STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910251	12/09/2016
NAME OF PROVIDER OR SUPPLIER **INDIAN OAKS MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **11355 131ST STREET N** **LARGO, FL 33774**	

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

0000 - Initial Comments

Assisted Living Facility

A Biennial Survey was conducted at Indian Oaks Assisted Living Facility on . Indian Oaks Assisted Living Facility had deficient practice identified at the time of survey.

License: 6056

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on interview and record review, the facility failed to maintain required documentation of an annual, negative examination for 1 (Staff B) of 3 records reviewed.

Findings Included:
An employee record review was conducted on . It was discovered that the staff B had no documented proof of an annual, negative examination (exam) in personal file.
An interview with the Administrator on 2:11 P.M. confirmed staff B currently provides daily care and services to Residents on a daily basis, however did not have a annual (examination) within the past year. No further documentation was provided at this time.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

[illegible], 2016

Administrator
Indian Oaks Manor
11355 131st Street N
Largo, FL 33774

Dear Administrator:

This letter reports the findings of a biennial state licensure survey that was conducted on [illegible], 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 [illegible], 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 [illegible]ufman
Field Office Manager

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

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