STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968585	C 01/04/2017
NAME OF PROVIDER OR SUPPLIER **A BETTER CARE LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **308 SOUTH 30TH STREET** **FORT PIERCE, FL 34947**	

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

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

Based on observations, interview and record review, the facility failed to:
1. Ensure staff members with a Level II Background Screening conducted prior to being hired did not have a 90-day break in employment requiring Level II Background Screening for 1 of 3 sampled Staff (A).
2. Maintain employment status of all staff members within the Care Provider Background Screening Clearinghouse for 5 of 6 sampled Staff (A, B, D, E and F).

The findings included:

Review of facility and staff records was conducted / with the facility's Administrator present. The following concerns were identified.

1. Staff A was hired on 11/ . Staff A Level II Background Screen documented an eligible date of , more than 1.5 years prior to his hire at this facility. Further review of his staff record revealed no documentation showing if he was employed in a position (that requires Level II Background Screening) for the 90-days prior to being hired at this facility. Staff A was observed providing direct care to residents throughout the survey conducted / . This was discussed on / at 1:05 PM with the Administrator. He confirmed Staff A provides direct care to the facility's residents.

2. Review of the facility's current Care Provider Background Screening Clearinghouse record revealed the following:
A. Staff A was hired on 11/ . He was not listed in the facility's record in the clearinghouse.
B. Staff B was hired on . She was not listed in the facility's record in the clearinghouse.
C. In an interview at the time of record review, the Administrator stated the following. Staff D was hired ; Staff E was hired ; and, Staff F was hired . He stated all 3 were no longer facility staff. He acknowledged their "End Dates" were not entered in the clearinghouse.

The above concerns were discussed with the Administrator on / at 1:05 PM.

Unclassified

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

Based on observations, interviews and record review, the facility failed to obtain the required Affidavits of Compliance with Background Screening Requirements, for 3 of 3 sampled Staff (A, B and C).

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The findings included:

Review of staff records was conducted on 01/04/2017 beginning at 1:05 PM with the facility's Administrator present. The following concerns were identified:

1. Staff A was hired 11/ .
Review of his staff records revealed no signed Affidavit of Compliance with Background Screening Requirements form AHCA Form 3100-0008. Employee A was observed providing direct care to residents throughout the survey conducted / .

2. Staff B was hired . Review of her staff records revealed no signed Affidavit of Compliance with Background Screening Requirements form AHCA Form 3100-0008.

3. Employee C was hired . Review of her employee records revealed no signed Affidavit of Compliance with Background Screening Requirements form AHCA Form 3100-0008.

These concerns were discussed with the Administrator at the time of review. He confirmed these staff members provided direct care to the facility's current 6 residents.

Unclassified

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0000 - Initial Comments

A Complaint Investigation, CCR #2016014368, was conducted on 01/04/2017 at A Better Care LLC, license #12524. The facility had deficiencies at the time of the investigation.

0009 - Admissions - Admission Package - 58A-5.0181(3) FAC; 400.0078(2)

Based on record review and interview, the facility failed to make the facility's resident elopement response policies and procedures available to new residents as part of the admission packet and/or resident agreement for 3 of 3 sampled Residents (#1, #3 and #5).

The findings included:

Review of the facility's sample admission packet/resident agreement for Residents #1, #3 and #5's resident agreements was conducted / with the Administrator present.

The admission packet and resident agreements for Residents #1, #3 and #5 revealed no reference to the facility's resident elopement response policies and procedures. Page 1 of the contracts included, "... the facility agrees to provide or otherwise make available the following services ... 24-hour supervision." This was acknowledged by the Administrator on / at 1:27 PM.

During the survey conducted / , multiple inadequate versions of written policies and procedures related to resident elopement response were presented.

Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on record review and interview, the facility failed to comply with required elopement standards for 3 of 3 sampled Residents (#1, #3 and #5). The facility had conflicting and inadequate written policies and procedures related to resident elopement response, and failed to implement same.

The findings included:

Review of facility records and resident records conducted on / revealed:

During an interview at 10:37 AM, with the Administrator, he was asked and stated the facility definition of "elopement" was if a resident leaves and has not returned within 24 hours. A copy of the facility's written policy and procedures related to resident elopement response was requested from the facility's

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Administrator.

A written copy of the facility's entire policies and procedures was received, it contained no provisions related to resident elopement response policies and procedures.

In an interview conducted I/ at 11:08 AM, the facility's Administrator stated Resident #3 is at risk for elopement and has to be monitored constantly. She will insist on, or attempt to go outside by herself. Staff will accompany her as she walks down the street. She will then lay down on the ground, complaining she is having a . Staff call 911. The Emergency Personnel respond, they are familiar with this behavior and know her by name. They will evaluate her, tell her she is fine, and she gets up and returns to the facility accompanied by staff.

At 11:07 AM, the Administrator presented a one-page document, "Page 10" as the facility's resident elopement response policies and procedures. It disclosed in it's entirety:
"If a resident is missing from facility more than 24 hours without the knowledge of whereabouts from a sign in sheet or verbal communication with staff this is deemed an official elopement.
1. If resident has left premises without staff knowledge management should be notified immediately.
2. Management will order search on premises and to known normal where known normal whereabouts of resident if not at facility.
3. If medication administration time has passed and resident has not returned to facility for medication administration, 911 should be notified as well as any family members.
4. If a 24 hour period has passed at this time the resident will be deemed an elopement. Physician will need to be notified to make any necessary adjustments for elopement risk. Incident report to AHCA need to be file immediately."

At 1:27 PM, the Administrator presented a third version of the facility's resident elopement response policy and procedures. Review of this policy revealed:
i. "Definitions - Elopement - means an occurrence in which a resident leaves the facility without following policy and procedure, s. 58-5.011 (14), FAC. Persons who elope differ from wanderers in that they are purposeful and may repeatedly attempt to leave."
ii. "Admissions - ABC's resident elopement response policy will be included in the admission package. All new admissions assessed as at risk for elopement will have a recent photo provided to, or taken by, the facility within 10 calendar days of admission."
iii. "General Policy and Procedure - ABC's facility shall make, at a minimum, a daily effort to determine that at risk residents have identification on their person that include their name and the facility's name, address, and telephone number ... If a current resident is assessed as a risk for elopement, the facility shall obtain or take a current photo and have it placed in the resident's file within 10 calendar days of the

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assessment. [Augment policy with names or positions of first-tier and second-tier staff responsible for checking resident identification and the time of day such checks will take place. Include names of persons responsible for making sure the photograph gets in the resident ' s file within 10 calendar days.] Record-keeping - The facility will keep a current copy of the facility ' s resident elopement policies and procedures in the facility records. The facility will also document the resident elopement response drills and maintain this documentation in the facility records. The [Administrator] will be responsible for ensuring that these records are in place. "

. "Resident Elopement Response Policy - " After two hours in which an ABC ' s resident has not been accounted for, said resident shall be considered as having possibly eloped ... STAFF POSITION will check with Transportation ... STAFF POSITION will notify Security ... STAFF POSITION instruct Communications to put a radio call to all staff carrying radios ... If the resident is not found within 30 minutes, the on cite staff will call 911 ... the resident's family and the facility's CEO ... ABC's staff will be the incident commander, coordinating facility efforts, directing action, facilitating communication, including communication with family members." The policy did not identify staff responsible for each component of the resident elopement policies and procedures.

In an interview conducted / at 12:20 PM, Staff A, was asked and stated if he checks Resident #3 for any identification on a daily basis. He stated he doesn't check on a daily basis but she carries emergency contact and identification information. At 12:28 PM, this writer and the Administrator followed Staff A to the back patio area where Resident #3 was smoking a cigarette. Staff A asked Resident #3 if she had anything with her that showed her name, the facility name, and the facility's address and telephone number. She looked through her wallet and stated, "No".

On / at 12:35 PM, the Administrator was asked if they had any photographs. He produced what he described as a "third-generation copy" of a drivers license issued on . The picture was not indicative of the resident ' s current appearance, the Administrator agreed. Review of the facility's written Elopement Procedures and Policies disclosed, "ABC's facility shall make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that include their name and the facility's name, address, and telephone number. Staff attention shall be directed towards residents assessed at high risk for elopement, with special attention given to those with and related assessed at high risk. If a current resident is assessed as a risk for elopement, the facility shall obtain or take a current photo and have it placed in the resident's file within 10 calendar days of the assessment. [Augment policy with names or positions of first-tier and second-tier staff responsible for checking resident identification and the time of day such checks will take place. Include names of persons responsible for making sure the photograph gets in the resident's file within 10 calendar days.] Record-keeping - The facility will keep a current copy of the facility's resident elopement policies and procedures in the facility records. The facility will also document the resident

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elopement response drills and maintain this documentation in the facility records. The [Administrator] will be responsible for ensuring that these records are in place."

On I/ at 10:47 AM, documentation of facility resident elopement response drills for the past 2 years was requested. At 11:47 AM, the Administrator stated they conducted the drills and he was trying to locate documentation showing same. At 1:11 PM, he stated he found no documentation showing facility elopement response drills for the past 2 years. Review of the written policies and procedures disclosed, " Drills - ... ABC ' s " Code Red " (Resident Elopement Drill) drills shall be conducted twice a year. ABC ' s administrator and direct care staff must participate in the drills which shall include a review of procedures to address resident elopement. Facilities must document the implementation of the drills and ensure that the drills are conducted in a manner consistent with ABC ' s resident elopement policies and procedures. Participation in these drills shall be documented and kept in the staff records. Discrepancies and/or revealed through the drills will be corrected. "

The above concerns were discussed with and acknowledged by the Administrator on I/ at 12:42 PM.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on record review and interview, the facility failed to provide the required copy of facility resident elopement response policies and procedures for 3 of 3 sampled Staff (A, B and C).

The findings included:

Review of facility and staff records was conducted I/ with the facility's Administrator present. The following concerns were identified:

1. Staff A was hired I/ . There was no documentation showing he received a copy of the facility's elopement response policies and procedures.

2. Staff B was hired . There was no documentation showing she received a copy of the facility's elopement response policies and procedures.

3. Staff C was hired . There was no documentation showing she received a copy of the facility's elopement response policies and procedures.

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These concerns were discussed and acknowledged by the facility's Administrator on 01/04/2017 at 12:42 PM.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2017

Administrator
A Better Care LLC
308 South 30th Street
Fort Pierce, FL 34947

RE: CCR #20160143685

Dear Administrator:

This letter reports the findings of a state complaint survey that was conducted on , 2017 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2017.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure

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