STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910145	02/23/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sandpiper Alf	6439 First Avenue, South Saint Petersburg, FL 33707	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - L243 - 429.075(1) Fs; 58a-5.0191(8) Fac - Lmh - Training S-S= D

0000-Initial Comments

Assisted Living Facility

A biennial state licensure survey with limited mental health (LMH) services was conducted on .

The Sandpiper Assisted Living Facility had a deficiency at the time of the visit.

L243-LMH - Training 429.075(1) FS; 58A-5.0191(8) FAC

Based on interview and record review that assisted living facility failed to ensure 1 of 3 sampled staff (Employee A) who has direct contact with mental health residents obtained the required 3 hours of continuing education of specialized training in working with mental health residents.

Findings include:

On , a record review of Employee A's employee file revealed a Limited Mental Health (LMH) training certificate dated . No evidence was located in Employee A's file to confirm that Employee A received additional training.

On at 1:55p.m. an interview was conducted with the assisted living facility administrator. The Administrator stated Employee A had only one LMH training. The Administrator stated she was unaware of the required biennial 3 hours of continuing education LMH training update.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

..., 2015

Administrator
Sandpiper ALF
6439 First Avenue, South
Saint Petersburg, FL 33707

Dear Administrator:

This letter reports the findings of a biennial state licensure survey with limited mental health (LMH) that was conducted on , 2015, 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. Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiency identified on your survey.

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/kpr

Enclosure: State (5000-3547) Form

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