| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11969250** | **09/12/2018** |
| NAME OF PROVIDER OR SUPPLIER<br>**BEST LOVING CARE #1 LLC** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**448 SE JUSTINE TERR**<br>**PORT SAINT LUCIE, FL 34983** | |

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

**0000 - Initial Comments**

An unannounced licensure complaint survey, CCR#2018013180 commenced on [redacted] and concluded on [redacted] for Best Loving Care #1, LLC, License #13072. The facility had deficiencies at the time of the visit.

**0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC**

Based on resident record review and staff interview, the Provider failed to:
1) Ensure the appropriateness of 1 of 2 residents, whose records were reviewed, as it relates to the resident being assessed as requiring medication administration (Resident #1)
2) Ensure 1 of 2 residents, whose records were reviewed, had a face-to-face medical examination completed by a health care provider within 60 days prior to admission, with results of such examination documented on AHCA Form 1823 and placed within the resident's medical record at the facility (Resident #4).

The findings included:

1) On [redacted] during review of Resident #1's Health Assessment (AHCA Form 1823), dated [redacted], it was noted that Resident #1 was assessed as requiring Medication Administration.
During entrance conference on [redacted] at 9:00 AM, the Manager had stated she was a Registered Nurse. However, according to the Florida Department of Health License Verification website, the Manager is not a licensed nurse in the state of Florida, thus she would not be allowed to administer medications.

On [redacted] at 9:10 AM, the Manager stated that Resident #1 had refused all his morning medications that she had attempted to give him. The Manager stated he had also refused his evening medications the 2 nights previously. At 9:1 AM, the Manager tried again to get Resident #1 to take his medications, but he stated, "I told you I didn't want to take my medications. How many times do I have to tell you that I don't want them. You tried to put them in my mouth and make me take them, but I told you I didn't want them."

On [redacted] at 9:30 AM, the Manager was asked about the Health Assessment documenting Resident #1 required Medication Assistance. The Manager stated, "This is a mistake. He only needs assistance."

2) On [redacted] during record review for Resident #4, no Health Assessment (AHCA Form 1823) could be found within the resident's chart. Resident #4 was admitted to the facility on [redacted].

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11969250 | 09/12/2018 |

| 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** |

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

On at 10:45 AM, the administrator was asked for a completed Health Assessment for Resident #1. No document was provided at time of survey.

Class III

**0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC**

Based on record review and interviews, the Provider failed to contact appropriate parties to assist with maintaining the general health, safety and physical well-being for 1 of 4 sampled residents (Resident #1).

The findings included:

Review of the confidential documents regarding Resident #1 revealed the following:
A neighbor reported to police she was in her backyard cutting the grass and heard a shout. She looked over the fence and saw a man, 65, sitting in a plastic chair in the sun. After several minutes, she heard the male repeatedly calling for help. About 20 - 30 minutes later, a woman (Staff D) walked out to the man. The woman and the man exchanged words.
The neighbor told police the woman grabbed the man's upper arms and lifted him halfway from his seated position, and then let go. The man back in the chair, and the woman went back inside. After several more minutes, the neighbor called 911.
When police and Fire District officials arrived, the man was barely responsive. The back gate was locked, and when officials called out, they heard someone respond, "Please help," in a very weak voice. Rescue officials at the front door encountered Staff D, who took them to the man. He was suffering from possible symptoms of heat exhaustion. A walker was in front of the man, but he lacked the strength to use it. He said he wanted to go to the hospital.
Staff D told police the man was fine and had a habit of pulling stunts like this. She said she couldn't get the man [Resident #1] inside, and 911 wouldn't come to the house for him anymore.

The Manager stated on at 9:15 AM, "I am a Registered Nurse and I don't think [Resident #1] suffered from heat exhaustion. "[Staff D] was visiting from Jamaica for 3 weeks. Her husband went to NY. I went out with my husband and [Staff D] was here with the residents. She was not an employee, she was a visitor. [Staff D] called me and said that [Resident #1] was being difficult, and I told her not to touch the resident. The Resident was not in any distress. He was taken to the hospital and after 1 hour, the hospital discharged him back here."

On at 10:05 AM, Resident #1's Case Manager/Nurse was interviewed. He stated, "I was

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11969250 | 09/12/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BEST LOVING CARE #1 LLC** | **448 SE JUSTINE TERR**<br>**PORT SAINT LUCIE, FL 34983** |

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

notified after the event that occurred regarding [Resident #1]... In the place he was living previously, he was going to the hospital every 3 days. He has a tendency to lie down and want staff to pick him up when he is capable of getting himself up. He does these things because he wants attention. Someone from the FACT team visits him at the facility 3 times a week." [The Case Manager] stated there had not been any concerns during the previous visits.

During interview conducted with Resident #1 on at 10:23 AM, Resident #1 stated, "I don't need my walker to walk, but it's nice to have close by ...[Staff D] was working here. [The Manager] will tell you she wasn't but she was. She was charged with felony neglect. She did neglect me. The neighbors called because they heard me calling for help...Another time, I was sitting out under the tree; it was pouring down rain and lightening... On the day I was neglected, I don't remember where I was sitting outside. Sometimes when I am in the wrong chair, I can't get up because of an injury I got when I was in prison playing volleyball ..." Resident #1 has a diagnosis of and , . Resident appeared to be several times during interview (i.e. claiming to be the President of the United States, being engaged to Unit Nurse at a local hospital, etc.)

Resident #2, an alert and oriented resident who was at the facility during the incident and recorded some of the event with his phone, stated on at 11:29 AM, "[The Manager and Staff D] tried to help [Resident #1] a couple of times but he would not get up. It really wasn't [Staff D's] fault... There was a time when [staff] did leave [Resident #1] out in the rain. He couldn't get up. But the day the neighbor called, [the staff] were not neglecting him. [Resident #1] didn't want to get up, and the girl couldn't lift him."

A review of the video submitted by Resident #2 showed Resident #1 sitting in a white plastic chair located in the facility's back yard. The chair was positioned in the direct sun. The facility Manager tried to assist the resident out of the chair 3 times, telling him he needed to get out of the sun, but each time the resident told the Manager not to touch him and refused to move.

On from 9:00 AM until 2:00 PM, Resident was observed ambulating with his walker and transferring from chair to standing, with and without walker several times throughout the day. Resident was observed going in and out of the house aided only by his walker, and sitting and getting up from white plastic chair located in the back yard of the facility.

Even though the facility staff were not neglectful in trying to assist the Resident #1 out of the chair and into the house, when Resident #1 refused to come out of the sun, the Manager should have taken steps to contact appropriate parties (Case Manager, Mental Health Provider, Ambulance, etc.) to assist in ensuring the health and safety of the Resident.

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11969250** | **09/12/2018** |
| NAME OF PROVIDER OR SUPPLIER<br>**BEST LOVING CARE #1 LLC** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**448 SE JUSTINE TERR**<br>**PORT SAINT LUCIE, FL 34983** | |

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

Class III

**0028 - Resident Care - Activities of Daily Living - 58A-5.0182(4) FAC**

Based on observation, record review and interviews, the Provider failed to provide assistance with activities of daily living (ADLs) for 1 of 4 residents as it relates to bathing, toileting and dressing.

The findings included:

On . . . . . at 10:23 AM, Resident #1 stated, "I have had . . . . for 2 days. I have poop in my underwear and on my sock. [The Manager] won't help me clean myself." Resident #1 stated to the Manager, "I need help, and you won't help me!" The Manager did not respond to Resident #1.

On . . . . . at 10:25 AM, Resident showed me his sock he was wearing on his right foot. On the inside of his ankle, at the top edge of his shoe, was a brown spot, approximately the size of a quarter. According to Resident #1, this spot was caused by his . . . . dripping onto his sock because the Manager would not assist with cleaning himself when he went to the toilet, and refusing to help him change into clean clothes.

A review of Resident #1's Health Assessment (AHCA Form 1823) documents Resident #1 requires assistance with all of his ADLs. Observations made on revealed no ADL assistance to Resident #1 by the Manager or Staff C.

On . . . . . at 10:30 AM, the Manager denied Resident #1's accusation of not assisting him with ADLs.

Class III

**0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS**

Based on observation and interviews, the Provider failed to allow 1 of 4 residents the right to make independent personal decisions regarding daily activities and attendance at religious services (Resident #4).

The findings included:

. . . . . at 11:29 AM, Resident #4 stated, "[The Manager] makes me attend her Haitian church. I don't want to go, but she won't leave me here alone, so I have to go."

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11969250 | 09/12/2018 |
| NAME OF PROVIDER OR SUPPLIER<br>**BEST LOVING CARE #1 LLC** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**448 SE JUSTINE TERR**<br>**PORT SAINT LUCIE, FL 34983** | |

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

On . . . . . at 11:22 AM, review of confidential records revealed the following. She stated she had been contacted by Resident #4's Case Manager with Humana. She and her client (Resident #4) stated that on . . . . . , the Manager of the facility took the resident to McDonald's and left him there unattended for 5 hours because she didn't want to leave him alone at the facility.

On at 2:30 PM, this surveyor arrived back at the facility. Upon arrival the police officers stated they were called by the Manager because she claimed Resident #4 had threatened to kill her. The officers did not substantiate this claim.

On at approximately 3:00 PM, the police officers stated they had substantiated that the Manager took Resident #4 to McDonald's on Wednesday, . . . . . , and left him there for approximately 5 hours because the Manager had no one available to stay with him. Resident #4 did not want to go on errands with the Administrator. She had given Resident #4 an ultimatum, either go to McDonald's or stay outside until she returned. The resident's husband is CORE Trained and has a valid background screening. A reason was not provided as to why he was not able to stay with Resident #4.

The Case Manager for Resident #4 arrived at the facility on at 2:45 PM, and stated she had found another facility that would take Resident #4. Resident #4 was transported to the new facility by its Administrator on . . . . . at 3:30 PM.

Class III

**0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC**

Based on observation, interview and record review, the administrator failed to:
1) Be 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
2) Ensure the person appointed as facility manager satisfied the same CORE training competency test requirements and continuing education requirements of an administrator.

The findings included:

1) On . . . . . at 9:00 AM, the Owner of the facility stated she was the Manager of the facility, and was observed on this date to act as the facility Manager. The person named as the Administrator did not make his presence known on . . . . . or on . . . . . during the time this surveyor was at the facility

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11969250 | 09/12/2018 |

| 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** |

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

conducting the complaint investigation.

On at 11:14 AM, the [entity] stated she was unable to speak to the Administrator, as he had not returned any her call.

On at 11:29 AM, Resident #4 stated the Manager was never at the facility when Staff D was staying at the facility. Resident #4 was not aware of another Administrator. He stated, "I have never seen or heard of anyone by [the administrator's name]. I don't know who that is."

On at 12:00 PM, Resident #1 was asked if he knew the Administrator, and he stated he did not know him.

at 12:44 PM, the Manager stated, "[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 Administrator. When asked when he was scheduled to be at the facility, he stated he could not answer any questions at this time. I asked him for 30 seconds to tell me the names of the residents who were currently residing at the facility, as none of the residents knew who he was. He took more than 30 seconds to explain to me that he already told me he couldn't speak to me, and I would need to schedule a time to speak with him. We were to speak on at 7:00 PM, but he never returned the called.

During record review, it was found that this Administrator is listed as Administrator for 1 other facilities, and Assistant Administrator for a 3rd facility, both located within 20 miles of Orlando.
On at 11:48 AM and 2:29 PM, I sent the 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 has been received as of this date ( ).

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 .

2) The Facility Manager completed CORE Training on , but did not pass the CORE Exam, which is required to be a Manager of an assisted living facility. There was also no documentation showing completion of required 12 hours annual continuing education requirements.

3) Staff C also completed CORE Training on , but did not pass the CORE Exam. There was no

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11969250 | 09/12/2018 |
| NAME OF PROVIDER OR SUPPLIER<br>**BEST LOVING CARE #1 LLC** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**448 SE JUSTINE TERR**<br>**PORT SAINT LUCIE, FL 34983** | |

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

documentation showing completion of required 12 hours of annual continuing education requirements.

Class III

**0078 - Staffing Standards - Staff - 58A-5.019(2) FAC**

Based on record reviews and interviews, the Provider failed to ensure 3 of 4 staff had a documented negative ( ) examination on an annual basis (Staff A, B, C).

The findings included:

Review fo staff files revealed the following.
1) Staff A's last annual documented negative examination expired on .
2) Staff B's last annual documented negative examination expired on .
3) Staff C's last annual documented negative examination expired on .

On , a request was made to the Manager to provide documentation showing current Negative examinations for Staff A, B, and C. No documentation was provided.

Class III

**0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC**

Based on observation, interviews and record review, the Provider failed to follow the posted approved lunch menu or substitute food items of comparable nutritional value, for 4 of 4 residents (Residents #1, #2, #3, #4).

The findings included:

On at 10:23 AM, Resident #1 stated, "[The Manager] is not a good cook; the food is not very good," On at 11:29 AM, Resident #2 stated, "I don't eat here. The food is horrible."

On at 12:40 PM, a lunch observation was made. The menu posted stated the lunch meal for this date was to inlcude 4 oz meatloaf, 1 c. mashed potatoes, 1/2 carrots, and 1 c. mixed salad with 2 T. dressing. The food served to the residents was a large plate of pasta (approx. 2 c.) with plain tomato sauce (approx. 1/2 cup). No mixed salad was served with the meal. There was no protein to substitue for the meatloaf, and no vegetable to substitute for carrots.

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11969250** | **09/12/2018** |
| 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** | |

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

On , at 3:30 PM, the residents had not yet been served lunch prior to this time due to Manager being busy with police and [entity]. When residents were fed, they were given a large bowl of chicken noodle soup containing a soup bone with meat attached. The scheduled meal to be served, according to menu, was 4 oz Turkey with gravy, 1 c. sweet potato, 1/2 cup green beans, 1 cup of mixed salad with 2 T. dressing. There was no substitution provided for the green beans or mixed salad.

During both observations, the food provided smelled and looked appetizing.

The need to follow the menu or provide appropriate substitutions was discussed with the Manager.

Class III

**0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC**

Based on observation and interviews, the Provider failed to:
1) Provide a safe living environment for 4 of 4 residents related to:
a) The presence of shuttered windows and keyed deadbolts creating a potential hazard in the event of fire (Residents #1, #2, #3, and #4).
b) The presence of potential hazards related to rusty tree saw blade propped up next to house near seating area used by residents, and exposed bolts sticking out of wall in shared .
c) The failure to maintain appurtenances in good working order.
2) Provide a decent living environment for 1 of 4 residents related to the provision of clean bedding (Resident #1);

The findings included:

1a) During observational tour of the facility on , the living were covered with slatted metal shutters, bolted on from the outside of the house. The front and back doors were equipped with deadbolts requiring a key to operate. On at 2:00 PM. the Administrator was informed of the need to change the deadbolt unless the facility was operating as a locked facility. At this time, a copy of the Fire Inspection Report was requested. The Administrator stated she could not find the Fire Inspection Report.

On at 2:30 PM, a return visit to the facility showed shutters were still in place on the windows and keyed deadbolts were still in place.

On at 9:59 AM, a voice mail was left for the Fire Prevention Bureau,

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11969250 | 09/12/2018 |
| NAME OF PROVIDER OR SUPPLIER<br>**BEST LOVING CARE #1 LLC** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**448 SE JUSTINE TERR**<br>**PORT SAINT LUCIE, FL 34983** | |

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

On at 10:16 AM, an email was sent to Fire Marshall notifying the Fire Marshall of the presence of shutters on windows at the assisted living facility and keyed bolts installed on the front and back doors.
On at 3:00 PM, the Staff Assistant to the Fire Chief, returned my call and stated this facility's last fire inspection was done in of 2017, so it would have expired of 2018. She stated she would send an inspector out regarding the shutters and keyed deadbolt on doors.

On at 3:54 PM, the Staff Assistant called to inform me that inspectors would be at the facility the following Monday morning ( ) at 9:00 AM. If the inspector found the shutters and the keyed deadbolts in place, the owner would be issued an immediate cease and desist order.
On at 1:42 PM, a voice message was left on my phone by Staff Assistant to the Fire Marshal stating a Fire Prevention Investigator went to the facility and had the provider remove the shutters and change the keyed bolts on the front and back doors. Staff Assistant also stated that while the investigators were there, the provider paid the fee to have the annual fire inspection scheduled.

b) During observational tour of the facility on at 12:30 PM, a rusted tree saw was seen propped against the back of the house, next to residents' sitting area, easily accessible to the residents, and with the potential to down upon a resident seated in the chair close by (photo evidence on file). Also, in the shared residents' , there were 2 long rusted ends of bolts protruding out of the wall, opposite the toilet, and at a level where the bolts could potential cause to residents' legs (photo evidence on file).

c) During observational tour on at 12:30 PM, a rusted C-clamp was seen in place of broken shower knob in shared Resident's (photo evidence on file).

2) On at 11:14 AM, an interview was conducted with [entity] who stated she had spoken with Resident #4 and was told that Resident #1 had wet his bed the previous night, and the Manager told Staff D to take the sheets out and lay them on the grass to dry. The APS investigator went over to Resident #1's bed and smelled the sheets, and they smelled strongly of . The APS investigator stated she informed the Administrator to change and wash the sheets.

Resident #4 provided a picture of Resident #1's sheets laying out in the grass to dry (photo evidence on file).

Class III

**0160 - Records - Facility - 58A-5.024(1) FAC**

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11969250 | 09/12/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BEST LOVING CARE #1 LLC** | **448 SE JUSTINE TERR**<br>**PORT SAINT LUCIE, FL 34983** |

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

Based on facility record review and staff interview, the facility failed to provide annual fire inspection report at the time of survey.

The findings included:

On . . . . . at 3:15 PM, and again on . . . . . at 3:50 PM, a request was made to the Manager for the annual fire inspection and DOH reports. She stated at these times that she could not find the reports.

Per interview with Staff Assistant to the Fire Marshal on at 3:00 PM, the facility's fire inspection had expired in . . of 2017, and a new inspection had not yet been paid for and scheduled.

Class III

**0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC**

Based on facility record review and interviews, the Provider failed to maintain personnel records for 1 of 4 staff members (Staff D) which is to contain, at a minimum, the following: employment application with references; verification of freedom from communicable . . . . , including ; documentation of Level II background screening; and documentation of compliance with all state required trainings.

The findings included:

During an interview with facility Manager on at 9:00 AM, she stated, "[Staff D] was not an employee." She stated she had no personnel records for Staff D, and a background screening had not been completed. The Manager stated she had left Staff D alone with the residents on , and that Staff D had attempted to assist Resident #1 out of the chair located in the backyard. According to the Manager, Staff D had been living at the facility for 3 weeks.

On at 10:23 AM, Resident #1 stated that Staff D assisted him with bathing and washing his hair. "[Staff D] was working here. [The Manager] will tell you she wasn't, but she was."

On . . . . . at 11:29 AM, Resident #4 stated, "[Staff D] was working here; [The Manager] is lying. I have video of [Staff D] providing medications to a resident."
Review of video produced by Resident #4 does show Staff D providing Medication Assistance to Resident #3.

On at 12:09 PM, Resident #3 stated, "[Staff D] tried her hardest to do the work around here,

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11969250 | 09/12/2018 |
| NAME OF PROVIDER OR SUPPLIER<br>**BEST LOVING CARE #1 LLC** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**448 SE JUSTINE TERR**<br>**PORT SAINT LUCIE, FL 34983** | |

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

cooking and cleaning, and cleaning the derriere of an old man."

Class III

**Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS**

Based on record review and interviews, the Provider failed to maintain the employment status of 4 of 4 employees within the Agency's Clearinghouse (Staff A, B, C, and D).

The findings included:

A review of the Providers Clearinghouse account showed no employees listed on the faciltiy's employee roster.

Per interview with facility Manager on . . . . . at 9:00 AM, she stated, "[Staff D] was not an employee." The Manager stated she had left Staff D alone with the residents on . . . . . , and that Staff D had attempted to assist Resident #1 out of the chair located in the backyard. Per Manager, Staff D had been living at the facility for 3 weeks, and she had access to resident property and living space. The Manager stated that she, her husband, and the Adminstrator were the only employees.

On . . . . . at 10:23 AM, Resident #1 stated Staff D assisted him with bathing and washing his hair. "[Staff D] was working here. [The Manager] will tell you she wasn't, but she was."

On . . . . . at 11:29 AM, Resident #4 stated, "[Staff D] was working here; [The Manager] is lying. I have video of [Staff D] providing medications to a resident."
Review of video produced by Resident #4 does show Staff D providing Medication Assistance to Resident #3.

On . . . . . at 12:09 PM, Resident #3 stated, "[Staff D] tried her hardest to do the work around here, cooking and cleaning, and cleaning the derriere of an old man."

Unclassified

**Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS**

Based on record review and interviews, the Provider failed to order a Level 2 Background Screening for 1 of 3 employees whose responsibilities may require him/her to provide personal care, or have access to residents' personal property, or living areas (Staff D).

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11969250** | **09/12/2018** |
| NAME OF PROVIDER OR SUPPLIER<br>**BEST LOVING CARE #1 LLC** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**448 SE JUSTINE TERR**<br>**PORT SAINT LUCIE, FL 34983** | |

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

The findings included:

Per interview with facility Manager on [redacted] at 9:00 AM, she stated, "[Staff D] was not an employee." She confirmed a background screening had not been completed for this person. The Manager stated she had left Staff D alone with the residents on [redacted], and that Staff D had attempted to assist Resident #1 out of the chair located in the backyard. Per Manager, Staff D had been living at the facility for 3 weeks, and she had access to resident property and living space.

On [redacted] at 10:23 AM, Resident #1 stated Staff D assisted him with bathing and washing his hair. "[Staff D] was working here. [The Manager] will tell you she wasn't, but she was."

On [redacted] at 11:29 AM, Resident #4 stated, "[Staff D] was working here; [The Manager] is lying. I have video of [Staff D] providing medications to a resident."
Review of video produced by Resident #4 does show Staff D providing Medication Assistance to Resident #3.

On [redacted] at 12:09 PM, Resident #3 stated, "[Staff D] tried her hardest to do the work around here, cooking and cleaning, and cleaning the derriere of an old man."

A review of the Background Screening website verified no Background Screening had completed for Staff D.

Unclassified

**Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c) FS**

Based on record review and interviews, the Provider failed to ensure 1 of 3 employees required to have a Background Screening completed and signed an Attestation of Compliance with Chapter 435 (Staff D).

The findings included:

Per interview with facility Manager on [redacted] at 9:00 AM, she stated, "[Staff D] was not an employee." She confirmed a background screening had not been completed for this person. The Manager stated she had left Staff D alone with the residents on [redacted], and that Staff D had attempted to assist Resident #1 out of the chair located in the backyard. Per Manager, Staff D had been living at the facility for 3 weeks, and she had access to resident property and living space.

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11969250** | **09/12/2018** |
| NAME OF PROVIDER OR SUPPLIER<br>**BEST LOVING CARE #1 LLC** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**448 SE JUSTINE TERR**<br>**PORT SAINT LUCIE, FL 34983** | |

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

Manager provided no documentation related to the employemnt of Staff D, including a signed Attestation of Compliance.

On . . . . . at 10:23 AM, Resident #1 stated Staff D assisted him with bathing and washing his hair. "[Staff D] was working here. [The Manager] will tell you she wasn't, but she was."

On at 11:29 AM, Resident #4 stated, "[Staff D] was working here; [The Manager] is lying. I have video of [Staff D] providing medications to a resident."
Review of video produced by Resident #4 does show Staff D providing Medication Assistance to Resident #3.

On . . . . . at 12:09 PM, Resident #3 stated, "[Staff D] tried her hardest to do the work around here, cooking and cleaning, and cleaning the derriere of an old man."

Unclassified