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
	AL11943161	A. BUILDING: _____ B. WING _____	02/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE ALF	1430 PALMETTO STREET CLEARWATER, FL 33755

(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 Assisted Living Facility On , an abbreviated biennial state relicensure survey with limited mental health (LMH) was conducted at Best Care. Deficient practice was identified during the survey. (License # 8472)	A 000		
A 008 SS=D	429.26(4-6) FS; 58A-5.0181(2) FAC Admissions - Health Assessment 429.26 (4) If possible, each resident shall have been examined by a licensed physician, a licensed physician assistant, or a licensed nurse practitioner within 60 days before admission to the facility. The signed and completed medical examination report shall be submitted to the owner or administrator of the facility who shall use the information contained therein to assist in the determination of the appropriateness of the resident ' s admission and continued stay in the facility. The medical examination report shall become a permanent part of the record of the resident at the facility and shall be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (5) Except as provided in s. 429.07, if a medical examination has not been completed within 60 days before the admission of the resident to the facility, a licensed physician, licensed physician	A 008		

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
	AL11943161	A. BUILDING: _____ B. WING _____	02/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE ALF	1430 PALMETTO STREET CLEARWATER, FL 33755

(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 008	Continued From page 1 assistant, or licensed nurse practitioner shall examine the resident and complete a medical examination form provided by the agency within 30 days following the admission to the facility to enable the facility owner or administrator to determine the appropriateness of the admission. The medical examination form shall become a permanent part of the record of the resident at the facility and shall be made available to the agency during inspection by the agency or upon request. (6) Any resident accepted in a facility and placed by the department or the Department of Children and Families shall have been examined by medical personnel within 30 days before placement in the facility. The examination shall include an assessment of the appropriateness of placement in a facility. The findings of this examination shall be recorded on the examination form provided by the agency. The completed form shall accompany the resident and shall be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or , , nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident providing it was completed within 90 days prior to admission to the facility. The applicable department shall	A 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11943161	A. BUILDING: _____ B. WING _____	02/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE ALF	1430 PALMETTO STREET CLEARWATER, FL 33755

(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 008	Continued From page 2 provide to the facility administrator any information about the resident that would help the administrator meet his or her responsibilities under subsection (1). Further, department personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The applicable department shall advise and assist the facility administrator where the special needs of residents who are recipients of , require such assistance. 58A-5.0181 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a face-to-face medical examination completed by a health care provider as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days before to the individual ' s admission to a facility pursuant to Section 429.26(4), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations; 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living; 3. Any nursing or services required by the individual; 4. Any special diet required by the individual; 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication; 6. Whether the individual has signs or symptoms of , or any other	A 008		

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
	AL11943161	A. BUILDING: _____ B. WING _____	02/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE ALF	1430 PALMETTO STREET CLEARWATER, FL 33755

(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 008	Continued From page 3 communicable . . . . . , which are likely to be transmitted to other residents or staff; 7. A statement on the day of the examination that, in the opinion of the examining health care provider, the individual ' s needs can be met in an assisted living facility; and 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care provider. The medical examination may be conducted by a health care provider licensed under Chapter 458, 459 or 464, F.S. (b) A medical examination completed after the resident ' s admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, 2010. The form is hereby incorporated by reference. AHCA Form 1823 may be obtained http://www.flrules.org/Gateway/reference.asp?No =Ref-04006. Faxed or electronic copies of the completed form are acceptable. The form must be completed as instructed. 1. Items on the form that may have been omitted by the health care provider during the examination do not necessarily require an additional face-to-face examination for completion. The facility may obtain the omitted information either orally or in writing from the health care provider. 2. Omitted information must be documented in the resident ' s record. Information received orally must include the name of the health care provider, the name of the facility staff recording the information, and the date the information was provided. 3. Electronic documentation may be used in place of completing the section on AHCA Form	A 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11943161	A. BUILDING: _____ B. WING _____	02/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE ALF	1430 PALMETTO STREET CLEARWATER, FL 33755

(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 008	Continued From page 4 1823 referencing Services Offered or Arranged by the Facility for the Resident. The electronic documentation must include all of the elements described in this section of AHCA Form 1823. (c) Any information required by paragraph (a) that is not contained in the medical examination report conducted before the individual ' s admission to the facility must be obtained by the administrator using AHCA Form 1823 within 30 days after admission. (d) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.26, F.S., and this rule. (f) Any orders for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility issued by the health care provider conducting the medical examination may be attached to the health assessment. A health care provider may attach a DH Form 1896, Florida . . . . . Form, for residents who do not wish , , ... to be administered in the case of . . . or , , . . (g) A resident placed on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility ' s	A 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11943161	A. BUILDING: _____ B. WING _____	02/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE ALF	1430 PALMETTO STREET CLEARWATER, FL 33755

(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 008	Continued From page 5 admission and discharge log and counted in the facility census; a facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission This Statute or Rule is not met as evidenced by: Based on record review and interview, the health assessment for one of one resident sampled (#3) contained incomplete and/or contradictory information, while the contract for Resident #3 referred to inaccurate parameters said medical examination report must adhere to. Findings included: A review of Resident #3's file during the survey found a health assessment with the following issues: a) with respect to the resident's physical and mental status, including health-related problems and functional limitations, it stated "Please see attached H & P." However, it was unclear where this , document was located in the resident's record. b) Regarding a list of current prescribed medications and whether Resident #3 would require any assistance with the self-administration of these pharmaceuticals, the health assessment indicated that medication administration was required and that "the med list was on the attached MAR." Again, it was unclear where this , document was. In addition, interview with the administrator at	A 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11943161	A. BUILDING: _____ B. WING _____	02/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE ALF	1430 PALMETTO STREET CLEARWATER, FL 33755

(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 008	Continued From page 6 1:20pm on [redacted] confirmed that this resident was not receiving medication administration. Further review of Resident #3's record found a [redacted] signed residency agreement that stipulated "the resident needs to be certified appropriate for admission to the facility no more than 30 days prior to, and 30 days after, being admitted to the facility." However, this conflicts with the requirement that "the medical examination needs to be completed within 60 days before admission to the facility and within 30 days following admission." Interview with the administrator at 1:25pm on [redacted] verified that she was unaware this clause was incorrect. Class III	A 008		
A 077 SS=D	429.176 FS; 58A-5.019(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator has completed the applicable core educational requirements under s. 429.52. 58A-5.019 Staffing Standards. (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by Part II, Chapter 408,	A 077		

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
	AL11943161	A. BUILDING: _____ B. WING _____	02/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE ALF	1430 PALMETTO STREET CLEARWATER, FL 33755

(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 077	Continued From page 7 F.S., Part I, Chapter 429, F.S., Rule Chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], 1995, have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to Sections 408.809 and 429.174, F.S.; and 4. Complete the core training and core competency test requirements pursuant to Rule 58A-5.0191, F.A.C., no later than 90 days after becoming employed as a facility administrator. Individuals who have successfully completed these requirements before [illegible], 2014, are not required to take either the 40 hour core training or test unless specified elsewhere in this rule. Administrators who attended core training prior to [illegible], 1997, are not required to take the competency test unless specified elsewhere in this rule. 5. Satisfy the continuing education requirements pursuant to Rule 58A-5.0191, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the [illegible] of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraphs (1)(a)4. of this rule to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11943161	A. BUILDING: _____ B. WING _____	02/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE ALF	1430 PALMETTO STREET CLEARWATER, FL 33755

(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 077	Continued From page 8 competency test requirements pursuant to Rule 58A-5.0191, F.A.C.; and 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements of an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , 1997, are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to Section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , 2013, which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04002.	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11943161	A. BUILDING: _____ B. WING _____	02/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE ALF	1430 PALMETTO STREET CLEARWATER, FL 33755

(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 077	Continued From page 9 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the administrator had completed the 12 hours of continuing education hours every 2 years. Findings included: A personnel record review during the survey revealed that Staff A (administrator) had only obtained six (6) of the required 12 continuing education hours for administrators over the last two (2) years. In an interview with Staff A (administrator) on [redacted] at 2:45pm, she acknowledged the six (6) hours were lacking, but explained that she thought the mandatory training hours such as [redacted], FA, nutrition and medication assistance satisfied this requirement. Class III	A 077		
A 093 SS=D	58A-5.020(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current summary of Dietary Reference Intakes established by the Food and	A 093		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11943161	A. BUILDING: _____ B. WING _____	02/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE ALF	1430 PALMETTO STREET CLEARWATER, FL 33755

(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 093	Continued From page 10 Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~/media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents ' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents.	A 093		

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
	AL11943161	A. BUILDING: _____ B. WING _____	02/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE ALF	1430 PALMETTO STREET CLEARWATER, FL 33755

(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 093	Continued From page 11 (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider ' s order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident ' s refusal to comply with a therapeutic diet and provide notification to the resident ' s health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A	A 093		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11943161	A. BUILDING: _____ B. WING _____	02/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE ALF	1430 PALMETTO STREET CLEARWATER, FL 33755

(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 093	Continued From page 12 supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on hand. (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has contracted with residents to serve, must be on hand at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility had not been posting its menu in a conspicuous place. Findings included: During the initial tour of the facility at 10am on , as well as throughout the remainder of the survey, no official menu was noted to be posted anywhere on the premises. Interview with caregiver staff at 11am on revealed that "one of the residents constantly took it/tore it down, and they were trying to figure out how to post it in a way it would not be in harm's way." Class III	A 093		
AL242 SS=D	429.075(2) FS; 58A-5.029(3) FAC LMH - Responsibilities of Facility	AL242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11943161	A. BUILDING: _____ B. WING _____	02/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE ALF	1430 PALMETTO STREET CLEARWATER, FL 33755

(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
AL242	Continued From page 13 429.075 (2) Facilities licensed to provide services to mental health residents shall provide appropriate supervision and staffing to provide for the health, safety, and welfare of such residents. (3d) Assist the mental health resident in carrying out the activities identified in the individual ' s community living support plan (3) RESPONSIBILITIES OF FACILITY. In addition to the staffing and care standards of this rule chapter to provide for the welfare of residents in an assisted living facility, a facility holding a limited mental health license must: (a) Meet the facility ' s to assist the resident in carrying out the activities identified in the Community Living Support Plan; (b) Provide an opportunity for private face-to-face contact between the mental health resident and the resident ' s mental health case manager or other treatment personnel of the resident ' s mental health care provider; (c) Observe resident behavior and functioning in the facility, and record and communicate observations to the resident ' s mental health case manager or mental health care provider regarding any significant behavioral or situational changes that may signify the need for a change in the resident ' s professional mental health services, supports, and services described in the community living support plan, or that the resident is no longer appropriate for residency in the facility; (d) If the facility initiates an involuntary mental health examination pursuant to Section 394.463, F.S., the facility must document the circumstances leading to the initiation of the examination;	AL242		

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
	AL11943161	A. BUILDING: _____ B. WING _____	02/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE ALF	1430 PALMETTO STREET CLEARWATER, FL 33755

(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
AL242	Continued From page 14 (e) Ensure that designated staff have completed limited mental health training as required by Rule 58A-5.0191, F.A.C.; and (e) Maintain facility, staff, and resident records in accordance with the requirements of this rule chapter. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility did not maintain a thorough written record of its observations and communications to the mental health case manager or mental health provider with respect to one of one mental health resident sampled (#3) regarding significant behavioral changes. Findings included: Observation of Resident #3's . . . . 10am on . . found the near wall next to Resident #3's bed to have a very large hole. Interview with the administrator at this time revealed that "Resident #3 had made this hole and that he/she had been declining behaviorally, and that he had been exhibiting increasingly destructive conduct." Further interview indicated that "the administrator and her husband (co-owner) had apparently been in touch with the resident's case manager and physician, and that the latter had been attempting to modify the medication regimen." Review of the resident's file found no progress notes addressing any of this--with the exception of a note from . . pertaining to the resident "hearing voices" and one from . . stating "minimal response from resident." Interview with the administrator at 1pm on . . verified that "she knows she should	AL242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11943161	A. BUILDING: _____ B. WING _____	02/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE ALF	1430 PALMETTO STREET CLEARWATER, FL 33755

(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
AL242	Continued From page 15 have written more of this down." Class III	AL242		
AL243 SS=D	429.075(1) FS; 58A-5.0191(8) 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 deficiencies or 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. Such designation may be made at the time of initial 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 will be provided by or approved by the Department of Children and Families. 58A-5.0191 (8) 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	AL243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11943161	A. BUILDING: _____ B. WING _____	02/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE ALF	1430 PALMETTO STREET CLEARWATER, FL 33755

(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 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. Staff in " direct contact " means direct care staff and staff whose duties take them into resident living areas and require them to interact with mental health residents on a daily basis. The term does not include maintenance, food service or administrative staff, if such staff have only incidental contact with mental health residents. c. 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(4), 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 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 mental health needs, services, behaviors and appropriate interventions; resident progress in achieving treatment goals; 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(4), F.S., and subsection (1) of this rule. 4. Administrators, managers and direct contact staff affected by the continuing education	AL243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11943161	A. BUILDING: _____ B. WING _____	02/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE ALF	1430 PALMETTO STREET CLEARWATER, FL 33755

(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 17 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 on record review and interview, the facility failed to ensure that three of three direct care staff sampled (A, B, and C) had completed the minimum three hours of continuing education (CE) required in a Limited Mental Health (LMH) facility. Findings included: A personnel record review on , 2017 revealed that Staff A (hired 1997) had no documented CE in subjects dealing with mental health required for a limited mental health (LMH) facility since before 2013; A personnel record review on , 2017 revealed no documented CE in subjects dealing with mental health required for a LMH facility for Staff B (hired 1997) since before 2013; and	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
	AL11943161	A. BUILDING: _____ B. WING _____	02/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE ALF	1430 PALMETTO STREET CLEARWATER, FL 33755

(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 18 A personnel record review on , 2017 revealed no documented CE in subjects dealing with mental health required for a LMH facilitys since for Staff C (hired). In an interview conducted on , 2017 at 2:45pm, the administrator acknowledged the missing CE for each staff - A, B, and C. The administrator was also unable to show proof that any of these staff - A, B, or C, had taken the minimum required continuing education hours for this biennial period. Class III	AL243		

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943161	**02/14/2017**
NAME OF PROVIDER OR SUPPLIER **BEST CARE ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **1430 PALMETTO STREET** **CLEARWATER, FL 33755**	

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

0000 - Initial Comments

Assisted Living Facility

On , an abbreviated biennial state relicensure survey with limited mental health (LMH) was conducted at Best Care. Deficient practice was identified during the survey.

(License # 8472)

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and interview, the health assessment for one of one resident sampled (#3) contained incomplete and/or contradictory information, while the contract for Resident #3 referred to inaccurate parameters said medical examination report must adhere to.

Findings included:

A review of Resident #3's file during the survey found a health assessment with the following issues:
a) with respect to the resident's physical and mental status, including health-related problems and functional limitations, it stated "Please see attached H & P." However, it was unclear where this , document was located in the resident's record.
b) Regarding a list of current prescribed medications and whether Resident #3 would require any assistance with the self-administration of these pharmaceuticals, the health assessment indicated that medication administration was required and that
"the med list was on the attached MAR." Again, it was unclear where this , document was. In addition, interview with the administrator at 1:20pm on confirmed that this resident was not receiving medication administration.

Further review of Resident #3's record found a signed residency agreement that stipulated "the resident needs to be certified appropriate for admission to the facility no more than 30 days prior to, and 30 days after, being admitted to the facility." However, this conflicts with the requirement that "the medical examination needs to be completed within 60 days before admission to the facility and within 30

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943161	02/14/2017
NAME OF PROVIDER OR SUPPLIER **BEST CARE ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **1430 PALMETTO STREET** **CLEARWATER, FL 33755**	

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

days following admission." Interview with the administrator at 1:25pm on verified that she was unaware this clause was incorrect.

Class III

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on record review and interview, the facility failed to ensure that the administrator had completed the 12 hours of continuing education hours every 2 years.

Findings included:

A personnel record review during the survey revealed that Staff A (administrator) had only obtained six (6) of the required 12 continuing education hours for administrators over the last two (2) years. In an interview with Staff A (administrator) on at 2:45pm, she acknowledged the six (6) hours were lacking, but explained that she thought the mandatory training hours such as , FA, nutrition and medication assistance satisfied this requirement.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation and interview, the facility had not been posting its menu in a conspicuous place.

Findings included:

During the initial tour of the facility at 10am on , as well as throughout the remainder of the survey, no official menu was noted to be posted anywhere on the premises. Interview with caregiver staff at 11am on revealed that "one of the residents constantly took it/tore it down, and they were trying to figure out how to post it in a way it would not be in harm's way."

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943161	02/14/2017
NAME OF PROVIDER OR SUPPLIER **BEST CARE ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **1430 PALMETTO STREET** **CLEARWATER, FL 33755**	

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

L242 - LMH - Responsibilities of Facility - 429.075(2) FS; 58A-5.029(3) FAC

Based on observation, record review and interview, the facility did not maintain a thorough written record of its observations and communications to the mental health case manager or mental health provider with respect to one of one mental health resident sampled (#3) regarding significant behavioral changes.

Findings included:

Observation of Resident #3's 10am on found the near wall next to Resident #3's bed to have a very large hole. Interview with the administrator at this time revealed that "Resident #3 had made this hole and that he/she had been declining behaviorally, and that he had been exhibiting increasingly destructive conduct." Further interview indicated that "the administrator and her husband (co-owner) had apparently been in touch with the resident's case manager and physician, and that the latter had been attempting to modify the medication regimen." Review of the resident's file found no progress notes addressing any of this--with the exception of a note from pertaining to the resident "hearing voices" and one from stating "minimal response from resident." Interview with the administrator at 1pm on verified that "she knows she should have written more of this down."

Class III

L243 - LMH - Training - 429.075(1) FS; 58A-5.0191(8) FAC

Based on record review and interview, the facility failed to ensure that three of three direct care staff sampled (A, B, and C) had completed the minimum three hours of continuing education (CE) required in a Limited Mental Health (LMH) facility.

Findings included:

A personnel record review on , 2017 revealed that Staff A (hired 1997) had no documented CE in subjects dealing with mental health required for a limited mental health (LMH) facility since before 2013;

A personnel record review on , 2017 revealed no documented CE in subjects dealing with

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943161	**02/14/2017**
NAME OF PROVIDER OR SUPPLIER **BEST CARE ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **1430 PALMETTO STREET** **CLEARWATER, FL 33755**	

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

mental health required for a LMH facility for Staff B (hired 1997) since before 2013; and

A personnel record review on , 2017 revealed no documented CE in subjects dealing with mental health required for a LMH faciltys since for Staff C (hired).

In an interview conducted on , 2017 at 2:45pm, the administrator acknowledged the missing CE for each staff - A, B, and C. The administrator was also unable to show proof that any of these staff - A, B, or C, had taken the minimum required continuing education hours for this biennial period.

Class III