STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910842	**07/10/2014**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Oaks Of Clearwater, The	**420 Bay Avenue Clearwater, FL 33756**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Revisit Corrected Tags:

0052-Medication - Assistance With Self-Admin-07/10/2014
0091-Training - Documentation & Monitoring-07/10/2014

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

July 10, 2014

Administrator
Oaks of Clearwater, The
420 Bay Avenue
Clearwater, FL 33756

Dear Administrator:

This letter reports the findings of a state licensure follow-up (desk review) conducted on July 10, 2014, by representative(s) of this office.

Attached is the provider's copy of the State Form 5000-3547, which indicates the previously cited deficiencies were found corrected on the day of the desk review.

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(s). Should you have any questions please call **Paul Brown**, HFES, at (727) 552-2000.

Sincerely,

for Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State Form 5000-3547

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