STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL11969598	RIVERS EDGE ASSISTED LIVING LLC

Type of Survey (select all that apply)

2 D

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
M Other
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW

Extent of Survey (select all that apply)

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1. 48098	08/25/2026	08/25/2026	0.25	0.00	3.00	0.00	2.50	0.50
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.25

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.50

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

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
	AL11969598	A. BUILDING: _____ B. WING _____	R 08/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE ASSISTED LIVING LLC	1315 ROCKLEDGE DR ROCKLEDGE, FL 32955

(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 A revisit to the re-licensure survey and generator monitoring was conducted at Rivers Edge Assisted Living with Limited Mental Health on 8/25/26. The facility had no deficiencies at the time of the survey.	{A 000}		

AHCA Form 3020-0001

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