

Agency for Health Care Administration

|                                                      |                                                                                                                                                                                                                                              |                                                                                |                                                                                                                          |                          |                                                        |
|------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  |                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11943161</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/26/2012</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BEST CARE</b> |                                                                                                                                                                                                                                              |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1430 PALMETTO STREET<br/>CLEARWATER, FL 33755</b>                            |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                 | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 000                                                | <p>Initial Comments</p> <p>Assisted Living Facility</p> <p>An abbreviated biennial state licensure survey was conducted on 12/26/12.</p> <p>The Best Care, assisted living facility, had no deficiencies found at the time of the visit.</p> | A 000                                                                          |                                                                                                                          |                          |                                                        |

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

6859

H11C11

If continuation sheet 1 of 1



RICK SCOTT  
GOVERNOR

ELIZABETH DUDEK  
SECRETARY

January 8, 2013

Administrator  
Best Care  
1430 Palmetto Street  
Clearwater, FL 33755

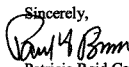
Dear Administrator:

This letter reports findings of an abbreviated biennial state licensure survey that was conducted on December 26, 2012, by a representative of this office. Attached is the provider's copy of the State (3020) Form, which indicates there were no discernible deficiencies noted on the date of the survey.

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. Should you have any questions please call **Paul Brown**, HFES, at (727) 552-2000.

Sincerely,

  
Patricia Reid Cauffman  
Field Office Manager

PRC/kpr

Enclosure: State Form 3020

