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
	AL11922280	A. BUILDING: _____ B. WING _____	06/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE SENIOR LIVING AT PORT RICHEY LLC	5905 PINEHILL ROAD PORT RICHEY, FL 34668

(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 A complaint (2022008022, 2022008393, and 2022009150) in conjunction with a generator monitoring survey was conducted at Best Care Senior Living at Port Richey on . Deficiencies(s) were identified at the time of survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:	A 025		

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A 025	Continued From page 1 (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review, and interviews, the facility failed to provide the personal supervision and oversight required for each resident, to include awareness of general health, safety, and well-being for 1 (Resident #2) of 75 residents. The lack of oversight and awareness of Resident #2's elopement led to an absence from the facility for approximately 20 hours before the facility was aware Resident #2 had been missing. Findings included: A review of the facility's incident report, conducted	A 025		

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A 025	Continued From page 2 on . . . . . revealed Resident #2 left the facility's memory care unit at approximately 11:58am. Resident #2 was found on . . . . . by local law enforcement and transferred to a local hospital. The facility notice she was not in the building approximately 8:35am. Local law enforcement notified the Administrator the location of Resident #2 approximately 11:15am on . . . . . . A record review conducted on . . . . . revealed Resident #2 was admitted to the facility on . . . . . and was diagnosed with , , , and High . . . . . There was no documentation of any interventions for elopement or risk behaviors for Resident #2. A record review conducted on . . . . . of the facility's undated policy and procedure titled "Elopement/Missing Resident Policy and Procedures" stated the following: 1.Prior to admission, the Resident will be assessed for potential risk behavior. Risk behavior could include, but not limited to, the following: a. History of . . . b. Cognition , c. Diagnosis of . . . . . 5. Residents without a history of . . . and/or elopement shall be accounted for at a minimum of every 2 hours, 24 hours a day. An interview conducted on . . . . . at 10:14am with Staff B (Medication Technician), she stated she periodically pokes her . . . into the rooms but there is no hourly checks/rounds or	A 025		

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A 025	Continued From page 3 documentation. A record review of the Resident #2's Medication Observation Report was conducted on reveled staff had signed out medications at 2:00pm on for Resident # 2 when she was not at the facility. Interview conducted on at 10:30 am with the Administrator, she stated Resident #2 left the building at 11:58am on based off the observation of the camera. The Administrator stated she is not sure why staff continued to sign off on medications on and . An interview conducted on at 11:13am with Staff A (Medication Technician), he stated that when the staff come on shift the are to do a count, there are no two-hour checks for residents that are conducted by staff. An interview with the Administrator, conducted on at 11:50 am, the Administrator agreed no one look for Resident #2 for lunch on which was a missed opportunity that the whereabouts of the resident. An observation was conducted on at 12:06pm, Staff A was observed providing care in building 4 in the living room area. The exit door on the side of building 4 was opened and unsupervised and no alarms were noted or observed. An observation on at 12:11pm Staff D was observed to enter through the opened side door. Staff D did not close or lock the door. Staff D did not notify anyone that the door was open	A 025		

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A 025	Continued From page 4 and unlocked. An interview was conducted on at 12:48 p.m. with the Administrator. She stated it was her expectation that if the door to any of the memory care unit was found open the staff should immediately notify the staff to perform a count. She stated if the doors are left open the Owner received an alert to her phone, the Owner would call the Administrator and the Administrator would notify the memory care unit of the alert. The Administrator stated she had not received any notifications that the door was open. An interview conducted on at 12:50 p.m. with Staff A stated he had not been informed the door was found open or to perform a count. During an interview conducted on at 2:12pm with Staff D (Medication Technician), she stated that when she got into work on the morning of she noticed that Resident #2 was missing and contacted the Administrator. During a phone interview conducted on at 2:26pm with Staff C (Medication Technician) she stated that Resident #2 had eloped on her first day of employment and the facility did not know Resident #2 was missing for at least 2 shifts. During an interview with the Administrator conducted on at 3:30pm, she stated there are no intervention in place in place for memory care and elopements risks, and there are no monitors on residents. The Administrator stated she was not sure why staff had signed out that Resident #2 medications had been given	A 025		

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A 025	Continued From page 5 when she was not in the building. Class II	A 025		