

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 12/20/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964831	(X3) DATE SURVEY COMPLETED 12/09/2016
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

A complaint investigation, (CCR# 2016010930), was conducted at Arbor Oaks at Tyrone on 12/9/16. Arbor Oaks at Tyrone had a deficiency at the time of the investigation.

(License # 9299)

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on interview and record review, the facility failed to provide proof of required in-service training, within 30 days of employment, for 1 (Staff C) of 4 employee records reviewed.

Findings included:

A review of employee records conducted on 12/9/16 showed that Staff C had a date of hire of 12/9/16. The review of Staff C's record also showed a lack of a training certificate in the subject of resident rights in an assisted living facility (Resident Rights).

Business Office Manager was interviewed at 2:45 PM on 12/9/16 concerning the lack of a training certificate for Resident Rights in Staff C's record. Business Office Manager reviewed the record and acknowledged that it wasn't there.

Class III



RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

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

RE: CCR# 2016010930

Dear Administrator:

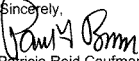
This letter reports the findings of a complaint survey that was conducted on , 2016, by representative(s) of this office.

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 the identified deficiency. 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.



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 Cauffman
Field Office Manager

PRC/kpr

Enclosure: State Form 5000-3547

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