AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910845	10/27/2016
NAME OF PROVIDER OR SUPPLIER **OAKWOOD EAST RETIREMENT CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **1210 EAST OAKWOOD** **TARPON SPRINGS, FL 34689**	

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

0000 Initial Comments

Assisted Living Facility

An abbreviated biennial state licensure survey was conducted at Oakwood East Retirement Center Assisted Living Facility on . Oakwood East Retirement Center, Assisted Living Facility, had deficient practice identified at the time of the survey.

(License # 4831)

Z814 Background Screening Clearinghouse

Based interview, and record review, the facility failed to maintain the employment status of employees within the AHCA background screening clearinghouse (Employee Roster), within 10 business days of initial employment or change of status, for 1 (Staff B) of 3 employees reviewed.

Findings included:

A review of employee records conducted on showed the following date of hires for staff: Staff B: / .
The Employee Roster was reviewed on and showed that staff B name was not listed on the AHCA background screening clearinghouse (Employee Roster).
The administrator was interviewed at 11:43 AM on and was shown the current Employee Roster on a computer screen. The administrator observed the Employee Roster and acknowledged that staff B name was not listed on the AHCA background screening clearinghouse (Employee Roster) at this time. The administrator confirmed staff B is a current employee and provides daily care and services to Residents at the facility.

Unclassified

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Oakwood East Retirement Center
1210 East Oakwood
Tarpon Springs, FL 34689

Dear Administrator:

This letter reports the findings of an abbreviated 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 deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency 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 deficiency 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.

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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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