

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910251	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER INDIAN OAKS MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 11355 131ST STREET N LARGO, FL 33774		
(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 Assisted Living Facility A revisit to the complaint surveys of ____/____/____ was conducted on ____ in conjunction with a revisit to the complaint surveys of ____/____/____, (see Aspen Event HLQN12) and the complaint surveys, CCR# 2012009832 and CCR# 2012007852, (see Aspen Event QRV511). Indian Oaks Manor assisted living facility had uncorrected deficiencies found at the time of the visit.	{A 000}		
{A 052}	58A-5.0185(3) FAC Medication - Assistance with Self-Admin (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) For facilities which provide assistance with self-administered medication, either: a nurse; or an unlicensed staff member, who is at least _____, trained to assist with self-administered medication in accordance with Rule 58A-5.0191, F.A.C., and able to demonstrate to the administrator the ability to accurately read and interpret a prescription label, must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. (b) Assistance with self-administration of medication includes verbally prompting a resident to take medications as prescribed, retrieving and opening a properly labeled medication container, and providing assistance as specified in Section 429.256(3), F.S. In order to facilitate assistance with self-administration, staff may prepare and make available such items as water, juice, cups, and spoons. Staff may also return unused doses to the medication container. Medication, which	{A 052}		

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0099

L22M12

If continuation sheet 1 of 10

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910251	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER INDIAN OAKS MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 11355 131ST STREET N LARGO, FL 33774		
(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 052}	Continued From page 1 appears to have been contaminated, shall not be returned to the container. (c) Staff shall observe the resident take the medication. Any concerns about the resident's reaction to the medication shall be reported to the resident's health care provider and documented in the resident's record. (d) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule which coincides with the resident's presence in the facility; 2. The medication container may be given to the resident or a friend or family member upon leaving the facility, with this fact noted in the resident's medication record; 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record; or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging; (e) Pursuant to Section 429.256(4)(h), F.S., the term "competent resident" means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication. (f) Pursuant to Section 429.256(4)(i), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (4) Assistance with self-administration does not include: (a) Mixing, _____, converting, or _____	{A 052}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910251	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER INDIAN OAKS MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 11355 131ST STREET N LARGO, FL 33774	
(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 052}	Continued From page 2 medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications through intermittent positive pressure breathing machines or a _____. (d) Administration of medications by way of a tube inserted in a cavity of the body. (e) Administration of _____ preparations. (f) Irrigations or debriding agents used in the treatment of a skin condition. (g) _____, or _____ preparations. (h) Medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident. (i) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to insure that staff followed the correct procedure for assistance with self-administration of medication for at least one of one (Resident #2) sampled residents. Failure to properly assist with self-administration of medication can place residents at risk through medication errors. Findings include:	{A 052}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910251	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER INDIAN OAKS MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 11355 131ST STREET N LARGO, FL 33774		
(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 052}	Continued From page 3 On _____ at approximately 7:45 AM, AHCA staff observed Employee B preparing medications for Resident #2. Employee B was at the medication cart in the main dining. Resident #2 was in her _____. Employee B pulled out labeled medications in bubble packs from the medication cart. Employee B then popped the medications into a souffle' cup. After popping the medications into the souffle' cup, Employee B initiated the MORS. Once she prepared the medications for Resident #2, Employee B prepared the medications for other residents in the same manner. At one point, Employee B stated she had to use the rest _____. She stacked the souffle' cups on top of one another in the medication cart, locked the medication cart and went to use the rest _____. Upon returning to the cart, Employee B placed the souffle' cups of medication on a plate and took them to the residents. Employee B approached Resident #2 in her _____. She handed her the souffle' cup with water. Employee B did not advise the resident what medications she was receiving or provide her any information on the medications. AHCA staff observed written instructions in the front of the MORS book advising that the MORS are to be initiated after the residents are observed taking their medications. AHCA staff interviewed the administrator on _____. The administrator acknowledged the findings and stated he would expect at a minimum that the souffle' cups have the resident's initials on them. Class III Widespread	{A 052}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910251	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER INDIAN OAKS MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 11355 131ST STREET N LARGO, FL 33774	
(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 4	{A 054}		
{A 054}	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed under subsection (2), the facility shall 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 shall maintain a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications or medication administration. A MOR must include the name of the resident and any known the resident may have; the name of the resident's health care provider, the health care provider's telephone number; the name, strength, and directions for use of each medication; and a chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. The MOR must be immediately updated each time the medication is offered or administered. (c) For medications which serve as chemical , the facility shall, 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, interview and record review, the facility failed to follow proper procedures for maintaining a daily medication observation record (MOR) for one of one sampled residents. (Resident #2) Specifically, the facility did not insure that staff recorded any	{A 054}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910251	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER INDIAN OAKS MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 11355 131ST STREET N LARGO, FL 33774		
(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)
{A 054}	Continued From page 5 missed dosages or refusals to take medications. Findings include: On _____ at approximately 7:45 a.m., AHCA staff observed Employee B completing a med pass at the facility. While preparing medication for Resident #2, Employee B stated that Resident #2 was out of one of her medications (_____ 40 MG) and it had not yet been delivered by the pharmacy. Employee B stated that Resident #2 had been out of the medication since the previous day. Employee B signed the MOR for the date and time of the dosage and circled the signature. AHCA staff asked Employee B how she documented the missed dose and Employee B pointed to the circled signature. AHCA staff asked if she documented the missed dose anywhere else and she stated "No." AHCA staff reviewed the MORS for Resident #2 and confirmed that there was no record of the missed dosages of medication outside of circling the signature. AHCA staff interviewed the administrator at 1:00 p.m. on _____ and the administrator acknowledged the findings. Class III _____		{A 054}	
{A 078}	58A-5.019(2) FAC Staffing Standards - Staff (2) STAFF. (a) Newly hired staff shall have 30 days to submit a statement from a health care provider, based on an examination conducted within the last six months, that the person does not have any signs		{A 078}	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910251	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER INDIAN OAKS MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 11355 131ST STREET N LARGO, FL 33774		
(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 078}	Continued From page 6 or symptoms of a communicable including . Freedom from must be documented on an annual basis. A person with a positive . test must submit a health care provider ' s statement that the person does not constitute a risk of communicating . Newly hired staff does not include an employee transferring from one facility to another that is under the same management or ownership, without a break in service. If any staff member is later found to have, or is suspected of having, a communicable he/she shall be removed from duties until the administrator determines that such condition no longer exists. (b) All staff shall be assigned duties consistent with his/her level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff shall exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident ' s record, and to report the observations to the resident ' s health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of Rule 58A-5.0191, F.A.C. (d) Staff provided by a staffing agency or employed by a business entity contracting to provide direct or indirect services to residents must be qualified for the position in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor shall specifically describe the services the staffing agency or contractor will be providing to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility shall: 1. Develop a written job description for each staff	{A 078}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910251	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER INDIAN OAKS MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 11355 131ST STREET N LARGO, FL 33774		
(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)	
{A 078}	Continued From page 7 position and provide a copy of the job description to each staff member; and 2. Maintain time sheets for all staff. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to insure that one of four sampled employees (Employee A) obtained annual statements from a medical provider indicating they were free of communicable including _____. Failure to insure that staff are free of communicable _____ can place residents at risk of illness. Findings include: AHCA staff reviewed the record for Employee A on _____. The record contained documentation signed by a medical provider indicating that Employee A had a _____ test on _____. The record had a statement signed by a medical provider indicating Employee A was free of communicable _____ dated _____. AHCA staff interviewed the facility administrator on _____ at approximately 1:00 p.m. and he acknowledged the findings. Class III	{A 078}		
{A 152}	58A-5.023(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to Section 429.28(1)(a), F.S.; and 2. Must be maintained free of hazards; and	{A 152}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910251	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER INDIAN OAKS MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 11355 131ST STREET N LARGO, FL 33774		
(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 152}	Continued From page 8 3. Must ensure that all existing architectural, mechanical, electrical and structural systems and appurtenances are maintained in good working order. (b) Pursuant to Section 429.27, F.S., residents shall be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress a comfortable height to ensure easy access by the resident; 2. A closet or wardrobe space for hanging clothes; 3. A dresser, chest or other furniture designed for storage of personal effects; 4. A table, bedside lamp or floor lamp, and waste basket; and 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility shall be free of tears, stains and not be This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain a safe living environment free of hazards for the residents.	{A 152}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910251	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/2
NAME OF PROVIDER OR SUPPLIER INDIAN OAKS MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 11355 131ST STREET N LARGO, FL 33774		
(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)	
(A 152)	Continued From page 9 Findings include: AHCA staff toured the facility on _____ at approximately 9:30 AM. AHCA staff observed the following: The sprinkler heads and the vents in the main dining _____ the tables were coated with dust. _____ smelled strongly of _____ and had brown stains on the tile floor by the bed and near the _____. _____ had a strong musty smell and there live ants in the _____, on the faucet and on the wall. The water fountain in the back dining running and leaking/dripping on the floor. A wall vent outside of _____ was hanging away from the wall and was covered in brown grime. The washing machines in the laundry laundry soap caked on them, along with gray dust/grime. AHCA staff interviewed the administrator on _____ and he acknowledged the findings and stated the staff have been doing a better job overall at cleaning the facility. Class III Widespread	(A 152)		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA /
Identification Number
AL11910251(Y2) Multiple Construction
A. Building
B. Wing(Y3) Date of Revisit
9/27/2012

Name of Facility

INDIAN OAKS MANOR

Street Address, City, State, Zip Code

11355 131ST STREET N
LARGO, FL 33774

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
	Correction Completed		Correction Completed		Correction Completed
ID Prefix A0025		ID Prefix A0026		ID Prefix A0029	
Reg. # 58A-5.0182(1) FAC		Reg. # 58A-5.0182(4) FAC		Reg. # 58A-5.0182(5) FAC	
LSC		LSC		LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix A0056		ID Prefix A0081		ID Prefix A0084	
Reg. # 58A-5.0185(7) FAC		Reg. # 58A-5.0191(2) FAC		Reg. # 58A-5.0191(5) FAC	
LSC		LSC		LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix AZ815		ID Prefix		ID Prefix	
Reg. # 408.809, 435.02(2), 435.06		Reg. #		Reg. #	
LSC		LSC		LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By

State Agency

Reviewed By

CMS RO

Followup to Survey Completed on:

Date:

10/8/12

Date:

Signature of Surveyor:

Date:

Signature of Surveyor:

Date:

Check for any Uncorrected Deficiencies. Was a Summary of
Uncorrected Deficiencies (CMS-2567) Sent to the Facility?

YES

NO

RICK SCOTT
GOVERNOR



Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Indian Oaks Manor
11355 131st Street N
Largo, FL 33774

Dear Administrator:

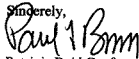
Re: Revisit & CCR# 2012009832 & CCR# 2012007852

This letter reports the findings of a state licensure survey revisit and two complaint surveys that were conducted on 07/27, 2012, by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the uncorrected deficiencies that were identified on the day of the visit relative to the revisit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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.

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

Sincerely,

for Patricia Reid Cauffman
Field Office Manager

PRC/kpr

Enclosures: Revisit Report & State Form 3020

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
<http://ahca.myflorida.com>



St. Petersburg Field Office
6525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone (727) 552-2000; Fax (727) 552-1161