STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105488	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverwood Healthcare & Rehabilitation Center	808 S Colley Rd Starke, FL 32091

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40559 Based on record review and interview, the facility failed to ensure assessments accurately reflected the resident's status for 1 of 5 residents reviewed for discharge, Resident #102. Findings include: Review of Resident #102's admission record showed the resident was admitted to the facility on [DATE] with diagnoses including type II diabetes mellitus, hypertension, osteoarthritis, depression, and anxiety disorder. Review of Resident #102's discharge summary dated 5/7/2024 showed the discharge date of [DATE] and discharge to assisted living facility. Review of Resident #102's progress note dated 5/9/2024 at 11:00 AM, showed it read, Resident discharged with transport. Resident discharged to [Name of an assisted living facility]. Resident left with no signs of distress. Resident left with all belongings. Resident left with no question comments or concerns per resident. Attempted to call [Name of an assisted living facility] to give report twice. Review of Resident #102's Minimum Data Set (MDS) Discharge Return Not Anticipated assessment dated [DATE] showed the resident was discharged to short-term general hospital. During an interview on 6/11/2024 at 2:41 PM, the MDS Coordinator verified that Resident #102 was inaccurately documented as being discharged to the hospital in the MDS assessment dated [DATE] due to him discharging to an assisted living facility. When a policy on completion of MDS discharge assessments was requested, she stated, We do not have a policy. We follow the RAI [Resident Assessment Instrument].

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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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39371 Based on observation, interview, and record review, the facility failed to ensure medications were secured in 3 of 5 hallways. Findings include: 1. During an observation on 6/10/2024 at 10:45 AM, Resident #72 had Dorzolamide HCl Solution at his bed side (Photographic evidence obtained). During an interview on 10/6/2024 at 10:45 AM, Resident #72 stated, Those are my eye medications and I use them. During an interview on 6/10/2024 at approximately 11:05 AM, Staff A, Registered Nurse (RN), stated, He [Resident #72] has a doctor's order to keep his medication in his room. I know that he can self-administer his eye drops. Staff A was not able to find an order for Resident #72 to self-administer his eye drops. Staff A stated, There is no order, then he should not have the medication at bedside. During an observation on 6/10/2024 at 12:30 PM, Resident #72 had Dorzolamide HCl Solution at his bedside. During an interview on 6/13/2024 at 7:35 AM, the Director of Nursing (DON) stated, My expectation is for nurses not to leave medications at bedside. My preference is for nurses not to leave medication at all. Review of Resident #72's physician orders did not reveal any order that resident was allowed to self-administer medications. Review of Resident #72's medication list showed Dorzolamide HCl Solution 2% (Instill 1 drop in both eyes two times a day related to absolute glaucoma), and Latanoprost Solution 0.005% (Instill 1 drop in both eyes two times a day related to absolute glaucoma). Review of the facility policy and procedure titled Standards and Guidelines: Medication Storage with the last revision date of 2/21/2023 read, Guidelines . 2. The nursing staff shall be responsible for maintaining medication storage and preparation area in a clean, safe and sanitary manner. 2. During an observation on 6/10/2024 at 10:55 AM, there was a medication cup containing seven pills on Resident #10's overbed table. During an interview on 6/10/2024 at 10:55 AM, Resident #10 stated, I have a pretty good idea of what they [medications] are. I haven't taken them because I don't like taking medicine on an empty stomach. I really don't like taking all of these pills at one time, there are 7 pills here. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/10/2024 at 11:33 AM, Staff F, RN, stated, I was getting his blood pressure and having problems with his wound vac [Vacuum], and I left them. Review of Resident #10's physician orders revealed no order for Resident #10 to self-administer medications. During an interview on 6/13/2024 at 10:50 AM, the DON stated, The nurse would observe the resident taking his meds [regarding expectations for residents with orders to self-administer their oral medications]. 40559 3. During an observation on 6/10/2024 at 10:53 AM, Resident #69 was sitting in bed with small plastic cup containing 4 pills on his bedside table. During an interview on 6/10/2024 at 10:54 AM, Resident #69 stated, These are mine to take in an hour. During an interview on 6/10/2024 at 10:30 AM, Staff G, Licensed Practical Nurse (LPN) stated that she had given Resident #69 his meds in the cup. Review of Resident #69's active physician orders as of 6/13/2024 did not reveal a doctor's order for self-administration of medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44571 Based on observation, interview, and record review, the facility failed to ensure food was stored, labeled, or discarded in the areas of the dietary department's walk-in cooler and the stock/storage room. Findings include: During an observation while conducting an initial tour of the kitchen on 6/10/2024 at 9:10 AM with the Dietary Manager (DM), there were one sheet pan with a total of 93 bowls labeled Lemon Gelatin with a use by date of 6/8 in the walk-in cooler, one tray with 70 glasses of iced tea with no type of identifying label or date, one clear container of vegetables with no identifying label, and one large clear container of soup with no identifying label. During an interview on 6/10/2024 at 9:30 AM, the DM confirmed the presence of the outdated gelatin and iced tea and stated that outdated foods should have been discarded. The DM identified the unlabeled containers as one containing peas and carrots and the other containing vegetable soup. The DM stated that the containers should be labeled and dated. During an observation while conducted the follow-up tour of the kitchen on 6/11/2024 at 6:30 AM with the DM, there were on package of hotdog buns with 3 buns remaining in the bag with no open date, one package of hamburger buns with 2 remaining buns with no open date, and an opened bag of sliced bread with 8 remaining slices with no open date. There was one partial container of oil, and one partial container of instant mashed potatoes with no open or use by date in the stock storage room. During an interview on 6/11/2024 at 6:35 AM, the DM stated that the opened bread items should have an opened or use by date and all products should be labeled and dated for storage, or an open date placed on bulk products that have been opened for use. Review of the facility policy and procedure titled Receiving dated October 2019 read, Action Steps . 4. The Dining Services Director or designee ensures that all non-perishable foods and supplies are stored appropriately . 6. All food items will be appropriately labeled and dated either through manufacturer packaging or self notation. Review of the facility policy and procedure titled Food Storage: Cold dated 10/19/2019 read, Action Steps . 6. The Dining Services department is to insure that food/drink items are discarded prior to the expiration date of the item or acceptable time frames for opened and dated items.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50695 Based on interviews and record reviews, the facility failed to ensure accurate and complete medical records were maintained for 1 (Resident #43) of 5 residents reviewed for discharge. Findings include: Review of Resident #43's admission record documented the resident was readmitted on [DATE] with diagnoses including Schizophrenia. Review of Resident #43's progress note authored by the attending physician dated 5/6/2024, documented, History of Present Illness: Patient is a [AGE] year old female with hx [history] of schizophrenia, hyperlipidemia, hypothyroid, chronic back pain, COPD [chronic obstructive pulmonary disease], and colostomy. She was admitted [DATE] for long term care. She is being evaluated due to decline. She was found eating her own feces and unable to sit in her wheelchair. She is responsive to tactile stimuli, would not tolerate IV [intravenous] rehydration. Recommending her to go to hospital for eval [evaluation]. Review of Resident #43's medical record on 6/11/2024 at 2:00 PM revealed there was no documentation related to discharge to the hospital on 5/6/2024 to include transfer form, physician order, change in condition and notification to responsible party. During an interview on 6/11/2024 at 2:20 PM, Staff I, RN, stated, I don't see anything [regarding the transfer in the electronic medical record for Resident #43 from 5/6/2024]. Let me ask [the Director of Nursing (DON)'s name]. During an interview on 6/11/2024 at 4:15 PM, the DON stated, We are working on that [locating transfer/discharge paperwork for Resident #43 from 5/6/2024]. Review of Resident #43's progress notes on 6/12/2024 at 10:50 AM, read, Health Status Note. Late Entry. Upon starting shift CNA [Certified Nursing Assistant] noted that resident was having a change of condition related to acute decline (eating her feces and poor trunk control in wheelchair). [Resident #43's attending physician's name] was in facility and gave a verbal order to send out to the hospital. I began filling out and printing [NAME] [Agency for Health Care Administration] and Ems [Emergency Medical Service] packets along with transfer forms, face sheet, and medication list. I attempted to contact family and left a voicemail. Unit manager and DON were notified. EMS arrived and I ADT'd [ACHA Discharge Transfer [process]] out of the system at 2022 [8:22 PM]. The progress note was signed by Staff H, LPN, on 6/12/2024 at 8:07 AM. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/12/2024 at 1:25 PM, the Regional DON stated, We called the nurse when we discovered the transfer form was not in the computer. He was adamant that he completed it and the EMS and AHCA paperwork. They make 2 packets, 1 for EMS and 1 for the hospital. When I looked in PCC [Point Click Care - electronic medical record system], I can see on the user report that he did the transfer form. You can see he pulled orders, labs, progress notes, and he ADT'd her out of the computer. We have no idea what happened to the form. We can see that it was started, and no one can delete the form. We put in a ticket [work order] to PCC to find out what happened to the form. We know that he completed the form because we have the unit managers check after every discharge or transfer to make sure everything was done. [Staff I, RN's name] would have checked on that the next day. During an interview on 6/13/2024 at 8:05 AM, Staff H, LPN, stated, I [would] create an order for the transfer in PCC. I specify whether it's a telephone or verbal order, print the face sheet, the meds [medications], labs [laboratory results] if done in the last week or two, any imaging, and DNR [Do Not Resuscitate] orders. I [would] fill out the EMS and AHCA packet, two copies, one for the hospital and one for EMS. I [would] get a nurse to assist me if necessary. I might have forgot to place the orders [for Resident #43's transfer to the hospital]. I know I did all the other steps. Right at change of shift, about 7:05 [PM], the CNA came and told me that there had been a change in her [Resident #43's] condition. It was easy to notify the doctor, because [Resident #43's attending physician's name] was in the building. I got an order around 7:15 [PM]. I started doing all the steps, it took about 45 minutes. EMS got here around 8:15 [PM], and I ADT'd her out of the computer around 8:22 [PM]. She was sent to UF [University of Florida Hospital], in Gainesville. During an interview on 6/13/2024 at 8:35 AM, Staff I, RN, stated, I make sure there is an order and the EMS and AHCA packet. EMS won't take them without the packet. On the 7th [of May], I cannot guarantee I checked for the transfer form. During an interview on 6/13/2024 at 11:00 AM, the Regional DON, stated, I couldn't find it [an order for transferring Resident #43]. I am sure the transfer form was done, because you can see he [Staff H, LPN] started one on the user report. Review of the facility policy and procedure titled, Standards and Guidelines: Transfer and Discharge last reviewed on 11/17/23, read, Standard: It is the standard of this facility to provide appropriate transfer and discharge services, documentation that will be included in the medical record, and who is responsible for making the documentation. The facility will allow for sufficient preparation and orientation by informing the resident where he or she is going to take steps to minimize anxiety . Unplanned Discharges/Emergency Transfer to Hospital: 1. When a change in condition or required transfer to the hospital or higher level of care is determined the facility should obtain appropriate transfer orders from the physician. 2. Documentation of the change of condition or required transfer should be reflected in the medical record . 4. Notification of the resident's representative should be denoted in the medical record as is appropriate per resident's capacity and choice, if applicable . 7. Details regarding the transfer from the facility should be documented in the clinical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50123 Based on observation, interview, and record review, the facility failed to ensure staff performed hand hygiene during medication administration and failed to ensure the residents' reusable medical equipment was properly stored to prevent the possible spread of infection. Findings include: 1. During an observation on 6/12/2024 at 8:00 AM, Staff D, Licensed Practical Nurse (LPN), began preparing Resident #60's medications without performing hand hygiene. Staff D entered the resident's room, did not perform hand hygiene and administered the medications. Staff D, LPN, exited the room, did not perform hand hygiene, returned to the medication cart and began preparing medications for another resident. During an observation on 6/12/2024 at 8:10 AM, Staff D, LPN, did not perform hand hygiene and began preparing Resident #20's medications for administration. Staff D entered Resident #20's room, did not perform hand hygiene, and administered the medications. Staff D exited the resident's room and did not perform hand hygiene. During an interview on 6/12/2024 at 8:20 AM Staff D, LPN, stated, I just forgot. I didn't realize I had to do it [perform hand hygiene] all of those times though. During an interview on 6/12/2024 at 8:40 AM, the Director of Nursing (DON) stated, They use hand sanitizer before they enter the room, when they exit the room, and they should use gloves when they are pulling up medications. Review of the facility policy and procedure titled Standards and Guidelines: Standard Precautions with the last revision date of 1/15/2021 read, Standard . Hand hygiene continues to be the primary means of preventing the transmission of infection. Review of the facility policy and procedure titled Standards and Guidelines: Medication Administration with the last revision date of 1/1/2021 read, Guidelines . 10. Established facility infection procedures (e.g. handwashing, antiseptic technique, gloves, isolation, precautions, etc.) must be followed during the administration of medications. 2. During an observation of Resident #10's room on 6/10/2024 at 10:55 AM, there was a nebulizer on the bedside table. The nebulizer was plugged into the wall with tubing and a face mask attached. The mask was not covered in a bag, and the tubing was not dated. During an observation of Resident #10's room on 6/10/2024 at 1:24 PM, there was a nebulizer on the bedside table with tubing and a mask attached. The mask was uncovered, and the tubing was not dated. During an interview on 6/10/2024 at 1:24 PM, Resident #10 stated, [Staff H, LPN's name] got that [the observed nebulizer] for me because I had a cough, but I've pretty much gotten over it. He said to keep it and use it when I needed it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of Resident #10's room on 6/11/2024 at 11:28 AM, there was a nebulizer on the bedside table with attached tubing and face mask. The mask was not in a bag and the tubing was not dated. During an observation of Resident #10's room on 6/11/2024 at 3:50 PM, there was a nebulizer on the bedside table. The face mask was located on the floor, not in a bag or covered. During an observation of Resident #10's room on 6/13/2024 at 9:45 AM, there was a nebulizer on the bedside table with the tubing and mask attached. The tubing was not dated, and the mask was uncovered (Photographic evidence obtained). During an interview on 6/13/2024 at 10:50 AM, the DON stated, Tubing needs to be changed weekly and as needed, and it should be dated. The face mask should be in a bag when not in use.