STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968643	R 07/05/2016
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

A revisit was c ompleted. Deficient practice was identified.

0080 Training - Core & Competency Test

Based on interviews and record reviews, the assisted living facility failed to ensure 2 of 2 core trained staff members (administrator and manager) complete the core training requirements after not maintaining 12 hours of continuing education every two years. Specifically, the administrator and manager failed to retake the assisted living facility core training and retake and pass the competency test.

Findings include:

1) A review of the Administrator and Manager's personnel file revealed their date of hire as . I/ . showed, Core trained certificates of 26 hours on . I/ and a certification issued on . There personnel files lacked continuing education hours.

2) During an interview on at 9:30 AM, the Manager reported that she and the administrator had not had any time to take continued courses or retake the core training. She stated the next available core training was available in Boca Raton but they have not registered.
3) During an interview on at 10:35 AM, the Administrator confirmed that she had not completed the core training requirements. She sated she think she will take the online core training course and sit for the test in Miami on .

Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11968643 Y1	A. Building B. Wing Y2	Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0025	Correction	ID Prefix A0030	Correction	ID Prefix A0093	Correction
Reg. # 429.26(7) FS; 58A-5.0182(1) FAC	Completed	Reg. # 58A-5.0182(6) FAC; 429.28(1-2) FS	Completed	Reg. # 58A-5.020(2) FAC	Completed
LSC		LSC		LSC	
ID Prefix AN277	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 58A-5.031(2) FAC	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	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
5/18/2016	

STATE FORM: REVISIT REPORT ( )

EVENT ID: W3MX12

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

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

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by a representative 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 a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than 12, 2016.** 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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