STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967286	R
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

A revisit to a complaint investigation, CCR# 2016001907, was conducted at Loving Care of St. Petersburg on . Loving Care of St. Petersburg, Assisted Living Facility, had an uncorrected deficiency at the time of the visit.

0052 Medication - Assistance with Self-Admin

Based on observation and interview the facility failed to ensure that staff C practiced control and followed the proper procedures during the morning medication pass for 4 (#1, #2, #3, #4) of 4 residents observed.

Findings included:

During an observation on / of the morning medication pass for residents (#1, #2, #3, #4) staff C did not address the residents by name, did not sanitize his hands and did not tell the residents the medication they were about to take.
The residents were lined up in front of the counter to receive their medication. At 7:58am resident #1 was first in line. The med/Tech gathered the medication, popped the pills into a souffle cup and gave the pills to the resident. The resident put the pills in his mouth and the med tech filled the souffle cup with water for the resident to swallow the pills then threw the souffle cup in the trash, and recorded his initials in the computer.
The med/tech went through the same process for the next 3 residents in line (#2) , (#3), (#4).
Staff C did not wash his hands or use a sanitizer throughout the medication pass.
During an interview on at 8:30am staff C stated he was a new employee at the facility. The employee stated he was the only employee on the floor.

Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
AL11967286		

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING CARE OF ST PETERSBURG	1001 9TH STREET NORTH SAINT PETERSBURG, FL 33701

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0053 Reg. # 58A-5.0185(4) FAC LSC	Correction Completed	ID Prefix A0079 Reg. # 58A-5.019(3) FAC LSC	Correction Completed	ID Prefix AZ814 Reg. # 435.12(2)(b-d), FS LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) PFB	DATE 6/15/16	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/21/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: SJHN12

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

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

Dear Administrator:

This letter reports the findings of a state revisit survey conducted on , 2016, by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, and the uncorrected deficiency that was identified on the day of the visit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **The deficiency shall be corrected no later than , 2016.**

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: Revisit Report
YOSF

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