

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105135	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER Riverwood Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2802 Parental Home Road Jacksonville, FL 32216	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30905</p> <p>Based on observations, resident and staff interviews, and record review, the facility failed to ensure that one (Resident #50) of 52 sampled residents currently residing in the facility, had access to his call light.</p> <p>The findings include:</p> <p>On 01/06/2025 at 12:05 PM, Resident #50 was observed seated in his wheelchair in his room at the foot of his bed facing the entrance to the room. He was wearing a short sleeved tee shirt, pants and non-skid socks. His right arm, wrist and fingers were contracted. He indicated he did not have any concerns. The call light was observed lying on top of the bed near the head of bed next to the pillow and out of reach of the resident. (Photographic evidence obtained) The resident was served lunch at 1:15 PM in his room, but his call light was not placed within his reach.</p> <p>On 01/07/2025 at 11:28 AM, Resident #50 was observed in his room. He was seated in his wheelchair at the foot of his bed. The call light was observed lying on top of the bed near the head of the bed next to the pillow. (Photographic evidence obtained) He was wearing a short-sleeved tee shirt, pants and non-skid socks. One of his socks was falling off. He was asked if he was warm enough. He shook his head and stated no. He was asked if he wanted a sweater on and he nodded his head and stated yes. Certified Nursing Assistant (CNA) C was asked to assist the resident. She entered the room and asked the resident if he wanted a sweater. He told her yes. She did not move the call light within his reach.</p> <p>On 01/07/2025 at 1:10 PM Resident #50 was observed eating his lunch independently. He was seated in his wheelchair at the foot of his bed. The call light was observed lying on top of the bed near the head of the bed/pillow.</p> <p>On 01/08/2025 from 1:13 PM to 1:30 PM Resident #50 was observed eating lunch. He was seated in his wheelchair at the foot of his bed. The call light was observed lying on top of the bed near the head of the bed next to the pillow. (Photographic evidence obtained) He was asked if he wanted more food. He stated yes and nodded his head. CNA C was asked to assist him. She entered the room and asked the resident if he wanted more food. He stated yes. She did not move the call light within his reach. She took his lunch tray, told him she would bring another plate for him, and left the room.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident #50's medical record face sheet revealed an admitted [DATE]. His diagnoses included: hemiplegia and hemiparesis (weakness, limited ability on one side of the body) following cerebral infarction (stroke) affecting the right dominant side; anxiety disorder; dysphagia (difficulty swallowing); asthma; dysarthria (unclear speech) and anarthria (a severe speech disorder that results in the complete loss of the ability to speak), major depressive disorder; gastrointestinal esophageal reflux disease (GERD); hypertension; cognitive/communication deficit; abnormalities of gait and mobility; muscle wasting and atrophy; cataracts in both eyes.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed that Resident #50 was assessed as having slurred or mumbled words; being understood and understanding others sometimes; impaired vision; a score of 09 out of 15 possible points on his Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment, and no evidence of inattention, disorganized thinking, or altered level of consciousness. He was assessed as having lower extremity range of motion (ROM) impairment on both sides and ROM impairment on one side in his upper extremity. He used a walker and a wheelchair for mobility. For eating he required only set up and clean up. He was able to feed himself. He required substantial assistance for oral hygiene, bathing, upper body dressing and personal hygiene, sitting to lying, lying to sitting, sitting to standing and transfers. He was dependent on staff for toileting, lower body dressing and putting on/taking off footwear. He required substantial assistance to wheel himself in his wheelchair, and he A ras currently receiving occupational therapy.</p> <p>A review of his care plan, dated 08/22/2023 and revised on 10/13/2024, revealed a focus area for activities of daily living (ADLs)/self-care related to chronic medical conditions, muscle weakness, hemiplegia and hemiparesis and a need for assistance with personal care. Interventions did not include encouraging the use of his call light. A review of the care plan dated 04/17/2024 and revised on 10/13/2024, revealed a focus area for being at risk for falls related to impaired balance and mobility, poor safety awareness due to cognitive decline, muscle weakness, abnormal gait and mobility, and use of psychotropic medication. Interventions included encouraging and reminding the resident to use his call bell and to wait for staff assistance with transfers, ambulation, toileting, etc. as indicated.</p> <p>A review of the occupational therapy recertification, progress report, and updated therapy plan for a certification period of 12/02/2024 through 02/28/2025, revealed that Resident #50 would increase his left upper extremity strength by 1-2 grades in order to enable him to assist more with functional transfers and maintain range of motion of the right elbow to prevent an increase in contractures.</p> <p>During an interview with the Director of Rehabilitation on 01/09/2025 at 11:25 AM, she stated Resident #50 was currently on case load for physical therapy (PT) and occupational therapy (OT) only. He had been receiving OT for at least a year and a half. She was not sure if the OT therapist was working on use of his call light or not.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Occupational Therapist (OT) B on 01/09/2025 at 11:34 AM, she stated Resident #50 was her resident for occupational therapy. She was working on his right hand and arm contractures. She was not working with him specifically for call light use. She stated he could use his call light and understood when to use it. She agreed to take Resident #50 back to his room to demonstrate his ability to use the call light. She wheeled him back to his room and backed him in next to his bed with his left hand nearest to the bed. His call light was on the bed next to the pillow. She took the call light and clipped it to the resident's shirt near his left hand. She explained to him that she wanted him to demonstrate the use of the call light. He immediately took the call light cushion and squeezed it. The call light was engaged. When asked if he understood that he should use the call light when he needed assistance, he nodded his head yes. OT B took the call light cord and stretched it out toward the end of the bed. It did not reach the end of the bed. She confirmed that the resident would not be able to reach it if he was sitting in his wheelchair at the end of the bed.</p> <p>During an interview with CNA C on 01/09/2025 at 12:01 PM, she stated Resident #50 could use his call light and knew when to use it. She stated, Oh yeah, he knows. She confirmed that the call light would not reach past the end of the bed if they had the resident sitting at the foot of his bed in his wheelchair. She confirmed that he would not be able to reach it when clipped to the bed cover near the head of the bed, nor would he be able to wheel himself around to reach it.</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48947</p> <p>Based on observations, interviews, record review, and policy and procedure review, the facility failed to honor the personal privacy of one resident (#81) reviewed for personal privacy from a total survey sample of 56 residents.</p> <p>The findings include:</p> <p>On 01/06/25 at 1:30 PM, Resident #81 was observed in her semi-private room. She had no privacy curtain.</p> <p>On 01/06/25 at 2:30 PM, the resident's room was observed. There was no privacy curtain in place for this resident.</p> <p>On 01/07/25 at 10:17 AM, the resident was observed standing inside her doorway looking out into the corridor. There was no privacy curtain in place for this resident's area of the room near the window.</p> <p>A record review revealed that Resident #81 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, neurological disorder due to known physiological condition with behavioral disturbance, mood disorder due to known physiological condition, and major depressive disorder.</p> <p>A review of athe resident's care plan revealed the following Focus Areas:</p> <p>Resident has ADL (activity of daily living) self-care deficit related to ADL needs and participation vary, chronic medical conditions, Dementia. (initiated 7/22/24, revised 11/05/24),</p> <p>Resident has impaired cognitive function/impaired thought processes related to Alzheimer's. (initiated 7/29/24, revised 11/05/24)</p> <p>On 01/08/25 at 4:33 PM, an interview was conducted with Licensed Practical Nurse (LPN) P, the nurse caring for Resident #81. She was asked who was responsible for hanging the privacy curtains in resident rooms. She stated, Housekeeping. They are also the ones who change the curtains as needed. She was asked who was responsible for making sure there was a privacy curtain for each resident. She stated, They have someone twice a week that goes around and checks all the rooms for different things like privacy curtains and the housekeepers also check it every day when they go in the rooms. The nurse was asked to accompany the surveyor to the resident's room to observe the privacy curtain. The nurse was asked if the resident had a privacy curtain. She stated, No ma'am, she doesn't but I can get her one.</p> <p>On 01/08/25 at 4:46 PM, an interview was conducted with the Administrator. She was asked what the facility had in place for monitoring the resident's rooms to ensure their environment provided privacy. She explained that the facility had a Guardian Angel Program, and the department heads and managers were assigned so many rooms to monitor 2-3 times weekly.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Guardian Angel Rounds worksheets were provided by the Administrator on 1/9/2025 at 11:00 AM which revealed that on 1/1/2025, a room round for room [ROOM NUMBER] B was conducted and No curtain, was identified.</p> <p>On 01/09/25 at 11:14 AM, an interview was conducted with Housekeeper X who spoke Spanish as a first language. Certified Nursing Asisstant (CNA) Y assisted with translation. Housekeeper X was asked who was responsible for hanging the privacy curtains in the resident rooms. She stated, the floor tech. She was asked how the floor tech determined which rooms needed privacy curtains. She replied, I'm not aware of a schedule, just as needed, anyone can put in TELS (computer work order program). It goes directly to maintenance and then to the floor tech.</p> <p>On 01/09/25 at 8:55 AM, the Administrator was asked to provide the facility's Privacy and/or Privacy Curtains Policy. At 9:01 AM, the Director of Nursing reported that the facility did not have a policy specific to privacy or privacy curtains. She provided the facility's Resident Rights Policy (issued 9/21, revised 1/24 - 2 pages):</p> <p>Standard: A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of residents.</p> <p>Procedure:</p> <p>1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:</p> <p>t. privacy and confidentiality</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50369</p> <p>Based on observations, interviews, record review, and policy and procedure review, the facility failed to implement the comprehensive care plan to meet the resident's medical needs for one (Resident #43) of one resident reviewed for transmission based precautions from a total of 56 residents in the survey sample. Specifically, isolation precautions were not followed as indicated in the care plan.</p> <p>The findings include:</p> <p>On 01/06/25 during a 12:33 PM interview, Resident #43 stated she had scabies but wanted to be out of isolation, as she was not being treated. No precautions sign or PPE (personal protective equipment) were on her door. (Photographic evidence obtained)</p> <p>On 01/07/25 at 9:00 AM, no precautions sign or PPE were observed on the resident's door.</p> <p>On 01/08/25 at 9:30 AM, no precautions sign or PPE were observed on the resident's door.</p> <p>A review of the resident's medical record revealed the following physician's orders:</p> <p>01/08/25 - Permethrin External cream 5%, apply all over head to toe topically every night shift for scabies for one day.</p> <p>01/05/25 - Contact precautions: Encourage and assist resident to maintain contact precautions for scabies from 01/05/25 to 01/08/25.</p> <p>12/28/24 - Clobetasol Propionate External Lotion 0.05%, apply to rash on body topically two times a day for rash and itch for 14 days, avoid face and genitals.</p> <p>12/27/24 - Contact precautions: Encourage and assist resident to maintain contact precautions (scabies) from 12/27/24 to 01/03/25.</p> <p>12/11/24 - Diphenhydramine HCL (hydrochloride) Oral tablet 25 mg (milligrams), Give 1 tablet by mouth every 8 hours as needed for itching.</p> <p>(Photographic evidence obtained)</p> <p>The resident's physician ordered on 01/08/25 at 8:52 AM that the isolation to be discontinued. A progress note dated 12/28/24 by the physician stated the resident was taken to Urgent Care on Christmas day by her daughter during LOA (leave of absence) and was treated for itching and rashes on her body with Permethrin. She returned to the facility on [DATE] with rash diminished. Per the physician's note, Patient is on contact isolation for scabies.</p> <p>A review of the resident's care plan dated 10/17/22, next review date 01/12/2025, revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident requires isolation related to scabies, isolation will be maintained while infection is actively transmittable, wear appropriate PPE when giving care to resident. (Photographic evidence obtained)</p> <p>A review of the resident's Kardex revealed it included a task for isolation precautions for high contact activities. (Photographic evidence obtained)</p> <p>A review of the medication administration record (MAR) revealed, Contact Precautions for scabies every shift until 01/09/25 with signatures noted indicating contact precautions were in place during that time. (Photographic evidence obtained)</p> <p>During a 01/09/25 interview with Certified Nursing Assistant (CNA) D at 9:50 AM, she stated she was a restorative CNA and worked in most areas of the facility. She further stated when she saw a yellow bag on a resident's door, she would ask the nurse what was going on with that resident. The facility also had in-service training about EBP (enhanced barrier precautions and TBP (transmission-based precautions). She stated it was put on the Kardex as well. She was aware of the difference in types of precautions and what PPE to don for each type. She stated she was not aware of any cases of scabies recently.</p> <p>During a 01/09/2025 interview with Licensed Practical Nurse (LPN) E at 10:45 AM, she stated she had been employed in this facility for three months. EBP and TBP were taught during orientation using a power point presentation. The unit manager took off orders, and would make sure a sign was on the resident's door as well as PPE. She was not aware of the contact precautions for Resident #43. She stated they ended on 01/05/25 per the electronic medical record. She did not look at all of the resident's orders, just the orders on the MAR. She stated the resident's daughter brought her back to the facility after being on a leave of absence and told the nurse she was treated with Permethrin at an urgent care clinic while on LOA.</p> <p>During a 01/09/25 interview with Unit Manager (UM) F at 11:00 AM, she stated Resident #43 should have been on isolation precautions until 01/08/25. She further stated the resident had her treatment and technically could be off precautions in 24 hours. When she was asked when the treatment was given, she searched through the electronic record for the date of treatment. There was a progress note dated 12/28/24 indicating that the resident's daughter had her mother treated at home on 12/25/24. She confirmed there was a current order for contact isolation until 01/08/25. She stated the infection control nurse would usually put the signage and PPE on resident doors once the order was completed.</p> <p>During a 01/09/25 interview with Infection Preventionist G at 11:20 AM, she stated she worked with the unit managers and nurses to ensure the residents' precautions were correct. She would ensure initially that the proper signage and PPE were on the residents' doors. If she was not in the facility, the Assistant Director of Nursing (ADON) would complete this task, and on the 3-11 shift, the house supervisor was responsible. She confirmed that there was an order for contact isolation for Resident #43 and the discontinuation date was 01/09/25. She stated this order should have been followed since it was an active order.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a 01/09/25 interview with the Director of Nursing (DON) at 11:52 AM regarding the isolation precaution order for Resident #43 ordered on 01/05/25 at 11:00 PM, she stated she completed this order and did not know why the signage or PPE was not put on the door. She stated the resident had treatment while on LOA with her daughter and the original contact precautions were discontinued on 01/03/25.</p> <p>A review of the facility's policy and procedure titled Standards and Guidelines: Physician Orders (revised 1/2024), revealed the following:</p> <p>Procedure:</p> <p>9. Physician orders should be followed as prescribed, and if not followed, this should be recorded in the resident's medical record during that shift. The physician should be notified and the responsible party if indicated.</p> <p>A review of the facility's policy and procedure titled Standards and Guidelines: Medication Administration (revised 1/2024), revealed the following:</p> <p>Procedure:</p> <p>19. Staff follows established facility infection control procedures (e.g. handwashing, antiseptic technique, gloves, isolation precautions, etc.)</p>

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<p>F 0676</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42442</p> <p>Based on observations, interviews, and record review, the facility failed to provide restorative nursing therapy to ensure that a resident's abilities in activities of daily living did not diminish for two (Residents #193 and #56) of two residents reviewed for the dining restorative program, from a total of 11 residents participating in the dining restorative program, in a total survey sample of 56 residents. The 11 residents on the dining restorative program were at risk of further decline. Resident #193 suffered a significant weight loss.</p> <p>The findings include:</p> <p>1. During the dining observation on 01/06/25 at 11:50 AM, Resident #193 was observed seated at the dining table in the Caring Way unit. She was served a mechanical soft meal on a regular plate. She consumed 25% of her meal and then scooped the remaining food from her plate onto a paper napkin that was provided with the meal tray. Resident #137, who was seated beside her, was observed eating the food from the napkin and eventually he tried to eat the napkin.</p> <p>During another observation on 01/07/25 at 12:00 PM, Resident #193 was observed seated at the dining table on the Caring Way unit. She consumed 25 % of her meal and was observed hand picking the rest of her food and putting it on an empty plate for a resident who was seated next to her. After emptying her plate, Resident #193 wheeled herself away from the table.</p> <p>A review of the Certified Nursing Assistants' (CNA's) task for eating revealed that Resident #193 was documented as having consumed 100% of her meals on 01/06/25 and 01/07/25 for the lunch meals observed.</p> <p>A review of the medical record revealed that Resident #193 was admitted to the facility on [DATE] with a re-entry on 10/16/24. Her diagnoses included, but were not limited to, traumatic subarachnoid hemorrhage without loss of consciousness, depression, anxiety, psychosis, urinary tract infection (UTI), and cellulitis.</p> <p>A review of the resident's active physician's orders revealed the following:</p> <p>10/07/24 - Buspirone 10 mg (milligrams) 2 tabs BID (twice daily) for anxiety.</p> <p>10/15/24 - Hydroxyzine 10mg, four times a day for anxiety.</p> <p>10/16/24 - Regular diet mechanical Soft texture, thin consistency.</p> <p>10/16/24 - Consult with Dietician d/t re- admin with right hip Trochanteric Fixation Nail Advanced (TFNA).</p> <p>10/16/24 - Restorative nursing program (RNP) to Provide set up assistance and verbal cuing to encourage intake. Goal - increase oral (PO) intake to prevent weight loss.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>10/21/24 - Ativan 0.5 milligrams (mg) one tablet two times a day (BID) for anxiety.</p> <p>10/26/24 - Zyprexa (Olanzapine) 5 mg in the morning for psychosis.</p> <p>11/01/24 - Dietary adaptive equipment - Scoop plate.</p> <p>01/02/25 - Ensure (nutritional supplement) three times a day for 30 days.</p> <p>A review of a Restorative program referral note dated 10/11/24, indicated that Resident #193 was referred to the Restorative program by the speech therapist for eating and swallowing assistance with set up and verbal cues to prevent weight loss.</p> <p>A review of the Weight Change note, dated 11/14/24, revealed that the resident was receiving a regular/mechanical soft/thin liquid diet. PO (oral) intake was documented as 100%. Resident #193 required set up/some assistance. The note further indicated that the author spoke with nursing who reported that the resident was very restless during the day and at mealtimes had difficulty getting food in her mouth sometimes due to constant movement. The resident's weight was noted to be 104.4 pounds (lbs.). Her body mass index (BMI) was 19.1; she had a height 62 inches, and she had a weight loss of 6.3% x 30 days and 9.1% x 90 days (significant weight loss). The goal was to have a stable weight. The recommendation included Ensure nutritional supplement daily (220 kcals, 10 grams protein) to support intake and weight stability.</p> <p>The Interdisciplinary team (IDT) note dated 12/20/24, indicated that the IDT met to discuss the resident's weight. The team recommended to increase the Ensure to BID, continue the plan of care (POC) of weekly weights, and the dietician to continue to follow up.</p> <p>A review of a Weight Change progress note dated 01/02/25, revealed that the resident was on a regular/mechanical soft/thin liquid diet. Oral intakes were 75% - 100% of meals. Weight loss included a 3.7% loss for (x) 30 days, a 2.8% loss x 90 days, an 8.8% loss x 90 days, and an 11.5% loss x 180 days. The recommendation was to increase the Ensure nutritional supplement to TID (three times daily) to support weight stability (660 kcal /30 grams protein).</p> <p>A review of the resident's care plan, revised on 10/17/24, revealed that Resident #193 needed limited to extensive assistance with eating. She needed help getting her meals set up (opening packages, cutting meat and buttering bread etc.) and would need some help eating. Resident #193 was at risk of for an alteration in nutrition related to her diagnoses of dementia, depression, malnutrition, requiring a mechanically altered diet, and weight loss. Interventions included encouraging /offering/assisting fluids to meals and throughout the day and encourage and assist the use of adaptive equipment. The care plan indicated that the resident had a need for the Restorative nursing program for eating/swallowing due to memory loss/cognitive decline.</p> <p>A review of the Modification of Significant Change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/17/24, revealed that the resident had a brief interview for mental status (BIMS) score of 05 out of 15 possible points, indicating severe cognitive impairment. The resident reported feeling depressed with little interest in doing things. No swallowing issues or dental issues were reported. The assessment noted that Resident #193 was on Restorative nursing.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105135	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER Riverwood Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2802 Parental Home Road Jacksonville, FL 32216	
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<p>F 0676</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the Weekly Weights from 10/16/24 through 01/01/25 revealed that Resident #193 had an approximately 2.0 lbs. weight loss every two weeks. (Photographic evidence obtained)</p> <p>A review of the facility's list of residents on the Restorative Nursing Program (RNP) revealed that Resident #193 was not on the list. (Copy obtained)</p> <p>In a joint interview on 01/08/25 at 1:55 PM, Licensed Practical Nurse (LPN) T stated she was new to the program and she was still in the transition phase. Registered Nurse (RN) G/Assistant Director of Nursing (ADON) stated LPN T was in training for the role since she was previously in charge of a RNP. When asked how residents were added to the RNP, LPN T explained they were added through therapy referrals and nursing assessments/reports were used to determine if a resident was a candidate for the RNP. She explained that once a resident was added to the program, the RNP task was added to the Kardex for the restorative staff to review and document when tasks were completed. When asked how residents were discontinued from the program, RN G stated residents were removed from the program when their goals had been met; when they refused to participate, or when the resident had reached their maximum potential (no further improvement). She added that she met with therapy weekly to discuss the residents' progress. LPN T confirmed that she was responsible for updating the RNP list and updating the residents' care plans. When asked about Resident #193, LPN T confirmed that Resident #193 was not on restorative dining. She said, She was discharged a month ago because she was able to feed herself. She confirmed that the resident had suffered weight loss. When asked to review the physician's orders and the care plan, she confirmed that Resident #193 had active orders for the RNP and stated it was her fault that she did not discontinue the orders. When asked to provide documentation of when Resident #193 was on the program, LPN T again confirmed that she could not find any documentation indicating that the resident had participated in the program.</p> <p>During the interview on 01/09/25 at 10:22 AM, the Registered Dietician (RD) stated she conducted evaluations on admission and quarterly; however, residents who were considered high risk, such as those with tube feedings, pressure wounds, dialysis, and those with weight loss were seen more frequently, monthly at a minimum. When asked how she determined the dietary interventions, she stated she used clinical guidelines like calculated needs, weight, PO (oral) intake and preferences to supplement. When asked how she monitored residents' intake, she explained that she reviewed the Intake Tracker completed by nursing staff; she interviewed staff and residents, and at times sat with residents during meals. She confirmed that Resident #193 was on her list of high-risk residents due to weight loss. She stated she had been seeing the resident monthly for weight and she had recommended Ensure nutritional supplement TID as well as weekly weights. She stated her goal was for Resident #193 to maintain a stable weight. When asked what the barriers to the resident's goals were, she stated nursing had reported that Resident #193 was restless during meals. When she was asked about the resident's PO intake, the RD stated it was documented that the resident consumed 100% of most meals. When the surveyor explained the observations in the dining room, the RD stated if she knew that Resident #193 was not consuming 100% of the meals, she would have explored other interventions such as an appetite stimulant or finger foods, etc. She emphasized the importance of Resident #193 being supervised during meals in order to record accurate information about her oral intake.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>2. During the dining observation on 01/06/25 at 11:50 AM, Resident #56 was observed having lunch in the Caring Way unit dining room. She was seated at a table by herself. She was eating mashed potatoes and she was leaving her carrots. She consumed 25% of her meal. When asked about the food, she stated she did not like carrots. She stated she only ate what she liked. When asked if she wanted a different item, she said, no. She thanked the surveyor for spending time with her and asked if the surveyor could return later.</p> <p>A review of the medical record revealed that Resident #56 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation, dementia, major depressive disorder, and anxiety disorder.</p> <p>A review of the active physician's orders revealed the following:</p> <p>11/26/24 - Mirtazapine 7.5 mg (milligrams) at bedtime for depression</p> <p>12/17/24 - Depakote ER (extended release) 125 mg BID (twice daily) for mood disorder, and RNP - resident requires minimum assistance for set up. Have resident seated at a table with other residents who are verbal and can participate in social interaction and conversation exchanges.</p> <p>A review of the resident's care plan, revised on 12/17/24, revealed that Resident #56 had a need for the Restorative Nursing program for eating/swallowing due to age-related comorbidities/medical condition. The goal was for the Restorative dining program to facilitate communication and social interaction outside of the memory care unit. Social interaction and conversational exchanges with peers and staff were needed in order to reduce social isolation.</p> <p>A review of the RNP task performed from 12/17/24 - 01/08/24 revealed that the task was noted as completed six times.</p> <p>During an interview on 01/09/25 at 1:34 PM, Certified Nursing Assistant/Restorative Aide S stated when residents were added to the RNP, LPN T notified her and the other restorative aides. She explained that LPN T also added the task to the Kardex for the aides to document when tasks were completed. She stated the therapy department provided education/training when they referred residents to the RNP. She stated there were three Restorative aides who worked Monday - Friday, and each aide had their assigned residents. When asked if Resident #56 was in the program, she confirmed the resident was on the RNP and she was assigned to her. She was then asked if Resident #56 participated in the program. She replied, Honestly, I don't remember getting her. I take her the days I remember. She confirmed that Resident #56 did not refuse to participate and acknowledged that the resident enjoyed conversations.</p> <p>A review of the facility's policy and procedure titled Restorative Nursing Services (revised 08/2022), revealed the following:</p> <p>The policy standards included: To promote the residents' optimum function, restorative nursing programs may be developed by proactively identifying, planning, and monitoring of a resident's assessments and indicators. This creative nursing program refers to interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical mental and psychological functioning. Restorative programs may be initiated by nursing and/or therapy.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Riverwood Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2802 Parental Home Road Jacksonville, FL 32216	
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<p>F 0676</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>GUIDELINE:</p> <ol style="list-style-type: none"> 1. Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services like physical occupational or speech therapies. 2. Residents may be started on restorative nursing program upon admission during the course of stay or when discharged to rehabilitative care. 3. Restorative indicators are resident specific information that when alone or combined with other indicators establish the level of resident restorative potential. 4. Restorative indicators may be identified by multiple disciplines utilizing various assessments physician orders progress notes environmental factors caregiver conversation and any other means of communication. 5. Restorative nursing functions can be within one of the following categories: <ol style="list-style-type: none"> a. Range of motion. b. Splint or brace assistance c. Bed mobility d. Transfers e. Walking f. Dressing or grooming g. Eating and swallowing h. Amputation and prosthesis care i. Communication j. Toileting program k. Bladder retraining 6. Restorative goals and objectives are individualized and resident centered and outlined in the resident's plan of care. 7. Nursing assistance aids and other staff who are trained, will document provided techniques past relative care plan in the medical records. 8. The registered nurse or licensed practical nurse conduct an evaluation on a routine basis to include progress towards goal and response to the program. Any changes will be documented in the medical record. The restorative care plan and care directive will be reviewed and revised as indicated. <p>(continued on next page)</p>		

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F 0676 Level of Harm - Actual harm Residents Affected - Few	9. Restorative goals may include, but are not limited to, supporting and assisting residents in a. adjusting or adapting to changing abilities b. developing maintaining or strengthening his or her physical and psychological resources c. maintaining his or her dignity independence and self esteem d. participating in development and implementation of his or her plan of care.		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48947</p> <p>Based on observations, interviews, record review, and policy and procedure review, the facility failed to provide fingernail care for one (Resident #47) of four residents reviewed for Activities of Daily Living (ADLs), from a total survey sample of 56 residents.</p> <p>The findings include:</p> <p>On 01/06/25 at 11:22 AM, Resident #47 was observed resting in bed with elongated, jagged fingernails on both hands. She was asked if the staff trimmed her fingernails and she replied, One nurse cut my nails once since I've been here. She was asked if she preferred her fingernails long. She stated, I prefer them short. She was asked how her fingernails had been maintained since she was admitted. She replied, Usually when I'm doing something they just break off down to the quick and hurt. The resident was observed with tremors of both hands. (Photographic evidence obtained)</p> <p>A review of Resident #47's medical record revealed she was admitted to the facility on [DATE] with diagnoses including congestive heart failure, COPD (chronic obstructive pulmonary disease), ASHD (arteriosclerotic heart disease), type 2 diabetes mellitus (DM), HLD (hyperlipidemia), polyneuropathy, Vitamin B12 deficiency, mood disorder, allergic rhinitis, depressive disorder, insomnia, and HTN (hypertension).</p> <p>A review of the quarterly MDS (Minimum Data Set) assessment, dated 12/20/24, revealed the resident had a BIMS (Brief Interview for Mental Status) score of 15/15, indicating that she was cognitively intact. No psychosis or behaviors were indicated. The resident was independent with eating tasks, but required substantial/maximal staff assistance with transfers and toileting, partial/moderate assistance with bed mobility, and substantial/maximal assistance with personal hygiene.</p> <p>A review of the resident's care plan revealed the following focus areas:</p> <ul style="list-style-type: none"> - Resident is at risk for skin impairment related to DM, fragile skin and incontinence. Intervention: Encourage resident with nail care as tolerated. (10/10/2023) - Resident has an ADL/self-care deficit related to chronic medical conditions. Intervention: Encourage and assist with all ADL tasks as indicated, as tolerated by resident, including locomotion/ambulation, bathing, bed mobility, transfers, toileting tasks, meals, personal/oral hygiene. (10/10/2023) - Resident is at risk for chronic pain and/or is at risk for pain related to chronic physical disability. <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/09/25 at 2:36 PM, an interview was conducted with Certified Nursing Assistant (CNA) V. She was asked who was responsible for trimming, cleaning and filing the fingernails of diabetic residents. She stated, I really can't answer that. I've only started working down here today, and diabetics are not always done like residents who are not diabetic. I would have to ask someone. She was asked when fingernail care was provided and if there was a schedule or specific time that fingernail care was done. She stated, Normally on a daily basis as needed. She was asked if she was taking care of Resident #47 today. She stated, yes. She was asked if she provided fingernail care today. She stated, no. She was asked if she received ADL (activities of daily living) training/education, and did it include fingernail care. She stated, Yes, it talked about fingernail care but not specifically fingernail care for diabetics.</p> <p>On 01/09/25 at 2:51 PM, an interview was conducted with Licensed Practical Nurse (LPN) U. She was asked if she was familiar with Resident #47. She stated, yes. She was asked if the resident required staff assistance with personal hygiene and grooming. She replied, Yes, but she can do more for herself than she does. We try to encourage her to get up out of bed more. She used to get up every day and go out to smoke, but she stopped. She was asked who was responsible for trimming, cleaning and filing the residents' fingernails including diabetic residents. She stated, The CNA. She was asked if there was a specific schedule for when fingernail care was provided. She stated, When it's needed.</p> <p>A review of the facility's policy and procedure titled ADL Care and Services (issued 04/2020, revised 01/2024), revealed:</p> <p>Standard:</p> <p>Residents will be provided with care and treatment, as appropriate to maintain or improve their ability to carry out activities of daily living. (ADLs)</p> <p>Guideline:</p> <p>Residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.</p> <p>Procedure:</p> <p>4. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with:</p> <p>a. hygiene (bathing, dressing, grooming, nail care and oral care)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>50968</p> <p>Based on observations, record reviews, and staff interviews, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of one (Resident #18) out of four residents observed during medication administration, from a total survey sample of 56 residents. Failure to administer medications correctly as ordered could result in side effects with serious harm to residents.</p> <p>The findings include:</p> <p>During medication administration observation on 1/7/25 at 9:40 AM, Licensed Practical Nurse (LPN) M was preparing medication for Resident #18. After reviewing the medication administration record (MAR), she stated she did not have the Fluoxetine that was ordered for Resident #18. She checked the MAR and identified that the medication had been ordered from the pharmacy on 12/29/24. She stated it should arrive later today. She then stated she would place an order for it again now, just in case, which she did.</p> <p>A review of Resident #18's physician's orders revealed an order dated 3/25/23 for Fluoxetine HCL (hydrochloride) oral capsule, give 20 milligrams (mg) by mouth in the morning for major depressive disorder, recurrent, unspecified. (Photographic evidence obtained)</p> <p>A review of Resident #18's January 2025 MAR revealed the Fluoxetine had not been not given on 1/7/25 or 1/8/25. (Photographic evidence obtained)</p> <p>During an interview with LPN M on 1/8/25 at 1:00 PM, she confirmed that the Fluoxetine had not yet been delivered by the pharmacy and Resident #18 had missed a second dose.</p> <p>An interview with the Director of Nursing (DON) on 1/8/25 at 1:35 PM revealed that the expectation was for the nurse to re-order medications within 3-4 days before they ran out. Delivery of ordered medications was expected every day, but the nurse should call the pharmacy to check when the medication will be delivered, notify the physician if the medication will be missed, and get an order to hold the medication if needed. The nurse should also check to see if the medication is available in the facility.</p> <p>A review of the facility's policy and procedure titled Standards and Guidelines: Physician Orders (revised 1/2024), revealed the following:</p> <p>Procedure:</p> <p>9. Physician orders should be followed as prescribed, and if not followed, this should be recorded in the resident's medical record during that shift. The physician should be notified and the responsible party if indicated.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy and procedure titled Standards and Guidelines: Medication Administration (revised 1/2024), revealed the following:</p> <p>Procedure:</p> <p>9. The individual administering the medication checks the label to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication.</p> <p>16. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document the rationale in the resident's medical record and notify the physician and responsible party if indicated.</p> <p>19. Staff follows established facility infection control procedures (e.g. handwashing, antiseptic technique, gloves, isolation precautions, etc.)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>50968</p> <p>Based on observations, record reviews, staff interviews, and policy and procedure reviews, the facility failed to ensure a medication error rate of less than 5% based on three errors out of 26 opportunities for error. The three errors (failure to administer medications and crushing enteric coated medication) resulted in an error rate of 11.54%. Two (Residents #18 and #51) of four residents observed during medication administration from a total survey sample of 56 residents were affected. Failure to administer medications correctly as ordered could result in side effects with serious harm to residents.</p> <p>The findings include:</p> <p>1. During medication administration observation on 1/7/25 at 9:40 AM, Licensed Practical Nurse (LPN) M was preparing the medication for Resident #18. After reviewing the medication administration record (MAR), she stated she did not have the Fluoxetine that was ordered for Resident #18. She checked the MAR and identified that the medication had been ordered from the pharmacy on 12/29/24. She stated it should arrive later today. She then stated she would place an order for it again now, just in case, which she did. She then proceeded to pull Potassium Chloride extended release (ER) and the rest of the scheduled medications for Resident #18 out of the medication cart. She put them into a clear plastic sleeve and crushed all of the medications together. She then put the crushed medication mix into a cup of applesauce and administered it to Resident #18. When the Potassium Chloride ER with Do Not Crush on the packaging was pointed out to her, LPN M stated she would have to call the doctor and get it changed to maybe a liquid form for Resident #18, as she needed her medications crushed. (Photographic evidence obtained)</p> <p>A review of Resident #18's physician's order, dated 9/4/22, revealed an order for Potassium Chloride ER extended release 10 MEQ (milliequivalents), give 1 tablet by mouth one time a day for hypokalemia, swallow whole, do not chew or crush. Another order dated 3/25/23, was for Fluoxetine HCL (Hydrochloride) oral capsule, give 20 milligrams (mg) by mouth in the morning for major depressive disorder, recurrent, unspecified. Further review of the active physician's orders revealed no order to crush medications. (Photographic evidence obtained)</p> <p>A review of Resident #18's January 2025 MAR revealed that the Fluoxetine was not given on 1/7/25. (Photographic evidence obtained)</p> <p>2. During another medication administration observation on 1/7/25 at 1:00 PM, LPN N was preparing medication for Resident #51. After checking the resident's blood sugar and the resident's MAR, LPN N began to prepare Humalog (a fast-acting insulin) from a multi-dose vial. He took out the vial and a new syringe. He then punctured the rubber top of the vial with the needle and pulled back two units of insulin into the syringe. According to UptoDate.com (an evidence-based clinical resource accessed on 1/9/25 at 1:00 PM), he should have cleansed the rubber top of the vial with an alcohol swab, drawn back air into the syringe of an equal amount of the Humalog that was to be administered (2 units) and injected air into the vial before pulling out the 2 units of Humalog from the vial.</p> <p>In an interview on 1/7/25 at 1:00 PM, LPN N confirmed that he did not wipe the insulin vial and stated that he was not aware that should be done.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with LPN M on 1/9/25 at 12:10 PM, she stated she knew there was no order for Resident #18's medications to be crushed, but she knew they needed to be crushed from the nursing report of all the residents assigned to Seaway Cart 1 (LPN M's cart) and having a C next to Resident #18's name. (Photographic evidence of the report obtained)</p> <p>A review of the facility's policy and procedure titled Standards and Guidelines: Physician Orders (revised 1/2024), revealed teh following:</p> <p>Procedure:</p> <p>9. Physician orders should be followed as prescribed, and if not followed, this should be recorded in the resident's medical record during that shift. The physician should be notified and the responsible party if indicated.</p> <p>A review of the facility's policy and procedure titled Standards and Guidelines: Medication Administration revised 1/2024, revealed the following:</p> <p>Procedure:</p> <p>9. The individual administering the medication checks the label to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication.</p> <p>16. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document the rational in the resident's medical record and notify the physician and responsible party if indicated.</p> <p>19. Staff follows established facility infection control procedures (e.g. handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications as applicable.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105135	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER Riverwood Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2802 Parental Home Road Jacksonville, FL 32216	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48947</p> <p>Based on observations, interviews, record review, and policy and procedure review, the facility failed to assist residents in obtaining routine and 24-hour emergency dental care for one (Resident #84) of two residents reviewed for dental care, from a total survey sample of 56 residents.</p> <p>The findings include:</p> <p>On 01/06/25 at 11:59 AM, Resident #84 was observed to be pleasantly confused. Even standing several feet away from her, she had noticeably foul-smelling breath.</p> <p>On 01/07/25 at 10:30 AM, Resident #84 was observed sitting up in a recliner in her room. Even standing several feet away from her, she had noticeably foul-smelling breath.</p> <p>On 01/07/25 at 3:30 PM, Resident #84 was observed and continued to have noticeably foul smelling breath.</p> <p>On 01/08/25 at 11:23 AM, a record review conducted for Resident #84 revealed an admitted [DATE] and diagnoses including dysphagia (difficulty swallowing), cognitive/communication deficit, and GERD (gastroesophageal reflux disease).</p> <p>A review of the resident's quarterly MDS (minimum data set) assessment, dated 09/30/24, revealed a BIMS (brief interview for mental status) score of 99, indicating that the interview was unable to be completed due to refusal, nonsensical answers to too many questions, or was unable to answer enough questions to accurately assess cognitive status. No psychosis or behaviors were indicated, and the resident required substantial/maximal assistance with eating, bed mobility, toileting, transfers, personal hygiene, and oral hygiene. The MDS indicated pain symptoms and vocalization of pain. No swallowing problems were indicated. A mechanically altered diet was documented but no dental issues or special treatments, procedures, or programs were noted.</p> <p>A review of the resident's active physician's orders revealed she was receiving a regular diet, pureed texture, and thin-consistency fluids.</p> <p>A review of the resident's active care plan revealed the following focus areas:</p> <ul style="list-style-type: none"> - Customer has behavioral tendencies of spitting in a cup. (initiated 12/22/20, revised 12/22/20) - Resident has a potential for side effects/adverse reactions related to use of medication related to insomnia. (initiated 1/13/21, revised 7/12/24) - Resident has an ADL (activities of daily living) self-care deficit related to chronic medical conditions. Goal: Resident will maintain and/or improve ADL functioning through next review. Interventions: ADL Care, the resident may need dependent assistance to limited extensive assistance x1 or x2 for ADL care. (initiated 10/10/23 revised 9/30/24) <p>(continued on next page)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Resident the has potential or an actual oral health concern, has cognitive impairments and needs assistance to complete oral care tasks. Goal: Resident will have no complications related to oral health concerns. Interventions: Assist with or provide mouth care as needed to ensure task completion. Review ADL care plan interventions for degree of assistance needed. Coordinate arrangements for dental consultation and transportation as needed or ordered. (initiated 7/12/24, revised 9/30/24)</p> <p>- Resident has impaired cognitive function/impaired thought processes related to a diagnosis of cognitive communication deficit (initiated 9/30/24, revised 9/30/24).</p> <p>A review of the resident's medical record from 01/01/24 through 01/08/25 revealed that there were no dental consultations or dental hygienist visit notes in the record.</p> <p>A review of CNA (certified nursing assistant) ADL (activities of daily living) tasks from 12/26/24 through 01/08/24 revealed that the resident received oral hygiene at least twice daily with no refusals documented.</p> <p>A review of a Quarterly/Annual/Significant Change Nursing Evaluation, dated 12/05/24, revealed that an oral assessment was completed. Section IX Oral/Dental Evaluation revealed</p> <p>A. Evaluation: #2 Teeth, b. No natural teeth, #9 Breath, c. Other (Specify below), #11 Comments regarding Oral/Dental Status: NA. B. Determination: #1 Notify MD for possible Dental Consult, b. No, 2. Additional Comments, NA. (A copy of the assessment was obtained.)</p> <p>On 01/08/25 at 12:33 PM, an interview was conducted with the Director of Nursing (DON). She was asked if the facility contracted with any vendors for dental services. She stated, I think we use [dental provider name]. She was asked how often they visited. She replied, I believe the dentist comes monthly and the hygienist comes twice a month, but you can verify that with social services. She was asked where the resident's dental consultation notes would be located in the record. She stated, They should be in the EMR (electronic medical record) under documents, but if not, they may be in medical records waiting to be scanned in. She was asked to provide any dental records the facility had available for Resident #84.</p> <p>(continued on next page)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/08/25 at 1:51 PM, the interview resumed with the DON. She reported that the facility was unable to locate any dental consultation reports or any dental progress notes for Resident #84. She was asked what the facility's process was for new admissions regarding dental evaluations. She reported that the oral assessment was completed by the nurse within the admission assessment that was completed by the admitting staff. She was asked if all residents admitted to the facility were required to be evaluated or screened by dental services. She stated, Dental services does not usually evaluate or screen all new admissions, only by request of the resident or resident representative, or by the nursing staff when issues are identified. She was asked if there would be any reason why a resident would not have been screened by dental services, with the exception of refusals. She stated, If they've never requested services or there was never a need identified. She was asked if she was familiar with Resident #84. She stated, yes. She was asked if she was aware of the resident's oral condition. She stated, I'd have to get back with you on that; I'm not sure. She was asked what process the facility had in place to improve the resident's oral health. She stated, I will get back with you on that. The dental services policy was requested. She was asked how often the residents received oral care. She stated, Definitely daily, or more. She was asked to explain the process if a resident refused oral care. She explained that the CNA (certified nursing assistant) should attempt to provide oral care 2-3 times, and if the resident continued to refuse, the CNS should notify the nurse, who also attempted to get the resident to cooperate. If the nurse failed, the family was notified. She was asked if a resident had any health issues, where that information would be located. She stated, The CNA can look on the Kardex for anything related to ADL care; the nurse looks on the care plan. The DON was asked to review the resident's care plan pertaining to the resident's oral condition. The DON was unable to describe what the resident's particular oral condition was, how it was identified, and how that lead to a care plan being initiated on 07/12/24 and revised on 09/30/24.</p> <p>On 01/09/25 at 4:01 PM, an interview was conducted with CNA W. She was asked what her process was when a resident refused care. She stated, I go report it to the nurse. She was asked where the residents' hygiene supplies were kept/located. She stated, In a bag in their drawer with their name on it. She was asked how often she provided the residents with oral care. She stated, Once a shift since I work on the evening shift. She was asked to explain what she might observe for a resident when she performs mouth care. She stated, Bleeding of the gums, how the gums look if their swollen. She was asked if she observed something unusual, who she would report it to. She stated, To my nurse, whoever is working that evening. She was asked if she was taking care of Resident #84 today. She stated Yes, I take care of her every evening. She is on my regular assignment. She was asked if the resident was cooperative when she provided mouth care. She shook her head and stated, No, she is not cooperative with care. She was asked if she'd provided oral care for her today. She stated, Not yet, I usually wait until after dinner. CNA W was asked if she had noticed anything unusual when providing mouth care for Resident #84. She stated, Yes, her breath has a terrible odor, and I've mentioned it to the nurse. She used to work on our shift but now I'm not sure what shift she works. She was asked if anyone had spoken with her about the resident's breath and further care/consultation to be provided. She replied, Not to my knowledge, they just tell me to brush her teeth, and I tell them that I do brush her teeth, but I believe there's something else wrong that goes beyond brushing her teeth.</p> <p>A review of the facility's policy and procedure titled Dental Consults (issued, 10/2020, revised 01/2024), revealed:</p> <p>Standard: The facility will facilitate dental services through the services of a Consultant Dentist as indicated.</p> <p>(continued on next page)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Guideline:</p> <ol style="list-style-type: none"> 1. Our facility does not have dental providers on staff, and therefore contracts with external providers to provide dental services to residents as indicated. 2. The facility will contract with an external Dental provider to provide Dental Services to residents as indicated and to provide the following: <ol style="list-style-type: none"> 1. providing consultations to physicians and providing other services relative to dental matters. 2. Providing a dental assessment of residents as ordered by attending physician. 3. Performing or supervising an annual re-evaluation for each resident as needed. 5. Providing necessary information concerning residents to appropriate staff, care planning conferences, and/or committees. 		