

STATE WORKLOAD REPORT

Provider/Supplier Number

AL11968875

Provider/Supplier Name

OUR HOME AT RIVERWOOD

Type of Survey (select all that apply)

3				
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- | | | | | | |
|---|-------------------------|---|-----------------------|---|-------------------|
| A | Complaint Investigation | E | Initial Certification | I | Recertification |
| B | Dumping Investigation | F | Inspection of Care | J | Sanctions/Hearing |
| C | Federal Monitoring | G | Validation | K | State License |
| D | Follow-up Visit | H | Life Safety Code | L | CHOW |
| M | Other | | | | |

Extent of Survey (select all that apply)

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- A Routine/Standard Survey (all providers/suppliers)
 B Extended Survey (HHA or Long Term Care Facility)
 C Partial Extended Survey (HHA)
 D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 40559	10/30/2025	10/30/2025	0.50	0.00	5.50	0.00	1.00	1.00
2. 51447	10/30/2025	10/30/2025	0.50	0.00	5.50	0.00	1.50	1.00
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours....

0.25

Total RO Supervisory Review Hours....

0.00

Total SA Clerical/Data Entry Hours....

0.25

Total RO Clerical/Data Entry Hours....

0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968875	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/30/2025
NAME OF PROVIDER OR SUPPLIER OUR HOME AT RIVERWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 6873 SW US HWY 27 FORT WHITE, FL 32038		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 000	Initial Comments An unannounced complaint investigation (complaint number 2025012154) was conducted at Our Home at Riverwood on 10/30/25. The facility had no deficiencies at the time of survey.	A 000			

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE