STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106043	A. BUILDING _____ B. WING _____	**09/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVERCHASE HEALTH AND REHABILITATION CENTER	**1017 STRONG RD QUINCY, FL 32351**

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)
F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** Based on observations, interviews and record reviews, the facility failed to provide necessary services for residents who require assistance with activities of daily living, specifically nail care, for 6 of 12 residents randomly sampled for nail care (Residents #2, #6, #7, #8, #13 and #14). The findings include: On 9/1/2020 at 10:23 AM, a telephone interview was obtained with Resident #2's daughter and representative who stated she was concerned by her mother's appearance when she saw her on a video call arranged by the facility after not seeing her face-to-face for several months due to the COVID-19 visitation restriction. She continued that she ended up seeing her mother in person while she was at the hospital and was concerned at the condition of her nails as they were long and filthy. She stated that the nurse at the hospital was also concerned about the condition of her mother's nails and assured her that they would be taken care of prior to her mother's discharge. She confirmed that the hospital trimmed and cleaned her mother's nails before sending her back to the facility. On 9/1/2020 a review of Resident #2's medical record was conducted. Review revealed that the resident was readmitted to the facility from the hospital approximately two weeks ago. Review of the plan of care which had an initiation date of 10/20/2019 and a scheduled review date of 9/8/2020 revealed that the resident required assistance with bathing, grooming and dressing daily related to impaired mobility. Care plan interventions revealed the following: provide oral care in the morning, evening, and as needed, assist with grooming and dressing daily, bath or shower three times per week, dress age appropriate and groom neatly daily and as needed. Review of the resident's daily task sheets, which are completed by the Certified Nursing Assistants (CNAs), revealed no fields related to nail care. On 9/1/2020 at 5:23 PM, an interview was conducted with CNA D, a CNA who works on the South Wing. The surveyor asked CNA D if nail care is scheduled to be completed on bath/shower days. CNA D informed the surveyor that there's no schedule for completing nail care, it's just completed as needed. The surveyor asked CNA D where the completion of nail care gets documented and she replied that it doesn't get documented anywhere. The surveyor asked what nail care should look like when it's being completed and she stated soak the residents' fingers in warm soapy water and use an orange stick to clean out from under the nails and then use a washcloth to clean around the nail bed and apply ointment to dry areas. The surveyor asked CNA D how residents' needs are being met while manicure activities have been suspended and the beauty shop is closed. CNA D hesitated and then shrugged. On 9/1/2020 at 5:27 PM, the surveyor and CNA D entered several South Wing rooms together to examine the condition of resident fingernails, beginning with the room that housed Resident #2. Resident #2's nails were observed to have a brown substance underneath the free edges of the nails on both hands. The surveyor and CNA D entered the room belonging to Resident #6 and Resident #7 next. When the surveyor asked to see Resident #6's nails, she stated that she she asked a staff member to clean under her nails and they said they would if they had time, but they never did. Resident #6 was also observed with a brown substance underneath the free edges of the nails on both hands. Resident #7 was observed with her right thumb nail extending approximately a centimeter beyond the end of the thumb. A brown substance was visible underneath the free edges of the nails on both Resident #7's hands. The surveyor asked if she'd allow staff to trim and clean her nails and she nodded her head and said yes. The surveyor and CNA D entered the room belonging to Resident #8. CNA D stated that Resident #8's toes were bad. She applied gloves and removed the resident's socks. The second toe on each foot overlapped onto the great toe. The great toenails were discolored with a black hue. Resident #8 shifted in her wheelchair and CNA D asked her if it was painful having her toes touched and she nodded her head yes. On 9/1/2020 at 5:45 PM, the surveyor inquired to the South Wing Assistant Director of Nursing (ADON) about Resident #8's toes. The ADON stated that she's had those hammer toes since before she arrived and the podiatrist hasn't been to the facility for some time due to COVID-19 but she was on the list to be seen when the podiatrist visits on 9/10/2020. The ADON continued that the previous treatments ordered including soaking and moisturizing them. On 9/1/2020 at 5:53 PM, the surveyor toured the facility's North Wing and observed a random sample of residents for fingernails. The surveyor entered the room belonging to Resident #12 and Resident #13. Resident #13 was using her left hand to eat rather than using a utensil. All nails on the left hand were excessively long and food was collecting underneath the nails. The surveyor asked Resident #13 if staff trim her nails and she replied, Yes, but it's been awhile. The surveyor asked if she'd like her nails trimmed and she replied, Yes. The surveyor entered the room belonging to Resident #14. A brown substance was visible underneath Resident #14's nails on both hands. Resident #14's nails were very short and he stated he bites his nails. On 9/1/2020 at 6:08 PM, an interview was conducted with CNA G who was working on the North Wing. The surveyor inquired about resident nail care and she stated that there's usually nail kits in the dayroom where residents can have their nails filed and painted. The surveyor stated that she was aware of manicures being a scheduled activity at many facilities prior to COVID-19 and asked about what alternatives have been offered since group activities have been canceled and residents are encouraged to stay in their rooms. CNA G replied, I really don't know. On 9/1/2020 at 6:40 PM, the surveyor met with the Nursing Home Administrator (NHA) and DON. The surveyor informed them of her concerns related to residents not being seen by the podiatrist for months, not documenting if and when nail care is provided, and not implementing an alternative to the pre-COVID scheduled manicure activities. The surveyor further informed them that residents were observed with excessively long nails and brown substances underneath the nails and that a resident had made a request for nail care earlier which went unanswered. The DON confirmed that the podiatrist had not been in the building since March or April and was scheduled to come for two days to address resident needs. The NHA and DON did not dispute the surveyor's concern regarding nail care not being adequately addressed.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.