AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963946	04/20/2016
NAME OF PROVIDER OR SUPPLIER **BROOKDALE OAKBRIDGE**	STREET ADDRESS, CITY, STATE, ZIP CODE **3110 OAKBRIDGE BLVD E.** **LAKELAND, FL 33803**	

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

0000 Initial Comments

Assisted Living Facility

A complaint investigation (CCR# 2016002125) was conducted at Brookdale Oakbridge on Brookdale Oakbridge, Assisted Living Facility, had a deficiency at the time of the visit.

0025 Resident Care - Supervision

Based on interview and record review the facility failed to ensure the resident call bells are responded to in a timely manner.

Findings included:

In an interview with 6 residents, 3 of 6 (residents #3, 4, & 7) stated the call bells were not answered in a timely manner.
On at 3:00 pm Resident #3 stated she has waited up to 40 minutes for someone to respond after she pushed her call pendant.
On at 1:02 pm resident #4 stated she has waited up to 20 minutes for someone to respond when she pushed her call pendant.
On at 3:00 pm resident #7 stated she has waited 38 minutes for someone to respond after she pushed her call pendant, resident #7 also stated her call pendant has not worked in a long time. Resident #7 stated that the administrator, activities director and resident aides have been made aware of her broken pendant and it is still not working.
On / at 3:00 pm staff B stated she would replace the pendant that day.
On / at 3:30pm in review of the resident council minutes 3 residents (residents #3, #4 and #7) stated the facility did not respond to their call bells in a timely manner.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Brookdale Oakbridge
3110 Oakbridge Blvd E.
Lakeland, FL 33803

RE: CCR# 2016002125

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on , 2016, by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency 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 deficiency. Submit summary and documents to the Field Office no later than , 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 deficiency 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.

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Thank you for the assistance provided to the surveyor(s). Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

FOR Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State Form 5000-3547

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