

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969250	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 07/19/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BEST LOVING CARE #1 LLC

**448 SE JUSTINE TERR
PORT SAINT LUCIE, FL 34983**

(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 third revisit to the Complaint survey #2018013180 was conducted on _____ at Best Loving Care #1 LLC, License #13072. The facility had uncorrected deficiencies identified at the time of the survey. This revisit was conducted in conjunction with the Relicensure survey.	{A 000}		
{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, 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 _____; 2. If employed on or after _____, 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	{A 077}		

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969250	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 07/19/2019
NAME OF PROVIDER OR SUPPLIER BEST LOVING CARE #1 LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 448 SE JUSTINE TERR PORT SAINT LUCIE, FL 34983		
(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 1 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 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 , 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 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 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	{A 077}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969250	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 07/19/2019
NAME OF PROVIDER OR SUPPLIER BEST LOVING CARE #1 LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 448 SE JUSTINE TERR PORT SAINT LUCIE, FL 34983		
(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 2 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 _____, 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, _____, which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04002. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the Facility continues to fail to be under the supervision of an Administrator who meets the regulatory requirements. The current Administrator has failed to complete the CORE competency test requirements, pursuant to Rule	{A 077}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969250	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 07/19/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BEST LOVING CARE #1 LLC

**448 SE JUSTINE TERR
PORT SAINT LUCIE, FL 34983**

(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 3 58A-5.0191 F.A.C., no later than 90 days after becoming employed as the facility Administrator. The findings included: 1) During a complaint survey on _____, none of the current residents were familiar with the previous Administrator-of-Record at the time. On _____ at 12:44 PM, the Former Manager and Owner of the Facility stated, "[Previous Administrator] comes every 2 weeks for a good 6 hours. I talk to him frequently on the phone. He lives in Orlando." On _____ at 12:43 PM, a call was placed to the facility's previous Administrator, who declined to speak with me at this time, and who never called me _____ to speak with me. During record review, it was found that the previous Administrator was also listed as Administrator for 1 other assisted living facility, and as the Assistant Administrator for a 3rd facility, both located within 20 miles of Orlando. Employee record review revealed the Administrator of record (_____) passed the Core Exam on _____ and had maintained the 12 hour continuing education credits every 2 years. His Background Screening showed eligibility date of _____. On _____ at 11:48 AM and 2:29 PM, I sent the previous administrator 2 emails, one for each of the emails listed on separate facility provider pages. I requested that he contact me as soon as possible to discuss this facility. No response was ever received. 2) During revisit on _____ at 9:30 AM, the Owner of the facility stated she was still the acting Manager of the facility, and was observed on this	{A 077}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969250	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 07/19/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BEST LOVING CARE #1 LLC

**448 SE JUSTINE TERR
PORT SAINT LUCIE, FL 34983**

(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 4 date to act as the facility Manager. The person named as the Administrator at this time did not physically visit the facility or speak to me on the telephone during the revisit on . On at approximately 10:25 AM, the Facility Manager confirmed she had still not completed and passed the CORE Training Exam, and no date for taking the exam had been scheduled. The Manager stated it would probably be another 2 months before the exam would be taken. The Manager completed CORE Training on . The Manager spoke with the Administrator on the telephone at approximately 10:30 AM on ., and at this time she asked if he wished to speak with me. The Administrator stated he did not have the time to do so. On ., according to information contained in the FloridaHealthFinder.gov website, the previous Administrator was still listed as Administrator for a 2nd facility and Assistant Administrator for a 3rd facility, both the 2nd and 3rd facility are within 20 miles of Orlando. 3) During 2nd revisit on . at 9:35 AM, the Owner of the facility stated she was still the acting Manager. The Owner/Manager had completed CORE Training on ., but she confirmed she still had not passed the CORE Training Exam and no date for taking the exam had been scheduled. The Plan of Correction submitted on . documented: "The Owner of the facility is in the process of finding a new administrator and also planned to take the next scheduled CORE exam in this area." The Owner had requested an extension to the correction date to complete the exam.	{A 077}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969250	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 07/19/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BEST LOVING CARE #1 LLC

**448 SE JUSTINE TERR
PORT SAINT LUCIE, FL 34983**

(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 5 ... at 9:45 AM, a brief interview with the previous Administrator was conducted, he stated he visited this facility once a week, with next scheduled visit to be (Sunday). The previous Administrator confirmed that he was the Administrator for a 2nd facility and the Assistant Administrator for a 3rd facility, both the 2nd and 3rd facilities are within 20 miles of Orlando. The Administrator was notified verbally during this conversation that a Manager must be appointed to this facility who meets the regulatory requirements, one being that he/she must pass the CORE exam. On ... at 10:30 AM, the state regulation regarding requirements for Administrators and Managers of an ALF were again explained in detail to the Owner/Manager. She stated she understood and repeated that she must either look for a new administrator or manager for the facility, or pass the CORE exam. 4) During offsite preparation for the Relicensure survey, which was conducted at the same time as the 3rd revisit (...), it was noted that the Owner and previous Manager was now listed as the Administrator of this facility. Upon arrival at the facility on ... at 9:10 AM, the Owner/Administrator confirmed that she is now the acting Administrator for this facility. She also confirmed that, as of ..., she has not yet taken and passed the CORE exam. She provided no date for any future exam scheduled. A review of the Administrator's CORE training certificate showed she had completed CORE training on The Administrator had completed the required 12 hours of annual continuing education since completing her CORE training.	{A 077}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969250	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 07/19/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BEST LOVING CARE #1 LLC

**448 SE JUSTINE TERR
PORT SAINT LUCIE, FL 34983**

(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 6 A review of documents submitted to the Agency's Licensure Unit revealed a letter of resignation written by the previous Administrator to be effective The Owner, and now acting Administrator, submitted a Change of Administrator Form to the Licensure Unit stated she will become the Administrator effective State Regulation requires a new Administrator to complete CORE training and Competency Exam within 90 days of employment as an Administrator. On, it had been 93 days since the current Administrator became Administrator-of-Record with AHCA. It was also noted that on the CHANGE OF ADMINISTRATOR form submitted to the Assisted Living Licensure Unit, dated, this new Administrator checked off a box that indicated she was a licensed Nursing Home Administrator and her Registered Nurse license number in the place designated for a Nursing Home Administrator's license number. The Owner/current Administrator is not a licensed Nursing Home Administrator. Class III Uncorrected	{A 077}		