STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968875	C 02/05/2019
NAME OF PROVIDER OR SUPPLIER **RIVERWOOD LODGE ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **6873 SW US HWY 27 FORT WHITE, FL 32038**	

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

0000 - Initial Comments

On [redacted] through [redacted], an unannounced biennial re-licensure survey in conjunction with Emergency Power Plan (EPP) monitoring survey and complaint investigation survey (CCR #2018017733) was conducted at Riverwood Lodge Assisted Living Facility (License #12714), Fort White, FL. Deficient practice was identified at the time of the survey and the compliant allegation was substantiated, being cited under 0093--Dietary Standards-Food Service.

0008 - Admissions - Health Assessment - 429.26( ) FS; 58A-5.0181(2) FAC

Based on record review and interview, the facility failed to ensure 3 of 3 reviewed residents (Resident #1, #5, and #6) had a complete Resident Health Assessment (AHCA Form 1823).

Findings:

A record review of Resident #1's most recent health assessment revealed that page 4 was missing. Page 4 contains the date of assessment and health care provider signature.

A record review of Resident #5's most recent health assessment (dated) revealed that page 2 contained no comments as to what type of assistance the resident needs and page 3 contained no comments under "Task" as to what type of assistance the resident needs.

A record review of resident #6's most recent health assessment revealed that page 4 was missing. Page 4 contains the date of assessment and health care provider signature.

On at 1:30 PM, an interview was conducted with the Administrator, who confirmed that the Health Assessments (AHCA Form 1823) for Resident #1, #5, and #6 were incomplete.

Class III

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

Based on observation, record review and interview, the facility failed to ensure 1 of 4 reviewed residents (Resident #1) received proper assistance with self-administration of medication.

Findings:

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SUMMARY STATEMENT OF DEFICIENCIES
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On at 10:03 AM, Staff A/Medication Technician was observed assisting Resident #1 with self-administration of medication. Staff A handed one 25/250 mg tablet to Resident #1 to take.

A record review of Resident #1's physician order revealed that Resident #1 was ordered to receive two 25/250 mg tablets by every two hours while awake, beginning on .

On at 11:00 AM, an interview was conducted with Staff A/Medication Technician, who confirmed that she failed to review Resident #1's physician order to confirm the medication was two 25/250 mg tablets.

On at 11:30 AM, an interview was conducted with the Administrator, who confirmed that Resident #1 should have received two tablets of 25/250 mg instead of one.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on observation, record review and interview, the facility failed to update Medication Observation Record after a change in physician order to reflect the new dosage for 1 of 4 reviewed residents (Resident #1).

Findings:

On at 10:03 AM, Staff A/Medication Technician was observed assisting Resident #1 with self-administration of medication. Staff A handed one 25/250 mg tablet to Resident #1 to take.

A record review of medication records was conducted for Resident #1. Medication label reads: " 25/250 mg tablet, Take two tablets by every two hours while awake". Medication Observation Record reads: " 25/250 mg tablet, Take one tablet by every two hours while awake". Physician order revealed that Resident #1 was ordered to receive two 25/250 mg tablets by every two hours while awake, beginning on .

On at 11:30 AM, an interview was conducted with the Administrator, who confirmed that

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SUMMARY STATEMENT OF DEFICIENCIES
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Resident #1 should have received two tablets of [redacted], - [redacted], 25/250 mg instead of one.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation, interview, and record review, the facility failed to have all regular and therapeutic menus reviewed annually by a licensed or registered dietician, a licensed nutritionist, or other approved professionals to ensure the meals meet established nutritional standards, failed to conspicuously post menus or make them easily available to the residents, and failed to maintain an emergency three-day supply of non-perishable food and water for a census of twenty residents.

Findings:

On [redacted] at 12:30 PM, during dining and food services observation, no weekly menus was observed conspicuously posted in the facility. There was a dry erase board in the dining area, on which the breakfast, lunch, and dinner menus was written for one day ([redacted].)

On [redacted], at 09:30 AM, an interview was conducted with Staff B/Cook, who stated that the food service program at the facility was not currently under the supervision of a registered dietician. Staff B confirmed that the weekly menus were not conspicuously posted.

On [redacted] at 10:00 AM, a record review of the facility menus was conducted. According to the documents on file, the last time the facility menus were reviewed and approved by a registered dietician was on [redacted]. There were no other more recent menus on file that are currently in use.

On [redacted] at 10:15 AM, an interview was conducted with the Facility Manager, who confirmed that the facility's menus had not been recently reviewed by a dietician or nutritionist.

On [redacted] at 10:30 AM, an inventory of the facility's emergency food and water supplies was observed as accompanied with Staff B. Staff B verified that the following food items were in stock for a census of twenty residents: one case (6 qts) of soy milk, two 80-oz jars of peanut butter, one 48-oz jar of apple sauce, nine 7-oz cans of chicken noodle soup, two 26-oz cans of chicken and rice soup, two 10.5-oz cans of vegetable soup, five 20-oz cans of tuna fish, three 12.5-oz cans of tuna fish, two 48-oz containers of orange juice, two 48-oz containers of apple juice, and two 9-oz packages of dried vegetable beef soup. Emergency water supply was not adequate.

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SUMMARY STATEMENT OF DEFICIENCIES
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On at 10:30 AM, during an interview, Staff B confirmed that the facility did not have adequate emergency food and water supply for the census of twenty residents.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observation and interview, the facility failed to have a functioning emergency power source maintained at the facility.

Findings:

On at 2:00 PM, an observation of the facility portable generator/emergency power source was conducted. The observation revealed that the facility portable generator was not working.

On at 2:30 PM, during an interview with the Administrator and the Facility Manager, they confirmed that the facility portable generator was not working.

Class III