STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967288	**05/09/2018**
NAME OF PROVIDER OR SUPPLIER **A TROPICAL PARADISE ALF LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **5228 23RD AVENUE** **SAINT PETERSBURG, FL 33710**	

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

0000 - Initial Comments

Assisted Living Facility

On , a biennial relicensure survey was conducted at A Tropical Paradise (Lic. #11367). Deficient practice was identified during the survey.

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

Based on record review and interview, one of two staff sampled (B) who had been employed at least 30 days had not yet submitted a written statement from a health care provider attesting to their freedom from signs or symptoms of communicable .

Findings include:

Although a personnel file review revealed that Staff B, hired , had a ( ) assessment from (set to expire by the end of the month), further review of the record found no documented evidence of any subsequent evaluation pertaining to Staff B's freedom from other communicable . Interview with the administrator at 1:00pm on provided no clarification for this oversight.

Class III