STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943161	**02/25/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Best Care ALF	**1430 Palmetto Street Clearwater, FL 33755**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0000 - - Initial Comments
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= C

Specific Tag Findings:

Assisted Living Facility

A Biennial Licensure Survey with Limited Mental Health (LMH) was conducted on .

Best Care, Assisted Living Facility, had a deficiency identified at the time of the visit.

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

Based on record review and interview, the facility failed to ensure that one (1 out of 3) staff members obtained within 30 days of hire, a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable and evidence of a negative examination on an annual basis.

Findings Include:

A record review on of Staff B, revealed a hire date of and did not have the required, free of communicable statement and a examination both required within 30 days of hire. Further review of Staff B's records revealed there was no annual examination in 2013 and 2014.

An interview with the Administrator on at approximately 2:50 p.m., stated there is not a free of communicable statement, or a examination(s) for Staff B.

CLASS III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Best Care ALF
1430 Palmetto Street
Clearwater, FL 33755

Dear Administrator:

This letter reports the findings of a Biennial state licensure survey with Limited Mental Health (LMH) that was conducted on , 2015 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiencies identified on your 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(s). Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

Patricia Reid Caufman
Field Office Manager

PRC/src
Enclosure: State (5000-3547) Form

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