AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932380	R
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
BAY PINES MANOR	**10591 BAY PINES BLVD. SAINT PETERSBURG, FL 33708**	

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

0000 - Initial Comments

Assisted Living Facility

On [redacted] A revisit was conducted to complaint surveys, CCR# 2014011865.

Bay Pines Manor had uncorrected deficiencies at the time of the visit.

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on record review and interview the facility failed to ensure Staff A a live in employee had documentation of completeing the requried training with in thirty days of employement. Staff A had a backgeound check available for review on line.

Findings include :

During a revisit to complaint survey CCR32014011856 and CCR# 2014011962 it was revealed the live in employee Staff A who was hired on [redacted] did not have evidence of completeing the required training with in thirty days of employement.
The employee's file did not contain documentation of completed trainings and there were not training certificates available for review.

During A phone conversation with the administrator he stated he was selling the busness and has not taken the time to make the corrections from the past survey.

Class III

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

Based on a phone interview with the administrator on [redacted] at approximately 11:30 AM he did not complete the annual [redacted] test and did not have documentation from a health care provider that he did not have signs and systems of communicable [redacted]

Finding Include:

During a revisit to complaint survey CCR32014011856 and CCR# 2014011962 it was revealed the administrator had not completed an annual [redacted] examination and the last documented [redacted] test expired [redacted] During a phone conversation the administrator on [redacted] at approximately 11:30am he confirmed there was not the required annual [redacted] test or a written statement from a health care provider stating he did not have signs or systems

AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932380	R **05/06/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
BAY PINES MANOR	**10591 BAY PINES BLVD. SAINT PETERSBURG, FL 33708**	

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

0078 Continued From page 1

of communicable ..... available for review.
Class III

0080 - Training - Core & Competency Test - 429.52(1-2) FS; 58A-5.0191(1) FAC

Based on an interview with the administrator it was revealed he had not completed the required core training.

Finding Include:

During a revisit to CCR32014011856 and CCR# 2014011962 it was revealed the administrator did not have a plan of correction completed. A phone conversation on ..... at approximately 11:30 AM it was stated by the administrator that he had not attended the required core training. The administrator stated he had not had the opportunity to find out when the core classes were available and had not signed up for the training yet.
Class III

AH Form Approved

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11932380	A. Building B. Wing	05/06/2015

Name of Facility	Street Address, City, State, Zip Code
BAY PINES MANOR	10591 BAY PINES BLVD. SAINT PETERSBURG, FL 33708

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix A0161 Reg. # 429.275(2) FS; 58A-5.024(2) LSC		ID Prefix AZ815 Reg. # 408.809, 435.02(2), 435.06 LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	[signature]	5/15/15		
Reviewed By CMS RO				

Followup to Survey Completed on:

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

YXLH12

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2015

Administrator
Bay Pines Manor
10591 Bay Pines Blvd.
Saint Petersburg, FL 33708

Dear Administrator:

This letter reports the findings of a revisit survey conducted on , 2015 by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

All deficiencies shall be corrected no later than , 2015.

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. Should you have any questions please call this office at (727) 552-2000.

Sincerely,

for Patricia Reid Caufman
Field Office Manager

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

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