STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910396	08/30/2013
NAME OF PROVIDER OR SUPPLIER **Oakbridge Terrace Assisted Living At Indian River**	STREET ADDRESS, CITY, STATE, ZIP CODE **2200 Indian Creek Blvd. Vero Beach, FL 32966**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0000 - - Initial Comments
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D

Specific Tag Findings:

0000-Initial Comments

An unannounced Assisted Living Facility abbreviated relicensure survey was conducted on Oakbridge Terrace, had a licensure deficiency found at the time of the visit.

0078-Staffing Standards - Staff 58A-5.019(2) FAC

Based on interview and record review, it was determined that this facility did not ensure each employee had obtained a statement from a health care provider, based on an examination conducted within 6 months of hire, that the employee does not have any signs or symptoms of a communicable including , for 1 out of 6 sampled employees selected for review (Employee B).

The findings included:

During interview and personnel record review conducted with the Director of Residential Nursing, on beginning at approximately 1:30 PM, she was provided the opportunity to locate a statement that Employee B (date of hire noted as was free from communicable including She was unable to find this required documentation. She acknowledged that Employee B has been working in a direct care provider position for approximately 7 months at the facility.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2013

Administrator
Oakbridge Terrace Assisted Living At Indian River
2200 Indian Creek Blvd.
Vero Beach, FL 32966

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on . 2013 by representatives 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. Staff from this office will conduct a review after , **2013** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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 this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager\par

AMD
Enclosure

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone (561) 381-5840; Fax (561) 496-5924