AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964831	03/22/2016
NAME OF PROVIDER OR SUPPLIER **ARBOR OAKS AT TYRONE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1701 68 STREET, NORTH** **SAINT PETERSBURG, FL 33710**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

ASSISTED LIVING FACILITY

On ,2016, a biennial relicensure survey was conducted at Arbor Oaks at Tyrone assisted living facility. Deficient practice was identified during the survey.

0078 Staffing Standards - Staff

Based on record review and interview, the facility did not receive a written statement from a health care provider documenting the staff does not have any signs or symptoms of communicable within thirty (30) days of hire for one (#B) of three direct care staff who were sampled for communicable statements.
The facility failed to have personnel files which contained annual examination for one (#B) of three direct care staff who were sampled for examinations.

Findings included:

Record review on of direct care staff #B's personnel file revealed she was hired on and there was no communicable statement in her file. Staff #B had thirty (30) days to give the communicable statement to the facility.

Record review on / of direct care staff #B's personnel file revealed the last examination was on on . examinations must be done annually.

The administrator verified on at 2:00 pm that staff #B did not have a communicable statement in her file and her examination had not been done annually.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Arbor Oaks At Tyrone
1701 68 Street, North
Saint Petersburg, FL 33710

Dear Administrator:

This letter reports the findings of a biennial state licensure survey that was conducted on , 2016 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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
Field Office Manager

PRC/clt
Enclosure

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