STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943004	**10/29/2014**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Cox Adult Living Facility	**1906 Oscar Cox Trail Plant City, FL 33567**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Revisit Corrected Tags:

0083-Training - First Aid And Cpr-10/29/2014
0084-Training - Assis Self-Admin Meds & Med Mgmt-10/29/2014
0093-Food Service - Dietary Standards-10/29/2014
0123-Fiscal - Resident Trust Funds-10/29/2014

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

October 29, 2014

Administrator
Cox Adult Living Facility
1906 Oscar Cox Trail
Plant City, FL 33567

Dear Administrator:

This letter reports the findings of a state licensure follow-up (desk review) conducted on October 29, 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,

Patricia Reid Caufman
for Field Office Manager

PRC/cit

Enclosure: State (5000-3547) Form

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