STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965411	**03/08/2018**
NAME OF PROVIDER OR SUPPLIER **LIFETIDES HOME, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **3133 LAS OLAS DRIVE** **DUNEDIN, FL 34698**	

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

0000 - Initial Comments

Assisted Living Facility

On . . . , 2018, an abbreviated biennial re-licensure survey was conducted at Lifetides Home, Inc. Deficient practice was identified during the survey.

(License #9832)

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

Based on record review and interview, the facility failed to provide proof of a written statement from a health care provider, within 30 days of employment, that individuals did not have any signs or symptoms of a communicable (Communicable Statements) for two (Staff A and Staff B) of three employee records reviewed.

Findings included:

A review of employee records conducted on . . . . showed that Staff A had a date of hire of . and Staff B was hired on . A review of Staff A's and Staff B's records showed no proof of Communicable . . . . . Statements.

An interview was conducted with the Administrator at 1:43 PM on . . . . concerning the lack of Communicable Statements in Staff A's and Staff B's records. The Administrator reviewed the two records and acknowledged that the Communicable . . . . . Statements were not present.

Class III