STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910538	12/27/2016
NAME OF PROVIDER OR SUPPLIER **ROBINSONS RESIDENTIAL CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **11921 CARUSO DRIVE** **PANAMA CITY, FL 32404**	

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

0000 - Initial Comments

An unannounced Biennial Licensure survey to include Limited Mental Health was conducted at Robinson's Residential Care (license #7166) located in Panama City, Fl on 12/27/2016. Deficient practice was identified at the time of the survey.

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and staff interview, the facility failed to ensure each staff had a written statement from a health care provider documenting the individual does not have any signs or symptoms of communicable within 30 days after beginning employment for 1 of 3 sampled employees. (Employee A)

The findings include:

Review of employee A's file revealed a hire date of / as direct care staff. The file contained a statement dated of freedom from communicable but it was not signed by a health care provider. It was only signed by employee A. An interview was conducted with the Administrator on at approximately 12:01 PM. The Administrator observed the statement and confirmed it was not signed by a health care provider.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observations and staff interview, the facility failed to ensure resident were clean and maintain all existing architectural and structural systems in good working order for 3 of 10 resident (1,7 and 8), the television 1 of 5 observed.

The findings include:

A tour of the facility was conducted on beginning at approximately 10:42 AM. A baseball sized hole in the wall was observed in the last the main long hallway, a golf ball sized hole in the wall was observed near the entrance to the the end of the long hallway. The ceiling fans in and 8 were observed to have accumulation of dust along the blades. The window sill in the television busted with , edges. (Photographic evidence was obtained). The Administrator observed the areas on at approximately 10:50 AM and stated a resident had put the holes in the wall, staff should be cleaning the ceiling fans during daily and the window sill had been in disrepair since she came to work here.

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	AL11910538	**12/27/2016**
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

On 12/27/16 at approximately 10:45 AM, room 7 was observed during a tour of the facility. The window of the resident room was observed to have a window that was in disrepair (photographic evidence was obtained). An interview was conducted with the Administrator on at 3:25 PM. The Administrator was shown the in and stated they have been replacing the window blinds but it is difficult to keep up as this is a limited mental health facility and they can be pretty destructive.

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on record review and staff interview, the facility failed to ensure each staff had a written statement from a health care provider documenting the individual does not have any signs or symptoms of communicable within 30 days after beginning employment for 1 of 3 sampled employees. (Employee A)

The findings include:

Review of employee A's file revealed a hire date of / as direct care staff. The file contained a statement dated of freedom from communicable but it was not signed by a health care provider. It was only signed by employee A. An interview was conducted with the Administrator on at approximately 12:01 PM. The Administrator observed the statement and confirmed it was not signed by a health care provider.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2017

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

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 2016 by representatives 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 a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2017.** 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 surveyors. Should you have any questions please call me at (850) 412-4540.

Sincerely,

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

DH/kb
Enclosure
XG90

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