STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910124	01/10/2017
NAME OF PROVIDER OR SUPPLIER **RIVERVIEW RETIREMENT CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **4470 SOUTH WASHINGTON AVE.** **TITUSVILLE, FL 32780**	

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

0000 - Initial Comments

The re-licensure survey was conducted on , 2017. Riverview Retirement Center, license #7358 had a deficiencies found at the time of the visit.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review and interview, the facility failed to contact the health care provider for 1 of 2 sampled residents (#6) who exhibited a significant change.

Findings:

Record review for resident #6 revealed a progress note dated / that read 'observed resident with slurred speech upon waking up from a nap after returning from . She complained of tongue . Facility staff called 911. The resident refused to go to the hospital. The resident was more responsive with clearer speech. The resident's brother was notified.'
There was no documented evidence the health care provider was notified of the significant change.
During an interview with the administrator on / at 1:52 PM, she said she notified the secretary at the health care provider's office and she confirmed there was no documentation in the record to confirm the health care provider was notified.
Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

, 2017

Administrator
Riverview Retirement Center
4470 South Washington Ave.
Titusville, FL 32780

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2017 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 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 , 2017.** 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(s). Should you have any questions please call Lorraine Henry at (407) 420-2502.

Sincerely,

Lorraine Henry

Theresa DeCanio, RN
Field Office Manager

TDC:clr
Enclosure

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