Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911240	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE SENIOR LIVING AT SAINT JOSEPH	4406 MELTON AVE TAMPA, FL 33614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation (complaint number: 2021014706) was conducted at Best Care Senior Living at Saint Joseph on . Deficiencies were identified at the time of survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911240	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE SENIOR LIVING AT SAINT JOSEPH	4406 MELTON AVE TAMPA, FL 33614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 1 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to provide adequate supervision to prevent elopement and failed to conduct a thorough investigation for an elopement incident for one (Resident #1) of one sampled. Additionally, the Facility failed to follow their elopement policy and incident reporting policy and procedures and failed to re-train staff regarding elopement and incident reporting policy and procedures and rounding of residents after an incidence of elopement for one Resident (#1) of one sampled resident that eloped from the facility and continued to be missing. Findings Included:	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911240	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE SENIOR LIVING AT SAINT JOSEPH	4406 MELTON AVE TAMPA, FL 33614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 2 A review of an Adverse Incident Report (AIRs) submitted by the facility, conducted on , revealed that Resident #1 eloped from the facility at an undetermined date and time. Staff noticed on at approximately 08:00am at breakfast that Resident #1 was missing. The AIRs stated that Staff A did not report the missing resident until at some time in the afternoon. A review of the Agency for Health Care Administration's survey, conducted on , revealed that the Facility failed to disclose that Resident #1 continued to be missing from the Facility. A review of the admission and discharge log, conducted on , revealed that Resident #1 continued to be listed as an in-house resident. During an observation of 100% of all in-house residents, conducted on between 12:00pm through 12:30pm, revealed that Resident #1 was absent from the facility. During an interview with Staff A, conducted on at 02:01pm, Staff A stated that she noticed that Resident #1 was not at breakfast on , went to his room and he wasn't there, and she searched the bathroom, and he wasn't there. Staff A stated that she was called away to assist another resident and forgot to report that Resident #1 was missing. Staff A stated this was her first incidence of a missing resident and that she did not get any training about missing residents. A review of the Facility's elopement drills,	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911240	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE SENIOR LIVING AT SAINT JOSEPH	4406 MELTON AVE TAMPA, FL 33614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 3 conducted on . . . . . , revealed that the facility held elopement drills on and . . . . . which were prior to Staff A's date of hire of . A review of Resident #1's Medication Observation Record, conducted on . . . . . , revealed that there was not documentation that Resident #1 took any medications after his scheduled 08:00pm medications on . During an attempt to review additional elopement trainings/in-services for all employees, conducted on , revealed that there were no additional elopement trainings/in-services provided for all employees. A review of the elopement policy and procedures, conducted on . . . . . , revealed that the elopement policy and procedures stated that: -If staff could not locate a resident, then the procedures would be conducted promptly and systematically search for and locate the resident. -All staff in the building would be alerted and conduct a thorough search of the Facility by searching all rooms and closets, bathrooms, dining room, pantries, laundry room, storage areas, common areas, courtyards, and surrounding outdoor areas. -Staff would report the elopement to their supervisor. -An in-house incident report would be filled out. During an interview with the Administrator, conducted on . . . . . at 11:35am, the Administrator stated that the Facility did not notify the proper local adult protective services as required. At 01:10pm, the Administrator stated that Resident #1 continued as missing and there continued to be an active Law Enforcement	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911240	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE SENIOR LIVING AT SAINT JOSEPH	4406 MELTON AVE TAMPA, FL 33614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 4 investigation. The Administrator stated that: -Staff A failed to immediately report Resident #1 as missing which delayed their search efforts for approximately twenty-four hours and did not document in Resident #1's observation log to note that he was missing. -Staff B did not do every two hours checks on residents during the night of , did not document in Resident #1's observation log, and did not report the resident as missing. Staff C did not report Resident #1 as missing. -Staff D did not document in Resident #1's observation log or report the resident as missing. -Staff E did not do every two hours checks on residents during the night of and did not report that Resident #1 was missing. At 02:21pm, the Administrator stated that there was no formal written investigation of Resident #1's elopement incident and that she had not reviewed the entirety of all video cameras during the probable elopement on after bedtime medications through until at 08:00am breakfast when he was noticed missing by Staff A. The Administrator stated that the last known evidence that Resident #1 was in the building was when his medications were documented as given at bedtime. At 03:18pm, the Administrator stated that the staff on the 11-7 shift on did not perform their rounds as required every two hours and if they did their rounds, they would have known that Resident #1 was not in his room and there was no in-house incident report for Resident #1 because the Facility submitted an AIRs report. At 03:25pm, the Administrator stated that there was no written or formal investigation or incident report for Resident #1's elopement. The Administrator agreed that the Staff A delayed notification which delayed search efforts for Resident #1 and that there was	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911240	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE SENIOR LIVING AT SAINT JOSEPH	4406 MELTON AVE TAMPA, FL 33614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 5 no re-training of staff for the Facility's policy and procedures regarding incident reporting, elopements, and rounding of residents. Class II	A 025		
A 080 SS=D	429.52( ) FS; 59A-36.011(1) FAC Training - Core & Competency Test 429.52 (2) Administrators and other assisted living facility staff must meet minimum training and education requirements established by the agency by rule. This training and education is intended to assist facilities to appropriately respond to the needs of residents, to maintain resident care and facility standards, and to meet licensure requirements. (3) The agency, in conjunction with providers, shall develop core training requirements for administrators consisting of core training learning objectives, a competency test, and a minimum required score to indicate successful passage of the core competency test. The required core competency test must cover at least the following topics: (a) State law and rules relating to assisted living facilities. (b) Resident rights and identifying and reporting , neglect, and (c) Special needs of elderly persons, persons with mental illness, and persons with and how to meet those needs. (d) Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food. (e) Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication. (f) Firesafety requirements, including fire	A 080		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911240	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE SENIOR LIVING AT SAINT JOSEPH	4406 MELTON AVE TAMPA, FL 33614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 080	Continued From page 6 evacuation drill procedures and other emergency procedures. (g) Care of persons with [illegible]'s [illegible] and related [illegible]. 59A-36.011 (1) ASSISTED LIVING FACILITY CORE TRAINING REQUIREMENTS AND COMPETENCY TEST. (a) The assisted living facility core training requirements established by the department pursuant to section 429.52, F.S., shall consist of a minimum of 26 hours of training plus a competency test. (b) Administrators and managers must successfully complete the assisted living facility core training requirements within 3 months from the date of becoming a facility administrator or manager. Successful completion of the core training requirements includes passing the competency test. The minimum passing score for the competency test is 75%. Administrators who have attended core training prior to [illegible], and managers who attended the core training program prior to [illegible], shall not be required to take the competency test. Administrators licensed as nursing home administrators in accordance with chapter 468, part II, F.S., are exempt from this requirement. (c) Administrators and managers shall participate in 12 hours of continuing education in topics related to assisted living every 2 years. (d) A newly hired administrator or manager who has successfully completed the assisted living facility core training and continuing education requirements, shall not be required to retake the core training. An administrator or manager who has successfully completed the core training but has not maintained the continuing education	A 080		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911240	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE SENIOR LIVING AT SAINT JOSEPH	4406 MELTON AVE TAMPA, FL 33614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 080	Continued From page 7 requirements will be considered a new administrator or manager for the purposes of the core training requirements and must: 1. Retake the assisted living facility core training; and, 2. Retake and pass the competency test. (e) The fees for the competency test shall not exceed $200.00. The payment for the competency test fee shall be remitted to the entity administering the test. A new fee is due each time the test is taken. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the Facility failed to have an Administrator that completed the core education requirements pursuant to rule 59A-36.011, Florida Administrative Code within ninety days after becoming employed as the Facility's Administrator. Findings Included: During an observation of the Administrator, conducted on from 09:45am through 04:30pm, the Administrator was actively working in the Facility and functioning as the Administrator. An employee record review for the Administrator, conducted , the Administrator's employee record contained two documents of twenty-six-hours core training program completion dated and . There was no evidence that the Administrator took and passed the core training competency test. The Administrator was hired on .	A 080		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911240	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE SENIOR LIVING AT SAINT JOSEPH	4406 MELTON AVE TAMPA, FL 33614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 080	Continued From page 8 A review of the core competency test website https://alfmacdonald-research.com/SuccessfullExamineesList.aspx, conducted on , revealed that the Administrator had not taken and/or passed the core competency test. During an interview with the Administrator, conducted on at 01:54pm, the Administrator stated that she would have to contact the university where her core competency test was taken to obtain the certification of passing the core competency test. Class III	A 080		
A 083 SS=D	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND ( ). A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training	A 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911240	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE SENIOR LIVING AT SAINT JOSEPH	4406 MELTON AVE TAMPA, FL 33614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 083	Continued From page 9 requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to provide staff on each shift with training in , , , ( ) and First Aid as required. Findings Included: A review of the staff scheduled, conducted on , revealed that the Facility did not provide employees that had and First Aid trainings. On Staff D and Staff E worked the shift together without any other staff present. On Staff D and Staff E worked the 11pm-7am shift together without any other staff present. The schedule for showed that Staff E and Staff H were scheduled to work the 11pm-7am shift together without any other staff scheduled (photographic evidence obtained). An employee record review for Staff D, Staff E, and Staff H, conducted on , revealed that Staff D, Staff E, and Staff H did not have trainings in and First Aid. Staff D was hired on and her and First Aid trainings expired on . Staff E was hired on and did not have evidence of and First Aid trainings in her employee record. Staff H was hired on and her and First Aid trainings expired on . During an interview with the Administrator, conducted on at 01:40pm, the Administrator agreed that Staff D, Staff E, and Staff H did not have current and active and First Aid trainings. The Administrator agreed that	A 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911240	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE SENIOR LIVING AT SAINT JOSEPH	4406 MELTON AVE TAMPA, FL 33614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 083	Continued From page 10 Staff D and E worked together on [redacted] and [redacted] and that there was no other staff present in the Facility that had current and active [redacted] and First Aid trainings. Class III	A 083		
A 086 SS=D	59A-36.011(10) FAC Training - ADRD (10) [redacted] AND RELATED [redacted] ("ADRD") TRAINING REQUIREMENTS. Facilities which advertise that they provide special care for persons with ADRD, or who maintain secured areas as described in Chapter 4, Section 464.4.6 of the Florida Building Code, as adopted in rule 61G20-1.001, F.A.C., Florida Building Code Adopted, must ensure that facility staff receive the following training. (a) Facility staff who interact on a daily basis with residents with ADRD but do not provide direct care to such residents and staff who provide direct care to residents with ADRD, shall obtain 4 hours of initial training within 3 months of employment. Completion of the core training program between [redacted] and [redacted] shall satisfy this requirement. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. Initial training, entitled "[redacted] and Related [redacted] Level I Training," must address the following subject areas: 1. Understanding [redacted]'s [redacted] and related [redacted]; 2. Characteristics of [redacted]; 3. Communicating with residents with [redacted]'s [redacted]; 4. Family issues; 5. Resident environment; and,	A 086		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911240	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE SENIOR LIVING AT SAINT JOSEPH	4406 MELTON AVE TAMPA, FL 33614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 086	Continued From page 11 6. Ethical issues. (b) Staff who have successfully completed both the initial one hour and continuing three hours of ADRD training pursuant to sections 400.1755, 429.917 and 400.6045(1), F.S., shall be considered to have met the initial assisted living facility and Related Level I Training. (c) Facility staff who provide direct care to residents with ADRD must obtain an additional 4 hours of training, entitled " and Related Level II Training," within 9 months of employment. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. and Related Level II Training must address the following subject areas as they apply to these : 1. Behavior management, 2. Assistance with ADLs, 3. Activities for residents, 4. Stress management for the care giver; and, 5. Medical information. (d) A detailed description of the subject areas that must be included in an ADRD curriculum which meets the requirements of paragraphs (a) and (b) of this subsection, can be found in the document "Training Guidelines for the Special Care of Persons with 's and Related ," dated , incorporated by reference, available from the Department of Elder Affairs, 4040 Esplanade Way, Tallahassee, Florida 32399-7000. (e) Direct care staff shall participate in 4 hours of continuing education annually as required under section 429.178, F.S. Continuing education received under this paragraph may be used to meet 3 of the 12 hours of continuing education	A 086		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911240	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE SENIOR LIVING AT SAINT JOSEPH	4406 MELTON AVE TAMPA, FL 33614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 086	Continued From page 12 required by section 429.52, F.S., and subsection (1) of this rule, or 3 of the 6 hours of continuing education for extended congregate care required by subsection (7) of this rule. (f) Facility staff who have only incidental contact with residents with ADRD must receive general written information provided by the facility on interacting with such residents, as required under section 429.178, F.S., within three (3) months of employment. "Incidental contact" means all staff who neither provide direct care nor are in regular contact with such residents. (g) Persons who seek to provide ADRD training in accordance with this subsection must provide the department or its designee with documentation that they hold a Bachelor's degree from an accredited college or university or hold a license as a registered nurse, and: 1. Have 1 year teaching experience as an educator of caregivers for persons with . . . . . or related . . . . . , or 2. Three years of practical experience in a program providing care to persons with . . . . . or related . . . . . , or 3. Completed a specialized training program in the subject matter of this program and have a minimum of two years of practical experience in a program providing care to persons with . . . . . or related . . . . . . (h) With reference to requirements in paragraph (g), a Master's degree from an accredited college or university in a subject related to the content of this training program can substitute for the teaching experience. Years of teaching experience related to the subject matter of this training program may substitute on a year-by-year basis for the required Bachelor's degree referenced in paragraph (g). This Statute or Rule is not met as evidenced by:	A 086		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911240	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE SENIOR LIVING AT SAINT JOSEPH	4406 MELTON AVE TAMPA, FL 33614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 086	Continued From page 13 Based on record review and interview, the Facility failed to have all employees trained in 's and related level one training (ADRD-1), within three months of employment, for one employee (Staff E) of four sampled staff that interacted daily with residents with and . Findings Included: A record review for Staff E, conducted on , revealed that there was no evidence in Staff E's employee record that the employee had completed a four-hour required training for ADRD-1 within three months of employment. Staff E was hired on . During an interview with the Administrator, conducted on at 01:40pm, the Administrator was unable to provide a training certificate that Staff E had obtained four-hours ADRD-1 training. Class III	A 086		
AL243 SS=D	429.075(1) FS; 59A-36.011(9) FAC LMH - Training 429.075 (1) To obtain a limited mental health license, a facility must hold a standard license as an assisted living facility, must not have any current uncorrected violations, and must ensure that, within 6 months after receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than 6 hours related to their duties. This designation may be made at the time of initial	AL243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911240	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE SENIOR LIVING AT SAINT JOSEPH	4406 MELTON AVE TAMPA, FL 33614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
AL243	Continued From page 14 licensure or relicensure or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with this part, part II of chapter 408, and applicable rules. This training must be provided by or approved by the Department of Children and Families. 59A-36.011 (9) LIMITED MENTAL HEALTH TRAINING. (a) Pursuant to section 429.075, F.S., the administrator, managers and staff, who have direct contact with mental health residents in a licensed limited mental health facility, must receive the following training: 1. A minimum of 6 hours of specialized training in working with individuals with mental health diagnoses. a. The training must be provided or approved by the Department of Children and Families and must be taken within 6 months of the facility's receiving a limited mental health license or within 6 months of employment in a limited mental health facility. b. Training received under this subparagraph may count once for 6 of the 12 hours of continuing education required for administrators and managers pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 2. A minimum of 3 hours of continuing education, which may be provided by the ALF administrator, online, or through distance learning, biennially thereafter in subjects dealing with one or more of the following topics: a. Mental health diagnoses; and, b. Mental health treatment such as: (I) Mental health needs, services, behaviors and appropriate interventions; (II) Resident progress in achieving treatment	AL243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911240	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE SENIOR LIVING AT SAINT JOSEPH	4406 MELTON AVE TAMPA, FL 33614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
AL243	Continued From page 15 goals; (III) How to recognize changes in the resident's status or condition that may affect other services received or may require intervention; and, ( ) Crisis services and the . . . . . procedures. 3. For administrators and managers, the continuing education requirement under this subsection will satisfy 3 of the 12 hours of continuing education required biennially pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 4. Administrators, managers and direct contact staff affected by the continuing education requirement under this subsection shall have up to 6 months after the effective date of this rule to meet the training requirement. (b) Administrators, managers and staff do not have to repeat the initial training should they change employers provided they present a copy of their training certificate to the current employer for retention in the facility's personnel files. They must also ensure that copies of the continuing education training certificates, pursuant to subparagraph (a)2. of this subsection, are retained in their personnel files. This Statute or Rule is not met as evidenced by: Based upon record review and interview, the facility failed to ensure that all employees had the required three-hours of continuing education every two years for limited mental health (LMH) training for one employee (Administrator) of four sampled employees. Findings Included: An employee record review for the Administrator, conducted on , revealed that the	AL243		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911240	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE SENIOR LIVING AT SAINT JOSEPH	4406 MELTON AVE TAMPA, FL 33614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
AL243	Continued From page 16 Administrator had a six-hours LMH training on and an eight-hours LMH training on . There was no evidence that the Administrator had the three-hours of LMH continued education from through date of survey . During an interview with the Administrator, conducted on , the Administrator agreed that she had not obtained the required three-hours of LMH continued education from through the day of survey . Class III	AL243		