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	AL11969035	**05/21/2018**
NAME OF PROVIDER OR SUPPLIER **RIVERVIEW SENIOR RESORT**	STREET ADDRESS, CITY, STATE, ZIP CODE **3490 GRAN AVE** **PALM BAY, FL 32905**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

The re-licensure survey with Limited Nursing Services (LNS) and Extended Congregate Care (ECC) was conducted on . Riverview Senior Resort, license #12862, had deficiencies at the time of the visit.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on resident record review and interview, the facility failed to ensure the health assessment (1823) was updated annually for 1 of 1 residents sampled (#12) who was receiving Extended Congregate Care Services (ECC).

Findings:
Review of the record for resident #2 revealed he was admitted on . The health assessment form (1823) was dated . The resident's diagnoses included 's . He required medication administration, was hard of hearing and was receiving hospice care. His record documented he was admitted to ECC services on . There was no 1823 found for 2018.

On at 2:15PM, the director of health services confirmed the findings.

Class III

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record reviews and interview the facility failed to ensure an interdisciplinary care plan was maintained in the file for 1 of 1 sampled resident (#13) who received Hospice services.

Findings:

Record review for resident #13 who was identified by the facility staff as receiving hospice services revealed there was no hospice interdisciplinary plan in his record or the hospice record available for review.

On at 2 PM, the director of health services confirmed the findings.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

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Based on record review and interview, there was no documentation of a significant change (hospice admission) and that the health care provider and family were notified for 1 of 4 sampled residents (#13). In addition, the facility failed to provide personal supervision for 1 of 3 sampled residents (#14) and did not maintain a general awareness of the resident's whereabouts while he was in their care.

Findings:

Record review for resident #13 who was identified by the facility staff as receiving hospice services revealed there was no documentation of the significant change/decline in health that required the hospice admission. There was no documentation that the family and health care provider was contacted.

On . . . . . at 12 PM, the director of health services confirmed the findings.

On . . . . . at 3:45PM, Staff B reported that resident #14 eloped "a few months ago" from the facility. He was a memory care resident (5th floor) and had been brought to the activities M2 (unsecured area). He walked down the stairs and out the door. As she was driving into work one day, she found him walking up the road near a busy highway (US Route 1).

On at 4:00 PM, the administrator stated resident #14 went out the fire escape door. The door had a key , . . which required a code to open, but was not alarmed at that time. He stated the nurses turned it off because they covered 2 floors for medications. The administrator stated the resident forced his way out, walked down 4 flights of stairs and went out the fire escape door. He was found in the parking lot.

On / 18 at 4:10 PM, Staff G stated on the day resident #14 eloped; the door alarm was turned off by maintenance because they were moving things between the 4th & 5th floors.

A request to review the closed record for resident #14 found the facility only had the business office file containing a contract and the original health assessment. The admission and discharge dates for the resident were unknown due to the admission-discharge log not being up-to-date. The health assessment for resident #14 was dated with a note that the last examination was actually on . The diagnoses included . . . . . secondary to . . . . use and . . /motor neuron . . . . . . The form indicated he walked without assistance, but had precautions. He was documented to be an elopement risk. The risk for wandering was mentioned again on page 2 of the assessment.

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Staff H (3-11 charge nurse) stated the event occurred when the facility was switching computer systems. She confirmed there was no chart, and no notes available to review. A copy of the health assessment form was located in the business office file and reviewed. When asked when the elopement occurred, she replied, "I'm not sure. I cannot give you an exact date. The CNAs were looking for him outside the building. I don't know how long he was missing."

On at 5:15PM, the administrator stated he could not find any adverse reports or incident reports. He stated the former Health Services Director would have submitted the report and currently no one in the facility had access to AHCA to submit or review adverse reports.

On at 5:32PM, the administrator sent an email to the surveyor stating he was unable to find any other documentation regarding this incident.

On at 11:25 AM, a final exit was conducted by telephone with the administrator. He stated again that he did not have any other documentation related to the elopement reported to us by Staff B. He said he was remembering an event in 2017 when the resident got out into the parking lot when the doors were open due the workers laying new carpet. He confirmed that he spoke with Staff B and she told him the same information as she told the surveyors on and that she reported everything to the director who is no longer at the facility.

The facility was unable to provide documentation regarding the circumstances leading to the elopement or steps taken afterward to prevent further occurrences. Resident #14 was found near a busy highway. A caregiver who was coming in to work that day found him. There was no documentation that any other staff were aware the resident had left the facility when Staff B found the resident.

Class II

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on record review, medication observation record (MOR) review and interviews, the facility failed to ensure a licensed nurse provided medication administration for 1 of 4 sampled residents (#13).

Findings:

Record review for Resident #13 revealed a health care assessment form 1823 dated . The health care provider noted he needed medication administration (nurse to provide).

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The director of health services reviewed the MOR and identified the initials in the spaces on and was an unlicensed staff that had given the resident his medications as follows:

9 AM- CD capsule extended release 24 hour give 1 capsule one time a day for
hold for rate (hr.) less than 50
9 AM- tablet 125 microgram (mcg) 1 time a day for . Hold for HR less than 50.
9 AM- Docustate 10 milliliter one time a day for
9 AM- 1 tablet one time daily for
9 AM- Tablet 250 milligrams (mg) one two times a day for
9 AM- delayed release 10 mg 1 two times a day for
9 AM- 25 mg 1 two times daily for agitation
10:21 AM- HCl 2 mg 1 every 6 hours as needed for

On at 1 PM, the director of health services confirmed the findings.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on review of a medication container, record review, and interview the facility failed to ensure a medication container was properly labeled for a resident (#6) who received assistance with self-administered medications.

Findings:

Review of resident #6's health assessment form 1823, dated on , and revealed she required assistance with self-administered medications.

Resident #6's 2018 Medication Observation Record (MOR) listed an entry for 25-100 milligram (mg) tablet, take one and a half tablets by mouth four times a day at 7 am, 11 pm, 2 pm, and 5 pm.

However, the prescription label on the package of indicated that one and a half tablets were to be taken three times a day at 8 am, 12 pm, and 4 pm, which differed than the instructions on the MOR. The medication package did not contain an alert label to direct staff to examine the revised directions for use on the MOR.

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On at 11:05 am, nurse F confirmed the findings.

A health care provider's order, dated on , indicated resident #6 was to take 25-100 mg tablet, take one and a half tablets by mouth four times a day at 7 am, 11 am, 2 pm, and 5 pm, which confirmed the directions for use on the 2018 MOR were the most recently prescribed directions for use.

Class III

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

Based on personnel record review and interview, the facility failed to ensure that 2 of 5 sampled staff (A & D) had obtained a statement from a licensed healthcare provider documenting freedom from communicable . In addition, based on medication observation record (MOR) review, record review and interview the facility allowed unlicensed staff to perform duties that were not consistent with their level of education, training, preparation, and experience, the unlicensed staff took 1 of 4 sampled resident's (#13) and exercised judgment as to whether or not the medications were needed.

Findings:
1. Review of the record for Staff D, the administrator (date of hire) did not reveal a freedom from communicable statement.

On at 3:30 PM, the administrator confirmed the findings.
2. Caregiver A's personnel record contained a hire date of . The record did not contain a written statement from a health care provider documenting that caregiver A did not have any signs or symptoms of communicable , as required.

On at 2 pm, the administrator confirmed the findings.
3. Record review for resident #13 revealed a resident health assessment form 1823 that was dated . The health care provided noted his medications needed to be administered (nurse only).

Review of the MOR for revealed it noted - CD capsule extended release 24 hour give 1 capsule one time a day for , hold for rate (hr.) less than 50 and tablet 125 mcg 1 time a day for , . Hold for HR less than 50.

The director of health services reviewed the MOR and stated that on and at 9 AM for both

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medications, the staff initials that were in the spaces as given the medications was an unlicensed staff. She said the nurses were the only staff that was to give him the medication.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on personnel record reviews and interview, the facility failed to ensure that 5 of 5 sampled staff (A, B, C, D and E) received the required in-service training within 30 days of hire.

Finding:

1. Personnel record review for staff C hired . . revealed he had obtained online training that was not facility specific regarding the facility's emergency procedures including chain-of-command and staff roles relating to emergency evacuation and the facility's resident elopement response policies and procedures within thirty (30) days of employment.

On at 2:30 PM, the administrator confirmed the training was not facility specific training as required.

2. Review of the personnel records for staff B (date of hire . . .), and staff D (date of hire . . .) revealed that each had completed an online training in elopement and emergency procedures. Further review did not reveal any evidence of training specific to the facility's policies and procedures regarding emergency procedures including chain-of-command and staff roles relating to emergency evacuation, or training in the facility's elopement policies and procedures.

On . . . . at 2:30 PM, the administrator confirmed the findings.

3. Caregiver A's personnel record revealed a hire date of . . . . The record did not contain documented evidence to indicate caregiver A received in-service training that covered facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation and the facility's resident elopement response policies and procedures, as required.

On . . . . at 2 pm, the administrator confirmed the findings.

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4. Personnel record review for staff E, hired on [redacted] and a Registered Nurse revealed certificates dated [redacted] that indicated she attended an Internet in-service training regarding elopement and emergencies. However, there was no evidence to confirm she attended/received an hour in-service training regarding the facility's elopement policy and procedures and an in-service regarding facility's emergency procedures including chain-of-command and staff roles relating to emergency evacuations.

In an interview with the administrator [redacted] at 4 PM, who confirmed the findings.

Class III

0082 - Training - / [redacted] - 58A-5.0191(3) FAC

Based on personnel record review and interview, the facility failed to ensure that 1 of 5 sampled staff (C) had obtained the one-time education course on [redacted] and [redacted] within 30 days of employment.

Findings:

Personnel Record review for staff C, a caregiver hired [redacted] revealed there was no documentation to confirm he had obtained a one-time education [redacted] and [redacted] including the topics prescribed in the Section 381.0035, F.S. within 30 days of employment.

On [redacted] at 2:30 PM, the administrator confirmed the findings.

Class III

0086 - Training - ADRD - 58A-5.0191(9) FAC

Based on personnel record reviews and interview, the facility failed to ensure 1 of 3 direct care staff (A) received 4 hours of [redacted] and Related [redacted] (ADRD) continuing education annually and failed to ensure 1 of 5 staff (D) obtained [redacted] level 1 training within three months of employment.

Findings:

1. Caregiver A's personnel record revealed a hire date of [redacted]. The record contained documentation that indicated she received [redacted]'s level 1 and 2 training on [redacted] and 16 hours of [redacted] and [redacted] training on [redacted].

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The record did not contain documented evidence to indicate she received the required minimum of 4 contact hours of continuing education in 2017.

On at 2:54 pm, the administrator confirmed the findings.

2. Review of the record for Staff D, the administrator, who had regular contact with the residents but did not provide direct care (date of hire), revealed an training update dated . No documentation that the required 4 hours of 's Level I training was competed was found in the record.

On at 3:30 PM, the administrator confirmed the findings.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on personnel record reviews and interview, the facility failed to ensure 5 of 5 sampled staff (A, B, C, D, and E) received at least one hour of training in the facility's policy and procedures regarding ( ) within 30 days after employment.

Findings:

1. Caregiver A's personnel record revealed a hire date of . The record did not contain documented evidence to indicate she received at least one hour of training in the facility's policy and procedures regarding , as required.

On at 2:30 pm, the administrator confirmed the findings.

2. Review of the personnel records for Staff B (date of hire) and D (date of hire) revealed that each had completed an online training in . Further review did not reveal any

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evidence that staff B or D had received training specific to the facility's policies and procedures.

On at 2:30 PM, the administrator confirmed the findings.

3. During interview on with staff C a caregiver at 12:45 PM he did not know what a was or the facility's policy regarding .

Personnel record review for staff C hired revealed there was an online training regarding , there was no documentation to confirm he had received at least one hour of training in the facility's policies and procedures regarding ('s) that included information in Rule 58A-5.0186, F.A.C. within 30 days after employment.

On at 2:30 PM, the administrator confirmed the findings.

4. Personnel record review for staff E, hired on and was a Registered Nurse revealed a certificate dated that indicated she attended an Internet in-service training regarding . However, there was no evidence the in-service was based on the facility's policies and procedures.

In an interview with the administrator at 2:30 PM, who confirmed the findings.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on menu review, observations and interview the facility did not maintain dated menus as served for 6 months including substitutions and enough water for drinking and meal preparation for the 95 residents of the facility to be used for emergencies.

Findings:

Review of the cycled menus provided by the facility revealed they did not include the dates as served for 6 months nor the substitutions.

On at 1 PM, the food service manager said the facility did not maintain the dated menus as served for 6 months nor the substitutions.

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Observations of the water stored for emergencies for the 95 residents revealed there was only 5 gallons available.

On at 1 PM, the dietary manager confirmed the findings and stated the water was on order.

Class

0160 - Records - Facility - 58A-5.024(1) FAC

Based on admission-discharge log review and interview, the administrator failed to ensure the log accurately reflected when residents were admitted or discharged from the facility.

Findings:

Review of the admission-discharge log revealed no residents had been documented as being discharged or admitted since , 2017.

On at 2:10 PM, the administrator confirmed the findings and said they had several changes in personnel and the person who was maintaining the log had recently left the facility.

Class III

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on review of the facility's Comprehensive Emergency Management Plan (CEMP) and interview, the facility failed to have documentation the CEMP was approved by the local emergency management agency according to 58A-5.026(2)(c) (1) FAC.

Findings:

Upon request to review the facility's CEMP, the administrator provided an approval letter dated from the County Office of Emergency Management.

On at 10:20 AM, the administrator confirmed he did not have a more recent approval letter from the County and stated his current plan had just been submitted for review earlier in , 2018.

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E206 - ECC - Service Plans - 58A-5.030(7) FAC

Based on observations, record review and interviews the facility did not ensure the service plan was developed and agreed upon by the resident or designee, and reflected the responsibility and right of the resident to consider options and assume risks when making choices pertaining to the resident's service needs and preferences for 1 of 5 sampled residents (#9), who received Extended Congregate Care (ECC) services.

Findings:

During the facility, entrance on at 9:30 AM resident # 9 was identified as receiving Limited Nursing Services for the application and removal of compression hose.

During an interview with the resident on at 11:20 AM, the resident was in her , sat in a recliner, watched television and had a sling on her left arm. She said the staff put the sling on and took it off for her, as well as the hose. The staff present during the tour on at 10 AM said the resident needed total care with her activities of daily living.

Resident record review revealed a facility's quality of life assessment dated indicated the resident needed assistance to turn and reposition in bed, needed total care for bathing and showering and is a 2 person assist.

In an interview with the Director of Health Services on at 4 PM, who said the resident did not need total care with bathing, but the quality of life assessment was a guide for the caregivers to know what the resident's needs were.

Class III

E210 - ECC - Training - 58A-5.0191(7) FAC

Based on personnel record review and interview, the facility failed to ensure that 1 of 5 sampled staff (B) had received the required in-service training regarding Extended Congregate Care (ECC) within 6 months of employment.

Findings:

Review of the personnel records for Staff B (date of hire), did not reveal any training in the ECC

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program.

On at 3:30 PM, the administrator confirmed the findings.

Class III

N278 - LNS - Records - 58A-5.031(3) FAC

Based on observations, interviews and record review the facility failed to ensure that nursing progress notes were maintained for 1 resident (#9) in a sample of 5 who received Limited Nursing Services (LNS) and that nursing assessment were conducted at least monthly.

Findings:

During the facility, entrance on at 9:30 AM resident #9 was identified as receiving Limited Nursing Services for the application and removal of compression hose.

During an interview with the resident on at 11:20 AM noted the resident was in her , sat in a recliner, watched television and had a sling on her left arm. She said the staff put the sling on and took it off for her, as well as the hose. The staff present during the tour on at 10 AM said the resident needed total care with her activities of daily living.

Resident record review revealed a facility's quality of life assessment dated that indicated the resident needed assistance to turn and reposition in bed, needed total care for bathing and showering , 2 person assist.

Progress note dated "Nursing to put on in morning and remove in the evening one time a day for circulation; order clarification needed, as to what to remove. Will pass concerns to oncoming shift. Progress notes dated , , 4/9, , to put on in morning and remove in the evening one time a day for circulation. Note dated indicated she had no hose to be removed, remove regular socks.

Review of the resident's notes, where nurses document the application and removal of hose (- embolic deterrent hose), revealed the notes did not describe the date, type, scope, amount, duration, and outcome of services that are rendered; the general status of the resident's health; any deviations; any contact with the resident's physician, but rather indicated " hose on, hose off". There were no notes for , , and .

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There were no notes, except for , for the application and removal of the left arm .

Progress note dated indicated assist resident with , to left arm during the day as needed for supportive device , may use as needed for support , not at bedtime.

Continued review revealed a healthcare order summary dated indicated that as of to apply and remove the left arm , and to apply in the morning and remove in the evening since (needed clarification of what is to be applied and removed).

Continued review revealed no evidence a monthly nursing assessments were conducted for the months of and , 2018.

In an interview with the Director of Health Services on at 4 PM, who said the former Director of Health Services left and she could not locate any documentation.

Class III

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on Agency Clearinghouse Website Review and Interview, the facility failed to register and maintain the employment status of employees within the Agency's Background Screening Clearinghouse for two of 6 sampled staff employees (E & F).

Findings:

Review of the Agency's Background Screening website for 2 sampled staff revealed that Staff E (ECC supervisor) and F (dietary manager) were not on the clearinghouse roster for the facility.

On at 3:30 PM, the administrator confirmed the findings.

Unclassified