

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932515	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/15/2022
NAME OF PROVIDER OR SUPPLIER OAKVIEW TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 7220 BAILLIE DRIVE NEW PORT RICHEY, FL 34653			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 000	Initial Comments A complaint (complaint number 2022006903 and 2022007973) survey in conjunction with a revisit to the biennial survey of 4/22/2022 and second revisit to the complaint (complaint numbers 2022001529, 2022001673 and 2022002992) survey of 3/2/2022 and fourth revisit to the complaint (2021015328 and 2021015724) survey of 11/17/2021 and a generator monitoring survey was conducted at Oakview Terrace on 6/15/2022. The facility had no deficiencies at the time of survey.	A 000			

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE