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
	AL11969094	A. BUILDING: _____ B. WING _____	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING CORP	28265 SW 173RD CT HOMESTEAD, FL 33030

(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 survey (complaint number 2022013395) was conducted at Loving Corp. on to . Deficiencies were identified at the time of the survey	A 000		
A 011 SS=G	59A-36.006(5) FAC Admissions - Discharge (5) DISCHARGE. If the resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident's needs, as determined by the facility administrator or health care practitioner, the resident must be discharged in accordance with Section 429.28, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to discharge a resident after the resident did not meet the continue residency requirement for one out of six sample residents (Resident #1). Finding include: A review of the facility Admission and Discharge Log on , it showed that Resident #1 was admitted to the facility on and discharged on . On , the resident was transfer to Homestead Hospital and was then transferred to a Skilled Nursing Facility (SNF). A review of Resident #1's Health Assessment dated showed that the resident had a medical history and diagnoses of , , and with behavioral disturbance. The resident required assistance with ambulation, bathing, , eating, self-care, toileting, and transferring. According to the health assessment, the resident was not bed bound and did not have any , 3, and 4	A 011		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 011	Continued From page 1 , ... The resident was not under hospice care or receiving home health agency (HHA) services. A review of Resident #1's Health Assessment dated showed that the resident had a medical history and diagnoses of 's and , . The resident needed assistance with ambulation, eating, self-care, toileting, and transferring. The resident required total care with bathing and . . . . According to the health assessment, the resident was not bed bound and did not have any . . . .,3, and 4 , ... The resident was not under hospice care or receiving HHA services. A review of Resident #1's Primary Care Provider Notes dated , the provider wrote that the resident's right was . . . . . and when it is touch grimacing is noted. The resident also had a . . . . . in the area. In addition, the resident used a wheelchair and required assistance with all her ADL. A review of the Home Health Certification and Plan of Care developed by the Primary Care Provider showed that the care needed to start on . . . . . and end on . . . . . The resident had a , in the area that was . . . . . As for functional limitation, the provider stated that the resident had "- . . . . . (. .) when walking more than 20 , , decrease Rang of Motion (ROM)/mobility, poor stability, and low , ". The , increases with ambulation. A review of Resident #1's Home Health Comprehensive Adult Nursing Assessment dated	A 011		

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A 011	Continued From page 2 , the examining nurse wrote that the resident has a , on the that is and "patient unable to walk, bed bound, needing human assistance for daily living". A review of Resident #1's Primary Care Provider Notes dated showed the provider noted that the resident had , decreased strength, and /arms . As for the , , the was and . The had a foul odor with black edges. The resident was transported via ambulance to the hospital for further treatment. In an interview on at 10:36 AM, the Administrator stated that the resident was not receiving hospice care and that the resident was not ambulatory. She further stated that the resident had not walked for at least the prior three months. She also stated that the resident's extremities were rigid. Finally, she stated that from , the resident was bed bound, and her , did not improve and got progressively worse. On at 11:28 AM, Staff B (caregiver) stated that Resident #1 was unable to walk due to , on her . She stated the , had started about two months earlier. In an interview with the Care Nurse on at 3:21 PM, the nurse stated as for the resident mobility, the resident was rigid. Need assistance from staff to move. In her opinion, the resident was "bed bound". A review of Resident #1 Resident Records on , there was no documentation that the	A 011		

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A 011	Continued From page 3 facility requested a new Health Assessment or issued a 45 day notice of termination of residency to Resident #1 or the resident legal guardian after the resident had a significant change in condition. A review of the Resident #1 Hospital Record dated [illegible] showed that the resident was admitted to the hospital on [illegible] and discharged on [illegible]. The resident was diagnosed with [illegible], bacteremia, [illegible], of the right [illegible], fecaloma (fecal impaction), associated [illegible] pressure injury ([illegible]), [illegible] of multiple sites, [illegible] of the left [illegible], pressure injury of the right lateral ankle, [illegible], and [illegible]. Class II	A 011		
A 030 SS=J	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) 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 59A-36.006, 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	A 030		

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A 030	Continued From page 4 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. (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 59A-36.006, 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 standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (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	A 030		

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A 030	Continued From page 5 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. 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	A 030		

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A 030	Continued From page 6	A 030		

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 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,

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A 030	Continued From page 7 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 must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. 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	A 030		

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A 030	Continued From page 8	A 030		

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 Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida.

429.27 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

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A 030	Continued From page 9 resident. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to provide access to adequate and appropriate health care for one out of six sample residents (Resident #1). The lack of adequate and appropriate medical care leads the resident to develop multiple [illegible] on the right and right lateral ankle including an [illegible] in the [illegible] area. The resident was not treated for the injuries for at least five days, and the injuries became progressively worse until the resident was hospitalized on the and received surgical treatment for the injuries. Finding Include: A review of the facility's Admission and Discharge Log on showed that Resident #1 was admitted on and discharged on . A review of Resident #1 Health Assessment dated , showed that the resident had a medical history and diagnoses of 's and , . The resident needed assistance with ambulation, eating, self-care, toileting, and transferring. The resident required total care with bathing and . According to the provider completing the assessment,, the resident did not have any , 3, or 4 , and was not bedridden at the time of admission. On at 12:03 PM, the Administrator stated that on she called Resident #1's	A 030		

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A 030	Continued From page 10 Primary Care Provider regarding a . . . . in the area. A picture of the was taken and sent to the provider. the Administrator stated that the primary care provider did not evaluate the resident until . . . . . The picture showed that the resident had a , in the area. A review of Resident #1 Primary Care Provider Note dated , showed that the resident had a medical history that included . . . . 's . . . . , , , and . . . . , ... The resident was being seen to follow-up on a that was reported by the Assisted Living Facility (ALF) staff. The resident used a wheelchair and required assistance with all activities of daily living (ADL). The resident's right was and when touch . . . grimacing is noted. The resident has a , that is . . . . . Care orders send to a HHA (Home Health Agency). The primary care provider did not document any other . . . . in the resident's body. In an interview with the Administrator on . . . . . at 10:36 AM, the Administrator stated that the Home Health Agency (HHA) started doing . . . care (. . . . area) for the resident on . The home health nurse would come to the facility daily to do . . . . care. The resident did not improve and got progressively worse. From . . . . . to . . . . . , there was no documentation on file that the Administrator notified the resident's Primary Care Provider that her was getting worse or that she requested that the resident be transferred to a hospital. In an interview with Resident #1's Primary Care	A 030		

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A 030	Continued From page 11 Provider on [redacted] at 11:46 AM, the provider stated that she saw the resident on [redacted]. She stated that the resident had an [redacted] in the [redacted] area. She said there was a yellow [redacted]. She also stated that the resident did not have any other [redacted], and that [redacted] care orders were sent to the HHA, which began service on [redacted]. Finally, the provider stated that on [redacted], the HHA notified her because the resident's [redacted] got worse. A review of Resident #1 's Home Health Comprehensive Adult Nursing Assessment dated [redacted] showed that the resident had a [redacted] on the [redacted]. The assessment noted that the [redacted] was [redacted]. In addition, the assessment showed that the resident had a [redacted] on the left [redacted]. There was no documentation that the left [redacted] was treated by the [redacted] care nurse. Finally, it stated, "Patient unable to walk, bed bound, needing human assistance for activity of daily living. A review of Resident #1's HHA [redacted] Care Notes, it showed that the [redacted] care treatments started on [redacted]. From [redacted] thru [redacted], the [redacted] care nurse documented that there were no sign or symptom of [redacted]. A review of Resident #1's HHA [redacted] Care Notes dated [redacted], it showed that there were sign and symptom of [redacted] to the [redacted]. The resident Primary Care Provider was notified of the situation. A review of Resident #1's Primary Care Provider Order dated [redacted], the new [redacted] care order stated, "Skilled Nurse to cleanse [redacted] with normal [redacted] solution and apply [redacted] and cover with 4x4 gauze and	A 030		

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A 030	Continued From page 12 secure with tape daily and discontinue , and , ". There was no documentation that the provider evaluated the resident's . A review of Resident #1's HHA Care Notes dated showed that a new care order was received and started. The document noted that there was sign of . It stated that the caregiver was educated to turn and reposition the resident every 2 hours. It stated Resident #1 had a hospital bed with mattress. A review of Resident #1's HHA Care Notes dated documented that the continued to be . It stated care was provided, and documented that the nurse instructed the caregiver to avoid slipping or sliding and try to avoid positions that put pressure the . There was no documentation that the Primary Care Provider was notified of the situation. A review of Resident #1's HHA Care Notes dated showed, "The continuous to be . The resident's primary care provider was present during the care and decided to transfer the resident to the hospital." On at 11:28 AM, Staff B (Caregiver) stated that the got worse with care nurse. She stated, "I reported it to the Administrator." Further review of the resident record found no documentation that the Administrator took any action prior to the resident been sent to the hospital on . A review of Resident #1's Primary Care Provider Notes dated showed that the resident	A 030		

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A 030	Continued From page 13 had a [redacted] to the [redacted] area that was [redacted], with foul odor and black edges. The note stated, "[redacted] bed is brownish and yellowish in color. Orders to sent resident to the Emergency Department for possible [redacted]." The provider did not document that the resident had other [redacted] in her body. A review of Resident #1's Hospital Records dated [redacted] showed that the resident was admitted to the hospital on [redacted] and discharged on [redacted]. The resident was transported to the hospital by ambulance for an [redacted] ([redacted]). Upon Emergency Department arrival, the patient was tachycardic at [redacted] (according to Mayo Clinic, [redacted] is the medical term for a [redacted] rate over 100 beats a minute. If left untreated, some forms of [redacted] can lead to serious health problems, including [redacted], [redacted] or sudden [redacted]), and [redacted]. Laboratory results showed [redacted] (elevated white [redacted] count- a sign of [redacted]) at 22, hemoglobin of 9.4 (low), and mild (elevated [redacted]). In addition, the resident had an [redacted], fecaloma (fecal impaction), and [redacted] with redness to the area. The resident presented to the hospital with multiple [redacted]. Further review of the record showed the resident was admitted to the hospital [redacted] ([redacted]) in critical condition. The resident's [redacted] were examined/treated by the [redacted] care consultant. The consultant diagnosed the resident with: 1. [redacted] pressure injury ([redacted] area)- resident was taken to the operating room on [redacted] for debridement of [redacted] pressure injury.	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969094	A. BUILDING: _____ B. WING _____	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING CORP	28265 SW 173RD CT HOMESTEAD, FL 33030

(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 030	Continued From page 14 2. [illegible]: right and left [illegible] and [illegible]. 3. [illegible] pressure injury to left [illegible] 4. [illegible] pressure injury to right lateral ankle On [illegible], the resident was discharge to a Skill Nursing Facility (SNF). Finally, the resident discharge diagnoses were: [illegible], [illegible], Bacteremia, [illegible], [illegible] of right [illegible], Fecaloma, [illegible] associated [illegible], [illegible] pressure injury, [illegible] of multiple sites, [illegible], [illegible], and [illegible]. In addition, the resident's [illegible] extremities were [illegible]. In a telephone interview on [illegible] at 11:59 AM, the Administrator stated that Resident #1 only had a [illegible]. She denied that the resident had any other [illegible] on her body. the Administrator stated that the resident's skin was fine in [illegible] but got this way on [illegible]. Class I	A 030		