

**AGENCY FOR HEALTH CARE  
ADMINISTRATION**

PRINTED: 07/25/2017  
FORM APPROVED

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| STATEMENT OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>AL11967370</b>                    | (X3) DATE SURVEY COMPLETED<br><br><b>06/29/2017</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LIVING WELL ALF #2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>21280 OLD CUTLER ROAD<br/>CUTLER BAY, FL 33189</b> |                                                     |
| SUMMARY STATEMENT OF DEFICIENCIES<br>(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                |                                                     |
| <p><b>0000 - Initial Comments</b></p> <p>A Monitoring visit for checking on residents' status was conducted on . Living Well ALF #2 with a Standard license #11461 had the following deficiencies found at the time of the visit:</p> <p><b>0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC</b></p> <p>Based on record review and interview facility failed to appoint a Manager for the facility who did not administer other facility.</p> <p>Findings included:</p> <p>Review of the facility finder Webster showed that the facility's Administrator managed 2 facilities.</p> <p>A review of employee records reviewrevealed that the Facility had not appointed a Manager .</p> <p>On at 9:51 AM the Administrator stated that the facility did not have a manager yet because many changes have happened so fast and he had not had a chance to assign one.</p> <p>Class III</p> |                                                                                                |                                                     |

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| <p><b>Z809 - Proof of Financial Ability to Operate - 59A-35.062(3)(e)&amp;(7);408.803(7) &amp;.810(8)</b></p> <p>Based on record review and interview, the facility failed to provide documentation to show financial stability and ability to operate.</p> <p>Findings included:</p> <p>Record review showed the facility did not have the income and expense records for the previous three months in the facility. Bank statements for the last six months were requested but only one month was given.</p> <p>On ..... at 10:00 AM on an interview with the administrator he stated that he stated that he did not have the bank statements in the facility at the time of the survey because he kept them at his house. He further stated that he had sent to Tallahassee the change of owner and change of administration at the end of ....., no specific date was provided and he received a letter from Tallahassee dated ..... letting him know that he had 21 days to correct any deficiencies or documents missing and he did not know why we were asking the same document again if he had 21 days to provide them.</p> <p>Unclassified Deficiency</p> |                                                                                                |                                                     |