STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968643	R 09/14/2015
NAME OF PROVIDER OR SUPPLIER **RIVERTOWN SENIOR CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **17112 NW CHARLIE JOHNS ST** **BLOUNTSTOWN, FL 32424**	

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

0000 Initial Comments

An unannounced Revisit survey was conducted at Rivertown Senior Care Assisted Living Facility located in Blountstown, FL on 9/14/2015. Deficient practice was identified during the survey.

0030 Resident Care - Rights & Facility Procedures

Based on observation, staff interview and record review the facility failed to provide adequate and appropriate health care for 1 of 3 residents during medication pass (#1), the glucometer used for 2 residents was not cleaned in accordance with the manufacturer directions.

The findings include:

An observation of resident #1 checking her sugar was conducted on at approximately 1:00 PM. The Administrator cleaned the glucometer, lancet device and fabric zip pouch with 50% rubbing prior to giving the machine, lancet and fabric zip pouch to resident #1. The Administrator stated resident #1 and another resident use the same machine to check their sugar. Resident #1 checked her sugar, then laid the glucometer back on the open fabric zip pouch with resident #1's on the test strip still in the glucometer. Further interview was conducted with the Administrator on / at approximately 1:27 PM. She stated she had not contacted the glucometer manufacturer to see if the machine could be used on multiple residents or how to effectively clean the glucometer between multiple resident use. The Administrator confirmed she did not clean the glucometer with 70% rubbing

The glucometer owner's manual was reviewed on / in the presence of the Administrator. Page 52 of the manual stated the glucometer should be cleaned with 70% rubbing and does not address the use of the device for multiple residents.

0051 Medication - Pill Organizers

Based on observation, record review and staff interview the facility failed to use pill organizers only for residents who self-administer medications and failed to document the date and time the organizer was filled in the resident's record for 1 of 3 sampled residents observed during medication pass. (#1)

The findings include:

Observation of medication pass with the Administrator was conducted on at approximately 12:50 PM. The Administrator took a filled weekly pill organizer labeled with resident #1's name to

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resident #1 at the dining table. The Administrator then instructed the resident to remove the pills from the noon section of the organizer for that day and told her what the pills were. The Administrator observed the resident swallow the medications then took the organizer from the resident and signed the Medication Observation Record (MOR).

Review of resident #1's health assessment (AHCA form 1823) completed by the physician and signed on was conducted on . The health assessment indicated the resident required assistance with self-administration of medications. The record did not have any physician orders stating the resident could self-administer medications independently or documentation of the Administrator filling the pill organizer. An interview was conducted with the Administrator (a Licensed Practical Nurse) on / at approximately 1:29 PM. The Administrator stated she had changed all of the residents in the facility to pill organizers in an attempt to correct the last deficiency. She confirmed resident #1 was not assessed to self-administer medications and stated she did not document filling the pill organizer in the resident record.

Class III

0078 Staffing Standards - Staff

Based on record review and staff interview the facility failed to ensure staff have documentation of a negative test on an annual basis for 2 out of 3 sampled employees. (employees A and B)

The findings include:

Review of employee A and B's record was conducted on . Both employee A and B had hire dates of . Both employee A and B had negative tests on file dated . No other tests were on file. On at approximately 11:19 AM employee A (facility owner and direct care staff) confirmed she and employee B had not had a negative test in over a year.

Class III

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11968643	A. Building B. Wing	9/14/2015

Name of Facility	Street Address, City, State, Zip Code
RIVERTOWN SENIOR CARE	17112 NW CHARLIE JOHNS ST BLOUNTSTOWN, FL 32424

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix A0054 Reg. # 58A-5.0185(5) FAC LSC	Correction Completed	ID Prefix A0079 Reg. # 58A-5.019(3) FAC LSC	Correction Completed	ID Prefix A0081 Reg. # 58A-5.0191(2) FAC LSC	Correction Completed
ID Prefix A0082 Reg. # 58A-5.0191(3) FAC LSC	Correction Completed	ID Prefix A0090 Reg. # 58A-5.0191(11) FAC LSC	Correction Completed	ID Prefix A0092 Reg. # 58A-5.020(1) FAC LSC	Correction Completed
ID Prefix AZ816 Reg. # 408.809(2)(a-c) FS LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:** 9/17/15
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on:			**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES** **NO**

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Rivertown Senior Care
17112 NW Charlie Johns St
Blountstown, FL 32424

Dear Administrator:

This letter reports the findings of a State Licensure Revisit Survey conducted on 14, 2015 by a representative of this office. Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2015.**

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, MSW
Field Office Manager

DH/dh
Enclosure

YOSF

Tallahassee Field Office
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