

Agency for Health Care Administration

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|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11964831</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>03/19/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ARBOR OAKS ASSISTED LIVING FACILITY</b> |                                                                                                                                                                                                                                                            |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1701 68 STREET, NORTH<br/>SAINT PETERSBURG, FL. 33710</b>                    |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                               | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 000                                                                          | Initial Comments<br><br>A complaint investigation [complaint number 2025017485] in conjunction with a Generator monitoring was conducted at Arbor Oaks Assisted Living Facility on 03/19/2026. 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

(X8) DATE