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
	AL11969250	A. BUILDING: _____ B. WING _____	10/07/2019

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 Complaint survey, #2019014588, was conducted on . . . . . and . . . . . at Best Loving Care #1 LLC. The facility had deficiencies at the time of the survey.	A 000		
A 030 SS=D	58A-5.0182(6) FAC; 429.28(. .) FS 429.27 Resident Care - Rights & Facility Procedures 58A-5.0182 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 58A-5.0181, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; . . . . . , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- . . . . . or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.	A 030		

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A 030	Continued From page 1 (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 58A-5.0181, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical	A 030		

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A 030	Continued From page 2 by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . . . . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the	A 030		

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A 030	Continued From page 3 resident or, if applicable, the resident ' s representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making . , , ... for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days ' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set	A 030		

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A 030	Continued From page 4 forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents ' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident ' s access to a telephone to call the State Long-Term Care Ombudsman	A 030		

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A 030	Continued From page 5 Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27(1)(a), FS Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to honor a resident's right to exercise their civil liberties by not allowing the resident to move out of the facility for 1 of 1 sampled Residents (Resident#1). The findings included: During a telephone interview conducted on at 2:22 PM, Resident #1 was interviewed by telephone and provided the	A 030		

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A 030	Continued From page 6 following information. She lived at the facility for a couple months. The facility rent used up all her money so her Case Manager (CM) was looking for a new place for her to stay. She found a place in mid- [illegible] but had to wait until she had the money to move with. The Owner knew she was moving out. The day her CM came to pick her up to move, the Caregiver on duty at the time called the Owner to tell her she was moving out. The Owner told her to not let them out. The Caregiver locked the door from inside and would not let them out. Resident #1 could hear the Owner yelling on the phone; she could tell the Caregiver was nervous. The Caregiver told the CM she had to do what she was told. She was scared the Owner would not let her move out. Then the CM called [illegible]-1, she told the [illegible]-1 operator what was going on. She stayed on the phone with the [illegible]-1 operator. The Owner got there and was "almost yelling" about getting paid for the rent but she opened the door. The CM started taking her things out to the car. Then the police came and talked to everyone and we left. In a telephone interview conducted on [illegible] at 8:57 AM, Resident #1's CM provided the following information. She's known Resident #1 for more than a year. She was assigned to her before and after her hospital stay. She was moved into the assisted living facility by the hospital about mid- [illegible]. She had been trying to place the resident in a facility that was less expensive. She visited the facility around mid- [illegible] and, at that time, believes she told the facility Owner the resident would be moving out. The Owner asked for something in writing. The CM made multiple attempts to fax it to the facility but kept getting busy signals or transmission errors so she mailed the notice to the facility.	A 030		

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A 030	Continued From page 7 On . . . . . , the day of the move, the CM called the Owner about one hour before arriving; the Owner voiced concerns regarding being paid for rent. The Owner stated she would need to discharge the resident's medications but the CM stated there were none because the resident had run out the day before. The CM arrived at the facility, presented her identification badge to the Caregiver present at the time, and signed in. She observed the resident was packing her belongings. The CM brought two bags of personal belongings out of the resident's bedroom and attempted to bring them to her car. She noted the front door was locked and she could not open the door. At that time, the Caregiver stated the Owner told her to lock the door and not let them leave; the Owner wanted them to wait until she got there. The CM told the Caregiver they would not leave before she got there; she just wanted to start packing her car. She asked the Caregiver to call the Owner. The Owner instructed the Caregiver to not unlock the door. The CM called her Supervisor and was told to call the police. They asked the Caregiver to call the Owner again and tell her if she is not there in five minutes, she will call the police. The Owner responded she does not care who she calls. The CM then phoned -1 and reported what was happening; the -1 operator stayed on the phone with the CM. The Owner arrived shortly after that with another individual. The Police Officer arrived and the CM asked him to check on Resident #1. The CM explained what happened to the second Officer. The Officer asked Resident if she wanted to leave with the CM, she said yes. The Owner claimed she did not know who the CM was, and tried to hide the facility's sign-in sheets. The Caregiver was asked and stated the CM had signed in and showed the Officer the sign-in sheet. The CM and Resident #1 left the facility.	A 030		

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A 030	Continued From page 8 The CM estimated they were locked in for about 20 minutes. In an interview conducted on at 9:45 AM, the facility's Owner provided the following information. Resident #1 lived at the facility for about one month. On , A CM came to take her somewhere. The Caregiver called her, she was five minutes away but they would not wait for her to get there. They refused to wait and said they would call -1. The resident owes one month rent. The [company name] was supposed to tell her how she would be paid but she never heard from anyone. She later confirmed she received $1,900 in rent on and again on . Resident #1 was running low on medications and needed her bi-weekly shot. She told the resident she needs a 30-day notice she is leaving. She told the FACT team she would need to be picked up by the 12th regarding rent. The resident was packing, the CM waited outside and called the police, who arrived 15 minutes later. The Owner told the CM to sign the sign-in sheet, the CM put the wrong date. She further stated that earlier that morning, the CM called saying she was trying to reach Resident #1, she had been calling the house phone, but can't find her. The Owner told her the resident is there, and she would come to the facility. The CM said the resident would be discharged today, the Owner said okay, the CM told the Owner to tell the resident to get ready. In an interview conducted on at 12:22 PM, the facility's Administrator provided the information. On in the morning, the facility's Owner called her and told her someone from the [company name] team was on their way to move Resident #1 out with no advance notice. She told the Owner to seek identification and that	A 030		

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A 030	Continued From page 9 they could not take the resident without prior notice. She told the Owner she needs about 45 minutes to get to the facility. When she was about 25 minutes away, the Owner informed her the police were here and said it was okay for her to go. Review of facility records and Resident #1's records revealed an admission and discharge log showing, she was admitted to the facility on . . . . . and discharged on . . . . . . Further review of facility records revealed Resident #1's CM signed in to visit Resident #1 on . . . . . and . . . . . . Although, the Owner indicated she was not aware of the person to pick up Resident #1. In conclusion, the facility violated Resident #1's right to exercise her civil liberties by not allowing her to leave the facility on . . . . . when she attempted to move out of the facility. Class III	A 030		
A 165 SS=D	429.23(&) FS; 58A-5.0241 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond	A 165		

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A 165	Continued From page 10 quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. [illegible]; 2. [illegible] or [illegible] damage; 3. Permanent [illegible]; 4. [illegible] or [illegible] of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.	A 165		

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A 165	Continued From page 11 (6) [redacted], neglect, or [redacted] must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The Department of Elderly Affairs may adopt rules necessary to administer this section. 58A-5.0241 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The	A 165		

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A 165	Continued From page 12 preliminary adverse incident report required by Section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to Rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1) above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to Rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to provide 1- and 15-day adverse incident reports as required for 1 of 1 sampled Residents (#1). The findings included: Based on interviews conducted on . . . . . at 9:45 AM with the facility's Owner; at 12:22 PM with the facility's Administrator; on at 2:22 PM with Resident #1; and, on . . . . . with Resident #1 Case Manager, an adverse incident occurred on at the facility. Resident #1 attempted to move out of the facility with the assistance of her Case Manager. The staff member on duty at the time of the incident was instructed by the facility's Owner to lock the front door from the inside and not allow the resident or case manager to leave the building. The resident and case manager were locked in the building for about 20 minutes; the case manager called the police for assistance. The Owner arrived and the case manager was allowed out of the building. Police arrived, assessed the situation, and the resident was allowed to leave, with her personal belongings, with the case manager. In conclusion, the facility	A 165		

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
	AL11969250	A. BUILDING: _____ B. WING _____	10/07/2019

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 165	Continued From page 13 violated Resident #1's right to exercise her civil liberties by not allowing her to leave the facility on . . . . . when she attempted to move out of the facility. (see Citation A0030 herein). Further record review revealed no documenation showing the facility submitted the required 1-day and 15-day adverse incident reports to the Agency. In an interview conducted on . . . . . at 12:32 PM, the facility's Owner, with the Administrator present, stated she did not know an adverse incident report was required. She stated the police were present for only two to three minutes. Class III	A 165		