Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910371	A. BUILDING: ______ B. WING ______	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBRIDGE TERRACE ASSISTED LIV RES - EDGEW.	23305 BLUE WATER CIRCLE BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced Relicensure survey was conducted at the Oakbridge at Terraces Assisted Living Residences at Edgewater Pointe on ... . - ... . The facility had deficiencies at the time of the survey.	A 000		
A 009 SS=B	58A-5.0181(3) FAC; 400.0078(2) Admissions - Admission Package (3) ADMISSION PACKAGE. (a) The facility must make available to potential residents a written statement(s) that includes the following information listed below. Providing a copy of the facility resident contract or facility brochure containing all the required information meets this requirement. 1. The facility's admission and continued residency criteria; 2. The daily, weekly or monthly charge to reside in the facility and the services, supplies, and accommodations provided by the facility for that rate; 3. Personal care services that the facility is prepared to provide to residents and additional costs to the resident, if any; 4. Nursing services that the facility is prepared to provide to residents and additional costs to the resident, if any; 5. Food service and the ability of the facility to accommodate special diets; 6. The availability of transportation and additional costs to the resident, if any; 7. Any other special services that are provided by the facility and additional cost if any; 8. Social and leisure activities generally offered by the facility; 9. Any services that the facility does not provide but will arrange for the resident and additional cost, if any;	A 009		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910371	A. BUILDING: _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBRIDGE TERRACE ASSISTED LIV RES - EDGEW.	23305 BLUE WATER CIRCLE BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 009	Continued From page 1 10. The facility rules and regulations that residents must follow as described in rule 58A-5.0182, F.A.C.; 11. The facility policy concerning [redacted] pursuant to section 429.255, F.S., and rule 58A-5.0186, F.A.C., and Advance Directives pursuant to chapter 765, F.S.; 12. If the facility is licensed to provide extended congregate care, the facility's residency criteria for residents receiving extended congregate care services. The facility must also provide a description of the additional personal, supportive, and nursing services provided by the facility including additional costs and any limitations on where extended congregate care residents may reside based on the policies and procedures described in rule 58A-5.030, F.A.C.; 13. If the facility advertises that it provides special care for individuals with [redacted]'s [redacted] and related [redacted], a written description of those special services as required in section 429.177, F.S.; and, 14. The facility's resident elopement response policies and procedures. (b) Before or at the time of admission, the resident, or the resident's responsible party, guardian, or attorney-in-fact, if applicable, must be provided with the following: 1. A copy of the resident's contract that meets the requirements of rule 58A-5.025, F.A.C., 2. A copy of the facility statement described in paragraph (a) of this subsection, if one has not already been provided, 3. A copy of the resident's bill of rights as required by rule 58A-5.0182, F.A.C.; and, 4. A Long-Term Care Ombudsman Program brochure that includes the telephone number and address of the district office. (c) Documents required by this subsection must	A 009		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910371	A. BUILDING: _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBRIDGE TERRACE ASSISTED LIV RES - EDGEW.	23305 BLUE WATER CIRCLE BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 009	Continued From page 2 be in English. If the resident is not able to read, or does not understand English and translated documents are not available, the facility must explain its policies to a family member or friend of the resident or another individual who can communicate the information to the resident. 400.0078 2) Upon admission to a long-term care facility, each resident or representative of a resident must receive information regarding: (a) The purpose of the State Long-Term Care Ombudsman Program. (b) The statewide toll-free telephone number and e-mail address for receiving complaints. (c) Information that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. (d) Other relevant information regarding how to contact representatives of the State Long-Term Care Ombudsman Program This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the resident contract included all required information and documents for 2 of 2 sampled resident records reviewed. (Specifically Resident # 10 and # 11). The findings included: 1) On . . . . . a review of the contract for Resident # 11 was conducted. It was revealed that Resident # 11 was admitted into the facility on . The contract did not include a policy regarding the 45-day discharge notice issued by the facility 2.) The AHCA 1823 dated for Resident	A 009		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910371	A. BUILDING: _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBRIDGE TERRACE ASSISTED LIV RES - EDGEW.	23305 BLUE WATER CIRCLE BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A	Continued From page 3 #10 with a date of admission . . . . , the Contract Review section was reviewed. The contract agreement that includes the Bill of Rights in the admission package did not include the 45 day notice. On at 4:00 PM and interview was conducted with the Administrator and Staff D. The findings were acknowledged and no additional information was provided. Class	A 009		
A 010 SS=D	429.26(1&9) FS; 58A-5.0181(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination shall be based upon an assessment of the strengths, needs, and preferences of the resident, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the	A 010		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910371	A. BUILDING: _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBRIDGE TERRACE ASSISTED LIV RES - EDGEW.	23305 BLUE WATER CIRCLE BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 010	Continued From page 4 appropriate contact person in the applicable department. (9) A [illegible], ill resident who no longer meets the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident are being met. 58A-5.0181 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a [illegible]-to-[illegible] medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 58A-5.0131, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days. (b) A resident requiring care of a [illegible] may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider,	A 010		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910371	A. BUILDING: _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBRIDGE TERRACE ASSISTED LIV RES - EDGEW.	23305 BLUE WATER CIRCLE BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 010	Continued From page 5 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care provider, the resident must be discharged from the facility. (c) A [redacted] ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training.	A 010		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910371	A. BUILDING: _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBRIDGE TERRACE ASSISTED LIV RES - EDGEW.	23305 BLUE WATER CIRCLE BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 010	Continued From page 6 (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure that a resident's Health Assessment (AHCA 1823 form) was accurate and reflective of a resident's care needs (including any third party services and nursing needs) , for 1 of 2 sampled resident records reviewed (Resident # 10). The findings included: The AHCA 1823 form dated for Resident # 10 with a date of admission did not have the treatment of listed under Nursing/Treatment/ Service Requirements on page 1 of 5 and did not indicate if the resident was able to administer without assistance on page 4 of 5. On at 11:34 AM an interview was conducted with Resident # 10. The surveyor observed in the resident's room. The resident stated that she self-administers the and it is monitored by an outside agency. On at 3:00 PM a record review was conducted on Resident # 10's chart. There is no documentation on the AHCA 1823 that she is receiving and there is no documentation that she self-administers the . On at 3:22 PM and interview was conducted with Staff D and the Administrator regarding Resident # 10's AHCA 1823 not being updated with the and the	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910371	A. BUILDING: _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBRIDGE TERRACE ASSISTED LIV RES - EDGEW.	23305 BLUE WATER CIRCLE BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 010	Continued From page 7 self-administration of . ,, . Staff D stated that Resident # 10 came from the Skilled Nursing Facility (SNF) and they were completing the AHCA 1823's incorrectly. She stated that the SNF has a doctor that is completing the AHCA 1823's and they are inaccurate when they are sent to the Assisted Living Facility (ALF). She provided the surveyor with the physician order for the ,, . The physician order for the . ,, . (O 2) dated stated O 2 at 2 liters via (NC) every shift for , . , . . self administer. On . . . . . at 3:30 PM an interview was conducted with Staff E. She stated that the . ,, . was a medication and not a diagnosis for treatment so it should not be listed on the AHCA 1823. The surveyor explained to Staff E that the ,, has to be regulated and that it is the facility responsibility to ensure assistance and/or training is provided to the resident on how to perform these functions. On . . . . . at 04:30 PM, an interview was conducted with the Administrator. She acknowledged the findings. Class III	A 010		
A 031 SS=D	58A-5.0182(7) FAC 429.255(1)(b). FS Resident Care - Third Party Services 58A-5.0182 (7) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the	A 031		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910371	A. BUILDING: _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBRIDGE TERRACE ASSISTED LIV RES - EDGEW.	23305 BLUE WATER CIRCLE BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 031	Continued From page 8 resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the resident's needs. (c) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. 429.255(1)(b) All staff in facilities licensed under this part shall exercise their professional responsibility to observe residents, to document observations on the appropriate resident ' s record, and to report the observations to the resident ' s physician.	A 031		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910371	A. BUILDING: _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBRIDGE TERRACE ASSISTED LIV RES - EDGEW.	23305 BLUE WATER CIRCLE BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 031	Continued From page 9 However, the owner or administrator of the facility shall be responsible for determining that the resident receiving services is appropriate for residence in the facility. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure all staff in facilities licensed under this part shall exercise their professional responsibility to observe residents, to document observations on the appropriate resident ' s record, and to report the observations to the resident ' s physician for 1 of 2 sampled resident records reviewed. (Specifically, Resident # 11). The findings included: On a review of the facility census revealed that the Director of Assisted Living highlighted the name of Resident # 11 to identify the fact that she was receiving Third Party Provider services. Resident # 11's name was marked with a note indicating "Home Health." On a review of the medical record was conducted for Resident # 11. The demographics form indicated that the Resident was admitted into the facility on . The initial Florida Health Assessment (AHCA 1823 form) reviewed was dated . The updated Florida Health Assessment (AHCA 1823 form) dated , revealed that the Resident suffered from the following diagnosis: , , , Hyperliidemia, 's , and . She requires assistance with bathing and . The Resident ambulates with a walker. The AHCA 1823 form did not reflect Home Health services were provided under the section of Nursing/treatment/ , , services.	A 031		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910371	A. BUILDING: _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBRIDGE TERRACE ASSISTED LIV RES - EDGEW.	23305 BLUE WATER CIRCLE BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 031	Continued From page 10 On at 03;00 PM, a request was made to the Director of Assistant Living to provide nursing progress notes that coincide with the updated 1823 form, dated . The progress notes for the year 2019 were not received by 04:40 PM on . The documentation was not received to reflect the significant change in the Resident's condition. The notes were not provided indicating the type of service provided by Home Health, the frequency of their visits and the outcome of this service. On at 04:00 PM, an interview was conducted with the Director of Assistant Living, Registered Nurse (RN). She stated that the Resident has 's . She indicated that her condition has worsened. She stated the Resident and her Care Manager consented to daily Home Health Services to provider personal care for bathing and . She indicated that the Progress notes are updated in their electronic system based on exception, (change in condition). These notes were not evidenced. On at 04:30 PM, an interview was conducted with the Administrator. She refuted the findings. Class III	A 031		
A 032 SS=B	58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(i) Resident Care - Elopement Standards 58A-5.0182 (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified	A 032		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910371	A. BUILDING: _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBRIDGE TERRACE ASSISTED LIV RES - EDGEW.	23305 BLUE WATER CIRCLE BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 032	Continued From page 11 so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 58A-5.0181(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 58A-5.0191(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910371	A. BUILDING: _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBRIDGE TERRACE ASSISTED LIV RES - EDGEW.	23305 BLUE WATER CIRCLE BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 032	Continued From page 12 premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to sections 429.41(1)(a)3. and 429.41(1)(l), F.S. 429.41(1)(a)3 & 3(l),FS 3. Resident elopement requirements.-Facilities are required to conduct a minimum of two resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills which shall include a review of procedures to address resident elopement. Facilities must document the implementation of the drills and ensure that the drills are conducted in a manner consistent with the facility's resident elopement policies and procedures. (l) The establishment of specific policies and procedures on resident elopement. Facilities shall conduct a minimum of two resident elopement drills each year. All administrators and direct care staff shall participate in the drills. Facilities shall document the drills. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that resident elopement requirements are met. The facility failed to	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910371	A. BUILDING: _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBRIDGE TERRACE ASSISTED LIV RES - EDGEW.	23305 BLUE WATER CIRCLE BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 032	Continued From page 13 conduct a minimum of two resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills which shall include a review of procedures to address resident elopement. The findings included: On at 10:00 AM, a request was made of the Administrator and the Director of Assisted Living to provide the documentation and evidence of the elopement drills for the past two years. The facility failed to include two resident elopement prevention and response drills for the past two years including Mock drills and a review of the procedures to address resident elopement. On . . . . . a review of the elopement drills was conducted. It was revealed that the all direct care staff on each shift, along with the Administrator completed the Mock drills on the following dates: . . . . . , ... A review of the employee records reveal an in-service reviewing the procedures to address resident elopement was conducted . On at 04:30 PM, an interview was conducted with the Administrator. She refuted the findings as she stated that the Director of Assisted Living had conducted a desk review (in-service), for the elopement drills was conducted with all direct care staff. She was advised that the requirement was not met, as the regulation requires participate in the drills which shall include a review of procedures to address resident elopement. Class	A 032		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910371	A. BUILDING: _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBRIDGE TERRACE ASSISTED LIV RES - EDGEW.	23305 BLUE WATER CIRCLE BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 054	Continued From page 14	A 054		
A 054 SS=B	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known [illegible] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [illegible], the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on observation and record review, it was determined the facility failed to follow the proper procedures for providing assistance with self	A 054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910371	A. BUILDING: _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBRIDGE TERRACE ASSISTED LIV RES - EDGEW.	23305 BLUE WATER CIRCLE BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 054	Continued From page 15 -administration of medication, for 1 out of 2 sampled residents (Resident # 11) by pre-signing the Medication Observation Record (MOR) that the medication was given at the facility when the medication was given to the resident's family member to give to the resident later that day and failed to document in the MOR that the medication was given to the family member upon leaving the facility. The findings included: During a medication-pass observation conducted with Staff A at 12:00 PM on , she stated that the medication for Resident # 11 was given to her son to take home with her to be given at 12:00 PM. The medication for Resident # 11 is , - , Tablet 24- 100 MG Give 1 tablet by for 's . Staff A pre-signed the MOR for the 12:00 PM medication for Resident # 11 that the medication was given by her at the facility. On at 2:21 PM, the surveyor spoke with Staff A, Staff D, and Staff E regarding Resident # 11 medication being sent home with the son to be given at 12:00 PM. The MOR was signed by Staff A at 12:00 PM that the medication was given by Staff A to Resident # 11 at the facility. Staff E stated that they do not keep a log where they track medications that are given to the family members or representatives to take with them when the resident leaves the facility. She stated that they never thought of it that way. She said that they would have to speak with upper management to see if there is some where in the computer that they can log when the medication is given to the family member to take home, but they were not aware of it.	A 054		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910371	A. BUILDING: _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBRIDGE TERRACE ASSISTED LIV RES - EDGEW.	23305 BLUE WATER CIRCLE BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 054	Continued From page 16 On at 3:05 PM, Staff E stated that they have an option in the computer but they were not using it. There is an option in the computer where they can select that they did not give the medication to the resident and the resident can take the medication with them. Staff E stated that she did not know that she could do that. During an interview with the Administrator on at 4:38 PM, she acknowledged the findings and no additional information was provided. Class	A 054		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910371	A. BUILDING: _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBRIDGE TERRACE ASSISTED LIV RES - EDGEW.	23305 BLUE WATER CIRCLE BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ814 SS=C	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12(2) Care Provider Background Screening Clearinghouse.- (b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; [illegible]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure an employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any	CZ814		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910371	A. BUILDING: _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBRIDGE TERRACE ASSISTED LIV RES - EDGEW.	23305 BLUE WATER CIRCLE BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ814	Continued From page 1 changes in status must be reported within 10 business days for 17 of 17 sampled employees. (Staff A - Staff Q). The findings included: On . . . . . a review of the Background Screening Clearing House was conducted for the Assisted Living Facility (ALF), license. It was revealed that the facility staff was not listed on the employee Roster. The following Staff were not listed: Staff Hire Date A . . . . . . B C . . . . . . D E . . . . . . F G . . . . . . H I . . . . . . J K . . . . . . L M . . . . . . N O . . . . . . P On , a review of the employee staffing schedule was conducted. It was revealed that there were 17 direct care staff employed in the facility. On . . . . . at 04:00 PM, an interview was conducted with the Administrator of the facility. She was advised that the employee names were not located under the Assisted Living employee	CZ814		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910371	A. BUILDING: _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBRIDGE TERRACE ASSISTED LIV RES - EDGEW.	23305 BLUE WATER CIRCLE BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ814	Continued From page 2 roster. She stated that the previous Surveyor advised her that she could list the names of the ALF employees under the Skilled Nursing Home roster. She refuted the findings. Unclassified	CZ814		
CZ816 SS=C	408.809(2)(a-c); 59A-35.090(2)(d)-(3) Background Screening-Compliance Attestation 408.809 (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's ... to the Federal Bureau of Investigation for a national criminal history record check unless the person's ... are enrolled in the Federal Bureau of Investigation's national retained print notification program. If the ... of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit ... electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the ... to the Federal Bureau of Investigation for a national criminal history record check. The ... shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print notification program when the Department of Law Enforcement begins	CZ816		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910371	A. BUILDING: _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBRIDGE TERRACE ASSISTED LIV RES - EDGEW.	23305 BLUE WATER CIRCLE BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ816	Continued From page 3 participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person . Until a specified agency is fully implemented in the clearinghouse created under s. 435.12, the agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the agency, the Department of Health, the Department of Elderly Affairs, the Agency for Persons with , the Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 59A-35.090(2) Processing Screening Requests, Required Documents and Fees. (d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09106, and available from the Agency for Health Care Administration at:	CZ816		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910371	A. BUILDING: _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBRIDGE TERRACE ASSISTED LIV RES - EDGEW.	23305 BLUE WATER CIRCLE BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ816	Continued From page 4 http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Regulations_Forms.shtml. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if . . . . . for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to , , . to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the . . . . report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with section 435.06(3), F.S. (c) The eligibility results of employee screening and the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., must be in the employee's personnel file, maintained by the provider.	CZ816		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910371	A. BUILDING: _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKBRIDGE TERRACE ASSISTED LIV RES - EDGEW.	23305 BLUE WATER CIRCLE BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ816	Continued From page 5 This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the eligibility results of employee screening and the signed Attestation must be in the employee's personnel file, maintained by the provider. The facility failed to ensure that every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening for 3 of 3 sampled staff records reviewed. (Specifically, Staff A, B, and C). The findings included: On a review of the employee personnel files was conducted. The following direct care staff was found to have an Attestation form that was not consistent with the Level II Background Screening completed. Staff Date of hire Attestation date Level II Screening Staff A Staff B Staff C On at 04:30 PM, an interview was conducted with the Administrator. She acknowledged the findings. Unclassified	CZ816		