STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965654	**03/30/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
BETTER CARE HOME	**7599 WEST 4TH COURT HIALEAH, FL 33014**	

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

0000 - Initial Comments

A Standard Biennial survey was conducted on , 2015. Better Care Home had the following deficiencies at time of the survey.

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

Based on record reviews and interview, the facility failed to ensure that the Resident Health Assessment form, AHCA Form 1823 for one of three sampled residents (Residents #2) reflected whether the Resident needed assistance with medication. Facility failed to have an initial health assessment completed for one of six sampled residents (Resident #5).

Findings included:
A review of the health assessment form for Resident #2 on revealed that the Resident Health Assessment form, AHCA Form 1823 (dated) did not indicate what kind of assistance the resident needed with medication.

Further record review on to Resident #5 (admitted on) revealed that her Health Assessment 3008 (dated on) was not completed. Also, there was no information about eating .

Interview on with Resident's (#5) father revealed that she was hospitalized for three days due to eating .

During an interview on at approximately 1:05 p.m., Employee A said that the doctor was coming the following week and she would ask for Resident #2's Health Assessment form to be updated.

Class III

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observation, record review and interviews, the Administrator failed to document significant change in a resident ' s health status for 1 of 3 sampled residents (Resident #2).
Findings included:
During a tour of the facility at 9:05 a.m. on , a door knob safety device was observed on the facility ' s interior front door handle.
Record review on revealed a prescription from the health care provider stating that Resident #2 was diagnosed with as of and that the Health Assessment , AHCA Form 1823 was not updated to include the diagnosis.
During an interview on at 1:30 p.m., Employee A sated that she didn't know why the Health Assessment form was not updated, but that she would ask the doctor to do it.
During an interview on at 3:30 p.m. when asked why the door knob safety device was in place, Employee A

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sated that Resident #2 had recently wandered away from the facility on a couple of occasions, and that she didn ' t want him to leave and be in danger.
Class III

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

Based on record review and interview the facility failed to maintain a written record any illnesses that resulted in medical attention for two out six (#s 1 and 5) residents sampled.

Findings included:

Record review on revealed the facility did not have written information regarding Residents (#s 1 and 5) in their files or/and progress notes.

An interview with Resident (#1) stated that she went to the hospital for 4 days because she . . l. Resident (#1) stated that she did not break a bone, but she dislocated the right shoulder.
Interview on at 11:44 am with Resident's (#5) Father stated that he took Resident (#5) to the doctor one months ago because she was not eating, and she lost some weight (eating), and she was hospitalized for three days. Also, Resident's (#5) Father stated that she had a new medication to help her to eat.

Interview on at 1:00 pm with Staff A revealed that Residents (# 1 and 5) were hospitalized in this year, but she has no progress notes about that. She also stated, " I did not know why Resident (#5) was hospitalized, her father took her to the doctor, and he never gave me any explanation." Staff A also stated that she knew that Resident #1 but it was last year in , but she did not have information recorded about it to prove it.

Class III

0026 - Resident Care - Social & Leisure Activities - 58A-5.0182(2) FAC

Based on observation and interview the facility failed to have an update monthly activity schedule displayed in a conspicuous place.

Findings included:

Observation on at 9:09 am revealed that there was an activity schedule posted in the facility dated on 2014.

Interview on at 12:00 pm revealed that the administrator acknowledged that the facility did not have an updated monthly activity displayed in the facility at time of survey.

Class III

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

Based on observation, record review and interviews, the facility failed to include a clause in the resident contract which requires that residents receive at least 45 days advance notice of the facility's intent to terminate residency from the facility for non-emergent reasons for 6 of 6 sampled residents (Residents 1-6). Facility failed to honor resident rights for one out six (# 1) sampled residents to not blocked with a sofa while lying on bed. The facility failed to ensure that one out of six sampled residents (#4) was treated with consideration and recognition of personal dignity.

Findings included

Observation during facility tour on at 9:10 AM showed Resident (#4) sleeping in (# 3) with a sofa blocking Resident ' s (#4) bed. Also, Resident (# 1) sleeping in the was the office, too. Three out of four lightbulbs in Resident ' s (#3) (#1) were out, and the facility had an odor of in the hallway between (#s1 and 2).

Further observation on from 9:08 am - 3:45 revealed that Staff A was working in Resident ' s (#1) (office) answering the phone and doing office work while Resident #1 was seating next to her on a chair.

Record review on of the signed contract for Residents (#1- 6) revealed that a requirement for residents to give notice, which states: ' If resident or responsible party decides that he/she no longer wishes to remain in this facility, thirty (45) days written notice must be submitted to the administrative office.'

Record review on of the signed contract for Residents (#1- 6) revealed that there was no clause contained in the document which stated that the facility will give residents at least 45 days advance notice of intent to terminate residency.

Interview on at 9:14 am with Staffs (B and A) revealed that Resident (#4) slept with a sofa blocking bed to prevent her to from bed. Interview also revealed that Staff B stated, " Resident ' s (#1) the office, and I sleep with her in a sofa/bed. "

During an interview on at 3:15 p.m., the owner stated "Yes, of course, this clause needs to be put into the contract." Also, Staff B stated, " The bulbs of # was not working and she will fix it. "

Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185(3) FAC

Based on observation and interview the facility failed to assist with self-administration of medication for two out six (#s 2 and 4) sampled residents.

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Findings Include

Observation on at 12:00 pm revealed that Staff B took a spoon, a cup with apple sauce, and medication (, Fuma IR 50 MG) already crashed inside. Then, Staff B asked Resident (# 4) to open her mouth and pour the apple sauce with crashed medication into Resident's (#4) mouth. There was no Medication Observation Record (MOR) to record and/or verify medication, and Staff B did not provide any information regarding the medication to Resident (#4).

Further observation on at 12:10 pm revealed that Resident (#2) had his medication in a medicine cup placed on his lunch tray by Staff B. She did not come to the table to observe whether he took the medications or not. When asked what he was taking, the resident said he didn ' t know, but that it was all ' good stuff ' to keep him balanced. About 5 minutes later he said he thought 2 of the medications were and .

Record review on at 1:00 pm revealed that Resident (#4) did not have any doctor order to crash her medication.

Interview on at 2:00 pm with Staff A revealed that she acknowledged that Staff C did not assist with self-administration of medication properly to residents (# s 2 and 4). Also, Staff A stated that she did not have a doctor order to crash Resident ' s (#4) medication.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on observation, record review and interview the facility failed to record properly the Medication at the Medication Observation Record (MOR).

Findings included:

Record review on at 11:00 am revealed that Resident ' s (#2) MOR ' s medication (10 mg tab/ 8:00 pm) it was already signed.
Further record review on at 11:10 am revealed that Resident ' s (#3) medication (2 mg tablet) it was not signed on , but it was signed on (pm) already. Also, per medication (20 mg) there was not time (hour) specified, and it was indicated per pharmacy prescription as two time a day, and it was signed only from -
Interview with Staff A on at 1:44 pm revealed that he also acknowledged that residents (#2 and 3) did not have their medications properly recorded at the MOR.

Class III

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

Based on record review and interview, the Administrator failed to include documentation of having a high school diploma on site in the personnel record.

Findings included:

Record review on of the administrator's personnel record revealed that a copy of the high school diploma was not on file.

During an interview on , the facility owner confirmed the findings and stated: "I don't know why it's not in the file."
Class III

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

Based on record review and interviews, the facility failed to ensure that two out of three (Administrator and Employees A and B) had evidence of a negative examination.

Findings included:

During record review on , an annual updates of the test for the Administrator and for Employee A, due by , were not found.

During a review of Employee B ' s personnel record on (Hire date 2010), no statement of freedom from communicable or was found.

During an interview on at 2:30 pm showed that Employee A stated that she and the Administrator did not have updated statements of freedom from . She stated "The doctor will be here next week to update them." She also stated that Employee B had never submitted a statement of freedom from communicable or even though she had been asked for it several times.

Class III

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

Based on observation, record review and interview the facility failed to have a health department review updated. Facility failed to have a staffing pattern in the facility.

Findings included

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Observation on at 9:08 am revealed that the facility had displaced a Health Department review dated on . Also, there was no staffing pattern displaced on the board.

Interview on at 11:00 am revealed that the Health Department needed to be update, and there was no staffing pattern in the facility at time of survey.

Class III

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

Based on record review and interview, the facility failed to keep documentation of the results of the Level II Background Screening on file for the Administrator.

Findings include:

Record review on of the Administrator's personnel record revealed that no documentation that a Level II Background Screening was conducted to verify that the Administrator was eligible to work at the facility.

Interview on at approximately 2:45 p.m., Employee A stated that the money had been paid and the Administrator had completed the background screen, but that they had not printed a copy of the results for the file.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record reviews and interviews, the facility failed to ensure that one of six sampled residents (# 1) receiving assistance with the activities of daily living was weighed semi-annually, and that the residents (# 1,4,5 and 6) signed the written informed consent to unlicensed staff assisting the resident with medication.

Findings included:

Review of Resident #1's record on revealed that the resident was last weighed on and that residents ' (#s 1, 4, 5 and 6) informed consents to unlicensed staff assisting with medication were not signed by the residents or facility staff.

During an interview on at approximately 1:00 p.m., Staff A said that she didn't know that Resident #1 hadn't been weighed recently. Moreover, she confirmed that she hadn ' t signed the informed consent.

Class III

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L241 - LMH - Records - 58A-5.029(2) FAC

Based on record review and interview, the facility failed to ensure that the require Community Living Support Plan for 2 of 2 sampled Limited Mental Health residents (Residents # 2 and 3) were updated annually. Facility failed to maintain an up-to-date admission and discharge for all mental health residents
Findings included:
During a record review on , only a Community Support Plan completed on was found in Resident 3 ' s file.
During a record review on , only Optional State Supplement from - was found in Resident 3 ' s file. Moreover, Resident 3 health assessment (1823) diagnosis was ' history of condition. '
Further record review on revealed that the admission / discharge log did not have Residents # 3 identify as Limited Mental Health residents.
Interview on revealed that Staff A admitted that Resident #3 was a Limited Mental Health, he received his Optional State Supplement and he was . Moreover, Staff A stated that she did not know that she had to identify resident # 3 as Limited Mental Health on the admission and discharge log.
During an interview at approximately 2:00 p.m. on , Employee A stated that the doctor would be at the facility next week and she would ask him to update the Community Support Plans.
Class III

L243 - LMH - Training - 429.075(1) FS; 58A-5.0191(8) FAC

Based on record review and interview, the facility failed to maintain documentation that the Administrator and 2 of 3 employees (Employees #A and B) received 3 hours of training every two years for Limited Mental Health designation.
Findings included:
During a review of records on , documentation of the Administrator ' s Limited Mental Health updated since 2012 Training was not found.
Record review on revealed that Employees #A and B had not received updated Limited Mental Health Training since 2012.
During an interview on with Employee A at approximately 1:30 p.m., she stated that facility staff had not updated the training.
Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, , 2015

Administrator
Better Care Home
7599 West 4th Court
Hialeah, FL 33014

Dear Administrator:

This letter reports the findings of a standard biennial survey that was conducted on , 2015 by representative(s) 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.

Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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 surveyor(s). Should you have any questions please call Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:kb
Enclosure
XG90

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