

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964831	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/18/2025
NAME OF PROVIDER OR SUPPLIER ARBOR OAKS ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1701 68 STREET, NORTH SAINT PETERSBURG, FL. 33710		
(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 follow-up survey was conducted via desk review on 12/19/2025 for Arbor Oaks Assisted Living Facility. Previously cited deficiencies were corrected. Amended 12/19/2025	{A 000}			

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE