STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968228	**02/06/2018**
NAME OF PROVIDER OR SUPPLIER **BEST SWEET HOME ALF INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **8365 SW 147 COURT** **MIAMI, FL 33193**	

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

0000 - Initial Comments

An Abbreviated Biennial survey was conducted on . . . . . Best Sweet Home ALF with limited mental health component (AL 12160) had the following deficiencies identified at the time of the visit:

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

Based on observation, record review and interview, the facility failed to meet continued residency for 1 out of 6 (Resident #1) facility residents.

Findings as follow:

On . . . . . at 7:50 a.m. observed resident #1 in bed with both feet contracted.
On . . . . . at Resident Staff C and D lifted resident from the wheelchair and sat her on a couch. The resident could not stand up. Residents hands observed closed. Staff C stated the resident was not ambulatory and she was transferred by two Staff. Staff stated the resident was bed bound, ... and defecated in bed. Staff stated that she was bathed and changed in bed.

A review of Resident #1's health assessment dated . . . . . showed that the resident needed assistance with all activities of daily living except with dressing, for which she needed supervision.

Class III

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

Based on record review and interview the facility failed to have a Power of attorney for 1 out of 6 (Resident #1) facility residents. The facility also failed to ensure that Resdient #1's health assessment was accurate.

Findings:

1)Record review showed the contract (Dated . . . . .) was signed by the resident's son. Further record review showed the facility had no documentation of a Power of attorney available for Resident #1.

On . . . . . at 10:30 a.m. the administrator stated the Son of Resident #1 had the Power of attorney at his house.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968228	**02/06/2018**
NAME OF PROVIDER OR SUPPLIER **BEST SWEET HOME ALF INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **8365 SW 147 COURT** **MIAMI, FL 33193**	

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

2) On . . . . . at 7:50 a.m. observed resident #1 in bed with both feet contracted.

On at around 7:50 a.m, Staff C and D lifted resident from the wheelchair and sit her in a couch. The resident could not stand up. The resident's hands observed closed. Staff C stated resident was not ambulatory and she was transferred by two Staff. Staff stated that the resident was bed bound, ... and defecated in bed. Staff stated that the resident was bathed and changed in bed.

A review of the resident record showed that the resident was under hospice care.

A review of Resident #1's Health Assessment dated . . . . . showed that the resident needed assistance with all ADLs except with dressing, for which she needed supervision.

Class III