

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/02/2021
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BETHESDA ASSISTED LIVING, LLC

**624 BARBER AVE
LAKE WORTH, FL 33461**

(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 An unannounced Complaint survey (#2020016979) was conducted on _____ at Bethesda Assisted Living LLC. The facility had a deficiency identified at the time of the survey.	A 000		
CZ828	408.813(3) FS Administrative Fines; Violations 408.813 Administrative fines; violations.-As a penalty for any violation of this part, authorizing statutes, or applicable rules, the agency may impose an administrative fine. (3) The agency may impose an administrative fine for a violation that is not designated as a class I, class II, class III, or class _____ violation. Unless otherwise specified by law, the amount of the fine may not exceed \$500 for each violation. Unclassified violations include: (a) Violating any term or condition of a license. (b) Violating any provision of this part, authorizing statutes, or applicable rules. (c) Exceeding licensed capacity. (d) Providing services beyond the scope of the license. (e) Violating a moratorium imposed pursuant to s. 408.814. (f) Violating the parental consent requirements of s. 1014.06 This Statute or Rule _____ is not met as evidenced by: Based on observations, interview and record review, the facility failed to ensure that they did not exceed licenses occupancy of 5 residents. As evidence of the facility current census of 7 residents (Resident #1-#7). The Findings included: On _____ at 09:00 AM a tour was conducted	CZ828		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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NAME OF PROVIDER OR SUPPLIER BETHESDA ASSISTED LIVING, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 624 BARBER AVE LAKE WORTH, FL 33461		
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CZ828	Continued From page 1 of the facility with the Administrator/Owner. She stated the facility had 5 residents. However, the tour revealed the facility census was 7 residents (Resident #1-#7), present at this time. The facility license was observed on the office wall posted that showed the capacity 5 residents. The Administrator during interview at 10:30 AM was questioned regarding the 2 additional residents observed in the facility beyond the licensed capacity of 5. She stated that "Resident #6 and # 7 are Daycare only". On _____, a review of the online Florida Health Finder System was conducted. It was revealed that the facility has a license capacity of 5 residents for a standard license. Review of Resident #6 and #7's file provided by the Administrator showed a Residency Agreement/contract. Review of Resident #7's Resident Agreement revealed no monthly amount, however, each page was initialed by the Resident #7. Further review of Resident #7's contract showed "Daycare" noted in the right upper corner. Review of Resident #6's Resident Agreement noted "Daycare" in the right upper corner. However, further review of this contract revealed the monthly rate of 3760 month for semi-private. Contract was signed by the resident's representative. On _____ at 11:15 AM, an interview via telephone was conducted with Resident # 6 emergency contact person. It was revealed that resident has been living at the facility as a full-time resident since _____. Interview was conducted on _____ at 12:00 PM with Resident #6 Third Party Services revealed that resident is a full-time resident.	CZ828			

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CZ828	Continued From page 2 On _____ at 12:30 PM and interview via telephone was conducted with the Third Party Services revealed that resident # 6 and #7 are fulltime resident at the facility. Administrator was requested to provide evidence of a capacity increase for the 2 additional residents. She was unable to do so currently. Further review of Agency records revealed no application. On _____ at 2:00 PM, an interview was conducted with Administrator and the findings were discussed.	CZ828		