AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967286	04/21/2016
NAME OF PROVIDER OR SUPPLIER **LOVING CARE OF ST PETERSBURG**	STREET ADDRESS, CITY, STATE, ZIP CODE **1001 9TH STREET NORTH SAINT PETERSBURG, FL 33701**	

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

0000 Initial Comments

Assisted Living Facility

On , , 2016 a Biennial relicensure with LMH survey in conjunction with complaint survey (CCR#2016001907) (Aspen file SJHN11) was conducted at Loving Care of St. Petersburg. Deficient practice was identified during the surveys.

0083 Trainina - First Aid and

Based on interview, observation and record review the facility failed to ensure a staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses was in the facility at all times.

Findings include:

On / / a record review was conducted for staff B who was hired on / / . Staff B's record review revealed her and First Aid expired on / .
On / at 6:00 am Staff B was observed by the surveyor to be working alone in the facility.
On / at 6:00 am an interview was conducted with Staff B. Staff B stated she works alone and is currently the only staff member in the facility.
On / at 12:56 pm an interview was conducted with the Administrator. The Administrator stated Staff B works alone in the facility.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Loving Care of St Petersburg
1001 9th Street North
Saint Petersburg, FL 33701

RE: CCR #2016001907 & Biennial with Limited Mental Health (LMH)

Dear Administrator:

This letter reports the findings of a complaint & a biennial with limited mental health (LMH) state licensure 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 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 , 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.

St. Petersburg Field Office
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Youtube.com/AHCAFlorida
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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,

Paul J Brown

for Patricia Reid Caufman
Field Office Manager

PRC/clt

Enclosure: State (5000-3547) Form

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