairs had been made by the facility to address concerns cited on the survey.

had four dressers. Two of the dressers were each missing 1 drawer, and a third dresser was missing a handle.

, 5 and 7 each had 1 dresser with a missing handle.

had one dresser missing handles on all 3 drawers.

An interview was conducted with Staff F on at approximately 11:30am. Staff F stated that he thought that all of the dresser handles had been replaced.

Class II

{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

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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 pressure ; 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 , the date of .
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 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

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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 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

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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 staff interview and review of incident reports and resident records, the facility failed to keep an up-to-date record of major incidents. There were no incident reports for the elopement and/or calling of the sheriff for 2 of 2 sampled residents who eloped, Resident #4 and #15. During the licensure survey of , it was identified that resident #4 had eloped, and the sheriff was notified on and again on . During the follow-up survey of it was identified that resident #15 had eloped on and the sheriff was notified. There were no incident reports regarding any of these elopements.

The findings:

Previously 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. On a follow-up record review was conducted of the facility's incident reports. There was still no documentation of any

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client eloping from the facility, and no documentation that a sheriff had been called. The most recent incident report was dated .

On at approximately 2:02pm, the policy and procedure on incident reports was requested. The assistant administrator stated "there's a grievance policy, would that help"? The assistant administrator then stated that the policy on the reporting of incidents "might be in the policy book". We went through the policy book cover to cover. No policy was found on facility incident reports or on adverse incident reports. The administrator, who was also present, stated that he does not recall a policy on the incident reports.

It was cited on that resident #4 had eloped from the facility on at least 2 occasions, once on and again on . Evidence from the survey:

On at approximately 9:43AM a staff interview was conducted with Employee #A. Employee A stated that 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.

At approximately 10:34AM during the resident interview resident #4 was asked concerning his wandering from the facility. 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 reported that the unknown man took him to bay medical. Resident #4 stated that after he left bay medical he walked to the rescue mission.

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There were 2 separate reports on elopement of Resident #4 by the Bay County Sheriff's Office. They were dated and .

A record review was conducted of the Bay County Sheriff's Office Offense/Incident report dated at 17:49 (5:49pm). 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 (4:30pm). The officer wrote that along with staff, they searched the premises for Resident #4 to 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 dated at 17:42 (5:42pm). 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 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

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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.

During the follow-up survey of , an interview was conducted with Staff I at approximately 2:00pm. Staff I stated that about a month a ago Resident #15 eloped. "He was mad with anther resident, and he went storming up the road. When he didn't come back in a bit, I got in my car and went after him. He would not get in my car, so I called the Sheriff. He came back on his own before the Sheriff got here". There was no documentation of this event in the facility incident report book. A record review of Resident #15's file was conducted. There were no progress notes of any kind.

On at approximately 2:33pm, an interview was conducted with the assistant administrator regarding the elopement and sheriff being called for Resident #15. The assistant administrator could not find any documentation at all regarding Resident #15 leaving the facility and the sheriff being called. The assistant administrator stated that Staff I should have completed at least an incident report on that. The assistant administrator asked Staff I about the incident report. Staff I stated that she did file an incident report. "I remember because I went to the filing cabinet and got the form out and filled it out". Neither staff was able to locate the incident report. Staff I stated that the incident would be recorded in the communication book.

Staff I was observed to search through about 10 different communication books looking for her

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entry regarding the elopement. On at approximately 3:00pm, a follow-up interview was conducted with Staff I. Staff I stated, "I looked through about 10 notebooks and finally found my note. There is no system for the communication book. You just grab one and find a blank page, and document. I document everything". The communication book entry stated, "On , (Resident #15) got into an argument with (another resident). He walked off . I searched for approximately 40 minutes then called sheriff. He returned before the sheriff came out". Staff I stated, "I am putting these other books in the office so that I don't have to go through that again. Took me nearly 15 minutes to find my note from .".

Class III

{A 165} SS=G	429.23 FS; 58A-5.0241 FAC Risk Mgmt & QA; Adverse Incident Report	{A 165}	

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 exercise control rather than as a result of the

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resident ' s condition and results in:
1. [illegible];
2. [illegible] or spinal damage;
3. Permanent [illegible];
4. [illegible] or [illegible] 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) [illegible], neglect, or [illegible] 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 reviewed by the agency. The agency shall

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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 http://ahca.myflorida.com/reporting/index.shtml;

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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 interviews, staff interviews and record review the facility failed to investigate all allegations of and failed to report all allegations of to the hotline (Department of Children and Families) for 4 of 11 sampled residents. (#8, #9, #10 and #13). The facility also failed to maintain an adverse incident report for an elopement for 2 of 11 sampled residents. (Resident #4 and #15) During the licensure survey of , it was identified that resident #4 had eloped, and the sheriff was notified on and again on . During the follow-up survey of it was identified that resident #15 had eloped on

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and the sheriff was notified. There were no adverse incident reports regarding any of these elopements.

The Findings:

1. :

An interview was conducted with resident #13 on at approximately 10:33a.m. During this interview the question was asked of resident if she had experienced any physical or since the survey of . Resident #13 that there has been no improvement with the . Resident #13 reported that Employees #B, #E and #J yell at her, calling her names which include the "B" word. Resident #13 stated that this occurs nearly every day. Resident #13 reported that she has informed the Administrator and Assistant Administrator and they do not do anything. They say they will talk to these employees. Resident #13 stated that she feels and angry sometimes when these employees yell at her.

An interview was conducted with resident #8 on at approximately 10:53a.m. During this interview resident #8 reported that Employee #E who used to work at the facility in the past is now back as the part-time cook and he also lives at the facility. Resident #8 reported that since Employee #E has returned to the facility to work he yells at me when I go to the kitchen and ask for any food items out of the kitchen. Resident #8 reported that Employee #B continues to yell at her, stating the last time she yelled at her was on this past Friday. Resident #8 Stated that she was tired of Employee #B yelling at her and that she reported the to the Administrator who is over the facility because the

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has gotten worse.

An interview was conducted with resident #10 on at approximately 11:02a.m. Resident #10 reported that she has experienced and it could get worse. Stated that Employee #B yelled at her not to long ago. Stated she yells at me to get up out of bed even when I am not feeling well. Resident #10 stated that Employee #J yells at her also.

An interview was conducted with resident #9 on at approximately 11:19a.m., who reported and nodding her head pointed out Employee #B who was in the laundry , stating that she does not do anything to Employee #B and she yells at me for no reason. Resident #9 reported that she witnessed two residents arguing and Employee #B went in the residents' started yelling and arguing with the residents. Resident #9 stated that employee #B is not supposed to argue with the residents, she should be fired. At approximately 12:12p.m. client returned and stated that she changed her mind that Employee #B should not be fired, but needs to receive a warning for yelling at the residents.

An interview was conducted with the Administrator and Assistant Administrator on at approximately 2:22p.m. The Administrator reported that he had not received any reports from any residents that they were being by any employees and if he did, he would have taken action. The Administrator reported that Employee #B was suspended after the survey in pending the investigation with the Department of Children and Families investigator. The Administrator reported that the investigator came to the facility and interviewed one resident and stated that he

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found no indicator of and that the employee could return to work. The Assistant Administrator reported that she re-trained all staff members on . The Administrator reported that one resident reported that Employee #B talks in a loud tone of voice. The Administrator reported that he had an informal meeting with Employee #B, he described, "parking lot meeting." The Administrator and Assistant Administrator stated that they have not received any report from any resident or staff that any staff members were verbally to them. The Administrator or the Assistant Administrator could not provide documentation that an investigation had taken place to validate the allegations of from the residents. The Administrator and Assistant Administrator denied calling the hotline of having knowledge of staff calling the hotline regarding the allegations of .

2. Adverse Incident Reporting

It was cited on that resident #4 had eloped from the facility on at least 2 occasions, once on and again on . Evidence from the survey:

On at approximately 9:43AM a staff interview was conducted with Employee #A. Employee A stated that 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.

At approximately 10:34AM during the resident interview resident #4 was asked concerning his wandering from the facility. Resident #4 stated

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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 reported that the unknown man took him to bay medical. Resident #4 stated that after he left bay medical he walked to the rescue mission.

There were 2 separate reports on elopement of Resident #4 by the Bay County Sheriff's Office. They were dated and .

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A record review was conducted of the Bay County Sheriff's Office/Offense/Incident Report dated at 17:42 (5:42pm). 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 and mild mental as per his medical chart,

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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.

During the follow-up survey of , an interview was conducted with Staff I at approximately 2:00pm. Staff I stated that about a month a ago Resident #15 eloped. "He was mad with anther resident, and he went storming up the road. When he didn't come back in a bit, I got in my car and went after him. He would not get in my car, so I called the Sheriff. He came back on his own before the Sheriff got here". There was no evidence that an adverse incident report had been submitted to AHCA (Agency for Healthcare Administration).

On at approximately 1:10pm, an interview was conducted with the assistant administrator regarding the filing of adverse incident reports. The assistant administrator was asked for evidence that the adverse incident reports had been filed for the elopements of Resident #4 (cited on). The assistant administrator stated that she does not have a paper copy, and cannot produce evidence that the adverse incident reports were filed. She further stated that she does not have access to a computer at work. She stated, "The administrator was supposed to file this".

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An interview was conducted with the Administrator and Assistant Administrator at approximately 1:52p.m. During this interview the Administrator reported that the facility did not file an adverse incident report for resident #4. The Administrator reported that he was not aware that resident #4 had eloped from the facility, he was aware that resident had gone to the emergency . The Administrator reported that the employee that was on duty at the time of the elopement should have filled out the incident report and should have faxed it to the appropriate agency and if that staff did not file the adverse incident report then the Assistant should have completed the form. The Assistant Administrator reported that she has not been trained to complete the adverse form electronically. The Administrator confirmed that he did not file the adverse form because he did not know to do whether to submit the hard copy of via online. Again, the Administrator stated that whatever staff was on duty at the time of the elopement was supposed to complete and submit the form to appropriate agency. The Assistant Administrator reported that she would complete and submit the form to the appropriate agency.

On at approximately 1:22pm a phone call interview was conducted with the Complaint Administration Unit (CAU) at AHCA. CAU stated that AHCA had not received any adverse incident reports from Robinson's Residential Care. There were no incident reports for resident #4 or resident #15 (or any other resident).

Class II

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

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(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. 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

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 _____	R

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 40	{AL241}		

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, 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

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{AL241}	Continued From page 41	{AL241}		

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;
(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

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{AL241}	Continued From page 42	{AL241}		

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.
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

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{AL241}	Continued From page 43	{AL241}		

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 Form, CF-ES 1006 ( ) for 7 of 11 sampled Mental Health residents. (Residents #1, #2, #3, #6, #7, #8 and #9)

The Findings:

Record review of seven mental health Residents' (#1, #2, #3, #6, #7, #8 and #9) medical records were reviewed for documentation of the forms. The forms were not found in the resident's medical records.

An interview was conducted with the Administrator on at approximately 2:09p.m. During this interview the Administrator reported that the case manager at Life Management never followed up with the facility to provide the forms to him after the survey. The Administrator confirmed that he does not have copies of the resident's forms in the file. The Administrator provided a copy of the Agreement stating that he has an updated copy but could not find it at this time, but

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{AL241}	Continued From page 44 the wording has not changed, just the date. Record review of the , Agreement Between the Assisted Living Facility and the Mental Health Provider dated indicated that the Mental health provider would: A. Initiate placement for its resident whose needs can be met in an assisted living facility. B. Provide case management services to its clients who reside in the facility C. Participate in developing and updating its clients' community living support plans D. Provide clinical mental health services for its clients in accordance with their treatment plans and make the facility aware of the time and location for its clients to receive clinical mental health services. The Responsibilities of the facility: B. Notify the provider of significant behavioral situational changes concerning its clients who are residents of the facility. C. Facilitate client participation in clinical mental health services D. Facilitate access between provider's case managers and their clients. Class III	{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.	{AL243}		

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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:
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

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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 ensure that each employee received an initial 6 hours of specialized mental health training for 2 of 5 sampled employees (Staff F and G). The facility failed to ensure that each employee received a minimum of 3 hours of continuing education in mental health topics for 4 out of 5 sampled employees.(Staff E, F, A, and G)

The findings:

Employee personnel record reviews for mental health training were conducted on .

Staff E had received mental health training on . Staff E was terminated from employment in of 2011 and rehired in of 2012. There was no documentation that staff E had received any mental health training since being rehired in 2012.

Staff F had worked at the facility for over a year. There was no documentation of mental health

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training.

Staff A had received mental health training on . There was no documentation showing the 3 hour biennial mental health training updates.

Staff G had worked at the facility for at least a year. There was no documentation of mental health training.

An interview was conducted with the assistant administrator on at approximately 12:45pm. The assistant administrator also looked through the employee files and was unable to locate the missing mental health trainings.

An interview was conducted with the administrator on at approximately 3:00pm. The administrator stated that he took the 6 hour mental health course in of 2011, and he remembers Employee A being at the class with him.

Class III

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11910538	A. Building B. Wing	3/4/2013

Name of Facility	Street Address, City, State, Zip Code
ROBINSONS RESIDENTIAL CARE	11921 CARUSO DRIVE PANAMA CITY, FL 32404

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **A0026** Reg. # **58A-5.0182(2) FAC** LSC	Correction Completed	ID Prefix **A0032** Reg. # **58A-5.0182(8) FAC** LSC	Correction Completed	ID Prefix **A0055** Reg. # **58A-5.0185(6) FAC** LSC	Correction Completed
ID Prefix **A0075** Reg. # **429.255 FS** LSC	Correction Completed	ID Prefix **A0162** Reg. # **58A-5.024(3) FAC** LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency — **Reviewed By** — **Date:** 3/18/13 — **Signature of Surveyor:** — **Date:** 3/18/13

Reviewed By CMS RO — **Reviewed By** — **Date:** — **Signature of Surveyor:** — **Date:**

Followup to Survey Completed on:

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

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 state licensure survey revisit conducted on , 2013 by representatives of this office. Enclosed is the provider copy of the Statement of Deficiencies and Plan of Correction, (State Form 3020), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

You are hereby directed to provide a written plan of correction to this Field Office, in accordance with enclosed instructions, for the identified deficiencies within ten working days of receipt of this faxed report. You will not receive a copy of this report in the mail, you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2013.**

The inspection resulted in findings of non-compliance in the following areas:

1) A 0030 Resident Rights - Class II
The Assisted Living Facility failed to maintain an environment that was safe and free from and bed bugs. This noncompliance possesses a direct threat to the health and welfare of residents living in the facility.

2) A 0152 Physical Environment - Class II
The Assisted Living Facility failed to maintain an environment that does not pose a risk to resident's safety and welfare. The facility has been having problems with bed bugs for over 1 year. This noncompliance possesses a direct threat to the health and welfare of residents living in the facility.

3) A 0165 Risk Management, Adverse Incident Report – Class II
The Assisted Living Facility failed to investigate all allegations of , and failed to report all allegations of to the hotline. The facility failed to maintain an adverse incident report for elopements.

Your plan of correction **must** include the following:

1. Documentation of an independent treatment analysis by a licensed pest control company who specializes in treatment of bedbugs.

2. A written description of how you plan to prepare for treatment (before and after) as directed within the treatment protocol/instructions provided by the licensed pest control company.

3. A written plan of how the facility will ensure the safety, well-being and placement of the residents during the treatment process, as directed by the licensed pest control company.

4. A written roster of all residents seen and treated by his/her physician regarding bed bug bites (including plan of care/treatment). This should be updated on a daily basis.

5. Develop and implement a written control protocol to prevent reoccurrence of bed bug infestation.

6. Conduct an in-service with facility staff regarding your control protocol. Please ensure that all in-services are documented on a certificate that included title/subject of the in-service, date, time, attendees name and presenter's name, as required.

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,

Donah Heiberg, M.S.W.
Field Office Manager

DH/kb
Enclosures

HTVO