AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943004	09/09/2016
NAME OF PROVIDER OR SUPPLIER **COX ADULT LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **1906 Oscar Cox Trail** **PLANT CITY, FL 33567**	

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

0000 Initial Comments

On , , 2016 an Abbreviated relicensure survey with Limited Mental Health was conducted at Cox Adult Family Living. Cox Adult Family Living had deficient practice at the time of the survey.

License # 8319

Z814 Backaround Screenina Clearinahouse

Based on interview and record review, the Assisted Living Facility failed to register 3 of 3 sampled employees (Employee A, Employee B and Employee C with the Background Screening Clearinghouse within 10 days upon initial employment.

Findings include:

A review of the Background Screening Clearinghouse on revealed that Employee A, Employee B and Employee C's names did not appear on the Facility Employee Roster.

On / at 11:00 am, an interview was conducted with Employee A. Employee A stated she was unaware that the employees of the Assisted Living Facility needed to be registered on the Background Screening Clearinghouse.

At this time, the reason for registering employees was explained and the number to call was given. Employee A stated she called the number provided and is awaiting an email with instructions on how to register her employees with the Background Screening Clearinghouse.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

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

Dear Administrator:

This letter reports the findings of a abbreviated biennial state licensure survey with limited mental health (LMH) 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,

for Patricia Reid Caufman
Field Office Manager

PRC/clt
Enclosure: State (5000-3547) Form

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