STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968643	05/18/2016
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 17-18, 2016 a biennial re-licensure survey with Limited Mental Heath (LMH) and Limited Nursing Services (LNS) was conducted at Rivertown Senior Care Assisted Living Facility. Deficient practice was identified during the survey.

0025 Resident Care - Supervision

Based on observation, interview and record review, the facility failed to ensure an awareness of general health, safety, and physical well-being for 3 of 4 sampled residents, #3, #5, and #8. The facility also failed to contact the resident's health care provider about bed bug bites for 2 of 3 residents sampled for bed bug issues, #3 and #8. In addition, the facility failed to maintain a written record of changes that required treatment by a medical doctor for 4 of 4 residents sampled with health changes, #2, #3, #5, and #8.

Findings include:

An interview was conducted with the facility Administrator on at 09:05am. The Administrator informed the team that the facility currently had a bed bug infestation and that four resident had bed bugs, A-1, A-2, A-3, and A-4. She stated that the residents were removed from their and placed in other within the facility. She stated that two residents had been bitten by bed bugs, Residents #2 and #8. She stated that Resident #2 was prescribed cream for the bed bugs. The Administrator reported that she had also been bitten multiple times by the bed bugs.

An interview was conducted with Resident #2 on at 10:42am. Resident #2 reported that the facility told him bed bugs were in his about a week. He stated that they sprayed his . A review of his medical record showed an order from the doctor dated for 1% cream. This medication is used to treat caused by . There are no notes written on this resident since . An interview was conducted with the Administrator on at 10am. She stated, "There are no progress notes written about him having bed bugs or about being bitten. I haven't documented anything yet. It has been a bad month. I haven't had time. "

An interview was conducted with resident #3 on at 2:45pm. The resident stated, "I'm not sure if I had bed bugs but I was getting bitten at night on my neck." The resident stated that she had told staff members she had been bitten.

A review of Resident #3's notes revealed no documentation about the resident being bitten by bed bugs, nor was there any documentation of the resident seeing a physician for the bed bug bites.

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An interview was conducted with resident #8 on at 11:00 am. He reported he felt bugs crawling on him and believes he had been bitten. He reported the Administrator had seen where he had been scratching on his leg and arm. He stated the Administrator gave him some rubbing . During an observation on at 11:28 pm, Resident# 8 had a nickel size like mark on his and a two inch dark scab like area on his lower left leg.

An interview was conducted with Resident#8's case manager on at 2:58pm. She stated that Resident#8 spoke with her briefly and reported that the facility had bed bugs. He showed her where he had been scratching. The case manager also reported that she observed the resident scratching his legs while he was at the office. A review of Resident#8's medical records revealed the last written notes dated .

An interview was conducted with the Administrator on at 10am. She stated, "Resident#8 has an so I wasn't sure if he was itching because of that or not. He just started itching a couple of days ago on Sunday. During my assessment I noticed that he had a few bites on his back. I asked him if it itched and he said yes. He will see he doctor when he comes by on Friday. I haven't documented anything on him yet."

An interview with the Administrator was conducted on at 11:00am. She stated, "When the doctor came by last month he asked if I wanted the entire facility treated with a cream. I told him no because at that time only one resident had been bitten. I should have had him treat everyone at that time."

An interview was conducted with resident #5 on at 10:12am. He stated, "I'd rather be in a pine box than live here. I haven't tried to kill myself here yet. I've told the staff." During a follow up interview at 3:30pm, the resident confirmed he felt the same way.

An interview was conducted with the Administrator on at 10:35am. This surveyor asked if she knew that Resident#5 was . She stated, "Yes, he said he was when we took his belongings from his few weeks ago." During a follow-up interview at 1:50pm, she reported notifying the resident's case manager about his thoughts. Also, she reported to Law Enforcement and the resident was on .

A review of the resident #5's record lacked documentation of the thoughts and no documentation the on . Also, there were no indications that the family was notified of the change on .

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An interview is conducted with the Administrator on at 10am. She stated, "No, I haven't documented anything about him from yesterday.

Class III

0030 Resident Care - Rights & Facility Procedures

Based on observation, interview, and record review, the facility failed to provide a safe and decent living environment related to bed bugs. This failed practice had the potential to affect all 11 of 11 residents living at the facility including sampled residents #1, 2, 3 and 8.

Findings include:

An interview was conducted with the facility Administrator on at 09:05am. The Administrator informed the team that the facility currently had a bed bug infestation and that four resident had bed bugs, A-1, A-2, A-3, and A-4. She stated that the residents were removed from their and placed in other within the facility. She stated that two residents had been bitten by bed bugs, Residents #2 and #8. She stated that Resident #2 was prescribed cream for the bed bugs. The Administrator reported that she had also been bitten multiple times by the bed bugs. She reported the bed bug issue had been going on for about 2-3 weeks.

An interview with resident #2 was conducted on at 10:42am. He reported he was told that bed bugs were in his a week ago. He stated that they sprayed his . A review of his medical record on showed an order from the doctor dated for 1% cream. This medication is used to treat caused by .

An interview with resident #3 was conducted on at 2:45pm. The resident stated, "I'm not sure if I had bed bugs but I was getting bitten at night on my neck."

An interview was conducted with resident #8 on at 11:00 am. He reported he felt bugs crawling on him left leg last week and believes he had been bitten. He reported the Administrator had seen where he had been scratching on his leg and arm and gave him some rubbing .

During an observation on at 11:28 pm, Resident# 8 had a nickel size like mark on his and a two inch dark scab like area on his lower left leg.

An interview was conducted with Resident#8's case manager on at 2:58pm. She reported she had not been to the facility in about 4 weeks because there was bed bug. She stated that Resident#8

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reported to her that the facility had bed bugs as well. He showed her where he had been scratching. The case manager also reported that she observed the resident scratching his legs while he was at her office.

An interview was conducted with the Administrator on at 10am. She stated, "Resident#8 has an so I wasn't sure if he was itching because of that or not. He just started itching a couple of days ago on Sunday. During my assessment I noticed that he had a few bites on his back. I asked him if it itched and he said yes. He will see he doctor when he comes by on Friday."

An interview was conducted with the Administrator on at 11:30am. The Administrator stated that she was aware that the facility had bed bugs for about 2-3 weeks after Resident#2 was bitten. She stated that she contacted a pest control company but the quote they gave her was quite expensive and she felt she could treat the bed bugs herself. She provided the surveyor with a bottle of Concentrate made by FarmGard. She reported Resident #8 was bitten after her treatment.

An interview with the Administrator was conducted on at 11:00am. She stated, "When the doctor came by last month he asked if I wanted the entire facility treated with a cream. I told him no because at that time only one resident had been bitten. I should have had him treat everyone at that time."

An interview with Resident #1 was conducted on at 10:19 am. He reported seeing the Administrator and employee B spraying the residents . He stated he seen a bed bug in the hallway and a piece of toilet paper and through it in the trash.

An interview was conducted with the Pest Control Company on at 2:27 pm. The Pest Control Manager reported that the last service visit was and that visit consisted of routine pest control visit. She reported that the Administrator contacted the Pest Control technician regarding a bed bug treatment quote but the technician had not heard back from the Administrator after he provided her the quote of $3,000.00. The amount would have included two treatments and an inspection to ensure the bed bugs were gone.

Class II

0080 Training - Core & Competency Test

Based on interviews and record reviews, the assisted living facility failed to ensure 2 of 2 core trained staff members (Administrator and manager) received 12 hours of continuing education every two years.

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Findings include:

1) A review of both the Administrator and Manager's personnel files revealed their date of hire as / . They had Core training certificates of 26 hours on / and a certification issued on . Their personnel files lacked continuing education hours.

2) During an interview on at 9:30 AM, the Administrator reported that she and the Manager had not received any continuing education hours and confirmed she knew the 12 hours were due.

Class III

0093 Food Service - Dietary Standards

Based on interviews and record reviews, the assisted living facility failed to ensure that facility menus were reviewed annually by a licensed or registered dietitian.

Findings include:

1) A review of the facility's 4 week menu cycle revealed the registered dietitian last reviewed and approved the menus on .

2) During an interview on on 1:00 PM, the administrator stated, "I have not had the menus updated." "I noticed last week that they needed to be updated and I am in the process of switching to a new dietitian."

Class III

N277 LNS - Resident Care Standards

Based on observation, record review, resident interview and staff interview, the facility failed to ensure that nursing services were conducted and supervised by a registered nurse for 1 of 1 sampled resident receiving Limited Nursing Services, #6.

Findings include:

An interview was conducted with resident #6 on at 11:22am. The resident stated that staff helps her with her ostomy by changing the appliance, the bag and wafer as needed. She states that usually they will just empty the bag and snap back on to the wafer.

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A review of Resident#6's records revealed the resident was receiving LNS (Limited Nursing Services) for a . The record also contained an order from the hospital dated to provide care.

An interview was conducted on at 10:51am with direct care staff, employee B. She confirmed that Resident#6 had a . "I help her with checking the bag. If it needs to be emptied, I snap it off the wafer and empty the bag and then reapply the bag. If the wafer needs to be replaced, I take it off and clean her. I get a new wafer and cut the hole in the middle put back on her. I change the bag and the wafer if it needs to be done." The employee showed the surveyor an ostomy bag that is a two piece unit. There is a separate wafer and separate bag to the appliance. The employee indicated this is the appliance used on the resident. Again, the surveyor asked the employee if she changes the wafer. The employee stated, "Yes, if it needs to be changed or put back on I do change it."

An interview was conducted with the Administrator on at 12:00pm. She reported, "We had an emergency situation a few months ago where I wasn't here and an employee had to change it (wafer). But that was an emergency." The surveyor asked if the resident was capable of changing the ostomy on her own. The Administrator stated, "No, some days she can empty it, other days she can't. She's not capable of changing the wafer."

A record review of the Limited Nursing Services (LNS) book revealed monthly assessments for Resident#6. The last assessment was completed on . The assessments dated and were not signed by a physician or registered nurse. An interview was conducted with the Administrator on at 12:35. She stated, "I know they aren't signed. I was going to get the doctor to sign them when he comes on Friday."

A review of the facility's LNS policy and procedures revealed that a nurse will provide LNS services, including care and maintenance.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Rivertown Senior Care
17112 NW Charlie Johns St
Blountstown, FL 32424

Attention: Britney Ann Wesner, Administrator

Dear . Wesner:

This letter reports findings of complaint investigations conducted from - to - by a representative of the Agency for Health Care Administration. You are directed to comply with the tangible steps outlined below in order to correct the deficient practices. Attached are the deficiencies noted in the investigation.

The investigation resulted in findings of noncompliance related to the Class II deficiency in the following areas:

A 30 – Resident Rights, Physical Environment - Class II - The facility failed to provide a safe and decent living environment which was free of bed bugs.

Your facility must comply with the following related to the Class II deficiency. Please be advised your facility is also expected to correct all other outstanding deficiencies:

1. To ensure the facility is pest and bug free, it must contract with a State licensed pest control company which will evaluate and treat the facility in its entirety, including the treatment of bed bugs. This must be completed by

2. The facility must follow the licensed contractor's directions including, but not limited to, having to temporarily relocate each resident from their another available the facility or relocate residents temporarily outside the facility. This must be completed by

3. The facility must seek specific written direction from the licensed contractor to determine the individual resident procedure, including the handling of each and every resident personal belonging. If the licensed contractor will require that each of the resident's clothing or personal items must be treated in high heat, the facility must log every resident item undergoing this process. This must be completed by

4. The facility must provide documentation that it has followed the licensed contractor's procedure to achieve proper facility bed bug mitigation process. This must be completed by

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SlideShare.net/AHCAFlorida

5. The facility must properly cover all of the gaps and spaces in or around its air conditioning units throughout the facility as part of having a pest-free environment for the facility residents. This must be completed by

6. The facility must have a satisfactory health inspection from the Calhoun County Health Department upon completion of treatment. This must be completed immediately upon completion of the licensed contractor's facility treatment.

7. The facility must develop and implement a policy and procedure to prevent future infestation of bed bugs that includes, at a minimum, the following:

   a. During intake interviews, ask questions regarding unexplained bite marks and ask about infestation at prior residences, including assisted living facilities.

   b. Prevent access to resident areas prior to the intake interview and inspection of clothing and belongings.

   c. Thoroughly inspect the resident's belongings for signs of infestation during the intake or upon resident return from any temporary absences from the facility.

   d. Launder patient clothing and belongings using high heat for drying if there are concerns about infestation.

   e. Discuss bed bug prevention with any health care providers coming into the facility and consider inspecting any medical equipment brought in.

   f. If the facility is concerned about an infestation, immediately prevent access to the affected , seal clothing and bedding in plastic until laundered and dried on high heat and inspect common areas frequented by the resident.

   g. The facility staff must be trained on the policy/procedures and documentation of the training must be available upon request. These policies and procedures must be completed within 10 days of receipt of this DPOC.

Please be advised that nothing in this Directed Plan of Correction limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact Laura Manville, Assisted Living Enforcement Team Manager at 727-552-1955 or Kristi Conoly or Karla Beasley, Assisted Living Supervisors, Area 1/2 Field Office, at (850) 412-4540.

Sincerely,

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

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