STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953536	**01/10/2018**
NAME OF PROVIDER OR SUPPLIER **BETTER LIFE ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **5750 NW 192 STREET** **MIAMI, FL 33015**	

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

0000 - Initial Comments

A Standard Biennial survey conducted on and concluded on at Better Life Assisted Living Facility. Better Life Assisted Living Facility had deficiencies at the time of the survey. Facility license #88774.

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

Based on observation, record review, and interview the facility failed to obtain a written physician order for use of half bed rails for one of seven Resident (#3) sampled residents. The facility failed to have two of seven sampled residents (#s 2 and 3) sleeping in their assigned . The facility failed to ensure that one of seven sampled residents (#1) did not have a bed against the resident's bed used as a . The facility failed to treat with dignity and respect for three of seven Residents (#s 1-3).

Findings included:

Record review revealed Resident #1 had a half bed rail order ( ) in the hospice book. Resident #3 did not have a bed rail order in his record.

Interview on at 10:00 am Staff A stated Resident #1 and #2 lived in # and Resident #3 and #4 lived in # .

Interview on at 12:50 pm Resident #3's sister stated, "My brother's #1."

Observation on at 6:20 pm revealed Resident #1 sleeping in # with a half bed rail plus a bed against her bed. However, Residents #2 and #3 were not on the premises of the facility.

Interview on at 6:20 pm Staff A confirmed, "Resident #3 left with his sister, and I do not know about Resident #2." The administrator started to yell, Resident #2's name.

Observation at 6:20 pm showed Staff A walked to the dark backyard yelling, yelling Resident #2's name. Then, Staff A walked around the facility still yelling Resident #2's name.

Observation on at 6:20 pm showed Staff A stood in front of the door and yell, "Open the door; it is me." A woman opened the door, and Resident #2 was coming out from the closet which was used as a a bed and clothes. The door had no space to open completely.

Interview on at 6:20 pm Staff A stated, "This no light." However, a man voice was

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overheard in the dark . Surprisingly, Staff A found the light and Resident #3 was the man who was talking.

Observation on at 6:23 pm revealed Resident #3 lying in bed with a full bedside rails. Another bed in the between those beds one mattress on the floor. In total, there were three beds in the unapproved two Residents (#2 and #3).

Record review revealed that Resident #1's ( ) health assessment had the following diagnosis, , 2nd degree Atrioronticular , type 2, and . Resident #1 needs total assistance with her daily living activities.

Record review revealed that Resident #2's ( ) health assessment had the following diagnosis: and ." Resident #2 had Gait , Low Memory, and and precaution.

Interview on at 6:42 pm, Staff A confirmed, "I know that I should not have seven residents living here, but my mother , and I have so much problems. I have no words or excuses. I am not allow to put Staff #3 to sleep in the renting full bed rail, and Resident #2 should be sleeping in # instead of being in the renting . Staff A also reported, "I put the bed against Resident #2's bed (#) because the hospice did not approve a full bed rail for her; they approve only a half bed rail. I was preventing her to ."

Class III

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

Based on observation, record review, and interview the facility failed to follow the correct procedure outlined by the state when assisting with self-administration of medications for seven of seven sampled residents (1-7).

Finding included:

Record review on at 11:07 am revealed the Medication Observation Records (MORs) documented night medications at 7:00 pm and 8:00 pm.

Interview on at 6:20 pm Residents #4 and #7 stated, "We all have our medications already."

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Observation on at 7:00 pm revealed the residents' (1-6) medication cards did not have medications for 7:00 pm and 8 pm. In addition, the Medication for at 7:00 am were not in the card.

Record review revealed the Residents' MORs for 7:00 pm and 8:00 pm were initialed as given. In addition, the medications for at 7:00 am were initialed.

Interview on at 6:30 pm Staff A stated, "We provide the medications for 7:00 pm and 8:00 pm at 6:00 pm; however, the pills for tomorrow ( ) are still here. They are inside of cups for morning and I signed them in advance."

Interview on at 7:10 pm Staff E confirmed that she provided the medications for 7:00 pm and 8:00 pm for all residents (1-7). Staff E also stated, "I works nightshift."

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observations, record review, and interview the facility failed to ensure that licensed personnel administer medications to one of seven (#1) sampled residents.

Findings included:

Observed on at 12:00 pm revealed Staff B feeding Resident #1.

A review of the Medication Observation Records (MORs) revealed Staff A was providing Resident #1 medications.
Record review revealed Resident #1's health assessment stated Resident #1 needed total assistance with activities of daily living.

Interview on Staff A stated, "I am providing Resident #1's medications due to hospice is not giving her the medications, but I will change of hospice agency.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview the facility failed to keep medications locked at all times.

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Findings included:

Observation on at 10:03 am showed medications (Ducolax Suppositories, , 660 mg suppositories and Olopatadine , 0.1 %) inside the refrigerator. The medications were unlocked.

Interview on at 10:03 am Staff A stated, "Those medications belonged to my mom, when she used to come here. She recently ."

Class III

0125 - Fiscal - Surety Bonds - 429.27(2) FS; 58A-5.021(3) FAC

Based on record review and interview the facility failed to have a surety bond with the minimum bond proceeds that equal twice the value of the residents' monthly aggregate income for one of seven (#5) sampled residents.

Findings included:

Interview on at 11:42 am Staff A revealed that the facility was payee to Resident #5. Staff A confirmed that the facility did not have Surety Bond.

Record review revealed the facility did not a surety bond.

Class III

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

Based on record review and interview the facility failed to have an accurate health assessment for one of seven sampled residents (Resident #1). The facility failed to have a hospice care plan for one of seven sampled residents (Resident #1).

Findings included:

Record review revealed Resident #1's health assessment (dated) was not updated regarding the level of medication assistance. Record review revealed Resident #1's hospice book did not have care update information. Last hospice care plan dated on - . It reflected Resident #1's last care to the right heel dated on . Record review revealed Resident #1 did not have an updated care plan in her file.

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Interview on at 11:30 am Staff A acknowledged Resident #1 did not have an update care plan in her file.

Class III

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on record review and interview the facility failed to have the emergency management plan reviewed annually.

Findings included:

Record review revealed that the facility submitted the emergency management plan (EMP) on . The facility's approved EMP was until .

Interview on at 12:00 pm Staff A confirmed that the facility did not have a receipt.

Class III

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

Based on observation, record review, and interview the facility failed to ensure that one of four sampled staff have completed level 2 background screening.

Findings included:

Observation on at 6:20 pm revealed Staff E was working alone in the facility with the census of seven residents.

Personnel record review of Staff E revealed staff did not have a level 2 background screening in the facility.

Interview on at 6:40 pm Staff A stated, "Staff E started to work three days ago."

Interview on at 6:40 pm Staff E stated, "I should not be working in this facility, but the woman who used to work here was yelling at the resident. And Staff A took her out and let me work here. I do not have papers, this is the reason, and I have no records.

Unclassified

Z828 - Administrative Fines; Violations - 408.813(3) FS

Based on observation, record review, and interview the facility failed to obtain a licensure capacity increase prior to providing personal care and meals to a census of seven residents. The facility provided services to residents outside the current license capacity of six.

Findings included:

Observations on at 9:30 am found Resident #7 sitting in the sofa at the living Residents 1, 3, 4, 5 and 6.

Interview on at 9:30 am Staff A stated, "Resident #7 is a daycare client, and he does not live in the facility." Staff A also stated that a family member would pick him up in the afternoon.

Interview on at 12:35 pm Resident #4 stated, "I have a (Resident #7). He lives here, too. He has his clothes and medication here. He is part of the facility as all of us."

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Observation on at 12:33 pm revealed Resident #7 nonverbal, he communicated with his hands. Resident #7 showed his , bed and clothes, which are in # .

Observation on at 6:15 pm revealed Resident #4 was sitting in the living . Resident #7 was also in # .

Interview on at 6:20 pm revealed Residents 4 and 7 stated, "We all have our medications already."

Record review revealed Resident #7's signed daycare contract dated was from 8:00 am to 4:00 pm.

Interview on at 7:10 pm Staff E reported she provided the medications for 7:00 pm and 8:00 pm for all residents (1-7).

Interview on at 7:12 pm Staff A stated, "I know I should not have seven residents living here, but my mother , and I have so much problems. I have no words or excuses. I am not allowed to put Resident #7 to sleep in that full bed rails, and Resident #2 should be sleeping in # instead of being in the private ."

Observation on at 7:30 pm found Staff A walked to the kitchen, and obtained eight named cups with pills inside. One of the cups belonged to Resident #7. Then, Staff A stated, "It is my fault; he takes his medications here; I was making him feel as it was his fault."

Unclassified