STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968572	07/24/2015
NAME OF PROVIDER OR SUPPLIER **RIVERTOWN ASSISTED LIVING LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **16354 SW CHIPOLA RD** **BLOUNTSTOWN, FL 32424**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

An unannounced biennial survey was conducted at Rivertown Assisted Living Facility on . Deficiencies were cited.

0083 Trainina - First Aid and

Based on employee record review, review of the monthly schedule and staff interview the facility failed to ensure a staff member who hold a valid card for First Aid and was in the facility at all times for 1 out 3 (B) employees reviewed for First Aid and certification.

The findings are:

A review of the employee file for staff B revealed a date of hire / . The First Aid certification card in this employee file expired in 2012. No other documentation of Current and First Aid certification was in the employee file.

A review of the monthly staffing schedule shows employee B has worked several shifts independently.

An interview was conducted with the Administrator on at approximately 12:00 PM. She stated the employees will work by themselves but she and the other owner will come in and out. She confirmed that she is not here the entire time that employee #2 is working. She further stated she miss read the expiration date on the and First Aid card the employee provided.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Rivertown Assisted Living
16354 SW Chipola Rd
Blountstown, FL 32424

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 by representative(s) of this office. Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach your corrective action and any additional documentation to support correction of identified deficiencies and send to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call me at 850-412-4540.

Sincerely,

Donah Heiberg
Field Office Manager

DH/dh
Enclosure

XG90

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