STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968643	07/14/2015
NAME OF PROVIDER OR SUPPLIER **RIVERTOWN SENIOR CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **17112 NW CHARLIE JOHNS ST** **BLOUNTSTOWN, FL 32424**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

On an unannounced LNS monitoring was conducted at Rivertown Senior Care. Deficiencies were cited.

0030 Resident Care - Rights & Facility Procedures

Based on observation, resident interview and staff interview the facility failed to honor residents rights by failing to allow 2 out of 12 (#2 and #6) residents to retain their own clothing in their . The facility also failed to provide adequate and appropriate health care for 3 of 7 residents during medication pass (#3, 5, 6), pills were dropped, touched with bare hands and glucometer was not cleaned between residents.

The findings are:

During the survey observation of care revealed resident #2 and resident #6 had told the staff member they needed clothing to get dressed. Staff member C took Client #2 and #6 to their to assist. She stopped at a locked utility . She unlocked the utility obtained clothing for resident #6. Resident #2 had followed the staff member to this . Resident #2 was allowed to choose clothing for the day from this .

Observation of the by resident #2 and #6 revealed in the closet was 2 night gowns the staff member C identified as belonging to Resident #6. In the chest of drawers was observed 1 bra, 1 pair of socks and 1 pair of underwear identified by staff member C as belonging to resident #2. The other drawers and closet space was observed void of clothing.

An interview was conducted with resident #2 on at approximately 9:11 AM. She stated it was not right that she could not have her clothing in her drawers in her . She stated, "All the other residents have their clothing and it is not right that I cannot have mine".

On when the nurse was observed unlocking the utility obtain the residents clothing she was asked why their clothes were locked up. The Administrator who is the nurse providing the care stated their clothes are kept locked up because they (the residents) were really and scattered them all over the facility. Further interview with the Administrator was conducted and she stated resident #2 had behaviors such as washing out her clothing even when they were clean and hanging the clothes all over the dry.
A review of the clinical record for resident #2 on revealed no behaviors of scattering clothing or washing clothing had been documented.

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During the medication pass observation the nurse was observed dropping a pill on the counter and using her bare hands picked up the pills and placed them in a cup and provided them to the resident #3. The nurse was observed dropping several pills on the counter then using the medication card scooped the pills off the counter placed them in a cup and provided them to the resident #5.

Resident #3 had checked her glucose at approximately 7:08 AM. The glucometer was placed back in the holder. Without cleaning the lancet or the glucometer (meter for checking sugar level) the nurse checked the glucose of resident #6 at approximately 8:30 AM. After checking resident #6 sugar at 8:30 Am the nurse placed the lancet, still with the used needle in it and the meter back into the cover pouch and zipped it up again without cleaning.
An interview was conducted with the Administrator /nurse on at approximately 12:15 Pm. She stated she did not have a policy in place for cleaning the glucometer. She confirmed she did not clean the meter or remove the used lancet (needle used for accessing).

Class III

0054 Medication - Records

Based on observation and staff interview the facility failed to maintain daily medication observation records for out 7 of 7 residents observed during medication pass (#1,3,4,5,6, 7, 8).

The findings are:

On at approximately 8:30 AM the nurse had started her medications pass. After the first medication was administered the nurse went to sign the MOR (medication observation record) and realized that all the medications had been documented as given for the date of .

MOR's reviewed for residents #2, 9,10,and 11 revealed that all medications for the date of had been previously signed as administered.

On an interview was conducted with the administrator who is the nurse providing the medication at approximately 8:30 AM. She stated she does not know how she had already signed the medications. She confirmed that she had initialed the wrong date during a previous medication pass.

Class III

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0078 Staffing Standards - Staff

Based on employee record review and staff interview the facility failed to provide proof of a written statement from a healthcare provider indicating the employee was free of communicable for 1 of 3 (employee B) and failed to ensure evidence of a negative test was documented for 1 of 3 (B) employees reviewed for and communicable statements.

The findings are:

A review of the employee record for employee B revealed a date of hire . There is no documented proof of a written statement from a health care provider that this employee is free of communicable including . There was no proof of documentation that the employee had received testing within 30 days of hire.

An interview was conducted with the administrator on at approximately 12:30 PM. She was not aware that the employee had to have a test. She stated the health department would only do a screening. She confirmed the employee B did not have a test and employee B did not have a written statement that confirmed employee B was free of communicable .

Class III

0079 Staffing Standards - Levels

Based on observation and staff interview the facility failed to maintain a written work schedule that reflected 24 hour staffing patterns.

The findings are:

A review of the staffing levels revealed the administrator provided two pieces of paper from a notepad for her two new employees that had documented they worked 9:00 Am to 2:00 PM daily for 7 days. The administrator's hours are not written down anywhere. The administrator does not have a written schedule.

An interview was conducted with the administrator on at approximately 3:00 PM. She stated she thought she did not have to have a written schedule until she had 16 residents.

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Class III

0081 Training - Staff In-Service

Based on employee record review and staff interview the facility failed to ensure staff who provide direct care to residents received 1 hour in-service training within 30 days of hire for ADL (activities of daily living) and behaviors, Emergency preparedness, Resident Rights, Recognizing and reporting , neglect and , and safe food handling for 1 out 3 (B) employees reviewed for required training.

The findings are:

A review of the employee file for employee B revealed a date of hire .
There is no documentation that the employee was provided 1 hour in-service training within 30 days of hire for ADL (activities of daily living) and behaviors, Emergency preparedness, Resident Rights, Recognizing and reporting , neglect and , and safe food handling.

An interview with the administrator was conducted on at approximately 12:30 PM. She stated she was sure she had provided the education to employee B and had not documented the training with certificates.

Class III

0082 Training - /

Based on employee record review and staff interview the facility failed to ensure 1 of 3 (B) employees reviewed for required training had received / training within 30 days of employment.

The findings are:

A review of the employee file for employee B revealed a date of hire . There is no documentation the employee received education on / within 30 days of employment.

An interview was conducted with the Administrator on at approximately 12:30 PM. She stated she had provided the education to the employee but had not provided a certificate for proof of training.

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Class III

0090 Training -

Based on employee record review and staff interview the facility failed to provide 1 out 3 (B) employees reviewed for required training with training within 30 days of employment.

The findings are:

A review of the employee file for employee B revealed a date of hire . There is no documentation the employee received education on policy and procedures.

An interview was conducted with the Administrator on at approximately 12:30 PM. She stated she had provided the education to the employee but had not provided a certificate for proof of training.

Class III

0092 Food Service - General Responsibilities

Based on observation and staff interview the Administrator failed to serve food in a safe and sanitary manner by not wearing gloves when handling food.

The findings are:

An observation of the breakfast meal was completed on .

The administrator was observed serving food on . AT 7:58 AM she was observed stacking pancakes on one plate using a spatula, then without applying gloves she took her bare hand and took the pancakes off the stack and placed the pancakes on the individual plates and served them to 3 residents.

An interview was conducted with the administrator on at approximately 8:00 AM. She stated when handling food she usually always uses utensils and could not say why she used her fingers instead of a spatula to serve the pancakes.

Class III

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Z816 Background Screening-Compliance Attestation

Based on employee record review and staff interview the facility failed to complete Level II Background screen requirements by having the employee complete an attestation of compliance for 3 out of 3 employees (A, B and C) reviewed for background screening.

The findings are:

A review of the employee record for employee A date of Hire revealed a level II background screening had been completed on . There is no attestation of compliance signed by employee A.

A review of the employee record for employee B date of hire revealed a level II background screening had been completed on . There is no attestation of compliance signed by employee B.

A review of the employee record for employee C date of hire revealed a level II background screening had been completed on . There is no attestation of compliance signed by employee C.

An interview was conducted with the administrator on at approximately 12:30 PM. She confirmed that the employees had not completed the attestation of compliance form.

class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Rivertown Senior Care
17112 Nw Charlie Johns St
Blountstown, FL 32424

RE: LNS MONITORING

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 by representative(s) of this office. Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. 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. **Please attach your corrective action and any additional documentation to support correction of identified deficiencies and send to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 surveyor(s). Should you have any questions please call me at 850-412-4540.

Sincerely,

Donah Heiberg
Field Office Manager

DH/dh
Enclosure
XG90

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